Kidney International, Vol. 55 (1999), pp. 724–732

COMMENTARY

The ethics of organ transplantation reconsidered: Paid organ donation and the use of executed prisoners as donors[1]

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The ethics of organ transplantation reconsidered: Paid organ donation and the use of executed prisoners as donors. We examine the arguments for and against the practice of paid organ donation and the use of judicially executed prisoners as seen in a world context. Although Western opinion is almost universally against both practices, we seek to establish that this has arisen largely from justification of an initial revulsion against both and not from reasoned ethical debate. In examining the most commonly cited arguments against these practices, we demonstrate that this revulsion arises mainly from the abuses to which both processes have been subjected, rather than the acts themselves, together with opposition to a death penalty. At the moment and for some future time, in the absence or shortage of dialysis in large parts of the developing world, transplanted organs represent the only means of treating end-stage renal failure. Thus, a clear ethical conflict arises as to whether greater harm or good is done by allowing individuals to die or adopting strategies for obtaining organs that raise ethical problems. We call for continued reasoned ethical debate on both issues, rather than accepting that the argument is already over.

Ethics is "the science of morals; the department of study concerned with the principles of human duty" [1].

Ethics is a discipline with its own structures and rules of debate (see Appendix) [2]. One definition emphasizes the close links between ethics and morals. Another way, as stated by Miller, is that ethics "systematically examines what is right, good or just in human conduct. Morality is the social, religious or professional tradition of values about what is right, good or just in human conduct" [3].

Formal ethical analysis of a problem should proceed in a clear and rational way. What should be done? Who should decide? On what basis? Is this what I would wish for myself in a similar position [3]? The issues with which ethics deals are often ones that arouse strong immediate emotions, and it is often necessary to try to mute one's initial reaction—favorable or unfavorable—and see where an intellectual analysis of the question leads. Not that feelings of repugnance for some acts are inappropriate—they represent the outward expression of a complex of beliefs that define the individual's or society's morality and, without this morality, would not exist—but repugnance of itself does not justify an attitude or action.

[1] **See Commentary by Miller, p. 733**

Key words: renal transplantation, end-stage renal failure, death penalty, dialysis shortage, paid organ donors, ethics in nephrology.

Received for publication February 3, 1998
and in revised form August 24, 1998
Accepted for publication August 25, 1998

WHY WE NEED ETHICAL DEBATE

Table 1 lists a few of the most pressing ethical issues [3–9] with which nephrologists are faced in their daily practice. Some are common to other areas of medicine. They include new issues arising from our increased power to influence outcome through advances in reproductive biology and molecular genetic manipulation, as well as older issues, such as the relationship between doctor and patient within health care systems, the duty of doctors to their patients in their daily practice, in war, in the face of administration of torture, in eugenics, and in a host of other areas such as euthanasia, confidentiality, and abuse of profit.

Hitherto, the International Society of Nephrology (ISN) has had almost no involvement with ethics in relation to nephrology and, unlike a number of other international medical societies, has conducted no public debate and issued no statements or guidelines on ethical issues. However, the ISN is now one of the largest international medical societies, with increasing membership and participation in developing countries. The multiple programs now run or sponsored by the ISN all over the world make it increasingly difficult for it to remain outside ethical debate. Can the ISN be sure that the support it provides is being applied toward projects that are ethically acceptable? This question may not be easy to answer in the context of the different cultural approaches to ethical issues that exist throughout the world. One cannot assume that the philosophies applied to ethical problems in the West will be shared universally, as is demonstrated in this review.

Table 1. Some ethical questions in nephrology

General nephrology
Allocation of resources: individual versus population
Acute renal failure–when is it futile to continue?
Clinical and molecular diagnosis of inherited disorders
Dialysis
ESRD treatment in an unequal world
Who should receive dialysis?
Withholding dialysis
–loss of the patient's ability to decide
–advance directives
–euthanasia
Transplantation
Source of donor organs
Anencephalic babies
Living donors
–paid
–unpaid
–coercion
–minors
Executed prisoners
Patients in a persistent vegetative state
Animals (xenotransplantation)
Equitable distribution of organs

SOME DEBATES IN THE ETHICS OF ORGAN TRANSPLANTATION

Examining the ethics of organ transplantation remains difficult [6–9] because entrenched positions are encountered, some of which seemed to be based more on emotional reactions than on logic. The literature on the subject shows how often practice has been confused with principle, and how specific issues relating to organ donation have been confused with nonspecific wider issues such as global inequalities and inadequacies of processes of law. Stories with the power of modern myths circulate without any evidence [10], such as the kidnapping of children in order to provide organs for transplantation, and it is difficult or impossible to obtain valid reliable data in many areas, for example, the number of paid living donations in India [7] or other countries, and almost all aspects of organ retrieval in the People's Republic of China, especially those arising from implementation of the death penalty.

