AN ETHICAL ANALYSIS OF AN ORGAN MARKET:

IN DEFENSE OF
BUYING AND SELLING KIDNEYS

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SUMMARY

The lack of kidneys available for transplantation results in thousands of deaths every year. A regulated market for kidneys from living suppliers might solve this problem. Yet such a market is widely opposed based on the argument that it necessarily entails immoral acts. This thesis examines this argument by evaluating the necessary acts involved in a regulated living kidney market using four ethical frameworks—namely, utilitarianism, Kantian ethics, virtue ethics, and principlism. I conclude that the argument is unfounded. The objections against an organ market are either ineffective, misinterpreting the regulated organ market or the demands of the ethical frameworks, or overly broad, condemning every type of organ transplantation from the living. Furthermore, I argue that the prohibition of a regulated living kidney market is unjustified within these frameworks. Finally, I discuss the practical aspects of the question, arguing for the necessity of the basic regulation for ensuring informed consent and showing that the existing guidelines’ opposition to a regulated organ market lacks ethical basis.
CHAPTER 1

INTRODUCTION

Every year, many patients who wait for an organ transplant are removed from the waiting list because they become too sick to survive the procedure, or because they die while waiting for a donor. In 2011 alone, there were 10,795 such patients in the United States, 1,9,936 of whom were waiting for a kidney or liver transplant. Since 1995, the number of patients who have been waiting for a kidney or liver transplant and had to be removed from the U.S. waiting list for being “too sick to transplant” is 29,535, while the number of removals due to death is 88,517. In the United States, every day approximately 30 people waiting for an organ transplant die or are informed that they will die since they are too sick to survive the transplant surgery. Out of these patients, around 19 are kidney patients and almost 8 are liver patients.

These saddening numbers are the outcome of a severe imbalance between the need for organ transplants and the available supply. Had they received an organ in time, these patients would almost certainly have survived, as organ

2 Calculation based on OPTN’s tables for “Removal Reasons by Year” for kidney candidates and liver candidates.
3 Ibid.
4 Calculation based on OPTN’s tables for “Removal Reasons by Year” for all candidates.
5 Calculation based on OPTN’s tables for “Removal Reasons by Year” for kidney candidates and liver candidates.
transplantation now achieves survival rates of 95.9% from deceased donors and 98.5% from living donors for kidney transplants and 87.8% from deceased donors and 91.7% from living donors for liver transplants.⁶ In the United States, there are currently 113,771 patients waiting for single or multiple organ transplants, 91,714 of whom are waiting for a kidney.⁷ By contrast, in 2011, there were only 14,146 donors and a total of 28,535 transplants performed in the United States,⁸ out of which only 16,812 were kidney transplants.⁹ Numbers for most other countries are not more encouraging.¹⁰ This imbalance causes many patients to spend years on the waiting list. Their conditions decidedly worsen during this waiting period and make them ineligible even if an organ finally becomes available. While patients who are waiting for heart, lung, pancreas, or intestine transplants almost completely depend on donations from deceased donors, patients who wait for kidney and liver transplants have the chance to receive a kidney or a partial liver from a living donor, which also results in better survival outcomes than transplants from deceased donors. Yet, the current system of organ donation fails to meet the needs of the patients whose lives depend on transplant surgery.

¹⁰ For example, by the end of 2007, 58,182 patients were on the waiting list for organ transplants in the European Union and only 25,932 transplants were performed during the same year. See Council of Europe, Trafficking in Organs, Tissues and Cells and Trafficking in Human Beings for the Purpose of the Removal of Organs, 2009, 20, accessed April 9, 2012, http://www.unhcr.org/refworld/docid/4b1ce76f2.html.
Adopting a market system for organs from the living, especially for kidneys, is a potential solution to the problem of not having enough organs available for transplant. By providing incentives, a kidney market is likely to motivate more individuals to provide their organs and increase the number of available organs significantly. However, from policy makers to medical professionals and academics, many strongly argue against an organ market. Many, if not most, opponents of organ market base their view on ethical grounds. They argue that introducing financial incentives to the system of organ transplantation causes severe ethical problems.

An example of such a claim can be found in the World Health Organization (WHO) Guiding Principles on Human Cell, Tissue and Organ Transplantation. In this guideline, the WHO takes a firm position against an organ market for the reason that “[p]ayment for cells, tissues and organs is likely to take unfair advantage of the poorest and most vulnerable groups, undermines altruistic donation, and leads to profiteering and human trafficking. Such payment conveys the idea that some persons lack dignity, that they are mere objects to be used by others.” In other words, this claim suggests, an organ market necessarily entails immoral actions. The statement clearly refers to the Kantian idea of human dignity and the moral duty for not treating others as a mere means. However, the WHO’s statement, as well as the vast majority of such comments, does not


furnish a clear, full analysis to support this ethical claim. As I shall argue in this thesis, this deficient analysis leads to an erroneous conclusion that costs thousands of lives every year.

In this thesis, I fill this major gap for a coherent and comprehensive ethical analysis of an organ market from the living. The paradigm case that I consider is a regulated market for kidneys; however, I mostly use the generic term organ market to indicate that the analysis would also hold for other non-vital organs, such as the liver, that can be transplanted from living donors without causing significant harm to the supplier. I evaluate the claim that an organ market necessarily leads to immoral actions within the frameworks of the three major ethical theories—namely, utilitarianism, Kantian ethics, and virtue ethics—and a cornerstone bioethical theory—namely, principlism. I look at each ethical theory in depth and analyze how a regulated organ market and the actions that it entails fit into these frameworks. I argue that a regulated market can and plausibly will involve morally permissible actions regardless of which theoretical perspective is adopted to evaluate them. None of these theories, I claim, opposes a regulated organ market. In fact, I find that all four theories provide grounds for an argument against a prohibition of the market. No justification for a prohibition can be found in any of the theories, and, moreover, three of them—utilitarianism, Kantian ethics, and principlism—even lead to the strong conclusion that such a prohibition is immoral.

This thesis provides an ethical justification for a regulated organ market. I start, in Chapter 2, by distinguishing an organ market from organ trade. Organ
trade is an unregulated commercial transaction, like the illegal trade that often catches media attention. By contrast, the organ market proposed and evaluated in this thesis is a regulated commercial transaction. For the purposes of the ethical evaluation, I refrain from endorsing a specific set of regulations. However, I assume a basic requirement in any type of regulated organ market: fully informed, rational, and voluntary participants. I discuss further details of the distinction between organ trade and organ market in Chapter 2. I argue that many objections brought against an organ market rely on the unregulated nature of organ trade and hence are not valid when applied to a regulated organ market. In Chapter 2, I also describe different types of organ transplantation—such as donation, reimbursement, and compensation—which I will generically refer to as incentivized and non-incentivized systems.

In Chapter 3, I commence my exploration of ethical theories, starting with utilitarianism. I first evaluate the individual’s act of providing or receiving a kidney in terms of its effect on overall utility understood as preference satisfaction or as happiness. I argue that in either understanding of the term, the individual maximizes utility by engaging in a commercial kidney transaction with informed, rational, and voluntary individuals. Since utilitarianism employs the same method to judge individual actions as well as systems, I then evaluate the non-incentivized and incentivized systems in terms of the utility that they generate. The utilitarian calculation at this point mostly depends on the empirical data on consequences. In view of the existing studies, I claim that an incentivized system, and particularly an organ market, is the option that utilitarianism favors. By
relying on comparisons and determining the morally right action as the one that maximizes utility, utilitarianism condemns every other option as morally wrong. Therefore, according to utilitarianism, not only is a regulated organ market morally justified and right, but a prohibition is morally wrong because it reduces utility.

In Chapter 4, I move on to Kantian ethics. I appeal to the formula of humanity and to the formula of universal law to evaluate the actions (in this case, the maxims) involved in a regulated organ market. I argue that, being based on the rational nature, the formula of humanity properly understood only objects to certain (mis-)treatment of others’ and one’s own ability to set and pursue ends. It follows that, contrary to Kant’s famous claim against selling one’s tooth, donating or selling an organ does not necessarily violate one’s humanity. This understanding of humanity also provides a basis to analyze Kant’s idea of dignity and how it relates to an organ market. I argue that dignity, being ascribed to human capacity for rationality, does not object to commercial transaction in organs. The formula of universal law leads to the same conclusion through the analysis of the plausible maxims that the participants of the organ market would hold. I argue that both recipients’ and suppliers’ maxims in an organ market are universalizable without contradictions. Hence both recipients’ and suppliers’ actions are morally permissible.

After establishing that Kantian ethics finds an organ market (or more precisely, the actions involved in an organ market) morally permissible, I turn to the prohibition of the organ market. I argue that far from morally condemning
organ sales, the formula of humanity actually requires that organ sales be allowed. I argue that the prohibition violates the formula of humanity by preventing one from following one’s imperfect duty for self-preservation in the only way possible for the desperate recipient who does not receive an organ through donation.

The conclusions of Chapter 4 are particularly noteworthy because Kantian notions such as dignity and humanity feature prominently in the objections to organ markets, as exemplified by the cited passage from the WHO’s statement. This chapter shows not only that these objections misunderstand Kantian ethics, but also that Kantian ethics in fact leads to the exact opposite position—namely, condemning the prohibition.

Chapter 5 takes the discussion to a less explored ground and looks at the issue of organ market from the perspective of virtue ethics. To evaluate the moral status of individual actions in an organ market, I ask if a virtuous agent would remain virtuous in a regulated organ market. Comparing a virtuous supplier’s and recipient’s attitude towards organ transplantation in a non-incentivized system to their attitude in an incentivized system, I argue that a virtuous agent would be reflecting as many if not more virtues by participating in a regulated organ market. Therefore, I conclude that virtue ethics does not provide grounds for the claim that an organ market necessarily entails immoral actions. After refuting the claim of immorality of an organ market, I go on to consider the moral grounds for a prohibition. This time I pose another question: Would a virtuous agent prefer one system to the other? Making a case that a virtuous person would favor a regulated market system, I argue that virtue ethics does not provide a strong
argument against a regulated organ market; in fact, it even sustains a case against prohibition of an organ market.

Finally, in Chapter 6, I move on to a more contemporary yet very influential ethical theory—namely, principlism. In this chapter, I first evaluate the recipient’s and the supplier’s positions in incentivized and non-incentivized systems of organ transplantation in relation to the four principles. I argue that neither of the systems causes necessary violations of the principles of respect for autonomy and justice. By contrast, I claim that the principle of nonmaleficence and beneficence may pose an objection to any type of organ transplantation. However, once the interpretation of these principles is extended to include psychological benefits, and hence to justify organ donation, a coherent application of principlism, I claim, also justifies a regulated organ market. Thereby, I conclude that a regulated organ market does not violate the requirements of principlism. On the other hand, I argue that a prohibition of a regulated market in fact violates all four principles. Hence, principlism also condemns the prohibition of an organ market.

The last chapter of the thesis serves two purposes: It questions the moral basis of the informed consent requirement that I imposed on a regulated organ market and provides regulatory arguments drawn from the justifications presented throughout Chapters 3 to 6. First, I argue that the basic requirement of informed consent is a necessary element for any ethical system of organ transplantation. Regardless of the involvement or lack of incentives, a system that does not ensure informed consent is condemned by all four ethical theories. In the last two
sections of this chapter, I first take a look at some regulations that I favor and justify them appealing to some of the ethical theories. Unlike the justification of informed consent, these regulations are not univocally justified by all four ethical theories. Finally, I turn to two major international guidelines that advocate the prohibition of an organ market: the Declaration of Istanbul (2008) and the WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation (2010). I argue that these guidelines, while making a strong assertion against an organ market, fail to provide any justification for their positions. Their claims apply to the unregulated organ trade, but are invalid against a regulated organ market.

This thesis concludes that the current position against a regulated organ market not only is unjustified but also rests on wrong assertions. Claiming to appeal to ethical justifications, the objections seem to invoke well-established theories. However, the truth is that none of the major ethical theories finds a regulated organ market immoral, let alone supports a prohibition of it. Unfortunately, these oppositions lacking valid justifications continue to give rise to the death of thousands of people every year.
PART I

BACKGROUND
CHAPTER 2

A REGULATED ORGAN MARKET

Organ market often invokes images of manipulated and exploited individuals, brutal scars and deteriorated health conditions, and trafficked humans for the purpose of removing their organs. These images come from the unregulated and illegal practice of organ trade. Unfortunately, with the repetition of horrific stories in relation to the monetary transaction, any form of commercialized organ transplantation raises strong feelings and objections from the public. However, a regulated organ market is significantly different from an unregulated organ trade.

This chapter is divided into two sections. The first section provides the definitions of the terms that refer to various types of organ transplantation—namely, donation, reimbursement, compensation, commercialization, organ market, and organ trade—which fall under two main categories: incentivized and non-incentivized systems. This section clarifies each system as well as the content of the categories. It also emphasizes the distinction between organ trade and the other systems in terms of the regulatory framework.

The second section focuses on the characteristics of the existing illegal organ trade and compares it to a regulated organ market. Spelling out the crucial and relevant distinctions between these two systems, this section shows that the
arguments based on the characteristics of the illegal organ trade become invalid when they are employed against an organ market. I consider the problems of autonomy and poor health outcomes in the organ trade and argue that these problems arise from the unregulated nature of the organ trade as opposed to the commercialization of organ transplantation. Additionally, by drawing the relevant connections between the system of organ donation and the organ market, I propose that both in terms of ensuring autonomy and optimum health outcomes, a regulated organ market is likely to mirror the system of donation and not the illegal organ trade.

I. Definitions

There are various types of organ transplantation, and the boundaries between them often blur, damaging the clarity of arguments. These types of organ transplantation can be further categorized as incentivized and non-incentivized systems. Before evaluating the arguments on organ market and incentives in organ transplantation, it is useful to clarify the terms that are used in order to refer to these various types of organ transplantation.

*Donation:* the type of organ transplantation where the supplier provides the organ without receiving any material benefits in return.\(^\text{13}\)

*Reimbursement:* the type of organ transplantation where the supplier’s transplantation-related expenses are covered. These expenses must be

\(^{13}\) Throughout this study, I mainly use the term *supplier* to refer to both donors and sellers within different systems of organ transplantation in order to avoid making a distinction between the subjects, and instead focus on the differences in the types of practices.
documented and must be strictly necessary for the supplier in order to provide the organ for transplantation. They may include transportation, accommodation, and necessary medical expenses such as patient evaluation (including hospitalization and clinic visits), hospitalization for the living organ transplantation surgical procedure, and medical or surgical follow-up clinic visits or hospitalization.\textsuperscript{14}

\textit{Compensation}: the type of organ transplantation where the supplier is provided with the reimbursement for the transplantation-related costs (such as those listed above) and other compensations. Compensation can be divided into two kinds: comprehensive reimbursement and incentivized compensation. In addition to the reimbursement of the documented costs, comprehensive reimbursement may include the loss of income caused by the leave that the supplier had to take from work for the pre-transplantation medical procedures and a short- or long-term health insurance, which is limited to the medical conditions caused by the transplantation. On the other hand, incentivized compensation may include other benefits such as tax deduction, college tuition, a long-term comprehensive health insurance, and a sum of money for the anxiety and inconvenience caused by the transplantation procedure.\textsuperscript{15}

\textit{Commercialization}: the type of organ transplantation where the supplier is paid for the organ. Commercialization may take the form of just a sum of money given to the supplier in return for agreeing to provide her organ for transplantation or it

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may also include, in addition to the sum of money, reimbursement for necessary post-surgery medical care including follow-up care and insurance for transplantation related health problems.

_Organ Market:_ the regulated subtype of commercialized organ transplantation. The kinds of organ market can range from a minimally regulated to a heavily regulated market with a monopsony distributing the organs according to a rationing method such as need or best health outcome.

_Organ Trade:_ the unregulated (and currently, illegal) subtype of commercialized organ transplantation. Typically, organ trade involves use of coercion and deception on vulnerable population by the middlemen, inadequate medical care for the supplier and recipient, and as a result, poor health outcome for both parties. Existing organ trade also includes human trafficking for the purpose of removal of organs and transplant tourism where the recipient travels to the country where the transaction (usually, illegally) takes place.

While the distinctions between these types of organ transplantation come into play in most guidelines and policies, the discussion of the moral status of an organ market is mainly based on the division of incentivized and non-incentivized systems. The incentivized systems include the compensated (in the form of incentivized compensation) and commercialized organ transplantation, while the non-incentivized systems include the organ transplantations through donation, reimbursement, and compensation (in the form of comprehensive reimbursement).

Even though commercialized organ transplantation, in principle, includes both the regulated organ market and the unregulated organ trade within its
definition, in the remainder of this thesis, I distinguish the organ trade from all the other types of organ transplantation by categorizing both the incentivized and non-incentivized systems as regulated systems. This implies that organ market and the commercialized organ transplantation refer to the same regulated commercialized system and can be used interchangeably.

Until the last part of the thesis that deals with the regulations and their ethical justifications, I proceed with the basic requirement for all these regulated systems to include only (1) fully informed, (2) rational, and (3) voluntary individuals. Any system that fails to ensure this basic requirement falls out of the categories of incentivized and non-incentivized systems. Organ trade differs from these systems on the basis on this particular requirement by allowing individuals to participate in the transaction without being fully informed, rational, and voluntary.

The types of organ transplantation are nested in the sense that the more general type includes all the practices of the more narrow type. In ascending order of generality, the types are donation, reimbursement, compensation, and commercialization. For example, compensated organ transplantation can include the practice of reimbursement and donation in addition to the practice of compensation, but reimbursed organ transplantation cannot include the practice of compensation. This also entails that the incentivized systems can include the practices within the non-incentivized systems but not the vice versa.
II. Organ Trade versus Organ Market

According to the WHO, every year, around 5% to 10% of all kidney transplants are performed through organ trafficking.\textsuperscript{16} In Pakistan, two-thirds of kidney transplants performed annually involve a foreign transplant patient.\textsuperscript{17} The ‘supply’ for this trade comes from many healthy but poor people, mainly living in underdeveloped or developing countries. These sellers usually live in such extreme poverty that their struggle is as survival oriented as the patients’. In most cases, the financial benefits that the sellers are expecting to gain from illegal organ trade are their last resort to provide for their families or in some cases to afford the medical treatment that a family member needs.\textsuperscript{18} Hence, both for the ‘sellers’ and ‘buyers,’ organ trade is a matter of life and death. Unregulated organ trade gives rise to many practical problems as well as ethical ones. However, I argue that these problems stem from the illegal and unregulated nature of the organ trade and not from its commercial nature. Therefore, they are not a necessary part of a legal and regulated organ market.

\textsuperscript{16} Council of Europe, \textit{Trafficking in Organs, Tissues and Cells}, 58.


A. **Problem of Autonomy**

Illegal organ trade targets two vulnerable populations: the uneducated poor and the hopeless ill. Both groups risk considerable harm to themselves while chasing the much-needed benefits. The suppliers are typically misinformed about the consequences and the risks that are involved in providing an organ, the conditions under which the operation will occur, and the post-surgery treatment that they will receive.\(^\text{19}\) In some cases, the educational background of the suppliers even makes them unaware of the fact that selling an organ is illegal, and therefore, they are not able to fight for the fulfillment of the agreement if they are cheated.\(^\text{20}\) They are not in the position to rationally weigh the risks against the benefits and judge whether the agreement is satisfactory for their purposes. Therefore, their compromised position in this transaction is mainly due to the lack of conditions that ensure their autonomous—that is, informed, voluntary, and rational—decisions.

A regulated organ market starts with the basic requirement of allowing only fully informed, voluntary, and rational individuals to participate in the system. A supplier is eligible to make her organ available only if she is competent to make a decision, if she has all the relevant information, and if her decision does not result from coercion or manipulation. The basic regulatory framework that


requires and ensures the autonomy of suppliers is already in place within the existing non-incentivized systems of organ transplantation. Since the organ market is a regulated system of organ transplantation, in order to follow the same eligibility criteria, it can import the same or comparable regulatory means.

Guaranteeing the autonomy of the supplier is as crucial in a non-incentivized system as in the incentivized systems. As it can be the case in organ market, also in organ donation, the supplier may want to make her organ available without completely understanding the consequences and the risks of this act. It may also be the case that even though she does not want to donate her organ, she is being coerced into doing so. In the system of donation, this can happen within the family, where the survival of a family member depends on another family member. Especially if the patient is in a more powerful position within the family, once a lower-status family member is found to be the match, she has less chance to refuse to give her organ. The regulations within the non-incentivized systems aim to eliminate such cases and only allow informed, voluntary, and rational individuals to donate organs. Similarly, a regulated market has to use a set of regulations to eliminate the ineligible suppliers. By doing so, the organ market differs from organ trade and excludes the suppliers who are recruited through manipulation and coercion.
The argument from vulnerability objects to the idea that the supplier’s autonomy can be ensured in an incentivized system where the supplier is most likely to be desperately poor. The argument points out that incentives have the power to convince the desperate to act in ways that they would not prefer under different circumstances. This implies that their economic situation impairs their competency for decision making by eliminating their voluntariness. According to this understanding of coercion, the desperate economic situation of the suppliers puts them in a position where their decisions do not aim to improve their conditions; rather, they aim to prevent a worse outcome that they will be facing unless they make these decisions. This objection, I argue, leads to the conclusion that a desperate person is incompetent to make a voluntary decision to perform any act—which I will refer as disagreeable act—that makes her worse off not in comparison to her actual situation but to the situation of a not desperate person. For this conclusion to condemn the sale of kidneys, the term ‘disagreeable’ must be defined in a particular way which most plausibly refers to the harm and risk of the act. However, in that case, many decisions, including job choices, of a desperate person become coerced even though actually they make her better off.

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Coercion is typically understood to involve the use of power—usually, in the forms of force or threat—to make one take an action that she would not have chosen otherwise and to impose “one’s will on the will of other agents.” A typical case of coercion involves a mugger pointing a gun at the subject and giving her two options: handing over her money or being shot. By using the threat of violence, the mugger limits the subject’s freedom to her own preferred situations and narrows down the subject’s options to two undesirable ones. Neither of these options is something that the subject would have chosen voluntarily, without the existing threat by the mugger, and both of these options are intentionally created by the mugger. Hence, coercion, understood in the form of force or threat, overrides one’s voluntariness.

Applied to the discussion on organ markets, the argument from coercion can be formulated in two ways. In the first formulation, the intentional and directed nature of force or threat is replaced by restrictive external conditions such as severe financial difficulties. Even though economic coercion, as the limiting factor of voluntariness for vulnerable groups according to this objection, does not work like an intentional agent exercising her will on the subject, it still narrows down the available options to undesirable ones. In order to avoid a worse outcome, the subject is ‘coerced’ by her financial condition to take an action that she would otherwise avoid. Economic desperation acts here as a factor that creates a ‘threat’ of worse outcome unless a certain act is taken. This threat, even

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though it is not intentionally created and inflicted upon the subject, limits the subject’s ability to make voluntary choices.

In the second formulation of the argument, economic agents—such as the government or capitalists—are taken as the agents who impose their will on the vulnerable groups by intentionally restricting their options to undesirable ones. They actively put people into vulnerable positions and *then* make them offers. In this situation, the vulnerable individual is ‘coerced’ to take their offer because it makes her better off in relation to her current condition. Yet, if the economic agents had not worsened the subject’s pre-offer condition, she would have preferred not to take the offer.

**Coercion through Economic Conditions**

Formulated in terms of external conditions restricting the choices to undesirable and disagreeable ones, the first formulation of the coercion argument seems to include many everyday situations. When a student spends all night studying, her action is driven by the ‘threat’ of being kicked out of the school. In order to avoid this ‘worse’ outcome, her only available choice is to study all night, which she would not otherwise choose to do voluntarily. Following the argument to the conclusion, the student is not competent to make the voluntary decision to study all night since she is deciding under coercion.

