Article

EJIR

European Journal of International Relations
2015, Vol. 21(3) 647–671

DOI: 10.1177/1354066114542664
ejt.sagepub.com
SAGE

Professional socialization and international norms: Physicians against organ trafficking

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Abstract
The concept of state socialization has been fundamental to the analysis of international norm dynamics. I argue that the establishment and spread of international norms may require the socialization not only of states, but also of non-state communities: through socialization, these communities move toward establishing the shared norms that are the foundation for their influence on states. Specifically, the article highlights socialization among professionals through social influence and persuasion. The efforts against organ trafficking demonstrate these micro-processes at work within the international medical community. Building on physicians' pursuit of status, and using persuasion and even coercion, the medical community has sought to establish professional norms that repudiate transplant commercialism and encourage ethical transplantation practices. On the basis of these norms, the medical community then urged governments to curb organ trafficking, resulting in a wave of legislative prohibitions on trading in organs. This case demonstrates that a full understanding of international norms may require us to examine socialization not just among states; the socialization of non-state actors may also play a crucial role in generating an international normative change.

Keywords
Constructivism, epistemic community, intergovernmental organization, non-state actor, norms, transnational civil society

Introduction

Socialization has been central to the constructivist research program in International Relations (IR). Numerous studies have sought to explain how social processes prompt actors to adopt and internalize norms, and how these norms, in turn, shape the actors'

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behavior (e.g. Finnemore, 1996; Flockhart, 2006). The IR literature on socialization has seen debates over what socialization is and how it operates; at the same time, it has been unified by a fundamental common assumption: the actor being socialized is the state. Whether treating the state as a unitary actor or examining state agents as individuals or groups, IR studies of socialization have largely focused on the state as the entity being socialized.

Yet, as a lens for analyzing international norm dynamics, the concept of socialization extends beyond the state. Indeed, *socialization of transnational non-state actors* may play an important role in the evolution of international norms. To date, the literature has highlighted the role of transnational actors — especially non-governmental organizations (NGOs) — in socializing states: transnational actors initiate norms and induce states to conform to these norms (Finnemore and Sikkink, 1998). Yet, prior to becoming agents that socialize states, *non-state actors may themselves undergo a process of socialization*. Through this process, members of the non-state community move closer to a shared normative view that is the basis of political action. While the literature recognizes that non-state actors may have divergent views and goals (Bob, 2005; Cooley and Ron, 2002), it often fails to identify how these actors reconcile their differences and reach agreement. In other words, the process of non-state socialization that may have preceded the process of state socialization typically remains under-explored.

This article highlights the oft-overlooked process of non-state socialization that serves as a foundation for the process of state socialization. It does so by looking at the internal dynamics of a professional community — the international medical community — in the case of organ trafficking. The organ trade emerged in the 1980s and vastly expanded throughout the 1990s. In the 2000s, this issue became a matter of international concern: countries that had previously tolerated the selling or buying of organs passed legislation that prohibits this practice (Danovitch and Al-Mousawi, 2012; Shimazono, 2007). On the face of it, the process of endorsing and implementing the organ-trade ban seems to fit the standard account of norm dynamics: a group of norm entrepreneurs — senior physicians supported by the World Health Organization (WHO) — convinced states that the organ trade is immoral and detrimental and, as such, should be eliminated. Yet, this conventional understanding of how states were socialized to accept the organ-trade prohibition masks an underlying process of non-state socialization — namely, how the international medical community itself came to embrace that prohibition and to demand that governments do so as well. The internal socialization of the medical community involved some of the micro-processes identified by the literature on state socialization, including social influence and persuasion. Only by understanding how these micro-processes diffused the anti-trafficking norm among physicians and prompted them to act politically will we fully understand the spread of the norm among states.

The article first explains how the concept of socialization may enrich our understanding of the internal dynamics of non-state communities. In particular, the micro-processes of socialization may be at work within *professional* communities, pushing the professionals toward shared norms and catalyzing them into a political force. Next, I explain how the international medical community has managed to move toward agreeing on a set of professional norms against organ trafficking, manifested in the Declaration of Istanbul on Organ Trafficking and Transplant Tourism. This became the foundation

for the medical community's political efforts — efforts that resulted in the adoption of the anti-trafficking norm and the enactment of relevant laws by both organ-exporting and organ-importing countries. In short, my dual goal is to explain how norms spread within a profession and how the wide acceptance of these norms facilitates the profession's influence on states, leading the latter to adopt norm-based policies.

Studying non-state actors in world politics: From external effects to internal dynamics

Constructivists award pride of place to transnational non-state actors in the life cycle of norms. In nearly any account of international norm dynamics, transnational actors play a major role in initiating international norms and in inducing states to endorse and implement them. Of the various types of transnational actors, international advocacy NGOs have received the most scholarly attention. Early on, the literature sought to demonstrate that NGOs indeed exert a meaningful influence on state behavior (Keck and Sikkink, 1998; Price, 1998). Current NGO scholarship has redirected its focus from the external effects of NGOs to their *internal* structures and dynamics. To explain how NGOs and their coalitions emerge and strategize and how they select issues for advocacy, scholars have used various theoretical perspectives: from collective action to the institutional design of international organizations (IOs) (Prakash and Gugerty, 2010; Stroup and Wong, 2013).

Beyond advocacy NGOs, the process of establishing and implementing international norms often involves another type of non-state actor: the professional community. While the concept of a profession is much disputed, professions are traditionally seen as occupational groups with exclusive control over the exercise of particular knowledge and expertise in a specific jurisdiction, based on educational credentials and recognition by the state (Djelic and Quack, 2010: 19). The increasing professionalization of state bureaucracies and IOs has allowed professionals to exercise considerable influence over the norms that these bodies promote, accept, or implement. Yet, even if not positioned within decision-making bodies, professionals may influence governments' ability and willingness to follow international norms. Through their recognized expertise and authority, professionals often play an advisory role in the policymaking process and participate in writing and implementing norm-related policies. Before making a policy change, governments typically consult the relevant professionals and seek their advice and approval (Finnemore and Sikkink, 1998: 905; Markoff and Montecinos, 1993; Nelson, 1987).

IR scholars have studied the role of professionals in initiating, spreading, and implementing international norms and policies. The ideas and networks of the economics profession have fueled the worldwide spread of neoliberal policies, such as privatization (Dezalay and Garth, 2002; Kogut and Macpherson, 2011; Weymouth and Macpherson, 2012). The legal profession has also influenced international processes and policies, and scientists have been shown to have such an impact as well (Burley and Mattli, 1993; Canan and Reichman, 2002). While professionals' political involvement has been the subject of a rich empirical literature, our *theoretical* toolkit with respect to the professions has remained surprisingly thin. In fact, a single analytical frame has dominated the

study of professionals within IR: epistemic communities. In a 1992 special issue of *International Organization*, Peter Haas defined an 'epistemic community' as 'a network of professionals with recognized expertise and competence in a particular domain and an authoritative claim to policy-relevant knowledge within that domain or issue-area' (Haas, 1992: 3). While members of epistemic communities may come from various disciplines, they hold shared normative and principled beliefs, shared causal beliefs, shared notions of validity, and a common policy enterprise. According to Haas, the complexity of policy issues leads policymakers to seek expert advice. As providers of expert information and advice, members of an epistemic community devise new policy ideas, select policies, and work out their details. Some epistemic-community members may actually hold bureaucratic authority within national governments and IOs, allowing them to facilitate international policy coordination in a manner consistent with the community's beliefs and preferences (Haas, 1992: 4, 15–16).

Since the advent of 'epistemic communities' as an analytical approach within IR, it has been featured in numerous studies. These studies typically identified a group of professionals as an epistemic community and examined that community's policy influence (e.g. Van Waarden and Drahos, 2002; Verdun, 1999). Like much of the NGO literature, these studies have focused on the *external* effects of professional groups — demonstrating that they indeed matter in world politics and identifying their tools of influence. Yet, as discussed earlier, in recent years, NGO scholars have begun employing various analytical frameworks to shed light on the *internal* dynamics of NGOs and their networks (Bloodgood and Schmitz, 2013). With regard to professionals, however, the IR literature has not seen a similar development: it has focused on professionals' involvement in and impact on policymaking, rather than on the internal dynamics that shape a profession's policy involvement.