It is the purpose of this editorial to provide information for debate to occur on two important issues facing those working in transplantation today. We do not propose solutions to these difficult ethical problems or represent the views of either the ISN Ethics Subcommittee as a whole, or its Executive and Council. In contrast, public statements and recommendations have already been made about ethical aspects of transplantation by major bodies [11], for instance, the World Health Organization, the European Union, the Transplantation Society, the European Renal Association, and the Asian Transplantation Society.

Few would argue with the first proposition (from which all our further discussion stems) that kidney transplantation is the most satisfactory and successful mode of treating end-stage renal failure in a majority of patients, as well as being by far the least expensive. Further, in some parts of the world today, transplantation is the only or nearly the only treatment option. The need for organs is indisputable, but everywhere there is a serious shortage, even when living related donors are used liberally; this seems likely to persist until (and if) xenotransplantation becomes a realistic option. Thus, it seems to us that any practice that augments the number of kidneys available for transplantation must be examined in this light and regarded as beneficent unless it carries with it overriding bad consequences that outweigh its benefits. The onus falls on those who oppose a specific measure to increase the supply of organs (for example, the sale of organs) to produce convincing arguments that this would be so. If they fail to do so, or if their arguments prove to be refutable, their opposition should fall away, and the proposed measure should be considered for adoption.

It is clear also that many of the problems with organ donation in a global context arise directly out of larger political and economic issues [7, 12–14], such as the huge variations in material wealth and control of lifestyle between countries and between individuals within those countries, and a penal code which in some countries—but not others—still condones and practices judicial execution. Important cultural and religious differences exist between countries and even between different groups in the same country so that uniformity of opinion is unlikely to be achieved. Nevertheless, efforts should be made to address the problems through logical and thoughtful debate, and not simply dismiss them on the basis of preformed ideas or prejudice.

To illustrate both the approach to ethical problems and the difficulties encountered in a global multicultural context, we have chosen two topics that generate heated discussion, and attempt to review the arguments from both sides: (*a*) paid living organ donation and (*b*) the use of executed prisoners as a source of donated organs.

PAYMENT OF DONORS FOR ORGAN DONATION

This topic has been debated widely [4–9, 12–19]. In most Western countries, including all countries in the European Union, the United States, and China, statutes have been put in place forbidding the purchase and sale of organs. A British minister of the crown stated in 1989 [20] that "*the concept of kidneys for sale is entirely unacceptable in a civilised society.*"

India passed a national law that came into force in February 1995 [21], which, among other provisions, forbade payment for organs [section 2(k) of the act], and this is gradually being implemented in the different states

of the Indian union. The sale of organs is proscribed in Chinese law. The World Health Organization has declared against the sale of organs under any circumstances [22]. In addition, most major national and international societies (including the Transplantation Society and the European Renal Association) [23, 24] have made public statements condemning the practice and are denying membership to those who participate in such acts.

In the face of such widespread condemnation, it might seem prudent to regard the matter as closed, but we and others feel that there are arguments in favor of the sale of organs that are sufficiently cogent to warrant further discussion [15, 18, 19, 25]. In order to demonstrate this, we list the main arguments that are commonly applied against the practice, as well as the counter arguments.

Five main arguments against payment for donation of organs are most commonly cited.

First argument

Organs are priceless and should only be donated for altruistic reasons. It is widely believed that provision of an organ should be seen as a donation or gift, and that it should be freely given in a spirit of altruism and not be subject to commercial interest [26]. Even a renewable resource such as blood should not be bought and sold; donors are, and should be, unpaid volunteers who donate from altruistic motives. This "gift relationship" should not be tainted and distorted by financial transaction and should not be a part of the usual, everyday commercially based world [26]. In theory and practice, it is impossible to put an agreed "value" on a donated organ. Human organs should be considered as priceless and should never be bought or sold. The ability to pay should never be a determinant of whether someone in renal failure receives a transplant, as this contradicts all principles of equity and justice.

