



Original article

A revealing scandal: The German transplant scandal between structural failures, moralizing rules, and ambivalent manipulations

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ABSTRACT

Introduction: In 2012, the German transplant scandal was uncovered and reported in the national and international media. This article offers an anthropological analysis of the scandal and examines its 'scandalous' characteristics by taking a close look at its extraordinary and ordinary features.

Methods: The article is based on ethnographic research using multiple methods including participant observation, interviewing as well as media and document analysis.

Results: The transplant scandal in Germany revealed systemic 'scandalous' features of the national transplant system. From a significant lack of transparency in decision making, a weak legal framework for accountability, adherence to moralizing rules about alcohol and abstinence, to media coverage that individualized the scandal. **Conclusions:** Looking at extraordinary events such as transplant scandals from an anthropological perspective offers an analysis that goes beyond the singular, scandalous event. An anthropological analysis allows to highlight the ordinary and ambivalent 'scandalous' features of transplant medicine. It examines transplant medicine at the intersection of biomedicine, politics, and morality.

1. Introduction

In 2012, the German 'transplant scandal' was uncovered and reported on in the national and international media [1–5]. As the social anthropologist Ciara Kierans states, scandals in the field of organ transplants have become a 'common trope' [6] in anthropological literature. From the well-known works of Nancy Scheper-Hughes on illicit international organ trade [7,8], to Sherine Hamdy's account of scandals around cornea grafting and debates on the proper treatment of dead bodies in Egypt [9], to Marie-Andrée Jacob's ethnography on the skillful navigating of legality around living donation in Israel [10], anthropologists have been offering critical perspectives on transplant medicine for decades [11,12]. Contributing to research on the scandalous features of organ transplants demands a critical stance toward how a scandal, the people involved, their motives, and the context they are embedded in are presented, discussed, and reflected upon to refrain from sensationalizing scandals in the Global South and contributing to a sense of moral superiority to biomedicine in the Global North [6,13].

This article offers an anthropological analysis of a transplant scandal

that unfolded in the Global North and shook the German transplant scene in 2012 and the years that followed. Similar to Kierans' [6] research, the German transplant scandal became public knowledge two years before I started my ethnographic fieldwork in 2014.¹ The scandal remained in the public eye for years, with ever more infringements being revealed and court cases pending. People, laypersons, specialists, and scholars tried to make sense of what exactly had happened, how to prevent future wrongdoings, and identify the loopholes that led to them.

In Germany, liver transplantation is part of the public health system, performed exclusively in public university hospitals and covered by statutory health insurance [14,15]. According to the Deutsche Stiftung Organtransplantation (DSO), which is responsible for organ donation in Germany, 834 liver transplants were performed in 21 hospitals in 2021 [16]. Compared to other European countries, this comparatively high number of transplant clinics² can be explained by the federalist political system in Germany, which leads to differences in the organization and practice of transplant medicine between the federal states and the clinics. A key factor influencing the practice of organ transplantation throughout the country, regardless of federal policy, is the low number

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¹ It is standard in social anthropology and ethnographic writing to present findings from a first-person perspective, giving account to the subjective and reflexive qualities of qualitative research.

² In the United Kingdom, e.g., over a similar period (April 2021–March 2022), only seven clinics performed 848 liver transplants [17].

of organ donations. Unlike other countries that rely on living donors, Germany has been very reluctant to actively promote the use of living donor organs for transplantation. This reluctance is due to the country's history, in particular the widespread abuse of and experimentation on the human body during the Nazi era [18]. Germany, which relies mainly on deceased donor organs allocated by the international non-profit organization Eurotransplant, has also been criticized internationally by other member states for profiting disproportionately from the cross-border exchange of donor organs [19].

In the same year that the transplant scandal became public knowledge and was reported in the media, the number of organs donated dropped significantly. Taken together, the scandal and the drop in organ donation created an atmosphere in which people were looking for answers and explanations. Was the drop in organ donation linked to the scandal? Had the public lost trust in the country's transplant system? Had there been any trust to begin with? In the years that followed, during the ethnographic fieldwork I conducted for my PhD, the question of who was responsible for the scandal and who was responsible for the declining organ donations came up again and again during conversations, talks and presentations. With an increasing number of patients listed for transplantation and waiting for a donor organ, the perceived impact of the scandal was long-lasting and critical to people's chances of survival.