This wide application of the concept of coercion can be restricted by employing Nozick’s idea of *baseline*. According to this idea, a baseline is the
“normal or natural or expected course of events” and if the threat or the offer worsens the person’s situation in comparison to the baseline, then these threats or offers are coercive.\textsuperscript{24} Nozick allows baseline to be taken as predictive or moral and provides two examples to clarify the use of both types. In one of his examples, a slave is given the choice between being beaten as usual and performing a disagreeable action A. In one sense, the offer is not coercive since it allows the slave to avoid an undesirable and expected situation, which is being beaten. But on the other hand, the offer acts as a threat by forcing the slave to do A with the threat of being beaten otherwise, which is not normal in the moral sense, as the argument claims.\textsuperscript{25} In this example, for the offer to be labeled as coercive, the baseline has to be taken not as a predictive one but as a normative standard where beating is wrong.\textsuperscript{26}

In the other example, Nozick shows the use of predictive baseline instead of a moral one. In this example, a drug dealer, who regularly gives drugs to an addict, tells her that unless she beats up a certain person, the dealer will not sell her the drug. Here, the predictive baseline of the addict always receiving drugs would determine this as a threat that puts her in a worse off position.\textsuperscript{27}

Applying Nozick’s understanding of baseline to the case of an organ market where the supplier is a member of a vulnerable group results in the following formulation of the argument: Both options that are available to the


\textsuperscript{25} Ibid., 450.

\textsuperscript{26} It is unclear what the term “moral” refers to in this claim. Since it is left unclarified, I take a common sense approach to it and interpret it loosely as “agreeable” or “what should be the case”.

\textsuperscript{27} Ibid., 447–448.
supplier—that is, not being able to meet her basic needs or selling her kidney—are making her worse off in comparison to the baseline. Therefore, the argument concludes, her decision of selling her kidney is a coerced decision, not a voluntary one.

This argument can be refuted if the baseline is taken as predictive; however, this would lead to problems when applied to other types of organ transplantation. If the baseline is predictive, then the conclusion does not follow given that the supplier’s expected and normal course of events include not being able to meet her basic needs. However, a predictive baseline causes problems when employed in organ donation. A person who is donating her kidney to a relative chooses this option among the two available undesirable and disagreeable options, namely, letting a loved one die or giving her kidney. None of these options is a part of normal or expected course of events. In this sense, the option of giving her kidney makes the donor worse off in comparison to a predictive baseline and the argument ends up ruling out the donor’s voluntary and competent decision of donating her organ to a dying relative.

On the other hand, if we take the baseline to be a normative one, then we have to assume that not being able to meet one’s basic needs—that is, living in extreme poverty—is a morally disagreeable position, just like being beaten in Nozick’s slave example. Hence, as all of the slave’s decisions to perform a disagreeable act that may allow her avoid being beaten are coerced, all of the poor’s decisions to perform a disagreeable act that may allow her to meet her basic needs are also equally coerced because they make her worse off in
comparison to the moral baseline. This leads us to the conclusion that the poor person is incompetent to make any voluntary decisions that include performing a disagreeable act even if it makes her better off.

*Coercion by Economic Agents*

The second formulation of the coercion argument shifts the focus from external conditions to an intentional agent acting as the coercer. In this formulation, the subject is put into a worse starting point by another agent, who later on makes an offer to her. In such a case, the offer is coercive because the agent intentionally robs the subject from better options before making her the offer. The example given by Zimmerman on this account goes as follows: The agent kidnaps the subject and takes her to an island where the available jobs are much worse than those in the mainland. The next day, the agent offers the subject a job, which provides her an option to avoid starving.28 In this case, the agent’s offer is coercive because the subject has a strong preference to another condition which is taken off the table by the agent before the offer.

Applied to the organ market case, the argument claims that the supplier is coerced into selling her kidney by the economic agents who actively push her into poverty. Therefore, the offer of selling her kidney in return of money is a coercive offer.29 However, this argument is not strong.

As argued by the critiques, Zimmerman’s account requires a further method to determine which initial comparison can be taken as relevant.\textsuperscript{30} Since, unlike in Zimmerman’s island case, there is no initial act done by the economic agents to change the supplier’s position, it is unclear what should be taken as the relevant comparison for the supplier’s position before interference of the economic agents. In the case of the organ market, the relevant economic agent who both puts the seller into an economically disadvantaged position and who makes the offer of buying her organ would be the government or the capitalists. However, it cannot be argued that whenever the government can provide a better situation for the seller, all the other offers are coercive. If that were the case, unless the government gives all the wealth to the supplier, the supplier always remains in the coerced position.\textsuperscript{31} Therefore, the claim for a coercive offer has to refer to a method of determining what the relevant comparisons or baselines for the supplier’s preferred situations could be. Moreover, such a method also needs to take into account the other subjects within the system. Given this understanding of coercion, any redistributive system that would put the supplier in a better position would run into the coercion problem in relation to those whose wealth or resources will be actively restricted for the sake of supplier.

For the sake of the argument, let us assume that some relevant comparison is formulated and the people who are economically disadvantaged in the existing system are in fact subjected to coercive offers whenever the capitalist system or government provides an option that is less desirable than the alternative pre-offer


\textsuperscript{31} Ibid.
initial state. This leads us to the same conclusion as the first formulation of the coercion argument in the previous subsection. According to this argument, every offer involving an unpleasant or disagreeable act for the poor person in the existing system is coercive. This either cuts across the board for most jobs and most living conditions of disadvantaged people or has to rely on an argument why kidney sale is ‘disagreeable’ whereas a risky or unpleasant job is not.

What is a ‘Disagreeable’ Act?

For the conclusion of either formulations of the coercion argument to hold in cases of kidney sale, there must be a relevant aspect of kidney transplantation that distinguishes it from other practices that the individual voluntarily engages in, which are found agreeable in comparison to a moral baseline. Organ transplantation is an irreversible process that involves certain risks to the supplier. If these risks are extreme, then the argument can point out that no one, who is not desperate, would voluntarily take such risks, which is a reason to doubt the voluntariness of the individuals in vulnerable group. However, this claim proves either to be weak or to render many other practices also ‘extremely risky’ once the relevant data on risk comparison is considered. The study that investigates the short- and long-term health risks of over 80,000 living kidney donors in the United States reveals that the mortality rate is 0.031% within ninety days after the donation procedure, and in the long run, the mortality rate of the donors does not
differ from the mortality rate of the control group.\textsuperscript{32} In a legal system of commercial organ transplantation, we can assume that the mortality rate will not differ from the organ donors, given that they will be subjected to the same standard of care. In comparison, according to the U.S. Bureau of Labor Statistics, in 2010, the annual fatal work injury rate for fishers was 0.116\%, for logging workers 0.092\%, and for aircraft pilots and flight engineers 0.071\%.\textsuperscript{33}

To be sure, the foregoing is not a perfect comparison, given that the kidney transplantation is a one-time act as opposed to an occupation. In order to provide a common denominator for comparison, we can focus on the risk and earning comparisons for a given period of time. For ninety days after the surgery, the supplier has a 0.031\% mortality risk, which is almost equal to the fisher’s mortality risk for the same period (0.029\%). According to the best available estimate, supply and demand in a market for kidneys in the United States would reach a balance at a price of $15,200 (in 2005).\textsuperscript{34} The annual median income for fishers is $27,000.\textsuperscript{35} Thus, in three months, the fisher would earn $6,750—less than half of what the kidney supplier makes—by taking approximately the same risk. Moreover, returning to work after a kidney donation takes only two to six

\begin{footnotesize}
\begin{itemize}
\item \textsuperscript{34} Becker and Elias, “Introducing Incentives in the Market for Live and Cadaveric Organ Donations,” 11.
\end{itemize}
\end{footnotesize}
weeks depending on the supplier’s type of work.\textsuperscript{36} This means that the kidney supplier has extra six weeks to work and earn more money in addition to the $15,200 she receives for the kidney.

These comparisons always remain inexact, given the several distinctions between a risky occupation and a risky act. However, if the objection is based on the idea that organ transplantation is so ‘extremely risky’ that one would never do it voluntarily, then we should also question the voluntariness of the decision of those individuals from vulnerable groups who would like to work as fishers or logging workers. Given this comparison, it can be reasonably argued that acting as a fisher for three months is much less beneficial but equally risky as selling one’s kidney; and hence more disagreeable for a non-desperate person. Asserting that they lack any decision-making capacity for things that are found ‘extremely risky’ according to an undetermined criteria of ‘extreme risk’ is a very strong and problematic claim that seems to lead to a conclusion that such risky occupations should only be available to the better-off members of the society, leaving the poor with even less options for making a living.

The upshot of this analysis of the argument from vulnerability is this: Regardless of the interpretation of the concept of coercion, the coercion argument leads to a claim of incompetency of vulnerable populations in many aspects of their lives. If the individuals’ coerced actions should be prevented, then much decision-making capacity needs to be taken away from vulnerable populations, which certainly contributes to their vulnerability even further. On the other hand,

if we assume that the economic difficulties are factors that restrict the individuals’ scope of actions but not their ability to act voluntarily, then by providing the necessary regulations that ensure autonomous decision making, a regulated market is competent to mostly eliminate the non-autonomous participation in the system. Any system, whether the system for selling or donating organs or taking a risky job, should be regulated such that the individuals participate in them voluntarily—i.e. without being physically forced, manipulated, threatened, etc. The problem of coercion is not specific to the incentivized systems of organ transplantation. For it to be specific, the act of selling a kidney in a regulated market would have to differ in a relevant sense from other risky or unpleasant acts that individuals do. In the coercion argument, relevant differences pertain to the baseline condition or individuals’ ability to understand the implications of their choice. No such differences would seem to exist. In conclusion, one cannot talk about how to eliminate coercion in incentivized systems as if it were a special case. If it exists, the problem of coercion is the same in other transactions like donation or work contracts. If we think the regulations of those other transactions are appropriate, we can extend them to the organ market; if not, we would need to reform them for all of these transactions.

B. Problem of Poor Health Outcome

Kidney donation surgery involves risks that are present in any major surgery: pain, infection, pneumonia, blood clotting, collapsed lung, allergic
reaction to anesthesia, and death.\textsuperscript{37} In organ trade, suppliers typically undergo this surgery without adequate pre-operation care to determine their eligibility, under inadequate operation conditions, with insufficient medical resources, and with incompetent medical staff. These low standards of medical care cause the procedure to result in many complications and to become severely harmful and even fatal for the supplier. In 58\% to 86\% of the illegal living kidney transplantation cases, the perceived health status of the supplier results in deterioration.\textsuperscript{38} On the other hand, under a well-regulated system where the suppliers are carefully selected, the medical staff and facilities are adequate, and pre- and post-surgery care is provided, these risks are considered to be “negligible,” says the WHO.\textsuperscript{39}

In the system of donation, the suppliers’ quality of life is not negatively affected by giving an organ; moreover, in a study conducted in Germany, 98.5\% of the suppliers reported that they did not regret their decisions.\textsuperscript{40} Since the relevant distinction between the health results of organ trade and organ donation stems from the difference in their regulations, a regulated system of organ market is expected to give the same health results as the system of organ donation. Considering that the suppliers in the organ market will be provided with the same standard of care as in the system of donation, the risks that they take will also be ‘negligible.’ By adopting the same eligibility criteria as the existing system of

\textsuperscript{38} Council of Europe, \textit{Trafficking in Organs, Tissues and Cells}, 62.
\textsuperscript{40} S. Wiedebusch et al., “Quality of Life, Coping, and Mental Health Status After Living Kidney Donation,” \textit{Transplantation Proceedings} 41, issue 5 (2009): 1486.
organ donation to screen out physically or psychologically weak suppliers, the organ market would ensure not to cause more harm than the donation system.\textsuperscript{41}

This claim can be challenged by skepticism. While the standard of care seems to be the principal factor for health-outcomes, one may argue that other factors such as the suppliers’ socio-economic conditions have unforeseeable effects on the result, and that these other factors are likely to be systematically different in an organ market as compared to the existing system of organ donation. Unfortunately, there is no comprehensive empirical data available about the health status of the organ suppliers in a regulated organ market since a legal incentivized system of organ transplantation only exists in Iran.\textsuperscript{42} The Iranian system is proven to be very efficient in providing organs; it eliminated the waiting list for kidneys in only eleven years.\textsuperscript{43} Yet, it also raised concerns about the well-being of the suppliers. A study conducted in 2000 on 300 suppliers found that 85\% of the suppliers regretted their decisions and 76\% would not recommend others to provide their organs.\textsuperscript{44} The study also reports many facts about the actual operation of the system indicating that the regulatory framework was compromised.\textsuperscript{45} However, more recent evidence does not agree with these findings. In a study conducted in 2005 and 2006 on 478 suppliers, 91\% were

\begin{itemize}
  \item \textsuperscript{42}The Iranian system is a government monopsony: all organs are procured and distributed by the government. The government provides the supplier with an “award” and health insurance. Most suppliers also receive “a rewarding gift” from the recipient through the government as intermediary. For further details of the Iranian system, see Ahad J. Ghods and Shekoufeh Savaj, “Iranian Model of Paid and Regulated Living-Unrelated Kidney Donation,” \textit{Clinical Journal of the American Society of Nephrology} 1 (2006): 1136–1145, doi: 10.2215/CJN.00700206.
  \item \textsuperscript{43}Ahad J. Ghods, “Renal Transplantation in Iran,” \textit{Nephrology Dialysis Transplantation} 17 (2002): 225.
  \item \textsuperscript{44}Javaad Zargooshi, “Quality of Life of Iranian Kidney ‘Donors’,” \textit{The Journal of Urology} 166 (2001): 1796.
  \item \textsuperscript{45}Ibid., 1790–1799.
\end{itemize}
satisfied with their experience and 53% recommended the procedure to others. While the data is restricted and a single country’s experience cannot be taken as representative of the health outcomes of the regulated market in general, the Iranian experience does not suggest a strong reason to doubt the assumption that the health outcomes are mostly determined by the regulatory structure and the standard of care. Therefore, as long as the same standard of care is applied to the organ market as in the system of donation, the health outcomes are expected to be very similar to the system of donation and significantly different from the illegal organ trade.

Unlike the typical supplier in organ trade, the recipient has a better understanding of the conditions of the trade. Even though the recipients are also likely to be manipulated and cheated by false securities and promises, their socioeconomic conditions and existing communication with health care providers usually grant them access to more information than is available to the suppliers. Yet, it can be argued that the desperation of their conditions, their physical and mental sufferings, and the immediate danger of death by organ failure hinder their judgment and cause them to take higher risks with high costs. The illegal characteristic of organ trade causes various risks to the recipient that could have been otherwise eliminated by a control mechanism. In organ trade, the best match for the recipient, the hygiene of the organ against donor-transmitted infections, the competency of the medical staff, and the adequacy of the medical center are not guaranteed. According to a study that compares the health results of recipients

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who received organs through transplant tourism, that is, by travelling to another country for organ transplantation from a local donor, and the recipients in UCLA, 27% of tourists had to be hospitalized for transplantation-related infections as opposed to the 9% among the UCLA patients. One-year graft survival was 89% in tourists while it was 98% in typical patients, and acute rejection in one year was 30% in tourists whereas the same condition only occurred in 12% of typical patients.47

Organ trade with or without the involvement of transplant tourism presents risks to the recipient that are avoidable in a regulated system. These risks do not result from commercializing organs as opposed to relying on altruistic motives. Instead, these risks are closely tied to the unregulated nature of the organ trade. Hence, in a regulated organ market, the health results for the recipients should demonstrate the characteristics of the health results within the system of donation, considering that both systems will follow the same standard of health care. Unlike organ trade, an organ market is likely to eliminate poor health outcomes that are due to the inadequacy of the procedure and deliver similar results as the system of donation.

**Argument from Motivation**

It is argued that a system of commercialization necessarily results in worse health outcomes for both the supplier and the recipient because of the limitations

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of pre-donation medical screening and the reliance of the information provided by the supplier. The argument is that while the supplier in the organ market is likely to hide information that may make her ineligible to provide an organ, the supplier in organ donation is open for disclosure since she has an interest in her well-being as well as that of the recipient.\textsuperscript{48} This objection has its roots in Richard Titmuss’s well-known book, \textit{The Gift Relationship: From Human Blood to Social Policy}. Published in 1970, the book advocates altruism as the preferable motive for blood donation as opposed to financial incentives, referring to the resulting low quality of blood that is sold by the desperate and also unhealthy individuals.

There are two problems with this argument: (1) It proposes a false dichotomy by comparing a ‘seller’ who does not care about the well-being of herself or of the recipient and a ‘donor’ who cares, and (2) it neglects the medical developments in the area of testing for diseases. In the existing system of donation, around 78.9\% of all transplantations are done from deceased donors.\textsuperscript{49} While the living directed donors—that is, donors who give their organ to a specific recipient who is usually a family member or a friend—may be typically more inclined for disclosure, this disclosure can certainly not be attained from the deceased donors. For deceased donors, the doctors have to rely on the medical tests that are done in a limited time frame and the medical history that is either unattainable or a mourning family member can provide. When it comes to the


altruistic living donors, the studies suggest that their motives do not necessarily entail complete honesty.\textsuperscript{50}

On the other hand, most of the existing information about the behavior of organ sellers comes from the illegal practice of organ trade where the suppliers are not well-informed about what the risks are both for themselves and for the recipients. These sellers are not representative of the suppliers in a regulated organ market. A big jump is needed in order to conclude that the aversion to disclosure under the circumstances of misinformation and manipulation in organ trade entails that the same behavior is to be expected from the well-informed suppliers in a trustworthy and functioning system. Moreover, while there are studies showing that illegal organ trade results in worse health outcomes for the recipients, several other studies, as well as the two largest studies done in the last fifteen years, documented that graft and patient survival do not differ significantly between recipients of donated kidneys and recipients who traveled for commercial organ transaction.\textsuperscript{51}

Medical technology has improved tremendously in the last fifty years. During the 1960s and 1970s, it was not as easy and quick to test blood for transmitted diseases as now. In the 1980s, AIDS cases and the difficulties of detecting the disease provided a reason to suspect that paying for blood donations would yield “bad blood,” causing more blood transfusion-related HIV

infections.\textsuperscript{52} Since then, however, medical technology has improved greatly, and laboratory testing is now available for many infectious diseases. Using the nuclear acidic testing, HIV infections can be detected with a seven-day window between the occurrence of infection and the detection of the virus.\textsuperscript{53} Under proper regulations, the supplier goes through a medical check-up for eligibility before being accepted as an organ provider, which guards the recipient from transplantation-related diseases. Moreover, a regulated organ market enables suppliers to be fully informed about the risks that they are also putting themselves into by not disclosing information.

The link between altruistic motivation and health outcomes is unclear. Titmuss’s study takes into consideration a medical technology that is significantly less developed than the current one. Moreover, it has also been suggested that his argument is based on a methodologically flawed model, causing his conclusion of blood donors’ altruistic motivation to be unsupported.\textsuperscript{54} An organ market shares a similar regulatory framework with the system of donation, securing optimum health results for the suppliers and the recipients. Most poor health outcomes can be prevented by proper pre-donation screening and compliance to adequate standard of care, which are absent in organ trade.

III. Summary

Organ suppliers’ unawareness of the risks, terms of agreement, and the standard of care make them vulnerable to be taken advantage of in a system of organ trade. Since by selling their organs, they participate in an illegal activity, they also cannot fight for their rights if they are deceived, taken advantage of, or physically harmed beyond what they have agreed on. They are typically promised a simple surgery and adequate post-surgery care, which they usually end up not receiving, and this causes their overall health to deteriorate. In the end, many suppliers spend the money that they have received for the organ to receive treatment for their own transplantation-related health problems.55

These problems of autonomy and poor health outcome in organ trade cause a negative reaction against the overall idea of commercialization of organ transplantation. Because the only characteristic that an organ market shares with organ trade is the commercial transaction of organs, many objections that the organ market is faced with refer to the problems that are due to the unregulated nature of organ trade. The causes of these problems do not lie in the commercial transaction, and hence, objections referring to these problems are irrelevant for the evaluation of an organ market.

PART II

MORAL STATUS OF AN ORGAN MARKET
As established in the previous chapter, many claims of immorality against an organ market are based on observations from and about the organ trade and fail to acknowledge the relevant distinction between the two. Since these objections are misdirected, they do not need to be further analyzed. Other objections appeal to ethical theories in order to make a case against an organ market. These objections typically point to an aspect of the organ market and claim that this aspect entails acts that are immoral within a given ethical framework. In order to examine this claim extensively, in this part, I evaluate the organ market in relation to four ethical theories, namely, utilitarianism, Kantian ethics, virtue ethics, and principlism. I argue that while some of these objections are invalid because they misinterpret either the characteristics of a regulated organ market or the demands of the ethical framework, others may successfully argue against an organ market while also condemning many other practices including organ donation.

In Part I, I have presented the definitions of various types of organ transplantation and categorized them under the systems of incentivized and non-incentivized organ transplantation. In Part II, I present the four ethical theories and evaluate these two types of systems in relation to these theories. By doing so, I not only analyze the arguments against an organ market but also consider how these arguments relate to non-incentivized systems. I conclude that none of these ethical theories has a strong objection against an organ market. On the contrary, I claim that these theories affirmatively favor an organ market. That is, I argue not only that the system of commercialization is morally permissible from the
perspective of all four of these ethical theories, but that these theories also provide grounds for arguing against the prohibition of an organ market.
CHAPTER 3

UTILITARIANISM

Many arguments on the moral status of organ transplantation systems focus on the consequences of these systems. In particular, supporters of the organ market often employ some type of utilitarian framework, where the moral status of the system depends on its maximization of utility, claiming that the organ market is the most likely system to bring out the highest utility.\footnote{Taylor, \textit{Stakes and Kidneys}; Charles A. Erin and John Harris, “An Ethical Market in Human Organs,” \textit{Journal of Medical Ethics} 29 (2003):137–138.} By contrast, opponents of the organ market, to the extent that they consider consequences, typically weigh them in accordance to other values such as equality and solidarity, instead of utility.\footnote{Debra Satz, \textit{Why Some Things Should Not Be For Sale} (New York: Oxford University Press, 2010), 189–205; S. M. Rothman and D. J. Rothman, “The Hidden Cost of Organ Sale,” \textit{American Journal of Transplantation} 6 (2006): 1524–1528, doi: 10.1111/j.1600-6143.2006.01325.x.} In this chapter, I provide a utilitarian justification for the organ market and evaluate the relevant objections within the boundaries of this framework, showing that they fail to make a strong case.

Utilitarianism has different versions, none of which is free from controversies. \textit{Classic utilitarianism}, as a hedonistic act-consequentialism, judges an act to be morally right if and only if its consequences bring out the maximum good or minimum bad, where ‘good’ refers to happiness or pleasure and ‘bad’ refers to suffering or pain. While capturing the basic value judgment in the utilitarian framework, this formulation runs into several problems such as how to
count or predict happiness and how to differentiate between various types of pleasure.\textsuperscript{58} Preference utilitarianism avoids some of these problems by replacing happiness and pleasure with preference satisfaction. Claiming that an action is morally right if and only if it satisfies the maximum number of preferences of the maximum number of people, this version of utilitarianism avoids the problems of predicting happiness and relies only on the actual, stated preferences of people.\textsuperscript{59}

In this formulation, the satisfaction of whatever a competent individual states to be her preference or desire is the ‘good.’\textsuperscript{60}

Although there is no unanimously favored version of utilitarianism, classical and preference utilitarianism are the leading versions that are widely

\textsuperscript{58} In many cases, application of the principle of maximizing happiness requires a choice between the immediate happiness and the overall happiness. In addition to this, there can be a mismatch between what will make one and others happy and what one thinks that will make one and others happy. Hence, one may misjudge which activity will create most pleasure both for oneself and for others while doing the utilitarian calculation with the aim of producing the most happiness for most number of people. For further discussion on main issues in consequentialism, see Walter Sinnott-Armstrong, “Consequentialism,” The Stanford Encyclopedia of Philosophy, last modified September 27, 2011, http://plato.stanford.edu/archives/win2011/entries/consequentialism/.

\textsuperscript{59} Preference utilitarianism may not differ from classical utilitarianism if it is assumed that satisfaction of desires and preferences increases happiness and pleasure or if the assumption is that one always prefers happiness and pleasure. In that case, it can be argued that any discrepancy between the calculation results of the classical and preference utilitarianism is caused by misjudgment or misinformation of the individual. Yet, the distinguishing factor between the classical and preference utilitarianism is the claim that one does not necessarily value overall happiness and may prefer to sacrifice happiness for things that she values more. An artist may think that unhappiness feeds her art and decide to sacrifice her happiness for her desire and preference to excel in her art. See, Peter Singer, Practical Ethics, 3rd ed. (New York: Cambridge University Press, 2011), 13–14.