Counterarguments

Experience in many parts of the world has proved this view, which emerges from deontology and not argument, to be untenable. In most countries (including North America but not in the United Kingdom), the supply of blood can only be maintained by offering financial reward. Altruism is not as widespread as it used to be assumed, and now in an era in which capitalist commercialism dominates thinking in most areas of life, the blunt fact is that altruism alone has failed to supply enough organs to meet the demand, and hence, the pressure to explore new avenues.

Second argument

Paid organ donation inhibits the development of cadaver programs. The use of paid living donors is likely to inhibit the development of cadaver donation programs and thereby diminish an ethical source and the total number of organs available, especially in developing countries.

Counterarguments

This argument has been promoted strongly, especially in some developing countries in which cadaver programs have failed to appear [7, 11, 14]. However, it has never been suggested that other forms of living organ donation act as anything but a supplement to cadaver donation, hence the renewed interest in promoting both familial and unrelated unpaid donation at the moment, both of which are viewed by most observers as ethical. Why should payment of the donor alter this relationship? In fact, no hard data are available to support the suggestion that paid donation inhibits cadaver donation programs. In India, for example, until the 1995 act, the main impediment to cadaver donation was that it remained illegal in all states of the Indian union except Maharashtra. Since the 1995 act simultaneously made paid donation illegal and cadaver donation legal, one can draw no conclusions as to the cause of the subsequent welcome development of modest cadaver donor programs.

It is possible that payment will be demanded by those who might normally have been expected to donate the organs of dead relatives purely from altruistic motives. This may be true, but the circumstances surrounding the death of a loved relative are different from premeditated donation from a live donor; the grief of surviving relatives may well be assuaged by the knowledge that the organs have been donated to save the life or relieve the suffering of someone else—as an act of altruism without financial reward. In any event, part of the payment to a live donor would be as compensation for the pain, discomfort, or inconvenience and perhaps even the risk of the operation—factors that do not come into account in the case of dead donors.

Third argument

Paid donation exploits the donor and diminishes his or her autonomy. The paid donor in a developing country is usually poor and ignorant concerning the whole process of organ donation and transplantation, and may be open to both coercion and exploitation and thus loss of autonomy. The practice of the poor selling their organs to the rich tacitly endorses the inequality of society and represents the ultimate exploitation of the poor by the rich. The majority of paid donations in India and elsewhere have been in a closed setting of exploitation, not in an open, supervised program with proper audit and care of the donor before and after the operation. Most paid living donor programs involve "middle men," who have major incentives to exploit the donor and are known to do so. The term *"rewarded gift"* is merely a cosmetic exercise designed to conceal the true commercial reality of the act. Admittedly, coercion and exploita-

tion may occur when there is a need for a donation within a family, but this does not contravene the general principle that this should be avoided whenever possible.

Counterarguments

It is the financial circumstances that make it necessary for someone to consider offering body parts for sale that defines exploitation of the individual. Prohibiting this often removes the best or only option the "donor" might have of earning money for a really important cause and thus deprives the individual of autonomy. The noted British ethicist Ranaan Gillon wrote the following [27]: "*the . . . notion that payment somehow undermines a person's autonomy sufficiently to disregard his or her decisions is absurd.*"

In the London trial of doctors involved in the sale of organs, it emerged that one of the donors was a Turkish man who offered his kidney for sale in order to be able to buy medicines for his daughter, who was suffering from tuberculosis; he had no employment and no other salable assets. By prohibiting him from selling his kidney, he was deprived of the only opportunity of saving his daughter. In doing so, are we applying our own perspective so that we can preserve our principles at the cost, perhaps, of his daughter's life? Are we really helping him from being exploited by denying him this option? If she had been suffering from end-stage renal failure and he had volunteered to donate a kidney, he would have been regarded as a hero, acting in her best interests. The fact that he was prepared to give up a kidney—for money—to save her from another disease does not detract from his altruism, nor does the performance of transplantation from familial donors avoid payment and/or coercion altogether, as all those directly involved in transplant programs are aware.