This is not to say that the existing literature has completely overlooked the internal workings of professions. Several studies have indeed highlighted the ideological heterogeneity and the resulting disputes within an epistemic community (Dezalay and Garth, 2002; Kogut and Macpherson, 2011). Yet, even when debates among professionals have been recognized, they have remained under-theorized. The reason is that the epistemic-community frame provides limited analytical leverage for understanding the internal dynamics of a profession. Indeed, the concept of an epistemic community *presupposes* shared beliefs and a common policy enterprise among professionals. As such, this concept is of limited use for explaining how members of a professional community come to resolve their controversies and adopt similar beliefs, and what motivates them to seek policy influence in the first place. In other words, 'epistemic community' may be an appropriate frame through which to examine the *external* effects of a group of normatively committed professionals, that is, how the group induces states to adopt and implement policies. However, we need another frame to explore the *internal* dynamics of professional communities: how the profession establishes a generally accepted view that is the basis of the norms and policies it propounds, and how members of the profession come to advocate for these norms and policies. I argue that 'socialization' is a theoretical perspective that can fruitfully answer these questions, giving us insight into the internal workings of professional communities and their impact on international political processes and state behavior.

Socialization of states and of professionals

Socialization is the set of processes through which actors are incorporated into a group and come to adopt the norms, values, attitudes, and behaviors accepted and practiced by that group. In IR, the unit of analysis — the socialized actor — has typically been the state or state elites (Johnston, 2008: 21, 27). Numerous studies have sought to show how states come to endorse norms, adjust their behavior so as to conform to norms, and even internalize norms (Goodman and Jinks, 2004; Towns, 2010).

States' changing of their behavior in pro-normative or pro-social ways may result from different micro-processes of socialization. According to Johnston (2008), these include mimicking, social influence, and persuasion. Mimicking is a process through which a novice copies the behavioral norms of the group. Social influence encompasses a set of micro-processes that encourage pro-normative behavior through the provision of social rewards or infliction of social punishments. Rewards may include status, psychological well-being, and a sense of satisfaction from conformity with role expectation; possible punishments are shunning, shaming, or dissonance arising from the inconsistency between actions and role or identity. These social influences generate group pressure that may lead an actor to behave in accordance with the group's position, without necessarily accepting that position. By contrast, changing minds, attitudes, and opinions is the hallmark of the third micro-process of socialization: persuasion. Persuasion involves a process of cognition whereby actors become convinced that certain values, norms, and causal understandings are correct and should influence their own behavior.

I argue that this understanding of socialization, which the IR literature has heretofore applied to *state* socialization, can inform our understanding of the processes and dynamics within transnational communities of professionals. By analyzing the socialization of professionals, we will be able to better grasp the latter's role in shaping international norms and changing state behavior. Studying professional socialization, however, requires us to supplement the general understanding of socialization with insights from the sociology of professions.

Socialization takes place among members of societies or communities. The starting point for the analysis of state socialization is that states form a society in which they interact and develop shared expectations concerning appropriate behavior (Bull, 1977; Finnemore, 1996). Similarly, the classical sociological literature characterizes professions as communities whose members share a language, work conditions, paths of career progress, and status in broader society. These common experiences give rise to a common identity and a set of shared norms for conducting professional work (Goode, 1957). Indeed, recent changes in the labor market may have undermined the bases of shared experiences and identity that establish a community within an occupation. A growing range of organizational forms and employment statuses have increased the heterogeneity among workers and weakened their cohesion (Gorman and Sandefur, 2011: 286–288). Nonetheless, various professions can still be meaningfully studied as communities bound by shared values, practices, and identity (Adler et al., 2008). This is particularly true of some of the professions involved in international political processes — such as lawyers and scientists.

Which mechanisms of socialization may move professionals toward shared norms and shape the policies they promote? Among the processes of social influence that can motivate group-conforming behavior is the desire to maximize status, image, and prestige, and its corollary, the desire to avoid shaming, exclusion, or loss of status (Goodman and Jinks, 2004: 641; Johnston, 2008: 82). Actors seek to maximize status for instrumental reasons, such as the power and deference that high status may bring; yet, maximization of status and prestige may also bring psychological benefits. An actor recognized by her reference group as enjoying high status is rewarded with a sense of well-being by 'backpatting.' Contrarily, an actor judged to have violated status-related norms and practices may suffer opprobrium or shaming for breaking widely accepted rules. The desire to enjoy backpatting and to avoid opprobrium acts as an incentive to group conformity: even actors that are self-interested may exhibit pro-group behavior in order to reap social rewards and escape social sanctions.

IR scholars have often attributed to states a desire to acquire status. States' pursuit of status has been identified as a source of international conflict, as well as a motivation for states to act cooperatively and conform to international norms (Eyre and Suchman, 1996). I argue that the goal of status maximization and the social pressures it generates apply not only to states, but also to professionals: through backpatting and shaming, members of a professional community may come to support a norm that will, in turn, anchor the community's policy enterprise. In fact, professionals pursue two types of status. The first is *extra-professional status*: professionals typically wish the public to respect them and hold them in high regard. High public status and prestige can bring material benefits, such as higher pay or more clients; it can also confer the psychological benefits that come from the recognition of one's worth by others (Weeden, 2002; Zhou, 2005). Our interest here, however, is in the second type of status — *intra-professional status* — namely, the status assigned to groups and individuals within a profession *by professionals themselves* (Abbott, 1981). For example, scholars have identified prestige hierarchies for medical specialties: health-care professionals tend to rank as more prestigious those specialties that require greater time investment, those for which training is tougher and more rigorous, and those that require concrete, specific skills. Thus, surgery typically tops the prestige hierarchy in the eyes of health-care professionals, whereas dermatology and pathology rank lower (Creed et al., 2010; Norredam and Album, 2007).

Intra-professional status may bring material benefits, such as research funds or the ability to recruit qualified personnel, as well as psychological benefits, such as fulfillment and a sense of accomplishment. Seeking high status and the respect of their peers, professionals may choose to conform to the views and norms prevailing in the profession or held by an influential or prominent group within the profession. Whereas conforming to the views held by the reference group will produce a 'backpatting' effect that increases the professional's well-being, deviating from these views could result in opprobrium, shame, and a blow to self-esteem.

The social pressure to conform to the views and norms espoused by a prominent or widely respected group may gradually lead to a growing similarity of views among professionals. Such pressure can relate to substantive questions with which the profession engages: Is privatization a good policy? How great is the danger of climate change? Yet, the social pressure to conform is particularly powerful in the case of professional ethics.

The ethical norms of the profession are at once determinants of both extra- and intra-professional status. *Extra-professionally*, that is, to audiences outside the profession, codes of ethics signal the profession's commitment to high moral standards and to a disinterested service, free of ulterior motives. Codes of ethics suggest that the profession is at least formally committed to prioritizing values such as truth, justice, social welfare, and health over financial profit and narrow self-interest. *Intra-professionally*, the acceptance of and compliance with the ethical rules of the profession is positively associated with one's status in the eyes of colleagues. Compliance identifies the professional's relation to the profession as one of allegiance and collegiality, and it presents the professional as a socially responsible, virtuous, and trustworthy individual (Abbott, 1983). The adoption of an ethical code thus puts pressure on members of the profession to conform: by embracing the code and behaving in a manner that the profession highly values, professionals exhibit their moral character and enhance their status among their peers; contrarily, rejecting or violating the ethical code might portray a professional as morally flawed, diminish their status, and bring opprobrium.

Thus far, I have examined how social influence — in particular, the desire to accumulate status — may bring a professional to conform to views and norms that are widely accepted or highly valued by the professional community. Yet, such conformity may also result from another micro-process of socialization: persuasion. Successful 'persuasion occurs when target preferences change in response to a sender's appeal' (Payne, 2001: 47). The ability to persuade may depend on the target's relationship with the sender. For example, according to Lupia and McCubbins (1998), persuasion is more likely when the persuadee considers the persuader to be knowledgeable about the relevant matter and sees her intentions as trustworthy. Within a professional community, persuasion may be more probable when the norm advocate is a high-profile, authoritative member of the profession (see Johnston, 2008: 159). In addition, persuasiveness depends on the actual content and framing of the message. Successful norms are those whose framing resonates with the target audience, that is, those whose framing matches the audience's culture, values, or life experience (Busby, 2010: 50–56). New norms are also more likely to be favorably received by the target audience if they seem to be connected to already-established norms. A well-known example is the successful framing of the landmine ban in terms of the indiscriminate effects of landmines, thereby invoking the taboos against weapons of mass destruction (Payne, 2001: 38–39; Price, 1998: 628). Similarly, persuasion of professionals may be facilitated by linking a new norm to well-established norms and practices of the profession.

