

Introduction: Medical Migrations

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This special issue of *Body & Society* brings together articles that describe contemporary forms of bio-medical travel.¹ The conjuncture of mobility and bodily states occurs at a particular epistemic moment: the first decades of the 21st century, when medical travels and travelers are participating in border crossings as self-consciously biological beings, and when biological life, health and sickness, survival and death, are central to subject formation, ethical practice, political struggle, regulation and governance. In the last several decades, increasing numbers of people have crossed national borders and traversed great distances for bio-medical, experimental or alternative (complementary) medical, surgical or cosmetic interventions and/or bodily transformations. Some of these travelers – often described by the mass media as ‘medical tourists’ (a term we subject to a pointed critique) – journey to foreign lands in search of cures and therapies for a variety of conditions. The elderly and well-insured are searching for cures to the maladies that commonly accompany aging: chronic, non-contagious illnesses and afflictions, from heart disease to end-stage kidney failure, from obesity to diabetes to congestive heart disease to dental care and depression. Women and their partners travel in search of solutions to infertility; men in search of cures for sexual dysfunction. Both men and women, young and old, search for cures to addictions and psychiatric illnesses. And many people travel across borders to purchase much sought-after and expensive

drugs – Lipitor, Viagra, Xanax – or their generic copies. Other travelers are afflicted with bodily ailments that have no known or ready cure, making them willing to journey to parts unknown to participate in clinical trials, experimental genetic medicine or stem cell transplants not yet (or likely ever to be) approved by the Food and Drug Administration (FDA) or the National Institutes of Health.

In the growing literature on this subject are discussions of Yemenites traveling to Jordan for surgery (Kangas, 2002), American retirees traveling to Canada for generic drugs (US Senate Special Hearing on Medical Tourism and Health Care Costs, 2007), Pakistanis going to Britain for maternity care (Bowes and Domokos, 1996), Americans enjoying the luxury of elite private cosmetic surgery spas in Costa Rica while undocumented Nicaraguan migrant workers who use emergency rooms for basic health care are blamed for the impoverishment and general decline of public health services and hospitals there (Ackerman, 2010), and South American elites enjoying the benefits of Cuba's medicalized revolution in private hospitals close to five-star tourist hotels on pristine beaches (Goodrich, 1993). Not only people and bodies – surgeons, patients, handlers and body parts – migrate, but also sometimes medical therapies that travel across geographical and political economic terrains are reshaped and modified in surprising ways. For example, Chinese heroin users (Hyde, this volume) travel across China to addiction recovery centers following an American-imported 12-step program that is seemingly out of step, or at least out of synch with post-Maoist political, medical and moral realities.

While most medical migrants are bio-medically technologically savvy and know what they are after, some medical travelers have lost their lives in the pursuit of false or non-existent cures.² Important but outside the purview of this special issue are the thousands of medical migrations each year by those in search of transcendental cures, whether pilgrimages to the high desert of Sedona, Arizona for self-healing through Native American sweat lodges managed by New Age gurus or medical tours to Central Brazil for psychic surgeries at the hands of João Teixeira de Faria, known locally as João de Deus ('John of God'), not to mention the many Catholic, Hindu and Muslim pilgrimages to holy sites, sacred wells, healing temples and basilicas.

The medical migrations that we are concerned with here are those of travelers in search of perceived 'better care' in wealthier nations, or cheaper and/or less regulated medical care in poorer or developing nations (Connell, 2006; Powers, 2007). Medical migrations conjure up an image of affluent Westerners taking advantage of the health care resources of poor nations. But many medical migrants today are poor and medically disenfranchised persons desperately seeking life-saving drugs and therapies and corrective surgeries that they cannot get at home.

Some medical migrants are so-called ‘illegals’, undocumented people traveling without tourist visas, including a good many Mexican and Central Americans who avoid crossing via official customs kiosks and who enter the US surreptitiously in search, not of employment, but of American health care at public hospitals, clinics and emergency rooms, against which there is today a strong popular backlash in conservative communities in the Southwest contributing to the angry, protectionist rhetoric – ‘No free health care to illegals’ – that led to Arizona’s harsh anti-illegal immigration act, Senate Bill 1070 (see Smith-Morris and Manderson, 2010).

Similarly, Jessica Santillan, an undocumented immigrant teenager from Mexico who lay dying at Duke University Hospital in February 2003 following a botched heart-lung transplant (using organs with an incompatible blood type) touched the hearts of many Americans while unleashing the anger of other Americans who believed that Jessica had no right to the precious, if mismatched, organs she received and that belonged in the body of an American child instead. Jessica’s death was seen by some as a kind of brutal poetic justice (Wailoo et al., 2006).

On the other hand, Americans, Canadians, Europeans and many people from the Middle East (both Saudis and Israelis) travel illegally on tourist visas with the full understanding that they are engaged in clandestine and illegal transplants that are against the law in the countries where these operations take place from Azerbaijan to Turkey and the Philippines (Scheper-Hughes, 2008). The legalities and illegalities of medical migrations are contested, and prosecutions of law-breaking in the pursuit of health, for oneself or by brokers and intermediaries, are few, but increasing since 2003.

Not all medical migrants are primarily seeking medical treatment. If North African migrants are able to prove that their biological well-being is imperiled at home, by torture or by lack of medical care, they can gain entry to France (Fassin, 2005; Fassin and D’Hallune, 2005; Ticktin, this volume), just as the victims, survivors and veterans of civil wars or dirty wars that were supported by the US military can turn their wounds and suffering into arguments for political asylum in US courts (Ordóñez, 2008). Health and sickness and health care are as fungible as capital, as Crandon Malamud (1993) illustrated in her classic study of how Bolivian Indians and Mestizos use health care as means to address social and political goals of inclusion and representation. Medical migrations, then, are not necessarily about medicine; they can be a search for citizenship or a way of seeing the world, inside-out – using one’s body or body parts as a kind of universal passport.

Finally, science, technology and medical research travels across the globe in search of subjects for clinical trails and for basic medical research (Petryna, 2009).

In this issue we have the example of US-based scientists who travel to Barbados to conduct asthma research on Afro-Caribbeans, whom the researchers erroneously assume to be biologically and bio-genetically the same as the African Americans they cannot access for research studies in Baltimore (Whitmarsh, this issue). In the early 2000s, Turkish-Cypriots were able to cross the militarized border to a place that, under the circumstances of war, was usually off-limits, to participate in bone marrow donor registration in the Greek Republic of Cyprus (Beck, this issue). Again, like other medical tourists, these travelers undertake their journeys under the auspices and protection of bio-medicine, *not only for therapeutics* but within the logic of the medically governed biological body – a body understood and experienced as subject to knowable biological processes (Lock and Nguyen, 2010).