Fourth argument

Paid living transplantation is performed in poor circumstances and increases risks to the donor. The conditions under which many paid living donor transplants take place are medically far from ideal, and the success rates are low [28]. The commercial objective encourages poor precare and aftercare of donors and inadequate screening for transmissible disease, thereby increasing the risk to both donor and recipient. Even in the best surgical hands, there is a small risk of death or serious damage to the donor, and the risk of death—even to one individual—should not be taken purely for financial gain. Doctors, whose primary concern should be for the patient, should not connive in a practice that subjects a donor to risk, not for his own benefit but for the potential recipient.

Counterarguments

The actual risk of loss of life during donation of a kidney has been estimated to be approximately 0.03% [29], which is considerably less than the risk associated with some paid occupations, for example, deep-sea diving, construction work, or mining, or even of dying in an automobile accident in many countries. As we do not express many qualms about these, why do we about organ donation? Why should the risk be different because the donor is paid?

The fact that paid organ donation usually takes place under unsatisfactory medical circumstances has no bearing on the argument. If one accepts the practice, then well-organized programs in which the donor is properly apprised of risk, fully assessed and followed up, with results available for public audit, can and have been organized, for example, in India [30, 31]. It is the marginalization of paid organ donation that leads to its performance in less than ideal circumstances. Paid organ donation needs be no more risky than unpaid.

Fifth argument

The purchase of organs allows rich individuals to "jump the queue" for organs and thus denies equity. More worthy but poorer recipients are denied access to organs because of lack of money, thus denying the basic ethical principle of justice [32]. Moreover, kidneys may be placed into recipients who are poorly matched, and thus be less than ideal from an immunologic point of view, and their potential for long-term function will be, in part, "wasted."

Counterarguments

This is a concern, but again, it is a matter of organization rather than ethics. The problem can be solved by incorporating organs donated for payment into the centrally coordinated organ banks already in existence [16, 17]. All organs would be sold to this agency and thus properly controlled to minimize exploitation by ensuring that the donor understood what was being done and the possible risk and consequences. The donor would be fully tested before organs were taken; the agency would ensure that organs were properly stored, matched to potential recipients, and disseminated according to medical or social need, not to the highest bidder. Anonymity of both donor and recipient within the agency would obviate possible contact between the two parties and overcome possible objections to directed donations.

SUMMARY ON PAID ORGAN DONATION

It should be clear that there is at least cause to keep open or reopen this debate, and not to regard this as a closed subject and exclude all future consideration of paid organ donation anywhere in the world. Certainly, it seems to be at the least a temporary option that many countries might examine as a partial solution to pressing current difficulties in treating renal failure. Thus, we differ from the committees of the major organizations

who have already stated their views. We find a number of their arguments, starting from the 1985 recommendations of the Transplantation Society, to be more knee-jerk reactions from a Western viewpoint, employing arguments that seem to have been generated *post hoc* to justify initial reactions. Also, these arguments seem more designed to protect Western sensibilities from distress in contemplating the fate of the would-be paid donor in the developing world, rather than to solve his or her problems.

Like Radcliffe Richards [18, 19] and Engelhardt [33], we find there to be no absolute moral imperative to prohibit the right to sell kidneys. Some propose—but here we do not accept—a deontological position, which states as a given fact that human organs are beyond price. We, in contrast, find only evidence of abuse of the situation by ruthless entrepreneurs, which requires, of course, different remedial action. This could be achieved by the insertion of a central handling agency between donors and recipients.

Real ethical questions remain concerning the balance of harm between death for some in renal failure on the one hand, and potential exploitation or damage to paid donors on the other. The denial of the ability to donate an organ for cash is a denial of autonomy for the poor individual who is deprived of the ability to decide what is best in dreadful circumstances for himself and his family. The cure for abject poverty and the restoration of autonomy is not achieved by a ban on the selling of organs. That paid living organ transplantation may inhibit the development of cadaver organ programs—which is open to dissent—is an operational issue and not an ethical one. It is against this background that we must make up our minds. A clear ethical dilemma exists and requires resolution between the desire to do good by expanding opportunities for transplantation, against possible abuse and exploitation of donors in the real world. We believe it should be possible to arrange matters so that exploitation and risk are minimized and maximum benefit is accorded to the most needy patients. A logical extension of this view would be to advocate use of paid living donors in developed countries to shorten waiting lists of patients already on dialysis, but here, the balance of harm and good is different.