While this study focuses on socialization mechanisms, it should be noted that norms may also spread among professionals through *coercive means* that involve material rewards for norm conformity and punishments for nonconformity. In the interest of obtaining peer recognition and career advancement, professionals often join professional associations, present their work at conferences, and publish in journals (Rittichainuwat et al., 2001). By denying access to these venues, a professional community can put coercive pressure on its norm-breaking members.

In summary, the foregoing analysis suggests that processes of socialization may move a professional community toward shared normative beliefs. Professionals may choose to conform to the views and norms advocated by their colleagues in order to maximize

status and escape opprobrium. Alternatively, they may be persuaded that the new norms are appropriate and should guide their conduct. These intra-professional processes of socialization, in turn, greatly affect the role and impact of professionals in political processes. Intra-professional socialization determines which norms professionals will advocate to policymakers; wide acceptance of these norms *within* the profession also gives them the necessary credence and legitimacy to facilitate their acceptance by policymakers. A government may be reluctant to embrace a norm that is contested within the profession, but will find it easier to subscribe to norms that enjoy wide professional support. With the backing and approval of professionals, it should be easier for the government to establish and implement norm-consistent policies and overcome skepticism and resistance.

The remainder of this article uses the case of organ trafficking to demonstrate two major points: first, how socialization processes within a professional community can spread norms among members of the profession; and, second, how the widespread acceptance of the norms by the professional community can facilitate that community's advocacy efforts and enhance its influence on states.

International efforts against organ trafficking: Professional socialization as a foundation for a political campaign

Organ transplantation is a wonder of modern medicine, responsible for prolonging and improving countless lives worldwide. Enjoying the benefits of transplantation, however, crucially depends on the availability of human organs. Starting in the 1980s, and increasingly throughout the 1990s, the growing demand for and diminishing supply of organs fuelled an illicit trade. Unable to receive an organ through legitimate means, desperate patients may obtain organs for transplantation — usually kidneys — by buying them through brokers from other individuals; in such case, the procedure is known as *commercial transplantation*. The trade in organs can take place within national boundaries, yet the Internet and the ease of international travel and communication have facilitated a cross-border form of organ trafficking known as *transplant tourism*: patients from rich countries travel to poorer countries, where they purchase an organ from a paid donor and undergo a commercial transplantation. Like other illicit trades, organ trafficking therefore involves 'exporting countries' whose impoverished citizens sell organs, and 'importing countries' from which the organ-buying patients originate. In 2007, a WHO-commissioned study identified China, the Philippines, Pakistan, Egypt, and Colombia as major organ-exporting countries (Shimazono, 2007). The major organ-importing countries have been the rich countries of East Asia (Japan, Taiwan, South Korea, Malaysia, and Singapore) and the Middle East (Saudi Arabia and Israel in particular).

In 1987, the WHO first expressed concern at the trade for profit in human organs; in 1991, the organization issued guiding principles on transplantation that require organ donation to be altruistic and prohibit the sale or purchase of organs.[1] Yet, many of the organ-exporting and organ-importing countries failed to enact organ-trade prohibitions and provided little government regulation and oversight of transplantation

activity. Even where a ban on commercial transplantation existed, it was weakly enforced, and the authorities avoided interfering with the thriving trade in organs (Muraleedharan et al., 2006).

Governments have typically tolerated the organ trade since its negative effects are not easy to detect. At the heart of this trade lies a transaction that seems mutually beneficial: the donor receives funds that supplement a meager income, while the patient may regain their health. In reality, this transaction carriers serious risks for the paid donors as well as the patients. Following the kidney removal, paid donors often experience physical and mental health problems, which could lead to income reduction, rather than the hoped-for economic improvement. For patients, commercial transplantations could lead to surgical complications and infections and likely result in lower patient and graft survival, compared with ethically compliant transplantations (Goyal et al., 2002; Naqvi et al., 2008; Rizvi et al., 2009). Such negative effects, however, are not readily observable. The direct bearers of these effects — the donors and patients — are either unaware of the risks or desperate enough to accept them. For governments, the organ trade is an easy and immediate solution to the shortage of altruistic organ donations — a solution that relieves the health-care burden of treating kidney failure.

And yet, over the past decade, the major organ-exporting and organ-importing countries have replaced their previous indifference toward the organ trade with measures to eliminate this phenomenon (see Table 1). These measures include, first and foremost, prohibitions on commercial dealings in organs. In addition, they have sought to strengthen the regulation and oversight of transplant activity and to encourage altruistic organ donation.

How can one account for this swift diffusion of the organ-trade prohibition among countries that had previously tolerated the trade? At first sight, a conventional account of international norms might seem to provide a satisfying explanation. That conventional account — most influentially expressed by Finnemore and Sikkink (1998) — highlights the crucial role of transnational norm entrepreneurs, often working with IOs. Indeed, at the heart of the efforts against the organ trade lies a campaign coalition consisting of the community of transplant professionals and an international organization: the WHO. In 2004, concerned about the booming organ trade, the World Health Assembly called on member states 'to take measures to protect the poorest and vulnerable groups from "transplant tourism" and the sale of tissues and organs.' The Assembly also asked the WHO Director General to update the 1991 guiding principles on transplantation;[2] the updated principles were endorsed by the Assembly in 2010.[3] Following the 2004 resolution, the WHO established collaboration with the Transplantation Society (TTS), an international association of transplant professionals; several TTS leaders were appointed as WHO advisors on organ donation and transplantation. The TTS advocacy of ethical transplantation norms exhibited the familiar pattern of combined pressure, from above and below (e.g. Murdie and Davis, 2012). The leaders of the TTS, as representatives of the international medical community, called on national health authorities to eliminate the organ trade and ensure ethical transplantation practices, especially by realizing the full potential of deceased donation (Budiani-Saberi and Delmonico, 2008); this call was reinforced by local transplant physicians. The respect for physicians as professional and

Table 1. Anti-organ-trafficking measures in the major organ-exporting/importing countries.

Country	Measure
Organ-exporting countries	
Colombia	Decree on organ transplantation (2004)
China	Organ transplantation regulation (2007); principles regulating living organ donation (2009); Hangzhou Resolution (2013), calling for compliance with international ethical standards on transplantation
Pakistan	Organ transplantation law (2007 and 2010)
Moldova	Organ transplantation law (2008)
Philippines	Regulations implementing anti-human-trafficking law with respect to organ trafficking (2009)
Egypt	Organ transplantation law (2010)
India	Amendment of organ transplantation law (2011)
Brazil	Regulations concerning transplanting of organs into non-residents (2012)
South Africa	Transplant-related provisions and regulations of the National Health Act (2012)
Organ-importing countries	
Taiwan	Regulation prohibiting physician involvement in organ trafficking (2006)
Malaysia	National transplantation policy (2007); prohibition on provision of immunosuppressive drugs to patients who received commercial transplants abroad (2012)
Israel	Organ Transplantation Law (2008)
Japan	Amendment of organ transplantation law (2009)
Singapore	Amendment of organ transplantation law (2009)
Qatar	Doha Donation Accord (2010) to encourage organ donation

Sources: Danovitch and Al-Mousawi (2012) and Danovitch et al. (2013), supplemented by the author.

moral authorities (Imber, 2008) has made governments receptive to their repudiation of commercial transplantation as an unethical and detrimental practice.

The preceding account of international normative change focuses on *state* socialization: how a transnational advocacy coalition persuaded states to adopt a new norm. This standard account, however, masks a process of *professional* socialization that underlay the physicians' efforts to socialize states. As the transplant community called on states to embrace the organ-trade prohibition, the community had to close its ranks and ensure widespread support for this prohibition among transplant professionals. Such support was far from obvious; establishing it entailed socialization of the transplant community.

Socializing the transplant community

Why rally the profession?

