ARTICLES

# Why a Market in Organs is Inevitably Unethical

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## Abstract

*In this paper I shall be arguing against the claim made by Erin and Harris (2003) and others, that creating a "regulated market" in organs for transplantation taken from living vendors is both viable practically and a moral imperative. No-one can doubt that there is currently a crisis in the provision of organs for transplantation, with a massive gap between supply and demand. There are a number of reasons for this crisis. Since its development as a life-saving measure in the second half of the last century, organ transplantation has expanded exponentially, both in terms of survival rates, the number of people on the waiting list for the procedure, and the range of transplantable organs. Advances in immuno-suppression and in prevention of infection have led to improvement in both the survival of the recipients and of the transplanted organs. At the same time, there has been an increase in repeat transplantations (following failure of the graft) and in multiple organ transplants. The range of conditions for which transplantation is offered has widened, and transplantable organs now include: kidney, liver (or sections of liver), pancreas, heart and lung. Brain-dead donors can provide all of these organs, while the kidney and sections of the liver and pancreas can also be obtained from living donors. Survival outcomes are better from living (related or unrelated) donors than from cadaveric donors, and, in the case of kidney failure, better from transplantation than from dialysis.*

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*The relevant question, however, is whether permitting a market in human organs is morally justifiable, and, even if it were, whether it would provide a solution to the current crisis. I argue in this paper that organ trading is wrong in principle, since it commodifies the human body and inevitably exploits the poor and the socially vulnerable, and that, far from alleviating the crisis, it is likely to make it worse. First we should note that there is an uncompromising opposition to all forms of organ trading from two major international healthcare organisations.*

*Keywords: market in human organs, commodification, exploitation, socially vulnerable*

In this paper I shall be arguing against the claim made by Erin and Harris (2003) and others, that creating a "regulated market" in organs for transplantation taken from living vendors is both viable practically and a moral imperative. No-one can doubt that there is currently a crisis in the provision of organs for transplantation, with a massive gap between supply and demand. There are a number of reasons for this crisis. Since its development as a life-saving measure in the second half of the last century, organ transplantation has expanded exponentially, both in terms of survival rates, the number of people on the waiting list for the procedure, and the range of transplantable organs. Advances in immuno-suppression and in prevention of infection have led to improvement in both the survival of the recipients and of the transplanted organs. At the same time, there has been an increase in repeat transplantations (following failure of the graft) and in multiple organ transplants. The range of conditions for which transplantation is offered has widened, and transplantable organs now include: kidney, liver (or sections of liver), pancreas, heart and lung. Brain-dead donors can provide all of these organs, while the kidney and sections of the liver and pancreas can also be obtained from living donors. Survival outcomes are better from living (related or unrelated) donors than from cadaveric donors, and, in the case of kidney failure, better from transplantation than from dialysis.

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## The International Consensus

Trading in human organs has been consistently condemned by the World Health Organization (2008) and this position has been endorsed in very similar terms by the Declaration of Istanbul, adopted by a meeting of The Transplantation Society and the International Society of Nephrology (Steering Committee of the Istanbul Summit 2008).

The Istanbul Declaration makes an unequivocal stance against organ trafficking, transplant commercialism and transplant tourism. Transplant commercialism is very broadly defined as "a policy or practice in which an organ is treated as a commodity, including being bought or sold or used for material gain" (Steering Committee of the Istanbul Summit 2008, 5). The basis for this stance is spelled out in Article 6 of the Declaration:

> Organ trafficking and tourism violate the principles of equity, justice and respect for human dignity and should be prohibited. Because transplant commercialism targets impoverished and otherwise vulnerable donors, it leads inexorably to inequity and injustice and should be prohibited (Steering Committee of the Istanbul Summit 2008, 5).

This unequivocal stance is also found in the WHO document on the topic in its Guiding Principle 5, which covers not only organ donation but also other tissue donations:

> Cells tissues and organs should only be donated freely, without any monetary payment or other reward of monetary value. Purchasing or offering to purchase, cells, tissues or organs for transplantation, or their sale by living persons or by the next of kin for deceased persons, should be banned (World Health Organization 2008, 4–5).