Writing about a transplant scandal must be approached carefully. By considering contextual and structural factors and drawing on a broad set of methods and data sources, anthropological analysis allows to dissect the scandal and go beyond its scandalous extraordinariness. It allows to foreground the everyday features a scandal reveals through close examination of the ways how one's interlocutors, the media and even academic scholars make sense of a scandal. This article is based on retrospective accounts on the scandal, from newspaper articles to investigative reports, to informal and formal interviews with patients and transplant specialists. Drawing on multiple methods, the anthropological account of the German transplant scandal reveals the systems 'scandalous' traits. What does the transplant scandal actually refer to: malpractice, manipulation, or falsification? How do they differ from each other? How was the scandal covered in the media? How did my different interlocutors try to make sense of the scandal? Did the scandal reveal any other problematic and much more 'ordinary' features of German transplant medicine?

After discussing the specifics of the applied ethnographic research method in more detail in Section 2, Section 3, 'Results', examines the 'scandalous' traits of the scandal, highlighting the ordinary systemic 'scandalous' features of the German transplant project rather than extraordinary events. These include media coverage that individualized the scandal, especially at the beginning (3.1), a significant lack of transparency about how decisions were made and weak legal frameworks to hold people accountable (3.2), the adherence to moralizing rules about alcohol and abstinence (3.3), and the ambivalence of manipulations (3.4). Based on an analysis of field notes, interviews, media coverage and investigative reports, the article sheds light on the political and moral features of transplant medicine as well as the temporal elusiveness and local situatedness of a scandal.

2. Methods

2.1. Design

The findings presented here are part of a larger social anthropological research project investigating how moral considerations shape experiences, discourses, and practices of 'intimate uncertainties' [20]. Ethnographic research uses multiple methods to collect heterogeneous data (including fieldnotes, interview recordings and transcripts, document and media analysis) to produce in-depth, contextualized accounts of social phenomena. Providing detailed accounts, or so-called 'thick descriptions' [21], of concrete settings, allows for discussion of the

complexities and ambivalences that shape everyday practice. Based on ethnographic methods and anthropological analysis, this article offers an insight into the 'situated knowledge' [22] that an ethnographic approach produces, providing an empirically grounded partial understanding that illustrates transplant medicine as a social, political and moral project.

2.2. Data collection and analysis

The data presented in this article are based on thirteen months of ethnographic fieldwork in Germany in 2014–2015. As part of my PhD research, I investigated how moral considerations and intimate uncertainties shape the practice of liver transplantation and the experiences of people affected by a failing liver [23]. Before starting the hospital ethnography [24,25] I spent several months attending patient support group meetings and events, conducting participant observation and informal interviews and conversations. These meetings were mainly attended by transplant recipients, some of whom I also visited at home for follow-up interviews. I also attended medical conferences and congresses to gain an insight into the prevailing atmosphere in transplant medicine at the time.

One transplant clinic served as the main field site for this study, with other sites and settings complementing it. This clinic was also involved in the transplant scandal. There, I conducted problem-centered interviews [26] with nineteen pre- and post-transplant patients, four of whom I interviewed repeatedly. I also had access to the patient documentation system and conducted regular ad-hoc ethnographic and problem-centered interviews with health care professionals. This allowed me to gain a better understanding of the diagnostic complexities of liver failure, the challenges of its limited treatment options, and the particularities of the German transplant system. It was during these interviews that the transplant scandal was discussed in particular, as violations had also occurred at the clinic that served as my main field site.

Empirical data from participant observation, ad-hoc ethnographic interviews, and informal conversations with pre- and post-transplant patients, their relatives, and various medical and non-medical experts were recorded in fieldnotes on the same day to support recall of events, descriptions, and conversations [27]. Recorded interviews were transcribed verbatim. All written data, field notes and interview transcripts were analyzed iteratively using a Grounded Theory approach [28]. All data were stored and archived securely, both physically and digitally, and were accessible only to the author.

