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Honestly Embracing Markets in Human Organs for Transplantation

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Introduction

The current prevailing moral judgment is that human organs may be donated for transplantation, but that they should not be sold, despite ongoing shortfalls in available organs and the consequent increase in human suffering and the loss of otherwise salvageable patient lives. As I will explore, this judgment relies on two foundational assumptions: 1) that human organs (and other body parts) should not be understood as commodities and 2) that organ procurement is only properly understood as an altruistic gift. My goal in this short essay is to explore the ways in which such assumptions are uncritically accepted even as they frame moral judgments and public policies regarding organ procurement and allocation for transplantation. I argue that each assumption is illegitimate. First, I argue that human body parts are in fact valuable commodities. Honestly confronting this circumstance will likely lead to greater public trust in organ transplantation and the medical use of human body parts more broadly. Second, I argue that legislating “altruism” on the part of donors (or the donor’s family) coerces self-sacrifice in an otherwise commercial setting, where surgeons, nurses, pharmaceutical companies, hospitals, third-party procurement agencies, government bureaucrats, as well as recipients of organs and other body parts, publicly profit.

In short, a market in human organs for transplantation should be openly embraced, including direct financial payments, and other valuable rewards, to compensate persons for donating their redundant or renewable internal organs while living, as well as to compensate families for donating the body parts of their recently deceased loved ones.

Background numbers

In the US alone, more than 6,000 people die every year while waiting for an organ transplant. According to LifeSharers an additional approximately 9,000 patients die each year after being removed from transplant waiting lists because they have become too sick to transplant (May 2009 update; www.LifeSharers.org ). Many others suffer, often in hospital on life support or with expensive outpatient treatments, while queuing for organs. In 2007, only 27,963 of the nearly 98,000 patients waiting for solid organ transplants in the US received them – waiting lists in the US have since surpassed 100,000 registrants (see www.unos.org ). Demand for transplantable organs has risen significantly, yet the organ donation growth rate has been relatively stagnant. In 1997 there were some 9,540 organ donors (living and deceased); in 2007 this increased to only 14,399 donors, which did not represent an effective increase in the availability of organs for transplantation since the waiting list grew from 55,501 registrants at the end of 1997 to more than 98,000 in 2007 (see www.unos.org ). Living donation for all organs surpassed deceased donation in 2000, 2001, 2002, and 2003; while living donation reflects mostly kidney donation, there are a growing number of living liver lobe donations. Given the growing disparity between the number of organs available and the number of patients in need of transplant, queuing times are increasing. In the US patients in need of a kidney transplant, with blood type O, who registered in 2003/2004, experienced a median wait time of 1,868 days – just over 5 years; those with blood type B, who registered in 2001/2002, experienced a median wait time of 2,033 days – just under six years. The usual circumstance of transplant patients without a private donor is an evermore significant wait and risk of death. Altruism-based policies of organ donation simply have not been adequate to meet the medical demand for transplantation.

As queuing time for organ transplantation has increased, direct and indirect health risks have increased as well. Patients with end-stage renal failure not due to diabetes have a mortality rate of approximately 60% at five years while waiting for transplantation; mortality rates are worse for
patients whose renal failure is due to diabetes. Even queuing for less than six months has long-term negative impact relative to preemptive transplantation (Meier-Kriesche & Kaplan, 2002; Abou et al, 2005). Over time the body becomes more fragile, creating greater risks of poor post-transplant outcomes (Matas, Hippen & Satal, 2008; Cas- ingal et al., 2006). The median wait for a donor kidney already routinely exceeds the median life expectancy of dialysis-dependent transplant candidates. If the median wait for transplant continues to increase, which seems likely, it will surpass the lifespan of an evermore significant portion of many patients on dialysis and other life-sustaining measures.