Both documents also agree that this ban "does not preclude reimbursing reasonable and verifiable expenses incurred by the donor, including loss of income" (World Health Organization 2008, 4), but they differ slightly on the issue of insurance. The Istanbul Declaration requires the provision of disability, life and health insurance "related to the donation event", in countries where such insurance is not universally provided. The WHO statement seems similar, but is clearly concerned to make sure that this is not a covert form of payment for the organ: "… incentives that encompass essential items which the donors would otherwise be unable to afford, such as medical care or health coverage raise concerns. Access to the highest attainable standard of health is a fundamental right, not something to be purchased in exchange for body parts. However,

free periodic medical assessments related to the donation and insurance for death or complications that arise from the donation may legitimately be provided to living donors" (World Health Organization 2008).

So, on what basis have these international bodies designated all forms of trading in body parts as clearly unethical? One can see two types of in principle argument against the creation of a market. The first relates to the unacceptability of treating the body or its parts as market commodities; and the second relates to the inequality between the buyers and sellers in such a market.

## Commodification

Why shouldn't body parts—or indeed one's whole body after death—be regarded as part of one's (tradable) property? After all, as Mahoney (2000) and others (Erin and Harris 2003; Steiner 2003; Waldby and Mitchell 2006) point out, many other parties benefit materially from human body parts—transplant surgeons, reproductive medicine providers, creators of cell lines, manufacturers of pharmaceuticals—so why should the organ donor be excluded from financial reward? Is this not a hypocritical appeal to an altruism that only one party to the transaction is expected to adopt? Any answer to this question must deal with the central issue of whether, even if body parts are—some senses, at least—one's property, they are also correctly viewed as tradable, that is, as commodities in a market.

In this part of my paper I summarise arguments that I have developed at greater length in my book, *The Body in Bioethics* (Campbell 2009). Following Radin (1996), we can identify three features of objects that allow us to describe them appropriately as commodities: alienability, fungibility and commensurability. Alienability describes my right to sell, mortgage, lease, give away or destroy, all or any of my possessions (assuming, of course, that I am the sole owner of the object in question and that no other person has claim upon it). Fungibility refers to interchangeability in a market without loss of value to the owner. For example, I may choose to trade in my old car in order to purchase a newer model. Assuming that the deal seems fair to me, I do not regard the trading in as a loss of the value of the car. There is a straightforward equivalence between the prior value of the car when I owned it and its new value as part of the purchase price of the new car. Commensurability refers to the ability of objects to be ranked in value according to a common scale, most obviously money, though other ways of ranking may be found, for example, equivalency of goods in kind. Taking these three features together, we can

define commodities as those items that are appropriately regarded as having a market value. Of course, market values are not fixed—they vary from time to time and from society to society—but the *appropriateness* of the value of objects being described in market terms is the essential point. It is because they are rightly viewed as alienable, fungible and commensurable that objects are appropriately described as commodities.

It must be obvious from the above description, with its use of terms like "appropriate" and "rightly", that descriptions of commodification are used evaluatively, not merely descriptively. For example, it is a correct *description* to say that there has been (and probably still is) a market in slaves, just as there is ample evidence of a continuing market in child sex workers (ECPAT 2005; UNICEF 2005). However, the fact that vulnerable adults and children are in fact treated as commodities does not mean that it is morally justifiable to treat them in this way. This denial of value extends to persons treating themselves as commodities. Let us imagine a desperate father selling himself into slavery in order to raise enough money to feed his family, at least for a few months. While we may understand such a desperate move, it cannot be viewed as morally right, for a human person is not an alienable object, which is fungible (interchangeable with other objects without loss of value) and commensurable with a monetary sum. Underlying this view of the moral wrongness of such commodification of persons is the dictum of Immanuel Kant that we should always treat moral agents, including ourselves, as ends in themselves, never as mere means.