Now we turn to an even more emotionally charged issue, about which hard information is difficult to obtain and views are even more entrenched.

USE OF EXECUTED PRISONERS AS ORGAN DONORS

The death penalty

It is critically important in this debate to separate two different arguments. The first is whether the death penalty should still be applied; the second assumes that it is being applied and argues whether, this being so, there is a case for using the organs of the executed person. Failure to achieve this distinction has obscured and confounded much discussion on this topic.

In all European countries, the death penalty is now prohibited or inactive. However, it remains on the statute book in more than 100 other countries worldwide, including (at the last count) 37 of the states forming the United States. There are a number of cogent arguments against retention of this penalty, some of a moral nature, others more practical. The latter include the inhumanity of many forms of execution, for example, electrocution and incarceration for years on death row, as practiced in some of the United States, or stoning to death; the possibility that the prisoner was incorrectly judged and sentenced; and the relative triviality of some of the crimes for which the death penalty is applied.

In China, like the United States and contrary to almost everywhere else in the globe, the number of judicial executions is increasing, and the death penalty may be applied currently in China for at least 68 offenses, including discharging a firearm, embezzlement, rape, car theft, and drug dealing. The number of executions in China now exceeds twofold all of the other judicial executions performed in the world today, even though Chinese account for only one fifth of humankind. Moreover, it is clear that to Western eyes, the routine treatment of the prisoners, including those condemned, falls short of that suggested by (for example) the United Nations Universal Declaration of Human Rights.

However, it is not our intention in this review to debate this important and emotionally charged issue. Strictly speaking, whether the death penalty should exist is outside the question we have to reconsider, namely whether the organs from legally executed prisoners should ever be used for transplantation. To debate this question, we need to assume that the death penalty is in place. A number of organizations, including the Transplantation Society [34], the European Renal Association [35], and the Asian Transplantation Society, have reviewed the evidence and made statements condemning the use of executed prisoners' organs, adding the threat of expulsion from the society for any member found to be engaged in performing or facilitating this practice.

Nevertheless, the use of executed prisoners' organs takes place. Much of the debate has centered on events in China, as this is where the majority of such transplants take place today. Discussion of the issue has been handicapped by the almost complete refusal of the Chinese government even to confirm that the practice of using executed prisoners' organs takes place [36–38]. It is worth noting, however, that other countries permit or have permitted the use of such organs: In Singapore, a statute permitting prisoners to donate organs has been in place since 1972 (although little used). Executed prisoners' kid-

neys were used in Taiwan from 1990 until 1994, and in France in the 1950s, organs were obtained from guillotined prisoners. In the United States during the 1960s, prisoners on life sentences were permitted to donate organs, a course of action advocated again recently [39].

THE USE OF EXECUTED PRISONERS' ORGANS FOR TRANSPLANTATION

Five main arguments against the practice of using the organs of executed prisoners have been advanced.

First argument

The process of execution may be modified with donation in mind. The possibility cannot be excluded of individuals being executed at a time and in a style (for example the normal practice in China is a bullet through the back of the head) to facilitate organ donation, or even executed with it in mind. There are unconfirmed reports that this has in fact occurred [36, 37, 40, 41], but understandably, such evidence remains anecdotal and usually anonymous.

Counterarguments

The important issue is whether the procedures necessary to procure organs might cause an increase of suffering to the prisoner or to his family. This would include the use of preparatory measures, for example, perfusion of organs before execution, psychological torment, or loss of dignity through procedures carried out at any time simply in the interests of preservation of organs or their retrieval. Provided assurance can be given about these aspects, the actual details of the execution process are not relevant to the argument. That abuse of organ donation might occur is not an argument in principle, it is an incentive to correct the abuse.

Second argument

Executions might be organized specifically to obtain organs for transplantation. It would be of the greatest concern if executions were carried out that would not normally take place, simply for obtaining organs in short supply.

Counterargument

There is no hard evidence that this is the case. Despite probably more than 10,000 judicial executions each year in China (official figures are approximately half this number), only some 1,600 executed prisoners donate 3,200 organs (Dr. Lei Shi Li's figures, personal communication, 1996). The limitation on organ availability is not the number of executed prisoners, from whom more than enough organs can be obtained already, but the high cost of immunosuppressive drugs.