Such suffering is all the more tragic since much of it could be prevented by legalizing an open market in human organs for transplantation. Policy that creates significant incentives for living organ donation will multiply the availability of transplantable organs, such as kidneys, bone marrow, and liver segments. Policy that creates incentives for families to donate body parts from recently deceased relatives will also increase access to non-redundant organs, such as hearts, bones, cornea and other useful body parts. Financial and other market-based incentives encourage persons to raise resources to further personal goals and social interests. The competitive stimulus to gain personal, financial, and professional rewards frequently drives technological and medical innovation; it possesses significant motivational force independent of civic mindedness, personal altruism and social solidarity. It is highly plausible that such incentives would be similarly successful in motivating the availability of human organs for transplantation. Using valuable incentives creatively to fashion public policy could effectively increase the availability of organs, thereby improving access to transplantation, reducing human suffering and saving lives.

Commodification of body parts

A widespread objection to a market in human body parts is that financial or other valuable incentives (e.g., college scholarships, see Linford, 2009; Cherry, 2009) inappropriately treat body parts as commodities. Many critics believe that offering financial or other valuable compensation to reward those who donate body parts exemplifies immoral commodification. The underlying moral intuition is that while some goods (e.g., books) are appropriately produced and distributed through the market, others (e.g., human kidneys) are not. Financial incentives for donating organs for transplantation or to compensate those who donate other body parts (e.g., sperm, ova, bones) would improperly commodify human body parts, it is argued, and consequently all valuable incentives should be prohibited. “Commodification” is presented as a moral invective – a rhetorical claim implying ethical degradation.

Here the core conceptual issue is to distinguish those characteristics that place goods into the category of “commodity”. Commodities are signified by objectification (“ascription of status as a thing in the Kantian sense of something that is manipulable at the will of persons”); fungibility (as “fully interchangeable with no effect on value to the holder”); commensurability (that “values of things can be arrayed as a function of one continuous variable”); and money equivalence (“the continuous variable in terms of which things are ranked is dollar value”) (Radin, 1996, p. 118).

The challenge for those opposed to the commodification of human organs is that organs are in fact manipulable at the will of persons and interchangeable with others of the same kind. These are the very reasons that organ transplantation is medically valuable. Once an organ is removed from the donor and surgically implanted in the recipient, the intention is that the organ will cease to be a living part of the donor and successfully become a part of the recipient. All systems of transplantation objectify human body parts and treat them as fungible. Donors, surgeons, procurement agencies, and recipients alike objectify organs and treat them as instrumentally useful medical resources. As the American Medical Association Council on Ethical and Judicial Affairs stated: “the shortage of organs is the most obvious example of scarcity in medical resources” (1993, p. 1, my emphasis). Transplantation as a medical practice requires that we think of these decidedly useful body parts as exchangeable objects.

Commensurability represents the ability to compare the values at stake, so that they can be reduced to some common measure. Many argue that financially compensating donors involves an exchange of incommensurable values. Critics raise the concern that financial compensation fails appropriately to weigh and compare economic versus non-economic values. Non-market-based strategies for organ procurement and allocation, however, face analogous difficulties. Government-based organ confiscation policies are often framed to appear altruistic even when they are in fact coercive. Presumed consent for organ donation, for example, involves no actual consent from any actual person; instead organs are simply taken, unless the
individual has officially registered his rejection of organ donation. Presumed consent and other types of “opt-out” organ procurement policies straightforwardly extend government-based confiscation to human body parts.

Financial transactions and other types of market exchanges do not require that the goods exchanged be precisely commensurable; such a restrictive requirement would rule out nearly all consensual transactions. Permissible transactions require that the parties transact voluntarily, that deception or other forms of coercion are not employed, and that each party agrees to the value or product to be received. This means that what is received in return is worth at least as much to the party as that which was given. Money equivalence is usually understood in terms of what persons are willing to pay for the transfer of ownership, even in the case of so-called “priceless” objects. As a result, one can buy or sell “priceless” works of art without claiming that the aesthetic or historic value is commensurate with the money that is paid (Wertheimer, 1992, p. 218). Similar equivalences can be created for organs and other body parts.