Members of the transplant community have held a spectrum of views regarding the organ trade, and been involved with it to varying degrees. At one end are physicians

who perform commercial transplantations. These physicians play a central role in the organ trade and benefit from it financially. Other physicians do not engage in commercial transplantations and are concerned about the exploitation and risks inherent in an unregulated, clandestine organ market. Nevertheless, these latter physicians oppose the ban on organ commercialism on principled and practical grounds. They believe that the traditional objections to paid organ donation — such as commodification of the body and exploitation of the poor — do not stand up to moral scrutiny, and that providing financial incentives in a carefully regulated organ market is an ethical and necessary method for increasing the supply of organs (Halpern et al., 2010; Matas et al., 2008). Many other physicians, the majority of transplant professionals, do not actively participate in commercial transplantations, nor do they support a regulated organ market. Rather, they believe that the organ shortage should be solved through other, non-monetary means that preserve the altruistic nature of the donation (Barnieh et al., 2012; Biller-Andorno and Capron, 2011). Nonetheless, even physicians opposed to organ commercialism have often played an indirect, reluctant role in it: they have conducted checks of their patients prior to the latter's travel abroad for commercial transplantations; and upon the patients' return with a new kidney, they have provided continuing care, including immunosuppressive drugs, and treated patients suffering complications from the transplantation overseas.

Following the 2004 WHO resolution, as the TTS was called upon to assist the efforts against the organ trade, the TTS's leaders realized that eliminating the trade required action along two interrelated, mutually reinforcing tracks. The first track was government-focused: the TTS sought to assist the WHO in forming an international consensus on ethical transplantation practices and bringing governments to implement them. As a necessary complement to the efforts to influence governments, the TTS had to establish a second, profession-oriented strategy: building and enforcing *intra-professional* standards that denounce organ commercialism and promote ethical alternatives.

Why establish a shared professional position? Why was the government track not sufficient? First, intra-professional activity was needed to create change on the ground, that is, to induce health-care professionals to cease their direct or indirect participation in the organ trade. Organ trafficking, after all, is not perpetrated by state agents, but by private actors: organ brokers and, crucially, transplant professionals. Yet, governments are often reluctant to police professional communities and interfere with their internal workings. Instead, they allow professionals autonomy in establishing and enforcing their ethical requirements and use the state's enforcement power only in the most serious, publicly visible cases (Friedson, 1975). Given the low visibility of the organ trade and its negative effects, governments were unlikely to make the efforts necessary for eliminating this practice. A fundamental change on the ground required the medical profession to establish its own standards and provide a clear framework for distinguishing between ethical and unethical conduct. Such a framework would identify physicians' involvement in commercial transplantations as a transgression and would also empower ethically compliant physicians to put pressure on their transgressing colleagues and on hospital administrators: exhortations against commercial transplantations would be more potent if backed by global professional standards.[4]

A predominant anti-commercialism view within the profession was also necessary for changing *governments'* attitude to transplantation and ending their tolerance of the organ

trade. To eliminate the trade, governments had to address the persistent shortage of organs that was the trade's cause. The WHO thus encouraged governments to increase deceased organ donations through educational initiatives, and by providing the medical and administrative infrastructure for maximizing donations (Delmonico et al., 2011). The intra-professional endeavors were a necessary reinforcement of the WHO's government-focused efforts, since physicians are key actors in health-care policymaking (Immergut, 1990). In reforming transplantation policies, governments were likely to consult local physicians and make sure that they approved of the proposed changes. Local physicians' endorsement of the efforts against organ trafficking would have facilitated government support for these efforts; by contrast, resistance on the part of local physicians would likely have hindered the change of government policy.[5] Furthermore, since organ trafficking is a crime involving health-care professionals, the medical community had to put its own house in order before urging governments to act. The medical community's denunciation of organ trafficking and commitment to its eradication would, in turn, legitimize the community's demands from governments. Armed with global professional standards, the community's call for government action would be more forceful and credible.

In short, combating the organ trade requires standards that are developed, owned, and endorsed by the medical profession. Such standards are meant to express the prevailing ethical view of the transplant community, identify those defying this view, and provide leverage for pressuring them. These standards are also a tool to mobilize the community for political action and convince governments that eliminating the organ trade is necessary and feasible. *Socialization aimed at establishing and spreading professional norms thus had to take place in tandem with the efforts to socialize states*. How did the anti-trafficking norm manage to gain wide adherence among transplant professionals?

Social influence

Shaming and opprobrium played a part in fostering conformity with the transplant community's standards. Specifically, physicians from countries identified as 'hotspots' of organ trafficking sensed that their own standing within the transplant community was diminished due to their countries' involvement in the organ trade. These physicians were themselves committed to ethical transplant practices and bore no responsibility for the organ trade; however, having come from countries where government officials and health-care professionals facilitated or participated in the trade, they felt ashamed and embarrassed before their international colleagues. As discussed earlier, professionals are concerned for their intra-professional status, especially regarding ethics-related issues. Indeed, the threat to their status and the sense of embarrassment before their colleagues mobilized the physicians. To repair their country's reputation and protect their own, they urged their respective governments to curb the organ trade. As the following examples demonstrate, the transplant community's social pressure motivated the physicians to make political demands and gave them leverage in their dealings with their governments.

In the 1990s and 2000s, Israel was a major organ-importing country: Israeli transplant tourists went as far as Turkey and the Philippines to undergo commercial transplantations of organs bought from locals. One cause of Israeli transplant tourism was the severe

organ shortage in Israel due to the low rate of organ donation. Another cause was an official policy, approved by the Ministry of Health, of reimbursing patients for commercial transplantations performed abroad. Using public funds, the non-profit Health Maintenance Organizations (HMOs) covered most of the cost of these transplantations, despite knowing them to be illegal in the countries where they were performed. The reimbursement policy allowed desperate kidney patients to regain their health immediately, rather than languish on the transplant wait list; it also allowed the state and the HMOs to save costs: paying for a one-off transplantation overseas was far cheaper than funding an extremely expensive and indefinite dialysis treatment. By making transplant tourism affordable, the reimbursement policy significantly increased the number of Israeli patients who traveled overseas in pursuit of organs (Efrat, 2013; Mor, no date).

The reimbursement policy made Israel a target of criticism within the transplant community since the early 2000s. Unlike other governments that passively tolerated the organ trade, the Israeli government actively facilitated the trade by providing funds through the HMOs. In medical conferences, Israeli transplant physicians felt ashamed before their colleagues: Israel was singled out for condemnation in nearly every panel discussion of ethics.[6] The feelings of embarrassment and shame motivated the Israeli physicians to take political action: they alerted the Ministry of Health to the criticism of Israel within medical circles and demanded an end to the reimbursement policy. Concerned for Israel's image within the world medical community, the ministry initiated a legislative process that culminated in the 2008 passage of the Organ Transplantation Law (Efrat, 2013). The law prohibits Israelis from being involved in transplantations that include payment for an organ and bans the HMOs from funding such transplantations overseas. The result has been a precipitous decline in the number of Israelis who receive transplants abroad (Lavee et al., 2013).

It is important to note that the Israeli physicians had concerns about the organ trade and their country's role in it regardless of the criticism by the international medical community. The physicians believed that transplant tourism is an exploitative practice; having treated returning transplant tourists, they had seen themselves that commercial transplantations, often performed in substandard conditions, could result in serious medical complications rather than improved health. Yet, it was their international colleagues' criticism that served as a catalyst for political action, leading the Israeli physicians to translate their concerns into pressure for legislation and deep involvement in the legislative process. The social pressure within the medical community created a sense of urgency and gave the physicians leverage vis-a-vis government authorities: Israel had to cease its support for the organ trade to rehabilitate its reputation within the international medical community.[7] This case thus demonstrates how professional socialization can facilitate an official policy change. As norms gain wide adherence within the professional community, members of the community may be motivated to bring their governments into conformity with these norms; they use the norms' acceptance within the profession as a justification for an official policy change.

Shaming had a similar catalytic effect in the case of Pakistan, a major organ-exporting country where impoverished individuals had been selling their kidneys to rich patients, especially from Arab countries. In the mid-2000s, a group of physicians based at the Sindh Institute of Urology and Transplantation (SIUT) — a public health-care

institution — launched a campaign against the flourishing organ trade in the private hospitals of Punjab. Like their Israeli counterparts, the SIUT physicians were primarily motivated by their view of the organ trade as an immoral practice that carries serious risks for both the paid donors and the patients (Naqvi et al., 2008; Rizvi et al., 2009). Yet, the social pressure from within the international medical community provided further motivation: at professional conferences, the Pakistani physicians were being identified as coming from 'the country that sells kidneys.' The SIUT physicians used Pakistan's poor image within the international medical community as ammunition: it reinforced their demand that the government pass legislation prohibiting organ trafficking.[8] That legislation was indeed enacted in 2007.