Third argument

Coercion of the prisoner will always be present. Neither the prisoner nor the family can possibly act without coercion where the prisoner has been condemned and is awaiting death, especially in what is a social situation of great shame and that involves the family as well as the condemned individual. The prisoner's own wishes are normally not registered in the system applied in China (confirmed by Dr. Li's testimony), and blood is taken for tissue typing and other tests without permission, thus violating the principle of autonomy.

Counterarguments

Although almost everyone in the West would agree that permission of the individual to be executed should always be sought as part of informed consent essential to organ donation of any type, in the Chinese context, the pressures toward individual autonomy are not so strong, and the family is the unit consulted. [It should be noted that in many Western countries, this can and is delegated to the "person in charge of the body," such as a coroner (medical examiner) after death from (say) road traffic accidents or murder, to hospital authorities in some countries, or (most usually) relatives, who can give or deny permission for transplantation to proceed.] In China, permission of the family (or in some cases the spouse), usually not the individual prisoner, as those responsible for the body of the executed individual is requested and granted in writing. As noted in the previous section, there are enough executions that coercion to donate is unnecessary to ensure a supply of organs.

Fourth argument

The use of executed prisoners organs condones and exploits execution. If deliberate execution of a human being for whatever offense is judged to be morally unacceptable, even if the practice persists in some countries, one should object to the use of organs taken from its victims, as this is seen to condone and may even perpetuate the practice.

Counterarguments

Whatever one's views of the death penalty may be, if it is a statute in operation, then the utility of this process to society should be maximized for the greatest good. One can consider that the prisoner is given the opportunity to help "repay" his or her debt to the society that they have damaged by donating organs. One could argue further that every executed prisoner in all countries practicing capital punishment should donate. The fact that the executed prisoner's organs are going to save the life of another individual or relieve suffering may bring solace to a family making some amends for whatever wrong doing he had committed and for his death.

Fifth argument

Organs of executed prisoners may be sold for profit, which is unacceptable. There has been well-documented repeated and organized abuse of organ donation from executed prisoners in China, with sale and purchase of organs in "hard" currency for nationals of other countries, in particular the United States and Hong Kong, from both civil and military hospitals [36, 37, 40–42].

Counterarguments

In fact, Chinese law forbids both taking organs from minority groups (non-Han Chinese) or the export of kidneys, corneas, or the very few livers currently obtained for use in foreign nationals. We refer to the arguments mentioned here in connection with the sale of organs. It is not necessarily the act that should be condemned, but the exploitation and abuse that may surround it. If such exploitation and abuse can be prevented or minimized, these objections fall away.

SUMMARY ON THE USE OF EXECUTED PRISONERS' ORGANS FOR TRANSPLANTATION

Western opinion has been almost unanimously against the use of organs from executed prisoners. Strong emotions are aroused. Rothman wrote the following: "*We would find it abhorrent if executed prisoners were fed to dogs; we should find the Chinese organ-retrieval process no more acceptable*" [37], but it seems to us that most of the revulsion that this practice attracts is based first on antipathy to the death penalty itself and, second, as a reaction to possible abuses of the situation, such as illegal commercial exploitation.

The affront to human dignity and autonomy is not the removal of organs after execution, but the execution itself. It is the use of organs from those legally executed under codes currently in force that we have to consider here. We must again ask what the balance of harm may be between death of an individual in renal failure and the obtaining of a kidney from an individual already dead by due legal process. That this process may be part of a faulty and repressive judiciary system that can and certainly has been abused (although these abuses are difficult to document) gives rise to immediate revulsion, but is not directly relevant to the purely ethical argument. As with sale of organs, if a death penalty is in force in countries without widespread availability of regular dialysis or cadaver transplantation, as a stage in development of chronic renal failure programs the use of executed prisoners' organs needs consideration.

GENERAL POINTS

The ISN intends to be—and now is—a truly global society, much more so than other comparable international organizations that remain financially and structurally based in Western/Northern countries. Thus, its behavior must reflect attitudes and ethical systems and relationships between individuals and society other than those that are an intrinsic part of the philosophy of economically developed Western and Northern countries. Indeed, the ISN could be open to charges of "cultural imperialism" if it were to attempt to impose ethical criteria based on Greek-Judaic-Islamic systems on other major countries of ancient civilizations that have developed their own ethical codes, for example, China, Japan, and India. Whether a system of universal ethics that can be applied worldwide can be developed will continue to generate debate; some (such as Engelhardt) [33] are of the opinion that the task is impossible.