Markets respect persons as morally in authority over themselves and as able to make choices in their own best interests. Persons are free to negotiate a bargain from which both parties expect to benefit: on the one side, a life is saved, on the other, a family is provided with resources to improve their lives. Those who do not wish to involve themselves with the organ market, or who find the arrangements to be insufficient for whatever reason, should refuse to participate, just as persons must make thoughtful choices regarding other opportunities and circumstances. Insofar as there is concern that persons will be willing to sell their body parts for too little money, a regulated market could in theory set minimum price standards, as well as other obligations, such as duties for follow-up care for living organ vendors.

Barter markets

The Oxford English Dictionary defines ‘barter’ as “The act of trafficking by exchange of commodities” (OED, 2009, on-line edition). Barter markets in human organs already exist: e.g., paired kidney exchanges and “triple swap” kidney donation and transplant operations, in which three patients, who are not tissue compatible with their own willing donors, exchange their donor’s kidney for a kidney from another of the three donors. Each willing donor provides a kidney to one of the three transplant patients. Such organ swaps have become more commonplace. With programs, such as MatchingDonors.com, those in need of transplant can even advertise for potential organ exchanges. A kidney exchange program was recently established in the Netherlands (de Klerk et al., 2005; 2006). Most exchanges have been swaps among kidney donors, but other types of organ trading are possible: for example, a lobe of healthy liver could be exchanged for a healthy kidney.

Indeed, the US Organ Procurement and Transplantation Act of 1984 was specifically amended in 2007 to specify that paired kidney exchanges, and certain other types of organ exchanges for transplantation, do not violate the law’s prohibition on receiving “valuable consideration” for donation. Amendment was necessary because receiving an organ in exchange for an organ, with each party thereby saving the life of a loved one, is quite obviously the receipt of “valuable consideration”; it is a “trafficking by exchange of commodities”.

Coerced and manipulated altruism

On-going debate regarding the morality of financially compensated organ donation does not really concern whether human organs should be commodified, but rather who should receive the valuable health care resource and who should bear the costs of appropriation and transfer. Each system of organ procurement and allocation stipulates conditions regarding who will bear the costs and reap the benefits of procurement, distribution, transfer, and transplantation. Insofar as donations are prohibited from accepting financial compensation, organs are a highly constrained commodity, where governments require donors to part with their property without material compensation, while others benefit financially and the recipient of the transplant benefits physically as well as financially, in terms of quality and quantity of life, perhaps being able to return to work, reduced medical bills, and so forth.

Moreover, requiring strict altruism would rule out many donations. Most living organ donations are to family members or close friends. Such donations are motivated by love, beneficence, loyalty, gratitude, guilt, or avoidance of the shame of failing to donate. For these donors, their willingness to donate stems from their relationship with the particular patient — and may not be fully altruistically motivated. Persons who stand to be financially supported by a person needing an organ might have other motivations than “charity” for donating an organ to a relative.
Donation may be motivated by psychological, emotional, and medical needs, as well as a desire to please others, rather than altruism. Family members and friends may agree to donate organs solely to avoid confrontations or to satisfy some social objective. Families have put forth children as potential living donors, with parents consenting on behalf of those children; couples have chosen to undergo in vitro fertilization with genetic testing and embryo wastage, so as to select embryos for implantation, who once born are destined to become a tissue donor for an already existing sibling (Sheldon & Wilkinson, 2004).

