Organ Trafficking:  
The Construction of a Social Problem in Israel  

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Glossary

**Chief Rabbinate of Israel:** The supreme Halachic and spiritual authority for the Jewish people in Israel, comprised of one Ashkenazi and one Sephardic Rabbi.

**Halacha:** The collective body of religious laws for Jews.

**IDF:** Israeli Defense Force

**Kiddush HaShem:** "Sanctification of the name of God" is a precept of Judaism. It includes sanctification of the name of God by being holy.

**Knesset:** Israeli Parliament, the legislative branch of the Israeli government.

**NIS:** New Israeli Shekel. The current exchange rate is 3.6 shekel for one dollar.

**Pekuach Nefesh:** A principle in Jewish law, according to which the preservation of human life overrides virtually any other religious rule.
CHAPTER 1: INTRODUCTION

The availability and spread of advanced medical procedures and biotechnologies to all corners of the world alongside market forces and the economy have produced a transnational practice of organ transplant and transplant tourism, much of which is illegal and covert. These new transplant trades stand for various dichotomies—altruism and theft, consent and coercion, care and human sacrifice—where both donors and recipients follow new paths of capital and medical technology in the global economy (Scheper-Hughes, 2003). This study examines the phenomenon of trafficking in persons for the purpose of the removal of organs (hereinafter: organ trafficking) and focuses on Israel as a case study. In particular it focuses on its current implementation as well as its construction as a social problem.

The definition of organ trafficking as agreed internationally is stipulated in Article 3, paragraph (a) of the Protocol to Prevent, Suppress and Punish Trafficking in Persons (2003). It defines trafficking in persons as: "the recruitment, transportation, transfer, harbouring, or receipt of persons by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power, or of a position of vulnerability, or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation. Exploitation shall include, at a minimum, the exploitation of the prostitution of others or other forms of sexual exploitation, forced labour or services, slavery or practices similar to slavery, servitude, or the removal of organs." It is important to emphasize that this definition requires that the act of exploitation of adult "donors" be carried out by any of the means put forth in the definition, such as coercion or the threat of use of force.

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1 The protocol to Prevent, Suppress and Punish Trafficking in Persons was adopted by General Assembly resolution 55/25. It entered into force on 25 December 2003 and it is the first global legally binding instrument with an agreed definition on trafficking in persons. See: http://www.unodc.org/unodc/en/treaties/CTOC/index.html#Fulltext, last access January 2013.
fraud and deception. Therefore, according to this definition, not all cases of purchasing organs are considered as acts of organ trafficking per se. Thus, cases where the organs are obtained willingly through informed consent and without the use of the above mentioned means may involve moral and ethical dilemmas but according to article 3 they are not illegal organ trafficking acts.

The first part of this study provides a description of organ trafficking and addresses the question of whether organ trafficking is a crime or whether it is only a myth. Then, it discusses the spread of organ transactions to all continents and to multiple countries, and expresses the impact of globalization that affects both research and control of the phenomenon. This research examines the globalized character of organ trafficking as reflecting the old dichotomy between developed and underdeveloped countries, i.e., between organ recipient nations and organ supplier countries. The form of internal organ trafficking, where the organ donors and recipients are from the same region or country, is discussed as well. To better understand the crime of organ trafficking, this study also focuses on the dichotomy between the poor and the rich. This dichotomy is reflected with regards to organ trafficking (both globalized and internal) when the circulation of organs follows the established routes of capital from poorer to more affluent people, or when other marginalized people—distinguished from others by their race, class and gender—are lured into selling their organs.

The theoretical chapter that follows concentrates on the social construction of crime and the development of social problems. Blumer’s (1971) five stage model of this process and its revisions and modifications are then presented and discussed. The five stages include the following: the emergence of a social problem, the legitimation of the problem, the mobilization of action with regard to the problem, the formation of an official plan of action, and the
transformation of the official plan in its empirical implementation. The process of making claims, the influence of social changes, and other modifications of this model are then presented in order to lay the theoretical foundation of the research questions that follow.

The second chapter presents research questions as well as the research design and methods. Specifically, the research aim is to trace the five stage model and its later revisions in the development of organ trafficking as a social problem in Israel. The research questions can be summarized as the following: has the shortage of organs for transplantation and its byproduct phenomenon of organ trafficking become a social problem in Israel and, if so, how did this occur; who are the major players in the process of constructing this social problem; who are the claims-making groups that support or oppose organ trafficking in Israel; and what are the vulnerability indicators of the disadvantage groups in the crime of organ trafficking in Israel. In order to answer these questions, this research presents three forms of data collection: content analysis, in-depth interviews, and observations. The methodology chapter discusses their relevance to this specific research and to the construction of organ trafficking as a social problem in Israel. The strengths and limitations of these data forms are also discussed.

The Data Analysis and Discussion chapters that follow reveal that Blumer’s model and its modification are confirmed in the specific case of organ trafficking as a social problem in Israel. However, two other key issues related to context and social changes, as suggested by later theorists, also largely influence the process: the religious character of the political life in Israel as well as the globalized character of the crime of organ trafficking. The research concludes with an outline of its limitations and a few recommendations for future research. Nevertheless, a short discussion of the significance of this research as well as a brief explanation
of Israel's political situation regarding separation of state and religion are required prior to the literature review of organ trafficking.

**The significance of the study**

My passion for researching the construction of organ trafficking as a social problem in Israel emerged when I wrote a paper for a research methods course I took for my graduate studies at the department of Criminology, Law and Justice at UIC. It was then that I encountered the phenomenon of organ trafficking along with its cruelty and the exploitation of the people on both sides of the equation: donors and recipients. I realized that for lucrative considerations people are being exploited by using their poverty and other circumstances to get their "approval" for their organ removal (donors). I was also amazed by the fact that this phenomenon of organ trafficking occurred almost everywhere on the globe, underscoring the old adage: "it's a small world after all". A few years passed, and unfortunately organ trafficking still exists and appears occasionally in the news headlines. In spite of the progress both in researching the phenomenon and in its prevention, much work is still needed. Understanding the construction of organ trafficking and its various stages and outcomes as a social problem is a major step in this direction.

It is important to understand the process that begins with a need of organs for transplantation and results in the practice of organ trafficking. Understanding this process and how it has become a social problem in Israel as well as the stages of this process (i.e., the formation of an official plan of action such as the outlawing of organ trafficking in Israel from 2008) may assist in creating relevant laws or other official plans of action to fight the illegal phenomena of organ trafficking as well as related criminal phenomena. Moreover, understanding
this process will help Israel and other countries in dealing with the factors that inhibit or delay
the formal responses to various phenomena of crime and social deviance. There is a social need
to accelerate society's legitimate responses by defining criminal phenomena as social problems.
In other words, since current criminal phenomena are dependent on various areas of knowledge
(e.g., science and medicine in the case of organ trafficking) and processes such as globalization
and exploitation of underdeveloped populations in different continents and countries, it is
imperative to address them in their new context. The first step is to define these behaviors as
social problems.

Furthermore, researching the construction of organ trafficking as a social problem in
Israel may also disclose different factors involved in the process either as initial barriers (i.e.,
religious beliefs) or as accelerating factors (i.e., access to media resources or government
support). These factors will be discussed broadly; however, understanding the opposing forces
that influence the process of constructing a phenomenon as a social problem (seen from one side
or the other) will enable their application in other countries or with different criminal
phenomena. The results of this research may help lay the foundation for the construction of other
social problems with similar characteristics of modern life, such as globalization.

However, it is important to understand that the phenomenon of organ trafficking does
not stand alone. Transplant tourism or any other form of organ trafficking is a direct outcome of
a severe shortage of organs for transplantations. In fact, the lack of available organs for
transplantations is the main cause for illegal organ trafficking. Therefore, while this research
focuses on organ trafficking, it also thoroughly examines the construction of the shortage of
organs for transplantations and the desire to increase legal organ donations' rates in Israel as a
social problem. In that sense, organ trafficking is a byproduct of the absence of organs for
transplantations, and it is noticeable throughout the different stages of the Israeli social problem. Indeed, this research reveals that these two interrelated issues (i.e., illegal organ trafficking and the shortage of organs as well as the desire to increase legal donation rates) were jointly constructed as the Israeli social problem.

In other words, the social problem was defined differently by diverse stakeholders and in different stages of its development, so that it was mutated into new categories and definitions of the same reality. Thus, according to a specific stage of its construction as an Israeli social problem and with respect to the specific stakeholder's interests, illegal organ trafficking was also regarded and defined as all of the following: the lack of organs for transplantations, the Israeli desire to increase organ donation rates, the Israeli immorality of being involved in global medical tourism, and its cultural concern to be condemned by the family of nations due to this involvement. Therefore, the specific definition used was in accordance with the stage under screening or with the interest group that was presented. No matter what term is used, all the terms represent the same constructed Israeli social problem: one that has been mutated into different definitions of the same reality. Another unique character of this social problem is that the social construction is mostly of the solution to the problem rather than the problem itself. As will be presented during description of the different stages of the social construction, the different interest groups involved strive for different solutions for the problem rather than the problem's definition.

This variation of the social problem definitions used by opposing interest groups and in accordance to the specific stage of the social problem construction reflects different, however related, acts: organs harvested from deceased and live donors. Thus, for instance, when the social problem focus was on increasing donation rates in Israel the terms "opting-out", "presumed
consent system", and "donor cards"—which are all related to cadaver organs—were used in the discussion. In other stages of the construction of the Israeli social problem or when the point of views of opposing interest groups were presented—for example, while discussing the Israeli 2008 legislation and the donors' remuneration—the focus remained on live donors. This distinction is important to understand and it is done by context.

It is also important to emphasize that there is a reciprocal connection between lawful and unlawful organ transplants and that they are inversely related. In fact, the social desire for the legitimate form of organ donations is the direct outcome of the social revulsion to the crime of organ trafficking. For example, this study claims that the 2008 criminalization of organ trafficking in Israel\(^2\) is the result of the illegal activity of organ trafficking and its definition as a social problem in Israel. Accordingly, one may imagine an ethical scale in which one end is the legitimate form of altruistic organ donations, mostly done between relatives and considered both ethical and legal, while the other end is criminal organ trafficking, done mostly for economic considerations and greed, which is illegal and unethical. The understanding that an increase in the legal organ donations has a major influence on the criminal activity of organ trafficking is a key factor in this research. Another key factor is the social and political context in Israel, where separation of state and religion is a complex and sensitive issue.

**Separation of state and religion**

Since this research study focuses on the construction of a social problem in Israel, it is crucial to understand the social and political situation that currently prevails in Israel. Specifically, it is important to understand that in Israel, unlike other democratic countries where

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\(^2\) This law is the first official legally binding prohibition of organ trafficking in Israel.
there is distance in the relationship between organized religion and the nation state (i.e., separation of church and state), there exists an integral complicated relationship between state and religion, and there is no separation between state and synagogue. In fact, the place religion takes in Israeli society's day-to-day life and its role in formulating government policy exceeds that envisioned by the state's founders. This complex issue of separation of religion and state in Israel can be seen either as a political struggle that revolves around preserving the power of political institutions, or as a struggle between Judaism on one hand and the democratic character of the state on the other.

Israel was founded as a Jewish state, and this is a definition that bares several practical implications. The following is a few examples of the Jewish nature of the state: The Law of Return (1950) gives Jews the right of return and settlement in Israel and grants them citizenship; the Jewish holidays are Israel’s national holidays and the days off from school and work, and Saturday is the formal day off when public transportation is prohibited; personal matters such as marriage and divorce are adjudicated (for Jewish couples) by rabbinical tribunals. All these and more reveal an image of a country that has an official religion and no separation between religion and state. Yet, Israel has a religious tolerance policy, and therefore citizens who are not Jewish are free to practice their religion. Secular Jewish citizens who do not perceive themselves as religious and non-Jews are not obliged to practice Judaism as long as they do not violate Israeli law.

To summarize, the issue of separation of religion and state in Israel is a constant heated debate. On the one hand, secular Jews and non-Jews have no desire to practice the religious commands and laws. Their main argument is that a modern democratic state should not impose outdated laws on its citizens against their will. On the other hand, religious people and their
supporters argue that separation of religion and state will result in the loss of Israel's character as a Jewish state. The Jewish nature of Israel has crucial political importance, and is declared in Israel's declaration of independence as well as on Israel's basic laws. Even though Israel has no constitution, being a Jewish state is one of the main principles secured in Israel's basic laws in conjunction with being a democratic state. This allows for many different interpretations of the basic laws and the intention of the legislature, and may be at times to the satisfaction of one party and at other times to its chagrin.

This intense debate regarding separation of state and religion involves all levels of society: from the level of the legislative branch (The Knesset) regarding various laws and their implications to the level of the people who may protest violation of religious rules—for example, by blocking roads in strict orthodox neighborhoods on Saturdays so that transportation will not pass through, or by holding public protests that call to allow raising pigs in Israel (pigs not being Kosher), or to recruit religious youth to the Israeli Defense Force, which is mandatory for non-religious Jews but not for religious Jews who wish to be Yeshiva students. This conflict is well rooted in Israeli society's daily life and public policy agenda, and it seems to intensify with time. Its influence is also noticeable in the construction of organ trafficking as a social problem in Israel as discussed in the next chapters.

Organ trafficking - a myth or an actual crime?

Several internet sources as well as national and international tabloids and the mass media offer horrifying stories about organ trafficking occurring throughout the world. Their argument is that organs are taken from human beings without their consent and sold on the black market for enormous amounts of money (Meyer, 2006). Donovan (2002) exemplifies it with a mass
distributed email message titled "reason not to party anymore"\textsuperscript{3}, which tells the story of a drunken student whose kidney was stolen. Scheper-Hughes (2006) argues that organ theft jokes, science fiction novels, surreal films, and urban legends deflect attention from the real trafficking of humans and their body parts. Accordingly, stories about the removal of organs from murdered children in Honduras, Guatemala, Argentina, and Brazil have been occurred. Such allegations have been stated not only by media journalists but also by national and international officials. For instance, the rapporteur for a committee of the European Parliament accused: “Organized trafficking in organs exists in the same way as trafficking in drugs ... it involved killing people to remove organs which can be sold at a profit” (Rothman, Rose, Awaya, Cohen, Daar, Dzemeshkevich, Lee, Munro, Reyes, Rothman, Schoen, Scheper-Hughes, Shapira, and Smit, 1997). But what is organ trafficking really about? Is it a myth or an actual crime? And what forms does the crime of organ trafficking take?

Both Donovan (2002) and Meyer (2006) conclude that the stories of organ- snatching criminals, who kill people in order to sell their organs, are more a crime legend or a myth than anything close to reality. Rothman et al. (1997) agree that there is no reliable data of murdered or kidnapped people of any age for their organs to validate these rumors. It might be that individual cases of this unproven form of organ trafficking did occur, but it is rather unlikely.

However, organ trafficking does exist, and even though its new form is not precisely taking people's lives, it does include exploiting their vulnerability for a monetary gain. This study focuses on this latter form of organ trafficking, the one that is documented and constitutes

\textsuperscript{3} See Donovan (2002), at 199. For example of a TV show, see Sanal (2004), at 281-2.
an actual crime, as well as a severe violation of human rights\(^4\). According to Aronowitz (2009), organ trafficking is in fact a hidden form of human trafficking since most of the attention has been directed toward international trafficking for the purpose of sexual exploitation and other forms of forced labor. Nevertheless, the author emphasizes that the trafficking of human beings for the purpose of organ removal (among other forms of hidden trafficking) does occur and requires more attention. Thus, for example, the WHO estimated that in 2004 10% of kidney transplantations worldwide were in recipients from developed countries who got the needed organ in underdeveloped countries (Jafar, 2009).

Moreover, current social problems are influenced by political and global changes, such as the opening of borders, which increase international communication and mobility, and make domestic affairs more "glocal"\(^5\). Thus, for example, Jamrozik and Nocella (1998) suggest that with the growing globalization of economic and political issues the studies of social problems should also aim to develop a global perspective; this would help to identify the diversity of social problems and their interrelationship in various parts of the world. Therefore, to fully understand the phenomenon of organ trafficking and its practices an initial examination of the social economic theory of globalization is required.

Globalization

Stiglitz (2002) defines the phenomenon of globalization as: "the closer integration of the countries and people of the world that has been brought about by enormous reductions of costs of transportation and communication, and also as the breaking down of artificial barriers to the flows of goods, services, capital, knowledge and people across borders." After all, as Stiglitz

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\(^4\) An example of how the actual crime of organ trafficking is done may be found at: [http://ipsnews.net/interna.asp?idnews=22524](http://ipsnews.net/interna.asp?idnews=22524) by Osava, M., last access on January 2013.

\(^5\) "Glocalization" is a mixture of globalization with local considerations.
exemplifies, no one wants to see their child die when knowledge and medicine are available somewhere else in the world. Thus, the following can be argued: globalization helped many countries grow far more quickly than they would have otherwise; many people in the world now live longer than before, and their standard of living is far better; and globalization has reduced the sense of isolation and has given people in developing countries access to knowledge, new technologies, and new markets and industries.

However, globalization has another dimension that seems to be darker. Stiglitz (2002) argues that globalization has not brought the promised benefits to many people in the developing world. Accordingly, the growing distinction between the haves and the have-nots has left increasing numbers of people in developing countries in dire poverty, living on less than a dollar a day. In too many instances, the prices paid for globalization were greater than the benefits since globalization also failed to ensure economic stability and caused the following: environmental damages, corrupted political processes, a massive growth of unemployment rates, and it also brought longer term problems of social dissolutions, including urban violence and ethnic conflicts. For instance, Glenny (2008) claims that what the ordinary citizen may gain in terms of lower food prices, they are at risk of losing in terms of criminal activity. With regard to the specific phenomenon of organs trafficking, Scheper-Hughes (2002) states that globalization has encouraged the development of new forms of “debt peonage” in which the commodified and fetishized organ occupies a critical role as someone’s ultimate collateral. Thus, for example, the spare kidney represents someone’s last economic resort.

Stiglitz (2006) refers once again to the two faces of globalization, and he emphasizes the idea that those who are discontented with globalization do not object to the greater access to global markets or to the spread of global knowledge. Rather, they raise five major concerns: first,
the rules governing globalization are unfair and specifically designed to benefit the advanced industrial countries; second, globalization advances material values over others such as a concern for the environment or for life itself; third, it is argued that globalization took away much of the developing countries’ sovereignty and undermined their democracy; fourth, although it was claimed that globalization will benefit everybody, there are many losers in both developing and developed countries; finally, globalization opponents argue that the economic system has been pressed upon the developing countries, sometimes even forced upon them. When analyzing globalization and poverty, Stiglitz (2006) points to one of the above mentioned concerns and emphasizes the growing number of people living in poverty. Accordingly, globalization has lifted several hundred million people out of poverty outside of China, while poverty in the developing world has increased over the past two decades. The worst example of failure is Africa, where the number of people living in extreme poverty has almost doubled.

Jamrozik and Nocella (1998) claim that social problems experienced on a global scale and particularly in third world countries—such as chronic poverty, malnutrition, and disease—are due to a number of interrelated factors, but the relentless pursuit of higher living standards in industrialized countries is one of the main determinants. Thus, they argue that any significant improvement in the quality of life in poor countries would depend greatly on the redistribution of resources on a global scale, or in other words, on lowering material consumption in affluent countries. However, the authors claim that redistribution of this kind is most unlikely since in the dominant world economic and political systems of such global measures would be regarded as "an impossible solution, or as empty rhetoric and a utopian notion".

Castells (2004) follows the same reasoning and claims that "the states’ control over space and time is increasingly bypassed by global flows of capital, goods, services, technology,
communication, and information". Accordingly, the state's power is undermined by globalization of economic activities, communication and by globalized crime, including the crime of human organs trafficking. Castell’s argument is that globalization, in its different dimensions, slowly weakens the autonomy and decision-making power of the different states. Moreover, Stiglitz (2002) argues that although we still have a process of globalization, we do not have a world government to oversee the globalization process in a fashion comparable to the way national governments guide the nationalization process. There are a few institutions that are closely linked to certain financial and commercial interests\(^6\), but many of those affected by their decisions are left nearly voiceless.

Therefore, Stiglitz (2002) argues that globalization can be reshaped to run properly and fairly with all countries having a voice or influencing the policies that affect them and that its growth can be more equitably shared. Stiglitz (2006) takes a further step and calls for a globalization reform. His argument is that globalization can be restructured so that those in both developed and developing countries, as well as current and future generations, will benefit. For him:

… another world is possible…necessary and inevitable… [a world where] we can have stronger economies and societies that put more weight on values, like culture, the environment, and life itself. (Id, at 24.)

Glenny (2008) traces the astonishing growth in organized crime around the world in the last twenty years and argues that the extent of the internationalization of organized crime would not have been possible without globalization, particularly the deregulation of international

\(^6\) Among these institutions one may find the World Bank, the IMF and the WTO, but since the discussion is mainly economic this research will not refer to it.
financial markets. His argument is that global markets that are either insufficiently regulated or markets that are too closely regulated spurred the dramatic growth of organized crime.

Scheper-Hughes (2003; in Beauchamp, Walters, Kahn & Mastroianni, 2008) refers specifically to the crime of organ trafficking and states that global capitalism has distributed to all corners of the world—not only advanced medical technologies, medications and procedures, but also new desires and expectations—and all those together have created strange markets and occult economies. Thus, the author claims that the ideal conditions of economic globalization have put into circulation mortally sick bodies traveling in one direction and healthy organs in another, and have therefore created an international market for organs’ trade. The emergence of these globalized organs markets, with links to organized crime, created a spectacularly beneficial medical tourism, much of it illegal and clandestine. The following chapters demonstrate how this crime of organ trafficking is spread over different continents and nation-states, how it is globalized by nature, and as such how it affects its research and control.

**Supplier and Demanding Countries**

The demand for organ transplants in rich countries is rising much faster than the supply of organs donated through traditional means. In response, a growing number of the worlds' poor are offering up their body parts for sale. The trade in organs from live donors generally flows from poor underdeveloped countries to rich developed ones, and kidneys are the most commonly purchased organs (Scheper-Hughes, 2005). Fox and Swazey (1992) argue that by 1990 trafficking of “human spare parts” was a booming business in developing countries that had no organized system for procuring cadaveric donor organs, no brain death statute, and no specific laws banning the sale of human organs and tissues. In fact, the donor countries are these with
extremely low socio-economic levels and very high unemployment rates, where most people have almost no chances to cover their living expenses. The demanding countries, on the contrary, are mainly industrial countries where a shortage of organs exists (Meyer, 2006). Schepers-Hughes (2003; in Beauchamp et al., 2008) mapped the routes and the international medical and financial connections of organ trafficking and found that it can bring together parties from three or more countries. For instance, one well-traveled route is that of small groups of Israeli patients that travel to Turkey where they are matched with kidney sellers from rural Moldova or Romania and are transplanted by a team of Israeli and Turkish surgeons. Another network unites European and North American patients with Philippine kidney sellers in Manila, arranged through an independent internet broker7. Table 1 exemplifies the regional patterns of organ trafficking.

### TABLE I: SUPPLIER AND DEMANDING NATIONS

<table>
<thead>
<tr>
<th>Common Countries for Donors</th>
<th>Common Countries for Recipients</th>
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<td>Bolivia</td>
<td>Australia</td>
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<td>Brazil</td>
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<td>China</td>
<td>Hong Kong</td>
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<td>Columbia</td>
<td>Israel8</td>
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<td>Egypt</td>
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<td>Malaysia</td>
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<td>Iraq</td>
<td>Oman</td>
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<td>Israel9</td>
<td>Saudi Arabia</td>
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<td>Moldova</td>
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<td>Nigeria</td>
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*Source: Aronowitz (2009).*

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7 See: [http://www.liver4you.org/](http://www.liver4you.org/), access to the original illegal website is no longer available since 2009.
8 Israel may also serve as an example of internal organ trafficking that will be discussed independently below.
9 Israel may also serve as an example of internal organ trafficking that will be discussed independently below.
Below are some examples to illustrate the differences between these two extremes: supplier as opposed to demanding countries.¹⁰

**Supplier Countries**

According to the World Health Organization and as published by Reuters.com¹¹ the five hotpots of organ trafficking are China, Pakistan, Egypt, Colombia and the Philippines. Below is a list of some of the major supplier countries and states. It is important to note, however, that there are more stories that are still untold.

**China**

On March 28, 2006, China's Health Ministry issued legislation that prohibited the trade of human organs and enforced regulation that requires written consent of organ donors. This legislation also mandate all hospitals with transplant units to form ethics committees in order to supervise each transplant procedure performed (Wuan, 2007). This relatively recent legislation will be discussed below; nevertheless, it is also important to examine China's former market in human organs.¹²

Prior to 2006, China's organ allocation system was based on sacrificing the life of an offender in order to save the life of one wealthier. Foster (1997) states that the practice of harvesting organs in China was organized by the government that was directly involved in

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¹⁰ Due to the paucity of scientific research, media reports, particularly newspaper articles and websites, were identified as significant complementary, and were cited in footnotes. That will be discussed in the methods chapter.


planning, implementing and profiting from organ trafficking from executed prisoners. Woan (2007) reinforces the existence of this phenomenon by referring to experts' reports proving that "…approximately ninety percent of all organs transplanted in China came from executed prisoners, yielding tens of millions of dollars in profit to the Chinese government." Rothman et al. (1997) claim that although the precise number of Chinese prisoners executed for their organs is not known, local news reported on roughly 2000 executions, and formal organizations (i.e., Amnesty International) argue that more precise estimate may be four to five times greater. With unlimited supply of organs (available almost on demand), Chinese hospitals were able to gain the financial profit and meet the demand for organs of recipients coming from other countries.

However, it is important to emphasize again that the new Chinese ethical guidelines expressly disapprove of obtaining organs from executed criminals without their consent and confirm China's absolute rejection of organ trafficking. Yet, the crucial question that should be asked is does it really work? In other words, did the Chinese well-organized system of organ transplantations supported by the government cease, or does it still cost the lives of prisoners who may be considered worthless people. Matas and Kilgour (2007) published a report with regard to allegations of organ harvesting of Falun Gong practitioners in China13. They have concluded that since 1999 the Chinese government was involved in the mass killing of unknown number of Falun Gong prisoners of conscience in hospitals, detention centers and "people's courts". These people, who became illegal by President Jiang since they belonged to organization that threaten the dominance of the ruling Communist Party, have been executed for their vital organs. Matas and Kilgour (2007) have also verified the allegation that the organs are

13 The detailed report is also available at: http://organharvestinvestigation.net Last access on January 2013.
involuntarily harvested\textsuperscript{14} from the prisoners while they are still alive and they are killed in the course of the procedures or immediately thereafter. Since the killed prisoners are then cremated, there is no evidence left. The authors do not hesitate to declare, based on their research\textsuperscript{15}, that these operations are a form of murder, a crime against humanity, and a severe human rights violation.

The report also refers to two other corroborating studies; both of them have come to the same conclusions. The first is a study by Kirk Allison, associate director of the program in human rights and medicine at the University of Minnesota, released on July 2006, which concluded that organ harvesting from Falun Gong prisoners did occur. The other inquiry was carried out by European Parliament Vice President Edward McMillan-Scott, who visited China in May 2006\textsuperscript{16} and interviewed two witnesses. Below is a section of one of these inquiries:

…enquired whether he was aware of any organ harvesting camps in China. He said he definitely knew of them and knew people who had been sent to them. He had seen the cadaver of one of his friends, a Falun Gong practitioner, with holes in his body, where the organs had been removed.

After Cao Dong left his meeting with McMillan Scott, he was arrested. He was prosecuted in December on four charges (Matas and Kilgour, 2007, at p.62). This is only some of the evidence the authors refer to in their report to support their disturbing conclusions.

It is important to emphasize the financial motive behind the horrific crime of organ trafficking in China. For instance, the Bloody Harvest Report refers to the Chinese health sector that lost government funds when China shifted to a market economy. As a result, organs became

\textsuperscript{14} Organ harvesting is a first step in the transplantation; its purpose is to provide the needed organs. Therefore, it can be done in a different location than the transplantation.

\textsuperscript{15} To understand the methods used as well as the horrific conclusion discussed one should read the detailed report, Supra note 11.

\textsuperscript{16} Both Kirk Allison and Matas and Kilgour could not get a visa for such a visit in China.
a financial source for hospitals, by which other health services could be provided. This desperate monetary need rationalized the idea that harvesting organs from prisoners whose life has no value was acceptable. It also allowed for not to question whether the prisoners were truly sentenced to death. Another example brought up in the report to emphasize the financial motive of organ trafficking is that of the Chinese army. The military, like the health system, has gone from public financing to private enterprise and has become a firm business that should cover its budget and increase income. Many of the Chinese hospitals and transplant units are run by the military and are financed by selling organs. However, the financial profit achieved is greater than needed to balance the hospitals' budget and it is used for the entire military expenses. Furthermore, the military is also involved in organ trafficking done in civilian hospitals. According to testimonies, organ transplantations in civilian hospitals were performed by military personnel that are impervious to the rule of law (Matas and Kilgour, 2007). There is no doubt that China serves as a terrifying example of organ trafficking and the exploitation of people who cannot secure their unfortunate fate for lucre considerations. Below are a few more brief examples of where and how the crime of organ trafficking is practiced throughout the world.

**The Far East**

In the Philippines, kidneys are legally purchased on an open market. Medical teams go into the poor areas, perform blood and tissues tests, and store the results. When a recipient arrives for a transplant the broker finds a donor based on these results. This practice is defended as a matter of free choice. The same trends are also found in Singapore and Thailand (Teagarden, 2005). It is important to note, however, that as of April 29, 2008, the Philippine government has
permanently banned organ transplants for foreigners in the country. Nevertheless, the ban does not affect Filipino donor-recipient arrangements, and its outcomes are still unclear\textsuperscript{17}.

This is also the case in India, where organ transactions are conducted openly in most states, and the phenomenon of "medical tourism", in which affluent Europeans, Middle Easterns, and Americans contract with Indian agents to arrange for transplantation, is common (Foster, 1997). In fact, Fox and Swazey (1992) argue that according to \textit{India Today}, one of India’s main newspapers, India led the world market in buying and selling kidneys from unrelated living “donors”, growing from an estimated 50 transactions in 1983 to more than 2,000 in 1990 and it seems that the numbers are still growing. For example, even though these “donations” became illegal in India, a kidney ring that was involved with around 400 to 500 kidney transplants over the previous nine years was exposed in January 2008\textsuperscript{18}. Moreover, since this legislation allows for hospital committees to permit nonrelated donors to give organs for transplant if they are emotionally close to the recipients, unrelated people are actually selling organs with 'approval' of the hospital authorization committees that recognize such an “emotional closeness.”\textsuperscript{19}

Furthermore, sometimes the ban on organ transactions in one country leads to higher rates for these transactions or other illegal activities related to organ trafficking in neighboring countries. Thus, for example, even though medical tourism of organ recipients to India declined due to new regulation banning the sale of organs, it was along with a growth in transplant tourism in other countries, such as Pakistan and the Philippines as well as in the underground black market in India (Shimazono, 2007).