2.3. Ethical consideration

Two transplant clinics gave permission for the study to be conducted, and ethics committee approval was obtained. All names, including people, places, and clinics, have been changed by the author to protect the anonymity of research participants. This research was carried out in many different settings, from transplant clinics to patient support group meetings, medical conferences, and people's homes. As such, this project relies on a variety of informed consent practices, ranging from signed written consent forms prior to interview recordings, to verbal consent at patient support group meetings and patient association seminars. Healthcare professionals in the transplant clinics were informed of the ethnographic study by their clinic manager and the researcher. In general, ethnographic research places responsibility for good ethical conduct on the researcher themselves [29,30]. This means that researchers must assess continuously and, depending on the particularities of a situation, interaction, or conversation, decide how to proceed in line with ethical research principles. Keeping the open approach of this research design in mind, allows researchers to adapt to unforeseen circumstances, which leads to an understanding of informed consent as ongoing practice throughout the research process, and a critical stance towards more clinically orientated informed consent practices [31].

3. Results

3.1. Media tales of a scandal

The year 2012 became a watershed moment for transplant medicine in Germany when the national media reported on misconduct at the transplant clinic of the university hospital of Göttingen. The scandal did not follow the usual tropes of transplant scandals, such as illegal organ trafficking or improper handling of bodies during organ donation; it involved falsified medical records and manipulated patient files to improve the position of patients on the waiting list. The transplant scandal made headlines in national newspapers such as the *Frankfurter Allgemeine Zeitung* [32], the *Süddeutsche Zeitung* [33], and *Zeit Online* [34], as well as international media such as the BBC [35] and the Guardian [3]. Academics wrote about the scandal in international journals, ranging from *Nature* [4] to the *American Journal of Transplantation* [36], and several others [5,14]. In Germany, the scandal was widely reported in medical journals such as *Deutsches Ärzteblatt* [1]. It was analysed by criminal law experts to determine whether the reported manipulations were a mere misdemeanor offense or whether those involved should be prosecuted for manslaughter [37], and by sociologists who were interested to understand whether corruption in clinics was driven by individual motives or part of organisational deviance [38, 39].

The scandal was triggered by an anonymous call to the Deutsche Stiftung Organtransplantation (DSO) reporting illicit practices at the transplant clinic at the university hospital in Göttingen [40–43]. The DSO then informed the Prüfungs- und Überwachungskommission der Bundesärztekammer (PÜK), the auditing and monitoring commission for transplant medicine at the German Medical Association. Investigations began and revealed that 75 percent of the cases investigated at the Göttingen clinic involved falsified medical records and patient files [44]. The infringements entailed the forwarding of falsified patient data to Eurotransplant, which then allocated donor livers on the basis of the falsified data. The falsified data included incorrect reports that patients were on dialysis (which put them in the high urgency category for a transplant), others were listed for a transplant despite their tumors transgressing accepted criteria, and in several cases, patients had received liver transplants despite breaking the ‘six-month abstinence rule’. As the scale of the scandal became clear early in the investigation, it was decided that all transplant programs in the country should be audited, especially those for liver transplants. The scandal turned out not to be an isolated incident. Several other transplant clinics had manipulated patient data.

As a result, charges were brought, and the head surgeon of the transplant clinic in Göttingen was charged in 2013 with eleven counts of manslaughter and three counts of bodily harm resulting in death [45]. The surgeon pleaded not guilty and was acquitted of all charges by a state court in 2015 and again by a federal court in 2017 [46,47]. Tampering with medical data was not a criminal offense at the time the tampering occurred, and it was impossible to determine whether patients died as a result of the surgeon’s practices. In other words, the surgeon broke some rules, in particular the official rules of the German Medical Association, but as these rules were not legally binding at the time, he did not break the law [37,48]. In addition, state and federal law claimed that some of the rules of the German Medical Association, some of which the surgeon had also broken, were unconstitutional. This included in particular the ‘six-month abstinence rule’, the requirement to abstain from alcohol for six months before receiving a liver transplant [49–51], on the grounds that this rule excluded people in need from life-saving treatment.