Medical Migrations – A Note on Terminology

Many of the travelers described in these articles, even those undertaking perilous journeys, are willing to describe and to experience themselves as tourists and global cosmopolitans, while others reject the term as trivializing their goals, whether these concern the production of science or the production of healthy, beautiful bodies, longevity or life itself. Medical tourism is a vexed term that was produced dialogically within a particular set of debates about globalization, mobility, neoliberalism and health care. It describes a social and medical reality that is being actively promoted by governments and by private companies in parts of the so-called developing world.³

As the articles in this issue attest, there are no easy ways to capture all the divergent experiences of medical travelers or their bodies and various states of embodiment that contribute to their medical migrations. Some are haves and others are decidedly have-nots in the global and medical order of things – the autonomous, self-managed, independent medical tourist on the one hand, and the exploited kidney seller or abject refugee on the other. For our purposes we have grouped travel in the pursuit of bio-medical treatment, bodily alteration or biological logics within the broader framework of *medical migrations*. Migration, at the most essential level, refers to the directed, regular or systematic movement of objects, organisms, viruses, animals, plants and people, as well as knowledges, therapies and technologies. These articles focus on how medical travel follows or is produced by what bio-medical technologies promise to provide at the destination. Medical migrations emphasize their production within particular political-economic configurations of globalized bio-medicine, which involve the disparate and unequal distribution of health and sickness, health care, and the maintenance of borders between bodies, social collectivities (classes,

castes, races), politics and nation-states. These configurations produce, or ‘enact’ in Annemarie Mol’s (2002) sense, a specific kind of body, a biological body that can be administered by and through bio-medicine, at a time when questions about what it is to be human are increasingly tied to biological status.⁴

The medical migrations documented in these articles can be linked to other kinds of therapeutic travel and healing pilgrimage, both current and past. Medieval North African Muslims seeking treatment from Bori priests in what is now Nigeria (Glazier, 2001) and medieval Mediterranean people who traveled to bathe in the healing waters of Pamukkule, in what is now Turkey, could be productively compared and discussed in relation to medical migrations. Crucially, though, those medical journeys are obviously distinct from the current production, conception and deployment of late 20th-century bio-bodies and bio-subjectivities in which the ‘body’ is largely fragmented and broken down into smaller and smaller identities and bio-genetic destinies that are artificially and tangentially (sometimes fantastically so) linked to kinship, political, economic, social, environmental or religious relationships (Cohen, 2005; Rabinow, 2002; Rose, 2007; Sharp, 2006).

Part of our project is to examine how artificial degrees of separation and belonging are productive of, and produced by, medical migrations. These articles show how medically situated suffering *bodies* can travel across borders, when socially situated *persons* often cannot. Additionally, contemporary medical migrations rarely involve the lure of geophysical characteristics, as they once did in the early 19th century, when therapeutic travels were closely tied to climate, topology and medical ecology – from the brisk, cold healing airs of the mountains to the dry airs of the desert or the healing waters of mineral springs (Miller, 1962; Wrigley and Revill, 2000).

Within the framework of medical migrations – understood as travel that involves bio-medically governed bodies and logics – we have mapped out three themes that emerge as central to the articles in this collection. In the first section, ‘Mobilities’, we explore the conditions that shape who can and cannot participate in medical migrations. The second, ‘Places’, looks at the variability of the migrants’ origins and destinations, contextualizing them within the larger political economy of sickness and health care. ‘Biologies’ looks at the specificities and variability of the bodies and corporalities (and corporeal subjectivities) involved in medical migrations. Taken together, we can see how the journeys of contemporary medical migrants in search of plastic surgery or organ transplants, citizens traveling to donate tissues, refugees seeking better health care, drug users sent far away by their families for medical treatments that are thoroughly alien, and research subjects who are asked to participate in medical research as racialized

proxy bodies/subjects for those who refuse to have anything to do with bio-medical researchers are shaped through contemporary enactments of mobility, place, and biology.

Mobilities

Bram Stoker's Victorian novel has Count Dracula leaving the backward hinterlands of the Carpathians and traveling to London, where his blood thirst might be both quenched and hidden in the teeming, industrialized city, with its ever-expanding and supernumerary underclasses. The Count is free to nourish himself on nameless/faceless lumpenproletariat Londoners – whom no one will miss – in order to become younger and more vital. It is a nightmarish version of therapeutic travel captured for centuries in European and circum-Mediterranean myths and legends that traveled across the world warning the poor and working classes of vampire-like creatures, such as the *pishtacos* and *sacra ojos* of the Andes, who were said to feed on human fat, blood and livers and other life-sustaining organic human substances (Weismantel, 2001). The Andean version of this belief, held widely from the colonial period to this day, maintained that sugar mills could not be started up at the beginning of the milling season without having been greased with human fat, normally *Indian* fat. The mills ran, then, by devouring humans. And children's body fat was believed to be the preferred mechanical lubricant. The Indians' distrust extended to engineers involved in the operation of mills, electric power complexes and factories (Oliver-Smith, 1969: 367). The Indians had reason to be suspicious. Mill and factory owners had egregiously exploited and mistreated the Indians as sugar workers for their own advantage and profit (see also, Taussig, 1987: 211–41). Sometimes, on examination, bizarre rumors can illuminate harsh social and political realities. When Food for Peace Programs began to provide free lunches to Andean school children, Indians stopped sending their children to school out of fear that the fat-stealing Americans were fattening up their children with nefarious motives in mind. Biological anthropologists in the Andes often encountered resistance to any research that required subjects to be measured or weighed. The anthropologists, calipers in their hands, measuring human fat folds were seen as modern-day *pishtacos* (Scheper-Hughes, 1993: 236–7).

Describing late-modern epidemics of witchcraft accusations in Southern Africa, Comaroff and Comaroff (1999) discuss 'occult economies' and focus on the fear of the procurement of magical surplus, health and longevity through the ingestion of the organs or blood of one's social or political enemies. What are often purely symbolic equations in one context of fear and suspicions of the

motives of outsiders can also find expression in everyday medical realities. In the real world, wealth (and not just fangs) allows for mobility and for corporeal transformations. Lawrence Cohen's apt term (this issue) *supplementarity* captures the vampiric expectations of medical transplant travelers seeking to survive by accessing the 'spare' organs of people living in poorer countries.

But many of the articles in this special issue document medical travel where the pathways of extraction do not move along the predictable and typical axes of power from north to south, or west to east. Cohen argues that medical migrations cannot presume the northern exploitation of the global south, because people don't stay in their 'proper' place. Indians living abroad and Chinese Malays return to their 'homelands' to supplement themselves on the organs of their own countrymen and women. The exploitation is internal and based on local economies of body trade.

The ability to travel and the status it embodies appears in several articles throughout this issue. Nancy Scheper-Hughes, 'writing against the grain' and even against her own corpus of work on organ sales, complicates the picture of transplant tourism by inverting the use of the term to describe the cohort of mobile Brazilian kidney suppliers as the only true agents of transplant tourism, in that many of the sellers agreed to be trafficked so that they could travel and see the world. The Brazilian kidney sellers Scheper-Hughes followed traveled to South Africa to make money, to make houses and to 'make it'. The Israelis who traveled to South Africa for transplants with kidneys purchased from the Brazilians described themselves as transplant 'tourists' to distance themselves from the human trafficking schemes that located their kidneys. But, like their Brazilian kidney providers, the Israelis were also searching for freedom and mobility, an escape from the dialysis machine and the freedom to roam. Nonetheless, these transactions – no matter how viewed by the participants – are built on constrained moral and economic choices that mask extreme global inequities.

In one of the most wrenching moments of Scheper-Hughes's piece, Geremias, an arrested kidney seller, argues in Brazilian court that he should be allowed to sell his kidney since the organ brokers offered him options while the Brazilian state never offered him anything. The rhetoric of individual choice and agency is often, as in this case, a red herring. Geremias was initially rejected by the surgical team in Durban because the young man, father of three, weighed less than 100 pounds and he had suffered previously from kidney stones. The surgery took place and Geremias and his family now have to live with the anxiety of possible kidney failure. The dreams of the Brazilian kidney sellers overrode the warnings of their family members who begged them not to do it. The sellers

wanted to participate in the global economy for once in their lives as ‘kings for a day’ with the kidney loot they earned with the strength of their bodies and their courage to climb onto the operating table in a land of strangers, whom they could not understand and among whom they did not know who to trust. It was pure bravado on their part and they would like the world to see them as rough riders and kidney cowboys. One seller, Albery da Silva, used his kidney money to buy a car. But because he couldn’t make the payments, he downsized to a jalopy, then a bike, then a pair of running shoes. His dreams of mobility gradually diminished – but in his view he did at least fulfill his dream of foreign travel, even if it was by way of a dangerous and clandestine medical migration.