But, assuming we grant this central moral principle about the moral wrongness of commodifying persons, does this prohibition extend to treating the (alienable) *parts of the bodies* of persons as commodities? Here we are in the realm of what Margaret Radin (1996) calls "contested commodities". She argues that there are currently powerful political and social forces leading us toward universal commodification of all aspects of persons, including their bodies. This derives from the pervasive influence of a free market philosophy, which in turn is based on "negative freedom" (Berlin 1958)—the freedom to trade without interference from others or from the state. Radin believes that this assertion of negative freedom is self-defeating, for how can a person be regarded as free, if at the same time she is regarded as no more than "a manipulable object of monetizable value (from the point of view of others)" (1996, 56)? In opposition to this all-pervasive market ideology, Radin argues for a positive, not a negative, view of freedom, one which emphasises the need for an enabling community in which the richness of total human flourishing is enhanced by non-market social structures. So, in opposition to the view that persons are merely traders in a "free" market, Radin describes personhood in these terms:

> … a better view of personhood should understand many kinds of particulars —one's politics, work, religion, family, love, sexuality, friendships, altruism, experiences, wisdom, moral character, and personal attributes—as integral to the self. To understand any of these as monetizable or completely detachable from the person … is to do violence to our deepest understanding of what it is to be human (1996, 56).

It is now time to consider how this discussion about limiting the scope of commodification relates to our topic—the viewing of body parts as commodities, items of trade in a market. Clearly our body parts, or at least some of them, are alienable, and indeed such alienation in the form of altruistic donation is actively encouraged for blood, gametes and transplantable organs. So if body parts are alienable in this morally justified way, then why should they not also be seen as tradable—fungible and commensurable in monetary terms?

Wilkinson (2003) argues that opposition to the commodification of body parts has confused moral objections to the treating of *persons* as mere means to an end (the Kantian objection) with moral objections to treating their *bodies* as suitable objects for trade. According to Wilkinson, such a view can be sustained only if we can "make sense of the claim that persons (and *a fortiori* their bodies) are unique". Since he can make no sense of this claim to uniqueness, he is "… left wondering whether commodification and fungibilisation are really independent wrongs or whether, instead, regarding persons as commodities is perturbing just because it's symptomatic of instrumentalisation, of regarding them solely as means" (2003, 55).

We are faced here with a quite fundamental philosophical divide. Wilkinson's view represents what Radin describes as "liberal compartmentalization". This can be traced back to Kant's "thin" account of persons solely as rational deciders. Radin writes: "Kantian persons are essentially abstract, fungible units with identical capacity for moral reason and no concrete individuating characteristics. They are units of pure subjectivity acting in and upon the world of objects" (1996, 35). In opposition to this, she writes:

> … when the self is understood expansively, so as to include not merely undifferentiated Kantian moral agency but also the person's particular endowments and attributes, and not merely those particular endowments and attributes, either, but also the specific things needed for the contextual aspect of personhood (1996, 60).

If we hold this richer view of the self, we are bound to regard with concern attempts to treat all aspects of the individual, including the person's bodily parts, as readily detachable from the whole, as no more than tradable items.

And thus we have the basis for an in principle objection to a trade in human organs. However, the claim that commodifying *any* part of the body, not just the body as a whole (as in slavery), shares in the moral wrong of treating persons as mere means is, as Radin points out, contestable. For those theorists who stress embodiment as a fundamental part of personhood, the wrong of such commodification is plain to see. But other philosophers, who attribute personhood solely to the capacity for self-awareness and moral agency, concern over bodily integrity is morally irrelevant. In light of this, the more powerful argument against organ trading is based on its exploitative character.

## Exploitation

A more compelling reason for opposing a market in organs is that it is inevitably exploitative. Unlike the commodification argument, this argument depends on study of the current situation and, on the basis of this, predictions of what would likely occur if the creation of a legalised market were internationally endorsed, rather than, as at present, being unequivocally condemned. Although this is a different type of argument, it remains an argument in principle (the moral wrongness of exploitation of the vulnerable). However, it also depends on both accurate descriptions of the current international situation and on predictions of future consequences if a market were allowed. In considering this aspect of the debate, I shall consider in turn three claims made by advocates of a regulated market: (1) it will benefit both seller and purchaser; (2) it will increase the supply of organs for transplantation; and (3) it will help to eliminate the current illegal and exploitative black market in organs.