While trying to eliminate the difficulties in predicting happiness, preference utilitarianism remains subject to similar problems encountered in classical utilitarianism, particularly the issues about conflicting present and retrospective preferences and weighing competing preferences. These problems show themselves in cases such as those involving one’s preference to smoke. One may have a very strong immediate preference for smoking, yet the same person may retrospectively state that her preference is never to have smoked, given her current smoking related illnesses. Similarly, it is not clear how the preference utilitarianism works when one’s desires for ends and means do not match such as the desire to be slim and the desire to eat high-calorie food. For further discussion of utilitarianism, see R. M. Hare, “A Utilitarian Approach,” in A Companion to Bioethics, ed. Helga Kuhse and Peter Singer (Oxford: Blackwell Publishers, 1998).

\textsuperscript{60} Sinnott-Armstrong, “Consequentialism.”
applied. Instead of taking a side on the debate of versions of utilitarianism, I use both classical and preference utilitarianism to evaluate the moral status actions in incentivized and non-incentivized systems of organ transplantation. To keep the two approaches more distinct from each other, while applying classical utilitarianism, I focus on the overall long-term happiness of individuals, whereas in applying preference utilitarianism, I keep the focus on the present rational, informed, and voluntary preferences of agents.

Unlike other ethical theories that I focus on in the following chapters, utilitarianism judges any system and policy by using the same method as it does for the individual action. Therefore, a utilitarian evaluation of the systems of organ transplantation can be given independently from the evaluation of an individual’s decision. Yet, since the main question that I examine while evaluating the moral status of these systems is based on the statement that an organ market necessarily entails immoral acts, in the first section of this chapter, I evaluate the individual’s actions within a utilitarian framework. This evaluation

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61 In this analysis, I do not explicitly appeal to rule utilitarianism, but the results would be the same. The main distinction between rule and act utilitarianism can be formulated in terms of the decision procedure. According to rule utilitarianism, “agents should decide what to do by applying rules whose acceptance will produce the best consequences” (see, Brad Hooker, “Rule Consequentialism,” The Stanford Encyclopedia of Philosophy, last modified January 9, 2008, http://plato.stanford.edu/archives/spr2011/entries/consequentialism-rule/). The result of this procedure diverges from the result of the act utilitarian decision procedure when the overall acceptance of a rule changes the utility effect. For example, the acceptance of the rule “keep your promises” allows trust relations to be formed in the society, which would not be possible if keeping a promise is dependent on the case-based expected utility at the moment when the promise is to be kept or broken. Assuming that the existence of trust relations in society increases overall utility, the results of the act and rule utilitarian analyses diverge in this case. However, there is no straightforward argument why such a divergence would be found in the case of evaluating the organ market, i.e., why a society-wide (ex ante) calculation for all possible donations should differ from individual (ex post) calculations. To be sure, arguments from crowding-out and social preferences could create such a divergence, but I discuss and refute them in the next section. Therefore, in the remainder of this chapter, I base my analysis solely on act utilitarianism.
argues that in a regulated organ market, the individual’s behavior does not necessarily entail immoral acts; on the contrary, in many individual cases, selling a kidney would be the morally right choice for the individual.

Utilitarianism relies on a comparison of consequences in order to determine the morally right act or the morally right system by the utility that it generates, and unless two actions or two systems result in equal happiness or preference satisfaction, only one of these actions or systems is morally right and permissible. Being based on consequences, in the utilitarian evaluation, the moral judgment on an act or a system essentially depends on the empirical evaluation once the ‘good’ is defined. Which act generates the maximum good? Retrospectively, it may be easier to answer this question by looking at the consequences of the act. However, in the decision-making process, this question becomes even more complicated by taking the hypothetical form, what would be the act that will generate the maximum good? Here, further complications arise from the uncertainty of predictions. Given these, the moral evaluation of organ transplantation systems largely depends on the comparison of best available predictions of the consequences that each system would generate.

Within the limitation of the uncertainty of these predictions, in the second section, I evaluate the prohibition of an organ market, comparing the incentivized systems and non-incentivized systems of organ transplantation to find out which system is most likely to maximize utility. The comparison reveals that the incentivized system, and especially a regulated organ market, is most likely to

62 Of course, questions like which consequences to take into account or how to measure the utility would still persist even in retrospective evaluation.
bring out the maximum overall long-term happiness and the maximum immediate preference satisfaction. This conclusion, which also entails that prohibition of the organ market is morally wrong, is challenged by the opponents of an organ market and at the end of this chapter, I turn to two of the most commonly raised objections against this evaluation—namely, the argument from crowding-out and the argument from social preferences.

I. Evaluation of Individual’s Action

Utilitarianism demands that for an individual’s act to be morally right, it must maximize the utility for the maximum number of people. This requires the individual to foresee her action’s consequences as well as the scope of their effects. Admittedly, this is a high demand, and in many cases, the individual is not likely to have a full grasp of the consequences of her action and to be able to make accurate predictions. Yet, within these limitations, an individual can still evaluate her options with the aim of maximizing overall happiness and preference satisfaction and determine her actions accordingly. From an individual’s perspective, the utilitarian calculation typically claims that providing and accepting a kidney is the morally right act, even though the morally right type of transaction—that is, incentivized or non-incentivized—is more case dependent.
A. **Kidney Transplant without Material Benefits**

A kidney transplant saves the life of the recipient with a very high survival rate, and it involves relatively low risks and a short recovery period for the supplier. In the kidney transplants done in the United States from a living donor, in 2008, the survival rate was 98.7%. The transplant not only drastically increases the recipient’s life expectancy, but it also enables her to lead a higher quality of life by freeing the patient from long-term and painful treatments such as dialysis.

On the other hand, in kidney donation, the supplier experiences some post-surgery pain but returns to her normal life in few weeks. Typically, the supplier does not suffer from long-term pain or discomfort related to the surgery, and as a systemic review on more than 5,000 kidney donors shows, the majority of suppliers do not experience any psychological or social problems related to donation. In a smaller study with 161 kidney suppliers, 96.1% was willing to donate again and 90.1% recommended donation. Moreover, the quality of life of the suppliers did not differ from the healthy standards. Two studies done in

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63 “One Year Adjusted Patient Survival by Organ and Year of Transplant, 1999 to 2008.”
65 Ibid.
67 Wiedebusch et al., “Quality of Life, Coping, and Mental Health Status After Living Kidney Donation,” 1485–1486.
Scandinavia show that in the long run, the longevity of patients who have one of their kidneys removed is not lower than in the overall population.68

Given this information, it can be argued that the recipient’s acceptance and the supplier’s offer of a kidney maximize overall utility. From the preference satisfaction perspective, it is clear that the recipient prefers to be alive and the supplier prefers to save the recipient’s life. Looking at the overall happiness, through kidney transplantation, the recipient avoids a great amount of pain and anxiety caused by long-term medical treatment such as dialysis, low quality of life, and fear of death. By increasing her quality of life and avoiding death, the recipient is expected to have more pleasure.

Similarly, by providing an organ, the supplier satisfies her desire to make her organ available. Even though the supplier suffers through the pain and anxiety of the surgery, her overall happiness is either increased by performing an act that she desires to do or decreased relatively minimally for only a short term. To summarize, it can be argued that even if the supplier experiences some pain and discomfort, the recipient’s increased utility outweighs the supplier’s relatively minor decrease in utility, causing the kidney transaction to maximize the overall utility.

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B. Kidney Transplant with Material Benefits

If kidney transplantation maximizes the overall utility, then from an individual’s perspective, in most circumstances, one should provide one’s kidney for transplantation. However, this does not entail that one should give a kidney without receiving any material benefits in return. Whether or not one should receive material benefits in return for providing one’s kidney is again a question of maximizing utility and is completely case dependent. From a classical utilitarian perspective, if the supplier knows that the happiness that the material benefits will bring her outweighs the negative effects on the recipient for paying these benefits, then the morally right act for the supplier is to provide her kidney in return for benefits. For example, if the supplier is extremely poor, which is the common assumption of opponents of the organ market for the typical supplier, then the morally right act for her is to sell her organ instead of giving it away, as long as the recipient is not financially even worse off. On the other hand, if the supplier will not derive any significant utility from the material benefits, while paying will cause great difficulties and suffering for the recipient, then the supplier should simply give her organ without receiving any benefits. From the preference utilitarian perspective, the supplier should seek the type of transaction that will satisfy both her and the recipient’s desires.

The same analysis holds for the recipient’s action. The recipient should also judge the utility effect of a possible material transaction and decide whether paying the supplier will create a higher overall happiness or not. To maximize the
preference satisfaction, just like the supplier, the recipient should also search for the transaction that will be satisfactory both for her and for the supplier.

Utilitarian evaluation of the systems of organ transplantation also includes the effects on third parties. Typically, while the recipient’s family and friends have a strong preference for the recipient to live, the supplier’s family and friends may prefer that she save someone’s life or may prefer that she avoid such risks. Similarly, while the family and friends of the recipient will avoid great pain and experience happiness when the recipient survives, the family and friends of the supplier may experience some anxiety about her well-being or pleasure because of their approval of this act. In the end, typically, it is clear that providing an organ will affect more people positively and intensely and less people negatively and temporarily.

Utilitarian analysis shows that in general, the morally right act for an individual is to participate in organ transplantation; however, the morally right form of this transaction—namely, whether or not it should involve benefits—is almost completely case dependent. This conclusion supports an organ market since the incentivized systems do not exclude the non-incentivized organ transplantation, whereas the system of donation only prohibits an organ market. Hence, in an organ market, the individual has more options that can serve to increase the utility.
II. Evaluation of the Systems of Organ Transplantation

A. Non-Incentivized Systems

The non-incentivized systems of organ transplantation include donation, reimbursement, and comprehensive reimbursement. The non-incentivized systems aim to enable the suppliers to participate in organ transplantation by removing disincentives without providing incentives to make an organ available. By removing as many obstacles as possible, these systems aim to increase the number of suppliers while keeping the motivation and the nature of the act of giving an organ unchanged.

As argued in the previous section, kidney transplantation increases the overall utility by saving the lives of recipients and causing only short-term and relatively minimal pain and discomfort for the suppliers while satisfying both parties’ preferences. The effect of kidney transplantation on the family and friends of the participating parties also generates greater happiness and preference satisfaction overall. Hence, all foreseeable things considered, the non-incentivized systems of organ transplantation lead to better consequences in terms of happiness and preference satisfaction than the absence of organ transplantation, and therefore they are the morally preferred choice among the two options.

By removing the disincentives such as the costs of pre-donation tests and screenings or of the post-surgery health issues related to the donation using reimbursements, the non-incentivized systems can allow more suppliers to take
part in the system without being restricted by the financial costs of the procedure. This enables the suppliers who desire to give their organs to have the chance to satisfy this preference. Also, by making it possible for more suppliers to be able to save recipients’ lives, the systems that remove more disincentives can bring about a higher amount of overall happiness and preference satisfaction.

B. Incentivized Systems

Unlike the non-incentivized systems, the incentivized systems of organ transplantation aim to increase the number of available organs by adding new motivations to participate in the system. Systems of compensation and commercialization use incentives in forms of money, health insurance, or tax reductions to make more individuals interested in being suppliers. By providing such benefits, the incentivized systems also work as a way of acquiring these benefits for those who need them and cannot afford them otherwise. Such a situation would give the individual a reason to consider providing her organ as a means of acquiring those ends even if she was not contemplating participating in organ transplantation before.

The assumption is that since the incentivized systems do not prohibit giving an organ without accepting the incentives (i.e., donating an organ or just accepting reimbursement in return), suppliers who are motivated by incentives add to the pool of already interested suppliers and result in an increased number of available organs for transplantation. Hence, an increased number of lives are
saved in such a system in comparison to the non-incentivized systems. Once the pool of available organs becomes large enough, there are additional benefits to just having more patients receive organs. A bigger pool of organs allows better matches to be found for the patients, and through good matches, the graft and patient survival rates increase while the rates of repeated transplantations decrease.69 This way, not only do more patients receive organs, but they are also less likely to return to the waiting list. Also, by shortening and even eliminating the period that the patient spends on dialysis, the incentivized systems aim to increase the patient’s quality of life and the graft survival after the kidney transplantation, given that the waiting time on dialysis has a significantly detrimental effect on the outcome of the transplantation.70

From the perspective of preference utilitarianism, the increased number of suppliers and recipients in the incentivized systems results in greater preference satisfaction. In addition to the satisfaction of the recipients whose lives are saved, of their families and friends who do not lose their loved ones, and of the suppliers who prefer to save lives without desiring the incentives, those suppliers who prefer benefits like medical insurance, tax reduction, or a sum of money have their preferences satisfied. Applying the classical utilitarian evaluation, recipients are avoiding great pain and deriving great happiness over time, especially with the bigger pool of available organs. On the other hand, suppliers also avoid the pain

resulting from lacking those benefits that they need, and derive happiness by using these benefits and/or by saving someone’s life. In conclusion, it can be claimed that the incentivized systems provide the maximum preference satisfaction and happiness in comparison to the non-incentivized ones.

The organ market is the most effective system of providing incentives since it provides a sum of money that the suppliers are free to use for any purposes that they prefer. It does not rely on a package of benefits to attract suppliers; instead, it provides the most straightforward type of incentive. This does not mean that it necessarily excludes any ‘free services’ for the supplier. Depending on how it is regulated, organ markets can take different forms, varying from a sum of money given to the supplier to free pre- and post-surgery care and health insurance for transplant-related problems in addition to the sum of money. Given its effective incentives, an organ market is most likely to provide the highest number of suppliers attracting not only those in need of specific benefit packages but also anyone who is interested in providing an organ in return for a sum of money.

In the incentivized systems, a bigger number of recipients’ most important preferences of staying alive and having a higher quality of life are satisfied. It can be argued that in the incentivized systems, recipients will have to pay for the organ or have the adequate insurance that will cover the costs of buying an organ, and they may prefer not paying for the organs and hence to be in a system of donation. However, the system of donation cannot supply enough organs to meet the needs of those who are in desperate need of organs, whereas an organ market
is likely to minimize or completely overcome the gap between the supply and demand with lower rates of repeated transplantations given better matches. Hence, the recipients cannot reasonably prefer the system of donation without preferring to drastically decrease their chances for survival. Also, since the incentivized systems do not prohibit donations, the option of getting an organ for free remains. When it comes to the suppliers, they only participate in this transaction if they find it satisfactory. Hence, from the preference utilitarian perspective, allowing organ market satisfies the supplier’s preferences as well as the recipient’s.

As before, the hedonistic account is in agreement with preference utilitarianism in the evaluation of an organ market. While the recipient increases her overall long-term happiness, the supplier is also likely to increase her happiness by agreeing to accept short-term pain and discomfort in return for money that the supplier is free to use for her education, for eliminating her debts, for medical services of her loved ones, for personal health care, for insurance, for starting a business, or for charity if she does not need the money for herself. The supplier can reasonably judge all of these benefits to override the short-term pain and discomfort related to the transplantation, especially if she also derives happiness from saving another person’s life.

Utilitarianism, taken in the form of preference satisfaction or maximization of happiness, leads to the conclusion that the incentivized systems, and specifically the organ market, is the morally right choice given that it generates the highest utility among the options. Of course, this is not an absolute result, and in specific cases or under specific conditions, unforeseeable
consequences or circumstantial factors may prove that organ market does not produce maximum happiness or preference satisfaction. If, for example, in a given country, the survival rate of organ transplantation is extremely low for both the recipient and the supplier, it may turn out that allowing more people to take this risk actually reduces the overall utility and preference satisfaction. For this example to work, the risk rate must either be misjudged by the experts or by the suppliers. In such a case, the misjudgment of risk and the inaccuracy of predictions would lead to a result where more people participate in organ transplantation, which results in worse consequences than having less people participate. However, given the existing information and the foreseeable consequences, a prohibition against an organ market from a utilitarian perspective is unfounded since the organ market is most likely to maximize overall utility and hence is the morally right system for organ transplantation.

III. Objections to an Organ Market

There are many objections to the conclusion that the regulated organ market for kidneys is the morally right choice and therefore should not be prohibited. I next consider two main objections that point out factors that may arise from endorsing an organ market: the crowding-out effect and the social preferences. Both of these objections challenge the idea that an organ market is likely to increase utility. The argument from crowding-out claims that the number of available organs may not be greater in an organ market than in a non-
incentivized system. And the argument from social preferences argues that the negative utility arising from public dissatisfaction of endorsing certain values may outweigh the positive utility the organ market offers.

Both of these arguments, as well as other arguments in relation to externalities, mainly ask an empirical question, and a satisfactory answer can only be provided through empirical research. In the following discussion, I refer to the existing studies on these questions to evaluate the strength and validity of these objections.

A. The Crowding-Out Effect

The first objection is based on the crowding-out effect. It is argued that the change from a non-incentivized system to an incentivized system would not increase the number of suppliers. Instead of keeping the number of existing suppliers who would be willing to make their organs available under the non-incentivized systems and adding to this number new suppliers who only make their organs available in return for benefits, the organ market would end up losing a substantial amount of the existing suppliers. The idea behind this objection is the following: People who decide to participate in organ transplantation under the non-incentivized systems do so because they derive happiness from the idea that they are acting altruistically and helping others by saving their lives. However, in an incentive-driven system, such as an organ market, this act loses its ‘heroic’ character and becomes a self-centered, if not desperate, act for financial benefits.
This change in the character of the act will exclude the suppliers in the non-incentivized systems and end up recruiting a new set of people, which may not be necessarily larger than the previous set.

An early formulation of this objection can be found in Titmuss’s book on blood donations. In The Gift Relationship, Titmuss argues for an altruism-driven system, claiming that financial incentives give rise to the crowding-out effect. This is ultimately an empirical question. Since Titmuss, there have been many studies conducted on the effects of incentives, and the available evidence strongly suggests that crowding-out of altruistic donors will not happen, or at least that it will be dominated by the increase in supply from other, financially motivated donors. The argument can be evaluated by asking two questions: First, which group of potential donors is likely to be affected by the incentives? Second, how would incentives play a role?

Effects on Altruistic and Directed Donors

In 2010 and 2011, in the United States, there were in total 366 anonymous—that is, altruistic, non-directed—kidney donors. This accounts for 3% of all living kidney transplants and only about 1.1% of all transplants, where the number of all transplants in 2011 accounts only for 18.3% of the patients waiting for a kidney.71 While each kidney donation is a crucial contribution to a specific patient’s life, given the percentage of altruistic donors in relation to the

71 Calculations are based on OPTN’s tables on “Living Donor Transplants by Donor Relation,” “Transplants by Donor Type,” and “Overall Waiting List by Organ” for kidney transplantation, last modified April 6, 2012, http://optn.transplant.hrsa.gov/latestData/step2.asp.
number of patients on the waiting list, the worry that incentives would decrease
the number of altruistic donations shows that the risk of crowding-out is not a risk
with high costs. On the contrary, if there is a considerable chance that incentives
can increase the number of suppliers—both altruistically and financially
motivated—then a decrease in the number of existing altruistic donors is a risk
that can reasonably be taken.

On the other hand, the objection from crowding-out can be formulated
also by focusing on the directed donors. According to this objection, the option of
buying an organ would make the would-be directed donors prefer going for the
market, resulting in a decrease in the total number of directed donors. This will
cause more patients to be added to the waiting list, forcing the commercialized
system to accommodate the patients who could have had a donor in a non-
commercial system. The objection claims that a patient’s family and friends, who
would be willing to donate their organs, now would be unwilling because given
the commercial options, they do not see themselves under the obligation as they
would have in a system of donation where they are the last resort for saving the
patient’s life.

This argument causes a problem in the utilitarian evaluation of
incentivized systems if and only if this change in attitude of would-be suppliers
causes the gap between suppliers and recipients to be larger than in a non-
incentivized system. In an incentivized system, either there will be enough organs
to eliminate the waiting list or the supply will remain somewhat short of the
demand. If there are enough organs to meet the demand, then the argument
becomes irrelevant. If the supply in the incentivized system does not meet the demand, then there are always other factors—such as priority on the waiting list, finding a good match, or having the adequate insurance—that determine whether or not a particular patient will be able to receive an organ. Here, if it turns out that the market cannot provide an organ for the patient in a reasonable time period, the would-be directed donors become again the sole lifesaving options, and the same motivation they have in the non-incentivized system should apply under these circumstances. Hence, the recipient who has a donor does not lose her chance to survive in an organ market. On the other hand, since the incentivized system is expected to recruit more non-directed suppliers, the recipient without a potential directed donor now acquires an increased chance of survival.

Role of Incentives

Having laid out how directed and non-directed potential donors may be affected by the incentives, now we can turn to the second point of the argument, which is the link between the incentives and the crowding-out effect. The argument suggests that once the incentives are introduced, the potential donor decides not to donate her organ given that, in an incentivized system, her act loses its character as an altruistic action.\(^\text{72}\) A response to this is found in a Swedish  

\(^{72}\) A Swiss study on the effects of compensation in relation to the “Not In My Backyard” problem supports this position by concluding that while 50.8% of citizens accept accommodating a nuclear waste repository in their neighborhood without compensation, once the compensation is introduced, this number drops down to 24.6%. See, Bruno S. Frey and Felix Oberholzer-Gee, “The Cost of Price Incentives: An Empirical Analysis of Motivation Crowding-Out,” *The American Economic Review* 87, no. 4 (1997): 748–749.
study that shows that crowding-out can be eliminated with simple design enhancement. The study compares blood donation rates under three options: no incentive, receiving $7 for donation, and the option of choosing to receive $7 or to donate this money to a charity. It concludes that while the group that is offered incentives show less willingness to donate any blood, by adding the option of donating the money to the charity, this crowding-out effect is fully counteracted in the third group.\footnote{Carl Mellström and Magnus Johannesson, “Crowding Out in Blood Donation: Was Titmuss Right?” Journal of the European Economic Association 6, no. 4 (2008): 845–863.} Adding the option of charity seems trivial given that any supplier would be free to give any money received to charity anyway. But the study suggests that having the option stated explicitly influences the individual’s decision. According to this study, there is no major gain in the number of suppliers from adding the incentives (with the option of charity) but this may well be due to the unattractiveness of the incentive ($7 for giving blood).

While the money offered in the Swedish study may be inadequate to act as an incentive for the time and discomfort involved in blood donations, another study suggests that the increase in supply in kidneys from commercialization would be very substantial even at relatively low prices. Using the U.S. data on risks involved in kidney transplantation and the value judgments expressed in 2005 dollars, the study argues that at about $15,200 per donor, “a very large supply of live kidney donors would be available.”\footnote{Becker and Elias, “Introducing Incentives in the Market for Live and Cadaveric Organ Donations,” 9–11.} This relatively low price is calculated by taking into consideration the risk of death, the time lost during recovery, and the risk of reduced life quality in kidney transplantation and the

estimates are based on the “economic research on individuals’ willingness to take on risk; the low mortality risk of kidney and liver donations; the expected change in quality of life; and the short recovery period.”

This conclusion that, with adequate incentives, commercialization is able to increase the number of available organs considerably is also in line with other empirical results. Surveys on the likely effects of incentives show that incentives increase the likelihood of making an organ available. The crowding-out argument is ultimately an empirical argument, and its validity depends on the available evidences. The existing evidence suggests that the number of altruistic donations is already extremely low, and incentives have the capacity to increase the overall number of available organs as long as they are determined and offered adequately. To conclude, the empirical evidence does not suggest a necessary link between incentives and the crowding-out effect unlike the assumption that Titmuss’s argument relies on.

B. Social Preferences

A group of arguments against an organ market refer to the social norms that people value, and claim that an organ market would reduce the overall utility by conflicting with these values. The claim is that people derive happiness and

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75 Ibid., 14.
satisfaction from living in a society where the promoted and condemned values match the people’s views on these values. The objection suggests that organ market may give rise to a dissatisfaction and unhappiness by causing a conflict between what people value and what society endorses by allowing an organ market. It is argued that, for example, allowing an organ market indicates that the values such as altruism and solidarity are being replaced with a monetary transaction, treating human body as a commodity. This change in social values may result in a lower overall utility, the argument suggests, given people’s unhappiness and dissatisfaction of living in a society, that promotes values that people disagree with.