Media coverage of the transplant scandal and the public attention it generated were crucial factors in the revision of regulations by the German Medical Association and the legislature. However, looking at the coverage from 2012 onwards, newspaper journalism also contributed to individualizing and exoticizing the scandal, focusing particularly

on the Göttingen case and its (former) chief surgeon. News reports about manipulation in other hospitals rarely mentioned the names or national backgrounds of the doctors involved. However, the Göttingen case, which stood out in terms of reports of manipulation, provided the media with a Jordanian-born doctor whose non-German background and name, Aiman O., was repeatedly mentioned in various media reports [43,45]. Looking at how the scandal was mobilized and how the media or the public reacted to it during these first months, the attempt to portray the scandal as the wrongdoing of a single individual, a black sheep, a surgeon ‘playing God’ [45] – even a ‘foreigner’ – becomes apparent. Over time, as the scandal spread to other hospitals (albeit to a lesser extent), and the systematic involvement of other clinics and physicians became apparent, media coverage began to focus less on the misconduct of a single doctor and more on systemic and structural aspects that contributed to the scandal [52].

3.2. A system under pressure, lacking transparency and accountability

Apart from Göttingen, the commission found violations and manipulation in three other liver transplant programs – including the university hospital where I conducted my research. There, the commission found that 32 percent of the cases examined had been manipulated [38, 44]. Two senior doctors were identified as responsible and were immediately dismissed. While Göttingen stood out in terms of the number of cases of manipulation, the trial and the pending verdict were seen as an indicator of what might be in store for other clinics and doctors involved in the scandal.

While the focus of my research was on the experience of waiting for a liver transplant, the question of how people, who worked in a transplant clinic that was directly involved in the scandal, made sense of these manipulations and violations was also part of the conversations and interviews. In general, there was very little talk among the various members of staff about the scandal and its particularities in ‘their’ hospital. In one telling incident, the head nurse of the transplant clinic eagerly cut out half a page of an information leaflet before handing it over to a patient. When I asked what exactly she had cut out, she explained that she had cut out the faces of the former surgeons, who were pictured in the leaflet. ‘The information is still valid,’ she said, ‘I just don’t want it to be associated with them anymore.’ The dominant approach to dealing with the violations at the clinic seemed to be to distance oneself and make the links to the scandal as invisible as possible.

One of my key informants, the transplant surgeon and director of the clinic, was suspended during investigations and after being cleared of any wrongdoings, reinstated as head of the clinic’s transplant program. When I asked him about the practice of liver transplantation, he reflected on the stress he felt in his surgical practice and emphasized the pressure to save lives by performing what he called ‘successful’ transplants. According to him, in the years leading up to the scandal, the clinical board had pushed the clinic to perform more and more transplants and had recruited a new surgeon to increase the number of operations. Together with a second surgeon employed alongside this ‘new surgeon’, the number of liver transplants increased significantly to 85 in the year the fraud was uncovered:

The year before the new surgeon started at our clinic, we performed 47 liver transplants. That was in 2006 and 2007. Forty-seven is a lot. And the quality was good. But apparently, this number was not considered sufficient. [...] Then, the system develops a momentum of its own. Because of this achievement [increasing the number of transplants], you also gain recognition and you become more valued in the transplant community. In this community, recognition comes with surgeries performed: the more transplants you do, the more you are valued locally and nationally. It is the quantity that counts, not the quality of these operations. And so, the whole system becomes self-perpetuating, as surgeons swollen with pride, receive more and more praise for more and more transplants. So, vanity played a big part in these manipulations – to stand out. Colleagues always ask for figures: ‘How many

have you done this year? What, only 30? Well, we already had 50. 'In many of these conversations, how these numbers were achieved seems secondary. You are always asked how many surgeries you did, never how many patients survived or died. These numbers seem to be of interest only to the quality assessment department. (Dr Schmidt, 7 December 2015)

The surgeon's account sheds light on a competitive field in which high numbers enhance reputation and, in rare cases, were linked to financial incentives, as the Göttingen case showed. It is supported by sociological studies that have also looked at the violations at this clinic [38,39]. According to these studies, the annual report published by the clinic in 2010 presented its transplant program as an outstanding success, emphasizing the clinic's improvement in performance only in relation to the increase in the number of liver transplants. The sociologists point out that this report, like many others, failed to mention other parameters such as quality ratings or survival rates. In their comparison of clinics involved in infringements, manipulations did not occur in clinics that were struggling to reach the minimum number of transplants, but only in those that already had a good standing.