As many of the articles in this volume demonstrate, borders shape possibilities for mobility. Sometimes people become medical migrants in order to cross borders. Throughout the 19th and 20th centuries, national and international borders were created and shaped by disease, especially infectious disease. In the 19th century, it was common for Western Europeans to travel to drier or ‘healthier’ climes to cure conditions like consumption (Porter, 1990). The development of germ theory, which produced specific diseases with clear mechanisms of transmission, reduced travel (Bashford, 2006). Once consumption was defined as infectious tuberculosis, travel cures made less sense. By 1903, when tuberculosis became recognized as a contagious disease, it was added to the list of conditions used to exclude immigrants to the US, as was HIV/AIDS in the last decades of the 20th century. While travel to places seen as ‘healthful’ for rest and relaxation continued, new diseases, produced within bacteriology, reshaped immigration making it more difficult for the sick to travel across national borders (Bryder, 1996).

In the late 19th and early 20th centuries, immigration policy and public health became more intertwined. Alison Bashford describes this as ‘a regulatory response to the phenomena of mass movement of circulating diasporic labor, of migrants, pilgrims and refugees’, and of the attendant microbes that could simultaneously move, and bind disease inside individual bodies (Bashford, 2006: 7). Aided by germs, borders became ever more exclusionary. After the first great wave of recruited labor in the 19th century, a ‘hygienic shield’ closed the American border to most newcomers for about 40 years, in order to quarantine the borders from communicable disease (Markel, 2004).⁵ ‘Disease was checked by border inspections of people – their bodies, their identity, their documents’ (Bashford, 2006: 7). Simultaneously, increased border inspections make it easier to count and survey disease.⁶ These ‘medical procedures made borders more than abstract lines on the map, but a set of practices on the ground’ (Bashford, 2006: 7), one of the ways that nation-states came to be realized in practice. The practices literally *make* nations – relatively new kinds of bounded places.⁷

Laws to contain infectious disease had pronounced effects on contemporary medical migrations. Today medical migrants tend to be people seeking medical procedures rather than cures for infectious disease. Travelers with infectious disease now tend to be stopped at the borders, exemplified in Stefan Beck's discussion of the militarized border between Greek and Turkish Cyprus. Beck argues that the ostensibly apolitical, altruistic character of bone marrow donation campaigns helped create new political possibilities in Cyprus. Started in 1998, a cross-border bone marrow registration program expanded in 2000 with the search for marrow for two boys suffering from leukemia, one Greek and one Turkish. Turkish donors were allowed to make medical migrations into the buffer zone between these regions, controlled by the United Nations, to give blood samples that were then tested for compatibility. The Greek boy lived after a successful match. The Turkish boy died after many bureaucratic delays by Turkish authorities, which prevented delivery of donated bone marrow. In anger at the Turkish-Cypriot state, the boy's father started an organization to support Turkish/Greek bi-communal development, which paralleled the efforts of a Greek-Cypriot organization already under way. While the negotiations between the two nations ultimately failed, the donor drive was a spectacular success, registering 13,500 potential donors in just 11 days, most of them Turkish-Cypriots who were then allowed to enter the buffer zone. Ultimately, the donor drive had a profoundly political effect. When the Turkish-Cypriots actually returned to the Turkish part of the island after registering, instead of leaving for the wealthier Greek part of the island, the Turkish-Cypriot government began to allow other kinds of individual visits across the buffer zone. As one commentator put it: 'The donor drive made the communities porous.' But while the drive allowed some Cypriots to pass through the border, it simultaneously emphasized the division between the two nations. Medical migrations can both alter and reinforce borders and consequently the nation-states on either side.

The impact of medical migrations on reinforcing nations and borders is also central to Wilson's piece on the medical tourism industry in Thailand. Instead of focusing on the experience of the tourists or their gatekeepers, Wilson attends to the macro-political effects of medical tourism across the scales of economy and the nation. Wilson argues that one can use medical tourism to de-naturalize the economy and the nation as units of calculation. Among critical geographers, scale is taken to refer not only to different levels of social organization – the local, regional, transnational or global, unproblematically viewed – but also as social creations that have very real biological-ontological effects. Using these insights Wilson explores how the cross-border movements of medical tourists are staged in the international press and by Thai state institutions as metrics of

economic growth that solidify and produce economic forecasts and the GDP. These calculations of traveling bodies help to constitute the Thai economy writ large. Her article draws on the work of feminist critical geographers of scale to correct the hierarchical, 'nesting doll' directionality that many social scientists of the body assume, where bodies are only inscribed within larger macro processes (Marston, 2000). Nesting-doll framing leaves unexamined how objects – whether an individual body or a country's GDP – are made to appear bigger or smaller. In accepting this view of scales, such that nations encase bodies, one fails to see how GDP and medical tourists alike are objects enacted and distributed through each other in ways that accommodate capitalist expansion. If instead we examine the practices and objects that enact the medical tourists who have surgery in Bumrungrad International Hospital, and whose bodies are counted for statistics which make up the GDP, the 'natural' hierarchical scale of body and nation collapses. Wilson's approach prompts us to examine both how bodies make borders and borders make bodies, and how these scalar processes encourage the mobility of foreigners with disposable income.

Miriam Ticktin's article, which describes refugees seeking medical asylum in France and the United States, offers a different way into examining how the mobile medicalized body can be used by the nation-state to enact its borders. Political refugees to these nations are forced to demonstrate illness or bodily damage to gain asylum. In turn, both France and the United States instantiate themselves as humanitarian nations that offer a haven to suffering people. In this case it is the suffering of these refugees and their relative helplessness – in contrast to the dogged initiatives of wealthier medical tourists – that allows them to traverse national borders in order to transform their lives. Asylum seekers are not affluent medical patients and they are not allowed to work; it is only their wounded or suffering bodies that can get them across. These abject suffering bodies contrast vividly with medical cosmopolitans who can travel freely to shape and uplift their bodies. Those lacking sufficient resources are stuck in place with fixed bodies articulating a singular truth of affliction.

Ian Whitmarsh's article on medical researchers who travel to Barbados for asthma research also shows the mutual production of bodies and borders. The compliant, educated patient bodies produced by the Bajan medical system are crucial to Barbados' emergence as an international destination for medical, especially pharmaceutical, research. His case study concerns medical researchers, mostly from Johns Hopkins, who manage to bypass the cultural and political obstacles to conducting their research in the sensitive, disenfranchised, urban, African American neighborhoods of Baltimore. Barbados offers them a 'relaxing' touristic research site among 'less fractious' Bajans, Afro-Caribbeans whom the

researchers assume possess the same genetic profile as African Americans back home. The similarity is understood as coming from the forced migration of African slaves through the middle passage. For their part, the Bajans who are the objects of the scientists' research express a thwarted desire to travel for care in a better place, but the lack of resources and visas constrains their crossing into the United States. Thus their willingness to participate in research is a kind of proxy travel, since, like the North African refugees (Ticktin, this issue) and unlike the Brazilian kidney sellers (Scheper-Hughes, this issue), they have nothing of value to sell that will facilitate a medical migration of their own.