This objection can be taken in two forms: appearance and substance. The first formulation, which is based on appearance, suggests that the society associates certain acts with certain values even though the association is not necessary and is unclear. In the example of organ transplantation, this would present itself in social understanding that giving a kidney without receiving any benefits in return demonstrates altruism and solidarity, whereas providing a kidney in return for material benefits shows selfishness. Even though it can be argued that donating a kidney is likely to be related to the values of altruism and solidarity, selling a kidney does not show the lack of these values. The person who sells a kidney may still have the best interest of the patient in mind while believing that other values such as justice or reciprocity would allow her to accept

77 Nancy Scheper-Hughes, “The Ends of the Body: Commodity Fetishism and the Global Traffic in Organs,” S A I S  R e v i e w 2 2 , n o . 1 (2 0 0 2 ) : 6 1 – 8 0 ; G ab r i e l M. Danovitch and Alan B. Leichtman, “Kidney Vending: The ‘Trojan Horse’ of Organ Transplantation,” C l i n i c a l J o u r n a l o f t h e A m e r i c a n S o c i e t y o f N e p h r o l o g y 1 (2 0 0 6 ) : 1 1 3 3 – 1 1 3 5 , d o i : 1 0 . 2 2 1 5 / C J N . 0 3 0 3 0 9 0 6 .
material benefits in return for this good deed. Alternatively, the person may desire to distribute the benefits to more people by accepting the money from a recipient who can afford it and giving it to those who are in financial need. On the other hand, a non-incentivized system does not guarantee altruistic acts since a kidney donor may also act on selfish reasons such as promoting her image within her social circle. And finally, the organ market does not prohibit individuals from donating their organs. Hence, allowing incentives does not necessarily eliminate social values such as altruism or solidarity, on the contrary, it may uphold even more social values such as justice, reciprocity, and charity.

This formulation of the objection shows that the problem is essentially one of appearance, and the society does not actually lose the values that people derive happiness and satisfaction from. Hence, with the right presentation and clarification of the policy, the problem of dissatisfaction can be eliminated. On the other hand, the second formulation assumes that the policy change actually causes a conflict in social values leading to people’s unhappiness and dissatisfaction. If, for example, people have a strong reaction against the involvement of money in organ transplantation, then they will necessarily be unhappy and dissatisfied with the introduction of an organ market.

In such a case, the answer again relies on the empirical evidence, which requires a comparison between the utility gained by saving the lives of the recipients and by meeting the needs and desires of the suppliers and the utility lost by endorsing the undesirable social values. While it is possible that the frustration and unhappiness over the undesirable social values outweigh the positive utility
that results from an organ market, that seems to be an unlikely scenario. In the case of an organ market, since the utility gain is likely to be extremely high, involving thousands of lives, the dissatisfaction resulting from endorsing monetary transaction needs to be very high to generate an overall negative utility. Also, it seems like the negative value judgment on the practice of an organ market is misplaced, given that similar practices already exist without causing extreme dissatisfaction or unhappiness in the society. Such extreme dissatisfaction cannot arise from the social endorsement of paying for body parts, given that it is already an accepted practice to pay for various body parts such as eggs, semen, and hair. On the other hand, if the dissatisfaction arises from the possibility that the extremely poor will take risks and endure the unpleasant procedure, it must be recalled that this is also an already existing practice since the risky and unpleasant jobs are likely to be held by the poor.

IV. Summary

In the discussion of incentives in organ transplantation, the utilitarian analysis proves that a prohibition against an organ market cannot be justified on moral grounds. For an individual, selling an organ does not necessarily maximize the overall utility, yet it is quite possible that given the circumstances, it turns out to be the morally right action. Hence, for the individual to have the chance to maximize utility, the option of selling an organ needs to be available. A comparison between incentivized and non-incentivized systems results in an even
bolder claim, stating that a regulated organ market is the system that is most likely to maximize the overall utility. Therefore, it is the morally right choice for policy. Two main objections against organ market aim to show that the organ market is likely to reduce overall utility; however, they fail to make a strong case. The utilitarian analysis is mainly based on empirical evidence and predictions. The existing evidence and study results do not support the claims that are put forward in these objections.
CHAPTER 4

KANTIAN ETHICS

In this chapter, I evaluate the claim that an organ market necessarily entails immoral actions with respect to Kant’s categorical imperative. I argue that (necessary behavior in) an organ market does not violate the categorical imperative. Quite the contrary, the categorical imperative requires permitting a regulated organ market, that is, any prohibition against organ market is morally impermissible.

All Kantian moral rules derive from the categorical imperative, “a law of pure reason applying to the will.” Kant presents the categorical imperative in various formulations, claiming they all refer to the same fundamental moral principle one must follow. Among these, Kant emphasizes two—the formula of universal law and the formula of humanity—by applying them to four cases. Whether these formulas are equivalent or represent different aspects of the categorical imperative has been a subject of controversy among Kant scholars.

80 Ibid., 31–39.
Refraining from taking sides on this discussion, I evaluate the systems of organ transplantation separately in relation to the formula of universal law and to the formula of humanity.

In a much-quoted passage from the *Metaphysics of Morals*, Kant condemns not only organ sale but also any type of organ transplantation.\(^8^2\) He claims,

> To deprive oneself of an integral organ (to maim oneself)—for example, to give away or sell a tooth to be transplanted into another’s mouth, or to have oneself castrated in order to get an easier livelihood as a singer, and so forth—are ways of partially murdering oneself. But to have a dead or diseased organ amputated when it endangers one’s life, or to have something cut off that is a part but not an organ of the body, for example, one’s hair, cannot be counted as a crime against one’s own person—although cutting one’s hair in order to sell it is not altogether free from blame.\(^8^3\)

Kant puts this claim in relation to treating oneself as a mere means, which is morally impermissible according to the formula of humanity.

As I argue in this chapter, this claim, like Kant’s other statements against organ transplantation, cannot be justified in a coherent interpretation of his ethical theory.\(^8^4\) The claim rests on the idea that one cannot forgo one’s healthy body parts to achieve another end. This seems in tension with Kant’s own evaluation of other situations, in particular his endorsement in his *Lectures in Ethics* of a

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circumcision if otherwise the person will be condemned to death.\footnote{For further discussion of Kant’s claims regarding the use of body parts, see Taylor, \textit{Stakes and Kidneys}, 146–157.} I do not need to explore this tension further, however, because I shall argue that Kant’s claim against organ transplantation is based on an overly broad interpretation of Kant’s own notion of “humanity.” While Kant’s ethical theory puts the human rational nature as the core of humanity, Kant’s claims about forgoing body parts understands this notion almost equal to the human body and bodily integrity, rendering any organ transaction—including donation—morally impermissible.

This chapter is divided into two sections. In the first section, I argue that, being based on the rational nature, the formula of humanity properly understood only objects to certain (mis-)treatment of others’ and one’s own ability to set and pursue ends. It follows that, contrary to Kant’s assertion, donating or selling an organ does not necessarily violate one’s humanity. Only transplantations from coerced or manipulated individuals, and transplantations that damage the individual’s rational capacity, are morally impermissible under the formula of humanity. This understanding of humanity also provides a basis to analyze Kant’s idea of dignity and how it relates to an organ market. I argue that dignity, being ascribed to human capacity for rationality, does not object to commercial transaction of organs. The formula of universal law leads to the same conclusion through the analysis of the plausible maxims that the participants of the organ market can hold. I argue that both recipients’ and suppliers’ maxims in an organ market are universalizable without contradictions. Hence, both recipients’ and suppliers’ actions are morally permissible.
In section two, I go further and claim that far from morally condemning organ sales, the formula of humanity actually requires that organ sales be allowed. The formula of humanity requires that people treat the rational nature as an end in itself. This entails an imperfect duty to contribute to the advancement of rational capacity, and preserving one’s life in morally permissible ways is an indirect duty that enables one to follow this imperfect duty. While there are generally many ways of doing so, buying an organ becomes the only way to fulfill this imperfect duty when the person’s organ fails and a donation is not forthcoming. Thus, prohibiting morally permissible organ sales makes it impossible to fulfill an imperfect duty in certain situations. Such a prohibition, therefore, violates the formula of humanity.

I. Moral Permissibility of a Regulated Organ Market

The claim that an organ market necessarily entails immoral actions cannot be justified in the framework of Kantian ethics. In the Kantian framework, individuals’ actions are judged by the maxims that underlie them. The maxims are determined to be morally permissible or impermissible depending on their conformity to the demands of the categorical imperative. Hence, in order to check the validity of the claim against the organ market, it is necessary to evaluate the possible and plausible maxims of individuals who participate in organ transplantation in relation to the formulas. In this section, I will put forward the possible and plausible maxims of the participants of a regulated organ market and
evaluate these maxims using Kant’s formulas of humanity and universal law. I will argue that both the recipients and the suppliers can act on morally permissible maxims and participate in a commercial transaction of organs without violating the categorical imperative.

A. Formula of Humanity

The formula of humanity states that you must “act that you use humanity, whether in your own person or in the person of any other, always at the same time as an end, never merely as a means.” The formula thus has two components: Never treat humanity as a mere means, and always treat it also as an end. Kant categorizes the duties that arise from this division under two types: perfect and imperfect duties. One has a perfect duty, a duty “that admits no exception in favor of inclination,” not to treat humanity as a mere means. And one has an imperfect duty to treat humanity as an end in itself. If one’s maxim, “the subjective principle of volition,” does not violate any of these duties, then it is morally permissible to endorse that maxim.

Kant uses four examples to illustrate how the formula of humanity judges a maxim’s moral status. As examples of maxims that treat humanity as a mere means and hence violate a perfect duty, Kant cites the maxims of suicide and of

86 Kant, *Groundwork of the Metaphysics of Morals*, 38.
87 Ibid., 31.
88 In *Metaphysics of Morals*, 194, Kant defines the imperfect duties as those whose fulfillment has merit but “failure to fulfill them is not in itself culpability but rather mere deficiency in moral worth, unless the subject should make it his principle not to comply with such duties.”
making false promises. In the suicide case, one is disposing of oneself in order to avoid intolerable conditions. In the case of making false promises, one is deceiving another in order to benefit oneself. By contrast, the maxims of never furthering one’s talents and never helping others do not treat humanity as a mere means, and hence do not violate a perfect duty. However, they violate the imperfect duty of treating humanity as an end in itself. A maxim treats humanity as an end by harmonizing with it and furthering it as an end. What Kant means by this becomes clearer in his examples. Furthering one’s talents is an imperfect duty because not doing so fails to further humanity, which has “predispositions to greater perfection, which belong to the end of nature with respect to humanity in our subject.” Similarly, by not helping others, one fails to treat humanity in others as an end in itself, since “ends of a subject who is an end in itself must as far as possible be also my ends.” The imperfect duty in relation to humanity is a positive and affirmative approach to the humanity committed to its furtherance, such as the furtherance of its capacities and the ends of others. By not helping others and not furthering one’s own talents, one fails to contribute to the advancement of humanity. In all four examples, endorsing these maxims is morally impermissible because the maxim violates a perfect or imperfect duty.

Kant’s application of the formula of humanity in these examples is not free from controversy. Nevertheless, it helps illustrate how the formula of humanity works as a guiding principle for action. At first glance, the formula of

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90 Ibid., 38.
91 Ibid., 39.
92 Ibid.
93 Ibid.
humanity seems to provide grounds for arguing against organ transplantation in any form with the understanding that the organ transplantation necessarily uses one human being in order to save another, which would be a violation of a perfect duty, which claims that one can never use humanity as a mere means. However, a deeper look reveals the actual scope of the formula’s demands and shows that according to the formula of humanity, neither organ transplantation in general nor organ sale in particular necessarily involves morally impermissible maxims.

Kant’s employment of humanity does not simply refer to the human person by virtue of her belonging to the species. Instead, it derives the value of humanity from the human capacity for rationality and ability to set ends and to pursue them.94 In the Metaphysics of Morals, Kant writes, “The capacity to set oneself an end—any end whatsoever—is what characterizes humanity (as distinguished from animality).”95 A coherent collection of Kant’s use of the concept of humanity also supports the idea that this concept refers to rationality and the capacity to set ends.96 Therefore, the formula of humanity concerns the treatment of this rational capacity. It demands that this rational capacity be acknowledged by prohibiting its impairment and by promoting its development—in other words, by never treating humanity as a mere means and always treating it as an end.97

94 Johnson, “Kant's Moral Philosophy.”
95 Kant, Metaphysics of Morals, 195.
97 Hill, Dignity and Practical Reason in Kant’s Moral Theory, 50–51.
Application to Non-Incentivized Systems

A typical supplier in kidney donation is not likely to be willing to put his life in great danger except in donations with special relations such as parent–child donations. Hence, in a non-incentivized system of kidney transplantation, the maxim that the supplier acts on can be plausibly formulated as “I will give my organ to save someone’s life if I value helping a person more than the negative consequences of transplantation on me as long as the procedure is not likely to cause my death or to impair my brain functions.” On the other hand, a typical recipient in a system of kidney donation, where the system has the basic requirement of ensuring the participant’s voluntary, informed, and rational decision, would have the luxury of not worrying about the well-being of the supplier and trust the supplier’s offer is not coerced or extremely risky. If this is so, the recipient’s most plausible maxim can be formulated as “I will accept organs to save my life from those who want to give their organs by their voluntary, informed, and rational choice as long as the procedure is not likely to cause the supplier’s death or to impair the supplier’s brain functions.”

Does such a transaction violate the formula of humanity? It might be argued that it does because the recipient uses the supplier simply as a means for an end—namely, to stay alive. If this argument were accepted, not only the recipient’s act but also the supplier’s act would be impermissible since the supplier would let herself be treated as a mere means.
Such an evaluation of organ transplantation would fail to fully grasp the maxims that are involved in this transaction and the actual demand of the formula of humanity. First, let us look at the supplier’s position. The transaction occurs through the free will and rational decision of the supplier. The supplier makes an informed, rational, and voluntary decision to give her organ in order to save another person’s life. The supplier’s maxim stated above does not violate the formula of humanity by treating her own or another’s rationality and rational capacity as a mere means or by failing to treat her own or another’s rationality and rational capacity as an end. Her act does not damage or interfere with rational capacity of anyone, and it contributes to the advancement of rational capacity by saving the recipient’s life.

The key distinction here is that the formula of humanity is mainly concerned with the rationality and rational capacity and not with the body and bodily integrity. The most coherent interpretation of Kant’s wide usage of the concept of humanity throughout his works shows the strong connection between humanity and rational nature, but almost no substantial evidence of the connection between bodily integrity and humanity. The formula of humanity is focused on the treatment of “the capacity to take a rational interest in something”\textsuperscript{98} or in other words, of “only those powers necessarily associated with rationality and ‘the power to set ends.’”\textsuperscript{99} Of course, this does not mean that Kantian ethics gives no importance to bodily integrity. It only means that bodily integrity is not valued as ‘humanity’ even if its value can be derived from other concepts.

\textsuperscript{98} Korsgaard, Creating the Kingdom of Ends, 114.
\textsuperscript{99} Hill, Dignity and Practical Reason in Kant’s Moral Theory, 40.
Given the lack of direct connection between the body and the humanity, even though Kant states his position against giving an organ as quoted at the beginning of this chapter, within his own system, this position is unfounded. Giving a body part does not entail a violation of one’s humanity. Therefore, any objection that is brought from the formula of humanity against organ transplantation has to be directed against the rational nature of the participants and not simply to their body parts.

This distinction between body and rationality suggests that the recipient’s act of accepting the organ does not violate her duties towards others. The recipient acts on the maxim of saving her life by accepting an organ from those who are willingly offering without greatly endangering their lives or their mental capacities. By acting on this maxim, the recipient does not treat the supplier as a mere means, given that the supplier’s offer is based on her rational decision and the recipient does not manipulate or deceive the supplier into making her organ available; she simply accepts the supplier’s offer. By not interfering with the rational capacity of the supplier and by respecting her decision to pursue this end, the recipient does not treat the supplier as a mere means to her survival but, on the contrary, treats her as an end by contributing to her rationally adopted end. The recipient clearly also does not violate her perfect or imperfect duties to herself in relation to the formula of humanity; she does not treat herself as a mere means, and moreover, she treats herself as an end by saving her life and saving her rational capacity.

100 There can be an argument against giving a part of one’s brain since even if we assume the person can survive, if the person loses her rational capacity, she will be violating the formula of humanity by using her rational capacity as a mere means.
In incentivized systems, the recipient’s maxim remains the same, but the supplier’s maxim changes to “I will sell my organ to save someone’s life if I value helping a person and/or the material benefits of selling my organ more than the negative consequences of transplantation on me as long as the procedure is not likely to cause my death or impair my brain functions.” This maxim can give rise to three types of action: (1) acting with the motivation of helping others and benefiting oneself, (2) acting with the motivation of only benefiting oneself, and (3) acting with the motivation of only helping others. By acting out of one of these motivations, does the supplier treat the humanity in herself or in others as a mere means?

In the first case, the supplier is motivated both by helping the recipient and by benefiting herself. By doing so, she does not treat the recipient as a mere means since she does not use the recipient’s rationality for her own ends. Her decision is influenced by the recipient’s desire to live, and the supplier aims to fulfill this desire while also benefiting herself. By helping the recipient to survive, the supplier also treats her as an end and contributes to the survival and advancement of her rational capacity.

It can be argued that by accepting the benefits the supplier shows that she is not motivated by saving lives at all. Otherwise she would have simply rejected the incentives, and if not, she would have given the money to charity. This claim rejects that an act can be done out of a mixed motivation and suggests that if one
is paid, then one’s action is based on self-interest. However, this reasoning would also apply to other cases that we commonly consider as acts that are partially, but undeniably, motivated by saving lives. For example, professionals such as doctors, nurses, or fire fighters are considered as people who are mainly motivated by saving lives and helping others. Yet, if we apply the same argument, since they accept payments that are more than reimbursements, they cannot be motivated by helping others but only by self-interest. It can be argued that these professionals are not motivated by self-interest but they simply cannot always volunteer since they also need to somehow make a living. Yet, this would suggest that a payment that covers their needs for survival or bare minimum life standards would suffice if their acts are motivated by helping others. While this conclusion suggests that such people are not acting only out of the motivation of helping others, it also does not reject that they can act out of a mixed motivation that takes into account both helping others and benefiting themselves. It can be argued that a doctor who earns more than minimum money or a person who makes her organ available for money may not be acting on the maxim that says “I will save others’ lives,” but her maxim can include this motivation by saying “I will benefit myself in ways that will also help saving others’ lives.”

In the second case, the supplier is motivated only by the incentives. It might be argued that this implies that the supplier treats the recipient only as a source for material gain, and hence as a mere means. The same argument would apply in the third case, where the supplier is motivated only by helping others, yet chooses to sell the organ instead of donating it. An example of such an instance is
found in the kidney sale scandal of 1989 in England, where the supplier sold his kidney in order to buy lifesaving medication for his child. In such a case, even though the supplier is completely altruistically motivated just like the supplier in a non-incentivized system, it might be argued that her maxim aims to use the recipient as a mere means to earn money to help someone else. Hence, so the argument would go, she treats the recipient as a mere means to reach another goal.

The preceding argument fails because it is based on an improper understanding of what it means to treat humanity as a mere means. Treating humanity as a mere means entails disregarding one’s own or someone else’s rational capacities. As long as the recipient makes a rational, informed, and voluntary decision to accept the organ, however, the supplier does not impair and make use of the recipient’s rational capacity for her own purposes. Even though the supplier treats the recipient as a means to gain personal benefits, it does not mean that the supplier treats the humanity in the recipient as a mere means.

The formula of humanity does not prohibit one to treat another’s or one’s own humanity as a means to an end, but it prohibits the treatment of humanity merely as a means. Most human interaction is based on means–ends relationships. When I take a taxi, I treat the taxi driver as a means to my end—that is, reaching my destination. When I listen to lectures, I treat the lecturer as a means to my end—that is, learning. Thus, if it were prohibited to treat another person as a means, most of our daily activities would violate the moral law.

Moral condemnation attaches only if one treats others as a mere means, ignoring their rational nature or obstructing their rational capacity. Forcing the

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taxi driver to take me to my destination even though she already called it a day would be treating her merely as a means since I do not care about her decision and want to use her as a purely instrumental ‘thing.’ In such a case, I would be morally blameworthy for violating her rational nature. On the other hand, if the taxi driver wants to get some customers to pursue her end—that is, to earn money—then my act of taking the taxi treats the taxi driver as a means to my end as well as respecting her rational nature by allowing her to pursue her own ends.

Returning to the case of incentivized organ donation, the supplier not only refrains from treating the recipient’s humanity as a mere means by engaging in a transaction where the recipient’s offer is rational, informed, and voluntary, but she also treats her humanity as an end in itself by saving her life and enabling the advancement of her rational capacity. The supplier’s maxim can violate the formula of humanity also if it allows the supplier to let her own humanity to be treated as a mere means or does not contribute to the advancement of her humanity. However, given that the supplier also makes a rational, informed, and voluntary decision and does not impair her future rational capacity, her humanity—namely, her rational nature—is not used as a mere means. Moreover, depending on her use of the benefits that she gains from this transaction, the supplier may further her rational capacities by enabling herself to set goals and pursue them.

As for the recipient, her maxim remains the same in the incentivized system as in the non-incentivized system. She acts on her desire to save her life by accepting an organ from rational, voluntary, and informed supplier who does not
put her life or her mental capabilities in great risk by giving her organ. As explained earlier, the recipient does not treat the humanity in her own person wrongly by acting on this maxim.

It can be argued that the recipient violates the formula of humanity in her treatment of the supplier. The recipient does not care whose organ she receives as long as it serves her survival and hence uses the supplier as a mere means to her end. This argument fails in exactly the same manner as the previous argument about the supplier’s treatment of the recipient. Since the supplier makes a voluntary, rational, and informed decision, and since her rational capacity is not impaired by this transaction, there is no moral obligation generated by the formula of humanity for the recipient to reject the supplier’s offer to sell her organ. By providing benefits for the supplier, the recipient also possibly contributes to the advancement of the supplier’s rational capacity.

The focus on rationality in the discussion of organ transplantation does not entail that any act that is rational is morally permissible. In an act where one party makes a well thought-out and non-coerced decision to murder or rape another person, such an act cannot be morally permissible given that the other party—that is, the victim—does not agree to participate in this act. This is not the case in a regulated organ market, given that the rational, voluntary, and informed participation of both parties is ensured. Another type of action where the well thought-out and non-coerced decision of the individual does not render the act morally permissible refers to that, which is concerned with an act that is opposed to rationality. In the case of suicide (or even consented murder), the act aims to
terminate the rationality of an individual. Such an act would treat humanity—that is, the rational nature—wrongly.¹⁰²

*Objection from Dignity*

Another objection against an organ market frequently mentioned in connection with the formula of humanity is based on dignity. The basis for this objection is Kant’s statement “In the kingdom of ends everything has either a *price* or a *dignity*. What has a price can be replaced by something else as its *equivalent*; what on the other hand is raised above all price and therefore admits of no equivalent has a dignity.”¹⁰³ Buying and selling organs, so the objection goes, treats humans as things that can be assigned prices and that can be replaced with another ‘thing,’ violating dignity.

Assessing this argument requires clarification of the notion of dignity. Kant describes dignity as “an unconditional, incomparable worth.”¹⁰⁴ As discussed earlier, Kant’s idea that human beings are ‘ends in themselves’ and that humanity in persons must be respected emanates from his position on what makes humans distinct from things. His claim is that the distinguishing factor is the rational nature of humanity. Humans’ rational capacity allows them to set their own ends and to pursue them. He claims that “[a]utonomy is therefore the ground

¹⁰² Kant does not argue that all self-killings are morally wrong. He holds the view that some cases of killing oneself as well as allowing oneself to die are morally justified. For example, in *Lectures on Ethics*, 150, Kant argues that it is better to die if one cannot live morally.
¹⁰³ Kant, *Groundwork of the Metaphysics of Morals*, 42.
¹⁰⁴ Ibid., 43.
of the dignity of human nature and of every rational nature."105 Because of this, they cannot be treated as things, which are instrumental, replaceable, and subject to others’ projects. Kant states that “morality is the condition under which alone a rational being can be an end in itself, since only through this it is possible to be a lawgiving member in the kingdom of ends. Hence morality, and humanity insofar as it is capable of morality, is that which alone has dignity.”106 To sum up, Kant’s understanding of dignity is based on the humanity’s capability of morality; and dignity, according to this understanding, is found in every human being with respect to her rational nature.107

Having clarified what dignity is ascribed to—namely, rational nature—now we can go back to the objection from dignity against a regulated organ market. The objection claims that organ sale violates the supplier’s dignity by treating her like an object. As I have emphasized, however, the supplier participates in organ transplantation through her informed, voluntary, and rational decision. Thus, the supplier, through her rational nature, sets her own ends (saving one’s life and/or receiving a sum of money) and pursues them. The supplier’s rational nature is respected by allowing her to pursue her morally permissible goals.

