

Exchange

The Commerce of the Body

Worries about the commodification of the body—from patenting human genes to buying human eggs to selling human organs—cut across the typical conservative-liberal divides in America. Some conservatives fear that human dignity is compromised by selling body parts; others believe that human liberty is undermined by restricting mutually beneficial transactions of the body. Likewise, many liberals believe that such buying and selling exploits women and the poor, while others defend the right to sell one’s body parts in the name of liberal autonomy. In the past few editions of The New Atlantis, essays by Eric Cohen (“Biotechnology and the Spirit of Capitalism,” Spring 2006) and Gilbert Meilaender (“Gifts of the Body,” Summer 2006) have considered these issues—first in general, then in the specific context of recent calls to permit an organ market in the United States in order to ameliorate the suffering of those waiting, perhaps in vain, for a transplant. To keep the conversation going, we asked Benjamin Hippen, a nephrologist, and Peter Lawler, a political theorist, to use the Cohen and Meilaender essays as the occasion to think about organ markets and the new commerce of the body.

The Case for Kidney Markets

Benjamin Hippen

According to Gilbert Meilaender, organ transplantation poses a profound challenge to the sacredness of embodied human experience—turning the human whole into a series of alienable parts. Meilaender has clearly thought deeply about the meaning of the body, and many people surely agree with him that the moral permissibility of giving and receiving organs requires that the giver is not a vendor and that the receiver is not a buyer. That is to say, it requires a system of gifting, not sales. But in making his case against organ markets, Meilaender is on weak philosophical ground—incorrectly attributing extravagant views about death to those morally committed to transplantation, advancing beliefs about the sanctity of embodied life that threaten to foreclose all forms of organ procurement (including gifting), and paying inadequate

attention to the moral complexity of gift relationships and market relationships. A morally defensible version of a regulated market in organs, which treats human beings as embodied moral agents, need not be synonymous with a corrosive dehumanization. And in a nation that grants individuals a considerable amount of freedom in the body, prohibiting the sale of organs is an unnecessary and unwise limitation on the basic right of self-determination.

According to Meilaender, understanding the organ shortage as a crisis to be solved ultimately implies that “Death is a problem to be solved.” For what it is worth, I have never met in the course of my medical training, nor have I ever come across in the medical literature, the belief that “death is a problem to be solved.” My dialysis patients certainly do not believe that the benefits of either dialysis or transplantation are predicated on such extravagant promises. For them, the endurance of thrice-weekly dialysis for 3 to 4 hours a session, the insertion of two 15-gauge needles into their arm or thigh, is a painful reminder of how death is not a problem to be solved, but merely averted, on a day-to-day basis. When things are working well, dialysis is tolerable, and indeed is stoically tolerated by hundreds of thousands of people in this country every day. When things are not working well, when a dialysis patient’s tether to life is compromised (by a catheter infection, a clotted access, a missed treatment, or worse), they can expect unscheduled disruptions of their already difficult lives, often of unpredictable durations. Here, antibiotics, catheter exchanges, access declots, emergency room visits for pulmonary edema, hypertensive urgency, life-threatening hyperkalemia, a myocardial infarction, or a stroke, are not unusual.

But perhaps it is not news to many that life on dialysis is a fragile, vulnerable existence. Does kidney *transplantation*, then, offer the promise of solving the problem of death? On average, my patients with kidney transplants take six medications, though often their medication lists extend to ten or fifteen different pills per day. In the first year after transplantation, they typically see a physician some thirty times in clinic, assuming the transplant proceeded without complication. Some develop side effects from the medication (hypertension, diabetes, hyperlipidemia, mouth ulcers, hirsutism, significant weight gain, diarrhea, skin cancers, etc.), and some are a prescription refill away from hospitalization. But even absent these problems, transplant recipients are committed to a lifetime’s worth of lab draws, doctor visits, medication adjustments, and

occasional setbacks. To be sure, most of them will tell you they are far better off than they were. But I can assert with confidence that no one seriously mistakes this kind of a life as a *solution* to the problem of death. Meilaender's suggestion—that if we were to “moderate the demands we make on medicine, we might be less pressured to think in terms of an organ shortage”—should be understood in light of the real experiences of kidney patients and kidney doctors. Neither proponents of organ donation nor of organ markets understand themselves to be offering paeans to immortality. Death modestly deferred is not death denied. If moderation is in order, it is not to correct widespread delusions of endless life without hardship. And indeed, the current disparity between the need for and the supply of available organs for transplantation makes a certain moderation not a choice, but a tragic inevitability.

Meilaender is correct when he objects that to conceive of the disparity between the demand for and supply of organs as a “crisis” is to move too quickly ahead in the argument. Meilaender's view is that death is an inexorable fate shared by all human beings, and the existential import of our mortality is at persistent risk of being obscured by the rhetoric of medical innovation. This rhetoric recapitulates suffering and death as a crisis, rather than as a sometimes-tragic, but essential, component of our common human experience. It treats all suffering as a medical problem in need of a medical solution. In so doing, the rhetoric of innovation allegedly threatens the existential inevitability of death, which in turn devalues human life in a morally salient way. Only by moderating our expectations and demands, suggests Meilaender, can we avoid succumbing to the misguided belief that the good of ameliorating suffering justifies every means of achieving it.