\textsuperscript{17} See: \url{http://www.medicalnewstoday.com/articles/105980.php} by Paddock, C. last access January 2013.
\textsuperscript{18} See: \url{http://www.nytimes.com/2008/01/30/world/asia/30kidney.html?_r=1&ex=1359349200&en=b4c62} by Gentleman, A. last access January 2013.
\textsuperscript{19} See: \url{http://www.vachss.com/help_text/archive/despite_ban.html} by Kumar, S. Last access on January 2013.
South America

According to Foster (1997), there is no firm evidence to support the organ snatching allegations in Latin America, and as a result he refers to these allegations as myths and rumors. Unfortunately, more current research proves the opposite. For example, Scheper-Hughes (2002) found that in Brazil many desperate people are willing to sell their kidneys for as little as 1,000 USD, and many of them wait outside transplant units hoping for a good match with a prospective buyer. In Argentina, the researcher discovered a horrific story of organ trafficking in an institution for the mentally disabled, where blood was taken from living inmates and cornea from the deceased almost always without consent. Aronowitz (2009) affirms these allegations and claims that Brazil and Columbia are the countries most often affected by international organ trafficking.

East Europe

The deprived countries are those that their citizens will mostly sell their organs to organized criminals. Within Europe, the countries most often associated with trafficking of human organs are Moldova, Ukraine, and Turkey. Most donors originate from Moldova and Ukraine whereas most transplantations are carried out in Turkey. Beyond these countries, Bulgaria, Georgia, Romania, and Russia have also reported the recruitment of donors for organ trafficking (Meyer, 2006).

The Middle East

Other supplier countries are Iran and Iraq, and South Africa, where organ sellers are recruited from the army, jails and prisons, unemployment offices, markets, and bars. In fact, Iran

20 See also Osava (2004), Supra note 2.
sponsors an official government program, the only one of its kind that regulates the sale of kidneys from poor donors to rich recipients (Scheper-Hughes, 2004). Jafar (2009) discusses this Iranian regulated system from 1988, which allows organs sale by living, unrelated, paid donors. In fact, the author stresses that the government register potential donors that go through a rigorous evaluation process of informed consent. Middlemen are not involved in the state-run program, which offers each donor a fixed amount of 1,200 USD, as well as free or post-transplant care. In 2007, approximately 1,500 kidney transplants were performed in Iran, 70% of which were compensated. Due to this model that substantially increased kidneys' availability the Iranian transplant waiting lists have been eliminated. However, transplant tourism is illegal in Iran and foreign nationals have no access to this regulated system. Jafar (2009) also reveals critics of the Iranian model and raises some ethical concerns. Thus it is claimed that even in the context of this legal model, coercion and financial duress are still present and may lead to exploitation of the poor and powerless. Furthermore, the fixed price per organ in the state run model seems to be unjust for the Iranian donor since it might be grossly undervalued compared with the potential price in a free unregulated commercial market. Other examples of supplier countries are found by Scheper-Hughes (2003; in Beauchamp et al, 2008), according to whom wealthy Palestinians travel to Iraq where they can buy a kidney from poor Arabs coming from Jordan.

**Africa**

Another route of organ tourism is the one established by a Nigerian doctor or broker that facilitates organ transplantations in South Africa or Boston, USA, according to the recipient’s choice, with a ready supply of poor Nigerian kidney sellers. The purchase agreement of that transaction is notarized by a distinguished law firm in Nigeria (Scheper-Hughes, 2003; in
Beauchamp et al, 2008). Moreover, according to Aronowitz (2009) not only is South Africa the second transplant tourism hub, there have also been media reports relating the trafficking of West African and Nigerian children to Europe for their body parts.

All of the above mentioned examples of supplier countries follow the same pattern of poor countries with very low rates of socio-economic levels or so-called private enterprises, such as the army and the health system in China, that need to cover their declining budget. On the other side of the equation, one may find the demanding countries as described below.

**Demanding Countries**

**United States**

According to Woan (2007) despite the formal ban on organ commodification in the United States, the market for organs is alive and thriving within American borders. Legal obstacles in the domestic level lead US recipients to look for organs in the international marketplace. In 1984, the U.S. Congress passed a law that made organ transaction an illegal act punishable by up to 50,000 USD fines, five years in prison, or both. Thus, according to National Organ Transplant Act; 42(a) USC § 274e - *Prohibition of organ purchases*\(^21\):

> It shall be unlawful for any person to knowingly acquire, receive, or otherwise transfer any human organ for valuable consideration for use in human transplantation if the transfer affects interstate commerce. The preceding sentence does not apply with respect to human organ paired donation.

Nevertheless, American recipients may avoid U.S transplant laws by traveling abroad for their needed organ and medical procedure. Another involvement of the United States in the organ market is described by Scheper-Hughes (2003; in Beauchamp et al, 2008) whereby

\(^{21}\) For further reading of the law, see: [http://www.law.cornell.edu/uscode/text/42/274e](http://www.law.cornell.edu/uscode/text/42/274e) last access: January 2013.
brokers in Brooklyn, New York, posing as a non-profit organization, traffic in Russian immigrants to service foreign recipients from Israel who are transplanted in some of the medical facilities on the east coast of the U.S. Accordingly, Aronowitz (2009) argues that organ donors and recipients meet in some of the finest hospitals in the world within the U.S. to carry out the illegal transplantation. For example, the author mentions reports of eastern Europeans that are trafficked to the U.S. and forced to sell their kidneys.

Furthermore, despite the altruistic organ allocation program, an American economic market for organs does exist. Thus financial considerations take place throughout the current model: organ recipient pays to receive the organ, procurement professionals are paid to recruit donors, doctors are paid to transplant the organ, and organ procurement organizations are paid for their services. The only service not receiving financial compensation seems to be the giving of the organ by the donor (Woan, 2007). In fact, even this service according to Foster (1997) is paid, and in many cases the donor is surreptitiously rewarded for his or her service. It is mostly common in interfamilial organ donation where the donor may get a new business or a new house just after he has donated his organ.

**Middle East**

In the Middle East, from the Gulf States to Israel, transplantable organs are extremely scarce due to religious reservation that is both Jewish and Islamic. Consequently for the last twenty years, organized programs have carried patients from Israel, Saudi Arabia, Oman, and Kuwait to transplants abroad (Scheper-Hughes, 2004). Thus, Rothman et al. (1997) reveal that in countries where religious or cultural beliefs prohibit organ donations the organ shortage is even worse. In the Middle East, religious principles discourage and sometimes inhibit cadaveric
organ donation. Islamic teachings, for example, require maintaining the body integrity at burial, and even though many religious leaders perceive organ donation as a gift of life, others continue to object to this practice. In the same manner, some orthodox Jewish rabbis sanction organ donation from the death on the grounds of "pekuach nefesh", the need to save a life. However, others reject the idea of brain death (comparing the use of organs from alive but debilitated with murder); therefore, organ retrieval becomes almost impossible\textsuperscript{22}. In fact, Israel is a major player in the global market for organs; its citizens purchase proportionally the largest number of organs in the global market, due to a highly educated and medically conscious public and a very low rate of organ donation. The Israeli Minister of Health has permitted the expansion of transplant tourism, which operates in one direction only, and no organs are sold from Israel to the global market (Schepер- Hughes, 2002).

**European Countries**

In some European countries where there is a major shortage of transplants (i.e., Belgium, Cyprus, Croatia, France, and the UK), citizens travel to donor countries in order to receive an organ in the black market (Meyer, 2006).

**Internal Organ Trafficking**

Wilson and Dalton (2008) claim that although human trafficking is a growing global concern, it is ultimately a problem identified locally. This is also correct when discussing organ trafficking. Internal organ trafficking is when the organ donors and recipients are from the same region or country. Israel is a prime example of a country where internal organ trafficking takes place (see Table 1) (Aronowitz, 2009). Even though medical tourism is not required in internal

\textsuperscript{22} These rationalizations, among others, against legal organ donations (in Israel) will be discussed thoroughly in the data analysis chapter of this research.
trafficking, exploitation and abuses of human rights are still inherently involved. Unfortunately, the problem of internal trafficking is more difficult to identify than international trafficking, and therefore it may be completely underestimated.

To conclude, these examples reflect the idea of globalization where the dichotomy between organ donor nations and countries, where socio-economic levels are very low, and organ recipient nations, which are more developed industrial and rich countries, is being re-enforced. The following chapter will examine the same unequal division with regard to people instead of countries.

The people involved

The rapid growth of "medical tourism" for transplant surgery and other advanced biomedical procedures as well as the black market of organs have emphasized the divisions between those who have and those who have-nots. In fact, this new globalized medical procedure separated the world into two groups: organ donors and organ recipients. This apartheid medicine privileges one class of patients, organ recipients, over another class of unrecognized "patients", organ donors, about whom almost nothing is known (Schepers-Hughes, 2002). This chapter will focus on the people involved in both sides of the equation: organ "donors" and the organ recipients.

Schepers-Hughes (2005) summarizes the characteristics of the typical organ "donor" as opposed to those of the typical organ recipient. Accordingly, the typical seller will be a Philippine male, aged 28.9 years with an annual family income of 480 USD and seven years of education. In sharp contrast, the organ buyer typically will be an Israeli male aged 48.1 years with an annual family income of 53,000 USD and a university degree level of education.
However, it is still crucial to understand who the different actors involved in this phenomenon of organ trafficking really are, what their motives are, and what consequences they have to face after the transplantation is over.

**The Recipients**

With regard to organ recipients, Sanal (2004) discovered that while affordability is the major motivation influencing their decision to buy an organ from a living donor, the recipients share other characteristics that may also influence their decision. For example in Turkey, most patients share the same family structure, place of birth, education, gender, income level, profession, and age range. All of these play a significant role in the decision to buy an organ from a poor seller. Other major influences are the quality of public insurance of the patient, and other patients' opinions, experiences, and advice. For example, most of the Israeli organ recipients received health insurance reimbursements of 70,000 to 80,000 USD for a lifesaving medical procedure performed abroad 23.

According to Scheper-Hughes (2004), women are rarely the recipients of purchased or purloined organs anywhere in the world, and organs usually follow the following routes: from females to males, from poor males to more affluent males, or from black and brown bodies to white ones. There is no doubt, however, that the main crucial motive for the recipients is the economic status; after all, according to the Council of Europe and the World Health Organization, the cost for a kidney on the black market ranges from 100,000 USD for organized criminals and 200,000 USD for the final recipient. Thus, the recipients are affluent people that can afford the organ price in the black market (Meyer, 2006).

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23 See: [http://ipsnews.net/interna.asp?idnews=22524](http://ipsnews.net/interna.asp?idnews=22524) by Osava, M., Supra note 3, last access January 2013. However, this reimbursement is no longer available if the supplier country outlaws organ selling.
The next question to be asked is how the recipients feel knowing that the organ that saved their lives has cost someone else pain and suffering. When hearing of the recipients' experiences of their transplantations, Sanal (2004) realized that crime was not something they felt they were engaged in, even if they purchased a kidney. They felt they were engaged in something else, some kind of "business of life", that only pertained to their own lives and the lives of those who gave them life.

Furthermore, Meyer (2006) states that the recipients can also be regarded as victims. Receiving an organ is a matter of life and death, i.e., they are making the decision to buy an organ in the black market out of despair and personal necessity, and the organized criminals take advantage of their health condition and charge them enormous amounts of money just for securing their survival. The recipients must deal with the shortage of donor organs when considering the legal alternatives, and they also deal with the endless waiting lists they might fail to make (Erin and Harris, 2003). For instance, Clay and Block (2002) argue that while there are approximately 80,000 people in need of an organ per year, only about 20,000 people receive them annually from people who donate their organ as a gift of life without any compensation for their generosity. To illustrate how grave the situation is, Foster (1997) states that each month more than 2,000 potential recipients are added to the national waiting list and about 3,000 people die while waiting for an organ every year. Accordingly, Rothman et al (1997) argue that between 1992 and 1997 the organ shortage has become more acute. Thus, most countries (with the exception of Spain, Belgium, and Austria) do not have sufficient organs supply to satisfy their demand. The United States, despite a well-organized national allocation model, successful public campaigns, and a law requiring hospitals to request donation within the family, still has 116,821
people on organ waiting lists. Each year, almost 10% of potential recipients of heart transplant die while on waiting lists because no organ is available. According to Teagarden (2005), in Europe 15% to 30% of patients die while on waiting lists as a result of the shortage of organs. Therefore, although there is no doubt that organ recipients create the demand for organs and are involved in transplant tourism, organ recipients may also be seen as victims due to their illness and vulnerability.

**The Donors**

The first question that needs to be asked when looking at the donors is whether they decide to sell their body parts out of their own free will. According to Meyer (2006) people who are willing to sell their organs come from extremely poor backgrounds where life seems to be worthless, there are high unemployment rates and very low socio-economic standards of living, which make the trade in organs real and possible. Selling an organ may be a profitable deal where a legitimate opportunity to cover cost of life is not available. Scheper-Hughes (2006) stresses that the "donors" of the organ trade make their fateful choices under extreme duress, utter and coercive poverty, in order to "earn" as little as 1,200 USD for a kidney in the Philippines or as much as 8,000 USD for a kidney from a Turkish donor. Sellers in the United States can receive up to 30,000 USD. Table 2 presents the price paid for a kidney by the donor’s country of origin.

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TABLE II: PRICE PAID FOR A KIDNEY BY THE DONOR’S COUNTRY OF ORIGIN

<table>
<thead>
<tr>
<th>Country</th>
<th>Price for kidney</th>
</tr>
</thead>
<tbody>
<tr>
<td>South Africa</td>
<td>$700</td>
</tr>
<tr>
<td>India</td>
<td>$1,000-1,200</td>
</tr>
<tr>
<td>Manila</td>
<td>$1,200-2,000</td>
</tr>
<tr>
<td>Moldova</td>
<td>$2,700</td>
</tr>
<tr>
<td>Egypt</td>
<td>$1,700-2,700</td>
</tr>
<tr>
<td>Turkey</td>
<td>$5,000-10,000</td>
</tr>
<tr>
<td>Peru</td>
<td>$8,000</td>
</tr>
<tr>
<td>Israel</td>
<td>$8,000-45,000</td>
</tr>
<tr>
<td>United States</td>
<td>$30,000 and up</td>
</tr>
</tbody>
</table>


Thus, it is argued in the background paper of The Vienna Forum to Fight Human Trafficking (2008) that although often organ donors consent to the removal of their organs and may even receive the agreed payment for them, it is common as in other situations of trafficking for any exploitative purpose that the provision of the ‘service’ is driven by extreme poverty. In other cases, even though many people consent to the removal of their organ, there still may be deception as to the amount of payment, if any at all. The donors sometimes are not fully informed about the procedure, its health effect and recovery. Moreover, donors may consent through varying degrees of coercion or abuse of their vulnerability, which is any situation in which the person involved has no real and acceptable alternative but to submit to the abuse involved. Therefore, it may be concluded that the social and economic contexts make the choice of selling an organ anything but a free or autonomous one.


\(^{26}\) See: http://www.nrg.co.il/online/29/ART1/988/330.html, last access January 2013. Please note the comments of this Israeli article, where people give their contact information for selling their kidney, the highest price asked is 350,000 NIS, which is approximately 93,000 USD.
This conclusion is even more striking when looking at the consequences the donors must face once they have sold their organ. First and foremost, the donors must deal with the risk of their own health condition. The lack of aftercare or any other medical support causes most donors damage to their health. Moreover, an unhealthy way of life (e.g., alcohol abuse) may affect the healing process and weaken the donors' own organs; this in turn causes the dependence on dialysis or a transplant in the long run for some donors themselves (Meyer, 2006). Scheper-Hughes (2003; in Beauchamp et al, 2008) argues that even in the best social and medical circumstances living kidney donors as well as partial liver donors do sometimes die after the medical procedure or are themselves in need of a transplant at a later date. Since the donors are likely to be extremely poor, often in poor health, and trapped in environments in which the everyday risks to their survival are legion, when their spare part fails they have no access to dialysis or transplantation. Most of the organ sellers avoid getting medical attention for fear of being seen and labeled as weak or disabled by their potential employers, their families, coworkers, and potential girlfriends for single men. Those who look for medical care are sometimes unable to pay for the treatment, and at other times they are turned away from the same hospitals where their operations were performed.

Scheper-Hughes (2003) reveals some other consequences that donors face after the transplantation, including unemployment, social isolation and stigma, and severe psychological problems. Thus, the organ donors often find themselves both sick and unemployed since they are unable to sustain the demands of heavy agricultural or construction work, the only labor available to men with their skills and backgrounds. They are also often alienated from their families and coworkers, churches, and if single they are even excluded from marriage because they lack the ability to support a family.
Therefore, it may be argued that the above mentioned medical, social and psychological conditions harshly affect organ donors that may experience health problems, illness, chronic pain, unemployment and lower incomes, family problems, depression, social isolation and damaged self-esteem. In Iran, for example, after the legal sale was completed the donors reported feelings of profound shame, resentment, and family stigma. The feelings toward the physicians who removed the donors’ kidneys, in multiple countries, were those of hostility and, in some cases, even murderous. The disappointment, anger, resentment, and hatred for the doctors and even for the recipients suggests that kidney selling is a serious social pathology (Scheper-Hughes, 2003; in Beauchamp et al, 2008). The harsh standards of life disadvantaged populations have to face (i.e., inadequate nutrition, substandard housing, unclean water, and parasitic infection) expose them to various risks in their day-to-day lives. Adding organ sale to this roster subjects an already vulnerable group to yet another threat to its physical health and bodily integrity (Rothman et al, 1997). All of the above disclose that any market price for organs, even a fair one, exploits the desperation of the poor, and turns their suffering into an opportunity.

Another distinction between organ donors and recipients is related to their gender. For example, even though women are rarely the recipients of purchased or purloined organs anywhere in the world (Schepers-Hughes, 2004), it seems that they do take a role as organ donors. For instance, Shimazono (2007) examined three different quantitative studies on organ donors in Egypt, Iran, and India and found that in Egypt 5% of the 142 participants were females, in Iran the women were 29% of the 300 participants and in India women constituted 71% of the 305 participants. Another gender distinction was found in Nigeria, where most of the poor kidney sellers were single women (Schepers-Hughes, 2003; in Beauchamp et al, 2008). Unfortunately, other data regarding women involvement was not documented. A systematic
search in websites such as UN statistics\textsuperscript{27}, World Health Organization\textsuperscript{28}, and Non-Governmental Organization\textsuperscript{29} was performed but no other documentations of women involvement in the crime of organ trafficking were found. The existing limited data makes it even more crucial to learn more about the role of women in the crime of organ trafficking.

To conclude, these examples illustrate that the circulation of organs follows the "established routes of capital from south to north, from poorer to more affluent bodies, from black and brown bodies to white ones", and occasionally from women to men. It is demonstrated that the new developments in transplant tourism have aggravated older divisions between the poor and affluent, and produce a new form of commodity-living organs. In these radical exchanges of body parts, life-saving measures demand a bodily sacrifice from the donor and self-mutilation from the recipient (Schepere- Hughes, 2004). It is also revealed that both recipients and donors may be seen as victims of this crime (Meyer, 2006). The following chapter outlines the development of social problems and examines the process of the social construction of crimes as the theoretical framework of the research questions that follow.

The Social Construction of Crime and Social Problems

The social constructionist approach

A growing interest in social construction of reality and in the recognition of both the relativity and the importance of meaning in social life has long been discussed. It is claimed that the ideas that meaning is not inherent, and that meaning is central to social life, have captured the imaginations of many different sociologists and social scientists. Indeed, scholars understand that


\textsuperscript{28} WHO-See: http://www.who.int/research/en/ last access January 2013.

\textsuperscript{29} NGO- see: http://www.un.org/esa/coordination/ngo/ last access January 2013.
people live in socially constructed realities, in indeterminate worlds that get their meaning only when ordered in social interaction. Hence, the central concerns of constructionist inquiry are to study what people “know”, and how they create, apply, contest, and act upon their ideas.

For instance, Harris (2006) argues that a constructionist inquiry will look at social-problems as states of affairs that are not inherently problematic exactly as someone says they are, since any putative social condition can be ignored, considered not to be a problem, or characterized as a problem of type X rather than as a problem of type Y. In the same manner, when defining deviance the claim according to the social constructionist approach is that no action or trait is inherently deviant, and behavior must be interpreted as deviant to be seen that way. Waters (1996) takes the very same approach and states that from this social constructionist perspective, human rights can encompass only those claims and entitlements that a political community recognizes as fundamental to the humanity of its members.

When applied to criminal justice, Rafter (1990) argues that the social constructionist approach examines how the fact of crime and crime control are produced. Asking how we arrive to knowledge within a field, it explores relationships among social structures, law, criminal acts, and perceptions. In fact, the constructionist inquiry focuses on the origins and effects of social theory, social movements, and social practices, and aim to understand not how to control crime but rather why we engage in different types of crime control at various times and places. Within the social constructionist approach, it was Quinney (1970) that popularized the idea that crime is a social construction that reflects societal power relations. His claim was that for the most part, acts defined as crime are behaviors predominantly undertaken by relatively powerless social actors. For him:
Crime is a definition of human conduct that is created by authorized agents in a politically organized society… Criminal definitions describe behaviors that conflict with the interests of the segments of society that have the power to shape public policy… Criminal definitions are applied by the segments of society that have the power to shape the enforcement and administration of criminal law (Quinney, 1970; p.15-22, emphasis added).

Anderson (2002) argues that according to these propositions those with power are the ones who socially construct crime and the criminal rather than society as a whole.30

Nevertheless, Lynch and Stretsky (2003) claim that the process of constructing crime is also subject to a legitimating mechanism as well as constraints and rules defining ‘fair play’. As a result, behaviors of the powerful may also be defined as criminal and the powerless group’s interest may be favored in this political process of constructing crime. Thus, it may be argued that law is legitimized because it appears as representing opposite interests of both the powerful (i.e., government officials and religious clusters) and the powerless (i.e., organ donors, organ recipients and activists) in society.

According to Lynch and Stretsky (2003), law is also a source of the collective consciousness that control and shape the society health and well-being. For them, the construction of crime is an arena of opposing views related to identity construction. As a result, while law primarily represents the powerful interests, it also seems to control their behavior. Understanding the law and its correlation to the process of crime construction and power relations explains how laws aimed to control the powerful, such as the outlaws of organ

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30 However, Anderson (2002) refers to a later work of Quinney where the author outlined a typology of crime and began in the opposite direction from that taken earlier. He dealt first with corporate crime, and then followed with “crimes of government”, everyday police repression and harassment of citizens, and human rights violation by state's authorities that result in race, gender and economic exploitation. Only then the author finally came to a fifth category, “criminality among the oppressed classes” which involves personal crime and resistance to the system.
trafficking, are possible.\textsuperscript{31} In sum, it may be concluded that the primary effect of crime construction and law reinforce existing power relationships in society. However, the social construction of crimes is also a political process that is fundamentally related to the development of social problems as discussed below.

**Social problems**

The concept of social problems has been broadly discussed among sociologists. They have tried to delineate the area and define the processes by which a condition facing a society becomes a social problem (Blumer, 1971; Kitsuse and Spector, 1973; Lauer, 1976; Manis, 1974; Spector and Kitsuse, 1977, 2001). For example, Merton (1976) argues that the sociological theory of social problems consists of developing sets of ideas that are designed to help us understand the kinds, sources, persistence, and consequences of major troubles in society. However, two distinct approaches to the definition of social problems were developed. These two approaches are the functionalist formulation of Robert Merton and the value-conflict approach of Waller, Fuller, Myers, and others. According to the objectivist model, knowledge of objective conditions is a necessary and largely sufficient condition for the identification of a social problem: social problems are those phenomena which are problematic for social well-being (Manis, 1974). Thus, functionalists stress the study of objective conditions and dysfunctions, while the value-conflict approach stresses subjective definitions and takes a more interactionist perspective (Kitsuse and Spector, 1973).

Since approximately 1920, the issue of whether social problems were inherently social problems (an objective orientation) or arose from the activities of claims-making groups (a

\textsuperscript{31} The authors originally refer to environmental laws; however, it seems applicable to laws that prohibit organ trafficking as well, since these also intend to limit the powerful.
subjective orientation) has been the subject of major debate. This issue is discussed at length by Spector and Kitsuse who clearly favor the "subjectivist" orientation to social problems (Randall and Short, 1983). Lauer (1976) argues that one of the difficulties in the study of social problems is the initial task of definition. However, the author stresses that sociologists from both subjective and objective approaches define social problems in a way that makes public opinion a prime source for identifying which conditions to treat as problems. In other words, social problems are a combination of objective and subjective elements, namely, certain objective conditions that are subjectively perceived to be undesirable by the public and therefore defined as a social problem. In fact, only when a considerable number of people decide that a certain phenomenon is harmful does it become a social problem. Moreover, according to Merton (1976) social problems have both subjective and objective aspects. Their subjective aspect appears in the perceptions and evaluations of social conditions by people in the society and their objective aspect in the social condition themselves.

Acknowledging the above mentioned debate but choosing not to join it, this research follows the idea that:

Social problems are not the result of an intrinsic malfunctioning of a society, but are a result of a process of definition in which a given condition is picked out and identified as a social problem. A social problem does not exist for a society unless it is recognized by that society to exist. (Blumer, 1971; p. 301)

Blumer (1971) rejects the view of social problems as social pathology or a consequence of social disorganization that exists independently with an intrinsic structure. For him, social problems are the main results of a process of collective definition. The following are a few examples that illustrate this idea.
Lopata (1984) argues that Horton and Leslie (1960) exemplify this position when discussing child labor. Accordingly, child labor was not a social problem as long as most people thought child labor to be acceptable; it became a social problem only with public awareness. The author also provides the example of “drunk driving” given by Gusfield (1981), who analyzes the processes by which "drunk drivers" were defined as a social problem. His claim is that driving under the influence of alcohol is singled out as a focus of public concern, as opposed to other social problems such as the distress of marital unhappiness that remains private due to the lack of public awareness. Other social issues that became social problems according to Randall and Short (1983) are discrimination against women in hiring and the risks of employment in hazardous/ toxic work environments. An additional example is the one brought up by Troyer and Markle (1984), who argue that the idea that the widespread use of coffee is harmful only became a social problem when public attention focused on medical research that suggested that caffeine may cause medical harm, despite the fact that coffee had been considered potentially harmful for more than 300 years. Cigarette smoking and nicotine went through the same process to become a social problem (Nuehring and Markle, 1974), while margarine experienced the opposite transformation where its status as a social problem was eliminated (Ball and Lilli, 1982). Other social problems that were examined thoroughly were mental disorders and drug use (Clausen, 1976; in Merton and Nisbet, 1976), alcoholism and problem drinking (Straus, 1976; in Merton and Nisbet, 1976), and sexual behavior (Davis, 1976; in Merton and Nisbet, 1976).32

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32 It is important to note that few of these discussions are not up-to-date, and it will be interesting to inquire how their status as a social problem was eliminated over time.
Nevertheless, the above stated examples also show that public awareness alone is not sufficient to create a social problem. Blumer (1971) points to a process of collective definition that passes through five stages: the emergence of a social problem, the legitimation of the problem, the mobilization of action with regard to the problem, the formation of an official plan of action, and the transformation of the official plan in its empirical implementation. Each of these stages will be discussed below. It is important to note, however, that when applicable Blumer’s model is modified with that of Spector and Kitsuse (1973; 1977) who emphasize the political variables critical to social problem development and the process of making claims. This four stage model of social problem development, as well as its modifications proposed by Randall and Short (1983), are a crucial part of this discussion.

1. The emergence of a social problem

Blumer (1971) lays emphasis on the process by which social conditions or arrangements come to be recognized as social problems, and points to the forces that make such recognition possible. Among these forces the author mentions the following: the role of agitation and violence in getting recognition for a problem; the role of opposing interest groups involved: their diverse motives, material gains and goals with regard to the problem, as well as their balance of power such as the impotency of powerless groups to gain recognition for what they believe to be problems; the role of political figures and powerful organizations and corporations in constraining or encouraging certain problems; the media role in selecting or ignoring social problems; and the influence of adventitious occurrences on public awareness.

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33 A parallel development of deviance and labeling theory is discussed by Kitsuse and Spector (1975), see also Emerson and Messinger (1977) that explore the processes whereby troubles are identified, defined, responded to, and sometimes transformed into a recognized form of deviance. Nevertheless, the focus in this proposal is on social problems and the collective level.

34 The authors stress the influence of power resources available to parties, including government agencies, in each stage of social problem development, as will be discussed below.
Thus, for instance, while tracing the emergence of drinking caffeine as a social problem, Troyer and Markle (1984) emphasize the importance of medical and psychological research (e.g., relating caffeine to cancer, birth defects, and heart disease), newspaper reports, and institutional warnings (e.g., the FDA warning to pregnant women) in the process. The authors also draw attention to coffee and soft drink industry groups that waged a pro-caffeine campaign at the same time. The above mentioned are examples of the opening stage of the social problem’s development, during which “some groups attempt to transform some putative condition into a public issue while others seek to prevent such public recognition”. As Blumer (1971) and Spector and Kitsuse (1973) have noted, “…during this emergent phase groups attempt to gain publicity and arouse controversy”.

2. The legitimation of the problem

After gaining initial recognition, according to Blumer (1971), a social problem must acquire social endorsement- "a necessary degree of respectability that entitles it to consideration in the recognized arenas of public discussion”, such as the media, religious institutions,

35 schools, civic organizations, legislative chambers, and the assembly places of officialdom. If a social issue does not carry the credential of respectability necessary for entrance into these arenas, it is ignored. For example, Nuehring and Markle (1974) outline the historical development of cigarettes and their re-emergence as a deviant behavior and disclose the following examples of public discussion:

…In the 1870's, competitive cigar manufacturers proclaimed that cigarettes were drugged with opium, their paper bleached with arsenic,… By the turn of the century, there was a great deal of religious and moral opposition against cigarettes… The Friends and Methodists began to insist that their ministers pledge abstinence from tobacco…Between

35 Blumer (1971) mentioned churches; however, considering the fact that this research of organ trafficking will take place in Israel; it seems that other religious means may be more relevant.
1895 and 1921, 14 states completely banned cigarette smoking… in the early years of this century, stop-smoking clinics were opened in several cities; and pervasive anti-smoking campaigns were in full swing… However, cigarette sales increased steadily… (Id, at 514-15, my omissions)

There is no doubt that such a debate meets the criteria of social endorsement in all sorts of public arenas.

For Spector and Kitsuse (1973) these two initial stages are in fact the attempts made by some groups (who may or may not be the victims of the imputed condition) to declare and define certain condition as adverse, offensive or harmful, to publicize these allegations in order to arouse controversy, and to stimulate public and political awareness. For them, critical concerns in this formative stage of social problems are the ways that complaints about the condition are raised and the strategies used to press the claims, gain publicity, and arouse controversy. The process of making claims, which is a crucial component in the development of social problem, will be discussed broadly following the discussion of the next stages in Blumer’s (1971) model.

3. The mobilization of action with regard to the problem

According to Blumer (1971) the third stage in the development of a social problem is a mobilization of the society for action on the social problem, which happen when the: "problem becomes the object of discussion, of controversy, of differing depictions, and of diverse claims. Those who seek changes in the area of the problem clash with those who endeavor to protect vested interests in the area. Exaggerated claims and distorted depictions that subserve vested interests become commonplace. Outsiders who are less involved bring their sentiments and images to bear on their framing of the problem. Discussion, advocacy, evaluation, falsification, diversionary tactics, and advancing of proposals take place in the media, in casual and organized meetings, legislative chambers, and committee hearings". The fate of the social problem depends
greatly on what happens in this process of mobilization: how the problem is defined and
determined, how it is bent in response to diverse interest groups, and how it reflects the society
balance of power.