A major question raised in both the debates outlined earlier here is whether practices that in themselves may be undesirable—or at least better avoided if possible—become acceptable if they are the only channel available to save life for individuals in renal failure at the moment. There is no easy answer to this ethical dilemma. Both debates also raise questions about the morality of some modes of behavior as they should or could be practiced, in contrast to their possible or actual abuse in the real world. For the moment, the Council and Executive Committee of the ISN have taken no action to restrict distribution of their grant programs on these grounds.

Let the debate continue, in the forums of the ISN itself and elsewhere.

ENDNOTES

Since this article was completed, an article has appeared that addresses our first topic in a similar manner [43], including a reiteration of the suggestion that organs paid for should be available through established organ-sharing networks to protect the quality of care received by donors and to promote equity of distribution. In reply, Velasco [44] makes a spirited attack on these arguments, citing his own [45] and others' experience in Saudi Arabia. However, our basic points remain intact: (*1*) the marginalization of paid donation increases the likelihood that donors will be exploited, and (*2*) that loss of autonomy results from poverty, not paid donation.

The views expressed in this commentary represent the opinions of the authors and not those of the Executive Committee or Council of the International Society of Nephrology or other members of its Ethics Subcommittee. Nevertheless, we are grateful to them for detailed discussions of the topics dealt with here.

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APPENDIX

Ethics and how it operates

It will come as no surprise that over the centuries, even with the ambit of only the Western tradition, several views of how ethical codes should be derived have arisen. Which view one espouses or uses in a particular case is important, because it will determine to a major extent how one approaches individual ethical questions. Despite the unfamiliarity of some of the language, the concepts enshrined in these different approaches will be familiar to most readers; many are incorporated into the Universal Declaration of Human Rights of the United Nations, which had its 50th anniversary last year. **Utilitarianism** is probably the most widely known: it is associated with the ideas of British philosophers Jeremy Bentham (1748–1832) and John Stuart Mill (1806–1873), and starts from the bottom up by examining outcomes of actions, defining "good" as that which promotes happiness, and "right" as that which produces the greatest good. In contrast, **absolutist deontology** (most often associated with the writings of the philosopher Immanuel Kant (1724–1804)) is a "top down," duty-based approach, which draws upon concepts of "natural" laws, divine and human, by which a moral man must live and which are independent of time or social situation, and therefore not negotiable (the categorical imperative). **Casuistry** reasons from individual cases, and has something in common with precedent in English and North American common law. Like precedents in law, judgment of an individual issue may change, and thus like utilitarian judgments, casuistry can vary with time and the societal context of the case, and can thus be described as contextual.

There are other approaches, for example, based upon contracts between individuals and obligations of professional groups. Many ethicists advocate the use of a combination of some or all of these attitudes to ethical questions. These primary attitudes become of particular importance when one attempts to consider cross-cultural ethics, paying attention not only to the Greek, Jewish and Christian traditions of Europe, but those of the ancient civilizations of the near East, India, China and Japan. Attitudes to (for example) death or suicide have been and are very different in different cultures, and the traditional or contemporary relation of attitudes to the freedom of individuals and their relation to society differs greatly across this spectrum of beliefs.

Finally, deontology, but also contextual approaches, incorporate a number of familiar basic principles of action as secondary attributes: the ability to choose one's own course, the obligation to help others, the obligation not to harm others, and the obligatioin to deal equally and fairly with competing claims (*autonomy*, *beneficence*, *non-maleficence* and *justice*). Further, whether the effects of a particular action are likely to produce beneficial states of being is important (*consequentialism*).

In many areas two different ethical analyses will lead to different conclusions, but this is healthy debate and a necessary part of deriving codes of practice. Conflicts of principle are common, leading to ethical dilemmas: rarely is a single resolution right or wrong from all angles. Much discussion in ethics centers around attempts to resolve these dilemmas. Another area of continuing effort is the application of general ethical principles in an appropriate and humane way to individual cases—just as one derives medical treatments specifically for individuals from a general body of medical information. As Churchill [31] points out: "*ethical principles do not solve problems, people do*."

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