### *Benefits to Both?*

The claim has been made (for example, by Radcliffe-Richards et al. 1998) that the market would be a "win-win" situation. Not only would the buyers receive a life-saving treatment, but the vendors would have their poverty alleviated and so would be better off than before. This claim goes entirely against the facts as we currently know them. Trade in organs is rife, particularly in parts of Asia (Philippines, India, China) and numerous studies of the outcomes for the sellers (Awaya et al. 2009; Mendoza 2010; Goyal et al. 2002; Shimazono 2007) have shown a plethora of adverse results, such as increasing rather than decreasing debt, problems finding employment, stigmatisation by their community, guilt and regret, and poor health caused by inadequate medical follow-up. It may be argued that these are a consequence of the current illegality of the

trade and that a "regulated" market would ensure benefits for both parties. But it is very unclear how this would be achieved. All the indicators are that few, if any, better-off people would be willing to sell their kidney (though they may be willing to donate to save another person's life, especially if the recipient is a relative or friend). Thus the sellers will nearly always be vulnerable people, struggling to manage financially and with little support in terms of social and welfare provision in their country. How would the regulators of the market make sure that the apparent financial benefit is not illusory? Markets themselves do not go beyond the transaction and are not geared to ensure anything other than a fair price for the seller of a commodity.

Equally, the market cannot ensure safety and benefit for the recipient. As with the market in blood, there is real risk of concealment of risks by the seller (for example, of the transmission of disease) and—unlike a normal market—the purchaser is in no position to return the faulty product. Evidence of such risks to the recipient of an organ under market conditions comes from studies of the health effects of "transplant tourism" (Fallahzadeh et al. 2013).

### *Increase the Supply?*

Advocates of a market claim that it would increase the supply of organs and so help to alleviate the crisis, but there is currently no evidence to suggest that this would happen and several indicators that it would not. For example, findings on the effect of the one national example of a legalised market—Iran—show that eligible family members are less likely to donate, thus reducing the overall supply (Ghods, Savaj and Khosravani 2000; Kazemeyni and Aghighi 2012). In addition, the financial incentives to living donation reduce people's willingness to donate their organs after death, thus once again reducing the overall supply. Supporters of a regulated market also claim that it would reduce or eliminate the black market. This seems very unlikely (see below), but if this were the case, then again the overall availability of organs would be reduced, not increased.

## Eliminate Illegal Trade

This also seems an improbable claim. Many transactions in commodities, which are supposed to be regulated, are very poorly controlled. For example, there is a black market in prescription drugs, such as tranquilisers, that fuels drug abuse and other inappropriate uses of medications. There are many such examples internationally, so there is a very weak basis empirically for believing that classifying organ sales as a regulated market will result in well-regulated and

safe practices. Proponents of this scheme assume some kind of international control over all such trading. It is entirely unclear what agency could carry out such regulation and whence it would derive its authority.

Thus, we have to ask: what difference would such a regimen make to countries where traders are active and well equipped to exploit the poor? The problem of control would be just the same as at present, since the huge profit made by illegal traders, especially the middlemen, the so-called “health concierges”, would still be an incentive to find buyers (rejected by the regulated system) and sellers (in desperate financial straits). Moreover, giving a moral stamp to the idea of trade in human body parts would very likely give fresh impetus to the illegal trade rather than reducing it. In Iran, for example, the market has resulted in widespread pleading by the poor to have their organs purchased (Dehghan 2012).