Spector and Kitsuse (1977) combine stages one to three into one stage in their model of
the process by which social problems develop and term it as “Social Problem Definition and
Issue Creation.” According to them, in the first stage of social problem development a group
asserts the existence of a condition, identifies the condition as undesirable and problematic, and
seeks to publicize these assertions to stimulate controversy and to create a public issue over the
condition. The authors note that the identification and development of a social problem is
negotiated through a process that is fundamentally political. Successful definition of a social
problem requires creation of a public issue and official recognition. Once achieved, official
recognition may or may not result in satisfactory measures (according to the claimants) to deal
with the problem. If dissatisfied, the claims-making group may or may not reach the point of
rejecting established procedures and pursuing alternatives.

Therefore, among the major political variables critical to social problem development,
Spector and Kitsuse (1977) mention the following: the use by claims-making groups of an
ideology to make the complaint more forceful; the ability to recognize the appropriate parties to
complain to; and the ability to marshal enough power to press claims. Randall and Short (1983)
use the latter model but emphasize the role of power resources and the role of government in the
construction of social problems. In their study of how the issue of “women in toxic work
environments” becomes a social problem, the authors argue that many public resources can be
useful to claims-making groups (and their opposition), but the most important resources in their
case study were access to the media, support from other groups, and government activity.
4. The formation of an official plan of action

This stage in the career of social problems, according to Blumer (1971), is the society's decision regarding the required changes derived from the problem. It is the formation of an official plan of action that may take place in legislative chambers and committees, as well as in executive boards. Mostly, the official plan is a product of negotiation, in which opposing points of view and interests are accommodated by compromises, exchanges, new judgments and understandings, deference to influence, and power interactions. This is a defining and redefining process of the collective social problem so that the final product may be different from the problem in its earlier versions. The official plan that is enacted includes the formal definition of the problem and represents how the society intends to act in response.

Spector and Kitsuse (1977) state that in the stage of official recognition of the problem the claims-making group seeks to convince an official agency to recognize the legitimacy of the claim, to obtain an official investigation of the claim, to have a remedy proposed that is favorable to the group's interests, and to have an agency designated to handle the claim. These may be enhanced by access to financial resources, by the ability to attract and to organize supporters, and by the effectiveness of information and communication skills designed to convince others of the legitimacy of claims. By employing financial resources, organizing boycotts, demonstrations, threats, mass media campaigns, and by attempting to exert influence through highly placed officials, a group may be able to force agency recognition. Once investigation into a social problem begins, the initiating group may begin to lose control over the claim, and the claims-making group seeks resolution of the social problem. According to Randall and Short (1983) the "final" resolution will reflect the distribution of power assets. At the end of this stage, a social problem is typically at its career peak: an agency has recognized the problem, thus officially
conferring legitimacy on it, and other groups may have joined in the conflict by supporting the initial claims-making group. The social problem may be "solved" at this point; however, another vital stage in its development is described below.

5. The transformation of the official plan in its empirical implementation

This stage according to Blumer (1971) is the practical implementation of the official plan. The plan as put into practice is modified and reformed to an unforeseen strategy in a new process of collective definition by all interest groups involved in the problem or touched by the plan. Thus, individuals or groups who are in danger of losing advantages due to the official plan of action struggle to limit it or change its operation to a better solution for them. On the other hand, those who stand to benefit from the plan will strive to preserve it or to achieve different opportunities. Sometimes, the opposing groups may strive to implement new accommodative arrangements unforeseen by the original plan. They both may develop new measures and policies that underlie the plan, these new adjustments were never officially intended.

Spector and Kitsuse (1977) divide this stage to two. The first is Group Dissatisfaction with Established Procedures, when more powerful groups will be able to renegotiate procedures, reform existing practices, and have a new, more specialized, institution established. Also, groups with fewer resources will be unable to influence the procedures established for dealing with the imputed conditions, to change the bureaucratic handling of complaints, or to generate sympathy for their complaints (Randall and Short, 1983). The second stage according to Spector and Kitsuse (1977) is the Rejection of Established Procedure, in which claims-making groups seek alternate solutions to their claims due to their dissatisfaction with official responses. Randall and Short (1983) emphasize that in this stage, as was in its previous, success is highly dependent
upon access to resources; whether a dissatisfied group has sufficient resources, discipline, and organization will determine the success of further efforts to address their claims.

Gusfield (1989) recommends studying social problems in correlation to the study of social movements. Therefore, it is important to understand how institutions and social movements influence and are influenced by interpretations, language, and symbols that are used to view a situation as a social problem in historical and institutional context. For him:

To "own" a problem is to be obligated to claim recognition of a problem and to have information and ideas about it given a high degree of attention and credibility, to the exclusion of others. To "own" a social problem is to possess the authority to name that condition a "problem" and to suggest what might be done about it. It is the power to influence the marshalling of public facilities—laws, enforcement abilities, opinion, goods and services—to help resolve the problem. To disown a problem is to claim that one has no such responsibility. (Id, at433)

Since the process of making claims is a fundamental element in all stages of the development of social problems, below provides a brief description of this process.

**The process of making claims**

Spector and Kitsuse (2001) argue that the sociology of social problems must take the members' perspective as the starting point, and focus on definitional claims-making activities as the primary subject matters. The authors propose the interaction between claims-making groups and others regarding the definition of social conditions and what should be done about them as the central interest of sociologists of social problems and deviance. Therefore, the researcher of a social problem should examine how individuals and groups become engaged in collective activities that recognize putative conditions as problems and attempt to establish institutional arrangements. For them, the central task of developing a theory of social problems is to understand the definitional collective process in which controversial conditions are declared to
exist and the resulting collective activities around the declarations. This theory would strive to describe how these asserted definitions are socially made and what institutional acts and official processes are taken in response to the social problem.

Therefore, it is argued that the making of claims and complaints is an integral part of social and political life. In particular, Spector and Kitsuse (2001) claim that the main matter for a social problems theory is "to account for the emergence, nature, and maintenance of claims-making and responding activities". The authors emphasize that a theory of social problems is a theory of claims-making activities and not a theory of conditions, and they stress that the existence of the condition itself is irrelevant to the analysis. As a result, such a theory should address the activities of any group making claims on others for alleviation of social, political, legal, or economic disadvantage. All those who involve themselves in claims-making activities participate in the process of defining social problems. To better understand this point, below are Spector and Kitsuse (1977) words:

The activity of making claims, complaints, or demands for change is the core of what we call social problems activities. Definitions of conditions as social problems are constructed by members of a society who attempt to call attention to situations they find repugnant and who try to mobilize the institutions to do something about them.... Claims-making is always a form of interaction: a demand made by one party to another that something be done about some putative condition. A claim implies that the claimant has a right at least to be heard, if not to receive satisfaction. (Id, at 78)

Since the activities themselves are the subject matter of social problems, the inquiry should focus on the forms of these activities and ask how those social problem activities become organized (Spector and Kitsuse, 2001).

As previously mentioned, a central task of developing a model of the emergence of social problems is explaining the process of translating personal concerns into collective issues. Spector and Kitsuse (1977) have argued that social problems are products of particular constructions of
social reality, rather than of actual physical conditions. For them, the claims-makers communicate their concern and the expectation of a solution to others, and thus create a social problem essentially in a process of social influence. Best (1987) argues that constructionist empirical research usually concentrates on the social organization of claims-making, classifying the key actors in the process, revealing the correlation of claims-making groups and their opposing interests, and explaining the stages in the problem's social construction. For him, typical case studies show how claims-makers mobilized to affect social policy. This argument is in accordance with the definition of Spector and Kitsuse (2001) that social problem activities are claims-making complaints and demands for the relief and amelioration of offensive conditions.

Claims-making is a rhetorical activity: claims-makers inevitably hope to persuade. Typically, they strive to assure others that a certain condition is a problem, that a specific group of people wants to solve the problem and has an optional solution, or that a certain policy should be adopted in order to do so. Indeed, if claims-makers are able to persuade others of the legitimacy of their concerns and are able to recruit early converts, a collective definition of a problem forms. To the extent that collective definitions of problems come to supplant individualistic definitions, a social problem can be said to exist (Blumer, 1971). It is also argued that in claims-making, the explicit emphasis is on observable behaviors and the direct confrontation of competing interests (McCright and Dunlap, 2000). Spector and Kitsuse (2001) emphasize that the construction of definitions of conditions, the expressions of claims, and the imputation of motives and values by different interest groups are the activities of members, and all are part of the phenomena of social problems.

Troyer and Markle (1984) conclude that only by studying how claims succeed or fail to create problems can we come to understand and appreciate the social problems process. Best
(1987) argues that while the success of claims-making may well depend in part on the different interest groups involved in the process as well as their resources, the way claims are expressed also affects whether they convince and motivate their target audiences. Spector and Kitsuse (1973) focus on “successful claims,” which are the claims that may lead to further actions that culminate in the establishment of a social problem, and they argue that this success is based on three factors. The first factor is the power of the group. According to the authors, more powerful groups (e.g., those that have more membership, greater constituency, more money, greater discipline, greater organization) will have a greater chance of being successful, but only through mobilizing that power through the claims they press. The second factor that also has a major influence in the process is the nature and variety of claims. The experience of dissatisfaction may vary considerably and thus affect the kinds of claims a group constructs as well as the way it expresses and directs these claims. The Mechanisms for Pressing Claims is the third factor; it is the way that claims are delivered, expressed, or made public. The fate of a claim may heavily depend on the channels through which it is pressed, the strategies used to achieve visibility of the imputed condition, and the auxiliary personnel who play a role in the process.

In fact, in this sense, the media has a major role in the social construction of social problems, and many of the discussions concerning the development of social problems mention the possibility of the media operating in significant ways. The media usually are discussed in terms of their impact during the emergent and legitimizing stages of social problems (Blumer, 1971). In these stages the nature, scope, and definitions of social problems may be heavily debated in the media and by various groups. Nevertheless, social problems in the media may also be in the institutionalized stage. Best (1987) argues that claims-makers often take special care when addressing the press. The news media serve as gatekeepers for would-be claims-makers;
simply receiving coverage helps validate a claim as worthy of consideration. However, the media may play other roles as well. Thus, it is argued that there may also be short-term or long-term changes in the hierarchies of importance assigned by the public to established social problems so that the media may play a role in shaping these conceptions of importance (Hubbard, DeFleur, & DeFleur, 1975). Moreover, in the age of mass communication, not only do the media play an important and powerful role in identifying social problems and in bringing them into public notice, the media also create social problems and construct reality (Jamrozik and Nocella, 1998).

Best (1987) adopts Toulmin’s principal categories of statements — grounds, warrants, and conclusions — to analyze the rhetoric of claims-making campaigns. According to Toulmin, every argument has a basic structure composed out of the following: claim/conclusion, whose merit we are seeking to establish; data/grounds, or the facts we appeal to as a foundation for the claim. The link between the data and the conclusion can only be established by reference to a third kind of proposition: the warrants. A broader examination of these appears below.

Grounds/data according to Best (1987) provide the basic facts that serve as the foundation for the discussion that follows. Claims-makers and their audiences may agree to accept grounds statements without question, or one or both parties may have reservations about the statements' truth, their relevance, the methods used to establish them, and so on. Some types of grounds statements reappear in many claims-making campaigns. Among the different types of grounds statements appearing in claims-making one may find definitions, examples, and numeric estimates. By defining the topic under discussion, claims-makers limit what can be said; a definition makes some issues relevant while relegating others out of bounds. Identifying may both establish a topic's domain and offer an orientation toward that topic. Even though definition might seem to be the logical first step in claims-making, it frequently follows an introductory
example, such as horrific stories in newspapers prior to the general discussion of the social problem itself. Once examples establish a problem's human dimensions, claims-makers often try to assess its magnitude. The bigger the problem, the more attention it can be said to merit, so most claims-makers emphasize a problem's size. This may be done by the following: statistics and incidence estimates; by growth estimates proving that the problematic condition is getting worse and, unless the offered solution is applied, there will be further deterioration; and by range claims that suggest that people may be indiscriminately affected and that the problem extends throughout the social structure.

Warrants, Best (1987) argues, have a special place in Toulmin's scheme; they are statements that justify drawing conclusions from the grounds. Disputes about grounds (e.g., whether stranger abductions annually number in the hundreds or the tens of thousands) need not damage conclusions that something has to be done. However, concluding that something must be done demands that one accept some warrant that the problem deserves attention. References to warrants may be oblique or implicit, and some warrants may be general justifications that may be found in claims-making about various social problems. For example, in the social problem of missing children the authors found the following justifications: the value of children, blameless victims, associated evils, deficient policies and lack of resources, historical continuity, and rights and freedoms. Lastly, the author refers to conclusions and stresses that claims-makers present conclusions that typically call for action to alleviate or eradicate the social problem. Claims-makers may have an agenda with several goals such as awareness and public attention, prevention, social control policies, and other objectives such as future research.

A most recent contribution for the study of social problems is the idea of social change. Ibarra (2009) has proposed the cause of problematic sociality; accordingly, social problems refer
to situations in which sociality is made problematic. Problematic sociality identified circumstances in which people find their social experiences and identities being problematized. Therefore, the author claims that: "social problems theory would be concerned to theorize the structures and processes that are common to the emergence, maintenance, and resolution of variations in problematic sociality". In conjunction with that, social problems study looks at the mechanisms through which people navigate problematic situations. Such a study would be concerned to research the courses of conduct, feeling, and thinking that enable social uncertainty and would focus on how people adjust to social changes. Among social changes salient in Israel, one may find both globalization and the rise of religious parties as influential forces in Israeli politics. Therefore, understanding the different stages in the development of social problems, the process of making claims, as well as the notion of social change and problematic sociality enables the specific examination of organ trafficking in Israel and its construction as a social problem.

**Summary**

The first part of the research provided a detailed description of the global crime of organ transactions and trafficking. After recognizing the phenomenon of organ trafficking as one that really exists and providing a brief examination of the social economic theory of globalization and its implications, the chapters that followed addressed the distinctions between two groups: organ recipients that usually come from more developed states — industrial and rich countries — and organ suppliers that usually live in states where the socio economic level is very low. It seems that the same old distinctions based on race, class, and gender are reinforced once again with regard to the people involved: organ donors as opposed to organ recipients. The main argument embedded in those old dichotomies is that organ trafficking strengthen the existing social
inequities and would also put powerless individuals and groups at still graver risk. The first part of the research also outlined a five stage model of the development of social problems and the social construction of crime. The different stages of the process were discussed broadly to enable examination of the process with regard to organ trafficking in Israel. The importance of the claims-making process as well as the power resources available to parties (e.g., access to media and government involvement) in each stage of social problem development was emphasized in order to provide a solid framework to the research questions and to allow for the case study of the development of organ trafficking as a social problem in Israel. Below is a brief description of the current study followed by the research design and methods.

The current study

The current study applies the theory of Blumer (1971) and its modifications as discussed above to the specific case of organ trafficking in Israel. For that reason, the model's stages were examined in order to discuss how the phenomenon of organ trafficking is constructed as a social problem. In order to answer these core questions and reveal the process of social problems development in the specific case of organ trafficking in Israel, the research also poses the following questions.

First, the research looks at the major players and claim-makers in the development of organ trafficking as a social problem in Israel. Thus, the research identifies the following: identification of the power and powerless in the development of organ trafficking in Israel as a social problem; the role of powerful organizations and corporations in that process; the claims-making actors pro and against organ trafficking and related legal practices in Israel; the social changes as well as problematic sociality; the social movements, institutions or other political
figures involved in this process if any; and the different interest groups as well as their motives, common means, and resources. Second, the research focuses on the process of claims-making and examines the different claims made by the different interest groups along the development of organ trafficking to a social problem in Israel; by doing so, the broader role of rhetoric in social problems construction will be examined. The research is based on the literature reviewed in the previous chapters and follows Toulmin’s principal categories of statements as employed by Best (1987) — grounds, warrants and conclusions — to analyze the rhetoric of claims-making campaigns of organ trafficking in Israel. The research examines the role of the Israeli mass media in selecting organ trafficking to be a social problem and the influence of adventitious happenings that shock public sensitivities. The research also examines whether organ donors and their supporters as well as organ recipients actually reveal the impotency of powerless groups to gain attention for what they believe to be a social problem. In order to answer all these research questions and to determine how organ trafficking was socially constructed as a social problem in Israel, the current study relies on three forms of data collection: observations, content-analysis, and in-depth interviews, as will be presented below.

CHAPTER 2: METHODS AND RESEARCH DESIGN

This study is based on observations, content-analysis, and in-depth interviews. The three forms of data collection will be discussed below; however, it is important to emphasize again the reciprocal connection between the legal aspects of organ donations and the criminal behavior of organ trafficking. Accordingly, increasing the legal organ donations rate will reduce the criminal activity of organ trafficking.
Observations

Atkinson and Hamersley (1994) argue that it is not easy to define participant observation inquiry since a distinction is made between participant and non-participant observations. The former refers to an observation carried out when the researcher is playing an established participant role in the scene studied. However, Atkinson and Hamersley claim, such dichotomy is not very useful because it seems to imply that the nonparticipant plays no recognizable role at all. Furthermore, since we cannot study the social world without being a part of it, and since in a sense all social research is a form of participant observation, it is not a particular technique but a mode of being in-the-world characteristic of researchers. Adopting that acknowledgement that there is no perfectly transparent or neutral way to represent the social world, the current research applies observations of two different conferences — the first is for a closed group of participants and the second is open to everyone — to study the construction of organ trafficking as a social problem in Israel as follows.

Observations of stakeholders presentations, dialogues, and discussions on the public responses to organ trafficking and the Israeli shortage of organ donations were done in two different conferences. The first consisted of four group discussions and their concluding joint session and focused on the obstacles to organ donations as seen in the Israeli society. The second conference was dedicated to different aspects of The Organ Transplant Act and the Brain and Respiratory Death Law five years after their legislation in 2008. In both conferences, stakeholders from different and opposing interest groups participated and shared their views, ideas, rationalizations, and recommendations for a better model. These will be presented in depth within the data analysis chapter; however, a short description of the conferences and their participants is required in order to better understand their implications.
In the first conference, I observed four group discussions and their concluding meeting; they were all related to the legal process of organ donation and its obstacles as described below. This conference was organized by the mutual contribution of The Israeli National Transplant Center, "Adi"\textsuperscript{36}, and The Chaim Herzog Institute for Media Politics & Society at the Faculty of Social Sciences at Tel-Aviv University\textsuperscript{37}. The participants were aware of my status as a PhD student from UIC who researches the construction of organ trafficking as a social problem in Israel. I took field notes of the four group discussions; however, I received permission to tape only the last meeting, where the conclusions of each of the previous discussions were presented.

Each one of the group discussions held 15 to 27 participants (not including myself) from different backgrounds related to the specific issue discussed, and each discussion lasted for about two to three hours. Some of the participants had more than one association with the topic discussed. When applicable, these cases will be presented in the data analysis section. For the description in this section I used the association they chose to present in the introduction session of each group discussion. However to simplify the discussion, I organized the participants in five different clusters that best reflect the interest groups involved in the construction of organ trafficking as a social problem in Israel. The participants in these clusters represent the different claims-making groups with regard to the legal form of organ donation, which might embody their approach to illegal organ trafficking as well. The clusters include the following: neutral participants, government officials, religious representatives, powerless groups, and the media. It is important to note that this division into clusters is applicable to other public discussions; it

\begin{itemize}
\item[\textsuperscript{36}] More detailed information regarding the national transplant center is available at: \url{http://kartisadi.org.il/eng/index.html}, last access January 2013.
\item[\textsuperscript{37}] The Herzog Institute's goals as published on its website are: "...to conduct academic research and to create a cross-disciplinary platform for conferences, seminars, meetings and discussions and critical appraisals as they relate to the reciprocal links, connections and influences between media, society, social issues and politics."
\end{itemize}
demonstrates a significant spread over all of Israeli society and also for the specific issue of organ trafficking. For example, the distinction between powerless people and government officials (as the powerful group) occurs in all societies and influences most of the debates on their public agenda. As seen above, this social distinction between the haves and the have-nots is not only a key factor of organ trafficking but also determines and influences other aspects of social life. Below is a brief summary of each cluster in the specific context of organ trafficking, and it is followed by the group discussions' presentation.38

**Cluster A: Neutral participants**

The people in this cluster are mostly from The Chaim Herzog Institute for Media Politics & Society at the Faculty of Social Sciences at Tel-Aviv University or from other faculties and universities. I chose the term "neutral" since they do not belong to one of the opposing interest groups that follow. However, when applicable according to their thoughts and ideas as brought up during the discussion groups, it might be appropriate to associate them with another cluster.

**Cluster B: Government officials**

As discussed in the theoretical framework, Randall and Short (1983) base their research on Spector and Kitsuse's (1977) model of the construction of social problems, but they emphasize the role of power resources and the role of government in that process. The authors argue that many public resources can be useful to claims-making groups (and their opposition), but the most important resources in their case study were the following: access to the media, support from other groups, and government activity. In order to find out whether this idea is validated in the specific case of organ trafficking in Israel, one of the core clusters is of government officials.

38 The very same clusters will be used in the other forms of data collection to explain the data in a unified manner in the discussion.
This cluster mainly consists of officials from the Israeli National Transplant Center, "Adi", and other officials from the Ministry of Health. It is important to note that the Israeli public health system is run by the government, and therefore officials from that system (i.e., hospital department heads or other physicians from the public health system and HMO representatives) are considered government officials as well.

**Cluster C: Religious representatives**

The Israeli society is characterized by a deep-rooted conflict between its diverse social strata, specifically the one related to different levels of religious and secular sectors. This conflict is also noticeable in the construction of organ trafficking as a social problem in Israel, and therefore one of the influential clusters is that of religious representatives. Although this cluster had few representatives in the group discussions at the conference, it might be one of the powerful clusters with access to power resources and therefore with major influence on the construction of organ trafficking as a social problem in Israel.

**Cluster D: Powerless groups**

With very limited representation — one to three people in each group discussion — this cluster consists of both organ donors and recipients. Even though usually the donors and recipients are considered as being on opposing sides of the equation, in this case of the construction of organ trafficking as a social problem in Israel they are both affected. Moreover, it was well established in the theoretical framework that organ recipients can also be regarded as victims. Since the discussion's focus was on the legal organ donation from the dead, it was the organ donors' families that came to tell their stories. The recipients in the conference may also be represented
by their family members or the specific organization they belong to (e.g., the Israeli National kidney Transplantees and Dialysis Patients).

**Cluster E: The media**

As discussed in the theoretical framework, one of the key elements to a successful development of a social problem is the groups' access to power resources and above all the media. In order to learn about the media's role in the construction of organ trafficking as a social problem in Israel, the fifth cluster consists of officials from different forms of media.

The following are short descriptions of the issues discussed in each group discussion and their concluding meeting as well as general outlines of the participants of each group discussion organized into the abovementioned clusters. The content of these different group discussions, when applicable, will be presented in the data analysis chapter.

**Group discussion 1**

The group discussed the issue of "barriers and inhibitions to organ donations." Therefore, a major part of the discussion was dedicated to the reasons and rationalizations people use for justifying their refusal to donate their deceased family members' organs. The group also brought up the different explanations used by people for rationalizing their disagreement to signing a donor card. The different rationalizations and explanations brought up will be discussed broadly in the data analysis section of this research. However, it is important to note at this stage that the group members mentioned the following reasons: cultural and religious beliefs, psychological, sociological and social aspects, lack of information (i.e., about the nature of the medical procedure), and lack of confidence in the health system and its operation in the context of organ donations. Some of these explanations were, in fact, separately discussed topics in other group
discussions. The main focus in this group was on how to promote the registration of potential legal organ donors and what crucial psychological issues need to be addressed when organ donation becomes a real option.

Group 1 was the largest group and consisted of 27 participants from the different interest groups related to the construction of organ trafficking as a social problem in Israel. This group discussion included the following stakeholders organized by clusters:

Cluster A: Neutral participants

- 3 people (i.e., the moderator and two participants) were from the Chaim Herzog Institute for Media Politics & Society at the Faculty of Social Sciences at Tel-Aviv University or similar faculties at other universities.
- 5 participants were from faculties such as psychology, sociology and bio-ethics (1 of whom was from Canada).
- 4 participants were from different MBA's and marketing faculties.

Cluster B: Government officials

- 7 participants were different officials from the Israeli National Transplant Center, such as transplant coordinators, legal advisors, and officials from transplants committees.
- 1 participant was from one of the HMOs in Israel.
- 1 participant was a representative of the Israeli Ministry of Health.

Cluster C: Religious representatives

- 2 rabbinic participants represented the religious people who promote organ donations.
Cluster D: Powerless groups

- 1 participant was a representative of the Israeli National Kidney Transplantees.
- 1 participant was an organ receiver.

Cluster E: The media

- 2 people were from one of the leading advertising companies in Israel.

**Group discussion 2**

The issue discussed in this group was "the lack of confidence in the health system." It was argued that one of the most common reasons for not signing an ADI donor card or for refusing to donate organs is lack of trust in the medical system. The purpose of this discussion was therefore to examine the reasons for this lack of confidence and trust as well as to figure out what are the best methods for reducing it and for encouraging people to sign donor cards.

This group discussion comprised 21 participants including the moderator and was organized by clusters as follow:

**Cluster A: Neutral participants**

- 5 participants (1 of whom is the moderator) were from different departments of communication from diverse Israeli universities.

**Cluster B: Government officials**

- 5 participants were different officials from the Israeli National Transplant Center (i.e., transplant coordinators and a Ministry of Health representative).
- 4 participants were physicians from different hospitals holding diverse specializations and occupations.
• 2 participants were from different HMOs in Israel.

Cluster C: Religious representatives

• None of the participants in this group discussion was a religious representative.

Cluster D: Powerless groups

• 2 participants including an organ recipient and a spouse of an organ recipient.

Cluster E: The Media

• 3 participants were media professionals (i.e., journalist, TV, or Radio officials).

Group discussion 3

Group 3 had a heated discussion that focused on the issue of "brain death." One of the key issues when considering deceased organ transplants is the determination of death. In the past, death was determined by cessation of the heart function. Nowadays, however, death is also determined by neurological criteria, while artificial respiration is used to ensure the preservation of organs. This change requires a different approach to death than the one that was customary in the past.

The group discussion focused on the obstacles that this issue arose. For instance, participants brought up a common public fear that physicians may disconnect the respirator when the person is still alive. It was also argued that people are confused between comas (which could be reversible) and brain deaths. Another hurdle that was debated thoroughly focused on the opposition among a minority of religious groups regarding the definition of brain death as death. Therefore, the major goal in that group discussion was to determine how to deal with these religious beliefs and common fears about brain death and to understand their implications that prevent people from donating organs and signing donor cards.
17 participants were part of this discussion; their professions organized by clusters are shown below:

Cluster A: Neutral participants

- 2 participants (1 of them was the moderator) were from the Faculty of Social Welfare and Health Sciences.
- 4 participants were faculty members from the schools of education or communication.

Cluster B: Government officials

- 5 participants were different officials from the Israeli National Transplant Center (i.e., transplant coordinators and a Ministry of Health representative).
- 3 participants were representatives of the Ministry of Health or other government institution.

Cluster C: Religious representatives

- 1 participant was an official from the Halachic Organ Donor (HOD) Society.

Cluster D: Powerless groups

- 1 participant was from an organ donor family.

Cluster E: The media

- 1 participant was a journalist.

**Group discussion 4**

The last group discussion addressed the following topic: "Ethical challenges: altruism, mutual support and social norms." Some people argue that altruism is an important motive for organ donation; their belief is based on organ donors' claims that their motive was altruistic. Others, however, stress that the altruistic argument has run its course and is no longer helpful to increase the willingness to donate organs from the dead. Some of the latter group believe that
only personal incentives will increase people's willingness to sign donor cards; others suggest changing the paradigm of altruism to a community solidarity approach that emphasizes mutual aid and support. The discussion in this group was intended to clarify these dilemmas and other ethical challenges related to organ donations from the dead. Most of the people that participated in this group discussion were either from different faculties related to the issue discussed (e.g., bio-ethics, sociology, psychology) or from the Israeli National Transplant Center, "Adi."

The concluding session

The concluding session incorporated the key issues that were discussed broadly in the different group discussions. The main purpose was to reveal the conclusions and suggestions that arose in each of the group discussions for a better organ donation system in Israel. All the participants from the group discussions were present. Besides presenting the different groups' ideas and recommendations, the concluding meeting also discussed the following:

First, a personal story of a recipient family was told that focused on the donor-recipient relationship, which develops during the transplantation process but is well established only after the transplantation is done. Then a personal story of a donor family was told. Their argument was that people are not aware of the donation's benefits and how the family's day-to-day life becomes easier thanks to the organ donation. Second, a comparison to other countries was done, and the activities of the Israeli National Transplant Center were presented. A Ministry of Health representative then discussed the challenges that the current system must face in order to increase organ donation rates from all subclasses and different subcultures in Israel. The third issue deliberated was the one of "religion and organ donation," where opposing points of view were discussed. The final session was concluded with an optimistic report on the previous night
success of three new agreements to donate organs, obviously, due to the hard work done by all concerned.

The second conference took place on March 11, 2013, at Tel Aviv University. The conference was organized by the mutual contribution of the Israeli National Transplant Center and The Edmond J. Safra Center for Ethics at Tel Aviv University. The conference took place exactly five years after the passing of The Organ Transplant Act and the Brain and Respiratory Death Law (2008) and was dedicated to the examination of different aspects related to these two combined laws. This conference was divided into three sessions, each consisting of four related lectures given by different stakeholders that represent different and sometimes opposing interest groups involved.

The first session tried to determine whether The Organ Transplant Act and the Brain and Respiratory Death Law (2008) did eradicate the phenomenon of organ trafficking in Israel. In order to answer this question and to determine whether these combined laws managed to achieve one of their main goals, the discussion held by Rabbi Yuval Cherlow brought together the following lecturers:

- The legal advisor of the Ministry of Health talked about the considerations of the legislation of The Organ Transplant Act from 2008.

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39 The Edmond J. Safra Center for Ethics at Tel Aviv University is dedicated to promoting the interdisciplinary study of ethics. Research at the Center focuses on the study of ethics not merely as abstract norms but in their social, cultural, and institutional contexts. The Center enhances the study of ethics by integrating insights from law and philosophy – which have traditionally focused on ethics – with knowledge and insight from other disciplines including medicine and the life sciences, the social sciences, and the humanities. See: [http://www.law.tau.ac.il/Eng/?CategoryID=473](http://www.law.tau.ac.il/Eng/?CategoryID=473) last access, March 2013.

40 Rabbi Yuval Cherlow is a modern orthodox rabbi and posek. He is Rosh Yeshiva of Yeshivat Hesder (i.e., the students both study the Torah and join the Israeli Defense Force). The rabbi serves on various committees of the Ministry of Health that deal with issues of medical ethics.
• A representative of one of the Israeli HMOs discussed the differences in transplantations performed in Israel and abroad prior to the laws and after their legislation.

• An insurance company representative discussed the laws' impact on insurance companies and on people that are on waiting lists for transplantations.

• A professor from the law School of Ono Academic College discussed the dichotomy of altruism and organs trade.

The second session was held by the head of the National Transplant Center and focused on social interactions and altruism, particularly with regard to live organ donations. This session consisted of the following presentations:

• Director of one of the transplantation units in Israel discussed the laws' influences on the socio-demographic profile of live-organ donors.