The IV drug users in Sandra Hyde's article are also locked within a national frame, albeit one undergoing transformation. These drug users move vast distances across post-socialist China for treatment in a residential drug program imported from the neoliberal United States. The migration of these addicts, as well as the drug treatment model itself, embodies debates within China over whether to punish, to reform or to rehabilitate drug addicts. The debate was particularly potent in the context of the country's rapidly shifting political economic terrain, which has exacerbated drug use itself through social dislocation and the opening of heroin trade routes from Southeast Asia across China and into Eastern Europe. Hyde argues that 'mobile therapeutics' is a framework that is best suited to understanding 'how therapeutics and bodies become mobile global entities and practices'. With the mobile therapeutics involved in drug treatment Hyde tracks four key elements: the historical mobility of opiates, the migration of Western drug treatment models, the migrations of religious NGOs, and finally the migrations of China's own political ideologies (the methods used to purge 'wrong people and ideas' during the Cultural Revolution).

Hyde shows how the shifting economy of health care in post-socialist China shapes the destination of drug users who arrive at the Sunlight treatment center, where they must pay out of pocket for treatments that aim to rehabilitate, rather than punish them. But simply because the therapeutic model is neoliberal does not mean its clients are. The selves that are 'worked on' within Sunlight are more than individuals to be disciplined from within. The intensive group sessions, which focus on collectivist interventions rather than individualized pharmaceutical interventions, induce anger (scream therapy) and signal the deep alignments between the families who sent them from all over China and traditional authoritarian state institutions. Residents in Sunlight are processed through an assemblage of kin-like care practices, that combine Narcotics Anonymous, Maoist self-criticism and Christian confessionals to rehabilitate and shape new post-socialist persons within a hyper-capitalist, authoritarian regime, not easily or readily classified as neoliberal.

Collectively, these articles point to the many ways that mobility provides both liberatory possibilities as well as constraints, often side by side. They show how borders produce and are themselves produced through various kinds of medical migrations. The experience of travel is understood as a constitutive experience of the subject in the late modern world. But as these articles attest, mobility is contingent. The ability to move, to be mobile, is a defining feature of individual life in today's world only for certain kinds of subjects. Those who travel at will to transform themselves are seen as moderns. Crossing borders and reshaping bodies via participation in biomedical technologies are characteristics of the global cosmopolitan. Medical migrations that do not involve such a degree of freedom to move and to reshape the body belie the contingencies that constrain mobility and do not follow the trajectory of North to South, West to East. These constraints are glaringly obvious to those who are unable to participate in border hopping and medical transformation. The opportunity for bodily transformation, for health and life is shaped by the most basic and yet complex of human efforts – the ability to move.

Places

The Cape of Good Hope figured in the Dutch colonial imagination as a *luilekkerland*, 'lazy luscious land', a place of natural beauty, ease and plenty, where even 'the savages' seemed hardly to labor to feed and decorate bodies described by the first European visitors as healthy, supple and full-bodied. When Jan Van Riebeeck, the head merchant for the Dutch East India Company, and his men arrived and established the first European settlement in the Cape in the mid-17th century, they had no intention of exploring the vast interior of the peninsula. Van Riebeeck wished to contain the first European settlement to the cultivation of a network of coastal gardens to serve as a supply station for ships *en route* between Europe and the East (Coetzee, 1988; Schepers-Hughes, 2006). In the late 19th century, South African health authorities tried to make their country a destination for early modern medical travelers. Health authorities promoted the nation as a salubrious location for ailing Europeans, touting the healthiness of its climate (Deacon, 2000). For a time, South Africa attracted ailing British colonial employees stationed in India who needed to recover from tropical afflictions, in a temperate climate thought to be more suited to their northern constitutions.⁸

Through the late 19th century, before microbiological understandings of disease came to dominate medicine, Western understandings of health and disease often involved an acute sense of place as either beneficial or detrimental

to the particular traveler (Temkin, 1977; Wrigley and Revill, 2000). Individually and in small groups, people have always packed up their gear and searched for healthier climes, famed healers, personal and food security, or simply to leave behind the disease and death of the current campsite (Dunn, 1968). Pilgrimages from the early Middle Ages up through the present century have been motivated by the quest for individual, social and spiritual renewal, redemption and bodily transcendence. The earliest documented case of disease in Mesopotamia (the so-called Mari Tablet ARMX, 129), dating from the 18th century BCE, shows that the idea of contagion was linked to place and to the words for pestilence, scourge and plague, leading archeologists to identify human flights from epidemics following the annual Nile floods (Dauphin, 1999). Similarly, Hippocrates' *On Airs, Waters, and Places*, written around 400 BCE, associated place with bodily states (Porter, 1990). The treatise was a practical manual for traveling healers who would encounter varied afflictions in a variety of regions. Many of these journeys emerged from the robust connection made between place and bodily states.

Likewise, in Western Europe until the mid-19th century, physicians were considered experts of place, since place was so inextricably tied to health and disease. Doctors were consulted on the best location to build schools, churches and other institutions. Much of their expertise in matters of health and place came from their ability to detect miasmas – noxious forms of ‘bad air’ filled with particles from decomposed matter (miasmata), which caused illnesses and which hovered in particular locations (Wrigley and Revill, 2000). Malaria (literally, ‘bad air’) was attributed to foul air and the vaporous gases of swamps. The connections between bodies and geographies were open-ended. Wet, foul-smelling secretions could flow alike from person and place. Cultivation of the land could cure the moral and physical dilapidations of wilderness through the modification of vegetation and topography, just as physicians could alter their patient’s bodily states through emics and cathartics. Travel, then, offered the chance, or threat, of altering bodily states through encounters with new places.

With the late 19th-century bacteriological focus on disease with pathogens that came to be understood as existing separate from environment, place lost much of its hold on the diagnosis of human afflictions, and this long-established reason for therapeutic travel subsided. Contemporary pathogens are not held *in place*, so to speak, and bodies do not fall prey to place, as they did in a time when travel had the ability to transform the body for good or ill. For the majority of today’s medical migrants, the destinations involved in therapeutic travel are not seen as intrinsic to bodily transformation; instead, these diverse destinations offer differentiated economic or political geographies in which to alter bodily states. Nonetheless, certain places or environments do play a part

in the contemporary marketing of medical travel. Costa Rica, for example, is advertised as a healthful paradise, where plastic surgery patients can recover from their procedures (Ackerman, 2010). But this claim only works in conjunction with cheaper costs, or with a treatment superior to what is available in the patient's home country.

The notion of *place*, then, plays a different kind of role in most of the medical migrations within these articles, where the destinations of medical migrants are produced through variations between cost, and legal requirements, and global economic structures rather than the geographical or spiritual characteristics of place. The destinations of medical migrations explored here are shown to be shaped by the geopolitics of international economic inequality; and such inequality is indisputably place-based. People in areas with poor health care and social services travel to areas with better health care, usually paying out of pocket. Treatments tend to be cheaper in postcolonial nations that have built functioning medical infrastructures. The characteristics that produce these destinations are familiar to medical anthropologists practiced in demonstrating how health and sickness, vulnerability and risk, are created by economic, political, and historical conditions (Castro and Singer, 2004).