The objection from dignity suggests that the “actions of the type ‘selling a tooth to increase comfort’ tend to promote a notion that is inconsistent with the idea that humanity has dignity, namely the notion that a person is available for the

105 Ibid.
106 Ibid., 42.
107 Hill, *Dignity and Practical Reason in Kant’s Moral Theory*, 47.
right price for others to use as they will.” It is clear that putting a price to a person conflicts with the Kantian morality. One cannot sell a person at any price. However, the ground for this moral prohibition is rational nature, since this is what the dignity is ascribed to. By making a person available for the right price—that is, by selling a person—one sells one’s capacity to set ends for oneself and to pursue them. On the other hand, this prohibition does not dictate one never to put a price to anything related to being a human. An accountant lends her rational ability to calculate in return for money. A taxi driver lends her ability to drive in return for money. A shoemaker lends her talent to make shoes in return for money. These are all human capacities, and it would be absurd to refuse to pay the providers by claiming that this would be assigning a price to their humanity and would violate their dignity. By being involved in these transactions, none of these people lose their dignity; on the contrary, they exercise their rational capacity by pursuing their ends. Similarly, selling a kidney or a tooth does not impair one’s rational capacity and hence, does not violate the supplier’s dignity. It can be argued that selling a body part differs from selling a capacity; however, it is unclear how this point is relevant to dignity since dignity is much more closely related to the human capacities than to human body parts unless the body part is what enables rationality, like the brain.

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B. Formula of Universal Law

The formula of universal law states that you must “act only in accordance with that maxim through which you can at the same time will that it become a universal law.” Kant illustrates how this formula works with the same four examples as in his discussion of the formula of humanity. He asks whether the maxim generates contradictions once it becomes a “universal law of nature.” He distinguishes two types of contradictions, with different moral implications. The first type is a conceptual contradiction (an “inner impossibility”), which occurs if it is not even possible to think of a world where all rational beings follow such a maxim. Maxims that generate this first type of contradiction result in a perfect duty to refrain from endorsing them at all times without any exceptions. If the maxim passes this step, then the second type of contradiction—a contradiction in the will, which occurs if it is impossible to will this maxim to be a universal law—may still arise. Maxims that fail only this second test result in an imperfect duty to refrain from endorsing them while admitting exceptions in favor of inclinations. Only maxims that generate neither contradiction are morally permissible and may form the basis of a moral act.

To clarify how this method works, let us turn to two of Kant’s examples. According to Kant’s analysis, the maxim for making false promises

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110 Ibid.
111 Ibid., 33.
112 Ibid., 31–33.
113 Ibid., 33.
114 Johnson, “Kant’s Moral Philosophy.”
when one is in need fails the first round of the test. It generates a conceptual contradiction because once it is universalized, it becomes impossible to act on this maxim. Once every rational being makes false promises when in need, no one believes another’s word, making it impossible for the practice of promising to even make any sense. Kant calls this an “inner impossibility,” meaning that such a “maxim cannot even be thought without contradiction as a universal law of nature.” Since universalizing such a maxim causes conceptual contradiction—that is, inner impossibility—according to the formula of universal law, refraining from making false promises is a perfect duty towards others—that is, a duty that should never be violated.

By contrast, the maxim of never helping others does not generate a conceptual contradiction. As Kant points out, it is imaginable to have a world where no one helps another. Kant claims, however, that such a world cannot be willed and that “a will that decided this would conflict with itself.” Consequently, Kant judges the maxim of never helping others impermissible and categorizes the maxim of helping others under the imperfect duties that one should strive to fulfill.

What Kant means by the will contradicting itself is open to interpretation. One interpretation is that the rational will cannot oppose what enables one to reach one’s own happiness, because according to Kant, “the natural end that all human beings have is their own happiness.” The maxim of never helping

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116 Ibid., 33.
117 Ibid.
118 Ibid., 39.
others, once universalized, would cause a contradiction in this sense because without help, we are unlikely to be happy.119

Another interpretation appeals to the purpose of the will being “effectiveness in the pursuit of its ends, and its freedom to adopt and pursue new ends.”120 In the example, the maxim of never helping others fails because, once universalized, it opposes mutual cooperation, which supports the will’s effectiveness and freedom. Without help, it is unlikely that one will be able to pursue her ends as effectively as one would with help.

Application to Non-Incentivized Systems

As before, I assume that the supplier in non-incentivized systems acts on the maxim, “I will give my organ to save someone’s life if I value helping a person more than the negative consequences of transplantation on me as long as the procedure is not likely to cause my death or to impair my brain functions.” This maxim does not violate the formula of universal law. Clearly, there is no conceptual contradiction as in the example of making false promises. Nor is there a contradiction in the will. The maxim’s aim—saving lives—is in line with the purpose of the will, such as setting ends and pursuing them. The maxim preserves and promotes the will’s freedom and effectiveness.

The same conclusion applies to the plausible maxim that the recipient is prepared to act on: “I will accept organs to save my life from those who want to

119 Johnson, “Kant's Moral Philosophy.”
120 Korsgaard, Creating the Kingdom of Ends, 96.
give their organs by their voluntary, informed, and rational choice as long as the
procedure is not likely to cause the supplier’s death or to impair the supplier’s
brain functions.” Again, the maxim does not cause any conceptual contradiction
or contradiction in the will once it is universalized. Like the supplier’s maxim,
this maxim aims to save lives (in this case, the individual’s own life) and by doing
so supports the will’s purpose of being free and effective by ensuring the
underlying condition—namely, the will’s existence.

Application to Incentivized Systems

The recipient’s maxim remains the same in the incentivized system. Therefore, its analysis in relation to the formula of universal law also remains the
same. In any regulated system of organ transplantation, whether or not it is
incentivized, where the participants are informed, voluntary, and rational, the
recipient’s maxim of saving her life through an organ that is offered freely in
exchange of money or as a gift does not cause any type of contradictions.

By contrast, the supplier’s maxims in the incentivized systems require
additional analysis. As I have already discussed, the supplier’s position in
incentivized systems admits additional motivations as compared to non-
incentivized systems: “I will sell my organ to save someone’s life if I value
helping a person and/or the material benefits of selling my organ more than the
negative consequences of transplantation on me as long as the procedure is not
likely to cause my death or to impair my brain functions.” That is, the supplier
may now act with the motivation of (1) only helping others, (2) only benefiting
herself, and (3) helping others and benefiting herself. Clearly, none of these
maxims causes a conceptual contradiction; and I shall argue here that none of
them causes a contradiction in the will either.

Since the supplier’s maxim in a non-incentivized system does not cause a
contradiction in the will, in order for such a problem to arise in the incentivized
system, there needs to be a relevant distinction between the maxims in the
incentivized and non-incentivized systems. The first maxim in the incentivized
system captures the same act with the same motivation as in the non-incentivized
system, even though the people that the supplier prefers to help may vary (she
may be motivated to use the money to help someone else). The second maxim
replaces this altruistic motive with a self-centered motivation. And the third
maxim allows both motivations to persist in the sense that the supplier is
motivated both by saving the recipient’s life and by benefitting herself. The
contradiction in will arises from the conflict between the aim of the maxim and
the purpose of the will, which can be defined as effectiveness in pursuing ends
and freedom to adopt and pursue ends121 or pursuing its natural end of
happiness.122 Selling an organ in order to help others and/or to pursue one’s own
ends does not conflict with the will’s purpose defined as such.

The universalization of the first maxim does not differ significantly from
the universalization of the supplier’s maxim in the non-incentivized system. Since
it aims to help others, this maxim is in line with the will’s purposes. The second

121 Ibid.
122 Johnson, “Kant's Moral Philosophy.”
maxim assumes that the supplier does not take into consideration any altruistic reasons for her action such as saving the recipient’s life or helping someone else, but she only acts for the benefits. This maxim, capturing the motivation and the action of the supplier in a transaction that involves two informed, rational, and voluntary parties, does not cause a contradiction in the will once it is universalized either. Since it leads to an act that serves the purpose of furthering both parties’ ends and provides them with means for adopting and pursuing new ends as well as their happiness, even if the supplier does not care about the recipient’s end, the maxim is still in line with the will’s purposes. And the third maxim poses a mixed motivation for the supplier’s act. In this case, the supplier’s motive is to benefit herself while helping others. In other words, her maxim aims at furthering both her own and others’ ends. A world where all rational persons are willing to give their organs to benefit themselves and others would harmonize with the will’s purpose of effectiveness in pursuing ends, freedom to adopt new ends, and pursuing its natural end of happiness.

II. Moral Impermissibility of a Prohibition

In the previous section, I refuted the claim that an organ market necessarily entails immoral actions within the framework of the Kantian ethics. Consequently, Kantian ethics does not provide a reason to prohibit a regulated organ market. In this section, I ask a more ambitious question: Does Kantian ethics provide a reason not to prohibit a regulated organ market? In other words,
would the prohibition of an organ market be morally impermissible in Kantian framework?

I shall answer this question in the affirmative. The core of my answer will be my argument that the recipient has an imperfect duty to promote her health and survival. If this is accepted, prohibiting regulated purchases of organs is morally wrong because it interferes with the recipient’s only way of fulfilling her duty. Purchasing an organ is the recipient’s only choice if her health will likely deteriorate significantly without a transplant and a donation is not forthcoming. A prohibition that stops this transaction would require a morally wrong act on the part of the person who interferes with the recipient’s act.

The argument of this section is not just a simple corollary of the previous section’s argument. The previous section showed that participants’ maxims in a regulated organ market do not necessarily violate the categorical imperative. But this analysis does not by itself entail any duty to endorse these maxims. To derive such a duty, we need to consider the maxims’ negations. As Kant’s examples implicitly show, for something to be a duty, its negation should violate the categorical imperative. According to Kant’s analysis, refraining from making false promises and helping others are duties because their negations (i.e., making false promises and never helping others) fail the test for universalization and fail

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123 This point is also made by Onora O’Neill in “Environmental Values, Anthropocentrism and Speciesism,” *Environmental Values* 6 (1997): 135–136. She illustrates the difference between an obligation and optional principles through the examples of fasting and injuring. She suggests that both fasting and eating during the day can be universalized, and therefore there is no obligation to fast. However, since a principle of injuring others cannot be universalized, we have an obligation to reject injury.
to treat humanity as an end in itself. In what follows, I therefore consider the negations of the maxims of the participants of systems of organ transplantation.

A. **Negation of the Supplier’s Maxim**

I will begin with the negation of the supplier’s maxim. I will suggest that there is an imperfect duty to *provide* an organ, but there is no duty specifically to do so in a *sale* if and because donation remains an alternative. Consequently, the supplier’s duty would morally oppose a prohibition of any organ transplantation, but not a prohibition of a specific system such as an organ market.

*Non-Incentivized Systems*

The negation of the supplier’s maxim in non-incentivized systems can be precisely formulated as “I value helping a person more than the negative consequences of transplantation on me and the procedure is not likely to cause my death or impair my brain functions, but I will not give my organ to save someone’s life.” For purposes of the analysis below, the following simpler maxim can be assumed equivalent: “I will never give my organ to save someone’s life.” Such a maxim violates both the formula of humanity and the formula of universal law. This implies that one has an imperfect duty to give her organ to save other’s life.
The maxim of never giving an organ violates the formula of humanity because it does not treat humanity as an end. By endorsing this maxim, the individual refrains from furthering others’ ends and fails to contribute to the rational capacity to set ends and pursue them. In fact, she allows this capacity to diminish in another person.

The maxim violates the formula of universal law by causing a contradiction in the will. In many cases, the survival of an individual depends on receiving an organ. Hence a person’s will which has a purpose of effectiveness and freedom of setting and pursuing ends or of pursuing happiness will contradict with a universal law that prevents receipt of a life-saving organ once her organs fail.

Incentivized Systems

The same analysis does not hold for the negation of the supplier’s maxim in the incentivized system. Here the negation states that one will never sell one’s organ to save someone’s life. But this is neither a failure to treat humanity as an end in itself nor a contradiction in the will because one can always simply give one’s organ in order to save someone’s life. As long as donation is an option, not selling one’s organ does not mean that one endorses the inevitability of death once somebody has an organ failure. One can equally well contribute to the rational nature of another by giving her organ as by selling. Likewise, one can
consistently will a universal law prohibiting organ sales since individuals can avoid death from organ failure by accepting an organ donation.

B. Negation of the Recipient’s Maxim

I now move on to consider the negation of the recipient’s maxim. I shall argue that the negation would violate the categorical imperative, implying an imperfect duty to receive an organ by whatever morally permissible means is available, including purchase. In fact, this duty will often narrow down to a duty to purchase if and because donations are not forthcoming, leaving purchase as the only way of fulfilling the duty. This is the crucial difference to the supplier’s case: Unlike the supplier, the recipient does not have the luxury of choosing between donation and purchase.

The basic argument for the recipient’s duty to accept an organ mirrors the discussion of the supplier’s duty to give an organ. Complications arise, however, from Kant’s view that acting from duty and from inclination are incompatible. This might be understood to mean that the recipient, being naturally inclined to save her life by accepting the organ, is not under a duty after all. I will consider the basic argument first, and then move on to the complications.
Basic Argument

The recipient’s maxim is the same in incentivized and non-incentivized systems. The precise negation of this maxim is, “The procedure is not likely to cause the supplier’s death or impairment of brain functions and I will not accept organs to save my life from those who want to give their organs by their voluntary, informed and rational choice.” Again, for purposes of the analysis, the following simpler maxim can be assumed equivalent, “I will never accept organs to save my life.”

This maxim violates the formula of humanity and the formula of universal law in the same way that I have presented in the supplier’s case. The difference that the recipient would harm her own life rather than someone else’s is immaterial under both formulas.\(^{124}\) The formula of humanity does not differentiate between the treatment of humanity in others, on the one hand, and in oneself, on the other. Hence, in allowing oneself to die, one fails to treat humanity as an end in itself in the same way as one would in allowing someone else to die. In relation to the formula of universal law, one can claim that a will that allows its own termination causes a contradiction in the will given that the will’s purpose is to set and pursue ends and to pursue its natural end of happiness.

However, the parallels between the analyses of the negations of the supplier’s and recipient’s maxims end here. The supplier can choose between

\(^{124}\) As Kant argues, one not only has duties to others but also to oneself. In the *Groundwork* (30–31), he uses the examples of suicide and not furthering one’s talents as violation of one’s duties to oneself (the first one refers to a perfect duty, and the second one to an imperfect duty). In the *Metaphysics of Morals* (216–217), he evaluates other self-regarding duties such as moral self-preservation, perfecting oneself, and refraining from murdering oneself.
various ways of making her organ available and, by doing so, act on her imperfect
duty to provide her organ. By contrast, for the recipient, buying an organ may be
the only way to fulfill her imperfect duty. If it is the case that a commercial
transaction of organs can be done in a morally permissible way (which is the case,
as I have shown in the previous section) and any other system fails to provide the
necessary organ for the recipient (which is the case under the current system of
donation, as I have shown in Chapter 2), then her imperfect duty demands that she
accepts the offer of a rational, informed, and voluntary supplier.

Complications

In the preceding analysis, I have omitted a possible complication arising
from Kant’s view on duties and inclinations. Kant argues that an action done from
inclination does not carry the same moral worth as an act done out of duty.\(^\text{125}\) In
particular, Kant claims that preserving one’s life is a duty but usually also an
inclination. Hence, in most cases, an individual’s act of taking “anxious care”
does not have any “inner worth” and any “moral content” since it is not done
“from duty” but only “in conformity with duty.”\(^\text{126}\) If one does not have an
inclination to preserve one’s life, however, doing so out of duty is morally
worthy.\(^\text{127}\) Applied to organ transplantation, this would mean that a recipient who
desires to live does not act “from duty” in accepting a transplant. Only the

\(^{125}\) Kant, *Groundwork of the Metaphysics of Morals*, 11.

\(^{126}\) Ibid.

\(^{127}\) Ibid.
recipient who does not want to live and yet accepts a transplant acts with moral worth.

There are two ways to understand this interaction of duty and inclination. One way is to view duty and inclination as co-existing. In this view, the individual inclined to perform a morally required act may not be motivated by duty but still fulfills a duty in performing the act. As Kant puts it, such an individual may perform the act “in conformity with duty but not from duty.”\textsuperscript{128} In this interpretation, the individual’s duty persists regardless of inclination, and the basic moral argument against a prohibition of an organ market put forth above goes through unchanged.

There is another way of understanding the interaction of duty and inclination, however, that would complicate the moral argument against prohibition. Inclination might displace duty; in this view, inclination and duty could not co-exist. I shall call this exclusivity. Under exclusivity, recipients who want to receive a transplant do not have a duty to do so, and hence a prohibition would not interfere with their duties. Under exclusivity, then, the argument against prohibition would have to proceed along one of two different routes.

One route is to appeal to the treatment of recipients who are prepared to give up life (hence, those who lack the inclination). Even under exclusivity, these recipients do have a duty to accept an organ from a willing supplier.

Another route is to appeal to Kant’s idea of indirect duties. An indirect duty is one that does not itself derive from the formulas but facilitates the fulfillment of other duties that do. As an example, Kant mentions the indirect duty

\textsuperscript{128} Ibid.
not to treat animals cruelly (serving the direct duty of not treating humans cruelly since one may develop a natural disposition for cruelty),\textsuperscript{129} “to cultivate the compassionate natural feelings in us” (serving the direct duty to sympathize actively in the fate of those who are less fortunate)\textsuperscript{130} and to promote one’s own happiness (serving the direct duty to promote others’ happiness).\textsuperscript{131} Indirect duties foster a certain attitude (as in the case of avoiding cruelty and cultivating compassion) and remove obstacles that may distract one from one’s duties (as in the case of promoting one’s own happiness so that one does not get tempted to violate one’s duty to promote others’ happiness because of “adversity, pain, and want”).\textsuperscript{132} They are not ends themselves but they are merely means—permitted means—for removing obstacles to morality.\textsuperscript{133}

Along these lines, preserving life may not be a direct duty for those who are inclined to do so, but it is an indirect duty that would allow the individual to pursue moral ends. By staying alive, the individual supports her own rational and moral nature as well as allowing herself to pursue her direct duties such as helping others. Moreover, one’s pursuit of health can also qualify as an indirect duty for the same reasons. An unhealthy person will have many obstacles that may lead her to disregard her direct duties, and by pursuing her health, she indirectly

\textsuperscript{129} Kant, \textit{Metaphysics of Morals}, 238.
\textsuperscript{130} Ibid., 250–251.
\textsuperscript{131} Ibid., 192.
\textsuperscript{132} Ibid., 193.
\textsuperscript{133} Ibid., 192–193.
pursues the end of acting morally.\textsuperscript{134} Applied to the case of organ transplantation, this argument suggests that even those who are naturally inclined to pursue their survival and their health have a duty—an indirect duty—to promote their survival and health.

\textsuperscript{134} If we assume that people have an inclination for their health, then the pursuit of health can only be an indirect duty. However, it is also reasonable to argue that health is a direct duty given that in many cases, people are not inclined to pursue their health but only their pleasure (an easy example for this is smoking and using drugs). Since being healthy contributes to the rational nature of the person and her ability to set and pursue ends, it can be argued that promoting one’s health is a direct imperfect duty.
CHAPTER 5

VIRTUE ETHICS

_Virtue ethics_ is a moral framework that emphasizes the agent’s moral character as opposed to the consequences or the rules. This implies that application of virtue ethics to judging the moral status of actions is not as clear as other moral frameworks.\(^{135}\) Consequently, virtue ethics cannot evaluate policies simply by looking at each action by itself. Perhaps for this reason, virtue ethics rarely enters the discussion of organ market.\(^{136}\) Virtue ethicists have worked on ways, however, to overcome this problem and to apply the theory to the evaluation of certain practices.\(^{137}\) One of the most explicit and coherent attempts is Rosalind Hursthouse’s “Virtue Ethics and Abortion,” and I will mostly rely on her model in my analysis of an organ market.

According to virtue ethics, an action is morally right only if it corresponds to what a virtuous agent—an agent who exercises virtues—would do in given circumstances. _Virtues_ are the character traits that one needs in order to attain

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human flourishing (eudaimonia), the supreme good for oneself.\textsuperscript{138} Virtue ethics thus builds a conceptual connection between the right action and virtuous agent, and between virtue and flourishing.\textsuperscript{139} While this conceptual link allows the virtue ethicists to provide an answer to the objection that virtue ethics cannot be action guiding, it does not completely solve the problem. Many criticisms are directed at the absence of a method for balancing competing virtues, the epistemic problem of knowing what a virtuous agent would do, the emphasis on virtues as character traits that are both ontologically questionable and do not form a necessary link with a particular action in any given situation, and the moral relativity problem given that the value and substance of virtues vary between different cultures.\textsuperscript{140}

These problems pose serious concerns about how to employ virtue ethics for decision making. Virtue ethics provides neither an algorithm for determining the moral action—as utilitarianism and Kantian ethics—nor a check list for moral concerns—as principlism.

Virtue ethics does not necessarily lead to a single morally right action for each circumstance. According to virtue ethics, more than one action can be right, unlike, for example, in the utilitarian framework.\textsuperscript{141} Since there is no clear rule of prioritizing between the relevant virtues, it is not possible to simply follow virtues

\textsuperscript{138} Hursthouse, “Virtue Ethics and Abortion,” 225–226.
\textsuperscript{139} Ibid.
\textsuperscript{141} Utilitarianism may claim that two actions are equally right under the same circumstances if and only if the consequences give rise to exact same amount of overall ‘good.’ In most cases, this leads to one action to prevail as the ‘right’ one.
as one follows absolute rules. To understand the relevant virtues in a given situation, to balance them and prioritize them, requires practical wisdom.¹⁴² Two virtuous agents can act differently under the same circumstances; there can be more than one ‘good’ choice. In particular, two virtuous agents can act differently without finding each other’s actions morally wrong.¹⁴³ I shall argue below that this openness to diversity translates into an argument for having more options, which gives the virtuous agent the ability to act on the virtues that she finds appropriate and relevant, so as to provide virtuous agent the opportunity to pursue her human flourishing with incentivized or non-incentivized transactions.

In relation to the claim whether a particular system necessarily entails immoral actions, the moral status of actions need to be judged. Hursthouse focuses on a specific agent-based question to make this judgment: By committing this action, would the agent be acting virtuously or viciously or neither?¹⁴⁴ In this sense, to address controversial practices such as abortion or organ sale, virtue ethics must appeal to the participating agent’s character traits and motives. The test is whether the agent’s participation is guided by virtues. To judge a claim against a system for leading to immoral actions requires examination of all the agents involved. If virtuous agents can sustain the system and remain virtuous in doing so, then the claim is invalid.

¹⁴² Hursthouse, “Virtue Ethics.” This point about practical wisdom also leads to problems in relation to the theory’s ability for action guidance. Practical wisdom allows the theory to take into account the relevant factors in a given situation and


¹⁴⁴ Ibid., 235.
Following this approach, in this chapter I analyze two questions to evaluate a regulated organ market from the perspective of virtue ethics. In the first section, I ask if a virtuous agent would remain virtuous in a regulated organ market. Comparing a virtuous supplier’s and recipient’s attitude towards organ transplantation in a non-incentivized system to their attitude in an incentivized system, I argue that a virtuous agent would be reflecting as many if not more virtues by participating in a regulated organ market. In the second section, I go on to consider whether a virtuous agent would prefer one system to the other. I shall make a case that a virtuous person would prefer a regulated market system because in this system, the virtuous agent has more options, which enable her to exercise virtues and pursue human flourishing in ways she judges to be most appropriate. In sum, I will argue that virtue ethics does not provide a strong argument against a regulated organ market; in fact, it even sustains a case against the prohibition of an organ market.

I. Virtuous Participant

In this section, I ask—and answer in the affirmative—whether virtuous agents would participate in both incentivized and non-incentivized organ transplantation systems, and remain virtuous while doing so. I will focus the
discussion on the participation of the supplier and the recipient. If virtuous agents participate in a regulated organ market and remain virtuous in doing so, then the virtue ethics would claim that the act of selling or buying an organ is morally right given that it corresponds to what virtuous agents would do. By showing that virtuous agents would participate in an organ market, I argue that the commercial organ transaction can be performed virtuously.