• A well-known rabbi discussed his association, Matnat Chaim\textsuperscript{41}, whose main goal is to encourage voluntary kidney donation between non-related donors and recipients.

• The altruistic gift of live organs was discussed once again by a professor from the Safra Center for Ethics, Faculty of Law at Tel Aviv University.

The third and last session discussed the Israeli Organ Transplants Law that enables donors and donor card-holders to get priority in transplantations over those who refused to sign donor cards. The lecturers were:

• Director of one of the transplantation units in Israel

• Professor from the department of General Philosophy at Bar-Ilan University.

• Professor from the department of Communication at Tel Aviv University.

\textsuperscript{41} See: \url{http://www.kilya.org.il/english/} last access, March 2013.
• Professor from the Faculty of Medicine at Tel Aviv University.

It is important to note that the discussions were open to the public, and therefore the audience included participants from the different clusters, including organs recipients, families of organs donors, people who were on waiting lists and their families, different organizations involved as well as faculty, staff, and students from universities, and the media. Not only did each speaker represent opposing interest groups and clusters, but also the audience represented varied interests, positions, and points of view.

**Content Analysis**

According to Aronowitz (2009), organ trafficking is perhaps the least profiled form of human trafficking; therefore, there exists almost no empirical research, and most research consists of individual stories and investigations of illegally harvested organs. Meyer (2006) claims that there are hardly any official or reliable data with regard to organ trafficking. Moreover as in other crimes, and specifically in organized crimes, most of the data is covert; unsurprisingly, people engaged in unlawful activities related to organ trafficking are silent. Therefore, one way to collect data regarding organ trafficking is through media reports. Taylor (2009) stresses that research of crime as published in the news media have relied on multiple methods, such as ethnography and interviews, but the most common methodology used is content analysis.

Wilson and Dalton (2008) emphasize the greater public attention to human trafficking and the seriousness of this crime. For them, the topic has drawn significant media attention, and as such they utilized content analysis of newspaper articles in their research of local human trafficking in two cities in the United States. There is no doubt that the particular case of organ
trafficking received wide-ranging media attention as well. Taylor (2009) argues that the media are the most common and influential guide for exploring social problems; in fact, the media play a powerful role in the construction and understanding of these problems. Hence, the author cites researchers who emphasize the importance of analyzing the media since: "the media are the primary source of information and understanding and thus action and change". Therefore, content analysis of newspaper articles and other forms of media was performed to better understand how the social problem of illegal organ trafficking in Israel was constructed.

According to Laswell (1968) the term content analysis is usually applied to refer to empirical examinations of the themes communicated in the media. The author further claims that content analysis provides an instrument of great potential since it enable inquiries of: goals' formulations, trends' descriptions, analysis of conditioning factors, predictions of future events, as well as innovation, implementation and evaluation of policies. Moreover, Hagan (2003) claims that content analysis is excellent for comparative and historical studies or for discerning trends in existing phenomena. Hence, using content analysis allows a better understanding of organ trafficking as carried out in different nations and countries or domestically within a country; it also provides more information regarding the recipients’ versus donors’ characteristics.

Furthermore, the possible uses of content-analysis procedures should be reconsidered. Thus, according to Mitchell (1967), although Berelson defined content analysis in 1954 as "a research technique for the objective, systematic, and quantitative description of the manifest content of communication,"42 today there is a growing interest in applying this research method.

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42 See Mitchell (1967) at 233.
for generating data that allow the researcher to make inferences about the latent or underlying meaning of themes and for getting explanations rather than only descriptions of the messages.

Berg (2004) agrees and argues that through content analysis a researcher can learn how authors of recorded material view the larger social world. He points out two dimensions of text for analysis: manifest content as opposed to latent content. The first discusses countable elements which are physically present; the latter refers to the deep structural meaning conveyed by the message. The researcher may use both dimensions when appropriate. Holsti (1969) claims accordingly that content analysis allows researchers studying information with low subjective inference (by coding manifest content), or with high inference (by coding latent content to understand and evaluate meaning). As such, the current study incorporates analysis of both the manifest and latent content in order to answer the research questions and to shed light on the illegal form of organ trafficking in Israel and its construction as a social problem.

Boots and Heide (2006) utilized content analysis of news reports to compare cases of parricide in the United States to other countries; they stress that when applying that method, the researcher has to begin with a research idea, form a sampling strategy, outline recording units such as ideas to be coded and then create categories for analysis. Therefore, content analysis of newspaper articles and other forms of media is performed to better understand the construction of organ trafficking as a social problem in Israel. Thus, the social artifacts used in this research of organ trafficking are both electronic newspapers and official documents review. Yet when relevant, websites as well as radio and TV shows are examined as well. More specifically, in order to answer the research questions and to better understand how organ trafficking was constructed as a social problem, I used the following social artifacts.
Official documents review

A review of official documents is conducted to allow for an extensive examination of the collective definition process of organ trafficking as a social problem in Israel. These documents were sourced from various legislative processes both proposed and signed into laws (e.g., the outlaw of organ trafficking in Israel). Other sources are protocols from court hearings, state comptroller’s reports, or other government officials’ statements such as the Ministry of Health representatives and the Israeli National Transplant and Organ Donation Center. The Hebrew law as well as religious community leaders’ public assertions related to organ trafficking were also studied.

Electronic newspapers

An examination of various databases that include local, regional, national, and international publications written in the English or Hebrew languages was performed to acquire newspaper articles regarding the illegal form of organ trafficking. These databases are accessible through university academic subscriptions and also through public access online. Thus LexisNexis, which allows for multistate and international newspaper comparisons, was used. This source was complemented with multiple databases and/or news sources (e.g., the search engine Google has the option of sending news stories regarding a key term to an electronic mail account). I have registered to have electronic newspaper articles from print media sent to my email account that contained the words “organ trafficking” located within the title or someplace within the article. Direct newspaper links provide additional information; for example,

When applicable, the legal form of organ donation was examined through electronic newspapers in order to study the construction of organ trafficking as a social problem in Israel. Two case studies using media reports were performed. For example, a detailed examination of the specific case of Avi Cohen, which sheds light on such a development, is analyzed. As a general overview, Avi Cohen was a well-known and truly honored Israeli footballer who was seriously injured and later died in a motorcycle crash. His family thought of donating his organs, but eventually did not, even though Avi was a donor-card holder. This aroused a heated public debate and all interest groups, powerless and powerful alike, were involved. The examination of the opposing sides, as revealed in the newspaper articles as well as in other forms of media and in the in-depth interviews was an excellent opportunity to learn about the process of constructing organ trafficking as a social problem in Israel. Another more recent case study that was examined was the successful liver transplantation done in Belarus for the former Director of the Israeli Mossad\(^{44}\): Mr. Meir Dagan. Needless to say, this case also aroused a heated public debate where all interest groups were involved.

**Radio, TV programs, and pictures**

Media reports on TV and the radio were examined as well, particularly when revealing information regarding organ trafficking related to Israel. For example, a discussion of organ

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\(^{43}\) Since Israel has a key role in organ trafficking and in this research, a major part of the articles are from Israeli electronic newspapers and therefore are translated to English.

\(^{44}\) The Institute for Intelligence and Special Operations is appointed by the State of Israel to collect information, analyze intelligence, and perform special covert operations beyond its borders. More information about one of the most honored Israeli institutions may be found on its website: [http://www.mossad.gov.il/Eng/AboutUs.aspx](http://www.mossad.gov.il/Eng/AboutUs.aspx) last access January 2013.
trafficking by NPR from July 200945 was reviewed, where one aspect of the Israeli participation in the international market was disclosed. In the same manner, an Israeli television program named "*Uvda*" in Hebrew, which means "A fact", that dealt with organ trafficking was examined as well. TV shows or news that dealt with the tragic death of Mr. Avi Cohen, or the successful liver transplantation done for Mr. Meir Dagan as already mentioned, were examined and when relevant will be discussed. Since the current study took place in Israel, I took pictures in order to better describe an idea or to help visualize it. A few of these pictures will be presented when applicable.

**Websites and secondary data analysis**

The main source of data in the category of websites was [www.Liver4you.org](http://www Liver4you.org). Here potential organ recipients (mainly liver and kidney) could find information regarding the transplantation procedure such as its cost and location as well as general information about the donors. The last access to this website was on March 2009. Today its domain has expired and new information and updates are no longer available; any relation to the previous illegal form is denied.

As already mentioned, other sources of the legal aspects of organ donations are analyzed to study the social construction of organ trafficking as a social problem in Israel. These include not only electronic newspapers, but also secondary data analysis and websites. For example, information is taken from the U.S. Department of Health and Human Services annual reports46,

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46 See for example: [http://www.ustransplant.org/annual_reports/current/data_tables_section10.htm](http://www.ustransplant.org/annual_reports/current/data_tables_section10.htm) last access January 2013.
The Organ Procurement and Transplantation Network (OPTN)\(^\text{47}\), and United Network for Organ Sharing (UNOS)\(^\text{48}\). Equivalent information from Israeli websites is not available. However, general information and links for medical and ethical articles are available, for example, through the Israeli National Kidney Transplantees and Dialysis Patients R.A.\(^\text{49}\)

Other websites that were screened in order to learn more about the different interest groups involved in the development of organ trafficking to a social problem in Israel are also related to the legal aspects of the issue (e.g., shortage of organs, organs transplantations, and organs donations). For example, a thorough examination of the different Israeli organs' associations was done\(^\text{50}\) to better understand the powerless group of organ recipients and their representatives. Another website that was examined is the Israeli national transplants center\(^\text{51}\), which represents the government officials' interest group. A better examination of the religious aspects was enabled through the website of the Halachic Organ Donor Society, "Hod.\(^\text{52}\) These websites emphasize, once again, the complexity of the public discourse of organ trafficking and organ donations alike.

Nevertheless, it is important to take into consideration some of the common limitations of content analysis. Content analysis does have limitations, particularly in selection bias. The data in this research are limited since the information available via the electronic databases is limited both by amount and scope. As such, newspaper articles as well as the other sources discussed

\(^{47}\) See: http://optn.transplant.hrsa.gov last access January 2013. The OPTN is the unified transplant network established by the United States Congress under the National Organ Transplant Act (NOTA) of 1984. The primary goals of the OPTN are to increase the effectiveness and efficiency of organ sharing and equity in the national system of organ allocation and to increase the supply of donated organs available for transplantation.

\(^{48}\) See: http://www.unos.org last access January 2013.


\(^{50}\) See for example the kidney transplantees association at Supra note 43.

\(^{51}\) See: Supra note 33.

\(^{52}\) See: www.hods.org last access January 2013.
may not reflect all cases of organ trafficking that occurred. Cases that are not reported in the newspapers or in the other forms of media may differ from those that are reported. This limits the extent to which the findings may be generalized.

Another limitation of content analysis that must be acknowledged here is the fact that these articles were written for a purpose other than those of the current study (Boots and Heide, 2006). Readers should consider the influence of reporters and editors points of view as well as the newspaper's overall political vision (Taylor, 2008). Moreover, the newspaper articles as well as other forms of media examined come from a multitude of different countries (e.g., when discussing the international trade of organ), media sources, and state and public news sources; this fact makes it particularly difficult to determine what cultural, political, or social biases may exist within these reports (Hagan, 2003). I tried to overcome this obstacle by presenting Israel specific state of affairs, such as that regarding to separation of state and religion and by referring to multiple sources of data.

In addition, bearing in mind that one of the core questions is the social construction of organ trafficking as a social problem in Israel, and considering many other researches of other social problems where the researchers relied on content analysis as the main and sometimes the only method, it seems that content analysis is essential for such a research. For example, see Ball & Lilly (1982) with regard to the menace of margarine; Best (1987) with regard to missing children; McCright & Dunlap (2000) with regard to global warming; Nuehring & Markle (1974) with regard nicotine; and Troyer & Markle (1984) with regard to caffeine. Therefore, even though content analysis might entail a few limitations, it is still a very useful method to enhance our understanding of organ trafficking and to help answer the research questions. Furthermore,
the data obtained by content analysis was used as a supplement to the data sourced at the observations as described above and from the in-depth interviews as follows.

**In-depth interviews**

In addition to content analysis and observations, 12 in-depth interviews were performed. Thus, interviews of the medical professionals and administrators involved in organ transplantations as well as interviews of activists for and against related legal practices (e.g., organ donation campaigns, national social security policies, legislation processes) were used to study the phenomenon of organ trafficking and to understand whether it became a social problem in Israel and if so then how. The following table divides the interviewees by clusters, as already discussed in the observations section.

**TABLE III: INTERVIEWS BY CLUSTERS**

<table>
<thead>
<tr>
<th>Cluster</th>
<th>Title</th>
<th>Number of interviewees</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cluster B</td>
<td>Government officials</td>
<td>7</td>
</tr>
<tr>
<td>Cluster C</td>
<td>Religious representatives</td>
<td>1</td>
</tr>
<tr>
<td>Cluster D</td>
<td>Powerless groups</td>
<td>3</td>
</tr>
<tr>
<td>Cluster E</td>
<td>The media</td>
<td>1</td>
</tr>
</tbody>
</table>

Since the content of the interview is highly dependent on the particular interviewee and his/her position, responsibilities, and personal agenda even in the very same cluster, there was no single guideline of questions to be asked. However, the following questions are the ones that the researcher strived to answer while interviewing: a brief description of the interviewee’s position, responsibilities, mission, and goals; the interviewee’s point of view with regard to organ trafficking and related legal practices in Israel; the main characteristics of the donors and recipients involved; the interviewee’s view of the evolution of policies, procedures, and
guidelines, and their perception of grounds behind such changes; references to other key persons related to organ trafficking. In fact, the interviewees' answers were the guidance for the follow-up questions that were asked; and therefore each interview was unique and different from the others.

Prior to the interview, interviewees were informed that their participation was voluntary and that they may cease the interview at any point. In addition, confidentiality and subjects’ privacy were ensured to minimize any risk of harm and to safeguard participants' ability to disclose all relevant information. Most of the interviews were taped, and when they were not the researcher wrote down an interview protocol as soon as the interview was done. Since this study took place in Israel, all the interviews were conducted in Hebrew, and therefore they were both transcribed and translated by the researcher. All participants were interviewed once; however in one case follow-up questions were asked by phone conversation. Interviews typically lasted for two hours and took place in different locations and times as per each participant's request. Therefore interview locations varied from the participant's specific workplace to a public café; each participant chose the most convenient location. Due to the wide variation in these interviews it is almost impossible to describe them as one unit. As a result, I will refer to the relevant interview and describe it when applicable in the data analysis chapter.

Various methodological issues related to the practice of interviews arose during the interviewing process of this study. For instance, even though it is argued that cross-cultural differences are increasingly being homogenized by globalization and therefore the problem of

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53 I referred only to these issues that had significant impact in the interviewing process. Other issues with limited relevance such as: risk of harm; the consent process; confidentiality and subject privacy; as well as getting access and establishing and maintaining rapport, were discussed in the research proposal and were addressed accordingly in the study.
cross-cultural interviewing may reflect a historical epoch (Ryen; in Gubrium and Holstein, 2002). I faced issues of international research, cross cultural research, and cultural sensitivity. Lincoln and Gonzalez y Gonzalez (2008) argue that researches performed internationally should serve both Western academic institutions and the communities in which the research was done. In that sense, the dual role of the researcher may cause international researchers to sometimes feel torn between responsibilities to their native contexts and professional responsibilities to their academic discipline. Other related issues, which I had to face during this study, were those of interpretation and translation that are common in cross cultural and cross-language studies and also the issue of transporting data across cultures without changing their contexts. I tried to overcome these obstacles by explaining the Israeli social-political context, for example, with regard to separation of religion and state as well as by presenting the participants' point of views without changing their meaning followed by an explanation when needed. Tilley and Gormely (2007) suggest that issues related to culture need to be recognized, acknowledged, and addressed in flexible ways; more attention (including the attention of the researcher) needs to be focused on the cross-cultural complexities of translating ethical principles into practice, and I followed their suggestion in this study.

The ethical dichotomy of insider/outsider, which is also correlated to other qualitative principles such as reflexivity and the researcher’s varied selves, was another issue in the current study. Zinn (1979) claims that insiders have monopolistic or privileged access to knowledge of a group while outsiders have unprejudiced knowledge about groups that is accessible only to nonmembers of those groups. Zavella (1993) argues that insiders are more likely to be cognizant and to accept complexity and internal variation and are better able to understand the nuances of language use. He also argues that they are less apt to be distrusted by those they study. Insiders
also have an easier time gaining access, and they are more sensitive to community sensibility.

However, being a member of a group under study carries particular problems and creates personal and ethical dilemmas. For example, insiders sometimes need to negotiate continually their status, and they also have the constraint of always being accountable to the community being studied. Insiders also have the responsibility to construct analyses that are sympathetic to ethnic interests. Shope (2006) claims that even though it may be easier to insiders to develop rapport with the respondents and they may be more familiar with cultural sensitivities, outsiders are also able to offer insights and to collaborate as allies in the struggle for social justice.

Moreover, sometimes the researchers’ status as outsiders became a resource through which they were able to acquire insiders’ perspectives, when people preferred to share confidences with strangers rather than with friends and acquaintances; see, for example Naples, (1996) and Reinharz (1997).

To resolve these issues I followed Bolak’s (1996) idea that the positions of either outsider or insider are relative and exist on a continuum. Bolak (1996) emphasizes the “outsider within” status that bicultural researchers face and argues that this in-between status helps the researcher to cope with the “pride before outsider” and “fear of moral judgments by insiders” that may inhibit participants from self-disclosure. Collins (1986) claims that the researchers' status as "outsider within" offers a powerful balance between their strengths of sociological training and their personal and cultural experiences. Thus in the current study, where participants are medical staff and administrators involved in organ transplantations as well as activists for or against related practices, and the researcher is an Israeli academic woman, I was both an insider based on language, nationality, and being an academic and an outsider based on the fact that I am not a physician or any other medical professional or an activist. Other selves and identities that I
brought with me to each interview changed my status as an insider or outsider given the similarity with the participants. By doing so I reflected the idea that the status of an insider or an outsider is not fixed or static; rather it is a fluid, ever-shifting social location, and the researchers are never fully outside or inside the community—their relationship with the subjects is constantly being negotiated and renegotiated (Naples, 1996).

According to Guillemin and Gillam (2004), a reflexive researcher is attentive to these potential influences and is able to criticize his or her own role in the research. Therefore, being reflexive will allow the researcher to improve the quality and validity of the research and to recognize its limitations. Adopting a reflexive research leads to more rigorous research of continuous process of critical analysis and interpretation with regard to the research methods and the data, as well as the researcher, participants, and the research context. Thus, being aware of the potential influences of my different identities (both brought to the field with me and recreated during the field work) enable me to criticize my own role in the process as well as the limitations of the knowledge I may produce. Revealing my own personal, professional, and structural positions as a researcher in the research process (e.g., from gaining access to the field through interpreting participants’ responses to the writing stage) helped me to avoid biases and to gain better research in terms of validity and quality. A continuous process of critical scrutiny and interpretation improved my research; see, for example, Guillemin and Gillam (2004) and Shope (2006).

Another methodological issue that arose during the interview process of this study was "studying up" or "elite research". The interviewees varied greatly, from people with positions with the Ministry of Health, lawyers, parliament members and their spokesmen, and representatives of different associations. Issues of control, power, and accessibility are common
in the process of interviewing elites. For example, Aldred (2008) argues that researchers who interview elites have limited control over the research direction, and the interactions involved are constrained. Acknowledging that obstacle, I was prepared to a limited data sourced from the interviews, and I had almost no access at all to potentially helpful elite participants for interviews. Surprisingly, I found out that the people that consented to interview were willing to talk and to disclose their feelings, thoughts, ideas, and suggestions. However, as a secular, academic woman I had almost no access at all to the religious cluster. With the exception of one interviewee, who was very liberal, no interviewee that belonged to that cluster agreed to participate in the study.

As a result, I refer to the three forms of data collection as supplemental, as the data from the difference sources complement each other. Thus, for instance, the fact that I interviewed only one representative of the religious cluster does not significantly affect the research since the religious cluster was highly represented by the observational and content analysis of the research. In the same manner, I had the opportunity to interview seven government officials from different backgrounds and positions. It was important to interview them since they were directly related to the social construction of organ trafficking as a social problem in Israel in its different stages, and that was the research main goal. The complementary character of the three forms of data collection helped to balance the disproportion in terms of number of participants from each cluster in the interviews. Additionally, on few occasions a participant could belong to more than one cluster, and in these cases I considered the participant in the manner he or she chose to present themselves. For example a government official, who was highly involved in the legislation process of 2008, was also both a religious person and an organ recipient. In that sense the participant might represent three different clusters; however, the specific classification is
done with accordance to how the participant self-identified and will be explained in the data analysis chapter that follows.

**Analysis procedure**

The current study utilizes a grounded theory approach for the analysis of a social process. Grounded theory is a qualitative research design in which the researcher generates a theory, a general explanation of actions, interactions, and social processes that are shaped by the participants’ views (Creswell, 1998; Strauss & Corbin, 1994, 1998). Grounded theory is utilized for the generation of a theory of actions, interactions, or processes through interrelating categories of information based on data collected from field research. It is an analytical method that applies an inductive approach to develop a theory based on data gathered from interviews or observations. In contrast to other methods that analyze data in order to describe phenomena or to test hypotheses, the main goal of grounded theory is to construct new theories when existing theories are lacking (McVea, Miller, Creswell, McEntarrfer & Coleman, 2009). Therefore, grounded theory researchers are interested in patterns of actions and interactions between and among various types of social units, and they are also interested in discovering processes of reciprocal changes of conditions either internal or external to the process itself (Strauss & Corbin, 1994). This research design has gained popularity in social science fields, and it is a well-accepted approach to qualitative research (Creswell, Hanson, Clark Plan & Morales, 2007; Strauss & Corbin, 1994).

Creswell (1998, 2009) presents clear guidelines for the processes of analyzing data in grounded theory research design by using qualitative coding. For the current study, these codes are initially written as names or short phrases next to a segment of data: an interview transcript,
an observation field note, or an official document / protocol, all of which are supplemented with open source data. The codes are later reviewed to determine the most significant or frequently used terms in order to sort, synthesize, and organize the data. Eventually, following the categorization and analysis of the data and emergent themes, a theory about the process that was studied is offered. Thus, Creswell (1998, 2009) argues that grounded theory enables the researcher to create categories of information (open coding), interconnect these categories (axial coding), develop a "story" that connects the categories (selective coding), and to end with theoretical propositions.

The current study employed grounded theory procedures to analyze the data and to develop a theory. More specifically, grounded theory analysis was used to modify a model of the construction of social problems by examining the construction of organ trafficking as a social problem in Israel. The grounded theory analysis was conducted in steps. After the initial steps of organizing and preparing the data, the initial reading yielded a set of concepts that were labeled, defined, and illustrated as several sets of categories that corresponded with the initial theoretical framework. Later, the data was coded in steps. The first coding step in the process was open coding, in which I examined segments of data to identify categories of information. These categories were organized along a continuum. New categories were generated until saturation was reached (Creswell, 1998, 2009). By evidence of data replication, the data set was considered complete such that no new insights were obtained and no new themes were identified. The process also included a search for negative cases or falsifying evidence that would contradict the modified model. In this regard, all negative cases that were found in the data were addressed; namely, conditional statements were refined and made final (Bowen, 2008).
The second coding step was axial coding, in which I identified the central process (i.e., “the construction of organ trafficking as a social problem”) and explored the categories (i.e., the different stages of Blumer's [1971] model and its modifications). The axial coding process examined the reasons and motivations of the different interest groups (i.e., participants organized by clusters) for their support or opposition to the construction of organ trafficking as a social problem. It also examined the context and intervening conditions that shaped the strategies they used and the consequences of undertaking those strategies (Creswell, 1998). Strauss and Corbin (1998) describe the third analytic coding step as “selective coding.” Applying this step, I first developed a theme that connected the categories and then a theoretical proposition. This theory or model modification is grounded or derived from participants' data as described below.

**CHAPTER 3: DATA ANALYSIS**

Since the primary aim of this research is to trace Blumer’s (1971) five stages model and its later modifications in the construction of organ trafficking as a social problem in Israel, the data collected is presented according to the following stages: the emergence of organ trafficking as a social problem in Israel; the legitimation of organ trafficking as a problem in Israel; the mobilization of action with regard to organ trafficking in Israel; the formation of an official plan of action considering the phenomenon of organ trafficking in Israel; and the transformation of the official plan in its empirical implementation. It is important to note that these stages are fluid and some activities or themes can be considered in more than one stage. In each one of these stages other core factors of the construction of organ trafficking as a social problem gathered in this study are discussed. Therefore, data corresponding to access to media, religious aspects, and globalization, where at times Israel is superior and in other times inferior, is presented accordingly.
However, in order to understand the application of the abovementioned stages on the specific case of organ trafficking in Israel, a brief examination of the opposing interest groups as well as their main goal with regard to organ transplantations is required. One of the core interest groups is the government officials.\textsuperscript{54} This cluster consists mainly of officials from the Israeli National Transplant Center “Adi” and other officials from the Ministry of Health or from the Israeli public health system, which is run by the government. Other representatives of this group are Knesset members,\textsuperscript{55} their spokespersons, the state comptroller, and others. Their main goal with regard to organ transplantations is to increase the low Israeli rate of organ donations by enlarging the pool of potential legal donors and to cease all forms of organ trafficking. Another interest group is the religious representatives.\textsuperscript{56} Israeli society is characterized by a deep-rooted conflict between its diverse social strata, particularly the one related to different levels of religious and secular sectors. This conflict is also expressed in the construction of organ trafficking as a social problem in Israel, mostly with regard to the question of brain death. Accordingly, some religious parties oppose organ donations since they do not accept the brain death criteria due to Jewish religious law, which prohibits mutilation of a dead body. The religious interest group seems to be one of the powerful clusters with access to power resources and therefore with major influence on the construction of organ trafficking as a social problem in Israel.

The powerless group\textsuperscript{57} consists of both organ donors and organ recipients that are represented mainly by their family or the specific organization to which they belong.\textsuperscript{58} Although both donors and recipients have little power or access to influential resources, and therefore they

\textsuperscript{54} This group is also known as cluster B in this research.
\textsuperscript{55} I.e., Members of the Israeli Parliament.
\textsuperscript{56} This group is known also as cluster C in the current study.
\textsuperscript{57} This group is also known as cluster D in this research.
\textsuperscript{58} For instance, the Israeli National kidney Transplantees and Dialysis Patients.
have in common a limited ability to act and have an effect, their interests and main goals differ. The recipients would rather enable as much donations as possible to improve their chances of obtaining an organ in a legal way. The donors would also strive to improve their situation: those of them who were exploited would try to obtain the promised "payment"; others would like to obtain the freedom to donate organs to their loved-ones without going through an exhausting process. The last group that is important is the Media, which consists of officials from different media forms, such as print journalists, TV, and radio people. Since one of the key elements to a successful development of a social problem is the groups' access to power resources and above all the media, these involvements will be discussed in the different stages of the model along with other key factors that influence the process of constructing organ trafficking as a social problem in Israel. Thus, the issues of globalization and religious aspects are presented along with the stages as claimed by participants from different clusters.

**Stage 1 - The emergence of organ trafficking as a social problem in Israel**

The need to legislate and regulate the issue of organ transplantations as well as its negative side effect of organ trafficking was already discussed in the Israeli parliament on July 12, 1978. It was then when the Law and Justice Committee of the Israeli parliament — the Knesset — discussed the medical method by which heart transplantation was performed in Israel, and they came to the conclusion that it was necessary to regulate organ transplantations. The Ministry of Health representative in that discussion announced its intention to prepare a bill that the committee hoped would be submitted to the Knesset soon. As it turns out, the promised proposal

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59 This group is known also as cluster E in the current study.
60 As already discussed in the theoretical framework, government activity is also an influential cause to the construction of a social problem. However, in the specific case of organ trafficking in Israel, one of the core clusters is the government itself and therefore this discussion is unnecessary.
or bill became a reality only years later, in 2008. During that early stage of the emergence of organ trafficking as a social problem in Israel, the Israeli society was not yet ready to take care of that problem. In fact, this stage discloses the impotency of both the powerless groups (i.e., organ donors and recipients) and the government officials to gain attention for what they believed to be a major social problem\textsuperscript{61}. As a result, the opposing religious cluster did nothing to change the current situation that best kept its interests. In accordance with that, it is hard to find any involvement of the mass media, political figures, powerful organizations, corporations, or any other measures that are necessary at this initial stage of the social construction of organ trafficking as a problem in Israel.

However 15 years later, the Israeli public was influenced by such measures and established the Israeli National Transplant Center in 1994. The Israeli center for transplantations, as published on its website,\textsuperscript{62} was established by the Ministry of Health in order to create a neutral government agency to manage and coordinate the array of organ donations and transplantations. The National Transplant Center is the only body in Israel that performs transplantations and manages the allocations of organs for transplantations. The need to set up an official body run by the government is the outcome of the collective discussion on organ trafficking and the severe shortage of organs in Israel. It was a government effort, led by the Ministry of Health, that laid the foundation for establishing the National Transplant Center as a first required step in targeting the emerging social problem of organ trafficking in Israel.

The establishment of the National Transplant Center may be also considered as part of the stages that follow, and it is brought up at this juncture for descriptive purposes. In this stage of

\textsuperscript{61} It might be also due to the fact that since the first heart transplantation done in 1968, it, among others, failed and caused the Israeli medical centers to stop the transplantation procedures in Israel. Only in the mid 1980's organs transplantations in Israel became a successful routine.

the emergence of organ trafficking as a social problem in Israel, it is important to note that prior
to the National Transplant Center, it was the "Adi" association, established in 1978, that was
responsible for the Israeli donor-card holders list. However, "Adi" was not an official
government organization; rather, it was an association run by family members of a kidney
recipient who died after his transplantation. One of the key position-holders at the association
described the early days of the association in her interview:

…While waiting at the hospital for a kidney, Adi [after whom the association is named] thought of establishing an association that would advance organ donation awareness in Israel. After his passing, his family regarded that idea as their beloved son's will and on the thirtieth day of his death, Adi association was founded… At the beginning the family issued donor cards … you know, in their own house … their goal was to distribute donor cards, so with family, friends and volunteers they got to 250,000 donor-card holders; however, the names of the donors were not saved. Then sign up for a card was also offered when renewing a driver's license so that every year the public was reminded about the need to sign a donor card… it became formal at some point, when it passed to the National Transplant Center and now it is done online…

In other words, even a highly respected representative of the association was convinced that only when the signing of the donor card was organized by the National Transplant Center did it become a serious matter, because it was then covered by official government policy.

The importance of instituting the Israeli National Transplant Center is emphasized by one of the key center representatives, who has worked in the same position since 1997 and has a personal relationship to organ transplantation and donations. The participant disclosed her personal story:

My connection to the world of transplantations began 20 years prior to the establishment of the National Transplant Center. I was Adi's mate throughout his illness until his death. I was in my last year at nursing school and at the hospital where I studied there was a very long hall, I walked to and from and I passed Adi's room routinely. He asked the nurses to bring us together and the rest is history … [Adi was the inspiration behind the establishment of the donor card association].