Until these violations were reported in 2012, transplant medicine in Germany was weakly regulated. The decision to list a patient for transplantation was made by a single doctor. After the scandal broke, the Transplantationsgesetz (TPG), the national legal framework, was revised and, from 2013, improper documentation became a criminal offense under national law. From then on, it was a transplant committee, including doctors not involved in the patient's care, that decided whether a patient should be placed on the waiting list for a transplant, rather than a single doctor making the decision. Manipulating data proved to be an expedient, albeit inappropriate, way to improve the standing of a clinic and the reputation of surgeons in the face of internal organizational pressures, competing transplant centers and weak regulations. With a high degree of professional competition, a lack of transparency and accountability, and an individualized approach to medical problems, Germany's federalist transplant system created the perfect atmosphere for these manipulations to develop and for some surgeons to systematically manipulate data.

3.3. Moralizing abstinence rules

A significant number of violations involved the six-month abstinence rule: the requirement to abstain from alcohol for six months before receiving a liver transplant, particularly for those with an alcohol-related liver disease. The rule, which is controversial and highly debated among transplant specialists [49–51], has been declared unconstitutional under state and federal law on the grounds that it excludes people in need of life-saving treatment. As the focus of the scandal has shifted away from individual misconduct and towards structural failures, the rules and regulations that govern transplant practices have become increasingly important.

In 2015, the 'six-month rule' was revised by the German Medical Association [53]. Although the rule remains in place, physicians can now apply for an exception to it, allowing patients in urgent cases to receive a transplant without six months of abstinence prior to surgery. This option was not available before. Looking at the high number of breaches of this rule as part of the scandal casts a different light on doctors' misconduct. The revisions to the rule suggest that the problem was not simply doctors breaking the rules, but the rules themselves.

However, granting exceptions is very different from abolishing a rule that has little medical justification [49–51]. Rather, it reveals the moralizing features inscribed in official regulations and medical practice. I have written elsewhere about the moralizing features of the six-month abstinence rule in more detail, focusing in particular on how the moralization of alcohol-related liver disease and alcoholism is gendered and affects the kind of care patients receive and consequently their chances of survival [54]. Here, I want to draw attention to the moralizing features inscribed in the regulations of transplant medicine. This moralizing goes deep, since the German Medical Association,

regardless of medical justifications and court rulings, adheres to it and only grants exceptions. Granting exceptions requires paperwork, time, and staff. In the context of an over-bureaucratized healthcare system that is short of both time and staff, the process of applying for an exemption adds another layer of uncertainty and unpredictability to the transplant process, particularly for those waiting for a liver.

3.4. Ambivalent manipulations

The transplant scandal revealed how falsified patient data was passed to Eurotransplant, which then allocated donor organs according to the falsified data. At the center of the scandal was the violation of rules and the manipulation of medical records by doctors. This final section focuses on ordinary manipulations and tinkering that increases a patient's chance of a transplant.

Transplant surgery requires manual manipulation because it involves cutting open abdominal cavities, removing and implanting livers, sewing blood vessels, and suturing wounds. Manipulation also extends beyond the operating theater to the necessary pretransplant treatment regimens. For patients with cirrhosis and liver cancer, their chances of receiving a transplant depend on certain criteria. The most important condition, which is also found in official guidelines and regulations [55], is that patients' tumors must be located exclusively in the liver. As their cancer has not metastasized, their chances also depend on the actual size and number of tumors. A common form of tinkering involves the controlled treatment of tumors. Patients receive 'extra' points either for a single tumor measuring no more than two to five centimeters or for a maximum of three tumors measuring less than three centimeters in diameter. Therefore, when treating these tumors, doctors must be aware of the specific rules for transplantation in order not to compromise the possibility of receiving a transplant. Too few or too many tumors, or tumors that are too small or too large, would cost a patient in need of a donor liver crucial points and reduce their chances of receiving the long-term treatment they so desperately need.