Some raise the concern that financial incentives will put a price on all organs and that those who do not sell their organs will be perceived as hoarders of something that is useful to others and that is financially valuable. Here, the moral challenge is that such concerns hold equally against systems of donation. As noted, transplantation recasts human organs as scarce medical resources; i.e., as things. Demand on family members, friends, and even strangers to donate organs is treated as if it were part of one’s moral and social obligations. Many may have preferred not to have had to make such a choice; many may have preferred not to have had others manipulate them into donating. Such manipulation comes at the hands of health care workers, family members, organ procurement agencies, government policy, and even through state-public education. In Spain, educational programs encouraging students to appreciate the moral importance of organ donation have been integrated into secondary education (López-Navidad et al., 2002; Alarcon, Blanca & Frutos, 2008). Studies of similar educational programs designed to improve attitudes towards organ donation were evaluated in Italy (Piccoli et al., 2004). Advocates have urged the creation of such programs worldwide (Cantarovich et al., 2000). As the US Institute of Medicine committee on increasing access to organ transplantation stated:

…[T]he goal should be to move towards a society where people see organ donation as a social responsibility. In such a society, donating organs would be accepted as a normal part of dying, and in cases where a person died without recording a specific choice about donating his or her organs, the surviving family members would be comfortable giving permission (Institute of Medicine, 2006, p. 2).

Persons who are unwilling to donate their organs while living or once deceased are castigated as immorally withholding life-sustaining medical resources and as in need of ideological re-education.

It is this re-conceptualization of persons as sources of scarce medical resources that in large measure has driven the ever increasing proposals for governmentally coercive “presumed consent,” “expected donation” or “routine salvage” systems of organ procurement. Concerns to avoid recasting persons as collections of spare parts or as hoarders of a scarce medical resource is not a challenge particular to financial transactions, and thus is not a legitimate objection to offering financial compensation to increase organ donation; this moral concern must be addressed under any system of organ procurement and allocation.

Critics of a market in human organs often claim that only the rich would be able to afford organs and that the poor would have to suffer in extra long queues for state-funded transplants. But, this consequence is unlikely for many reasons. Even with a market individuals could still donate organs for free to family members, friends, or strangers. Even if the organ market predominately advantaged only certain segments of the patient population, such activity would still be medically beneficial. Michele Goodwin, for example, argues in favor of the market in part on the grounds that African Americans would be very likely to sell organs to other African Americans, increasing access to organ transplantation for this minority group (2006). Many decry such possibilities, however, as immoral “queue jumping”. This criticism has, for example, been raised against the practice of directed donation (Palmeri, 2005). Importantly, however, programs such as “directed donation” usually bring additional organs into the transplant pool. (The famous African American singer Natalie Cole received a directed kidney donation at the beginning of June, 2009 – LifeSharers.) Insofar as financial or other valuable incentives bring organs into the system that would not otherwise have been available, they will likely increase access to transplantation, shortening overall waiting times for the entire waitlist, reducing suffering and saving money. It seems plausible, rationally and morally, to accept inequalities in exchange for a better chance at a quicker and more viable transplant.

Embracing body parts as commodities

To put the matter bluntly, the market in body parts is quite literally a billion dollar industry, reaching far beyond organ transplantation (Cheney, 2006; Waldby & Mitchel, 2006). The medical and research communities extensively utilize human body parts. Medical students learn financially valuable information and technical skill during medical training
working on human bodies and body parts. Human parts are valuable for pharmaceutical development, surgical equipment creation, technical practice, and cosmetic development, to name but a few marketable uses. Museums reap financial rewards for displaying preserved ancient bodies (e.g., mummies) as well as modern plasticized human bodies (e.g., the “Body Worlds” exhibits). The reproduction industry buys and sells sperm and ova, the wig industry buys human hair, and there is ever more potentially profitable research on human embryos, adult and embryonic stem cells, and DNA. The market in human plasma, a blood component, is booming with private centers in the US handling some 18.8 million transactions a year (Kimes, 2009). Body parts are commodities.