The participant might be considered both a government official and one of the powerless participants; however, due to her high governmental position and the fact that she considered
herself a government official, I did the same. In response to the questions "what made the establishment of the center so important?" and "what was its main opening goal?", the participant replied:

… The main change was that before the center was founded in 1993-1994 there were six different [medical] centers in the country, where they knew how to transplant…so there were donations in each one of them…. So as you see in the movies… when there was a donation, they took the donor down to the basement -surgery rooms are underground- and then in the elevator the donor malformed... Then you cannot artificially maintain the organs…and then there is no receptors work ...so the main change was to replace the social workers.

In response to the question "what do you mean by 'to replace the social workers'?", the interviewee replied:

Yes… they thought the most important thing is to talk with the coordinator and the family, so they took a social worker…each medical center had a social worker and when a potential donor came she was responsible to discuss the donation with the family…but she could not help when the donor's system collapsed and we lost many donations…so the director of the Ministry of Health decided to replace the social workers with nurses…

In other words, the interviewee explained that the main goal was to salvage as many organs as possible so that more organs would be available and suitable for transplantation. Other goals, such as helping the donor or recipient (as well as his/her family) cope with their health condition, emotions, feelings, difficulties, and mental state are not as important, at least not from the perspective of the National Center; therefore, the social workers are replaced with nurses. In a follow-up question, the interviewee was asked whether that was really the main change with the establishment of the Israeli National Transplant Center. The participant replied that only a few years later had the real change come. That change she mentioned was part of the second stage of Blumer's (1971) model, and it is discussed below.
**Stage 2: The legitimation of organ trafficking as a problem in Israel**

After gaining initial recognition—for example, by the establishment of the National Transplant Center in 1994—according to Blumer (1971), a social problem must acquire social endorsement. If a social issue does not carry the credential of respectability necessary for entrance into recognized arenas of public discussion, it is ignored. The specific case of organ trafficking in Israel was not ignored; it gained attention at this point of the second stage of the model mostly from the Israeli government. Thus, the government recognized the need to structure this matter so that illegal organ transplantations will not be allowed in Israel. In order to do so the Ministry of Health issued two internal regulations in 1997 and 1998\(^63\), respectively. The first dealt with live organ donations and was canceled in July 1998 with another internal regulation of the Ministry of Health\(^64\). The second was titled: "The prohibition of organ trafficking for transplantations". The title, however, does not quite reflect the content of the regulation, since its main goal was to remind physicians of their duty not to take any consideration for the service of transplantations. These regulations were beset by two related problems: first, with regard to their limited scope as internal Ministry of Health regulations and not parliament legislation; second, with regard to their content, which did not really announce the prohibition of organ trafficking but only discussed the medical aspects of transplantations. Nevertheless, it was an official government declaration that the issue of organ trafficking is worth of consideration and must acquire some social endorsement to become socially prohibited.

Two years prior to these internal regulations, another official declaration took place and served as a major milestone in the second stage of Blumer's (1971) model. The State

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\(^{63}\) See: "وزارة הבריאות 68/97, 2/97" Available only in Hebrew.

\(^{64}\) See: "وزارة הבריאות 10/98" Available only in Hebrew.
Comptroller's report from 1996 began the legitimation process by which the Israeli low rate of organ donations (which directly affects organ trafficking) was initially recognized as a social problem in Israel. Since the State Comptroller's office is independent from the government and responsible to the parliament, it is a powerful, well-respected institution. One of the main goals of the State Comptroller is to examine the executive authority and to define and report whether its activities have been carried out in compliance with the principles of economy, efficiency, effectiveness, and moral integrity; its reports are crucial when defining certain activities of the executive authority as problematic.

Thus, the State Comptroller's report of 1996 reviewed the function of the "National Center for Coordination and Management of Donors and Transplants" which was established by the Ministry of Health in 1994. The report stated the following regarding the conditions after three years of the National Center's operation: there were still no binding arrangements and procedures for cooperation between the National Center and local hospitals; the Ministry of Health did not examine the influence of the National Center on donors and transplantation rates; and financial deficiencies were found in budget preparation and in the formal registration of the National Center as an association. All of these surfaced as major deficiencies in the National Center activities along with the fact that there is also no full disclosure of potential organ donors and no valid procedure that require medical staff to report potential donors. Therefore, even though there is a major growth in the need for organs in Israel, these severe malfunctions impede the Center from improving the rate of organ donations. The fact that the State Comptroller audited the National Center of Transplantations served in itself as a legitimating stage of the shortage of organs as a social problem.

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65 That later became the Israeli National Transplant Center.
By law, the findings of the State Comptroller’s audit are brought to the attention of the audited bodies for their response and in order to induce improvement in management. It was in one of the interviews when the State Comptroller’s report of 1996 was mentioned. The participant of this interview holds one of the key positions in the Israeli National Transplant Center and has worked there since 1997. In response to the question "what are the major changes the National Center has gone through over the years?", the interviewee referred to the report:

…We've got the State Comptroller's report of 1996, where we [the National Center] were strongly criticized…we had to renew the system so it will work with a national waiting list. Prior to this change, each center worked individually so that if someone died (preferably a 29 year old motorcyclist) the social worker talked with his family and if that worked out and they consented to donating his organs- she took a cooler bag…you could never tell who died first and who the one that should get the organ is…

So the National Center for Organ Donations and Transplantations was extremely disorganized?

Disorganized is an understatement…it was a business run by the surgeons, maybe with a few social workers…each transplantation unit worked by itself according to its individual lists…if no one put the organ in the fridge – the surgeon could not do his part of the job…but after that report, I'm telling you, we changed it all, it was both the Minister of Health and the Director General of the Ministry of Health, back then, that required a national waiting list as all other civilized countries had…

As explained by the interviewee, the report had a major influence on the officials responsible for the National Center since it brought about important changes such as the national waiting list.

However, the interviewee, who stated that the National Center's most important goal is to significantly increase donations rate, also stressed the following:

… so we moved to a national waiting list like in the United States (if it is possible in such a big country we knew that we could do it too) but guess what? Nothing really changed—nothing! We still did not have enough donations! It did not work well...

In other words, the interviewee claimed that even though major changes had occurred, the primary goal of higher donation rate had not yet been achieved.
A few years passed, but the low rates of organ donations persisted and brought about a proposed law—the bill to encourage organ donations of 2000. The bill's purpose was to create a national framework and to initiate activities to encourage organ donations for transplantation. Thus according to the bill, holding a donor card is sufficient consent to organ donation so that the family's approval is not required. Furthermore, card holders would be given special privileges such as priority to transplants and 25% discount on health insurance taxes for three years. The immediate family of a deceased whose organs were donated would be also given priority to transplant as well as a discount of up to 50% on health insurance taxes paid for three years from the date of donation. The bill also recommended forming media broadcasting, commercials, and announcement to increase donation rates. On the other hand, the bill proposed that the medical team would not transplant until they have verified that the donor has given written consent for the transplant and stated that consent is free and voluntary and without receiving any reconsideration. Such an "opting-in" system of organ donation requires individuals to register their willingness to be a donor after their death. Another proposed amendment to the existing law to promote organ donations was the one that recommended changing the Israeli legal model of organ donations to a presumed consent model (i.e., "opting-out" system) by which if a person does not inform the authorities of her refusal to donate her organs after her death, the state will assume her approval.

These two did not become law due to major disagreements between the opposing clusters. However, some of these recommendations were discussed in 2007 with another proposed law.

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66 A direct link to that law proposal is not found. However, it is mentioned on the Knesset website: http://www.knesset.gov.il/library/heb/docs/sif032.htm last access February 2013, available only in Hebrew.
68 The legal model of opting out is still discussed nowadays in Israel and therefore it is part of the fifth stage of Blumer's (1971) model.
that was finally enacted in 2008 and is still applicable. Nevertheless, they all serve together as another factor in the public discussion on organ donations and organ trafficking as an emerging social problem that is legitimated and needs to be addressed. For example, in an interview of one of the parliament members that led the efforts on that bill, she explained:

I knew it was not going to be a law; I did it only for the declaration… it is a long process and only when the government coalition will be without the religious parties we would be able to change it. I can't imagine such a coalition—it is impossible…but it is important to reveal this issue even if it is only for declaration purposes…

So, even though both the bill and the proposed amendment were not approved and did not become laws, their public discussion was the starting point for the next stage that finally revealed explicitly and officially the discussion on organ trafficking.

Stage 3 - The mobilization of action with regard to organ trafficking in Israel

The mobilization of action regarding organ trafficking in Israel formally transpired with the proposed law that called for the prohibition of organ trafficking in 2003. For example, on the Knesset library's website, where issues on the public agenda are published, one may find a document about the sale of live organs for transplantation due to financial causes.69 This official document from 2003 describes a "new phenomenon" whereby the difficult economic situation pushes more and more Israelis, mainly single-moms, to sell their kidneys to support themselves and their children. The method is simple: newspaper ads recruiting donors. On average, 15 people a day respond and offer their organ for sale, particularly women from all over the country; they are all examined and those that are matched will get $7,000 to $25,000 for their kidney after its removal is performed abroad. This practice became relatively common so that for instance, a support group of almost 50 women that sold their organs for a living was established.

69 See: [http://www.knesset.gov.il/library/heb/docs/sif032.htm](http://www.knesset.gov.il/library/heb/docs/sif032.htm) last access February 2013. No English version is available.
The document continues by stating that the price paid by the organ recipients is approximately $150,000 and that the price difference sponsored the middleman.

Another example of organ trafficking performed in Israel worked in the opposite direction and was used to look for organ recipients. Picture 1 below illustrates such a case with an example of a newspaper advertisement calling for organ recipients. The New Life Company (N.L.C Ltd) defined itself in that advertisement as "the official Israeli medical tourism company" and promised low prices, the possibility to wait for the surgery in Israel, and an optional refund from one of the Israeli HMOs. The advertisement also highlighted the fact that the kidney transplantation as promised by the new life company is performed in a legal way. The website as published in this ad is no longer available and therefore more information, such as where the transplantation takes place and what the recipient's costs are, is not available. It is important to note, however, that since the legislation of The Organ Transplant Act and the Brain and Respiratory Death Law of 2008\textsuperscript{70}, such advertisements are no longer found in Israeli newspapers. The interaction between organ recipients or organ donors and the middlemen, if any, is done in a covert way.

**Figure 1: A newspaper ad for organ recipients**

![Newspaper Ad for Organ Recipients](image)

Source: Presentation given by Attorney General of the Ministry of Health, in Tel Aviv University.

\textsuperscript{70} These will be discussed in length in the fourth stage of the model.
These examples, among other similar cases, were already published by the media. However, the fact that it is officially discussed in the parliament and formally published on its website makes it an important issue that climbs its way up to become an Israeli social problem. The official document from 2003 emphasizes that there is no law prohibiting organ trafficking, and therefore persons suspected of it can only be accused of forgery, extortion, and threats. This lacuna calls for a legally binding plan to solve the socially constructed problem. Furthermore, the explanatory chapter\textsuperscript{71} of this proposed law revealed not only that it prohibited donors from receiving consideration for the donations and recipients from paying for organs, but also it ensured that medical teams will safeguard that rule, and criminal liability is posed on the middleman.

In response to the questions about what the differences between all these bills are and why only the bill from 2003 was seriously discussed (i.e., achieved more support and reached higher stages in the legislative process)—as opposed to the previous bill from 2000, for example—a Knesset member who promoted a few of the above mentioned bills replied:

> It highly depends on the initial goal: mine [with the 2000 bill] was to enact a law that prohibited organ trafficking, the other parliament member tried only to amend an existing law [The Anatomy and Pathology Law] so that it would include a clause that posed liability on those that are involved in organ trafficking…You have to understand…when I

\textsuperscript{71} See: \url{http://www.knesset.gov.il/privatelaw/data/16/1098.rtf}, available only in Hebrew, last access on February 2013.
brought up my bill it was when we all heard about these criminal gangs that were exploiting the families' vulnerability. Did I tell you that I met two poor women that went through awful deception? One of them was Arab and the other was Jewish from a Southern settlement...and I remember it as if it was today...she was divorced and she had to pay for her son's tuition and school trips and she couldn't afford it, she was promised that it is an easy operation and that she'll be out of the state only for a few days. The striking point is that she came to me not due to the hard medical operation she went through or because she didn't feel well but because they disappeared and did not pay her at all! She came to me because she wanted me to help her getting the promised money!

The interviewee explained that the bill failed because it dealt with marginalized people that do not have enough power and resources to promote their interests. After all, if an organ "donor" who donated her kidney to improve her financial situation cannot get paid as agreed, she also cannot promote the legislation of such a bill, if interested at all. Indeed, these women who moved the Knesset member into action and triggered his submission of the above mentioned bills were not aware of the process they took part in; however as the powerless cluster, they did recognize the appropriate parties to complain to in order to make their claim more powerful. By doing so they made their private claim a complaint that affected a larger sector and became a public issue that the Israeli society must address.

Among the opposing forces to these bills one may find the organ recipients who also belong to the powerless cluster. In order to gain more power, all organs transplant associations collaborated in one forum\textsuperscript{72} and sent two letters to the Chairman of the Committee of Social Affairs and Health in October, 2007. In these letters the forum objected to the proposed law of 2003. The rationalizations for the forum's protest were very emotional and included the following: The bill does not provide any response to the shortage of organs in Israel; the bill denies state funding through HMOs and puts bureaucratic barriers that will prevent life-saving transplantations; the bill will cause medical discrimination since wealthy patients will manage to

\textsuperscript{72} This forum included all organ transplantation associations- heart and lungs, kidney and liver.
get organs abroad and patients without financial resources will die while waiting for their transplantsations and therefore the bill, if accepted, will enable organ transplantsations only for the rich while the poor's fate will be pain, suffering, and death; the bill does not refer at all to live organ transplantsations and donations since its only goal is to avoid organ trafficking; the bill does not mention any long term solution that will increase the donation rates in Israel, whereas such a solution may be found in other countries' models.

Other recommendations that the forum specified in the letters were more practical. For example, the forum recommended compensation for organ donations from the deceased and financial consideration for live organ donors. Another practical suggestion was to enact the law with an interregnum of one year. The forum concluded its letters with an emotional rationalization and pointed out that all people involved in the bill's legislation process would act to the contrary if someone in their own family was in need of an organ. These letters serve as an influential act of the powerless cluster of organ recipients that, among the other opposing factors, helped to prevent the legislation of the bill. However, it is important to note that these proposed legislations and their parliamentary discussion as well as the protest against them are the mobilization of action with regard to organ trafficking in Israel.

Another influential protest to this bill as well as to other proposed laws was that of the religious cluster. Their point of view is discussed below. Spector and Kitsuse (1977) combine stages one to three into one stage in their model of the process by which social problems develop and term it as “Social Problem Definition and Issue Creation.” The stages as described above can be easily combined into one stage to fit their model, but for descriptive purposes they were considered separately. However, the constant themes that are influential elements in the social
construction of organ trafficking as a problem in Israel are presented below as stages one to three combined.

**Religious aspects: Stages 1-3**

In the opening stages of the social construction of organ trafficking as a problem in Israel, the religious opposition remained silent. Since the issue of organ transplantations was not yet organized and did not affect the religious community; their protest, if there was one, was not heard. It was towards the third stage of the model when the religious cluster began to protest publicly. Thus, the religious disapproval became noticeable only when a formal mobilization of action with regard to organ trafficking occurred in different forms, such as the bills of 2000 and 2003. For example, in an interview of a Knesset Member who promoted the bill of 2003, in response to a question about the religious parties and whether it was them that did not support the bill that would prohibit organ trafficking, the interviewee said: "I don't remember. I can't answer this question," but then continued:

It doesn't really matter; it is always the same people and we all know that their considerations are not relevant… but for me, if it is on the public agenda, I achieved my goal… and I also intend to leverage it, it is too early to discuss but for now if it is in the public awareness, it is something to be proud of.

Obviously, the Knesset member did not want to disclose the people who did everything they could to oppose the legislation of these laws. Nevertheless, the opposing clusters of this bill were discovered easily enough in the discussions' protocols of the Health and Social Affairs Committee, and they were members of the religious cluster. For example, in the committee meeting on May 30, 2005, the chairman explained that the major reason for the public not donating organs is that it is not regulated by the Israeli Chief Rabbinate requirements. In the subcommittee that discussed the same bill on November 15, 2006, it was said that the
disagreement was mutual, and both the Israeli Chief Rabbinate and the Medical Federation could not collaborate with each other. These disagreements prevented the legislation of the bill (2003), despite that it received more support in the legislative process.

In an interview with one of the high position holders in the Israeli National Transplant Center, the participant mentioned religious beliefs as well as lack of support from religious leaders as the main cause for the low rate of donor card holders. For her, the main force that prohibits organ donations and therefore increases organ trafficking is that of the religious cluster:

> It is not politically correct to say that…but they [the religious cluster] ruined it all… if the Orthodox Rabbis claim that they cannot accept brain death- it is a major constraint … and they asked me to train them- so I invested 50,000NIS in preparing a course for them and I invited 40 Rabbis, less than 30 of them came…and then at the end of the course the Chief Rabbi of Israel came and told them all not to sign a donor card… by that he ruined all the course… [The interviewee cursed badly] I apologize for that language but I hate them for that!

The training coordinator of the National Transplant Center referred to the same course and said:

> We have a problem when it comes to this sector [religious sector]…it varies from one rabbi to another…few will give their approval to sign on donor-cards, others will disagree…and there is also the political agenda…they will never come with a sweeping statement that organ donation is recommended…at the most it will be a specific approval- not a general call for signing on donor-cards…in that sense, the course did not help us…

In response to the question "did you really think that they might agree to organ donation?" the interviewee referred to a similar course they did for Imams:73

> We organized a course for the Imams and it was a great success: 30 Imams (out of 300 Imams who live in Israel) came and after the course we associated each one of them with a transplant coordinator next to his community, it is a basic foundation for more to follow…and each one of them signed a donor-card and then gave a sermon to his community…they became our representatives in their own communities…to help them we issued brochures in Arabic… it reminds me…the same brochures with a picture of a ten years old girl with a ballet outfit…the religious parties asked us to change it since she wore shorts and you could see her shoulders…so we had to take a picture of her face- we took her body out of the picture…and the Imams preferred this version too…

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73 *Imam* is an Islamic leadership position
As explained by both interviewees, success was limited even in the third stage of the model when the government officials (i.e., the National Transplant Center) issued courses to target these specific opposing sectors. The first interviewee expressed her hatred toward the religious sector that limits its support in organ donations and as a result, according to her, prevents the National Center from achieving one of its core goals. She felt that even though the National Center attempted to meet the religious cluster's requirements, the latter still rejected organ donations. The second interviewee compared the Jewish religious sector with that of the Imams; she presented similar outlooks such as in the case of the girl's picture, but emphasized the dissimilarity between the two. By doing so she demonstrated a utopic image according to which Rabbis should become the National Center representatives in their communities as did the Imams. However as explained by the interviewee, in that stage the Jewish religious cluster persisted in rejecting organ donations.

The religious disapproval of organ donation in this stage of the construction of organ trafficking as a social problem in Israel is described in the protocol of the Committee of Social Affairs and Health's meeting from November 2005. The director of one of the transplantation units in Israel in the opening explanatory section of the meeting said:

> Israel excels in the field of transplants in the world… However, despite the tremendous activity in the area, we have not achieved the main goal of more donor-card holders…in fact, we cannot get to a viable solution due to religious disapproval of brain death definition…I hope we eventually will find a solution, but meanwhile as an intermediate stage, I would like to offer the possibility of using organs after cardiac arrest…it will give us [the surgeons] 20 to 30 minutes before entering the operating room…we can get religious approval for that [specifying the medical technique]…we all know that it has been more than 15 years that we are waiting for religious approval (for brain death definition) and it will take 15 [years] more…

As the surgeon explained, the disapproval of brain death as an actual termination of life by the religious cluster is the main cause for religious leaders and their communities not signing donor-cards. For him, the ongoing discussion on that issue is crucial since most organ donations for
transplantation are done in the setting of brain death, and therefore he offered an optional medical solution. The physician, who belongs to the government cluster, does not believe that at this stage of the construction of organ trafficking as a social problem the religious cluster will change its attitude toward brain death and organ donations. Such a change occurred only later in the fourth stage of the model with the official plan of action with regard to organ trafficking in Israel.

**Globalization: Stages 1-3**

The term globalization as used in this part of the study refers to occasions in which representatives of the different clusters compare the Israeli field of organ transplantations or organ trafficking with its equivalents in other countries throughout the world. Mostly, the Israeli system is compared to invoking practices and activities in other countries that address the issues of organ transplantations and organ trafficking differently. As a result, the comparison depends on its content and may sometimes enhance the Israeli system and present it as superior to other countries, while at other times it may identify the Israeli situation as inconsiderable or inferior to its equivalents elsewhere. The term globalization is also used when representatives of different clusters mention other countries in a globalized context without comparing them to the Israeli state of affairs, or when they refer to different aspects and issues of globalization (e.g., the removal of organs from Chinese prisoners).

In the early stages of the social construction of organ trafficking as a problem in Israel, even though the main goal was creating an official national level—for example, with regard to a national waiting list of recipients or by regulating national standards for all medical centers and the establishment of the National Transplants Center—globalization was also a core part of the
discussion. In these initial stages of the process, globalization was mostly brought up to shed a negative light on Israel and to present Israel as inferior to other states and countries in the field of organ transplantation and organ trafficking. For instance as already cited above, an Israeli National Center's employee stressed that Israel needed a national waiting list like "all other civilized countries had", and that such a national list is possible in Israel because "if it is possible in such a big country [United States] we [The Israeli National Transplants Center] knew that we could do it too". In other words, the interviewee claimed that a national waiting list for organ allocation is an elementary requirement in most developed countries, and the fact that such a small state as Israel did not have one was a major malfunction of the Israeli healthcare system as run by the Ministry of Health.

In the protocol of the House Committee from July 5, 2005, when the committee discussed the bill from 2003 and focused on the issue of considering organ donation, one of the participants who is a father of a young organ receiver (and therefore belongs to the powerless cluster) relied on the fact that a few participants supported the idea of payment for the donors; he said that it would be better to get the money in advance and not only after the donor had died. He said: "give me the money today and I'll come back healthy from Colombia in a month…" The government cluster responded to his remark. One of the key position holders of the Israeli National Transplantation Center said:

He wants to send people abroad to get the needed organs… he wants to exploit the poor and the disadvantaged in India and China…

The Head of the House Committee noted:

… We [the government] are not going to be organ dealers or traffickers worldwide. We are not the world's organ-buyers…we are not going to treat other nations disrespectfully only because they are not Jewish. If it is covert we want nothing to do with it …but to legislate such a law by which we may buy organs in other countries but forbid it in our
own—we will be accused of racism and hate crimes! Such an option fits neither Judaism standards nor the law of ethics of modern life!

Globalization context was part of the discussion again in the same meeting when the head of the House Committee asked why buying an organ in a country that does not legally prohibit organs transaction (e.g., Turkey or China) will be considered illegal too. He was answered by the representative of the legal office of the Ministry of Health:

When the discussion is on live organ donations there is always a chance of trafficking in organs, particularly in China. We are not operating by ourselves; other countries and nations are involved and we are being examined. We do not want to bring organs from underprivileged countries like China, where there is reasonable suspicion that the organ was trafficked against the donor's will. We may allow removal of an organ only from the dead, where there is less fear of organ trafficking. Therefore, the Ministry of Health will restrict it so Israelis will not get organs in countries where organ trafficking may occur even as a remote possibility…

The response of the chairman of the Committee for the Dying Patient (i.e., powerless cluster) was that in China the organ removal is done after the person has died; so in fact, it is not a live organ but rather an organ from the dead. In his opinion, it is also not trafficking since it is not prohibited by the laws of the foreign nation. Therefore, his suggestion was "to add a condition to the law so that there will be no human rights violations either by the Israeli law or by the Jewish law of ethics". The meeting was concluded by saying that the committee will formulate such a condition.

In November 2005, the legislative committee had another meeting. It took place prior to what we classify here as the fourth stage of the model and the legislation of the two laws of 2008. This time the head of the committee asked the director of the transplantation unit of one of the major hospitals in Israel (i.e., government cluster) to open the meeting by giving some explanatory background. The globalized nature of the social problem discussed was emphasized

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74 The head of the committee was not the same one as before since this was a new parliament session.
again by repeated comparisons to other countries and nations. For example, the director of one of
the Israeli transplantation units mentioned the following:

Even though Israel excels as one of the pioneers in the field of transplantations in the
world, its advantage is vanishing…Since 1994, when the National Transplantation Center
was established, and despite its enormous efforts to augment the donation rates, this core
mission of the center has not been accomplished… Israel has less than 10 donors per
million population. Europe is coming today to 20 in most states. In the United States it
also comes to 25. In Spain and Belgium it reaches more than 30 donors per million
population. From our point of view, [physicians] it means long-term damage to our
profession, particularly considering Israel's small population, which means much lesser
activity… another concerning fact is that of the rate of willingness to donate. In Israel it
is approximately 45%, while in Europe and in the U.S. it reaches 60% to 80%. The
saddest fact is that despite all the campaigns and attempts to convince the public, only 4%
of the population of the country signed a donor card…

The participant expressed a negative comparison of the Israeli data with regard to organ
transplantations, both in terms of actual donations' rate and signing of donor-cards. The

The globalized nature of organ transplantation came up during this meeting once again when the
same director, a government official, mentioned the medical tourism sponsored by the Israeli
social security health insurance (HMOs) that used to cover these expenses:

The option to go through transplantation abroad became half-official and half-legitimate
in 1998, when HMOs paid 70% to 100% of the transplantation's expenses and the
Ministry of Defense paid it all75. It became the first alternative for many patients…
Today, more than 50% of the patients that we treat are patients who returned from
abroad. In terms of the fiscal outcome transplant… if you calculate the expenditure per
transplant, it is approximately two times more than if it was done in Israel since the
expenses are paid abroad but the hospitalization and post transplantation treatment (for
life) is done in Israel…Moreover, the transplant abroad is not supervised by the Ministry
of Health and by the National Transplant Center. Transplantation abroad is not always
necessary; sometimes we can take care of it in Israel… This trend also affects the
population's insight: it seems as if local Israeli transplantation does not exist… Israel is
being vilified in professional international forums, where we are reviled as leading the
way for medical tourism!

The legal advisor of the Ministry of Health, who represents the same cluster of government
officials, agreed and stated:

75 The Ministry of Defense full coverage was in these cases, in which the organ recipient was an IDF officer or a
soldier.
The Ministry of Health does not encourage people to transplant abroad… to some extent it is a necessity, caused by the deficiencies of Israel's current system. Israeli Criminal Law cannot prevent acts performed abroad. Criminal legislation is territorial legislation and ex-territorial prevention of these actions should be in the country where organ trafficking occurs…Our bill refers to situations where one of a chain of operations of the organ trade was here in Israel; only then, can we catch the agent or the person who runs this trade…

As explained by the government officials above, medical tourism and the resultant organ trafficking is not supported by the government cluster. Another negative approach towards that phenomenon is that of the powerless cluster. For example, a lawyer who represented both the Israeli Bar Association and the recipients' associations discussed the medical tourism done by Israelis abroad and said in the parliament committee meeting in November 2005:

The number of people on Israeli recipients' waiting list is decreasing. Even though the number of transplantations did not increase in recent years, the number of people on waiting lists decreased more than 20%...it is not a miracle…there are two reasons for that wonder: first, people are dying while on waiting list… every year 50 people on waiting lists die and 50 more will not be eligible for transplantation since their health condition will no longer allow it… the second reason, which is the main one, is medical tourism… according to a recent survey by the Ministry of Health, 45% of Israelis who need transplants do it commercially abroad... in other words, the solution is monetary, as horrible as it sounds - China, Colombia, Ukraine, anywhere you can buy an organ…and it is funded by the HMOs and by insurance companies…

Even though the lawyer represented the powerless cluster of organ recipients and therefore had different interests, he expressed the same condemnation of the practice of medical tourism. It is important to note, however, that by doing so he also raised his suggestion to enable a state system of considerations and payments in return for organ donations. In that sense, although the lawyer rejected medical tourism abroad, he offered a similar in-state system.

Another occasion in which Israel was presented in a negative light was in the second conference that was dedicated to the examination of the 2008 laws and their impact. In a lecture given by a transplantation surgeon who serves also as the director of one of the transplantation...
units in Israel, while presenting a historical overview of the Israeli organ transplantation development, he stressed that from the late 1990's and through the legislation of the law in 2008:

As a representative of the Israeli organ transplantations medical community abroad I was ashamed. I was embarrassed by the fact that our healthcare system sent our patients to find organs wherever they could… and I know that my colleagues felt the same… in fact, I remember myself in medical conferences abroad, I had to hide my connection to Israel… we were condemned by other nations… and we all know that it was not us…it was not the medical teams' responsibility… eventually we [the speaker and one of his surgeon colleagues] published articles in the Guardian and in "Ha' Refuah" [in Hebrew: "The Medicine"]… we had to prove that we are not part of the organ trafficking trade…

Other participants in the second conference agreed with this statement and supported it; one of the surgeon's colleagues said:

We were condemned by the family of nations and we knew that in order to get our status back we had to do something, we had to change the legal mechanism that enabled families to get the needed organ abroad and be refunded for their expenses upon their return to Israel… we could not feel proud in our medical achievements due to our state's involvement in medical tourism and the nationwide disapproval of it…

Although these participants understood that they had to do something about the situation and the nations' condemnation, they could not change the legal situation and stop the families' involvement in medical tourism abroad. It was still too early in the process of the social construction of organ trafficking as a problem in Israel.

However, they did publish articles as a form of protest, and by doing so the social construction of organ trafficking continued to the next stages of the model. For example, one of the above mentioned articles published in October 2006 called for terminating Israel's involvement in the Chinese trade in organs harvested from executed prisoners. It is important to note that the Israeli involvement, according to the author, was indirect and resulted from the insurance funding of the recipients' medical tourism that gave a sort of state's legitimacy to the

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whole process. Therefore, the author called for the cessation of that funding so that Israel as a state would not partake in the illegal trafficking of organs. The author mentioned this article in the second conference and said that writing it was the least he could do to improve Israel's bad reputation with regard to medical tourism and the resulting practice of organ trafficking. He also said:

It was in a medical conference in Prague I remember both of us [the two transplants surgeons]…we could not lie… we brought all the data and repeatedly said that we are against organ trafficking and that we are doing our best to cease any involvement in it…

In fact, the participant recalled the medical professionals' conflict between their dual roles. On one hand, their role as representatives of the Israeli health care system and the government that during these stages of the construction of organ trafficking as a social problem still sent Israeli organ recipients abroad and helped in refunding their medical tour expenses. On the other hand, as physicians these participants are obligated not to harm other people. The articles they published demonstrate their disagreement with the policy ran by the Ministry of Health, the Israeli HMOs, and insurance companies during the three first stages of the model.

**Media: Stages 1-3**

In the opening stages of the social construction of organ trafficking as a problem in Israel, the different interest groups did not massively use their access to media. However, occasionally and mainly during the third stage, different forms of advertisement were used. Most frequently the government cluster utilized access to the media as seen in the following examples. Thus, prior to the establishment of the National Transplants Center, the signing of donor cards was not promoted, and it was done mainly by word of mouth spread by the association "Adi". In the first years of the National Center, the public was asked to sign donor cards yearly, when the time to renew the driving license arrived. It was only later that the National Center began to advertise
signing donor cards in order to increase donations rate. Pictures 2 and 3 are examples of such advertisements.