In short, the desire to preserve their status within the medical community and to avoid the social sanctions that come from being associated with the organ trade mobilized physicians for political action. Physicians tend to identify themselves as members of a prestigious club committed to ethical behavior, and wish to be recognized by their peers as members in good standing of that club: 'In the medical profession, people care about what other professionals think about you; no one wants to be ostracized professionally from their colleagues.'[9] However, faced with criticism of their countries' conduct, physicians from 'organ-trade hotspots' felt a threat to their status and reputation. As a senior transplant physician put it, 'I have a position, I have prestige that I have to take care of. Would I like to come to one of these [international medical] meetings and be seen as "the guy who's in charge of organ trafficking"?'[10] Social pressure and professional acceptance — 'We all want to be respected by our colleagues'[11] — have thus been important drivers of the medical community's efforts against organ trafficking.

Persuasion

The efforts to forge an anti-trafficking norm within the international medical community involved not only social influence, but also active attempts at persuasion: to convince members of the community that organ trafficking is an immoral and detrimental practice that must be eliminated. The literature suggests that persuasion is more likely when the persuader is a highly authoritative member of a small in-group to which the persuadee also belongs; personal, face-to-face interaction may also generate the trust and affect that may lead to persuasion (Checkel, 2001: 222; Johnston, 2008: 158–159). Leaders of the TTS — including Professor Francis Delmonico of Boston and Professor Jeremy Chapman of Sydney, Australia — indeed took this route to persuasion. Building on their status as highly authoritative and well-respected members of the transplant community, they traveled worldwide to meet with transplant professionals. In these face-to-face meetings, they made the case for ethical transplantation policies and called for action. Another means of making this case was via publications in medical journals (Budiani-Saberi and Delmonico, 2008; Delmonico et al., 2011).

The most significant effort at persuasion and mobilization of the transplant community was the 2008 promulgation of the Declaration of Istanbul on Organ Trafficking and Transplant Tourism (hereinafter, the Declaration or DoI): a code of conduct for healthcare professionals and health authorities that is the fruit of collaboration between the TTS and the International Society of Nephrology (ISN). The Declaration defines organ trafficking, transplant commercialism, and transplant tourism and calls for their

prohibition and penalization. It also urges the establishment of laws and policies to maximize legitimate organ donation from deceased and living donors (Transplantation Society and International Society of Nephrology, 2008).

The DoI was meant as both a principled document and a plan of action to be implemented by medical professionals and governments. To ensure broad acceptance and implementation, the Declaration had to be widely seen as legitimate and to resonate with the relevant audiences. The legitimacy and resonance of the document were established in several ways. The engine behind the Declaration was a Steering Committee that was culturally diverse, every region of the world with transplantation programs being represented. The committee drafted a declaration for consideration by a larger group of participants at a summit meeting and assembled a list of participants that included medical professionals, alongside government representatives and social scientists. The summit's 152 participants were also geographically diverse, being drawn from 78 countries, and reflected a pluralism of views: whereas many of them opposed any kind of transplant commercialism, others were in favor of a regulated organ market (Steering Committee of the Istanbul Summit, 2008). At the summit, held in Istanbul between 30 April and 2 May 2008, each of several work groups considered a section of the draft declaration and proposed revisions. The groups' outcomes were then presented to all summit participants for deliberation in plenary sessions. The participants ultimately reached agreement — for example, rejecting the view of those who favored a regulated organ market — and produced the final text of the Declaration.

The choice of Istanbul as a venue for the summit was aimed at broadening the normative appeal of its outcome document. Istanbul is a symbol of multiculturalism: the meeting place of East and West and a melting pot of Islam and Christianity. A declaration coming out of Istanbul was more likely to be viewed as expressing a global consensus, rather than a Western imposition.[12] The choice of the document's title — the 'Declaration of Istanbul' — was a conscious attempt at grafting (Price, 1998), that is, amplifying the impact of the new transplantation norms by invoking older and well-established norms within the medical community: those set by the Declaration of Helsinki.

Adopted in 1964 and since revised several times, the Declaration of Helsinki is a statement of ethical principles to guide physicians and other participants in medical research involving human subjects. The drafters of the Declaration of Istanbul identified parallels between their vision of the ethics of transplantation and the Declaration of Helsinki's research ethics. First, the Declaration of Helsinki evolved from the 1947 Nuremburg Code, which responded to the abuse of human rights by the Nazis in the name of scientific research. Similarly, the need for stating the ethics of transplantation arose from human rights violations against vulnerable individuals who had been improperly induced to donate a kidney. Second, the Declaration of Helsinki states that physicians must protect the life, health, and dignity of the human subject, and that the latter's well-being takes precedence over the interests of society. This was consistent with the ethical premise of the efforts against the organ trade: concern for the well-being of the living donors, which should not be sacrificed for the sake of the organ recipients. Third, the Declaration of Helsinki makes clear that the subject's consent is not a free license that relieves the medical professional of their responsibility, and it requires that its protections of human subjects be universally respected. An ethical transplantation practice should do the same (Danovitch, 2008).

By naming the code of ethical transplantation practices the 'Declaration of Istanbul,' its drafters meant to echo the Declaration of Helsinki and bestow upon the new document some of the normative force of its older counterpart.[13] The Declaration of Helsinki expresses a global consensus among medical professionals and has become the cornerstone of clinical research: no clinical trial can receive funding without being Helsinki-compliant (Carlson et al., 2004). Similarly, the drafters of the DoI wished to signal that this document embodies the prevailing professional view that would become the ethical foundation of organ donation and transplantation. Grafting — a technique familiar from the efforts to socialize states — thus played a role in the process of socializing the international transplant community. So did the framing of the anti-organ commercialism principles. Explicitly referencing the Universal Declaration of Human Rights, the Declaration of Istanbul declares organ trafficking and transplant tourism to be contrary to equity, justice, and human dignity; it emphasizes the poverty and vulnerability of donors and identifies them as victims. Issues involving physical harm to vulnerable individuals tend to resonate strongly (Keck and Sikkink, 1998: 27); the use of this frame, alongside the justice and human rights frame, was intended to counter the alternative frames advocated by organ-commercialism proponents, such as the autonomy of the donor and market efficiency (Epstein, 2009).

To encourage the implementation of the Declaration of Istanbul, the TTS and ISN established the Declaration of Istanbul Custodian Group (DICG) as an overseeing body in 2010. The DICG uses various means to promote implementation, such as: urging health authorities to take action against transplant centers and physicians in cases of suspected trafficking; asking research-funding agencies and scientific-journal editors to ensure adherence to the Declaration in studies funded and articles published;[14] and asking pharmaceutical companies to ensure compliance with the DoI when backing a clinical trial (Danovitch and Al-Mousawi, 2012). Most importantly, the DICG encourages endorsement of the Declaration by regional and national professional societies associated with transplantation medicine, and it urges endorsing organizations to apply the ethical principles of the Declaration through various mechanisms, such as membership criteria or a requirement that conference papers be based on clinical and research activities that are consistent with the DoI. Given their limited membership, these societies are better equipped for monitoring and enforcing standards than is a global association such as the TTS[15] (Oye, 1985). Furthermore, the endorsement and implementation by professional societies, it was hoped, would produce a ripple effect vis-a-vis governments and health authorities: the endorsement would signal wide public and professional support for the Declaration and thus encourage its implementation in legislation and official policy. *In other words, a normative view widely accepted by professionals was thought to facilitate the profession's efforts to socialize states* (Danovitch et al., 2013). As of 2014, the DoI has been endorsed by approximately 100 medical organizations at the regional or national level. The WHO's guiding principles on transplantation, as revised in 2010, are consistent with the Declaration.