A. Non-Incentivized Systems

It is probably uncontroversial that all participants can act virtuously in a non-incentivized system. Clearly, giving a life-saving organ typically reflects virtues like generosity, benevolence, compassion, charity, and courage. Receiving an organ might at first glance appear neutral. But Aristotle’s understanding of human flourishing actually urges a stronger claim, namely, that a virtuous agent is most likely to accept an organ. According to Aristotle, human flourishing is an activity that requires “doing something” and not simply “being in

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145 If their participation is virtuous, the participation of third parties (i.e., doctors, medical staff, health care officials) will be virtuous as well, exhibiting benevolence and compassion by supporting the supplier’s and the recipient’s human flourishing. Virtuous third parties exercise compassion and kindness towards the recipient by helping to save the recipient’s life. They exercise benevolence by supporting virtuous suppliers’ and recipients’ exercise of virtues. Benevolence and compassion are among the virtues that some argue medical staff must prioritize. Edmund D. Pellegrino, “Professionalism, Profession and the Virtues of a Good Physician,” The Mount Sinai Journal of Medicine 69, no. 6 (2002): 381, argues that medical staff must prioritize certain fundamental virtues, namely, fidelity to trust, benevolence, intellectual honesty, courage, compassion, and truthfulness.

146 It might be argued that the level of virtues that the supplier acts on varies with the amount of costs that the supplier is willing to bear without reimbursement. But this is not necessarily true. The supplier might lack financial means to afford the procedure without reimbursement. Or the supplier might use the reimbursed funds to show generosity to someone else who needs it more. In any event, the virtuous agent could always forfeit the reimbursement if she finds that this is the most virtuous thing to do in a given situation.
a certain state.” It is not sufficient to possess certain virtues as character traits to achieve human flourishing; one must also be able to realize these virtues by acting on them. Aristotle acknowledges the crucial importance of means like health, wealth, and social status necessary to pursue human flourishing. Hence a virtuous organ patient will generally accept a transplant to preserve the necessary means, namely, her health, to continue her pursuit of the supreme good, human flourishing. This would also reflect the serious-mindedness in the recipient’s attitude with respect to the achievement of human flourishing.

B. Incentivized Systems

Supplier

Once the supplier receives an incentive, it is possible that the supplier no longer acts out of generosity, benevolence, compassion, charity, or courage, at least directly. Instead, the supplier might act only for the money. It does not follow, however, that such a supplier does not act virtuously.

First, even a supplier who is directly motivated only by the money may use the money for an act of generosity, benevolence, compassion, and charity. For example, a virtuous supplier might sell her organ to a well-off recipient to obtain funds to help someone in financial need. Thereby, the virtuous supplier may direct her acts of benevolence and generosity in a balanced way and by prioritizing the

148 Ibid.
needs of the people she aims to help. In such cases, an organ market would provide the most suitable financial benefits among the incentivized systems given that money is easily transferable to those who are in need, unlike specific compensations such as tax reductions or health insurances.

Second, and more importantly, a virtuous agent need not reject any personal gain, and can pursue personal gain and be benevolent, charitable, generous, and compassionate to others at the same time. As argued in the previous subsection, according to Aristotle, obtaining the worldly means—including financial means—to pursue human flourishing is not only legitimate but also necessary. Relatedly, other-regarding virtues, like any virtues, need not and cannot be followed at all times to the full extent at the exclusion of others. Aristotle’s understanding of virtue is based on the idea that the virtues are conditions between the states of excess and of deficiency.\textsuperscript{149} For example, being courageous is neither being cowardly nor being fearless; it is about understanding the dangers and the risks one can take given one’s position.\textsuperscript{150} Following this idea, an act of generosity, benevolence, charity, or compassion does not have to be an act that completely disregards the self. A virtuous agent can judge that these virtues lead her to make her organ available to a patient in need while also welcoming the personal benefits of this virtuous act. She does not have to be generous, benevolent, charitable, and compassionate to the point where she cannot accept any benefits for her act. At the same time, accepting the benefit

\textsuperscript{149} Ibid.
\textsuperscript{150} Ibid.
does not imply that the virtuous agent is ignorant or insensitive towards the life
and death situation of the recipient.

Some virtue ethicists critical of organ markets do not deny that selling an
organ could be guided by virtues, but claim that more likely than not the supplier
will misjudge the benefits and harms or misbalance the virtues. This claim is
highly problematic. While such misjudgment is possible, we have no more
grounds to assume it for sales than for donations. Just as the sale of an organ may
be affected by the supplier’s financial condition, the donation to a loved one is
affected by the overwhelming emotional character of the situation, which may
lead the donor to act out of fear of loss instead of courage and which may lead the
donor to take unreasonable risks. Yet, in both circumstances, we should presume
that a virtuous person validly judges the situation and balances the virtues.
According to Aristotle, the capacity to be guided by reason makes humans differ
from other species; living well means using reason well in order to live in
accordance with virtues. If reason is the very essence of being human, and
using reason is the key to living well, dismissing one’s actions as poorly reasoned
requires a good justification especially since, as explained above, two virtuous
agents may act differently under same circumstances.

The virtuous agent’s willingness to accept benefits while performing a
benevolent act is illustrated by our judgment of professionals who save lives, such

151 Among the limited number of articles on commercialization of organs from the perspective of
virtue ethics, Bjorkman and Gardiner make this case in their articles. Bjorkman in “Why We Are
Not Allowed To Sell That Which We Are Encouraged To Donate” argues that the seller displays
less courage than the donor, and Gardiner in “A Virtue Ethics Approach to Moral Dilemmas in
Medicine” argues that the seller would be the desperate poor who takes a high risk for some
immediate benefits.
152 Kraut, “Aristotle’s Ethics.”
as fire fighters and doctors. Since these are paid jobs, anyone who chooses these jobs does not necessarily do so only out of benevolence and courage. At least part of the motivation may be financial. But of course nobody would argue that a virtuous person could not be a fire fighter or a doctor, or that the decision to take such a job is not the result of a valid exercise of reason.

The existence of the incentives does not compel us to conclude that once there are incentives, the virtues vanish or are overwhelmed by irrational behavior. We can easily imagine a virtuous agent who chooses to be a fire fighter or doctor because of the virtues of saving lives and because of the benefits that allow her to attain the means for pursuing human flourishing. Similarly, a virtuous agent can provide her organ and accept the benefits in return.

**Recipient**

The virtuous recipient’s main motivation in incentivized systems is the same virtuous motivation as in non-incentivized systems. As in the non-incentivized system, the recipient mainly pursues the necessary means for human flourishing.

The incentivized system also accommodates additional virtues, however, by allowing the virtuous recipient to provide benefits to the supplier. These benefits directly or indirectly reciprocate the supplier’s act of saving her life. Depending on the conditions of the supplier and the recipient, the recipient’s act of reciprocity can reflect the virtues of benevolence, generosity, compassion, and
charity for a person who is in financial need and who saved her life, or simply kindness and thankfulness towards her life saver.

Reciprocity can also be an act of justice. In non-incentivized systems, the transaction remains unbalanced since the recipient only takes and the supplier only gives. Under certain circumstances (such as where the supplier is well off and the recipient is already financially challenged), this may be the only option. But if the recipient has the means, a virtuous recipient would find it unjust to take an organ from a supplier and not give anything in return, especially if the financial benefits will play an important role in the supplier’s life.

It is not a valid objection that the recipient takes advantage of a desperate supplier who gives her organ only to receive crucial and otherwise unattainable benefits. As pointed out above, virtue ethics acknowledges the importance of obtaining worldly means necessary for human flourishing. Thus the recipient contributes to the supplier’s pursuit of her own human flourishing by participating in the transaction and bestowing a benefit upon the supplier. Crucially, as I have argued in discussing the supplier’s decision above, the virtuous recipient should presume that the transaction is beneficial to the supplier as long as the supplier makes an informed, rational, and voluntary decision.

II. Choosing a Virtuous System

So far I looked at the incentivized and non-incentivized systems of organ transplantation in relation to the question, would a virtuous person remain
virtuous in this system? None of the systems render an act of providing or receiving an organ necessarily vicious; in fact, many virtues would lead one to participate in these systems. Now, the second question is whether a virtuous person would prefer one of these systems to the other. This question will enable an assessment of a prohibition against an organ market within the framework of virtue ethics. If the virtuous agent were to find all the systems equally good, this would make a weak case against a prohibition, given that an organ market includes all other practices (such as donation), whereas other systems do not include an organ market. However, if the virtuous agent were to prefer an organ market, the case against a prohibition would become stronger. It would still not necessarily imply that a prohibition is morally wrong from the perspective of virtue ethics, given the theory’s indeterminate nature. But I claim that the prohibition would be morally *unjustified* if a virtuous agent were to prefer an organ market, as I shall indeed argue is the case.

The virtuous agent can arguably make a comparison between incentivized and non-incentivized systems on three grounds: (1) Which one of these systems excludes more non-virtuous people from participating in them? (2) Which one allows more virtues to be eventually actualized? And (3) by choosing which system would a virtuous agent act virtuously? I will consider these questions separately, including whether they do indeed form a valid basis on which to compare the different systems.
A. Exclusion of Non-Virtuous Agents

The first question that the virtuous agent may consider while comparing different systems is to ask which one excludes more non-virtuous agents. In the previous section, we established that a virtuous agent can remain virtuous in all systems. It does not follow that these systems will all exclude non-virtuous persons or, more to the point, that they will do so to the same degree. In particular, it might be argued that incentivized systems attract non-virtuous agents, whereas non-incentivized systems recruit only those who are virtuously motivated. A donor necessarily acts on the virtues of benevolence, compassion, and generosity, or so the argument would go, whereas a seller may act on selfish reasons that cannot even be justified in terms of procuring “means for pursuing human flourishing,” such as using the money to buy drugs.

It is not clear, however, that this argument is empirically accurate—that is, whether most sellers do in fact act on vices when they sell their kidneys, whereas donors do not. To establish this fact would require empirical data. In the absence of such data, there is no obvious reason to assume this fact. To be sure, it is reasonable to assume that most donors act on virtues, even though some donors give their organs viciously in order to gain power within the family unit, to make the recipient feel in debt to her, or to manipulate others to think of her in a certain way. But it is unreasonable to assume that most sellers act viciously. The sellers who do not act only on other-regarding virtues are most likely to act on a mixed motive of saving another’s life (hence, acting virtuously) and helping themselves
to survive financial hardships (hence, contributing to their pursuit of flourishing) or helping their loved ones to survive by using the money to provide for them (hence, again, acting virtuously). Even if the seller does not care about the recipient, her aim of helping herself and loved ones is still likely to be guided by virtues and not vices.

Whatever the answer to this factual question, there is reason to doubt that a virtuous agent would even consider the answer in her decision which system to prefer. If one were to disallow practices merely because they can also attract vicious agents and behavior, many existing practices would need to be drastically restricted. In particular, remuneration would have to be eliminated from otherwise virtuous activities because it attracts some agents who act for vicious purposes. This would directly affect professions that help others and that would therefore be led by virtues of benevolence, compassion, kindness, and courage if remuneration were not provided. According to this reasoning, doctors, nurses, or fire fighters should not be paid. However, expecting such a behavior from these professionals would be forcing them to express excessive virtues and disregard their own human flourishing. Designing systems for heroes may exclude non-virtuous agents, but it will also exclude many virtuous agents and prevent them from pursuing their flourishing.
B. **Actualizing Virtues**

For the reasons stated in the preceding paragraph, a more sensible approach to virtuous systems comparison may be the second question, namely, which system enables more virtues to be realized? There are two aspects to this question: (1) Which system allows each individual to express more virtues, and to express them more strongly? And (2) which one allows more people to act virtuously? This question avoids the problematic conclusion that the previous question leads to. At the same time, one may argue that it introduces maximization, which may seem out of character for virtue ethics. However, the concern here can also be formulated in terms of providing individuals with opportunities to develop their virtues and therefore to attain human flourishing.

I will argue that the incentivized system seems preferable under both aspects. The incentivized system is more flexible and hence accommodates different balancing and prioritizing of virtues as well as allowing more variety of virtues to be realized.

*Virtues Expressed by Each Agent*

At a first and superficial glance, the non-incentivized systems might appear to foster ‘purer’ virtuous behavior. In a non-incentivized system, the supplier usually acts only out of kindness, courage, generosity, compassion, benevolence, charity, altruism, and thoughtfulness. By contrast, in the
incentivized system, a supplier may also act out of selfishness. Yet this view is shortsighted and overlooks three powerful countervailing arguments.

First, a virtuous agent who wants to emphasize only other-regarding virtues is free to do so in an incentivized system. Donations are not prohibited. Moreover, the virtuous agent can accept the reward but use it to support some third person who is more in need. In that way, the incentivized system expands the options where the virtues such as benevolence and charity can be appropriately realized.

Second, a virtuous agent may very well act virtuously by using the reward for her own benefit. As I repeatedly emphasized, Aristotle’s conception of human flourishing demands rather than disparages worldly means that enable one to pursue one’s flourishing. By accepting the reward, the supplier may very well be pursuing her human flourishing, which is the ultimate goal that the virtues help one reach. This is another way in which the incentivized system expands the space for the expression of virtues.

Third, and perhaps most importantly, to consider only the supplier’s virtues and neglect the recipient’s leads to an incomplete evaluation of the system. The recipient’s expression of virtues is in an exact opposite of the supplier’s in both systems. In a non-incentivized system, the recipient simply expresses her appreciation and serious-mindedness towards life and her pursuit of flourishing. Her act of accepting the organ does not reflect any virtues in relation to the supplier. By contrast, in an incentivized system, the recipient can also act virtuously towards the supplier by reciprocating her life saving act. The
recipient’s act of providing benefits for the supplier or agreeing to accept the organ only if the supplier is provided with some benefits can reflect her appreciation, gratefulness, kindness, compassion, and justice towards the supplier. This suggests that if we look at both recipients and suppliers, the incentivized system realizes more virtues.

Agents Acting Virtuously

The incentivized system seems to have a clear advantage from the perspective of the number of virtuous agents participating in the system (or to be more precise, the number of agents being able to act on the virtues by participating in the system). The most important advantage of the incentivized systems, and especially of a market, is the ability to attract more suppliers and thereby to increase the number of supplied organs. This expands the number of virtuous agents in two ways. First, by saving more lives, the incentivized system gives more people the chance to continue their pursuit of human flourishing. Second, being a reciprocal system, it allows more means to be transferred to the supplier enabling her pursuit of human flourishing.

A common objection in relation to the increased number of virtuous participants in the incentivized systems appeals to the crowding-out effect. This argument suggests that virtuous agents who would participate in donation might not participate in a market because they consider the act of providing an organ in

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153 For more information on the efficiency of incentivized systems, see Chapter 3.
154 For more information on the crowding-out effect, see Chapter 3.
a market polluted by the incentives. Again, there are two immediate problems with the crowding-out argument: In a market, a supplier remains free to make a voluntary donation (by refusing compensation) or to use the money for charity. But more importantly, from the perspective of virtue ethics, it is questionable whether a person who gives her organ only if her act is considered to be ‘altruistic’ genuinely acts on virtues of benevolence and compassion, rather than desiring to create a certain ‘virtuous’ image for herself. Given that the nature and the most important consequence of the act—namely, saving another person’s life—does not change between incentivized and non-incentivized systems, a genuinely virtuous agent should not be affected by the perception of her act.

C. **Virtuous Choice**

The last question that the virtuous agent may ponder is, which system would it be virtuous to choose? That is to say, rather than considering participants’ virtuous or vicious behavior, the agent might ask herself what virtues she herself expresses by choosing one system over the other. This amounts to considering the system in itself, but through the virtues of the agent making the choice. Thus, the virtuous agent would ask, by choosing which system do I promote justice, show compassion and benevolence to those who are in need, and so on? In this perspective, the organ market’s capacity to generate more organs and hence to help more patients would appear to strongly favor the organ market. Those who are most in need are those approaching death due to organ failure.
Whether or not they have the financial means, these people are racing against time while enduring pain and anxiety. By being most likely to save the most number of lives, the incentivized systems, and especially an organ market, facilitate their survival. In addition, the organ market also provides suppliers with necessary means to further their human flourishing, rather than just demanding a unilateral sacrifice as the non-incentivized system does. Hence the virtuous agent would appear to show most benevolence and compassion by choosing the organ market.

This presupposes, of course, that the market is regulated such that all participation is rational, informed, and voluntary, and manipulation is not an issue. Otherwise, a virtuous agent would have to be concerned about possible exploitation of the desperately poor in an incentivized system. If suppliers are well informed, however, the fate of even desperately poor suppliers actually argues in favor of the organ market, as it provides these suppliers with desperately needed means to further their human flourishing. As I argued in Chapter 2, selling a kidney is in fact a relatively low risk way to make money for the poor, even compared to such professions as fishing or logging in developed countries, and taking this option away would burden the poor even further. The small size of the risk for suppliers in proper care also implies that the patients requiring a transplant are certainly those who are most in need of benevolence and compassion. Also, when it comes to justice, incentivized systems can be argued to reduce irrelevant discrimination in determining which patients will survive. In a non-incentivized system, one can claim that there is injustice towards those patients who lack the social circle that provides them with the donor. The system
imprisons them in a web of social relations where one’s chances for survival increases drastically with the size of her family, the closeness of the family members, and the friendships that she has. On the other hand, an organ market gives a chance for those who cannot get an organ through donation without eliminating the option of donation.

III. Summary

In the first section, I showed that selling and buying organs can be done by the virtuous agents; and by participating in an incentivized system, the virtuous agents would still be acting virtuously. In the second section, I postulated three questions that the virtuous agent may ask in order to choose one system of organ transplantation over the others. The first question proves to be a controversial ground for comparison. The second and the third questions favor incentivized systems. Hence we can conclude that a virtuous agent would prefer a regulated organ market over other systems. A prohibition would conflict with this preference. Therefore, a prohibition of a regulated organ market would be morally unjustified from the perspective of virtue ethics.
As in other areas of bioethics, many arguments about the organ market are explicitly or implicitly based on principlism, four basic principles set forth in *Principles of Biomedical Ethics* written by Tom L. Beauchamp and James F. Childress and first published in 1979.¹⁵⁵ According to Beauchamp and Childress, four basic principles “function as general guidelines for the formulation of the more specific rules;” these are principles of respect for autonomy, nonmaleficence, beneficence, and justice.¹⁵⁶ In topics such as euthanasia or extreme measures for prolonging life, these principles serve as a basic checklist to determine the fundamental issues in the discussion of which action would be the morally right. Unlike utilitarianism and Kantian ethics, principlism does not possess a meta-criterion and does not explain how the four principles should be balanced.

Principlism’s appeal is its simplicity. It employs only four intuitive principles instead of a complicated comprehensive ethical theory. This makes principlism seem easy to apply especially for medical practitioners in many of the

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everyday problems that they encounter. For example, the four principles direct a surgeon to ensure that the patient makes an informed, voluntary, and rational decision (respect for autonomy), that the chosen procedure is expected to cause less harm and more benefit to the patient (nonmaleficence and beneficence), and that the patient is receiving the treatment that other patients under equal circumstances receive (justice). The downside of principlism’s simplicity is that it appears ill-equipped to address trade-offs between different principles, and between the same principle applied to different people. Such trade-offs inevitably arise in more complex situations such as organ transplantation that involves multiple parties.

In particular, the principle of nonmaleficence is in tension with any type of organ transplantation from the living. From the perspective of the supplier, the procedure is completely unnecessary while creating risk and discomfort. ‘Do no harm’ would seem not to allow this. In the first section, I argue that the principles of nonmaleficence and beneficence can be interpreted in a way that defuses this tension and justifies organ transplantation. Once this is done, however, a coherent application also justifies an organ market. Hence, I conclude that a regulated organ market does not violate the requirements of principlism.

In the second section, I evaluate the prohibition of a regulated organ market. This evaluation shows that such a prohibition in fact violates all four principles of the framework. Therefore, such a prohibition is morally wrong with respect to principlism.

157 Ibid., 280. Beauchamp and Childress do not endorse any particular theory of justice. They merely refer to the literature on justice and appear to sympathize with utilitarian and egalitarian theories.
I. Evaluation of Individuals’ Actions

A. Principle of Respect for Autonomy

The principle of respect for autonomy is founded on the patients’ “right to hold views, to make choices, and to take actions based on their personal values and beliefs.”158 It requires “acknowledging the value and decision-making rights of persons and enabling them to act autonomously.”159 Beauchamp and Childress understand autonomous action “in terms of normal choosers who act (1) intentionally, (2) with understanding, and (3) without controlling influences that determine their action.”160

In a non-incentivized system, an example of a violation of the principle would be a family member, who is under great pressure to give her organ since she is the only match in the family and the only hope for the recipient’s survival, even though her voluntary decision is against providing her organ. However, the structure of the transplantation systems ensures the informed, voluntary, and rational decision of the participants. Regulations such as informed consent aim to eliminate involuntary, coerced, or manipulated individuals and allow only those who autonomously agree to the transplantation to participate. Therefore, in non-incentivized systems, this principle is not violated.

The incentivized systems raise concerns about the supplier’s autonomy, bringing out the arguments on irrefutable offers to vulnerable groups that we have

158 Ibid., 103.
159 Ibid.
160 Ibid., 101.
already considered in Chapter 2. Once the system allows incentives, the argument goes, this enables those who are not motivated by the idea of saving another’s life to be a part of the system. Individuals who seek material benefits agree to make their organ available in order to acquire these benefits, and it is argued that the desperate people end up participating in the system non-autonomously.

Beauchamp and Childress emphasize the non-ideal understanding of autonomy in order to avoid an extremely demanding principle. They claim that an adequate theory of autonomy “coheres with the moral requirement that we respect the ways in which we govern our lives, such as the ways we take care of our health and take care of our children, as well as our everyday choices, such as opening bank accounts, purchasing goods in stores, and authorizing repair of an automobile.”161 This understanding of autonomy excludes those who are “immature, incapacitated, ignorant, coerced, or exploited” such as “[i]nfants, irrationally suicidal individuals, and drug-dependent patients.”162 By not using the idealized understanding of autonomy where one is considered autonomous only when one is free from all influences, Beauchamp and Childress also allow individuals from disadvantaged backgrounds and vulnerable populations to have the chance to act autonomously.163 Thereby, the theory does not differentiate between the incentivized and non-incentivized systems in terms of autonomy as long as both systems have regulations in place that ensure informed, rational, and voluntary participation.

161 Ibid., 101.
162 Ibid., 105.
163 Ibid., 254.
B. Principles of Nonmaleficence and Beneficence

The principles of nonmaleficence and beneficence complement each other in evaluating the procedure in relation to the individual’s well-being. Any evaluation of a procedure only in relation to one of these principles leaves the discussion incomplete. Therefore, while they bring out different aspects of the procedure, in the evaluation of organ transplantation systems, I apply them together.

Do No Harm

The second principle—namely, the principle of nonmaleficence, also named the *do no harm principle*—refers to the obligation of not inflicting harm on others.\(^{164}\) This principle is usually brought up in relation to the health care professionals to emphasize their obligation to refrain from performing any procedure that harms the patient. This requirement applies not only for the acts committed but also for the ones omitted. In other words, while there is an obligation to make sure that the treatment does not inflict any intentional or unnecessary harm to the patient, it is also necessary to ensure that there is no harm caused by the refusal of treatment.

Even though this principle seems to capture a core value in medical decision making, it does not work smoothly when it is applied to the organ transplantation from the living. While the procedure of organ transplantation does

\(^{164}\) Ibid., 149.
not conflict with the principle of nonmaleficence when we consider the recipient’s position, the problem occurs when we turn to the supplier. By undergoing a transplant procedure, the recipient is not harmed; on the contrary, the procedure saves her life. However, the procedure to remove the organ necessarily causes harm to the supplier given the anxiety and pain related to the surgery and discomfort during recovery. As a healthy person, the supplier does not have any medical reason for going through a surgery that has some risks and that results in a permanent alteration of her body. In this case, the doctor intentionally causes unnecessary harm to the patient by allowing her to go through a major surgery and removing the organ. There is no medical reason that justifies the harm that is inflicted upon the supplier. From the physical perspective, the supplier endures harm for a purpose that does not benefit her. The doctor’s duty of do no harm requires her to refrain from performing this medically futile procedure on her patient. Therefore, if we simply look at the physical harm and benefit to the supplier, the procedure of removing her organ cannot be justified.