**Figure 2: A coaster in a local pub in Tel-Aviv**

![Coaster](image)

*Source: An interview with the PR and training coordinator, the Israeli National Transplants Center.*

On this sarcastic beer coaster, the pub visitors could read "we have to discard the liver… but signing a donor card may save up to seven lives!" In the hospital advertisement, as seen in Figure 3, the logo 1=7+2 expresses the idea that one donor can save the lives of seven people and the sight of another two, as written.

**Figure 3: An advertisement in a Tel Ha'Shomer hospital**

![Advertisement](image)

*Source: personal*
In an interview with the Public Relations (hereinafter: PR) and training coordinator in the National Transplants Center, the interviewee explained that during these early stages they tried everything they could to increase the amount of donor-card holders by getting more signatures:

We tried with the beer coasters; we tried to give lectures in working places such as banks; we trained our own employees, mainly transplant coordinators; we made special courses for specific subculture representatives such as Rabbis and Imams; but it all failed. Thus, on the beer coasters people called us and complained that we were taking advantage of drunk people who are not eligible to sign; in the working places only very few people (six out of two thousand!) arrived even though it was on working hours; our employees enjoyed the training but we are all card holders…eventually we realized that the best thing to do is to educate the next generation…so we give lectures in schools (from third grade to high school) and in the army…it is a captive audience…once we have permission to lecture in the school they have to participate and listen…but we truly believe that it is most important- they are young and open minded and one day it will make a difference...

In response to the question "is it part of the curriculum in all schools or in the army?", the interviewee replied that she wished it was. In fact, she said that in certain places they are not allowed to get into schools or the school districts since the principal would not let them without explanation. According to the training coordinator, in the army it is also still not structured. It may be concluded, as explained by the interviewee, that during the initial stages of the social construction of organ trafficking as a problem, the use of media resources and advertisements was limited. Only toward the third stage of the model were more measures taken to increase the number of donor-card holders, but most of them failed. The National Center focused on giving lectures in schools and in the army in order to educate the next generation of potential organ

77 Imam is an Islamic leadership position; this is discussed in the religious aspects section above.
donors. This change will become apparent in the following stages of the social construction of organ trafficking as an Israeli problem.

In sum, the acute disagreements between the different interest groups involved—more specifically, government officials on the one hand and religious leaders on the other—as reflected in the legislative process and in the different interest groups actions along this process, fulfilled the third stage of Blumer's (1971) model and mobilized an initial action with regard to organ trafficking in Israel. During these stages, access to media was limited and focused mainly on advertising campaigns for signing donor cards. However, these three initial stages laid the foundation for the fourth stage of the model.

**Stage 4: The formation of an official plan of action considering the phenomenon of organ trafficking in Israel**

The fourth stage in the career of social problems, according to Blumer (1971), represents the decision of a society for how it will act with regard to the given problem; or in other words, it is an official plan of action. The legislation of The Organ Transplant Act and the Brain and Respiratory Death Law in 2008 are the official plan of action with regard to organ trafficking and its legal reflection of organ donations. These two laws represent the two powerful interest groups in the case of organ trafficking and donations: the religious representatives and the Israeli government. The bill of The Organ Transplant Act, which was officially dated from 2007 and was finally legislated as the two laws in 2008, was discussed for a long time and revealed heated debates and disagreements throughout the legislative process.

In fact, in order to finalize the legislative process of the Organ Transplant Act, the parliament had to form the Brain and Respiratory Death Law to satisfy the religious cluster with
regard to the problematic issue of determination of death. For example, the Brain and Respiratory Death Law ruled that a team of two physicians who are not involved in organ transplantations will determine brain death; the law also ruled that each hospital will have a special committee that will train the physician to do so, and the committee will include the following: three physicians, three rabbis (one of whom is also a physician), and three professors of bio-ethics, law, and philosophy. According to this law, to be authorized the physicians will have to learn medicine, law, ethics, and Jewish law (Halacha).

It is important to note that this bill from 2007, as well as its two outcome laws, did not come from a vacuum; they are part of the ongoing discussion that began in 1978 with the first stage of the model and were also the outcome of the previous disagreements between the opposing clusters during the course of the previous bills (e.g., those from 2000 and 2003) that failed and did not become laws due to these controversies. For instance, in the meeting’s protocol of the subcommittee of Social Affairs and Health from December 6, 2006, when the subcommittee discussed an amendment to the Anatomy and Pathology Law regarding organ transplantation, one of the participants emphasized the need to change the current situation so that all organ transplantation issues will be organized in one main law and said:

   In the Anatomy and Pathology Law there are two articles on organs…in my opinion we need to eliminate them…we should put it all together in one law… all matters pertaining to the transplantation of organs must be under one major law…

Indeed, the previous disagreements and endless discussions set the stage for one primary law, or a set of two laws in this specific case, that deals with the matter of organ transplantations in Israel. These two laws can be construed as reflecting the fourth stage of Blumer's (1971) model, and as such they are the official plan of action considering not only the legal matter of organ
donations and transplantations in Israel but also the illegal phenomenon of organ trafficking in Israel or by Israelis abroad.

Although the bill of 2007 did eventually become a law, it was after many discussions and disagreements between the different clusters involved. For example in the committee’s meetings of Social Affairs and Health from November 12, 2007 and November 19, 2007, which were dedicated to the bill’s legislation, the chairman in his opening speech said:

The law’s purpose is to regulate the issue of organ transplantations in Israel; to combat organ trafficking; and to increase organ donations in order to allow more people to undergo a transplant and save their lives in an orderly, legal and moral way...Naturally, this law had conflicts of beliefs, opinions, different ethical approaches and diverse attitudes of patients in need of transplants and people worried about organ trafficking or afraid of damaging organ donors from these regions where the organs mainly come. We [the committee] reached important agreements and progressed in many areas. There are two or three issues which we were unable to reach an agreement on and the various versions will be brought to a vote…

The crux of the disagreement was with regard to Article 20 of The Organ Transplants Act that addresses the issue of consideration for live organ donations. According to the bill, it was suggested that the Minister of Health will compensate live organ donors for their altruistic donation in a fixed payment. In previous discussions of the subcommittee on this matter, the suggested prices varied from 18,000NIS to 22,000NIS (approximately 4,900USD - 6,000USD)\textsuperscript{78}. Three opposing proposals for legislating such a clause were discussed and voted in the committee meeting; each one represents a different cluster’s interests, opinions, and beliefs.

The first proposal was from the Ministry of Health and represents the government officials’ cluster, according to which the Minister of Health with the approval of both the Minister of Finance and the Welfare and Health Committee shall pay a flat rate compensation to all donors for their reasonable financial loss from their organ removal. Also, it enumerated rules

\textsuperscript{78} One of the members of parliament mentioned also the sum of 36,000NIS (approximately 9,000USD) as the first sum. This number has a special meaning: it is twice the number 18 thousands, which in numerology is the word "chai" meaning "alive" that symbolizes the perpetual existence of Israel.
and conditions regarding refunds for the following: life and health insurance expenses as well as insurance for loss of work capacity or for loss of earnings; expenses for psychology treatments; and leave of recovery expenses. According to this proposal, the Minister of Health may determine a compensation for loss of earnings that may vary from one donor to another. This proposal was accepted with eight votes in support and only two votes against.

The second suggestion was brought up by politically liberal Members of Parliament (from different political parties) who are well known for their ongoing struggle against human rights violations and therefore are seen as the powerless cluster’s representatives. More specifically, they represented organ “donors” who are victims of organ trafficking both in Israel (i.e., internal organ trafficking) and anywhere else on the globe. Below is one of their statements from the first committee meeting:

We are talking about 18,000NIS…and I have to tell you that we cannot understand how significant this sum of money is for a poor person…Such a clause will create a clear and serious concern that people agree to mutilate their bodies and donate an organ in exchange for money…and for that reason only!

In fact, the participant stressed that such a consideration will increase the rates of the socially constructed problem of organ trafficking in Israel. Her claim is that since more poor people will feel compelled to give up their organs in order to get the official government's reimbursement as a last resort, any proposal that includes a monetary consideration is not acceptable. As a result, according to the second proposal, financial refunds will be possible only for medical and health care expenses related directly or indirectly to the surgery, financial loss caused as a result of the organ removal, and reimbursement of expenses due to loss of working days with a fixed maximum rate. Although this proposal was rejected and received only two votes in support, it is important to understand its rationalization as expressed in the committee meeting.
The other parliament member, who represented the powerless cluster, referred to the consideration of 18,000-22,000 NIS for live organ donation and emphasized the idea that a poor person will donate an organ not for altruistic reasons but for reasons of hardship. Below is her explanation [my emphasis]:

The intention to create a situation where not only rich people will be able to receive organ donations, but every person in Israel who needs an organ will be able to receive it, is good, but we cannot correct an injustice with another one... In fact we will create an actual organs' bank, where all the organs come from poor people... let's be honest with ourselves, how many of us, of our children, parents, and we're middle class, we are not very rich – how many of us will mutilate their bodies and donate an organ to save people they do not know? Yes, there are such altruistic cases and I respect and admire them, two such cases were in the last decade... But, in practice, we would encourage an industry, which is morally problematic, since poor people will have another source of income: they could allow removal of an organ from their body in exchange for a financial motive... We create a moral hell where the poor are being an organs' bank for the general public! We do not want this situation to happen!

After having justified the rejection of the previous proposal, the parliament member explained her own proposal as follows:

The proposed amendment reflects some of the state's obligations towards a person, who donated an organ for altruistic reasons; therefore, this person will be compensated for the loss of working days in accordance with his income in the past and will be eligible for certain insurance policies. However, we have to avoid the financial motive. We want that altruistic donations will be merely altruistic and not for other considerations or any financial gain.

The other parliament member, who supported this proposal, added [my emphasis]:

I have been a Member of Parliament for eight and a half years and I think this law is one of the most important, sensitive and extensive laws that is about to regulate the issue of organ transplants and organ trafficking...I would like to get to the issue of compensation to live organ donors- I admit, this clause particularly bothers me because if we accept the Ministry of Health's format, it would open the door to immoral organ trafficking and would increase the gap between rich and poor people. What bothers me is that if this proposal of the government is accepted, without our amendment, we will witness government-sponsored organ trafficking by giving a financial compensation to launder trafficking in organs... We know that a large group of patients is awaiting transplant and out of desperation they may turn to all kinds of resorts to buy an organ. If this committee will approve the law with the consideration clause, it would make poor people, such as single parents, look for a way to save themselves and their children from hunger. With this regulation we enable them "a new deal" - money for their organ... the
human body will be a warehouse for spare organs that we can sell… it is time to realize that our organs are not a marketable object and selling an organ is not an expression of individual freedom. It is not a free choice to sell an organ but a monetary decision…

As mentioned above, even though the Knesset members were persuasive and emotional, this proposal was not approved as only the two speakers voted in support of it.

The third and last proposal for Article 20 was that of a religious parliament member that also underwent kidney transplantation (donated by his son) and therefore represents the organ receivers group (i.e., another section of the powerless cluster). It is important to note that even though both proposals (i.e., the second and the third) represent the powerless cluster, each one has a different point of view and therefore different goals and sometimes opposing interests. Thus, according to the third proposal, the Minister of Health, with the approval of the Welfare and Health committee, shall pay a fixed payment to all donors for the following: financial loss resulting from their organ removal; private health insurance expenses; and insurance against injury, loss of working capacity, or loss of earnings. In addition, the donor will be entitled to a psychologist and one month of paid leave. These payments will be paid to the donor by the state through the National Organ Transplant Center only if the organ recipient is a resident of Israel.

The law, according to this proposal, also entitles the donor to other benefits as follows: scholarship for higher education for the donor and for his children; discount on property taxes; income tax exemption; free public transportation; and free entry to national parks and nature reserves in Israel.

The spokesperson for the kidney transplanted patients association, who expressed absolute support for the rabbi’s proposal, said [my emphasis]:

I speak on behalf of the three organizations concerned, the lung transplanted association, the liver and heart transplanted association, and clearly, the kidney transplanted association. I feel a moral right to take a stand on behalf of the clients of this law [i.e., organ recipients]; even if we have no right to vote… and in order not to repeat the
arguments… we classify ourselves in complete identification with the words of the 
rabbi.

In order to persuade the committee members to vote for his proposal, the religious 
Knesset member stated that the main purpose of his proposal is to cease organ trafficking and the 
immoral manipulation of organ recipients, who must sell everything they have in order to pay for 
their needed organ while knowing that most of the money (80%) goes to the middlemen. Below 
is the rabbi's explanation in his own words:

The first rational behind the bill was to stop organ trafficking…Therefore, we thought 
that we should assign all the responsibility to the state—either by the Social Security 
office or by the National Organ Transplants Center... The state will not engage in organ 
trade, but it could set a fixed price for every person that wants to improve his/her 
economic situation and get some financial independence if the state will help…The donor 
will not know who the organ recipient is; and the allocation will be according to the 
current queue of people on waiting lists and their medical criteria… In my worldview I 
think this is [live organ donation] one of the most beautiful and useful deeds, and I do not 
see anything wrong with it. The flaw, in my opinion, is when you open private or 
business networks for selling human organs…not when the state is responsible…

As for the second proposal's rationalizations, the rabbi, who represented the powerless 
cluster of organ recipients, said: [my emphasis]

We know that poor people suffer and rich people do not suffer at all. This law or any 
other law will not change this situation… a wealthy man, who has money, he would go 
anywhere in the world and pay and save his life at any cost. I have a friend, a very 
wealthy man and he went to the United States and bought a transplant and two days later 
it failed. They told him that if he wants to, he can do another transplant, another 200 
thousand dollars. Without batting an eyelid, he paid the 200 thousand dollars twice! Such 
people have no problem. This law came to solve the problem of the poor people, 
those, who have no money for organ transplantation; they have no money and no 
kidney…these people are sentenced to death under this law!

Then, he continued:

…I live in a poor neighborhood and I know what poverty is. My culture [i.e., a religious 
society] is poor and I live my day to day life like that... the donors from that society will 
not donate for money even if it is for 36,000 NIS (that was the initial amount that the 
Ministry of Health suggested). I agree with the idea that the Minister of Health will 
decide on the compensation sum. However, I got all the monetary elements out in my 
version of the bill…
The rabbi completed his speech by saying that a proposal that does not encourage donations by state policy, even if due to a liberal worldview, is in fact a proposal that knowingly allows for organ recipients' suffering and death.

The following discussion between opposing clusters' representatives arose in response to the rabbi’s explanation above:

**Rabbi:** "We have the basic law on Human Dignity and Liberty… the right to live… the question is what human dignity is?"

**A politically conservative Knesset member** [hereinafter: Conservative], who is also a physician said: "They say that if a person sells his/her kidney, it is a violation of human dignity… I still don't understand and I'm talking as a doctor: Let's suppose… I want to study medicine and my only way to learn medicine is to sell my kidney. Why won't you let me do that?"

**A politically liberal Knesset member** [hereinafter: Liberal] and human rights guardian responds: "Because you have the right to study medicine without selling a kidney."

**Rabbi:** "…and what if he supports his children and wife by doing it?"

**Conservative:** "we should avoid that debate that we discussed and argued for more than a year."

**Rabbi:** "first we should give him means of life. Our country has a law that requires the state to care for its people so they won't be deprived."

**Liberal:** "But not for his kidney, just because he is a human in the state… we can't allow organ trafficking."

The liberal Knesset member explained: … The heart of this law is its two pillars: the first is to enable as many more organ donations as possible to save lives, and the second is to prevent trafficking in organs… Each one of us has his own moral and I would like to share with you mine with regard to live organ donations: My way is that a person cannot become rich or save his life and improve his financial situation by donating an organ… it's against my moral that a person improves his financial status or his education by organ donation. That's the State's role and the role of our society to allow him to live with all the organs of his body and learn, allow him to have all the organs of his body and live a decent life... Moreover, it is clear that those who will have to pass the test are the most poor and the most disadvantaged- they will have to choose either to donate and eat or to avoid donation and starve … for that reason I will not support monetary consideration for live organ donations… refund for real financial loss such as loss of working days is ok, but compensation means that the donation is no longer altruistic…"
Rabbi: Instead of saying: 'this is my compensation' the donor will say: 'it is my atonement'.

At this point, another rabbi joined the discussion and said that as the Halacha representative he appeals to the other committee members to support the rabbi’s proposal, which is in his words "the best compromise". By doing so, the other rabbi made the third proposal applicable to the religious cluster. However, the rabbi also mentioned that if the third proposal will not be supported by all, the Ministry of Health's proposal may serve as a compromise proposal as well. At this stage, the legal advisor of the Ministry of Health took advantage of this idea and emphasized that the ongoing consistent position of the Ministry of Health is to fight organ trafficking. The religious cluster understood that it is time to compromise with the government's official plan as proposed by the Ministry of Health. As a result, the Ministry of Health's proposal was accepted as Article 20 of the Israeli Organ Transplants Act, 2008.

Although the government proposal was accepted, this discussion emphasized the different points of view of the powerless cluster. Thus, the liberal Knesset member represents the powerless cluster of organ donors and therefore suggests a model that prohibits organ trafficking and does not allow monetary consideration. The rabbi, who represents the organ recipients' subgroup of the powerless cluster, prefers a model that enables more organ donations and therefore supports monetary consideration for organ donations.

The official agency in both cases of legal organ transplantations and illegal organ trafficking is the Israeli National Transplants Center. The law of 2008 sets up the role of the Center as well as its goals and missions. The following interview excerpts may serve as

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79 Atonement in Judaism is the process of causing a transgression to be forgiven or pardoned, and therefore the rabbi implied that even without monetary consideration the donors earn a profit.
80 This is the collective Jewish body of religious laws, which includes biblical law (the 613 mitzvot), Talmudic and rabbinic law, as well as customs and traditions.
81 A liberal Knesset member opposed that definition and told the rabbi that he was not the only representative of Halacha.
examples of the Israeli National Transplants Center's functions as seen by its employees from different positions and levels. These excerpts also reflect the official plan of action as it is carried out by the Center. For instance, in response to a question about the National Center's goals, a high position-holder at the Center mentioned first the need to increase donation rates, but then stressed:

What I want is to **massively** increase the number of transplants per year... for that I have to raise public awareness and willingness to donate... but it's not just to increase it; it is also to make the transplantations better... I would like to enhance the system... it's also a quality-control goal.

When asked about the implications of the law of 2008 on the current system in terms of increasing organ donations rates, the interviewee said it is too early to discuss but also added in a whisper:

I don’t see any hysterical influx [of organ donations], but we have to give it some more time...

That observation was supported and explained in another interview with the training coordinator of the National Center, who revealed:

There is still no breakthrough... There are new members who sign the donor-cards but there is no sense of significant change... to tell you the truth... the new law did not increase the donations' rate... in fact it was an adverse change and last year we had 33 cases in which the physicians could not determine brain death because of that law... it is so bad! Not only did it not increase the donations rate but they actually decreased... we all hope it will improve soon...

With regard to organ trafficking, the high position-holder explained:

We [the National Center] have the committee that screens all donations... 30% to 40% of the cases do not pass the committee screening... sometimes it is because there is no relation between the donor and the recipient, in other cases it is because it is not altruistic and financial gain is involved, in most rejected cases we are talking about mentally ill people that cannot handle the stress that such a procedure requires... other people do not really understand the procedure's meaning and its implications... we have to help them to get out of this situation... here you go- I have some statistics for you: In 2010, 50 cases were transferred to the national committee (i.e., they were approved by the regional committee)- 43 cases out of these were invited to the committee (7 cases were removed because they have changed their minds prior to the hearing or due to medical considerations); 26 cases were approved, 17 were not approved: 8 due to medical or
mental condition of the donor (we discern these cases with the psych-diagnostic test); 7 cases due to monetary consideration; and 2 cases due to suspected peer or family pressure on the donor...

The interviewee could not provide more details and said that she also cannot reveal the identity of the committee members since the process is highly confidential. Moreover, she argued that they had a few cases in which the people involved learned the committee's guidelines and prepared the donors to give the "right answers" in order to get the committee's approval. The interviewee did not mention cases of medical tourism and organ trafficking abroad and focused on these cases that the ethic committee of the Ministry of Health screened.

The training coordinator of the National Center referred to the same kind of internal organ trafficking:

We found out that even today, after the legislation of the Organ Transplant Act in 2008, we still have to deal with middlemen, unfortunately they are still trying to take advantage of the vulnerable situation of others...they prepare you for the ethic committee's screenings so you'll say that you are my best friend and that you would like to donate since you love me and not for the 100,000NIS I'll give you right after the donation… didn't you read all the newspaper articles?

Interviewer: "I read and thought it was only urban legends…does that really exist?"

Of course it does! There are such cases in practice… It's not only press stories…The committee screens out most of the cases but the more sophisticated ones will get through…

As explained by both interviewees, even though the new law prohibits all kinds of organ trafficking (i.e., both organ trafficking by medical tourism and internal organ trafficking as described in these interviews), organ trafficking does occur and the official government body is aware of it.

The employee responsible for live donors' reparations in the National Center noted that this position is relatively new since donors' restitutions started only in 2010 due to "the new law from 2008...but we pay all donors who donated as of May 1, 2008 and on…” When her supervisor introduced us, she mentioned that the most frequent reparation is in fact
reimbursement for loss of earnings. The supervisor also emphasized that the Ministry of Health takes care of the donors and pays for their psychological treatments for up to three months after the procedure; the Ministry of Health also pay for their insurances (i.e., loss of earning capacity, life and health insurances) for five years after the removal of the organ. However, the interviewee stressed that all donors are also paid compensation of 2,500NIS (approximately 625USD) in addition to all the payments that her boss mentioned. In response to the question "2,500 NIS—What for?", the interviewee replied: "It is a one-time payment, no receipts are needed." This one-time payment was mentioned again in the interview when I asked about any unusual cases she might recall, to which the interviewee replied:

   There is one donor, out of neither 260 cases I've dealt with, who does not want to get the money…neither the one-time payment nor any other payment…he keeps on saying that he did not donate for the money.

This one-time payment reflects the government official proposal with regard to donor compensation and the related debate as described above. In response to the question about cases of donors who were disappointed because it was not enough money, the interviewee explained:

   Yes, there are always people who are not satisfied… some people argue that it was published that there is a one-time compensation of 30,000NIS…between us… there was a false publication… but we explain to them that we only cover for the loss of working days according to their salary slip…

Interviewer: "Did you ever hear someone saying that if he had known he would not get the 30,000NIS, he would not have donated?"

The interviewee replied, "No!" Then continued:

   They all say they did not do it for monetary considerations…they donated because they wanted to help their beloved one- a family member or a friend… it is the same with the insurance payments- sometimes I have to remind them again and again…they do not want to handle all the documents but we would like to help them it is for their own well-being.…
In response to questions about the new law's impact such as "did it really cause a change?", "are more people willing to donate organs?", and "does it really encourage donations?" the interviewee explained:

I think that since May 2008 there are more donations…Let's see…now it is something like 11 or 12 donations per month and before that it was 5-6 donations [she counted on her computer different months as examples]…so it is twice what it used to be…

It is important to note that this answer does not align with previous answers given by different higher position holders during their interviews. It seems that this answer was given after a brief look at the computer and without considering all the relevant factors. In fact, in the second conference that examined the impact of the law, the decline, as pointed out by the answers given by higher position-holders, was confirmed. Therefore, it is argued that in the first year after the legislation of the law there was a decline in the rate of donations.

The last interview that may shed light on the Israeli National Organ Transplant Center's functioning after the legislation of the Organ Transplants Act was with a transplant coordinator. In response to a question about her occupation objectives and missions, the interviewee replied:

There are many aspects to this job (it's like the Olympic symbol with five circles): The first and the easiest one is training—within the hospital, so that medical teams will be exposed to the issue of organ transplantations and will know how things get done...The second is marketing outside the hospital: to show our role and what is done with regard to organ transplantations in Israel; we have amazing lectures that are designed for a specific target audiences (from third graders to soldiers and students from different backgrounds and places) so we expose the issue and provide knowledge… Then there is the clinical aspect—with the medical teams in the hospitals, we also work with the donors' families in order to get their approval to donate…The fourth aspect is the role of coordinator, that is to say to relate a donor to a recipient, we also want to take good care of our patients and we also stay in contact with the families after the procedure is done…The fifth and last one is the academic work—we have various academic projects such as writing articles, building a website, etc.

The interviewee described a team of 17-18 coordinators that work in the different Israeli hospitals and help each other to cope with various situations throughout their day-to-day work.
In response to a question about the most shocking case she went through, the coordinator explained:

...nothing is shocking since even death holds within it some beauty...such as the continuity of life of others...

In response to a question about patients who asked about a financial gain for their donation, the interviewee replied:

Not directly... but some patients raise questions such as: "Is there any governmental participation? How does the government help for example with burial expenses, when the family has no money?" It comes from the families' distress, not for the monetary gain... but for the real despair they are facing...

According to the transplants coordinator who faces the donors' families in their difficult moments, the donations are altruistic and monetary issues are not a major part of the families' considerations.

These excerpts reveal how the Israeli National Transplants Center effectuates the Organ Transplants Act (2008) in the day-to-day work of its position-holders. In the legal arena, an actual application of the law occurred only on April 4th, 2013 in the Jerusalem District Court. 82

In this verdict, 83 the accused was convicted based on his confession on 13 different charges, all but one of which were offenses under The Organ Transplants Act. The 70 year old man served as a middleman between organ recipients and organ sellers 84 in 12 different cases, each of which concluded in a different way. He recruited both sellers and recipients using different kinds of ads and matched the pairs by going through medical examinations in Israel and sending them abroad 85 for the organ removal and transplantation. In a few cases the transplantations succeeded and the recipients are still grateful; in others it was not accomplished and both recipient and

82 The six district courts constitute the middle level courts of the judicial system in Israel.
83 See: Criminal Appeal (Jerusalem) 26647-08-10, available only in Hebrew.
84 I used the term "sellers" and not "donors" since they actually sold their kidney for money and did not reveal any altruistic consideration.
85 In this case to Ecuador, Panama, and the Philippines.
organ seller were seriously damaged. In two cases the organ sellers had changed their minds prior to the organ removal, and the accused threatened and forced them to do it; in another case he abused the vulnerability of a mentally ill person while forcing him to "donate" his kidney. The judge ruled that the accused exploited the recipients' hardship to obtain an organ and the sellers' desperate need of money for his own financial benefit. As a result, the judge accepted the mutual plea bargain and imposed penalties of 36 months of imprisonment, 10 months of probation for three years, and damages for four complaints in total of 345,000NIS.

During the hearings of the case mentioned above, the defense attorney emphasized the fact that the Israeli health system is still behind, and there is no actual solution to the desperate shortage of organs. The judge approved and repeated this fact in his judgment. Such a statement is an important element in the last stage of social problem development, which may occur when the social problem is not solved with the official plan of action. According to the data gathered, in the specific case of organ trafficking in Israel, the fifth stage did occur, and it is described below.

**Stage 5: The transformation of the official plan to its empirical implementation**

The last stage of the construction of social problems is the transformation of the official plan of action. It is the: "formation of new lines of action on the part of those involved in the social problem and those touched by the plan". Thus, all clusters were involved in the fifth stage and each persists in advancing its agenda and keeping its interests in the socially constructed problem of organ trafficking.

The government official cluster that legislated the Organ Transplants Act and provided for its implementation in practice was not completely satisfied with the official plan of action and its practical implementation. In fact, the National Transplants Center decision to organize the
two conferences served in itself as a statement of dissatisfaction. The main focus in the first conference, which took place in June 2011, was to acknowledge the obstacles to organ donation as seen in Israeli society in order to address them properly and to increase organ donation rates.

While interviewing the training coordinator of the National Transplants Center, she invited me to this conference and described it:

We [the National Center] have this feeling as if we are missing an opportunity…there is no breakthrough…only a stable line of the donors' rates … There are new donor card holders but no sense of significant change or improvement…it is a sense of a missed opportunity…although the law gives priority to those signing on a donor card… the idea was to say okay – we will have to discuss how to market it, how to change the public perception… and for that we invite experts: medical professionals, media experts, marketing and communication experts and bio-ethics as well as legal experts…you have to understand… we would like to change attitudes and perceptions, to promote this process so it will lead to social change…

As explained by the interviewee, the current situation was not as promising as the National Center thought it would be with the legislation of the official plan of action. Therefore, the goal of the first conference was to understand what the limiting causes that impede the Center from achieving its goals are and to address these obstacles with discussion among the invited experts. In fact, the training coordinator was dissatisfied with the practical application of the official plan of action and said:

Our idea is to give it [the law] a chance…we don’t want to disqualify it in advance… We all have to understand that there is no such a thing as a law that everyone promotes and supports…there will always be some that oppose it…we have to understand that it is not a one stage change; it is a process and we have to give it a chance.

This point of view, as described by the interviewee, was strengthened in the opening speech of the conference given by the director of the National Transplants Center. The speaker presented the three main goals of the conference as follows: first, to characterize and classify inhibiting factors and obstacles to organ donations; second, to develop a plan to address these inhibiting factors by thinking outside the box; and third, to formulate a strategic plan aimed at
increasing the public willingness to donate. The presentation of these goals revealed once again the dissatisfaction from the current situation.

The second conference organized by the National Transplants Center was dedicated to different aspects of The Organ Transplant Act and the Brain and Respiratory Death Law five years after their legislation in 2008 and took place in March 2013. This conference was open to all interested parties and was published in all Israeli newspapers. The opening speech of this conference was given by the Chairman of the National Transplants Center, who explained:

The National Organ Transplant Law regulates different issues of organ transplantations in Israel and by Israelis abroad and affects our position in the world ... We have an excellent national transplant system with excellent medical teams, with the ability to control all transplant centers, and with full cooperation between the centers... However, we also have some problems...and the main problem is with our people who still oppose organ donations... we still have only (close to) 50% willingness to donate organs...we have to increase this number! We have to increase the organ donation rate!

In other words, the speaker presented the progress brought about by the 2008 legislation but also referred to its limitations; specifically, he referred to the same problem that affects the Israeli transplantation system and that has to be changed: the problem of low Israeli organ donation rates. In fact, the dissatisfaction with the Israeli low rates of donations is one of the main reasons for organizing the conference.

As a result, a few recommendations to change the current system were discussed in the conference. For instance, changing the legal model to an opting out model (also known as presumed consent) was suggested to dramatically increase effective rates of consent for donation. A professor from the Center for Medical Law and Bioethics presented that option:

We would like to make organ donation the default norm... the collective payment, the premium is everyone's willingness to donate his/her organs in the future...without a real payment—it is an act of altruism.

In order to express his disappointment with regard to the low Israeli rates of donations, the professor referred to the case of Avi Cohen with regard to the opt-out model and said:
I'm not sure what is worse… to take organs from a deceased that did not explicitly sign a consent form (i.e., a person without a donor card) or not to take organs from a deceased that did explicitly sign a donor card…

Another legal recommendation that was raised in the second conference by the government officials' cluster was that of advancing organ recipients that hold donor cards in the waiting lists in case they or their family need transplantation in the future. A professor from the Center for Medical Law and Bioethics presented that option:

By choosing this solution we redefine organ donations—it will become the expected norm…those that do not explicitly reveal their willingness to donate will be the last ones to get an organ when needed…it is a reciprocal altruism by law that promotes the collective good…it is the right thing to do, to emphasize the willingness to donate as a precursor to the willingness to receive when needed.