With respect to the contemporary world we can ask what are the historical, economic, political and institutional characteristics of place that send or draw medical migrants? Why, for instance, is Thailand and not Laos a destination for medical tourists? Why have India, China, South Africa, Singapore and Turkey become destinations for very distinct kinds of organ trade and not Japan, Zimbabwe, Korea or Greece? Why is Barbados made into a research laboratory destination for medical researchers and not Trinidad? Why is there so much asthma in Barbados or in North American inner cities? Why do North African refugees seek medical asylum in France and not Poland? How do drug treatment models from the United States end up in China and not Canada? The answers to these questions about the production of place also contribute to our critical examination of the variable conditions that produce massive inequality in health care provisioning throughout the globe.

This special issue grapples with health inequalities that both shape and are shaped by transnational processes, such as the global traffic in organs, the influence of nations and NGOs on epidemic regulation, the circulation of biological concepts of health and identity, as well as political struggles over the incorporation of postcolonial subjects in the nations of their former colonizers. The shifting political economy of health shapes the kinds of destinations, the places that different refugees attempt to enter. While Cuba and France allow HIV+ individuals to enter their countries, the US continues to exclude all HIV+ people.

That France has state-funded health care and the United States does not influences the kinds of refugees that cross into each nation. A close examination of medical migrants, and the ways in which they encounter and provoke these tensions, helps us to understand the political economy of medicine and global inequalities of health care.

The migrants themselves – whether called medical tourists or refugees – inform ongoing debates about the services provided by public health care systems and the responsibility of the nation-state to care for its citizens and subjects. In February 2008, the World Health Organization (WHO) held a workshop in Kobe, Japan to address the ‘movement of patients across international borders’. One of the goals of that meeting was to ensure that ‘medical tourism’ would be supportive of national public health goals.⁹ The chief operations officer of the Medical Tourism Association and the editor of *Medical Tourism Magazine* gave a jarringly corporate and rhetorical pep talk, arguing that medical tourism trade could improve health care services in poorer nations. The view that a properly implemented medical tourism program can improve the underlying national public health care system and generate revenue for the nation is a particularly neoliberal narrative, in which the free market is said to offer a panacea for national health care needs. It promulgates the notion that developing countries lack public health programs, and ignores the existing public health infrastructure – often the very resources from which private medical tourist facilities were constructed.

In fact the destinations of medical migrants are often nations with working public health infrastructures. As Wilson demonstrates in her piece on Thailand’s ‘private’ medical tourism, partnerships between private hospital corporations and Thai state institutions were made possible through the earlier development of a strong public health care system. Thai state institutions further subsidize medical tourism by allowing the management of Thai national borders to take place in private hospitals, since visa control has now become a hospital-based hospitality service for these desirable foreign medical tourists. Thai medical tourism is exemplary of what the critical geographer Neil Smith (2004) calls ‘scale bending’. Scale bending can occur in ‘a period of scale reorganization in which an inherited territorial structure no longer fulfils the functions for which it was built, develops new functions, or is unable to adapt to new requirements and opportunities’ (2004: 201). The creation of and demand for medical tourism points to the shifting availability of medical care in patients’ home countries. These shifts are essential to understanding medical migrations in regard to the place of economy.

In a similar vein, Whitmarsh explores how the strength of Barbados’ health care infrastructure drew North American medical researchers: the public health

system already in place was able to track and monitor the incidence of asthma (although not work to prevent it), and the public health system produced fairly educated and compliant patients located in the place of Barbados, which made Barbados an attractive site for US researchers and pharmaceutical companies. The relationship of place to bodily state did have some role in drawing the researchers to Barbados. The researchers saw Africa – the place where Bajans were supposed to have started their journey – as central to the genetic formation of asthma and the Bajans' response to the disease. This genetic version of place has a fixity and timelessness that ignores the political ramifications contained in the older linkages of bodies to place. So, for instance, the medical researchers from the US did not see the island's dust and pollution as relevant to the high rates of asthma, an erasure of the medical and ecological politics of place developed in relationship to medical models of germs and genes. The genetic link of Afro-Caribbean bodies to Africa and the Bajan health care system together created bodies that were biologically available, essentially subsidizing the scientists' research in the place of Barbados.

Medical migrations are also enacted through the 'ethical variability' of places. Adriana Petryna (2009) uses this term to describe the efforts of pharmaceutical companies to find new, treatment-naïve populations in developing countries and sites around the world. Ethical variability can also be used to indicate a resource of place and economy, in which differences between national regulations make it possible for those with mobility to travel to destinations where laws and policies better suit their needs. Spain has a booming fertility industry, for example, that caters to residents of Britain where egg sales are banned (see Devlin, 2009). Western Europeans have come to the United States for years to hire surrogate mothers, a practice not allowed back home. Britons travel to India to receive stem cell treatments illegal at home (Bharadwaj, 2008), while Americans travel to Mexico to buy drugs without a prescription. In this issue Cohen shows how trade liberalization allowed for the development of mega for-profit hospitals and global medical corporations in India with a heavy focus on servicing non-residents. These hospitals are 'ethically variable', geared towards national and international scales. They employ distinct personnel to deal with the varying national and international ethical challenges surrounding organ sale and transplantation. As Cohen argues, such hospitals are and are not part of state economic policy, but rather a merger of corporation and nation, designing their practices – and maximizing their profits – around variable ethical regimes.

As we focus on the politics and economics of health, we must consider other reasons for migration – especially labor – that medical migrations might reshape. Across the 20th century, labor migration has been the most significant impetus

behind the century's unprecedented mass movements of people (Goss and Lindquist, 1995). Industrialization and its endless need for bodies drew Europeans to different parts of Latin America and North America in the early to mid part of the 20th century; the late 20th and early 21st centuries saw the biggest movement of people in history from rural to urban China. And currently, in Western Europe and North America, migrants – this time including many undocumented persons – are coming to fill service sector jobs and unskilled agricultural work.

In the early 20th-century United States, the need for labor was tempered by the poor health status of many immigrants from southern and eastern Europe; the fear of contagion (epitomized in the case of 'Typhoid Mary') was used to seal borders against those deemed undesirable. Full body screening of a sort that makes today's airport security checks look mild was an everyday practice at Ellis Island, where newly arrived immigrants were exposed to extreme medical selections. As described by Bateman-House and Fairchild:

Upon docking, PHS officers transferred steerage or third-class passengers to Ellis Island by barge. Proceeding one after the other and lugging heavy baggage, prospective immigrants entered the station and moved slowly through a series of gated passageways resembling cattle pens. As they reached the end of the line, they slowly filed past one or more PHS officers who, at a glance, surveyed them for a variety of serious and minor diseases and conditions, finally turning back their eyelids with their fingers or a buttonhook to check for trachoma. (2008: 235)

The diagnostic protocol exemplified the prevailing conviction that disease was written on the body. As one medical immigration officer stated: 'Almost no grave organic disease can have a hold on an individual without stamping some evidence of its presence upon the appearance of the patient evident to the eye or hand of the trained observer' (Bateman-House and Fairchild, 2008: 236).

Today, while wealthier tourists can travel to heal or transform their bodies for non-contagious bodily conditions, for the poorer migrants that Ticktin (this volume) describes, their corporeal suffering confers upon them an apolitical, non-economic status that constitutes them as suffering and therefore as 'virtuous' migrants instead of 'vicious migrants who steal jobs in post-industrial North America and Western Europe' (Hacking, 2002: 2).