Hepatologists explained to me how ethically 'slippery' the line is when it comes to tinkering with patients' treatment and health to achieve a particular long-term outcome. For patients with end-stage liver disease who are urgently waiting for a transplant, it may be in their best interests to not treat their kidney failure immediately, as their failing kidneys greatly increase their chances of receiving a transplant. This kind of manipulation and tinkering [56], with bodies rather than medical records, is ubiquitous in transplant medicine, far from being scandalous, but a normal part of medical care.

4. Conclusion: a German scandal

The transplant scandal, particularly the incidents at the clinic in Göttingen, and the subsequent trials covered unprecedented ground in Germany regarding media reporting, juridical uncertainties, moral ambiguities, and political implications. The uncovered manipulations were not extraordinary occurrences but rather systematic practice at several clinics. They were symptomatic of a competitive system that faced limited resources and lacked transparency as well as accountability. Foregrounding quantity over quality and celebrating surgeons for increasing the number of transplantations contributed to manipulations becoming systematic practice for some doctors. These manipulations were also symptomatic of a system that is driven by ideas of continuous progress, development, and expansion. Such a mindset is necessary for most medical developments to unfold, and transplant medicine would not exist as it does today without the impulse to push the boundaries of what is considered possible. However, this desire to push the boundaries beyond 'healthy' or sustainable limits can also be seen in the pressure to increase the number of transplants despite the limited resources of donor organs.

A significant number of infringements involved the violation of the six-month abstinence rule for patients with an alcoholic liver disease,

which courts later ruled to be unconstitutional. This rule has since been revised and according to current regulations exceptions to this rule can be granted. Nonetheless, granting exceptions differs significantly from abolishing a rule that lacks medical reasons for adhering to it, revealing the moralizing features inscribed in official regulations and medical practice. A significant number of violations uncovered by investigative reports would not necessarily be considered as such under current regulations. Regulatory frameworks change, as do medical limits and boundaries. These ‘scandalous’ manipulations point to the ephemeral nature of agreed limits and the need for constant reassessment of exclusionary rules. Nevertheless, they revealed structural shortcomings in the field of transplant medicine.

As a result, the legal framework regulating transplant medicine was revised to make it more transparent and infringements a criminal offense. The scandal gave rise to a revision of regulatory frameworks, indictments of doctors, and court cases that attracted substantial media attention. Besides these legal implications it also coincided with a decline in the number of organ donations. This drop was widely explained by the public and professional loss of trust in the national organ donation and transplantation system, and few identified larger structural problems in clinics, i.e., health care professionals’ lack of support for or skepticism about organ transplantations as the main reason for the low number of organ donations [13,14].

The low number of organ donors remains a political issue in Germany, with ongoing discussions about changing the legal framework from an opt-in to an opt-out system. In 2020, the German minister of health led a yearlong initiative to change organ donation from an opt-in to an opt-out system in order to increase the persistently low number of deceased donor organs. As the national parliament subsequently voted against this change, the current opt-in system remains in place [57] – against the recommendations of medical experts [15].

From an anthropological perspective, the German transplant scandal also revealed the impulse of individualizing and ‘othering’ in the face of scandalous events, especially in newspaper articles. The trope to either frame doctors as saints and saviors or as deviant sinners has also been discussed in the context of Mexican organ transplant scandals [6,13], Egyptian cornea procurement practices [9], or international organ traffic networks [7,8]. Compared to kidney transplants, liver transplants are more complicated to conduct. Firstly, due to the sheer lack of organs available and, secondly, due to the centralizing of expertise in the Global North [58]. While liver transplant programs aim to follow the globalizing trend of kidney transplants, the main expertise of transplanting livers remains in countries of the Global North, among them Germany. The German transplant scandal proved that scandalous medical practices are not a ‘problem’ of countries in the Global South. They occur in the heart of Europe. However, the scandal highlighted not so much the misdeeds of individual doctors, but a system that lacked transparency as well as accountability, and remains to be deeply moralizing. Cloaked in the idea of objectivity and evidence-based practice, the German transplant scandal illustrated how biomedical practice is always ‘more’ than medicine, and part of a political, moral, and social project.

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Declaration of Competing Interest

The author declares that she has no known competing financial interests or personal relationships that could have appeared to influence

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Supplementary materials

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