In summary, claims that a regulated market would be a solution to the organ crisis are far from convincing, quite apart from the moral ambiguity of treating the human body as an exploitable resource. These claims depend upon a set of predictions of outcomes that are notoriously hard to substantiate and could be shown to be true or false, only if the experiment were made to introduce such a market internationally (national boundaries are irrelevant in situations like trade in organs). But would such an experiment be ethical? What if it made the exploitation greater and actually reduced the supply of organs? Advocates of such a market argue that the risk is worth taking, given the numerous deaths currently happening as a result of the lack of suitable organs. Certainly, to oppose the market, one must come up with viable alternatives, which would both prevent illegal trading and would bring more justice in the distribution of organs by ensuring that they were allocated on the basis of medical need, not ability to pay. In the last section of my paper. I suggest some possible solutions, whilst admitting that there is no “quick fix” to the crisis of organ shortage.

## Alternatives

I suggest that there are three alternative ways of dealing with the current crisis: remove current disincentives to altruistic donation; increase deceased donation rates; and—in the longer term—promote much more actively than at present prevention strategies that will decrease the need for so many transplantable organs.

### *Removing Disincentives*

It is clearly unjust that people willing to donate their organs to save the lives of others, including, in a phrase of Richard Titmuss (1970), “unnamed

strangers", are penalised by incurring financial losses and also potentially incurring risks to their own health through inadequate medical follow-up. As noted earlier in this paper, opponents of a market in organs do not object to the provision of appropriate reimbursement of costs incurred by the donor and the provision of adequate health insurance to ensure follow-up. In Singapore, a revision of the Human Organs Transplantation Act (HOTA 2009) has authorised such payments, but subject to strict checking and controls and with the oversight of properly constituted transplant ethics committees. A notable feature of these committees is that they must have a lay person as one of the three members and that an objection by one member (after a secret ballot) is sufficient to stop the transplant.

### *Increase Deceased Donations*

As transplantation and methods of avoiding graft rejection have become increasingly skilled and sophisticated, the potential for long-term survival of a cadaveric organ is now almost as good as for donation from a living source (Lee et al. 2010; Lodhi and Meier-Kriesche 2011). However, the rate of deceased donation is extremely low in many countries; this is true even in some countries with an "opt out" system of donation, such as Singapore. There are many reasons for this, some of them related to the organisation of acute care in hospitals, some due to the attitudes of doctors caring for critically ill patients, and some due to cultural attitudes and beliefs. Moreover, as the case of Iran demonstrates, a market in live organ donation can decrease still further the deceased donation rates (Ghods, Savaj and Khosravani 2000). However, there is no justification in regarding this low donation rate as inevitable and at least one recent example of an active campaign to increase the rate (Kumar et al. 2014; Jha 2014) shows how much can be achieved in this area.

### *Prevention*

Finally, the debate over the shortage of organs has obscured almost entirely the need to face up to the factors that create such a major demand. One major cause is the dramatic rise in obesity internationally and the consequent surge in cases of Type II diabetes, which, if left undiagnosed, will result in end-stage renal disease (ESRD). In some countries the prevalence of ESRD is remarkably high, and this is true even in those counties with a well-developed health service such as Singapore (Khalik 2015). The failure to prevent organ failure in the case of kidneys is mirrored by other failures in prevention, for example,

liver disease caused by excessive alcohol consumption and heart disease related to untreated hypertension. Of course, it is no consolation to those in dire need of a transplanted organ to point out that in so many cases this could have been prevented! Nor will effective prevention have an immediate effect on the current crisis. However, the heated debate over organ transplantation should surely be mirrored by as active campaigning both for proper primary care provision to ensure early diagnosis and for political action against those food and beverage industries that have created the obesity epidemic. Unfortunately, it is nearly always acute medicine that gathers political attention and thereby increased funding. We are good at putting ambulance stations at the foot of dangerous cliffs, but much less good at erecting the fences that will prevent people from falling over!

## Conclusion

I conclude that, for all the reasons I have given, based on both moral principles and prediction of consequences, the introduction of a "regulated market" in organs from living donors will inevitably be unethical. I do accept that, as is the nature of consequentialist arguments, some of my predictions might be shown to be incorrect and so (if we reject the in principle arguments) such a move could have good effects and actually relieve the current crisis. However, the uncertainty of this is such that I believe an experiment of this kind would be unethical in itself.

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