While place is no longer understood as either intrinsically salutary or pathogenic, the divergent political and economic histories of specific places do shape and in fact can compel the movements of medical migrants. When we parse contemporary medical migrations as different from past forms of medical travel, a historic sense of the variation in how place has been linked to corporeal states allows us to see that place, albeit a different kind of place, is still essential in

producing these migrations. Today medical migrations respond to the always shifting terrain of the political economy of health. What we bring out in the next section, however, is how these articles on medical migrations demonstrate that health itself, and the biology that is presumed to affect health, is also politically and economically contingent. We can link the variability of biology back to a more political economic understanding of place itself in what produces contemporary medical migrations.

After a lapse of 200 years, South Africa has once again re-emerged as a destination for medical travelers, but this time for advanced medical technologies like plastic surgery (Souter, 2006) and for illicit organ transplants (Scheper-Hughes, this volume). 'Scalpel safaris' and 'transplant tours', even when they are advertised in medical tourism brochures complete with images of the side attractions of unspoiled beaches, penguins and wild animal safaris, have nothing to do with the temperate and healthy climate of postcolonial South Africa. Rather, they are the legacy of apartheid: the surplus population of highly trained surgical specialists no longer supported by the public health sector. In the New South Africa, the provision of basic health care has become a right for all citizens, but the state no longer pays for more expensive medical interventions, including organ transplantation, which moved into the private sector. This created a demand for well-insured or relatively wealthy paying patients that led to the aggressive importing of kidney patients via international organ brokers and human traffickers who infiltrated the largest private medical corporation in South Africa, Netcare, leading to the outrageous situation, described by Scheper-Hughes (2008, and this volume). Lax regulation of private medicine produced an environment conducive to illicit transplants that enriched private clinics, while public health services for the majority of South Africans lag behind. There is no trickle-down from transplant tourism to the public health sector in most developing nations.

Thus medical tourism and, within that umbrella term, the term *transplant tourism* are treated here as artificial inventions of the news media that play into the hands of the global tourism industry, for-profit medical corporations and even ministries of health desperate for capital, as in the Philippines. Cohen's description (this issue) of overseas Chinese Malays and diasporic Indians traveling back to their homeland to procure purchased kidneys in five-star hospitals provides another case of cognitive dissonance when the term *transplant tourism* is applied to nationals. Similarly the organization of international transplant tours by and for the diasporic Jewish community raises important questions about the nature of 'flexible citizenship' (Ong, 1999) built around the quest for health, longevity and beauty worldwide. The ability of Israelis to travel to South Africa for illegal transplants (with kidneys trafficked from Brazil and Romania)

at private Netcare clinics employing third-generation heirs of Christian Barnard – British, Afrikaner and Indian South African-trained transplant surgeons – and reimbursed by Israel’s national health care ‘sick funds’ underscores the differences between legitimate *medical tourism* and *transplant trafficking*, based on the transfer of energy, vitality and solid organs from one population to another, more economically advantaged population (Scheper-Hughes, forthcoming).

Just bubbling under the surface of the articles in this volume is the larger structural problem inherent to medical tourism itself. All medical tourism programs are rooted in a highly commercialized and commodified medicine and health care. Medical tourism does not conceive of health care as a *right or an entitlement of citizens* (as recognized in many constitutions, such as those of Brazil and South Africa) but rather as a thing, a commodity, that can be bought and sold through global medical markets (see Scheper-Hughes, 2005; Scheper-Hughes and Wacquant, 2002). Medical tourism is based on a neoliberal paradigm of commercialized medicine and individual choice that implies the ability of those who can do so to travel, often great distances, to purchase elsewhere what they cannot buy or otherwise procure at home. Thus medical tourism and medical commerce go hand in hand. Medical tourism for plastic surgery, reproductive technologies, experimental medical procedures, gender assignment, liposuction, etc. is not illegal, of course, but it is commercialized and commodified health care. All medical tourism leads to international competition among hospitals and health care corporations to establish themselves as international medical institutions and centers of excellence, and all based on the ability to pay.

Here we propose to treat medical tourism as one of many economic models/structures within which people travel in search of health, beauty, medical technologies, life enhancement, not all of them rooted in a commercialized, neoliberal and competitive model of health care. *Transplant tourism*, however, is a misappropriation of the term *tourism* – even though the agents and the victims both use the term to conceal the illegality of the arrangements. *Transplant traffic* is a term synonymous with international drug traffic and global sex trafficking, and they share the following: organized crime syndicates, traffickers posing as brokers or *passeurs* and vulnerable people used as ‘mules’.

If transplant trafficking is now accepted by the WHO, the UN Office on Human Trafficking and by the world’s transplant professionals as a crime and, in some cases, a crime against humanity, more ordinary and legal medical tourism (minus the coercion and exploitation inherent in what is called transplant tourism) is still a cause for concern when the medical resources – medical doctors, nurses and medical facilities – devoted to providing medical care to patients

from outside of a country undermine the country's ability to provide the same services for its own population (Ackerman, 2010).

Biologies

In the late 19th century, new and faster forms of transit doubled the number of pilgrims who made their way to Mecca each year, making the European powers who controlled the fading Ottoman Empire increasingly nervous. The cholera outbreak in 1865, which emerged in the Middle East and ravaged Europe, escalated these anxieties. This 'first pandemic of the industrial age' (Zylberman, 2006: 25) profoundly linked health with European security. That year, for the first time ever, pilgrims were detained, hassled and quarantined on their return to European-controlled ports of entry. New understandings of disease and contagion that eschewed place, the epidemiological link made between pilgrimage and cholera, and a deep-seated fear of a contagious pan-Islamism radically reshaped the pilgrims' mobility. Like the contemporary medical migrants described here, the *hajji* pilgrims' travels were altered by borders that were partially instituted to control biological contagion. But, of course, the pilgrims in Mecca in the mid-19th century did not experience themselves as mobile biological beings, despite their exposure to the expertise and social control functions of public health officials along their paths. It would be fascinating to know how past and contemporary pilgrims to Mecca understand and react to these new forms of biological governance (see Pandolfo, 1997: 315). Such an inquiry embodies the third theme of this volume: the biological logics that impel these journeys.

While biology shapes these travels, these authors don't take biology for granted. Rather, they inquire about the flexible and local nature of bodies, avoiding the scientifically normative assumption that bodies are everywhere and for all time biological entities. The migrants taking part in contemporary medical journeys might not experience themselves as biological beings at all; and, if they do, we cannot assume that medical migrants with diverse origins share the same biology. Bio-medicine and the biological sciences are produced in a time and place, which also help produce distinct corporalities, along with the specific means and modes of travel of those bodies. As we have already emphasized, medical migrations are less concerned with the healing possibilities offered by places than with the biological body. However, travel undertaken under the auspices of bio-medicine share with all past therapeutic journeys a focus on change in bodily state. Today's journeys need to be understood within their own universe, where pathogens – not places – are the source of most afflictions. In turn, affliction tends to be located in individual body parts, and those bodies are not governed

by the salubriousness or toxicity of particular places, but belong in an explicitly apolitical, amoral domain of nature. It is that which the apolitical domains of nature and biology allow that many of these articles explore.

Taking up Michel Foucault's work, scholars of the body have come to appreciate biology as a regime of power that regulates life at the level of the individual and the human population. Bodies are political, yet political power is derived from how biology is understood in relation to nature and outside the domains of politics and history. Biology confers authority and legitimacy, and increasingly has become the language through which claims to the truth are made and political struggles are waged. In the last few decades anthropologists, sociologists and historians have taken up Foucault's insights about how power relations are inscribed on bodies and documented how bodies are made, constructed, performed, assembled and enacted, (Haraway, 1991; Laqueur, 1990; Mol, 2002; Ong and Collier, 2005; Scheper-Hughes and Lock, 1987). Thus, we are more attuned today to the materiality of bodies – what Scheper-Hughes and Wacquant (2002) call 'real' bodies – and the ways that biology is entangled with in ideology and the ideological processes within human struggles for power. Thus, despite their seeming timelessness and universality, bodies are not the same as they were three centuries ago, and bodies in different places are not the same as each other.