These recommendations for a change underline the government official cluster's dissatisfaction with the current situation and the implementation of the official plan in practice. The latter was also expressed by the powerless cluster. Thus, a Knesset member, who represented the powerless cluster of organ donors, said in her interview:

A well-known law professor contacted me. He heard about the amendment I am trying to legislate with regard to the Organ Transplants Act [i.e., priority to organ-donors in organ allocation if needed]. He suggested I submit a new bill whereby all will donate their organs unless explicitly told otherwise [i.e., presumed consent or opting-out model]... To tell you the truth, I had already been planning that bill for a long time... when we legislated the Organ Transplants Act in 2008; I had already filed a series of objections that would prohibit organ trafficking...when I realized it does not work... I passed another law that prohibits trafficking in persons and there I put a clause on the prohibition of organ trafficking... but it was then when I thought about the idea that organ donation should be the default...Now I plan to submit it even if it is only for the declaration... even if it has no chance... because I think it does not matter what they do [the National Center, Adi association, etc.] there is no chance to reach the required quantity of organs.

The interviewee explained that a real change is required since the current legal system is not sufficient and could not provide the required amount of organs. As promised by the interviewee, she did act and represented the powerless by amending the National Transplants Act

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86 This suggestion is already part of the Organ Transplants Act (2008) after it was amended on July 2012.
(2008). According to this amendment, enacted in July 2012, the national transplants committee of the Ministry of Health is responsible for organs' allocation in Israel. This committee may advance a person on the recipient waiting lists based on his/her status as a donor-card holder, as was also recommended in the second conference. The other bill the parliament member talked about (i.e., the opting-out model) has not been enacted yet. However, in January 2013 a new Israeli parliament was elected, and since then the Minister of Health is a new liberal Knesset member. Since June 2013, it is occasionally published in the Israeli press that the new Minister of Health will initiate a reform, and that the presumed consent model will be implemented.

The powerless cluster of organ recipients was also dissatisfied with the current legal mechanism and its practical implementation. For the organ recipients, as long as there are not enough organ donations, they will likely not receive an organ in time. Furthermore, the 2008 legislation prohibits organ trafficking and state or private insurance refunds for those organs from a country of origin that does the same. In that sense medical tourism is no longer an option, at least not for non-wealthy organ recipients; those from the latter group, who chose to get an organ this way, are committing an illegal act. For example, in November 2011 due to a legal change in Colombia that prohibits organ trafficking, three Israeli organ recipients could not receive approval from the Israeli Ministry of Health, and therefore their transplantations abroad were delayed. This dissatisfaction is expressed by all organ transplantation associations. For instance, the Liver Transplants Association published an article on its website:

88 The previous formal Minister of Health was the Prime Minister; however, in practice the Deputy Minister of Health, head of Ultra-Orthodox political parties, managed the Ministry of Health affairs. The new Minister of Health is a liberal secular woman.
Since the law came into effect last year, more patients die waiting for a transplant... Experts explain that the law is the main cause for that...

In her interview, the PR and training coordinator at the National Transplants Center referred to the organ associations and said:

If you would like to hear that Israel and the National Transplants Center do not do a thing, you should go to the organ associations ...there you will hear that if you need an organ transplantation your last resort is the state... the only thing you can do is to curse... since the new law will not allow the state to help you: neither by refunding your expenses nor by having national decent rates of organ donations...

In other words, even position holders in the National Transplants Center (i.e., the government officials cluster) recalled the frustration and dissatisfaction of the organ recipients (i.e., participants from the powerless cluster).

In an interview with a liver recipient, who is also an active member in all organ transplants associations, the interviewee described her involvement and explained:

I participated in these parliament committee meetings that discussed the issue of organs from China: we all understand that Israel is unable to cooperate with countries that get organs in such a problematic way, I'm talking about all the rumors there were, for example, about prisoners in China, but then in these meetings there was a Knesset member who explicitly said: "I really understand this prohibitions but if my daughter needed a kidney and that were the only thing that would save her, then I do not really care where I get the kidney"... The law created a very difficult problem since on the one hand, the state declared that Israel, which is a progressive humanitarian state, will not cooperate with such disasters and human rights violations; but on the other hand, it does not give a solution, there is no way to go through a transplant without an organ... and that parliament member said it out loud, she said: "if my daughter needed it I would do everything I can..." and she meant everything!... The bottom line is that like always—those who have money will achieve it because the money is not a consideration... and I understand them... because people are dying on waiting lists... tomorrow it might be me...

As explained by the interviewee, the legal status quo is not good enough since people in need of organs cannot receive them. She agreed that getting organs from prisoners in China is not acceptable, but she could not ignore the fact that it means more deaths among potential organ recipients and therefore expressed her anger and disappointment with the current system.
Moreover, the first liver transplants she underwent took place in Belgium in 2005. The interviewee expressed real distress and fear from the fact that soon she will have to go through another liver transplantation—not only due to the fact that she is older and less healthy than she used to be, but also due to legal changes: she will not receive a refund for her transplant expenses, and since it is the second time she is at the end of the waiting list. The interviewee explained:

So here I am…once again on the waiting list…and there are people who are in intensive care and it happens that they die while on the list…and they know each other. I have two friends in need of a liver and, you know, they are next to each other…but only one liver and one of them, the girl, received it and our friend—he died… if there were more organs he would not be dead… at any given moment people die and their organs might save lives… those who died and did not donate - it really hurts! Think about the families, the kids! The way it is done… it's not appropriate…there are more options and we have to change it!

The religious cluster was divided in this stage of the social construction of organ trafficking as a problem in Israel: some religious leaders revealed support of the new legislation and its practical implementation, while others persisted in their previous point of view and strictly opposed organ donations. These two contrasting sub-groups are discussed in the religious aspects section below.

**Religious aspects: Stages 4-5**

In the last two stages of the social construction of organ trafficking as a problem in Israel, and after the different clusters compromised to a certain degree, a few representatives of the religious cluster overtly supported organ donations and disapproved of organ trafficking. In order to express their support and to change common beliefs about religious people—who agree only to receive organs but not to donate them—this part of the religious cluster began to act. For example, when some religious leaders understood that the religious community would not sign a
donor card because it did not fit with their religious beliefs and values, they issued separate donor cards for the religious public. This version of the card showed more regard for their sensitivities: it emphasizes the morality of organ donation as approved by the Israeli Chief Rabbinate's position, and it refers to a group of religious physicians that will determine death according to the Halacha.92 A few hundred Israeli rabbis, who hold this religious donor card "bilevavi"—which in Hebrew means "in my heart"—are presented on its website to promote it in their religious communities.93 The organization "Matnat Chaiim"94, or "gift of life" in Hebrew, is another example. This organization states on its website that since its establishment in 2009, it has recruited 96 kidneys for transplantations. The founder of this organization is a well-known rabbi, who also went through kidney transplantation. The main goal of the organization is to voluntarily encourage kidney donations from live-donors in Israel.

Another example of support from the religious sector is that of the Halachic Organ Donor (HOD) association.95 The HOD association states expressively on its website that its core mission is to save lives by increasing organ donations from Jews to the general population (Jews and non-Jews alike): "the HOD Society encourages organ donation from Jews to all of humanity." Among its goals, as written on the website, are the following: to educate Jews about the different Halachic and medical issues concerning organ donation; to offer a unique organ donor card that enables Jews to donate organs according to their Halachic belief; and to provide rabbinic consultation and oversight for cases of organ transplantations. Furthermore, the HOD association's accomplishments as published on its website include the following: performed a

92 More information about the religious card "bilevavi" can be found at http://bilvavi.co.il/Home/About last access May, 2013.
93 See: http://bilvavi.co.il/Home/Article/10 last access May, 2013.
Kiddush HaShem\textsuperscript{96} by changing perceptions about Jews regarding organ donation; and raised awareness of Halachic support for organ donation by publishing more than 100 articles, editorials, and letters to the editor. These published accomplishments and goals prove that in these stages of the construction of organ trafficking as a social problem, this part of the religious cluster expressed its support overtly and tried to influence its community to support organ donation as well. Not only did the religious cluster support organ transplantations due to the new legal determination of brain death, it also accepted the goal to reverse common beliefs and preconceptions of the general public. This idea was supported in an interview with one of the key position holders of the HOD association:

My main goal is to promote organ donations between Jews and all: Jewish and non-Jewish alike. I would like to change the common perception that Jews only receive organs and do not donate them…I would also like to prove that Jewish people support brain death and organ donations…to achieve these goals I wrote articles, I lecture and debate rabbis that oppose organ donations and brain death…I based these debates on Halachic considerations…one of my latest project is to recruit a network of Orthodox physicians that signed a donor card…they can influence the public who perceive them as experts who know both the religious law and the medical issues involved…

In response to a question about religious leaders or institution that opposed his activity, the interviewee explained:

I mostly cooperate with the National Transplants Center and Adi Association. I also cooperate with Tzohar.\textsuperscript{97} In Israel, the Chief Rabbinate supports brain death but does nothing to promote it…However, I do have disagreements with religious institutions and leaders abroad, for instance, a rabbi from the RCA[The Rabbinical Council of America]\textsuperscript{98} opposed brain death and organ donations and approved organ donations from non-Jewish donors to Jewish recipients…or in another occasion, in England, I tried to recruit an Orthodox physician to sign a donor-card…but she refused telling me that the rabbi opposed it and she is afraid since her sons go to his Yeshiva…So I do have opposing forces in England 2011—not Iran!

\textsuperscript{96} “Sanctification of the name” in Hebrew, Kiddush HaShem, is a precept of Judaism, according to which any action by a Jew that brings honor, respect, and glory to God is considered to be sanctification of his name.

\textsuperscript{97} Tzohar organization was founded by a group of rabbis from religious Zionism group; they sought to be partners in shaping the Jewish character of Israel from the dialogue and the search for common identity elements.

\textsuperscript{98} See: \url{http://www.rabbis.org/about_us.cfm} last access June 2013.
According to the interviewee some religious resistance occurred but outside of Israel. However, resistance to organ donations also occurred within the Israeli religious cluster. The case of Avi Cohen revealed such opposing forces. In this case from December 2010, the family of the deceased decided not to donate his organs due to religious beliefs. In fact, even though the issue of brain death was already addressed by the 2008 law and the Israeli Chief Rabbinate approved the specific donation, the family decided not to donate based on opposing religious recommendations. In a documentary TV program\textsuperscript{99} that covered this story two years later, the family of the deceased was interviewed and revealed why they decided not to donate his organs even though the physicians affirmed brain death according to the law's requirements. The spouse and son of the deceased explained their situation:

\begin{quote}
\ldots we were in hospital for nine days and so many people came...and they started to give us advice that even if you do not believe in you have to try...people that we do not know advised us to put on this cream...to give charity to this organization...to give money to homeless in the street...and we did it all...any single thing they told us to do we did...his room became a temple, any single necklace, book, picture, prayer, coin...we put there everything... but eventually it was brain death, dad died...
\end{quote}

In response to the question "who were the people that came", the director of the National Center replied: "They were these... who wear long black suits with scraggly beard..." and referred to ultra-Orthodox people. The director also explained how he was on his way to thank the family for their donation when he heard that they had changed their minds. In response to the question why he didn't try to influence Avi's family to reconsider, the director of the National Transplants Center replied:

\begin{quote}
I cannot compete with these people...what can I tell this family if the rabbi promised them that tomorrow their father will be alive...there is nothing to discuss...if the head of the Yeshiva sends people to tell the family that tomorrow morning Avi will get up as usual...there is nothing for me to say...I am mad. I am mad that the family disallowed the deceased's will to materialize and did not save so many lives... I am also mad about
\end{quote}

\textsuperscript{99}See: \url{http://ong.nana10.co.il/Article/?ArticleID=961360} this TV program from February 2013 is available only in Hebrew, last access June 2013.
these religious people… because this group of people allows irrational things to happen… they pose primeval fear on families…and it is also against the Halacha because they avoid saving the lives of others…

The CEO of the Football Players Association and a close friend of Avi's and his family said:

It was terrible; they applied tough pressure on the family… that I just felt sorry for them…Tamir [Avi's son] personally asked me- so the only thing I did was to go to Rabbi Kaniski and then a few days later one of the rabbi's people came and told us to give Avi another name…whether it was the rabbi's request or not- no one can tell…

The son continued:

I invited the rabbi, who is known as the "rentgen" [in Hebrew: x-ray]… I asked Ehud Olmert, a very close friend of dad, to bring the rabbi…and they brought him with a helicopter to Tel Aviv… he entered dad's room and was there by himself for about 40 minutes…he told me that the situation is very serious and that I need to prepare myself for my dad's death…

Avi was a donor-card holder, and his willingness to donate his organs upon his death was confirmed by one of his best friends. The family almost signed the consent form, but when they came out of the room this happened, as described by the son:

A religious person came to me and told me: "Do not donate! Do not donate! I dreamt about your father last night…take this coin…go to your father and pray he will wake up!"

The CEO of the Football Players Association described:

This person wearing a black suit and a beard came to Tamir with his hand up and told him within five days your father will stand up…

At the same time, seven organ recipients were told that they might receive their needed organ. They prepared to go through the transplantations that they had waited for a long time. When they realized that there was no donation their disappointment was indescribable. For example, the potential heart recipient argued in this program that he used to examine all accident stories in the news in order to find out about his chances to get the needed organ soon.

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100 Rabbi Yaakov Israel Ifergan. The term "X-Ray" was given to him due to his so-called ability to diagnose diseases and problems.

101 Mr. Olmert is an Israeli politician that served as the Prime Minister of Israel from 2006 to 2009.

102 For example, the potential heart recipient waited five years for transplantation.
After examining the specific case of Avi Cohen, the program also examined different rabbinical responses to a similar, albeit invented case: The physicians affirmed brain death, the deceased had a donor card but the family still did not consent to the donation. Rabbi Chaim Kanievsky\textsuperscript{103}, after receiving a payment for his consultancy, met the family and said:

It is unquestionable… donation is forbidden since the deceased's soul will continue to harass you…

The rabbi sent one of his followers to the hospital to meet the spouse of the deceased in order to help her reach the "right decision". The emissary explained:

The rabbi ruled that we have to bury the body in its wholeness…if not the deceased's soul would never find rest…You should be careful since there will be no serenity… According to Jewish law, it is forbidden to take a person's life in order to save another…

Another rabbi who visited Avi's family in the hospital and is known as "the X-Ray", was careful and said that he is not familiar with the state law, but according to the Halacha he suggested the family not donate the organs. His colleague said:

As long as a person breathes, he is alive… if you decide to disconnect him you are a murderer…

It is important to note that these suggestions contradict the Israeli Chief Rabbinate's recommendation that follows the Jewish law of "Pikuach Nefesh", according to which the preservation of human life overrides virtually any other religious consideration. Thus, Rabbi Amar, who is the Sephardi Chief Rabbi of Israel, said in the TV program:

If brain death was affirmed according to medical tests as prescribed by the law…the family is allowed to donate by Jewish law…

It may be concluded, as shown in this TV program, that although the Israeli Chief Rabbinate confirmed and supported brain death and organ donations, there are still religious leading figures

\textsuperscript{103} Rabbi Kanievsky is considered a leading authority in Haredi (Ultra-Orthodox) Jewish society.
that oppose it. The latter will influence families in these critical moments, as was done in the case of Avi Cohen to advance their own agenda and interests.

This opposing religious recommendation was condemned by the government official cluster and by other religious leaders. Thus, for example, the key position-holder at the HOD association referred to these opposing forces in his interview:

It is a national disaster…I'm not sure why and how he [the rabbi] was admitted to the hospital… he wanted media exposure…but it is not a good idea since his concern is that physicians are too eager to transplant… so they will determinate that a patient is dead, even though he still has a chance to live…it is unbelievable!

The National Transplants Center representatives gave an even harsher reaction:

Not only did we compromise and agree to all these stupid tests to determine brain death [i.e., the 2008 legal requirements] …then they asked us to make special donor cards for them with a blessing. I agreed, but told them that we, the secular people, want a blessing too, and they did not agree to that…but forget all of these…now they have a new idea- now they want that in all cases of brain death, I'll have to call their religious representatives and they will check how the physicians determined the death; they said they do not trust human beings; they need an instrument to determinate brain death ... and we then added an invasive examination by instruments - not to mention the costs- our health system is broken but we have money for religious considerations! All other considerations are gone- logistics, financial, medical—nothing is important!

Another position-holder in the National Transplants Center described it as well:

There's a whole section in the new regulation [i.e., 2008 legislation] that was not understood by the medical staff… you give the family a choice, but it's not a real choice, since sometimes you cannot really determine a brain death and the outcome is that they cannot donate... so we had a major decline—last year there were 33 cases of brain death that were not determined because of this change in the law… it is terrible: not only did the law fail to increase the number of donations, they have decreased! Moreover, now we have to do the instrumental test and apnea test …. In those cases when we could not make apnea, we could not determine brain death and we could not receive the organs for transplantation- even if the family consented!

As seen from these examples, few of the religious cluster approved brain death and organ donations and others strictly opposed it. This is also true of the current proposal of the new Minister of Health to change the Israeli legal model of organ donations to allowing presumed consent. For example, the former Deputy Minister of Health, who leads a coalition of two ultra-
Orthodox parties, strictly opposed it and said that this proposal does not make sense in a
democratic state that puts emphasis on ethical values and equality. Then, he blamed the State
with anti-religious coercion and said:

This is a bizarre proposal that has no place in a democratic, equitable and ethical state…
There is clearly an anti-religious and outrageous coercion. 104

It may be concluded that during the last stages of the process, there is still strong religious
opposition to organ donations, although some religious leaders support the practice.

The media: Stages 4-5

During the fourth and fifth stages of the construction of organ trafficking as a social
problem in Israel, the use of the media increased substantially. There was a national campaign
that utilized all forms of media and all channels within and called for people from different
backgrounds and subcultures to sign donor cards. A few of the Israeli e-journals created a special
channel in which transplantation stories were told. Thus, the Israeli audience could participate in
the following: watch organ trafficking news on current-affairs and documentary programs that
focused on organ trafficking, hear commercial advertisements that called for signing of donor
cards, watch an entertainment TV shows that cynically referred to organ trafficking, or read in
the newspaper about a celebrity or a well-known figure that signed a donor card. Picture 4 below
illustrates the idea to include well-known figures from as many fields as possible as donor card
holders: a national fashion model, the Minister of Education, a homosexual dancing

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choreographer, a journalist, and a famous IDF widow. Pictures 5 and 6 that follow show efforts to target the religious community.\footnote{Gender segregation is common practice among Orthodox Jewish communities; as a result two pictures are needed to avoid a picture of women and men combined. A detailed discussion on religious aspects in these stages follows.}

**Figure 4: An advertisement that promotes the signing of donor cards**

![Advertisement promoting donor cards](http://www.ynet.co.il/home/0,7340,L-10705,00.html)

**Figure 5: Orthodox rabbis promote the signing of donor cards**

![Orthodox rabbis promoting donor cards](http://www.hods.org/Hebrew/)

[A translated version of the heading: "hundreds of Rabbis are donor-card holders"]

**Figure 6: Religious women leaders promote the signing of donor cards**

![Religious women leaders promoting donor cards](http://www.hods.org/index.asp)

In the same manner, to increase the numbers of donor-card holders, the new advertisements explained the new legal model whereby people who hold donor cards will be advanced on organ recipients' waiting lists in case they or a family member will need an organ in the future. In order to make this advertisement more powerful and official, the presenter is the news anchorman of the Israeli National TV channel. The advertisement runs repeatedly and...
routinely in all media forms so that its motto and jingle became commonly used slang. It is therefore concluded that the higher the social problem of organ trafficking reached in its construction process, the more the government cluster used its media power resource. This conclusion is reinforced by the following media case studies.

The first is the case of Avi Cohen, a famous Israeli footballer that was seriously injured in a motorcycle crash and later died in December 2010. His family thought of donating his organs since Avi was a donor-card holder, but eventually they did not due to religious beliefs and rabbinical recommendation. The resulting public debate revealed the tension between the different interest-groups involved. Since the case happened after the 2008 legislation, and brain death was terminated as required by the law, and since Avi Cohen was a donor-card holder, it was supposed to be a perfect designated organ donation—a model case to increase organ donations and signatures on donor cards. However, the family's decision not to donate the organ changed it all. The case of Avi Cohen was mentioned in most interviews as one of the most striking cases that influenced the public agenda. Below is an excerpt that reveals the power of the media with regard to this specific case. The PR and training coordinator of the National Center explained:

*This case... it was amazing! Wow! It was all in the media... everybody was talking about it... it was a classic brain death and then after his son publicly declared the organ donation and it was the best we could ask, you know... soccer ball players and their fans are not really our cup of tea... but then they changed their minds... they said even though he has a donor-card we will not donate... the religious rabbis become involved and told him that such a donation is murder... you can't even imagine what it did! People were angry—they protest and said that the donor-card is irrelevant since eventually the family is the one to decide... they asked us to make it a legally binding agreement... it was a very heated public debate... some people were angry at us and told us that we made fools of ourselves since the card does not mean anything... others blamed the family... either way it was a media campaign for free! Although his organs were not donated it helped us... and yes, we still prefer to respect the family's decision because*

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106 The religious aspects that eliminated the donation have been discussed separately, in this section the focus is on media involvement.
there are very few cases like this…it is the exception… few people were very emotional; they said they will sue us for not following his request…but, you know, it depends on your reactions…and we replied and explained that we cannot do it against the family's will, we would like to empower the family so that people would sign easily…

The case of Avi Cohen was also helpful according to the transplantation coordinator of the National Center:

The case of Avi Cohen helped us a lot! It was an open public debate… and since then everyday they give these donation stories on the radio… It is also for us, the coordinators, that since then, when we face the families… when we come to explain what brain death is… they suddenly tell us: "Ah yes, like Avi Cohen"…it raised the public awareness… and we can also look on the positive aspect: instead of focusing on why the family did not donate, they should think about how many people he would have saved…

As explained by both interviewees, the case of Avi Cohen was a great opportunity for the National Transplants Center. Not only did it expand the target population of cardholders and reach the audience of sports fan and footballers, it also helped to expose the different interest groups' agendas and to publicly discuss the issue of organ donation from diverse points of view. The government official could explain its decision to respect the family choice not to donate in order to get more public support and recruit more donor cardholders. Referrals to this case were also done in real time, when the coordinator faced the potential donor family.

The second media case is the successful liver transplantation done for Mr. Meir Dagan, who was the former Director of the Israeli Mossad. Dagan, who was 67 years old, when this occurred, could not go through a liver transplantation in Israel or in the USA. At this point, three former Israeli prime ministers — the current prime minister, the president, the Minister of Foreign Affairs, and the current Director of the Israeli Mossad — were recruited to locate a

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107 The Institute for Intelligence and Special Operations is appointed by the State of Israel to collect information, analyze intelligence, and perform special covert operations beyond its borders. More information about one of the most honored Israeli institutions may be found on its website: [http://www.mossad.gov.il/Eng/AboutUs.aspx](http://www.mossad.gov.il/Eng/AboutUs.aspx) last access January 2013.

108 Liver transplantation in Israel is done only for recipients who are 65 years old or younger.

109 The waiting time for liver transplantation in the USA was about a year long, which was too long for Mr. Dagan to wait.
destination where he could obtain the needed organ as soon as possible. In a TV interview\textsuperscript{110} in response to the question about the special care he received due to his highly respected position as opposed to other Israeli people in need of an organ, Mr. Dagan replied:

My position makes it all more complicated…eventually, the decision is based on medical considerations…it is not up to your personal relationship or connections… I have to tell you that I did not get preferential treatment…the fact that it was me there only interfered…and I do not agree that someone else could not get the same treatment since everyone does the best they can do and it is decided by medical considerations and not by personal relationships…

Nevertheless, in the same TV interview Mr. Dagan said that it was his personal connections that brought him to India although his personal criteria (i.e., age and health situation) were not compatible with the Indian standards of transplantations:

Let's put it this way…the flexibility in a country of 1.25 billion people is greater than it seems… I have an Indian friend, Ratan Tata\textsuperscript{111}, who is a very special man and he told me that all will be arranged upon my arrival… however, I later found out that they [the Indians] do not really want me there…they did not want the former Director of the Israeli Mossad…and then I got the call from Belarus…it was a personal decision of the President of Belarus to confirm my transplantation.

As explained by Mr. Dagan, it was his highly respected position and his connections that brought him first to India and eventually to Belarus. Neither one of the participating clusters expressed dissatisfaction because of the special care the former Director of the Mossad received. To the contrary, the Israeli public supported Mr. Dagan.

\textbf{Globalization: Stages 4-5}

In the last stages of the social construction of organ trafficking as a problem, globalization context was frequently invoked. In these final stages and after the implementation

\textsuperscript{110} See: \url{http://www.mako.co.il/tv-ilana_dayan/2013-d64ccfe48005e310/Article-e1d6a741d815e31006.htm} available in Hebrew, last access June 2013.

\textsuperscript{111} The Tata Group and its companies and enterprises are perceived to be India's best-known global brand within and outside the country. The 2009 annual survey by the Reputation Institute ranked the Tata Group as the 11th most reputable company in the world.
of the 2008 legislation as the official plan of action, globalization was evident in two forms. First, and directly after the new plan of action was finally enacted on 2008, globalization enhanced the Israeli new legislation. In that form of globalization the comparison to other states and countries was done to shed a positive light on the Israeli official plan of action and to present Israel as superior to other nation states. Therefore, the main focus was on the Israeli new prohibition of organ trafficking and the state's policy that abolished refunds for medical tourism expenses by the government or private health insurances. The following are a few examples of this form of globalization.

Some government officials referred to the new legislation's clause whereby only the middlemen—and not organ donors or recipients—are the ones to be accused of organ trafficking in Israel. For instance, the legal advisor of the Ministry of Health repeated in both conferences:

It is important to note that we are the only country that does this; in other countries the laws and regulations with regard to organ trafficking prohibitions pose criminal liability on organ donors and organ recipients too... we think that we should not do it... we perceive organ donors and recipients as victims and not as criminals, and I think it's the right thing to do...

Other government officials such as the Knesset member that issued this legislation and the director of a transplantation unit supported that idea in the second conference. They all agreed that it is an exceptional regulation since it does not pose criminal liability on the victims of organ trafficking, namely organ donors and recipients.

In the second conference the legal advisor of the Ministry of Health referred to other aspects of the 2008 law:

We knew that the law will hurt the patients-the organ recipients, every law entails some limitations...however, we have to give the new regulation [i.e., priority to donor cardholders] some time, and we all believe that it will work out...it will be a successful practice as the prohibition on organ trafficking was!
In other words, the speaker argued that the new prohibition on organ trafficking achieved its goals. However, it is important to note that in this occasion he did not refer to the powerless subgroup of organ donors.

The head of one of the Israeli health insurance companies said in the second conference: This new legislation improved our status in the global community…it is not only our image…it is about being moral and enforcing national law of ethics…it is about implementing national norms and treaties that Israel is obligated to…

This time the speaker did refer to both organ donors and organ recipients:

…therefore we cannot invalidate the law…even if the law disadvantages certain groups—and we all know that it is the poor and the deprived that are hurt… it is the price we have to pay in return for Israel's ethical reputation among the global community.

The speaker explained that it is the 2008 legislation that brought Israel back to the family of nations and improved its ethical status. This idea was confirmed by other government officials.

For instance, the head of a transplantation unit said:

Prior to the 2008 legislation I wasn't proud to be an Israeli physician…we, the Israeli doctors, were condemned in medical conferences abroad…Israel was "the winner" in the field of organ trafficking…but nowadays, it is different… we got our ethical status back and we are part of the family of nations again…

The head of another transplantation unit supported that claim:

Not only did we gain our ethical status back, we also gained our involvement in WHO again…we all should remember that it is the only field in which trafficking was ceased globally…and we have to mention these cases, which we, Israeli medical teams, had to take care of due to malpractice transplantations done abroad…I'm not sure about other organs but I had more than 20 Israeli patients who had harvested the new kidney they came with…

The two physicians that prior to the 2008 legislation tried to exonerate themselves from involvement in organ trafficking by the Israeli government, did the same with regard to the Israeli new policy from 2008. Thus, in the attached NTD news program from March 2013, the Israeli

[112] http://www.youtube.com/watch?v=XodYeOailM&feature=youtu.be this 5 minutes link starts in Hebrew but after 40 seconds it is in English. Last access June, 2013.
physician encourages other states and countries (e.g., Taiwan) to block their patients from traveling to China, like Israel did, in order to cease organ trafficking. This conference coverage begins with the presentation of the Israeli legislation as a successful model for other states to implement and explains that Israel is the first country in the world that prohibits local health insurance to finance patients who request to go to China for organ transplantation. As seen in the attached link, this time the Israeli physician is proud of his Israeli origin and praises the Israeli legislation as a model for other countries to follow.

The other form of globalization appears mostly toward the end of the last stages and in fact is still part of the ongoing discussion. This form of globalization sheds a negative light on Israel and presents Israel as inferior to other states and countries—it notes the low rates of live organ donations, consents to donate by deceased families, and signatures on donor cards. These comparisons to other countries are mainly done as a call to change and improve the current situation in which the Israeli rate of organ transplantations is limited due to the severe shortage of organs. For example, the head of the National Transplant Center argued in the first conference that in some countries, 80% of the families of the deceased are willing to donate their loved ones' organs, while in Israel it is roughly 50%, a figure that "has to be improved". The presenter also explained in the opening speech of the second conference:

During the first year after the legislation of the Organ Transplants Act, we [the National Center] had a sharp decrease [in the number of people who signed up to become organ donors upon death] in organ donations...then in 2011 there was an increase and in 2012 another decrease, now we are slightly above the base line...but we have to examine these figures not after a year or two...In Israel we have an excellent system...we have great cooperation between the different transplantation units and the National Center controls their operation... we also have the best physicians and medical teams...but ...our severe limitation is that we do not have enough organ donations...we still have the same figure of 50% willingness to donate which is not sufficient...we have to reach other countries' rate of 70% ...the solution is within our borders and not abroad...we have to increase organ donations rate such as in the Scandinavian countries...
In fact, the head of the National Transplant Center presented all the positive aspects of the Israeli system and only then compared Israel to other states, in which the donation rate is much better.