Financial incentives would allow families to sell the organs of a deceased loved one, rather than just to donate the organs. Knowing that their families would benefit might persuade many more people to indicate their intention to donate upon death. Many might consider such compensated donation analogous to life insurance, which pays benefits once the person dies. Some might be willing to consider a futures contract in which they agree to sell any usable organs (or other body parts) upon their death. Usable organs could be sold to organ procurement agencies for transplantation, other body parts could be sold to researchers, medical schools, or other recipients, for educational, scientific or medical use. The money could then be paid as a death benefit to the donor’s heirs. Others might wish to sell a redundant internal organ, such as a kidney or liver lobe, while living. Indeed, some might see it as heroic — saving the life of another, at some risk to oneself. Altruistic organ donation is usually referred to as “heroic”. Why would money morally soil such heroism? Paid rescue workers risk their lives to save others in many areas of life (ski rescue teams, fire fighters, police officers and so forth), why not in organ transplantation? Moreover, intentionally obstructing a life-saving rescue attempt is typically understood as morally, and frequently legally, culpable as akin to murder. Yet, in the case of compensated organ donation, the state interferes in a life-saving rescue attempt as a matter of public policy.

Honestly recognizing and confronting the reality of the commodification of body parts will likely lead to the public’s placing of greater trust in the transplantation community. That governments require that organs, and other body parts, only be transferred at a price of zero does not thereby reduce the value of such parts to zero. It straightforwardly transfers the value of the body part from the donor to other parties. As a result, financially compensating donors of organs and other body parts would also be significantly more fair than the current prohibition on such payments. Failing to acknowledge that human body parts are valuable commodities, even while public policy, commercial interests, and the medical community treat them as such, encourages the continuation of a dishonest social political fiction and creates distrust between the general public and the transplantation community.

Conclusion

With market-based compensated donation the availability of organs and other body parts would not be limited to acts of altruism, government coercion, manipulative educational campaigns, or unscrupulous black market body brokers. Moreover, with proper regulation it should be possible to ensure that donors and their families are honestly treated. The development of a market for the procurement of organs provides no reason to stop asking patients or their families to consider uncompensated altruistic donation. In the US extensive charity infrastructures exist side-by-side with for-profit markets for food, medicine, and housing. Financial incentives do not preclude the liberties of the altruistically inclined to realize their need to take care of others. Individuals could still donate organs altruistically to family members or others in need. Market-based liberties include, but are not limited to, profit-seeking interests.

Market incentives encourage persons to raise resources to further personal as well as social interests and goals. Profits from organ sales would allow for the private pursuit of business and educational opportunities, or to further more public agendas. Given that social and personal advantage is often tied to education and business success, such incentives may be significant. Commercialization would create opportunities, which many may view as attractive, to secure resources for pursuing their own educational, business, political, and welfare interests. Consequently, it is likely that utilizing the market as a procurement strategy would encourage individuals who would not otherwise donate, to sell their organs, which would increase the availability of organs for transplantation. The market would also likely increase access to non-redundant organs and body parts with organ harvesting authorized by the families of deceased donors. Additional strategies designed to increase organ availability, such as directed donation, should not be seen as exclusive alternatives to the market.
Pursuing multiple parallel strategies may lead to the greatest organ availability for transplantation.

Castigating financial incentives and other market-based mechanisms for increasing access to organs for transplantation in favor of altruistic donation, all the while engaging in ideologically directed public education to convince individuals of their supposed moral duty to donate organs for use in this medical enterprise, strikes this commentator as side-stepping reality in favor of deceptive marketing practices. It is careful advertising, backed by powerful government and other special interests, designed to seduce healthy members of the public, children, and bereaved family members, into parting with very valuable property “altruistically”, within what is otherwise a financially valuable medical activity; thereby further muddying the waters of what ought to be a transparent and honest process. As I have argued elsewhere in more detail (Cherry, 2005), the goals of increasing organ availability, saving lives, controlling medical costs, and reducing human suffering, would likely be more effectively, honestly and morally secured with an open market in human organs for transplantation.

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