In her analysis of 18th-century medical texts, Barbara Duden (1991) found that provincial German women of the time experienced their bodies as integrally linked to their social and environmental surroundings, while their porous skin held in fluids constantly affected and transformed by the social world. These bodies were radically different from those of contemporary German women. And, as the medical anthropologist Margaret Lock found in her ethnographic study of middle-aged women in Japan and Canada, the bodily symptoms that make up menopause in North America, such as hot flushes, are not universally experienced. Lock and Kaufert's (2001) term *local biologies* has not been sufficiently appreciated outside the field of medical anthropology. Biological realities are produced, and transformed, in a range of political sites and scales, from the molecular to the individual and the societal to the global.

The articles in this volume illuminate how diverse kinds of travel produce diverse kinds of re-*localized* (i.e. traveling) bodies and biologies. They show how medical migrants come to understand themselves – or don't – as biological beings, whose qualities can be manipulated to cultivate certain modes of life. From the other end of the process, we also learn how biological knowledge enables researchers and governments alike to categorize and govern certain groups of people. We come to see how bodies are differently affected by travel,

particularly in relation to the bodily processes they each undergo. Medical migrations shake the grounds of human existence and transform what it means to be sick or healthy; in turn, the different biologies enacted by medical migrants can transform the experience of travel itself.

New bio-medical technologies offer interventions in the vital processes of human bodies (reproduction, aging and death) and create new norms, a particular definition of happiness (as linked to control over medical and biological destinies), and create new and possible futures – all of which are understood to lie outside the political sphere. A key point then that emerges through several articles is how the seemingly apolitical nature of medicine and biology motivates and produces medical migrations, when journeys are undertaken in the name of health are understood as somehow transcending politics.

This is especially evident in the global medical intervention in the name of humanitarianism (e.g. Partners in Health, Médecins Sans Frontières [MSF]), which claim health as a fundamental human right, external to national politics. For certain groups, like refugees, medical migrations undertaken in the name of health and life that provide legitimacy in border crossings are, in reality, a quest for work rather than the quest for access to advanced medical technologies, or corrective surgeries, or psychological therapies when there are often more immediate needs, such as families to be fed and children to be schooled. Humanitarian organizations operate from an assumption of a universal humanity, based on inherent and given biological rights and needs. Late modern humanitarianism and the promulgation of human rights are a reaction to the historical misuse of evolutionary biology and of medicine, as are racism and the creation of populations seen as less than fully human.

Biology is central to Miriam Ticktin's article (this volume), in which she argues that, for asylum seekers to France and the US, it is a denial of politics and personhood and the embrace of 'bare' and stripped-down life that allows them entry. The body's persuasive power lays its bearer's ability to claim suffering above politics. In France, demonstrable illness has become the only reliable means to apply for immigration papers. The number of refugees admitted through the country's 'illness clause' directly correlates with a decrease in the overall number of refugees admitted. Today, political refugees to both France and the United States cannot simply be escaping political persecution; they must be demonstrably sick or physically damaged.

Ticktin juxtaposes these refugees, who have only their broken bodies to show, with the experiences of enterprising global elites who are almost effortlessly mobile, and who can tinker with and alter their bodies and biological destinies with impunity. Their bodies are celebrated as endlessly protean through

plastic surgery, personal training and specialized diets. The migrants' bodies, on the other hand, must remain free of manipulation to testify to their corporeal condition – to the damage that was enacted upon them, not by them. When rumors spread that immigrants try to contract HIV in order to gain entry to France, they were not deemed enterprising but rather as beastly, uncivilized. The biological status of asylum seekers must be seen as free of politics and agency in order for them to cross the border. Similarly, humanitarian groups like Médecins Sans Frontières apply a version of universal, apolitical medicine to argue for asylum, as when torture is reinterpreted as a medical condition, as opposed to a political process. Torture inscribed on the body of asylum seekers marks them as sufferers without identified perpetrators.

Ticktin also describes how privileged biological connections, verified through DNA, such as mother and child, can be deployed for entry into and reunification in France. Meanwhile, angry Tea Party politicians in the US are arguing for a repeal of the rights to US citizenship of so-called 'anchor' babies, children born on US soil but to an undocumented mother.

Like Ticktin's article, Stefan Beck's article on bone marrow donations across the Greek-Cypriot/Turkish-Cypriot border also demonstrates how biology can serve political processes. Bone marrow migrations were allowed precisely because they were seen as transcending politics for a larger humanity, and transcending the ethnic identities that divide Turkish- and Greek-Cypriots. These kinds of biological mobility were supported by international aid organizations that used the apolitical marrow drive in their efforts to support negotiations to end hostilities between Turkish and Greek Cyprus.

While the multilateral agencies in Cyprus use a seemingly apolitical biology as a means to political ends, Whitmarsh's global researchers from Johns Hopkins seem more naïve about their application of an apolitical bio-medical model of disease. Although the medical researchers want to alleviate asthma for the underprivileged, their efforts decontextualize and depoliticize the immediate causes of these conditions in the postcolonial and global economy. As described above, the researchers ask little about the historical and material conditions that produce disproportionate rates of asthma among certain groups – an erasure of place. The researchers do assume sameness between African Americans and Afro-Caribbeans, fixing their bodies genetically in a time before the Atlantic slave trade. The subjects of their research, however, link biology, economy and politics to place and their corporeal states. The Bajans understand the island's high rates of asthma as the consequences of ongoing global inequality, car pollution, unregulated use of pesticides and an inadequate health care system. The assumption of biological fixity on the part of the researchers mirrors, in reverse, the frustration

of the Bajans, who agree to participate because they are, indeed, fixed in place, and cannot travel to the US for medical care unavailable in Barbados. Within the actualized medical migration of the researchers, and the thwarted migration of the research subjects, biology is not the same.

Beyond humanitarianism, the presumption of biological fixity and connections made of blood and genes makes it still possible to bind smaller groups, like families, and larger groups, like ethnicities or nations, through the idea of a shared substance, and to the exclusion of others. In Cohen's piece (this issue) this binding can compel medical migrations in the name of 'love'. Love is the language that allows new forms of kidney exchange in India, a love predicated on biological connection and similarity. In India, a recent regulatory crackdown on organ sales, meant to prevent exploitation and abuse, has made an exception for organ transplants between family members. The regulation presumes equality and love between biologically related kin. This regulation has worked to prevent kidney sales between Indians and non-Indians. However, the regulation has encouraged medical migrations of Non-Resident Indians to India to buy kidneys from strangers. Their phenotype allows state transplant authorities to believe that love is possible between, for instance, a weaver from rural Kumarapalayam and a Non-Resident Indian from California. Phenotype allows for the possibility of love, based in biology, which allows authorities to approve transplant. The coming together of the 'bio-available' and the 'supplementable' is rendered through the intimacy of kinship or affect that is based in biology. In turn, this love makes possible new forms of connection when the Non-Resident Indians put their kidney sellers' children through school, a kind of remittance to the recipient home nation, made possible through scale-jumping, transplant technologies (including the immuno-suppressant capabilities of cyclosporine), global stratification and the presumption that biologically based love prevents exploitation. The Non-Resident Indians who can now buy kidneys through the presumption of biologically based love are also participating in what Cohen finds is an established practice, where love for one's own biological children means never asking them for their organs.