In the second conference, the head of an insurance company recommended the opting-out model as a solution to this problem of the low rates of donations:

The only reform that the Ministry of Health has to implement in the Israeli Organ Transplants Act, in my opinion, is the legal model of presumed consent, so that unless the deceased explicitly expressed his/her refusal to donate he/she will become donors…we should look at Spain for example; 20 years ago it had the lowest donation rates and now Spain has the most donors per population rates…I also would like to address the organ recipients' low rates of donor cardholders …and I have to tell you [organ recipients] it is a sin! Those that would like to receive organs should be the first to donate them…

As part of the last stage of the construction of organ trafficking as a social problem, negative globalization came up mainly with regard to the opting-out model that was recommended frequently during the second conference. A bio-ethics professor referred to the contrary system of Singapore:

Singapore implemented the opting-out model…after the determination of a brain death a person that declared on his/her refusal of organ donation after his/her death is automatically removed from the optional organ recipients waiting-list in case of a need…in such a system organs become a collective resource…such a system also will solve the problem of free-riders…it is a legitimate solution whereby those that are not willing to donate will not be eligible for receiving an organ if needed…in that way Israel will be able to increase its donor cardholders among all, including the religious…

As explained by the professor, the current legal model in Israel (opt-in) entails some problems, such as free-riders, who are willing to receive organs but not to donate them. The professor referred to that part of the religious cluster that still refuses to donate. Therefore, by comparing Israel to Singapore, he suggests that the latter model is better and that Israel should implement it. These examples illustrate the negative globalization comparison used to shed a negative light on the Israeli current model and to motivate toward another reform in the construction of organ trafficking as a social problem in Israel.
CHAPTER 4: DISCUSSION

The social construction of organ trafficking as a social problem in Israel and claims-making activities were consistent with the models of Blumer (1971) and Spector and Kitsuse (1973; 2001). Thus, the history of organ transplantations in Israel revealed that the severe shortage of organ donations in Israel, and the increasing number of involvements in organ trafficking came to be recognized as a social problem due to the clashes between opposing interest groups. In general, the interest group of government officials attempted to transform the alleged condition of organ transplantations into a public issue in order to massively increase organ donation rates and prohibit both internal organ trafficking and organ trafficking done by Israelis abroad (e.g., medical tourism). In that sense, the powerless cluster of organ donors, with a limited representation (i.e., mainly of a few Knesset members) and almost no access to power resources, sought the same goal of organ trafficking prohibition. The opposing interest groups strived to avoid such public recognition: on the one hand, the religious cluster opposed the idea of brain death as actual death and therefore resisted organ donations; on the other hand, the powerless group of organ recipients opposed the idea of banning medical tourism refunds since no other means for receiving organs were available to them. The opposing interest groups' conflict developed over several acts along the continuum of the construction of social problems, namely the model's stages. In the first stage of this process, during the emergence of organ trafficking as a social problem in Israel, the Israeli society was not yet ready to take care of the issue. In fact, the data gathered for this stage disclosed the impotency of both the powerless group of organ donors and the cluster of government officials to gain attention for what they believed to be a major social problem. As a result, the opposing religious cluster did nothing to change the current situation that best kept its interests. In this initial stage, the powerless group of
organ recipients also did not have to be actively involved in the situation, since it enabled them not only to receive their needed organ abroad, but also to be eligible for the government's or private insurance's refunds for their medical tourism expenses. Consequently, it is hard to find any involvement of the mass media, political figures, powerful organizations, and corporations or any other measure that is necessary to the successful development of organ trafficking as a social problem. However, the government activities, such as the establishment of the Israeli National Transplant Center in 1994, achieved its goal: the issue of organ trafficking gained its initial recognition and continued its development as a social problem in Israel.

According to Blumer (1971), in the second stage of the model a social problem must acquire a necessary degree of social endorsement, so that it will be recognized and discussed by respectable position holders and public officials. The government official cluster was the main player in this stage. Thus, the State Comptroller's report from 1996 started the legitimation process by which the Israeli low rate of organ donations, which directly affects organ trafficking, was initially recognized as an Israeli social problem. The government also recognized the need to structure organ transplantations so that illegal organ trafficking would not be allowed in Israel or by Israelis abroad. In order to do so the Ministry of Health issued two internal regulations (1997; 1998) that did not successfully achieve their goals due to their limited content and scope. Nevertheless, it was an official government declaration that the issue of organ trafficking was and is worthy of consideration and that it must acquire some social endorsement to become socially prohibited.

Later on during this process of gaining social endorsement, two other attempts to change the legal rules related to organ transplantations were done: first, the 2000 bill initiated activities to encourage organ donations for transplantation; second, the proposed amendment of the
Anatomy and Pathology law recommended an opting-out model. Neither the bill nor the amendment became laws\textsuperscript{113}; however, they both serve as factors in the public discussion on organ donations and organ trafficking as an emerging social problem that is legitimated and needs to be addressed. Although organ trafficking achieved some official recognition, at this point it still did not result in satisfactory measures to deal with the problem. Thus, a law or at least a clause in the existing law prohibiting organ trafficking could not yet be legislated.

As a result, during the two initials stages of the process the opposing forces of both the religious cluster and the powerless cluster of organ recipients remained silent. These two clusters did not have to do anything to change the prevalent situation, which served their interests: the organ recipients could obtain the needed organ abroad without being accused of organ trafficking, and they could still receive a promised refund for their medical tourism expenses. Also, the religious cluster did not have to affirm brain death and to reform common Halachic rules among its communities to fit modern medical practices.

Nevertheless, the public discussion on the bill and proposed amendment was the starting point for the next stage that finally revealed explicitly and officially the disagreements regarding organ trafficking prohibition. The third stage in the construction of a social problem is when the problem became the object of discussion, of controversy, of differing depictions, and of diverse claims. To mobilize the society for an action on the social problem the different interest groups motivate debates to support their idea and falsify the opposing point of view, evaluations of the different proposals for advance their own or resist the others', and diversionary tactics. All of these take place in the media, in casual meetings or official conferences such as legislative forums and committee hearings. Successful definition of a social problem requires creation of a

\textsuperscript{113} Some of these recommendations were discussed later in 2007 with another proposed law that was finally enacted in 2008, and others are still under discussion.
public issue and official recognition (Blumer, 1971; Spector and Kitsuse, 1973; 2001). The mobilization of action regarding organ trafficking in Israel formally transpired with the 2003 proposed law that called for the prohibition of organ trafficking. This bill was proposed by a Knesset member as a response to organ trafficking stories she heard from exploited organ donors. As such, the bill represents both the powerless cluster of organ donors and the government official cluster.

Among the major political variables critical to social problem development, Spector and Kitsuse (1977) mention the following: the use by claims-making groups of an ideology to make the complaint more forceful; the ability to recognize the appropriate parties to complain to; and the ability to marshal enough power to press claims. There is no doubt that the organ donors, who prompted the Knesset member to act and submit the above mentioned bills, recognized the appropriate parties to complain to in order to make their claim more powerful. They, as the powerless cluster of organ donors, transformed their private claim into a complaint that affected a larger sector and became a public issue that the Israeli society had to address. This, along with other forces such as the parliamentary discussions and formal publications on the Parliament's website, served as both the government official and powerless organ donors cluster mobilization of action.

In the third stage of the model and since there was already mobilization of action with regard to organ trafficking in Israel, the opposing clusters began to act. The powerless cluster of organ recipients collaborated in one forum in order to gain more power. The forum's letters are an example of this cluster's protest, in which they apply emotional rationalizations as well as practical recommendations to hang onto the current situation that best keeps their interests. The religious cluster became active as well, and began to protest publicly. Indeed, the Israeli Chief
Rabbinate's disapproval of brain death and organ donations prevented the enactment of the above mentioned proposed legislations and bills. In the same manner, most government officials' interviewees referred to the religious cluster as the main opposing force that prohibited organ donations and therefore increased organ trafficking. Moreover, most of the government cluster interviewees and speakers thought that a religious reform towards organ donations and acceptance of brain death as an actual termination of life was not likely to happen at this stage of the process. However, even though the 2003 bill was not legislated either, the fact that organ transplantations and organ trafficking were officially and publicly discussed made it an important issue that climbed its way up to become an Israeli social problem. The disagreements between the different clusters involved fulfilled the third stage of the model and mobilized an initial action with regard to organ trafficking in Israel. That initial action laid the foundation for the fourth stage that follows.

In the initial stages of the process, the global context of organ transplant was mostly brought up by government officials to shed a negative light on Israel and to present Israel as inferior to other states and countries in the field of organ transplantations and organ trafficking. During the first stage, for example, the need to generate a national waiting list of potential organ recipients as other developed countries have became elementary. Later on, a negative approach towards the Israeli low rates of actual donations as well as the Israeli society's unwillingness to donate was repeatedly expressed. Globalization comparisons and context in these stages were also brought up with regard to medical tourism that was sponsored by the Israeli social security health insurance (HMOs) or by private Israeli insurance companies. Accordingly, Israel was perceived as inferior to other countries not only in terms of organ donation rates and rates of donor cardholders, but also with regard to state-sponsored medical tourism.
The powerless cluster of organ recipients also saw the low rates of donations in Israel as negative, but they remained silent with regard to medical tourism. In one occasion, an organ recipient's representative contradicted this practice, but at the very same time they proposed a similar Israeli system of payments for organs run by the government. The religious cluster was not involved in this part of the discussion either, but its protest against organ donations and transplantations in Israel was consistent. Therefore, although the government officials understood that they had to do something about the situation and the nation's condemnation, they were not yet able to change the legal situation and cease the organ recipients' involvement in medical tourism abroad. Nevertheless, they were unwilling to remain silent and revealed their protest in medical conferences and by publishing articles that resisted medical tourism by Israelis. This protest was another measure the government officials' cluster used to enable the next stages of the construction of organ trafficking as a social problem in Israel.

In the initial stages of the process, the different interest groups did not massively use their access to media. However, occasionally and mainly during the third stage, different types of advertisements were used, most frequently by the government cluster. During these early stages, the use of media resources and advertisements was limited, and only later were more measures pursued to increase the number of donor cardholders. However, most of these measures failed, and the National Center focused on giving lectures in schools and in the army in order to educate the next generation of potential organ donors. The use of media resources by the government cluster will be greatly increased during the following stages.

The fourth stage in the development of social problems is the society's decision as to how it will act in response to the problem (i.e., the official plan of action). The legislation of The Organ Transplant Act and the Brain and Respiratory Death Law in 2008 are the official plan of
action with regard to both legal organ transplantations and illegal organ trafficking. These two laws disclose the two powerful interest groups in the case of organ trafficking and donations: the religious representatives and the Israeli government. The Organ Transplant Act revealed heated debates and disagreements throughout the legislative process. In fact, the legislation of the Organ Transplant Act was only finalized after the religious cluster demands regarding determination of brain death were satisfied by the Brain and Respiratory Death Law.

According to Blumer (1971), the fourth stage is a collective reevaluation process of the social problem, in which the problem is redefined so that what emerges may be different from its initial definition. Therefore, the final versions of the two laws of 2008 are different from the previous bills, such as the bills of 2000 and 2003 that were discussed in the former stages of the construction of organ trafficking as a social problem in Israel. These defining and redefining processes are also well rooted in the statutory process of the two laws. Thus, although the bill of 2007 did eventually become a law, it was only after many discussions and disagreements between the different clusters involved. For instance, the committee of Social Affairs and Health that discussed the bill had an intense and long-lasting debate regarding the issue of consideration for live organ donation. The three proposals offered in the committee discussions represented the different interests of the clusters involved: government officials, the powerless cluster of organ donors, and the powerless cluster of organ recipients.

Although the proposal of the powerful cluster (i.e., government officials) was accepted, each clusters' representative made claims for the alleviation of social, political, legal, or economic disadvantages of his/her interest group and by doing so participated in the process of defining the social problem of organ trafficking in Israel. Thus, the definitions of organ trafficking as a social problem is constructed by these Knesset members who attempt to call
attention to situations they find unacceptable and who try to mobilize the institutions to do something about them. The liberal Knesset member, for instance, called for abolishing any compensation for organ donations in order to safeguard from exploiting the underprivileged and to keep the donations' altruistic character. Conversely, the organ recipients' representative made a demand to increase organ donation rates through compensation by the State for organ donors. He asked that something be done about the current situation that prevents people from receiving the needed organs. Both clusters' representatives understood that the middle-ground proposal by the State was the best compromise they could get. However, in accordance with the claims-making theory (Best, 1987; Spector and Kitsuse, 1973; 2001) their opposing claims implied that they have a right at least to be heard, if not to receive satisfaction. This debate with regard to consideration for live organ donation also fits Spector and Kitsuse's (1977) model according to which in this stage of the problem's official recognition the claims-making group seeks to convince an official agency (i.e., the Knesset) to recognize the legitimacy of the claim and to have a remedy proposed that is favorable to the group's interests.

The combined 2008 legislations as well as the fact that the government officials' proposal was eventually accepted are in line with Randall and Short's (1983) idea that the "final" resolution will reflect the distribution of power assets. Thus, the 2008 legislation is the direct outcome of the two powerful interest groups' claims and demands: the religious cluster and the government officials cluster. The legislation of the two laws is also the end of the fourth stage; this is when a social problem is typically at its career peak. Thus, both organ trafficking and some aspects of legal organ transplantations (i.e., shortage of organ donations) were officially recognized as a legitimate social problem that was being addressed. The legal issue of organ donations and transplantations is carried out by the National Center as seen in the interviews of
the different position holders (e.g., training coordinator, transplants coordinator, and the employee responsible for live donors' reparations). The illegal nature of organ trafficking was addressed by both regional and national ethical committees and by the 2008 laws, which are enforced and later applied by the Israeli judicial system as seen for instance in the criminal appeal. Criminal liability is imposed in Israeli courts for both forms of organ trafficking: internal and organ trafficking conducted by Israelis abroad.

However, although major progress was achieved, the formal agencies involved, the defense attorney, and the judge as well as different position holders in the National Center continued to express dissatisfaction with the current situation. More specifically, they all emphasized the fact that the Israeli health system is still behind, and there is no actual solution to the desperate shortage of organs. The interest groups' dissatisfaction is an important element in the fifth stage of the construction of social problems, since it reveals that the official plan of action is not sufficient. The last stage of social problem development may occur when the social problem is not solved with the official plan of action (Randall and Short, 1983). In the case of organ trafficking in Israel, the fifth stage did occur, by proposals of new plans of action by the different interest groups involved in or touched by the original plan. Thus, all clusters were involved in the fifth stage of the social problem development, and each one of the clusters persisted in advancing its agenda and keeping its interests in the socially constructed problem of organ trafficking in Israel.

The government officials cluster that led the legislation of the Organ Transplants Act and provided its implementation in practice was not completely satisfied with the resulting outcome and sought to reform the official plan of action and its practical implementation. In fact, the National Transplants Center's decision to organize the two conferences served in itself as a claim
of dissatisfaction. The main focus in the first conference was to acknowledge the obstacles to organ donation as seen in the Israeli society in order to address them properly and to increase organ donation rates. In the second conference, the progress achieved by the 2008 legislation was presented together with its limitations, the most salient of which has been the low organ donation rates in Israel. The powerless sub-clusters of both organ donors and organ recipients were also frustrated with the current situation, whereby state policy does not offer any solution to the shortage of organs. The organ recipients could neither receive an organ without examining its origin, nor get a refund for their medical tourism expenses. Organ recipients expressed real anger at the current legal rules for obtaining organs; although it improved the situation by ceasing illegal organ trafficking abroad, it still did not provide the required sufficient solution. In the same manner, the Israeli low rates of legal altruistic donations left potential organ donors exposed to the same risk of being lured to sell their organs.

The religious cluster remained divided in the last two stages of the process, after the different clusters compromised to a certain degree with the 2008 legislation. Some religious leaders revealed support of the new legislation and its practical implementation, while others persisted in their initial views and strictly opposed organ donations. The first subgroup supported organ donations overtly and tried to influence its community to support organ donation as well. To express their support and to change the unflattering beliefs about religious people — that they agree only to receive organs but not to donate them — a few representatives of the religious cluster began to act: they issued special donor cards for religious communities; they established organizations and associations to promote live organ donations and educate the public, both in Israel and abroad; and they guided both the general public and their own religious communities to support organ donations from Jews to all.
The other religious subgroup persisted in strictly opposing organ donations and rejecting brain death as actual death, even in the later stages of the construction of organ trafficking as a social problem and after the Israeli Chief Rabbinate accepted brain death and supported organ donations. As shown in the case of Avi Cohen, there are still religious leaders who oppose organ donation even if brain death is confirmed according to the 2008 laws' religious requirements. This group will influence families in their critical moment to advance their religious agenda and interests. The opposing religious subgroup is condemned by the government officials cluster and by the other subgroup of the religious cluster that supports organ donation. It is important to note that the same disagreement and subdivision within the religious cluster exists with regard to the current proposal by the new Minister of Health to change the Israeli legal model of organ donations to a presumed consent or opt-out one.

In the last two stages of the process, the government cluster's use of access to media increased significantly, and they exploited the powerful role of the media to identify social problems and bring them into public notice. Indeed, the higher the social problem of organ trafficking reached in its construction process, the more the government cluster used its media power resources. This conclusion is reinforced not only by common media channels such as advertisements, documentary programs, or personal stories, but also by the media focus on the stories of Avi Cohen and Meir Dagan. The case of Avi Cohen was mentioned in most interviews as one of the most striking cases that influenced the public agenda. As explained by interviewees, it certainly revealed the power of media. It was a great opportunity for the National Transplants Center to expand its target population of cardholders and reach the audience of sports fans and footballers. It also helped to expose the different interest groups' agendas and to publicly discuss the issue of organ donation from diverse points of view to influence and
increase Israeli organ donations rates. Thus, the government officials could explain its decision to respect the family choice not to donate in order to get more public support and recruit more donor cardholders.

The second media case is that of the successful liver transplantation done for the former Director of the Israeli Mossad, Mr. Meir Dagan. Although Mr. Dagan denied that his personal connections helped him, it was assumed that his contacts as well as his highly respected position brought him first to India and eventually to Belarus for his successful transplantation. In contrast to the case of Avi Cohen where the family as well as the opposing religious subgroup were condemned for their decision not to donate, in the Dagan case the Israeli public supported his actions and did not express any protest. Neither one of the participating clusters expressed dissatisfaction due to the special care the former director of the Mossad received. On the contrary, the public reactions were of concern for his welfare and expression of well wishes. It might be due to the differences between the two cases: first, Avi Cohen was a deceased potential organ donor while Mr. Dagan was a live organ recipient; second, the first case was within Israel's borders, while in the second case transplantation was done abroad and therefore did not affect the concerns of the opposing religious subgroup, which remained silent; lastly, in the first case the Israeli public was involved in real time, while in the second case the media coverage was mostly done after the fact. In spite of these differences, the power role of access to media and access to resources such as governmental connections is well noticed in both cases and fit well within Randall and Short's (1983) model modifications.

Although in the initial three stages of the construction of organ trafficking as a social problem, the context of globalization mostly shed negative light on Israel when compared to other states, in the final stages of this process globalization comparisons crystallized in two
forms. First and directly after the implementation of the 2008 legislation as the official plan of action, globalization comparisons enhanced the Israeli new legislation. In that respect, globalization comparison to other states and countries shed a positive light on the Israeli official plan of action and presented Israel as superior to other nation states. Accordingly, the main focus was on the Israeli new prohibition of organ trafficking and the state's policy that abolished refunds for medical tourism expenses by the state's or private health insurances. Some government officials also referred to the new legislation's clause whereby criminal liability is posed only on middlemen and not on organ trafficking victims (i.e., organ donors and recipients).

As in the case of the Israeli legislation that prohibits refunds for medical tourism, it was presented as a successful model for other countries to follow. Moreover, participants frequently explained that due to the new legislation, Israel was accepted as part of the family of nations again, and its ethical reputation among the global community was finally safeguarded.

The other globalization use sheds negative light on Israel and presents it as inferior to other states. This globalization was mostly brought up toward the end of the last stages, and in fact is still part of the ongoing discussion. This invoking of the globalization context focuses on the low rates of live organ donations, consents to donate by the family of the deceased, and signatures of donor cards. Therefore, Israel is contrasted with other countries in the hope of improving the current situation, in which the Israeli rate of organ transplantations is limited due to the severe shortage of organs. For instance, negative use of the globalization context was brought up frequently with regard to the recommended solution of the opting-out model. This negative use of globalization was employed by the government officials cluster to present the Israeli current model in a negative light and to motivate stakeholders toward another reform in the construction of organ trafficking as a social problem in Israel.
CHAPTER 5: CONCLUSION

The construction of organ trafficking as a social problem in Israel is consistent with the models of Blumer (1971) and Spector and Kitsuse (1973; 2001) that depict claim-making as pivotal in the construction of social problems. Thus, the severe shortage of organ donations and the increasing number of involvements in organ trafficking in Israel were a socially constructed problem. It was a process that began with the emergence of organ trafficking as an Israeli social problem through its legitimation, mobilization of action, and to its formation of an official plan of action. Indeed, this study indicates that at present the transformation of the official plan and its implementation is still an ongoing public discussion with no final resolution in sight. It is also established that access to power resources such as media and government involvement are crucial to the social problem's successful development (Randall and Short, 1983).

However, in this research of organ trafficking in Israel, as opposed to other social problems, the social construction is mostly of the solution to the problem rather than the problem itself. Thus, during the different stages of the social construction (mainly the latter stages) the claims-making activity focused on various solutions to illegal organ trafficking, medical tourism and to the Israeli shortage of organs, whereas in other cases the social construction is mostly of the problem itself. This distinction leads to another differentiation with regard to the interest groups involved: in most cases of social problems there are opposing groups with contrasting interests; however, in the case of organ trafficking, since the social construction is of the solution, the government was highly involved in the process and frequently led the claims-making activity and the construction development. In that sense, the government officials cluster played a major role in pushing for solutions rather than defining the social problem as such.
There were two aspects that mutually contributed to this socially constructed solution: the complicated relationship between the opposing political forces of the state and religious entities in Israel and the globalized nature of organ trafficking, including the Israeli fear of being condemned by the rest of the world. These factors also played a major role throughout the social construction process. Thus, in the first stages of the model, when the state policy was directed toward medical tourism since it enabled less domestic demand and therefore served the religious agenda, less claim-making activity was found and available data was rare. It might be that this paucity of data is due to the fact that the policy served the government interests of that era, and therefore it still did not offer solutions to the problem. In the same manner, issues related to organ transplantation were noticed back in 1978, but no major social activity related to it took place. One reason for that may be the Israeli participation in medical tourism and the low rates of legal donations due to commonly held religious beliefs. Only when Israel was severely condemned by the family of nations — only when there was no other way but to cease the Israeli involvement in medical tourism and its byproduct of organ trafficking — did the Israeli government lead public discussion and attention to possible solutions of the constructed problem. Subsequently, the government act provoked reactions by opposing interest groups that responded accordingly. This conflict increased the visibility of debate and facilitated the creation of Israeli public awareness to the proposed solutions. Therefore, it was only in the latter stages of the construction process when most of the claims-making and social activities occurred and were noticed. This process of definition, through which organ trafficking was defined as a social problem, took place in accordance with the globalized spread of organ trafficking to all corners of the world and with the government understanding that its involvement in medical tourism was no longer possible.
The claims-making theory of Best (1987) and Spector and Kitsuse (1973; 2001) offers an ideal model for the study of the construction of social problems; it emphasize the local, social, and political forces involved in these processes. The reciprocal influences and exchanges of the different interest groups involved in the construction of organ trafficking as a social problem in Israel illustrate this idea. Thus, the interactions between the government officials, the two subgroups of religious leaders, and both organ donors and organ recipients of the powerless cluster not only influenced the process but also shaped it in accordance with the clusters' play of forces. Indeed, the development achieved in each stage of the process reflected the distribution of power assets between the different clusters involved. It was (and still is) a process of collective definition from the initial appearance of organ trafficking in 1978 to its terminal point to be determined in the future, according to these social forces.

Nevertheless, while relying on the framework for social problems one needs to bear in mind its limitations. For example, when researching the construction of any social problem the actual phenomenon is not truly being examined. Therefore, it may be argued that this research did not reveal actual data with regard to organ trafficking as done by and for Israelis in reality, and that the actual extent and nature of organ trafficking per se is not presented. Reliance on a constructionist approach and a stage framework model such as the one used in this research may hinder the analysis. I agree that the main focus was on the construction process and the social forces in the development of organ trafficking as a problem, and therefore other aspects of the crime were not included in the discussion.

Moreover, this research used Blumer's (1971) stage model; accordingly, it is the process of collective definition that determines the fate of a social problem. It is also important to emphasize that according to the author, movement from one stage to the next is not certain and
may be problematic. Social problems may proceed to one stage or another and fail to proceed to subsequent stages. Thus, all five stages of the social problem career are selective process through which some social problems break through and survive while others are ignored or avoided. This "contingency" makes the research of social problems uneven and requires different kinds of approaches in each stage of the model. Nonetheless, in this specific case the collective definition did present itself and this revealed the development of the socially constructed problem. That does not mean that the socially constructed problem of organ trafficking has come to an end. Unfortunately, while writing this conclusion, organ trafficking is still committed by and for Israelis.

An important contribution for the study of social problems, as this research documents, is the need to consider the study of social change, or the cause of problematic sociality (Ibarra, 2009). A salient social change in Israel is the rise of religious parties as a major influential force in Israeli politics. In the current study of organ trafficking in Israel, it was the religious cluster that first prevented the emergence of organ trafficking as a social problem—including its legitimation and mobilization of action—and later shaped the official plan of action to suit its religious interests. Moreover, a subgroup of the same powerful religious cluster still resists organ donations and the brain dead definition of death. This resistance impedes the fulfillment and implementation of a new official plan of action to enable a better Israeli organ transplant system.\(^{114}\)

Another important social change is the emergence of a globalized context and a globalized way of thinking (Stiglitz, 2002; 2006). Globalization is a social change that has major

\(^{114}\) In fact, while writing this conclusion another instance of religious interference came to the public’s attention, in which the family of a deceased consented to donate organs, but the donation was thwarted due to rabbinical influence. However, according to the family, it was not religious rationalization that influenced their decision not to donate. See: [http://www.ynet.co.il/articles/0,7340,L-4409072,00.html](http://www.ynet.co.il/articles/0,7340,L-4409072,00.html) available only in Hebrew, last access July, 2013.
influence on the construction of social problems. In fact, globalization is not only an important cause for the successful development of social problems; it is also a crucial factor in their design. The adaptation of global processes to local needs and interests, such as in the idea of glocalization\(^\text{115}\), is an important element in the study of social problems. It also seems that the term "global social problems" fits well with some of the already socially constructed problems, such as other forms of human trafficking. Therefore, this research suggests that the study of social problems should also aim to develop a global perspective, since the context of globalization as well as other social changes may also be useful in the analyses of other social problems.

During the course of this research, even though the main focus was on the social construction of organ trafficking as a problem, I studied how the differing forms of organ trafficking are carried out, whether within Israeli borders or abroad. I found that all forms shared one common constituent—the exploitation of people's vulnerable situation (e.g., financial or personal). Thus, as emerged from the data collected in this study, not only were organ donors in severe financial need or utter poverty, they were also exploited based on their gender and personal status, such as in the cases of single moms in Jerusalem and the women that contacted the member of Knesset. Organ donors were also oppressed based on other personal, mental, or cognitive disabilities, as told by the National Center representatives with regard to such cases, which are screened out by the Ministry of Health Ethics Committee. These initial findings (that were sourced from secondary sources of data) are consistent with the theoretical background of this study with regard to the people involved in organ trafficking\(^\text{116}\). However, these findings also highlight the study's limitation due to limited access to data, as discussed in the methods chapter.

\(^{115}\) See footnote 5 above.

\(^{116}\) The description of the engagement in organ trafficking by Israelis abroad also fits the theoretical framework of the research with regard to supplier and demanding countries.
More research is needed to fully understand the phenomenon of organ trafficking. Thus, interviews of organ donors and organ recipients who took part in practices of organ trafficking will expand our understanding of the phenomenon from primary sources.

More research is also needed with regard to other aspects of Israeli society and its relation to organ transplantations. Even though this research examined the interactions between religious and secular clusters and their role and influence on the construction of organ trafficking as a social problem, the role of the Arab-Israeli conflict was ignored. The special context of the latter conflict may offer additional political and social forces that enable or prohibit organ transplants between Israeli Jews and Arabs or between Israeli Jews and their Arab neighbors. Such cases were occasionally reported in newspapers and may reveal the importance of allowing the practice of organ transplantation, its use beyond physical health, and as an act of peace seeking. This political message may require future research and was not part of this study. However, it may also fit the general implications for the study of claim-making and the construction of social problems as revealed in the current study.

This study revealed that outlawing organ trafficking in 2008 not only achieved its obvious goal of prohibiting organ trafficking, it also achieved a social symbolic aim related to claim-making theory and the construction of social problems. In other words, although the 2008 law made organ trafficking officially illegal and therefore forbidden, there is no doubt that organ trafficking still takes place and Israelis are still involved in different forms of organ trafficking. Formal statistics, for example, regarding the numbers of Israeli recipients who travel abroad for transplants are not available, particularly with covert operations. Therefore, one may argue that

117 See for example: http://www.nrg.co.il/online/1/ART2/476/008.html?hp=1&cat=402&loc=3 or http://www.nrg.co.il/online/54/ART2/479/470.html?hp=1&cat=873&loc=6 available in Hebrew, last access July 2013. This is also part of the broader discussion of medical care exchanges between Israeli Jews and Arabs or between Israeli Jews and their Arab neighbors, which was not addressed in this study.
the symbolic-cultural goal of the law prevail its substantive one. However, according to the data gathered in this study, there was a meaningful decrease in Israelis' participation in medical tourism abroad along with a sharp increase in live interfamily legal donations\(^ {118} \). Therefore, I argue that the 2008 outlawing of organ trafficking played a dual role: first, it played a substantive practical role of formally prohibiting any form of organ trafficking, and as a result it reduced Israeli involvement in organ trafficking; and second, it played a cultural-symbolic role of constructing an Israeli social problem of organ trafficking.

The cultural function of the process in the Israeli context was evident, for example, when the different claims-makers added some beneficial aspects to the practice of organ transplantations between opposing Israeli clusters (i.e., secular and religious Jews\(^ {119} \)). Therefore, harmony and social integration were part of the claims-making rationalizations to support organ transplantations when organ donations were reciprocally exchanged between secular and Orthodox Jews. In these cases, claims-making activities functioned to demonstrate the social risks of not supporting organ transplantations. The dangers the Israeli society may face by not allowing organ transplantation (e.g., an intensification of the opposing forces between the clusters) serve as a rationalization to support the practice. By doing so, the symbolic value of the practice between religious and secular Jews is recognized and affirmed, and it contributes to the overall justification for the activity of organ transplantations and the outlawing of organ trafficking. Social integration, and seeking peace between other opposing divisions in Israeli

\(^ {118} \) For example, during the second conference, participants (from different clusters) argued that the law did achieve its obvious goal of preventing all kinds of illegal organ trafficking and that Israelis participation in medical tourism ceased. Thus, for instance, an insurance company representative argued that since the 2008 law there was only one request for payment reimbursement for transplantation abroad.

\(^ {119} \) Other opposing clusters that were not examined in this study are Jews and Arabs, as explained above, a future research of that conflict and its implications on organ transplantations is needed.
society or in cross-national and cross-religion populations (e.g., between Jews and Arabs) may also serve as desirable justification to further allow the practice.

The data gathered in this research on social problems are drawn mainly from Israeli society, but the social significance of the data has wider implications. Drawing on data from one country may limit the ability to generalize the findings. However, Israel's population has roots in many cultures and also includes many differing degrees of religious and ethnic groups and subgroups. This multicultural character may reflect to a certain degree some of the worldwide tensions and global concerns whether economic, cultural, social, or religious in nature. Understanding the process by which organ trafficking was constructed as a social problem is a major milestone in dealing with it. It may, for example, help create more laws or other official plans of action to fight the illegal practices of organ trafficking as well as other criminal phenomena. Moreover, understanding this process will help Israel and other countries deal with delaying factors to expedite the formal responses to various phenomena of crime and social deviance. Understanding the opposing forces that significantly influence the process of constructing a phenomenon as a social problem will enable their future usage in other countries or with different criminal phenomena. The results of this study might help to lay the foundation for the construction of other current social problems with similar characteristics such as globalization or other social changes such as illegal trafficking of goods and services.
REFERENCES


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