Conditions conducive to socialization

The preceding analysis has documented a process through which the anti-trafficking norm has achieved predominance within the transplant community. It should be noted,

however, that this process was neither complete nor inevitable. In fact, socialization theory would lead us to expect a *divergent impact* of socialization mechanisms on different members of the profession. The persuasiveness of a message, for instance, depends on the persuadee's existing views and whether the persuadee belongs to the in-group of which the norm entrepreneur is an authoritative member. Actors are more sensitive to social influence the more they are concerned for their reputation and status and when they consider the reference group legitimate and care about its opinion (Johnston, 2008: 84, 157–159; Shelby, 1986).

In the context of transplantation, physicians employed in the public health sector are generally committed to public welfare (Delfgaauw, 2007) and thus may be more receptive to the arguments against organ trafficking than physicians working in the private health sector. Physicians also vary in their international engagement: some physicians receive training abroad, attend international conferences, and interact regularly with members of the international transplant community. This interaction should make them more susceptible to persuasion by prominent members of that community; it also makes them vulnerable to social influence, as they are concerned for their reputation in the eyes of the community. By contrast, less internationally oriented physicians are less likely to be influenced by the international transplant community — a community with which they have limited interaction and whose approval they do not seek. Finally, the impact of socialization-based influences also depends on the strength of the countervailing material interests and pressures. Physicians who are involved in commercial transplantations and benefit from the organ trade are more likely to resist social pressures that threaten a lucrative practice. This reinforces the aforementioned distinction between the public and private health-care sectors. In developing countries, private hospitals are weakly regulated compared to public hospitals (García-Prado and González, 2011); commercial transplantations thus typically take place in private hospitals, making their physicians less responsive to socialization mechanisms.

There is some evidence to support these expectations. Consider the case of Pakistan. As discussed earlier, the advocates of ethical transplantation practices in Pakistan were physicians at SIUT — a *public* health-care institution committed to serving the country's poor. These physicians, led by SIUT Director Professor Adib Rizvi, were deeply engaged with the international medical community and participated in the summit that produced the DoI. By contrast, resistance to the efforts against the Pakistani organ trade came from the physicians who participated in and benefited from this practice: physicians in the *private* hospitals of Punjab, who had little contact with the international transplant community (Moazam, 2011). The important point is that professional socialization, much like state socialization, may have a *divergent impact*: whereas some actors are more easily socialized into accepting new norms, others are less susceptible to socialization and could maintain their resistance to these norms.

Coercion

Coercive tools may also serve to spread norms among professionals. The transplant community reserved the exercise of overt coercion to the most severe case of transplant commercialism: China. Since the late 1980s, various sources indicated that the primary source of organs in the Chinese transplant programs was executed prisoners, and this was

confirmed by the Chinese government (Shi and Chen, 2011). This practice raises numerous ethical problems, including concerns that an organ donation by a prisoner facing the death penalty was not truly voluntary, and that the financial gain from transplanting prisoners' organs would motivate more executions. To condemn this practice and put pressure on the physicians participating in it, the TTS determined in 2006 that physicians involved in obtaining or transplanting organs from executed prisoners would be barred from becoming members. Additionally, studies involving patient data from recipients of organs from executed prisoners would not be accepted for presentation at TTS meetings, and TTS members were prohibited from collaborating in such studies. Clinical trainees from China would be accepted only if they agreed to comply with TTS standards throughout their careers (Tibell, 2007). In the following years, an increasing number of medical journals prohibited the publication of manuscripts whose data come from transplants involving organs obtained from executed prisoners.[16]

By withholding academic prestige and professional recognition from transplant professionals whose conduct is deemed morally reprehensible, the transplant community sought to signal to those professionals — and to their government — that there is a price for violating ethical standards. The professional ostracization of those involved in obtaining organs from executed prisoners was seen as a means of pressure at the disposal of the transplant community and a signal of its resolve to eliminate this practice (Danovitch et al., 2011). Similar to socialization, however, the effectiveness of coercion is not assured: it requires a significant number of physicians with international ties who would be vulnerable to pressure that threatens to sever these ties; it also requires government officials who care enough about such ties to change policy. An example of the latter is China's Health Minister Li Bin, who had expressed concern about the exclusion of Chinese transplant professionals from international academic exchange. This concern was among her motivations for supporting the 2013 Hangzhou Resolution that aims at the cessation of the use of organs from executed prisoners.[17]

Socialization within the medical community: Implications and conclusions

The international transplant community has gone through a process of socialization aimed at establishing a shared view among its members and mobilizing them for action against the organ trade. I have argued that the purpose of this process was not only to transform professional practice, but also to influence governments and effect official policy change: acceptance of ethical transplantation norms by the transplant community was necessary for bringing states to embrace these norms. To what extent has the goal of *political* norm change been achieved?

The transplant community managed to place organ trafficking on the political agenda and bring governments to take measures against it — including in countries that had been *the* centers of organ trafficking and transplant tourism. Legislative changes in the Philippines in 2008/2009 nearly eliminated incoming transplant tourism, and Pakistan's transplant legislation has considerably reduced the number of commercial transplants performed there (Padilla et al., 2013; Rizvi et al., 2011). Israel has stopped the official

funding of transplant tourism; instead, taking action to increase local organ donations (Lavee et al., 2013). Similar changes in policies and practices have occurred in various other countries (Abraham et al., 2012; Danovitch et al., 2013). The transplant community brought about these reforms by building support for a set of professional ethical standards and using them as a foundation for a political advocacy campaign. The pressure from local and international physicians, reinforced by media coverage of the organ trade, resulted in major policy changes and a reduction of the organ trade.

The picture, however, is not entirely rosy, since socialization and coercion may influence some professionals but not others. While the principles of the DoI have received broad support, there are still voices within the transplant community who call for a regulated organ market, defying the norm that requires altruistic donations. Some profit-seeking physicians continue to perform commercial transplantations, notwithstanding the social pressure and persuasive influence of the transplant community. In Egypt, the 2010 prohibition on organ trafficking has seen little enforcement in the unstable political environment that followed the 2011 revolution. In China, the transplant community's efforts have had a limited effect. High-ranking Chinese officials have indeed brought attention to the community's repudiation of the practice of using organs from executed prisoners, and the Chinese authorities have stated their intention to cease this practice and develop an ethical organ-donation system. However, while steps in this direction have been made (Wang, 2012), the use of organs from executed prisoners persists.

While the organ trade has not yet been eliminated, the international community has certainly made important progress toward achieving this goal. Previously indifferent to organ trafficking and transplant tourism, governments have come to recognize these practices as problems and have taken measures to curb them. Underlying this change of *political* norms is the move toward shared *professional* norms within the international medical community. The socialization of transplant professionals has laid the foundation for the socialization of states.

How generalizable are this study's argument and findings? A possible challenge comes from changes in the realities of professionalism. Today, many professionals work in organizations, rather than in solo practice, and these organizations typically have hierarchical attributes and come under growing market pressure. Some have argued that the rise of markets and hierarchy has resulted in the decline of professionalism and professional communities (Pfadenhauer, 2006). This would make community-based professional socialization less common. Yet, professional communities still exist, as they are a tool for creating and sharing knowledge. As Adler, Kwon, and Heckscher (2008) argue, knowledge workers require a community in which to learn skill sets and continually advance and share information about innovations and practice-based insights. While evolving in form in the modern economy, professional communities persist, especially in knowledge-intensive contexts. Thus, socialization processes similar to the one studied here may take place in other cases as well.

One might also question the political influence of a unified professional community. Most notably, the scientific community has long been in consensus regarding the impact of human activities on the Earth's climate (Oreskes, 2004); that consensus, however, has

not led to decisive political action to address climate change. Yet, the case of climate change is not inconsistent with the argument presented here. I have argued that a shared view can enhance the profession's policy impact; however, it does not *guarantee* such an impact. If the policy problem is particularly difficult to tackle, or if influential stakeholders seek to block policy change, a professional consensus may not suffice. Indeed, the enormous costs of mitigating climate change and the fierce resistance of powerful industries have diminished the impact of scientific evidence. The scientific community has placed climate change on the international agenda, but could not overcome the political challenges to an effective solution. By contrast, scientific consensus on the ozone problem has proven more influential, leading to an effective global regime addressing ozone depletion. The ozone problem was easier and less costly to tackle than climate change, and neither industry nor consumers opposed the change of policy (Bernauer, 2013; Canan and Reichman, 2002). In that sense, organ trafficking is closer to the ozone problem than to climate change. Compared to other illicit trades, such as in drugs or counterfeit goods, the organ trade is a relatively small-scale phenomenon[18] that financially benefits only a small group of physicians and brokers; furthermore, trade participants — paid donors, organ-buying patients, and physicians — are easy to identify and track down (Gill et al., 2008; Naqvi et al., 2008; Rizvi et al., 2009). This made the organ trade relatively simple to suppress and increased governments' receptiveness to the medical community's anti-trade advocacy. When the costs of policy change are high and the opponents of change are powerful, professionals' influence might be smaller than it has been in the case of organ trafficking.