Beauchamp and Childress argue that the principle of nonmaleficence is not an absolute rule.\textsuperscript{165} It does not have any priority over the other principles. Instead, it must be balanced with respect to the other principles, and especially to the principle of beneficence given their close relationship.\textsuperscript{166}

\textsuperscript{165} Ibid., 153.
\textsuperscript{166} Ibid., 150.
The principle of beneficence entails “obligations to confer benefits, to prevent and remove harms, and to weigh an action’s possible goods against its costs and possible harms”; yet this does not imply following a utilitarian model where “society’s interests to override individual interests and rights” is justified.\textsuperscript{167} Whereas the principle of nonmaleficence is a negative rule that restricts the actions in a manner that prevents harm to the patient, the principle of beneficence is a positive rule that requires the actions to benefit the patient. Applied to the health care professionals, the doctors’ duty does not end in ensuring that the patients are not harmed, but they actively need to work for improving the patients’ medical conditions.

In the case of organ transplantation, the procedure certainly benefits the recipient by saving her life. Yet, it does not contribute to the supplier’s physical well-being in any way. From the doctor’s perspective, the principle of beneficence entails that it is her duty to explore the possible means to provide the necessary organ transplant for the patient. However, the doctor’s duty changes when we consider the supplier’s position. The principle of beneficence does not seem to justify the doctor’s actions towards the supplier since medically the supplier does not need any improvement in her condition. In this sense, the doctor’s duty is simply to refrain from interfering with the already healthy supplier since she cannot benefit from the doctor’s services.

\textsuperscript{167} Ibid., 198.
Given the principles of nonmaleficence and beneficence, it appears as though organ transplantation cannot be justified. Not only the procedure physically harms the supplier, but also this harm cannot be justified in terms of the physical benefits that she will receive. However, as stated before, according to the principlism, none of these principles are absolute, and a balance between the principles should be sought.

The Balance

The understanding of balancing harm and benefits leads to the justification of minor injuries to the patient for the major benefits of life-saving interventions.\textsuperscript{168} Hence, a procedure like surgery is justified since the doctor should not refrain from harming the patient by cutting her if the surgery is going to benefit her by saving her life. This balance between the harm to the patient and benefit to the patient does not apply directly to the organ transplantation cases where the harm falls on one patient and the benefit on another. There are two ways of justifying the harm that the supplier bears in relation to the principles of nonmaleficence and beneficence.

Interpersonal Harm–Benefit Balance

The first option is to turn to a utilitarian method. The harm that is inflicted on the supplier is justified by the benefits that the recipient experiences. Due to

\textsuperscript{168} Ibid., 150.
the surgery, the supplier experiences short-term pain and discomfort but leads a healthy life afterwards. On the other hand, the recipient avoids pain and suffering of continuous medical treatment and regains a chance for a healthy life instead of waiting for a certain death. Clearly, the benefits to the recipient outweigh the harm to the supplier. This justification is a utilitarian calculation that favors organ transplantation by taking into account the overall harm and benefits.

One may argue, given that there are other principles such as respect for autonomy, that principlism does not collapse into a complete utilitarian framework. However, Beauchamp and Childress endorse that the principles are not absolute rules. Any principle is “[a] prima facie obligation that must be fulfilled unless it conflicts, on a particular occasion, with an equal or stronger obligation.”169 Hence, the principles are binding as long as another principle—“a competing moral obligation”—does not outweigh them.170 In other words, respect for autonomy is an obligation, yet if the principles of nonmaleficence and beneficence conflict with it, then it may be overridden. In which case, if the principles of nonmaleficence and beneficence are taken to include interpersonal justifications, then although principlism is not equal to the utilitarianism, it may collapse into a utilitarian framework under certain circumstances.

Even though this interpretation of striking a balance between the principles of nonmaleficence and beneficence justifies organ transplantation, Beauchamp and Childress explicitly disagree with a complete utilitarian

169 Ibid., 15.
170 Ibid.
approach.171 This suggests that this interpretation is not coherent with the framework that they offer. Yet, they also do not provide any limitations on how to balance the principles and stop them from collapsing into a utilitarian framework or from being arbitrarily neglected for the sake of other principles.

**Individual Harm–Benefit Balance**

One way to distinguish principlism from utilitarianism is by insisting on focusing on individuals and respecting all the principles at the highest possible degree. This understanding of principlism leads to a different interpretation of the principles of nonmaleficence and beneficence, and their application to the organ transplantation. Focusing on the individual, it is argued that the harm–benefit balance must be attained by considering only the individual; however, this does not lead to an immediate objection against organ transplantation. Instead, it is argued that the concepts of harm and benefit need not be limited to the physical aspects of the procedure.

**Physical and Psychological Harm and Benefit**

If the principles of nonmaleficence and beneficence are limited to the physical harm and benefit to the individuals, then many medical procedures become objectionable in relation to these principles. Many medical procedures involve harming the patient in a way that is not always justified by physical

171 Ibid., 198.
benefits. A common example of this is the cosmetic and reconstructive surgeries that do not involve lifesaving, life-prolonging or health-improving benefits. It is accepted as a common procedure that when an individual agrees to endure the pain and discomfort of the surgical procedure for breast enlargement or reconstruction of her breasts after mastectomy, the harm is not justified in terms of improving her medical condition but by the psychological or social benefits that the patient desires. As long as the patient is considered competent to make this decision and the risk is not judged to be too high for this specific surgery on this specific patient, the surgery is carried. This shows that conventionally, we do not dismiss every medical procedure that involves harm and that is not performed with the aim of improving the patient’s medical conditions.

The example of cosmetic surgeries suggests that the organ transplantation can also be justified on the same grounds. However, a careful analysis reveals that an analogy between cosmetic surgery and organ transplantation does not hold. In fact, this discrepancy serves well for showing that the justification of organ transplantation is quite controversial when applied to other procedures such as cosmetic surgeries.

It can be argued that similar to the cosmetic surgery cases, justification of organ transplantation relies on the non-medical factors such as psychological benefits. An argument defending the non-incentivized transplantation claims that the principles of nonmaleficence and beneficence include the “psychological and moral” effects as well as the physical ones.\(^\text{172}\) It is argued that even though the

supplier will endure physical harm with no aim of physical benefits by giving her organ, refusing her to serve as a supplier may cause “psychological and moral harms” on the individual. In a non-incentivized system, where the supplier acts on a desire to save her loved one’s life, not being able to do so will cause considerable psychological harm on the individual. By giving an organ, the supplier not only avoids the harm that will result from the helplessness in the face of watching a loved one die, but the studies show that she will also experience psychological benefits such as increased self-esteem after participating in organ transplantation.  

This argument does not rely on the familiar—yet, still controversial—justification of cosmetic surgeries; it relies on a more problematic position. While the procedure of cosmetic surgery results with a preferred state of one’s body, organ transplantation results with a permanent removal of a functioning and healthy body part for reasons that do not contribute to one’s preferences of one’s body. In the organ transplantation cases, the justification does not have anything to do with the individual’s own state but it is constructed by appealing to her relationships such as her connection to the ill family member. While the immediate benefit of the cosmetic surgery falls upon the patient, the immediate benefit of organ transplantation falls upon a third party. In other words, whereas the cosmetic surgery can be justified by the claim that it benefits the individual, organ transplantation cannot be justified by the same argument but it has to appeal

\[173\] Ibid.
to the benefit that the individual will receive by securing this particular relationship.\textsuperscript{174}

Problems with this justification are revealed better when we apply the same reasoning to the cosmetic surgeries. This reasoning can be found in a case where the individual does not have any problems and dissatisfaction about her breast size but is going through the surgery in order to comply with the preferences of her partner. In this case, just like in organ transplantation, there is no direct benefit to the patient but an indirect benefit by securing her relationship and avoiding the psychological harm of losing a loved one.\textsuperscript{175} Such a reason for cosmetic surgery is precisely the one that is widely perceived as the “wrong reason.”\textsuperscript{176}

In response to this position, an argument can be formulated by appealing to the nature and value of these relationships. However, the main claim of employing the example of cosmetic surgeries persists; the physical harm and risks

\textsuperscript{174} It can be argued that the psychological benefits of the cosmetic and reconstructive surgeries also do not only appeal to an individualistic perception, but in many cases they are done for the reasons that are based on social relationships and emotional attachments. For example, a breast enlargement surgery typically comes from the social preference for larger breasts, and the person who decides to undergo the procedure makes this decision by considering how she is perceived by others and her relationships with others. Such a case can be analogous for the transplantation cases where the person decides to give her organ in order to uphold a certain image that is socially approved. Yet, this does not include most types of organ transplantations. A typical supplier in a non-incentivized system gives her organ in order to save a loved one’s life; and therefore her act is aimed to satisfy the direct demands of a particular relationship.

\textsuperscript{175} Since here we only consider the individualistic harm–benefit balance, it is irrelevant what the effects of these procedures are on the third parties; and hence, a distinction cannot be created through appealing to the fact that one act saves the other person’s life while the other simply complies with her preferences.

of organ transplantation can only be justified by appealing to a wider and more controversial understanding of psychological harm and benefit.

Assuming we agree with this understanding of the psychological effects in individualistic harm–benefit balance, such a justification would hold more strongly in non-incentivized systems where the majority of suppliers are emotionally involved with the recipient. It can be argued that the commercial suppliers, being not motivated enough to give their organs for free, would not derive substantial psychological benefit from the act to justify the physical harm.

**Financial Harm and Benefit as a Factor in Well-Being**

If the psychological benefits are not as strongly present in the incentivized systems of organ transplantation as in the non-incentivized systems, does it entail that the incentivized systems violate the principles of nonmaleficence and beneficence? In non-incentivized systems, since the motivation of the supplier is only emotional, it can be argued that her decision to give her organ reflects her judgment of psychological benefits outweighing the physical harms. However, once the financial benefits are introduced, the balance between the physical and psychological harm becomes unclear. Therefore, the argument concludes that whereas a doctor in a non-incentivized system can be justified in acting on the supplier’s decision and removing a kidney from her for the purposes of transplantation, the same justification would not hold in an incentivized system.
Such an argument has two problems: (1) It overestimates the enthusiasm in non-incentivized suppliers and (2) it underestimates the role that financial means may play on one’s overall physical and psychological well-being. I argue that given the motivations of participants and the effects of financial benefits on the supplier’s well-being, this distinction between non-incentivized and incentivized systems vanishes.

The argument relies on the assumption that most suppliers in the non-incentivized system are directed suppliers who receive psychological benefits by avoiding the pain of helplessly watching a loved one die, whereas most suppliers in the incentivized system are non-directed suppliers who would not be psychologically harmed if they could not make their organ available. This argument may hold as long as this distinction is valid; however, this is not obvious. While the supplier in the non-incentivized system may judge the act of giving her organ to be the best available option when all things considered, this does not entail that each supplier is actually enthusiastic about this option and would suffer if they cannot complete their act. It may well be the case that in many—and even maybe in most—cases, the supplier acts on a duty that she may be happy to shake off if the option of donation were never available to her. It is reasonable to assume that a typical supplier in a non-incentivized system is motivated not by psychological benefits but by moral or social obligations that arise only with the existence of the option.

On the other hand, it is also possible that many—if not most—suppliers in an incentivized system are in fact motivated by the psychological benefits of
helping their loved ones. The suppliers in incentivized systems may act out of their desire to acquire the necessary means for a life saving treatment that a family member needs or for helping their families to get rid of debt. In such cases, the psychological harm of watching a loved one die is avoided in an indirect way by the financial means that the supplier acquires through selling her organ. Considering such cases, it is not obvious whether the argument relies on a real distinction.

This also points to the second problem with this argument, which is that it underestimates the indirect but crucial role that the financial means play in one’s physical and psychological well-being. As mentioned above, the supplier in an incentivized system may be motivated by life-and-death matters in her decision to sell her organ. Yet, even if the situation is not as crucial, the supplier may simply find the psychological benefits of a better education or the physical benefits of a comprehensive medical insurance that she can afford in return for selling her organ to outweigh the harm the procedure causes. In the end, given that the risk of kidney removal under adequate care is negligible, as the WHO states, there does not need to be extreme benefits in order to justify the harm.177

The individualistic approach of harm–benefit balance justifies organ transplantation only if the scope of harm and benefit is widened to include psychological effects of the procedure in addition to the physical ones.178 It is not

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177 “Human Organ Transplantation,” WHO.
178 It can be argued that while the physical and psychological harm and benefit in non-incentivized systems directly affect the well-being of the individual, the financial harm and benefit only indirectly factor in. This may be true in comparison to those cases where the individual derives a relatively more direct psychological benefit from being able to help a loved one or someone in need. However, if we assume that many donors act on the moral and social obligations, then many cases in non-incentivized systems also turn out to be indirectly justified.
simple to judge which non-physical benefits—that is, psychological, financial, or social benefits—outweigh the physical harms and risks of a procedure. Since one cannot refer to an objective measure in such comparisons, the judgment necessarily depends on the supplier’s decision. As long as the supplier is provided with all the relevant information and is considered to be competent to make a rational and voluntary decision, no outsider, including the health care professional, is qualified to override her decision. Therefore, according to the individualistic interpretation of the principles of beneficence and nonmaleficence, once the organ donation is justified, so is the organ sale.

C. Principle of Justice

The last principle that Beauchamp and Childress put forward is the principle of justice. This principle differs from the others in focusing on the society as opposed to individuals. The main demand of the principle of justice is that “[e]quals must be treated equally, and unequals must be treated unequally.”179 As Beauchamp and Childress point out, this is a very broad claim, and without identifying in which respect the equality is determined, the principle lacks substance. However, Beauchamp and Childress do not provide any particular account of justice; they simply refer to the various existing theories suggesting that every theory presents a “valuable perspective” while remaining incomplete and insufficient.180

179 Beauchamp and Childress, Principles of Biomedical Ethics, 242.
180 Ibid., 280.
In relation to the organ transplantation, the principle can be applied both to the procedure of procuring the organs and of allocating the organs within the systems of organ transplantation. One of the main concerns of the principle of justice is the distribution of burdens and benefits within the society. A move from a non-incentivized system to an incentivized system is often objected in relation to the distribution of burdens and benefits in the society. The widespread objection against an organ market refers to the vulnerable groups. It is argued that whereas the non-incentivized systems do not take advantage of certain groups in the population, the incentive-based systems target the vulnerable groups by providing attractive benefits for the desperately poor.

I have already dealt with this objection in relation to the principle of respect for autonomy. From the perspective of the principle of justice, Beauchamp and Childress take up this objection in relation to the research subjects and claim that “[n]othing about economically disadvantaged persons justifies their exclusion, as a group, from participation in research, just as it does not follow from their status as disadvantaged that they should be excluded from participating in any legal activity.”\textsuperscript{181} According to Beauchamp and Childress, “The presence of an irresistibly attractive offer is a \textit{necessary} condition of ‘undue inducement,’ but this condition is not by itself \textit{sufficient} to make an inducement \textit{undue}. A situation of undue inducement must also involve a person’s assumption of a sufficiently serious risk of harm that he or she would not ordinarily assume.”\textsuperscript{182}

\textsuperscript{181} Ibid., 254.
\textsuperscript{182} Ibid., 256.
Following this explanation, it is clear that the commercial kidney transplantation is not likely to give rise to “undue inducement” arguments. Beauchamp and Childress claim that “[i]nducements are not undue unless they are both above the level of standard risk (hence ‘excessive’ risk) and irresistibly attractive (hence ‘excessive’ in payment) in light of a constraining situation” where the level of excessive risk should be above “the level of common job risks such as those of unskilled construction work.”183 Kidney transplantation neither involves high levels of risk nor necessarily gives rise to excessive payment in a regulated market system.184

II. Evaluation of a Prohibition

As I showed in the first section, a prohibition against a regulated organ market cannot be based on a claim that the practice conflicts with the principles. Here, I take another step and claim that, in fact, the prohibition itself conflicts with the four principles. A prohibition against a regulated organ market prevents the eligible suppliers and recipients to engage in a commercial transaction. By doing so, the prohibition neglects their autonomy, enforces an ungrounded harm–benefit balance, and possibly creates an unjust system. Consequently, according to principlism, prohibiting an organ market is morally wrong.

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183 Ibid.
184 See Chapter 2 for details of risk comparison and market price for kidneys.
A. **Violation of the Principle of Respect for Autonomy**

Stopping the informed, rational, and voluntary supplier and recipient from participating in the commercial transaction violates the principle of respect for autonomy. In a regulated market, the autonomous decision of every participant is ensured (as I showed in the first section, the counter-argument from supplier vulnerability is unfounded). Hence respect for autonomy entails respect for the participant’s decision to sell her organ.¹⁸⁵ None of this to say, of course, that principlism favors the sale of an organ over a donation. But respect for autonomy demands that autonomous individuals to be allowed to make this choice themselves. The organ market accomplishes this because it includes in itself all other systems.

B. **Violation of the Principles of Beneficence and Nonmaleficence**

The prohibition also violates the principles of beneficence and nonmaleficence both towards the suppliers and the recipients. This is obvious with respect to the recipient who is left to die, or at least to spend painful time on the waiting list and on dialysis, because she is not allowed to purchase an organ. But it is also true with respect to the supplier, if one follows the understanding of the principles laid out in the preceding section. As I argued there, if non-incentivized transplantation is justified in terms of non-physical benefits, then a

coherent application of the principle of beneficence also demands the supplier to be justified to sell her organ. In terms of non-physical harm and benefit, not allowing the supplier sell her organ goes against the principle of beneficence.

C. **Violation of the Principle of Justice**

Finally, prohibiting the recipient and the supplier to participate in the commercial transaction can violate the principle of justice: it makes the survival of the patient dependent on her social connectedness, burdens family members to donate their organs out of desperation, robs the poor of an option of earning money, and, most importantly, causes a scarcity of organs and hence a major inequality between the many that the scarcity condemns to die and those lucky enough to receive an organ.

Oftentimes, one encounters the inverse argument, namely that a market for organs would create injustice because it supposedly ‘forces’ poor people to sell their organs. This argument, as I discussed in the first section, relies on a necessary condition of coercion, manipulation, or incompetence that results from being poor. However, this necessary condition of the argument is not a necessary condition of the system. A more direct concern that is rarely addressed is that a prohibition necessarily robs the poor from an acceptable option (in terms of its low risks and its valuable goal) of making money. By doing so, the prohibition further burdens the poor, which is not in line with the principle of justice.
What is generally overlooked is the massive inequality entailed by the scarcity that a prohibition creates. The Iranian experience shows that kidneys do not necessarily fall under the category of ‘scarce goods’. After legalizing commercial kidney transplantation in 1988, Iran eliminated the waiting list by the end of 1999.\textsuperscript{186} Thus, a prohibition creates crucial allocation problems, where any allocation will lead thousands of people to death, and any decision between different allocations is essentially arbitrary. In the current donation system, life or death hinge on the seconds of entering the waiting list, or points acquired by relatives who are willing to donate their organs after death.\textsuperscript{187} By contrast, a regulated organ market may reduce drastically the number of patients who do not receive an organ and maybe even eliminate it.

In a non-incentivized system where organs are scarce, directed donation is the best option with the least amount of waiting time (hence, the least amount of health deterioration and best health outcome after transplantation). This privileges patients with large families or a large group of social relationships. Less fortunate patients, like immigrants, orphans, or widows, have drastically fewer chances of finding a donor and hence for survival. In societies where women are disadvantaged within the society, women are most likely to be the donors and least likely to receive donations.\textsuperscript{188} To create more equal chances for survival requires a mechanism that provides organs for those who become disadvantaged in the system of donation. An incentivized system might provide more ‘just’

\textsuperscript{186} Ghods, “Renal Transplantation in Iran,” 225.
\textsuperscript{188} Farhat Moazam, \textit{Bioethics and Organ Transplantation in a Muslim Society} (Bloomington: Indiana University Press, 2006), 108.
conditions for these disadvantaged patients. To be sure, the incentivized system might disadvantage other groups, in particular those with little money who cannot afford to purchase an organ. This is not a problem of organ allocation, however, but rather one of health care allocation. Moreover, as a practical matter, the actual effect on poor patients is likely to be the exact opposite, i.e., an organ market would help those with limited access to health care. As I explained in Chapter 2, the expected price of a kidney is an order of magnitude lower than the price of even just one year of dialysis. Consequently, replacing the current system of donation with an organ market would make the system more inclusive for the poor, rather than less.

The lack of a commercial option also burdens family members by trapping them in a situation where the only option of saving their relative’s life is to give their own kidneys. This obligation puts unjustified pressure on those who are scared of donating their organs. Moreover, as mentioned, in societies where certain family members are in a more vulnerable position, the system forces them into complying with the pressure since the options are extremely limited.
PART III

PRACTICAL ISSUES
In Part II, I have evaluated the moral permissibility of a regulated organ market by focusing on the actions that it entails. I argued that the claim that an organ market necessarily entails immoral actions is unfounded in all four ethical theories that I have considered. I showed not only that the necessary actions in a regulated organ market are morally permissible but also that a typical transaction does not violate any moral principles.

I also analyzed the prohibition of a regulated organ market from the perspectives of four ethical theories. I concluded that a prohibition is morally unjustified in all four ethical frameworks and even strongly argued to be morally wrong in utilitarianism, Kantian ethics, and principlism.

In this last part, I turn to some of the practical aspects of the issue and use the analysis that I provided in Part II to evaluate some practical questions. First, I argue for the necessity of the condition in any system of organ transplantation that I have posed in Part I and assumed in Part II: fully informed, rational, and voluntary participation. In the second section, I take a look at three regulations: common database for organ matching, insurance coverage for purchase of organs, and insurance for the supplier for transplantation related complications. I argue for these regulations pointing out to the ethical theories that support them, even though none of them are supported by all four ethical theories. And finally, in the third section, I evaluate the existing guidelines on organ transplantation and sale of organs. I argue that these guidelines fail in two respects: (1) They do not distinguish between an unregulated organ trade and a regulated organ market, and
(2) their claims are not supported by any of the ethical theories that I have discussed in Part II.
CHAPTER 7

REGULATIONS AND GUIDELINES

In Chapter 2, I presented definitions of the systems of organ transplantation and limited the discussion in Part II to a particular set of systems. All of these systems shared a basic requirement: allowing only fully informed, rational, and voluntary individuals to participate in organ transplantation. This restriction aimed to keep the focus on the main distinction between the systems—namely, the role of incentives and monetary transaction. In this chapter, I first go back to this limitation (which I will call the requirement of informed consent) that I have put forward in the beginning and argue for its necessity.\(^{189}\) I claim that the basic requirement for informed consent of the participants is morally grounded, and forgoing it would characterize any system as morally impermissible whether or not it involves incentives. In the second section, I present and evaluate a number of regulations for an ethical organ market. Finally, I conclude the chapter by looking at the existing international guidelines in relation to organ market and argue not only that the guidelines are wrongly directed at a regulated organ market but that their claims are wrong.

\(^{189}\) It must be noted that I use the term informed consent to refer to the characteristics of the individual’s decision and not to the type of regulation such as requiring participants sign an informed consent form. The distinction is crucial in cases where the participant signs the form without fully understanding the information or the conditions that she agrees on.
I. Moral Necessity of Regulations in Organ Market

A market on organs differs from markets for many other ‘goods,’ such as consumer products like cars and clothes, and services like hair-dressers and restaurants. The ground of this argument is laid down by Kenneth Arrow in “Uncertainty and the Welfare Economics of Medical Care.” Arrow points out five distinguishing factors of medical care in comparison to “usual commodity”: the nature of demand, expected behavior of the physician, product uncertainty, supply conditions, and pricing practices. These distinguishing factors by and large also apply to the organ market.

In this section, I first present the differences between an organ market and a market for common goods. Then, I justify the necessity of the basic requirement, showing that for an organ transplantation to be morally permissible, all four ethical frameworks demand the participants to act on a fully informed, rational, and voluntary decision.

A. The Special Character of an Organ Market

The organ market involves two main parties: the supplier who provides the organ and the recipient who provides the money. However, unlike a transaction of usual commodities such as a car, the transaction of an organ occurs only once for the supplier and maybe even for the recipient, and it involves

further risks, which the parties are typically unaware of. In an organ market, the recipient has an urgent demand on which her life depends. She does not have the time to ‘shop around’ and in most cases, as the transaction is delayed, she also does not have a calm attitude towards the transaction. Even though, in comparison to the supplier, the recipient, through her interaction with the health care staff, has a considerably greater understanding of the situation, of the available options, and of what these options involve, she still typically lacks the understanding and knowledge that the health care professionals possess.