Presumptions of biological connection, this time more generally ethnic than familial, also emerge in the other half of Cohen's story, as Chinese living in Malaysia travel to the mainland to buy organs harvested from prisoners. The Chinese military-business complex courts these Chinese Malays and their desire to supplement themselves. Resident Chinese, however, resent these medical migrants, and believe that the harvested organs belong to the nation and should be available for the collectivized body. As a resident Chinese told a Chinese Malay receiving a kidney from a recently executed prisoner: 'This is not your

kidney – you have used your money. This kidney should be for us.’ The sentiment is jarring for the Chinese Malay, who saw the trip as a kind of homecoming, an essential one, given that they have little chance of receiving organs in Malaysia, since they are not ‘sons of the soil’. This journey for organs lays bare the contradictions inherent in universalist visions of biology. For the Chinese Malay, biology creates a racial bond with their mainland brethren – the body here is not universal, but it is national – and with it a sense of a shared right to the harvested organs. The resident Chinese, in contrast, are simply explicit about what humanitarian organizations and national governments intentionally elide: that biology is unavoidably, and necessarily, political.

The different biologies manifested in these medical migrations provide an important reminder of the provincial nature of the concept of ‘biological citizenship’ (Nguyen, 2005; Petryna, 2002; Rose, 2007; Rose and Novas, 2005). As anthropologists of the global South have shown, biological citizenship is not necessarily relevant in much of the world since both the political and the biological are enacted differently elsewhere (Das, 2001; Roberts, 2008). The articles in this volume push the concept of biological citizenship, as well as biology itself, by delineating mobilities between nations and regions whose residents might not participate in the same kind of apolitical biology now promulgated by humanitarian and medical institutions throughout the globe.

Taken together, these articles point to biology as inescapably embedded in the political. We see how crossing borders (or the inability to cross those borders) changes how individuals might experience themselves, and their biological corporality, especially when citizenship is tied to questions of biological existence throughout the world. This volume is thus part of an emerging literature that reveals how the rights, responsibilities and political struggles associated with citizenship increasingly take the form of access to medical care, while insisting that we don’t take for granted the singularity of the biology underpinning that care.

Conclusion

It is no coincidence that the vignettes that begin each of the three preceding sections all take place in the 19th century. The second half of the 19th century gave us germ theory, and the disease as apolitical object separable from bodies and places and economies, essentially changing medical travel, shaping the mobilities, destinations and biologies of the contemporary medical migrations described in this issue. By attending to the production of these diverse mobilities, places and biologies, this special issue raises key issues about how the regulatory

apparatuses of nation-states and private industries shape the contours of mobility for medical care, the vastly unequal conditions of the nations where medical migrants come from and travel to, and how contemporary bodies are produced within these global processes. These travels are varied, the destinations are varied and the effects of these migrations on the bodies, biologies and subjectivities of the migrant are varied as well. What the articles achieve in tracking the complexity of the medical migrations is a demonstration of how politics and economies are distributed throughout each migration.

The experience of travel and the practices of bio-medicine are, if not necessarily together, fundamental to the experience of most subjects in the modern world. The fortunes of people informed by the technologies of the increasingly medicalized body find some kind of expression with the material and metaphorical practice of travel. Along with uncritical celebrations of mobility and bodily transformation come other dreams, like the notion of a universal apolitical body. These articles point to ways that biological knowledge, norms and practices are contested, reconfigured, transformed, iterated, and how these medical migrations transform the biological. Medical migrations, then, open up a whole set of questions about what it is to live and be understood as biological organisms in the early 21st century.

Notes

1. The articles in this special issue come out of a 2009 workshop in Pescadero, California funded by the Wenner-Gren foundation for Anthropological Research and the National Science Foundation. In addition to those foundations, the authors would like to thank Matthew Hull, Naomi Leite, Julia Paley, Rebecca Hardin, Nadine Naber, and the generous and dedicated participants at the Medical Migrations workshop for helpful suggestions and much-needed criticism throughout the writing of this piece. Christopher Roebuck co-organized the workshop with Elizabeth Roberts. The introduction and the volume itself are shaped by his analytic creativity and especially his investment in questions surrounding the role of the biological body in medical migrations.

2. Coretta Scott King, for example, died at a 'holistic health' clinic in the city of Rosarito, Baja, California in 2006. The clinic, known by two names, locally as Clínica Santo Tomás and on its international website as Hospital Santa Monica, was owned and operated by a resident of San Diego, who practiced medicine without a license apart from a diploma (PhD) in nutrition awarded by his own university diploma mill. Scheper-Hughes interviewed an international organs broker who also had a PhD from the same diploma mill and who was a protégé of the owner of the clinic where Mrs King died. Although the clinic was subsequently closed down by the state commissioner of health in Baja, it has since reopened and advertises on the internet, advising those with a diagnosis of cancer to come earlier, rather than when it is too late for a holistic cure (see: <http://quepasabaja.com/?p=331>).

3. See Leite and Graburn (2009) for an overview of tourism literature; see also the special issue of *Medical Anthropology* (Smith-Morris and Manderson, 2010).

4. For Mol (2002), enactment signals how reality is produced relationally, and is malleable and differs between sites.

5. Historians point out that the initial spate of medical exams before the borders were closed kept out a very few European travelers. Health inspections were more a means of surveillance and inculcation into the habits of good American workers than a means to keep immigrants out. The medical exam did turn relatively more Latin Americans and Asians back, but even then they represented only a small percentage of those who came. Overall, the medical exam kept out a total of less than 1 percent of the millions who immigrated (Fairchild, 2003). Nevertheless the medical exam and the possibility of quarantine or denied entry radically changed the tenor of border crossing at the turn of the 20th century. The historian Irving Howe argued that it mattered little that the health exam only denied a few 'because everyone knew someone, or someone who knew someone, who was sent back because of a terrible disease. Every immigrant feared that an American doctor would suddenly pronounce them as ill or a danger to others even if they felt completely fine' (cited in Markel, 2004: 10).

6. The medical historian Alison Bashford calls colonialism 'the first age of universal contagion' since borders were relatively open at that point. She argues this against Hardt and Negri's contention that 'globalization is the first age of universal contagion' (Bashford, 2006: 6).

7. The ability of disease to make and reinforce borders was very much in evidence in the late spring and summer of 2009 when much of international air travel involved a set of practices that intensified the connections between travel and germs. In response to the H1N1 (swine flu) epidemic, local officials around the world put new travel advisories in place. Cuba and Argentina suspended flights to and from Mexico. Chinese authorities quarantined arriving passengers on planes with disease carriers. Australian airports would not allow North or South American planes to land without information about the health status of all passengers (Baskas, 2009). Crossing international borders then meant becoming subject to heightened surveillance and new border practices, which enacted afresh the existence of bounded, nation-states (Sharma and Gupta, 2006).

8. The development of medical travel had an economic basis, as well. As one British commentator wrote about South Africa in 1888: 'Invalids bring money with them, and for that reason, if for no other, I think it would be a very good thing if doctors would discover that our British colonies are good health resorts' (cited in Deacon, 2000: 290).

9. See: <http://www.medicaltourismmag.com/newsletter/7/medical-tourism-association-participates-in-world-health-organization-who-workshop-on-medical-tourism-in-kobe-japan.html>

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