The concept of professional socialization as theorized in this article can be fruitfully applied to the study of scientific communities. According to Kuhn (2012 [1962]: 94), scientific debates over paradigm choice are shaped by logic and experiment, as well as by techniques of effective argumentation. The analysis here suggests that social influence — driven by the pursuit of status — and even coercion may also be at work in such debates. For the study of international relations, this article has demonstrated the broad applicability and utility of the concept of socialization. While existing literature focuses on *state* socialization as the driver of international normative change, I have argued that socialization among non-state actors may also play an important role in norm dynamics. Specifically, socialization is a fruitful lens through which to analyze professional communities. Various social mechanisms within these communities can move professionals toward shared views, motivate their political involvement, and shape the norms that they advocate. Given the key role of professionals in policy design and implementation, understanding professional socialization is of value for the analysis of political change.

Acknowledgments

I thank Arie Kacowicz and two anonymous reviewers for their helpful comments.

Funding

This study has benefited from funding provided by the European Union's Seventh Framework Programme.

Notes

1. WHO Guiding Principles on Human Organ Transplantation, endorsed by WHA 44.25, Human Organ Transplantation, 13 May 1991.
2. WHA 57.18, Human Organ and Tissue Transplantation, 22 May 2004.
3. WHA 63.22, Human Organ and Tissue Transplantation, 21 May 2010.
4. Author's interview with Professor Jeremy Chapman, transplant physician and past president of the TTS, in Berlin, July 2012.
5. Author's interview with Dr Rudolf Garcia-Gallont, transplant physician and TTS Council member, in Berlin, July 2012.
6. Author's interview with Professor Jay Lavee, director of the Heart Transplantation Unit at the Sheba Medical Center, in Ramat Gan, May 2012; author's interview with Professor Eytan Mor, director of the Department of Transplantation at the Rabin Medical Center, in Petach Tikva, June 2012.
7. Interviews with Lavee and Mor (see note 6).
8. Author's interview with Professor Farhat Moazam, SIUT, June 2012.
9. Author's interview with Professor Gabriel Danovitch, transplant physician and TTS Secretary, in Berlin, July 2012.
10. Personal interview with author.
11. Interview with Danovitch (see note 9).
12. Interview with Chapman (see note 4).
13. Interview with Chapman (see note 4).
14. Several journals, such as *Transplant International* and *Transplantation*, have adopted policies that require all articles submitted to be consistent with the DoI.
15. As of 2014, the TTS has 6500 members, at least 80% of whom are physicians.
16. See, for example, the publication policy of the *American Journal of Transplantation*, the transplant community's flagship journal.
17. See the website of the DoI. Available at: http://www.declarationofistanbul.org/ (accessed 26 January 2014).
18. The estimated annual number of commercial transplantations is 10,000 — roughly 10% of all transplantations. See World Health Organization (2007) and Campbell and Davison (2012). The United Nations Office on Drugs and Crime (UNODC, 2012) suggests that trafficking for organ removal is much less prevalent than other forms of human trafficking.

References

Abbott A (1981) Status and status strain in the professions. *American Journal of Sociology* 86(4): 819–835.

Abbott A (1983) Professional ethics. *American Journal of Sociology* 88(5): 855–885.

Abraham G, Reddy YNV, Amalorpavanathan J, et al. (2012) How deceased donor transplantation is impacting a decline in commercial transplantation — the Tamil Nadu experience. *Transplantation* 93(8): 757–760.

Adler PS, Kwon SW, and Heckscher C (2008) Professional work: The emergence of collaborative community. *Organization Science* 19(2): 359–376.

Barnieh L, Klarenbach S, Gill JS, et al. (2012) Attitudes toward strategies to increase organ donation: Views of the general public and health professionals. *Clinical Journal of the American Society of Nephrology* 7(12): 1956–1963.

Bernauer T (2013) Climate change politics. *Annual Review of Political Science* 16: 421–448.

Biller-Andorno N and Capron AM (2011) 'Gratuities' for donated organs: Ethically indefensible. *The Lancet* 377(9775): 1390–1391.

Bloodgood EA and Schmitz HP (2013) The INGO research agenda: A community approach to challenges in method and theory. In: Reinalda B (ed.) *Routledge Handbook of International Organization*. London: Routledge, pp. 67–79.

Bob C (2005) *The Marketing of Rebellion: Insurgents, Media, and International Activism*. New York, NY: Cambridge University Press.

Budiani-Saberi DA and Delmonico FL (2008) Organ trafficking and transplant tourism: A commentary on the global realities. *American Journal of Transplantation* 8(5): 925–929.

Bull H (1977) *The Anarchical Society: A Study of Order in World Politics*. New York, NY: Colombia University Press.

Burley AM and Mattli W (1993) Europe before the court: A political theory of legal integration. *International Organization* 47(1): 41–76.

Busby JW (2010) *Moral Movements and Foreign Policy*. New York, NY: Cambridge University Press.

Campbell D and Davison N (2012) Illegal kidney trade booms as new organ is 'sold every hour.' *The Guardian*, 27 May.

Canan P and Reichman N (2002) *Ozone Connections: Expert Networks in Global Environmental Governance*. Sheffield: Greenleaf Publishing.

Carlson RV, Boyd KM, and Webb DJ (2004) The revision of the Declaration of Helsinki: Past, present and future. *British Journal of Clinical Pharmacology* 57(6): 695–713.

Checkel JT (2001) A constructivist research program in EU studies? *European Union Politics* 2(2): 219–249.

Cooley A and Ron J (2002) The NGO scramble: Organizational insecurity and the political economy of transnational action. *International Security* 27(1): 5–39.

Creed PA, Searle J, and Rogers ME (2010) Medical specialty prestige and lifestyle preferences for medical students. *Social Science & Medicine* 71(6): 1084–1088.

Danovitch GM (2008) From Helsinki to Istanbul: What can the transplant community learn from experience in clinical research? *Nephrology Dialysis Transplantation* 23(4): 1089–1092.

Danovitch GM and Al-Mousawi M (2012) The Declaration of Istanbul — early impact and future potential. *Nature Reviews Nephrology* 8: 358–361.

Danovitch GM, Shapiro ME, and Lavee J (2011) The use of executed prisoners as a source of organ transplants in China must stop. *American Journal of Transplantation* 11(3): 426–428.

Danovitch GM, Chapman J, Capron AM, et al. (2013) Organ trafficking and transplant tourism: The role of global professional ethical standards — the 2008 Declaration of Istanbul. *Transplantation* 95(11): 1306–1312.

Delfgaauw J (2007) Dedicated doctors: Public and private provision of health care with altruistic physicians. Tinbergen Institute Discussion Paper No. 2007–010/1. Available at: http://ssrn.com/abstract=958693 or http://dx.doi.org/10.2139/ssrn.958693

Delmonico FL, Domínguez-Gil B, Matesanz R, et al. (2011) A call for government accountability to achieve national self-sufficiency in organ donation and transplantation. *The Lancet* 378(9800): 1414–1418.

Dezalay Y and Garth BG (2002) *The Internationalization of Palace Wars: Lawyers, Economists, and the Contest to Transform Latin American States*. Chicago, IL: University of Chicago Press.

Djelic ML and Quack S (2010) Transnational communities: Shaping global economic governance. In: Djelic ML and Quack S (eds) *Transnational Communities: Shaping Global Economic Governance*. New York, NY: Cambridge University Press, pp. 3–36.

Efrat A (2013) The rise and decline of Israel's participation in the global organ trade: Causes and lessons. *Crime, Law and Social Change* 60(1): 81–105.

Epstein M (2009) Sociological and ethical issues in transplant commercialism. *Current Opinion in Organ Transplantation* 14(2): 134–139.

Eyre DP and Suchman MC (1996) Status, norms, and the proliferation of conventional weapons: An institutional theory approach. In: Katzenstein PJ (ed.) *The Culture of National Security: Norms and Identity in World Politics*. New York, NY: Columbia University Press, pp. 79–113.