The supplier, who enters the market with a desire to help or a desire to earn money, is in the beginning likely to be completely uninformed, misinformed, or at best partially informed about what this transaction involves. On the other hand, she has only one chance to participate in this market, whereas the recipient can technically buy an organ more than once if the previous purchase fails prematurely or simply ‘wears off’ with time. However, the recipient’s ability to participate in organ market depends on the consequences of the first transaction since a failed transplant may cause deterioration in her health, which may render her ineligible for further transplants.

These issues, which are necessarily a part of an organ market, do not constitute a crucial problem in a market for cars, for example. The buyers in a car market can acquire a good deal of information without buying the product. They can do test-drives, ask others who use the exact same car for the same purposes, and compare with other cars that they tested or bought before. If they are still dissatisfied by their choice, they can sell the car usually for a lower price and buy
a new one and repeat this as long as they can afford it. The need for a car is never as urgent as the need for an organ, and the effects of delayed purchase do not cause great stress to the potential buyer in comparison to a patient in the organ waiting list.

Given these crucial differences, it can be reasonably argued that a market for organs can be evaluated in its own terms distinct from a market for usual commodities. Such a market may require regulations that a market for usual commodities does not require. In light of this, throughout Part II, the systems of organ transplantation are discussed within the limitations of a basic requirement integrated into their definitions. The basic requirement is that every participant of organ transplantation has to be fully informed, rational, and voluntary. This necessary condition applies to both incentivized and non-incentivized systems. Even though the crucial role of this requirement presents itself most strongly when the supplier’s decision is concerned, it is also important for the recipient’s decision to undergo the procedure.

B. **Moral Evaluation of the Basic Requirement**

Any organ transplantation, whether or not it involves incentives, has to ensure the informed consent of the participants. By each ethical framework—namely, utilitarianism, Kantian ethics, virtue ethics, and principlism—this requirement is supported, and in the absence of this basic requirement for informed consent, the practice of organ transplantation cannot be morally
justified. To show this, let us examine the requirement for informed consent in relation to the four ethical frameworks focusing on the supplier and the recipient.

**Utilitarianism**

In the utilitarian framework, informed consent does not have a value by itself. Yet, it may and typically does have a derivative value from its contribution to the maximization of overall happiness or preference satisfaction. This connection is particularly close in preference utilitarianism, which takes as the ultimate yardstick what the individual chooses with full information, rationally, and voluntarily—that is, exactly what informed consent is designed to guarantee.\(^{191}\) Classical utilitarianism does not give such exalted status to individual choices. But assuming that individuals generally aim to maximize their own happiness, achieving maximum overall happiness is unlikely if individuals make predictions of happiness irrationally, or based on misinformation.

The immediate consequences of the organ transplantation fall on the supplier and the recipient. For acting morally in the utilitarian framework—that is, to maximize the preference satisfaction and overall happiness for both parties—the individual supplier and recipient need to determine their own informed, rational, and voluntary preferences, as well as having a reason to believe that the other party is also acting with informed consent. Similarly, in order to determine if a policy would maximize preference satisfaction, informed,

rational, and voluntary preferences of all parties should be taken into consideration.

Regardless of which system of organ transplantation is evaluated, in a system where the informed consent of the individuals is not ensured, the result is highly likely to fall short of maximum utility. From the individual’s perspective, for example, if the recipient does not have the full information about what is involved in the transplant procedure and what her other options are, she may agree to undergo a procedure that involves extremely high risks for great costs (such as transplants done in inadequate standards which have low likelihood of graft survival and high likelihood of donor-transmitted diseases), even though, given all information, she would have chosen to refuse the procedure. Moreover, if the recipient does not know whether the supplier is forced into giving her organ or whether she is fully informed about the procedure, she cannot judge whether accepting the organ will satisfy the supplier’s preferences or contribute to her overall happiness.

From the policy perspective, one may argue that in classical utilitarianism, it is not relevant what the individual thinks will make her happy; what matters is what actually will make her happy. This paternalistic approach suggests that the individual may think that she will be happier when she earns $5,000 for her kidney but actually she will be miserable because her health will deteriorate after the poorly done surgery. While this approach is questionable, even for making such a claim, the evaluation has to take into consideration the individual’s voluntary, rational, and informed decisions. It may be the case that the individual
made an autonomous decision to earn $5,000 under any circumstances because a lifesaving surgery that her child had to go through costs $5,000 and that is all that matters for her.

The utilitarian calculation is based on preference satisfaction or overall happiness and we do not have a direct access to the information on what satisfies people’s preferences or what makes them happy. Therefore, the most important source of information is the individual’s own statement of what makes her happy or satisfies her desires. Individuals often fail to make accurate predictions for their happiness and preference satisfaction; yet, it is reasonable to assume that they are more likely to come close to accuracy if their decisions are fully informed, rational, and voluntary. Therefore, any system of organ transplantation, whether it is donation or sale, cannot maximize the utility unless it ensures the autonomy of the participants.

This conclusion is supported by the empirical evidence on unregulated organ trade as opposed to a regulated system of donation. Most suppliers in organ trade regret their actions and report their happiness and health to be worse after the procedure. This can be traced to the discrepancy between what they were promised and what they actually received in terms of money and the standard of care. Suppliers usually end up with less money and worse health outcomes than what they agreed on. If the suppliers were fully informed about the risks and the benefits under given circumstances, they would have refused to sell their organs.\(^{192}\)

\(^{192}\) See Chapter 2 for more detailed discussion of suppliers’ post-operation conditions in illegal organ trade.
Informed consent, understood as fully informed, rational, and voluntary decision making, plays a very important role in the Kantian ethics. For our purposes here, we can simply focus on the formula of humanity, which emphasizes that one’s treatment of others as well as oneself must always respect the rational nature and never use one’s or the other’s rational nature merely as an instrument.

Any type of organ transplantation would violate the formula of humanity if the informed consent of the participants were not ensured. By accepting an organ from the supplier who is not fully informed, rational, or voluntary, the recipient treats the supplier as a mere means for her survival. If the supplier has not made an informed, rational, and voluntary decision, by accepting her offer—which results from coercion, manipulation, or ignorance—the recipient disregards the supplier’s rational capacity and aims to make use of her only as an instrument for her own survival. Given this, the recipient’s act of treating the supplier as a mere means and the supplier’s act of letting herself to be treated as a mere means lead them both to violate the formula of humanity.

In order to have individuals to accept or to provide an organ without violating the moral law, the informed consent of the participating individuals must be ensured. Otherwise, an organ sale as well as an organ donation is morally impermissible in the Kantian framework.
In Chapter 5, I used two questions to evaluate the moral status of organ transplantation systems: (1) Would a virtuous agent remain virtuous in this system? And (2) would a virtuous agent prefer one of these systems over others? Here, the same questions can be employed to examine the moral status of an act of providing or receiving an organ in a system that does not require informed consent.

To answer the first question, let us look at the recipient’s position in a system that does not ensure the informed consent of participants. In such a system, the recipient, who is motivated by her pursuit of human flourishing, would not know whether her act also ends up subjecting the supplier to vices such as injustice, cruelty, dishonesty, or selfishness. This is not to claim that the lack of knowledge about the decision of the supplier makes the recipient’s act vicious. Instead, it means that the virtuous recipient would be unable to accept the supplier’s offer considering that the supplier is taking a health risk and it is not clear whether her actions stem from a fully informed, rational, and voluntary decision. If the supplier is offering her kidney because of coercion or manipulation, the recipient, by accepting her kidney without seeking the supplier’s informed consent, would be taking advantage of this situation for her own good. Under these conditions, her acceptance of the organ without making sure of the supplier’s informed consent would reflect selfishness.
When it comes to the second question—would a virtuous agent prefer one of these systems to others—the reply is even more straightforward. The virtue ethics emphasizes the importance of practical wisdom in understanding the situation and enabling one to employ the appropriate virtues in the right balance. For instance, even though courage is a virtue, this does not mean that one must be courageous at all times. Instead, it entails that one must be able to recognize the situations where one should act out of courage and be neither excessively nor insufficiently courageous. A system without informed consent does not favor the disclosure of all information and allows the individual to decide without having a sufficient grasp of the involved factors.

If the supplier is coerced or manipulated into providing an organ, the virtuous agent would refrain from taking advantage of this situation. Without the requirement of informed consent, the virtuous agent lacks a full understanding of the situation and how her actions affect the other party. A virtuous agent would not prefer such a system.

Principlism

Principlism has autonomy as one of its four main considerations. Along with nonmaleficence, beneficence, and justice, respect for autonomy is one of the fundamental principles for a moral decision. It can be argued that a system that does not require the informed consent of the participants would be in conflict with the principle of respect for autonomy. However, this argument does not provide a
strong case given that the theory insists that none of these principles are absolute and they can be overridden by other obligations.

Let us focus on the supplier’s position in a system where the informed consent is not required. The first principle—namely, respect for autonomy—suggests that the supplier’s offer of providing her kidney should be respected once the decision is autonomous. In a system where the supplier’s decision is not informed, rational, and voluntary, this principle cannot be followed.

The principles of nonmaleficence and beneficence aim to balance the benefits and harms to the individual. As argued in Chapter 6, these principles need to be understood as including direct and indirect psychological harm and benefits in order to agree with organ transplantation. Once the scope is not limited to the direct medical benefits and harms, then the judgment of what is beneficial for the supplier can only be done by the supplier herself. And in order to make such a judgment, the supplier surely needs all the relevant information and should have the ability to reach a decision rationally and voluntarily. In a system where informed consent is not required, the harm and benefit judgment cannot be made.

The last principle to consider is the principle of justice. This principle is the vaguest one, given that there are a variety of theories of justice and principlism does not endorse any of these theories particularly. Even though a case can be made for informed consent in relation to a theory of justice, the support of this principle need not be sought. Principlism suggests that a principle can be overridden for striking a balance in other obligations. Therefore, regardless of the relation between justice and informed consent (even though it is most likely
to be a favorable relation), it can be claimed that the principlism demands a moral system of organ transplantation to require informed consent, given that the principles of respect for autonomy, nonmaleficence, and beneficence affirmatively and strongly support the requirement of informed consent for participating in organ transplantation.

II. Beyond the Basic Requirement

A regulated organ market is likely to have more regulations than just a basic regulation. While the basic requirement for informed consent can easily be justified on moral grounds within all of the four ethical frameworks, there are various other regulatory concerns that are justified only by some of the ethical theories. Here, I present arguments for three regulations: (1) a common system of allocation of organs, (2) health insurance coverage for the purchase of organ as a part of the costs of transplant procedure, and (3) insurance for the supplier for transplantation related complications. These arguments are not conclusive given that they are based on some—not all—ethical theories, and agreement with these regulations would need to presuppose an agreement with those ethical theories.

A. Common Database for Matching

An organ market can employ various different methods for matching the suppliers and recipients, ranging from ‘first come, first serve’ or urgency to best
result or price match. The allocation of organs can be done through private companies, online networks, or governmental agencies. Even though these methods of allocation are based on moral judgments, they are also strongly related to the empirical data that factors into the moral argument. For example, allocating the organs to provide the best result can be controversial even though it is justified on utilitarian grounds. If there is a great lack of organs, in such a system many patients, who have been on a dialysis for a while or who have other health conditions, would be left to die even though they can benefit greatly from the organ transplantation. This can give rise to issues about justice and value of individuals. On the other hand, if the supply meets the demand, then the ‘best result’ rule becomes uncontroversial and simply efficient.

The allocation methods are open for discussion, yet a less controversial regulatory point is related to a more basic issue in matching. The outcome of the organ transplantation is strongly dependent on how good the match is. Therefore, whether or not there are enough organs to meet the needs of the patients, it can be argued that the information pool for matching these organs with the donors should be sufficiently large in order to find the best matches.

This regulatory suggestion does not necessarily argue for a monopsony. It only argues against small clusters of information that are not used in collaboration. In other words, under such a regulatory rule, many small private companies that do organ matching can exist as long as they cooperate with each other by sharing their databases to find the best match for the patient in the shortest time. This also does not necessarily mean that all such companies should

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193 Friedman and Peters, “Make Me a Perfect Match: Understanding Transplant Compatibility.”
collaborate; instead, it only points out to the need for a large enough information network to provide the best and fastest matches.

This regulatory rule can be justified most strongly by a utilitarian framework. By finding the best and fastest matches, not only is the health outcome of the procedure optimized, but the recipient is also saved from having a low quality of life while being treated by medications and dialysis. On the other hand, this regulation can also be supported by principlism with an appeal to justice and beneficence. In a system with a common database for matching suppliers with recipients, best matches can be found for most recipients without having to choose between them on irrelevant grounds such as their exact second of entering the waiting list.

B. Insurance Coverage for Organ Purchase

Health insurance is an issue that is mainly discussed in relation to the justice in distribution of health care. Here, I will not discuss this issue but focus on a sub-question. Currently, many types of health insurance cover the costs of dialysis and organ transplantation. Both of these treatments are highly costly and in many cases, the patients are not lucky enough to avoid dialysis whether or not they receive an organ in the end. I argue that a regulation should require such health insurances to also cover the costs of purchasing an organ. This would allow those people who have such health insurance to be able to go through organ
transplantation instead of being dependent on their extra funds to pay for the organ.

One may argue that such a regulation does not provide more just conditions for the society, given that those who can afford such health insurances will be the better off, and the worse off will still suffer since they most likely do not even have any health insurance. This objection mainly attacks the lack of universal health insurance, which is a different problem. However, if we assume the existing health insurance distribution as a given, then by not covering the purchase of the organ, the system creates even more inequality between the patients who can just afford a health insurance and patients who can afford both health insurance and the cost of buying an organ.

From a utilitarian perspective, this regulation is also supported. Studies comparing the costs of kidney transplant and dialysis found that the “break even” point is at about 2.7 years after the transplantation for most patients and 1.7 years for the approximately 30% of patients who do not need readmission. After the break even point, the transplant patient saves about $28,000 per year.\textsuperscript{194} As mentioned in Chapter 2, the cost of buying a kidney is calculated to be around $15,200.\textsuperscript{195} By enabling a better treatment for a lower cost, such a system increases the happiness and preference satisfaction of the patients with kidney failure without taking the funds from other sources.


C. Insurance for Transplantation Related Complications for the Supplier

The non-incentivized systems, in their quest for increasing the supply of organs, aim at incorporating policies that remove disincentives. For this purpose, a system of comprehensive reimbursement can be designed to include follow-up care for the supplier up to a limited time or for specific conditions. An organ market is mainly based on monetary transaction instead of compensations such as insurance or tax reduction. However, it can be argued that an insurance for the supplier for transplantation related complications should be provided even in an organ market that operates with money and not with compensation.

By accepting this regulation, the policy makes the suppliers receive a smaller sum of money plus insurance for transplantation-related matters instead of getting a larger sum of money only. Such a policy can be justified within the frameworks of principlism and virtue ethics. From the perspective of principlism, it can be argued that such a regulation is in line with the principles of nonmaleficence and beneficence. By ensuring post-operative care for the supplier, the system minimizes the harm that can come to the patient while preserving her financial benefits. It thus creates a better balance of harm and benefits.

This idea can be objected by referring to the principle of respect for autonomy, which would find it disagreeable if the patient does not have a choice of foregoing the insurance for a larger sum of money. Given principlism’s lack of method for balancing principles, it is not clear how strong such an objection is. As

196 “Reimbursement of Travel and Subsistence Expenses Program”, Department of Health and Human Services.
the theory suggests, a principle can be overridden for the sake of other principles; in this case, principles of nonmaleficence and beneficence may outweigh the principle of respect for autonomy.

Another justification for this regulation can be based on virtue ethics. If the regulation asserts that the insurance for the supplier has to be provided by the institute that performs the transplantation surgery, then this system would reinforce a sense of responsibility to the health care staff. A virtuous person would be likely to prefer such a system given that it would minimize vices against the supplier such as cruelty, dishonesty, inconsideration, greed, recklessness, and thoughtlessness.

III. Evaluation of International Guidelines

Recognizing the problems with organ trade, both governments and international bodies strive towards preventing the occurrence of it. In their struggle to fight against the organ trade, they argue and act against any type of incentivized system of organ transplantation and especially an organ market. There are two problems with the justification of such a strategy: (1) The arguments against incentives and commercialization are based on characteristics that are unique to an unregulated system such as organ trade, and (2) these arguments applied to a regulated organ market lack any ethical basis.

As shown in Chapter 2, organ trade differs from organ market in terms of its lack of regulations. A regulated organ market has a minimum basic
requirement of informed consent. Given this distinction, any argument against organ trade can only be valid against organ market if it does not rely on the unregulated character of the trade. Furthermore, since these arguments object to an incentivized or commercial system for reasons of morality, there must be ethical justifications for such arguments. However, I argue that none of the guidelines bring out such a justification, and it is not clear how there can be an ethical ground for these objections.

A. The Declaration of Istanbul

In 2008, “The Declaration of Istanbul on Organ Trafficking and Transplant Tourism” was endorsed worldwide by transplantation societies, including national councils and the Council of Europe. The Declaration aims to fight against organ trade and to reinforce the principles to ensure the well-being of suppliers and recipients of organs. Principle 6 in the Declaration states,

Organ trafficking and transplant 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. In Resolution 44.25, the World Health Assembly called on countries to prevent the purchase and sale of human organs for transplantation.

a. Prohibitions on these practices should include a ban on all types of advertising (including electronic and print media), soliciting, or brokering for the purpose of transplant commercialism, organ trafficking, or transplant tourism.

b. Such prohibitions should also include penalties for acts, such as medically screening donors or organs, or transplanting organs, that aid, encourage, or use the products of, organ trafficking or transplant tourism.
c. Practices that induce vulnerable individuals or groups (such as illiterate and impoverished persons, undocumented immigrants, prisoners, and political or economic refugees) to become living donors are incompatible with the aim of combating organ trafficking, transplant tourism, and transplant commercialism.  

Given the definitions, organ trafficking and transplant tourism fall under the category of illegal organ trade, whereas transplant commercialism includes both organ market and organ trade.

While the characteristics of organ trade can be used in order to flesh out the arguments based on equity, justice, and dignity, it is not clear how the same arguments can be transported to the discussion of organ market. In an unregulated organ trade, the suppliers are misinformed, manipulated, and deceived with false promises. They unknowingly confirm to an agreement that is to their disadvantage and in many cases, they do not even receive what the agreement promises. Hence, it is clear why the organ trade can be labeled as unjust and undignified, since it prevents the supplier from acting as a rational, autonomous agent.  

On the other hand, it is not clear how transplant commercialism or an organ market leads to injustice. As discussed in Part II, the regulated organ market where all participants are fully informed, rational, and voluntary, both from the perspectives of virtue ethics and principlism, provides a better system in terms of justice than donation only. Moreover, as discussed at length in Chapter 4, there is certainly no violation of human dignity if the term is understood in a

199 See Chapter 4 for a more detailed discussion on dignity.
Kantian way. And finally, as the argument from vulnerability concludes in Chapter 2, as well as the understanding of competency for decision making, autonomous behavior, and undue inducement in the framework of principlism shows, an organ market does not exploit or take advantage of the vulnerable populations.

The Declaration of Istanbul fails to make a case for condemning commercialization of organ transplantation. Since organ trade has obvious problems, the justification for the Declaration’s position against organ trade is straightforward. But precisely because the Declaration’s justification relies entirely on these obvious problems of organ trade, it is not valid against the organ market, which does not have these same problems. The Declaration overlooks the crucial differences between the organ trade and the organ market, and does not attempt to provide a relevant connection between the two practices in order to make its objection against the market defensible.

B. WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation

In 2010, the WHO announced the updated version of “WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation.” These principles are “intended to provide an orderly, ethical and acceptable framework for the acquisition and transplantation of human cells, tissues and organs for therapeutic purposes.” Similar to the Declaration of Istanbul, the WHO Guiding Principles also prohibit the commercialization of organ transplantation. Guiding Principle 5

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200 “WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation.”
states that “[c]ells, 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.” In the commentary added to Guiding Principle 5, it is clearly stated that the WHO takes a firm position against transplant commercialism by claiming that “[p]ayment for cells, tissues and organs is likely to take unfair advantage of the poorest and most vulnerable groups, undermines altruistic donation, and leads to profiteering and human trafficking. Such payment conveys the idea that some persons lack dignity, that they are mere objects to be used by others.”

The same problem that occurs in the Declaration is repeated in the WHO Guiding Principles. While the condemnation of organ trade is understandable for the reasons that are explicitly mentioned in the commentary, the claim of commercialization necessarily leading to the same results, such as taking advantage of the poor and causing human trafficking, is not supported. For all we can claim given the existing evidence is that the lack of organs in the limitations of the system of donation is what gives rise to the organ trade and trafficking. Given the lack of justification why commercialism is likely to result in the exploitation of the vulnerable and the trafficking of humans, Guiding Principle 5 has no valid argument against an organ market.

In addition to this unsupported connection that is drawn between unregulated organ trade and regulated organ market, a reference to dignity is

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201 Ibid.
202 Ibid.
provided. This objection, echoing the Kantian formula of humanity, is valid within the illegal and deceptive nature of organ trade. Yet, as I have shown in Chapter 4, it loses all of its relevance when applied to a regulated organ market with informed, voluntary, and rational individuals.\(^{203}\)

The WHO Guiding Principle 3 states that “[l]ive donors should be informed of the probable risks, benefits and consequences of donation in a complete and understandable fashion; they should be legally competent and capable of weighing the information; and they should be acting willingly, free of any undue influence or coercion.”\(^{204}\) A proposed organ market also has to follow these criteria for the eligibility of living organ suppliers. These criteria are as crucial in an organ market as they are in a system of donation given that the emotional attachment of the supplier to the recipient certainly does not guarantee her competency for decision making or her voluntariness. Familial or social dynamics may give rise to the related donor’s involuntary acceptance of giving her organ, and the system of donation has to have the necessary safeguards in order to prevent this. Similarly, a system of commercialization may include those individuals who involuntarily agree to provide their organs because of coercion. An organ market should also prevent this from happening by using safeguards and protocols that aim to eliminate such individuals. The important aspect of this guiding principle is that it is relevant to any regulated system of organ transplantation and does not straightforwardly object to a system of

\(^{203}\) See Chapter 4 for a detailed discussion of Kantian ethics and dignity.

\(^{204}\) “WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation.”
commercialization since these criteria for living suppliers can be and should be fulfilled in such a system.

Considering that these guidelines fail to provide a justification for an objection to a regulated organ market and simply rely on arguments relevant to organ trade, it becomes unclear why an ethical system of organ transplantation must avoid incentives and commercial transaction. The existing guidelines are justified in their fight against the organ trade and practices that are entailed by organ trade such as trafficking and transplant tourism. Yet, if these guidelines aim to object any system of commercialization, then they first have to argue for the relevant connection between organ trade and organ market and then provide a moral justification for an objection. However, I argue that such a position is not defendable given the analysis that I have provided in Part II. A regulated organ market encounters no objections from four main ethical theories. By contrast, given that a prohibition proves to be ethically unjustified and even wrong, it is more likely that once these guidelines spell out their arguments, they will violate the demands of these ethical theories.

These policies and guidelines insist on the idea that making an organ available must be an act of generosity only and cannot be reciprocated. It is difficult to understand this position since in daily life, we do not expect people to act heroically, take risks, and endure pain in order to help others. Making an organ available is not a common action that can be expected from everyone given that it carries no benefits for the self and it requires risk and pain. Such an act is considered to be heroic and extraordinary. The empirical evidence on the
extremely low numbers of non-related non-directed altruistic living organ donations confirms this understanding. Most of our actions and decisions take into consideration the economic benefits of available choices, and our understanding of heroic acts typically finds it appropriate to reciprocate the hero’s ‘good’ act with a reward. However, there is an interesting conservatism when it comes to organ transplantation. An act that involves no material benefits or rewards is expected from the supplier. Unsurprisingly, this expectation results in an extremely low number of living anonymous donations. Current guidelines and policies find it reasonable to reimburse the suppliers for their financial loss, such as the time they have to take off from their work; and even compensate them for the risks by providing free medical care for transplantation-related problems. Yet, it becomes highly controversial to ‘compensate’ them for their real permanent loss—their organs. The opponents base their arguments on morality; yet, there is no moral justification for their positions. Most importantly, this discussion continues at the expense of the death of 11,000 people per year only in the United States and Europe—deaths that could be prevented by allowing an organ market.
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