Finnemore M (1996) *National Interests in International Society*. Ithaca, NY: Cornell University Press.

Finnemore M and Sikkink K (1998) International norm dynamics and political change. *International Organization* 52(4): 887–917.

Flockhart T (2006) 'Complex socialization': A framework for the study of state socialization. *European Journal of International Relations* 12(1): 89–118.

Friedson E (1975) *Doctoring Together*. Chicago, IL: University of Chicago Press.

García-Prado A and González P (2011) Whom do physicians work for? An analysis of dual practice in the health sector. *Journal of Health Politics, Policy and Law* 36(2): 265–294.

Gill J, Madhira BR, Gjertson D, et al. (2008) Transplant tourism in the United States: A single-center experience. *Clinical Journal of the American Society of Nephrology* 3(6): 1820–1828.

Goode WJ (1957) Community within a community: The professions. *American Sociological Review* 22(2): 194–200.

Goodman R and Jinks D (2004) How to influence states: Socialization and international human rights law. *Duke Law Journal* 54(3): 621–703.

Gorman EH and Sandefur RL (2011) 'Golden age,' quiescence and revival: How the sociology of professions became the study of knowledge-based work. *Work and Occupations* 38(3): 275–302.

Goyal M, Mehta RL, Schneiderman LJ, et al. (2002) Economic and health consequences of selling a kidney in India. *JAMA* 288(13): 1589–1593.

Haas PM (1992) Introduction: Epistemic communities and international policy coordination. *International Organization* 46(1): 1–35.

Halpern SD, Raz A, Kohn R, et al. (2010) Regulated payments for living kidney donation: An empirical assessment of the ethical concerns. *Annals of Internal Medicine* 152(6): 358–365.

Imber JB (2008) *Trusting Doctors: The Decline of Moral Authority in American Medicine*. Princeton, NJ: Princeton University Press.

Immergut EM (1990) Institutions, veto points, and policy results: A comparative analysis of health care. *Journal of Public Policy* 10(4): 391–416.

Johnston IA (2008) *Social States: China in International Institutions, 1980–2000*. Princeton, NJ: Princeton University Press.

Keck ME and Sikkink K (1998) *Activists beyond Borders: Advocacy Networks in International Politics*. Ithaca, NY: Cornell University Press.

Kogut B and Macpherson JM (2011) The mobility of economists and the diffusion of policy ideas: The influence of economics on national policies. *Research Policy* 40(10): 1307–1320.

Kuhn TS (2012 [1962]) *The Structure of Scientific Revolutions* (4th edn). Chicago, IL: University of Chicago press.

Lavee J, Ashkenazi T, Stoler A, et al. (2013) Preliminary marked increase in the national organ donation rate in Israel following implementation of a new organ transplantation law. *American Journal of Transplantation* 13(3): 780–785.

Lupia A and McCubbins MD (1998) *The Democratic Dilemma: Can Citizens Learn What They Need to Know?* Cambridge and New York, NY: Cambridge University Press.

Markoff J and Montecinos V (1993) The ubiquitous rise of economists. *Journal of Public Policy* 13(1): 37–68.

Matas AJ, Hippen B, and Satel S (2008) In defense of a regulated system of compensation for living donation. *Current Opinion in Organ Transplantation* 13(4): 379–385.
Moazam F (2011) Sharia law and organ transplantation: Through the lens of Muslim jurists. *Asian Bioethics Review* 3: 316–332.
Mor E. Transplant tourism in Israel: Effect on transplant practice and organ donation. Unpublished manuscript.
Muraleedharan VR, Jan S, and Prasad SR (2006) The trade in human organs in Tamil Nadu: An anatomy of regulatory failure. *Health Economics, Policy and Law* 1(1): 41–57.
Murdie AM and Davis DR (2012) Shaming and blaming: Using event data to assess the impact of human rights INGOs. *International Studies Quarterly* 56(1): 1–16.
Naqvi SAA, Rizvi SAH, Zafar MN, et al. (2008) Health status and renal function evaluation of kidney vendors: A report from Pakistan. *American Journal of Transplantation* 8(7): 1444–1450.
Nelson RH (1987) The economics profession and the making of public policy. *Journal of Economic Literature* 25(1): 49–91.
Norredam M and Album D (2007) Prestige and its significance for medical specialties and diseases. *Scandinavian Journal of Public Health* 35(6): 655–661.
Oreskes N (2004) The scientific consensus on climate change. *Science* 306(5702): 1686.
Oye KA (1985) Explaining cooperation under anarchy: Hypotheses and strategies. *World Politics* 38(1): 1–24.
Padilla B, Danovitch GM, and Lavee J (2013) Impact of legal measures to prevent transplant tourism: The interrelated experience of the Philippines and Israel. *Medicine, Health Care and Philosophy* 16(4): 915–919.
Payne RA (2001) Persuasion, frames and norm construction. *European Journal of International Relations* 7(1): 37–61.
Pfadenhauer M (2006) Crisis or decline? Problems of legitimation and loss of trust in modern professionalism. *Current Sociology* 54(4): 565–578.
Prakash A and Gugerty MK (eds) (2010) *Advocacy Organizations and Collective Action*. New York, NY: Cambridge University Press.
Price R (1998) Reversing the gun sights: Transnational civil society targets land mines. *International Organization* 52(3): 613–644.
Rittichainuwat BN, Beck JA, and Lalopa J (2001) Understanding motivations, inhibitors, and facilitators of association members in attending international conferences. *Journal of Convention & Exhibition Management* 3(3): 45–62.
Rizvi SAH, Naqvi SAA, Zafar MN, et al. (2009) Commercial transplants in local Pakistanis from vended kidneys: A socio-economic and outcome study. *Transplant International* 22(6): 615–621.
Rizvi SAH, Naqvi SAA, Zafar MN, et al. (2011) A renal transplantation model for developing countries. *American Journal of Transplantation* 11(11): 2302–2307.
Shelby AN (1986) The theoretical bases of persuasion: A critical introduction. *Journal of Business Communication* 23(1): 5–29.
Shi BY and Chen LP (2011) Regulation of organ transplantation in China: Difficult exploration and slow advance. *JAMA* 306(4): 434–435.
Shimazono Y (2007) The state of the international organ trade: A provisional picture based on integration of available information. *Bulletin of the World Health Organization* 85(12): 955–962.
Steering Committee of the Istanbul Summit (2008) Organ trafficking and transplant tourism and commercialism: The Declaration of Istanbul. *The Lancet* 372(9632): 5–6.
Stroup SS and Wong WH (2013) Come together? Different pathways to international NGO centralization. *International Studies Review* 15(2): 163–184.

Tibell A (2007) The Transplantation Society's policy on interactions with China. *Transplantation* 84(3): 292–294.

Towns AE (2010) *Women and States: Norms and Hierarchies in International Society*. New York, NY: Cambridge University Press.

Transplantation Society and International Society of Nephrology (2008) The Declaration of Istanbul on Organ Trafficking and Transplant Tourism. *Nephrology Dialysis Transplantation* 23(11): 3375–3380.

UNODC (United Nations Office on Drugs and Crime) (2012) *Global Report on Trafficking in Persons 2012*. Vienna: UNODC.

Van Waarden F and Drahos M (2002) Courts and (epistemic) communities in the convergence of competition policies. *Journal of European Public Policy* 9(6): 913–934.

Verdun A (1999) The role of the Delors Committee in the creation of EMU: An epistemic community? *Journal of European Public Policy* 6(2): 308–328.

Wang H (2012) New era for organ donation and transplant in China. *Bulletin of the World Health Organization* 90(11): 802–803.

Weeden KA (2002) Why do some occupations pay more than others? Social closure and earnings inequality in the United States. *American Journal of Sociology* 108(1): 55–101.

Weymouth S and Macpherson JM (2012) The social construction of policy reform: Economists and trade liberalization around the world. *International Interactions* 38(5): 670–702.

World Health Organization (2007) WHO proposes global agenda on transplantation. 30 March. Available at: www.who.int/mediacentre/news/releases/2007/pr12/en/index.html#

Zhou X (2005) The institutional logic of occupational prestige ranking: Reconceptualization and reanalyses. *American Journal of Sociology* 111(1): 90–140.

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