How Meilaender's moderation translates into the discussion of organ procurement is not entirely clear. It is perhaps most generously understood as an admonition rather than a specific policy prescription. The “wisdom and care” he recommends would seem to entail counseling persons who seek organ transplants, whether from donors or vendors, to come to terms with suffering and death in a different way, one which makes rather less extravagant claims on the organs of the living and the deceased. This readjusted comportment might be manifested as a stoic resolve, or a grim irony, or an acceptance of the “gift” of suffering. But, the specific details of such a disposition are less important than that it exhibits circumspection with regard to interventions which flirt with an alleged moral hazard. In

this case, the moral hazard is the threatened usurpation of the “sacredness of human life in the body” by (on one side) the crusading language of organ donation and (on the other side) the dismal, reductionist categories of supply and demand employed by proponents of organ markets.

This last point bears emphasis: Meilaender grants the criticism, made by Richard Epstein, that the preoccupation with a very particular understanding of the sacredness of the body applies, equally and unfavorably, to both traditional organ donation and to proposed organ markets. In both instances, Meilaender’s view of the sacredness of the body entails equivocating all organ procurement with what Leon Kass has elsewhere called “a noble form of cannibalism.” But, if transplantation is literally understood as *cannibalism* of the living and the dead, and cannibalism is wrong because it is alienating and dehumanizing, arguing about noble or ignoble forms of cannibalism is really just a discussion of degrees of egregiousness. If transplantation is cannibalism by another name, or a violation of the sacredness of the body, then all else is sophistry.

Meilaender does not accept this syllogism in full. In his view, altruistic living donation is permitted just insofar as it retains an embodied connection between the donor and recipient, though given what Meilaender understands to be at stake (i.e., the loss of what it means to be human), it is unclear why he thinks even this capitulation is justified. On the other hand, if the moral defensibility of alienating an inessential part of one’s body hinges on this moral connection, it may also be the case that not all gifts meet this standard, and not all market relationships fail to do so. In this case, the important moral issue is less the nature of the exchange (gift versus sale) than the meaning of the exchange for the participants, a conclusion Meilaender resists.

To believe that all organ transplantation is a form of cannibalism forecloses discussion with those morally committed to the endeavor of transplantation. The differences become too vast to be bridged by a common moral vocabulary. To use a phrase coined by H. Tristram Engelhardt, Jr., the conversation then becomes one between “moral strangers,” and the salient problem posed by Meilaender’s position thereby becomes a political rather than a moral one. The primary question is not, as Meilaender suggests, whether the organ shortage generates a moral obligation to fashion solutions that increase the organ supply. It doesn’t. The question is, given intractable contestations over the meaning of the body, under what conditions the state is or is not justified in legally proscribing free

individuals from actualizing their moral commitments in market relationships, whether by participation in or abstention from the buying and selling of organs.

Along these lines, those who argue for a regulated market in organs, *unlike those who advocate for increasing donation only*, need not insist that others agree that the current state of organ procurement is a problem to which a societal solution is a moral imperative. Market proponents need only insist on the *moral permissibility* of a market in organs and the lack of a moral justification for a legal ban, not a *moral endorsement* of participation in such a market. (I happen to believe, as elaborated below, that increasing the organ supply is a moral good, and that being an organ vendor, under certain conditions, merits not only permission but endorsement. But one can be morally opposed to organ selling in every circumstance, yet still conclude that it is wrong for the state to make such a practice illegal.) In a free society, a hallmark of which is an irreducible moral pluralism, this more modest view partially shifts the burden of proof to those who insist on maintaining the current legal proscription on a regulated market in organs.

Still, a discussion of the permissibility of a regulated market in organs cannot be understood outside the context of our current and future predicament. The consequence of failing to address the shortage of organs is, and will be, the multiplication of needless and unwanted suffering, and it is unreasonable to expect people to suffer and die voluntarily for moral precepts they do not accept. Some of the unnecessarily tragic consequences of preserving the current ban on organ markets include:

- An expansion of time on the waiting list, which effectively excludes the vast majority of patients on dialysis from getting a transplant unless they have a living donor;
- Recipients who are older and sicker when they come up for transplantation, as a consequence of their extended vintage on dialysis;
- Increasing emotional pressure on any available living donor to donate, and the consequent strain on the altruistic features of donor motivation;
- An upsurge in the practice of international organ trafficking—that is, traveling to a developing country for the purpose of purchasing an organ, in which the incentives for vendors are to avoid disclosing co-morbid conditions, brokers to suppress any information that might interfere with a successful transaction, and recipients not to disclose the transac-

tion for fear of prosecution or ostracism by health care professionals;

- A proliferation of the chaotic pathos inherent in desperate public solicitations of organs on the Internet and elsewhere.

These are the entirely predictable, and empirically verifiable, consequences of the organ shortage. Some of these consequences have already been realized, others are not far off. For those morally committed to the endeavor of transplantation, there is a grim irony in the fact that more moderate expectations of the current system of organ procurement (read as: death on or withdrawal from the waiting list) is not a choice but an inevitability for thousands of potential organ recipients. Irony turns to tragedy when one appreciates that the virtue of altruism, allegedly embodied in the current system, is being slowly eroded by the growing desperation of recipients on a burgeoning waiting list. Tragedy becomes *complicity* when one fully understands that the public policy failures in organ procurement in developed countries provide a robust economic foundation for gray-market organ trafficking in the developing world.

In defending a legal prohibition on a regulated market in organs, I believe part of the burden of proof lies with Meilaender and those who agree with him. The burden is not necessarily a challenge to his moral and metaphysical beliefs about the sacredness of the body, but the right to extend these beliefs to legal proscriptions on others who, in good faith, do not share them. Part of the burden of proof, however, also lies with defenders of organ markets—specifically, to paint a richer picture of the moral world that markets would encourage and the constraints that need to be met for kidney markets to be morally defensible.

A useful starting point is to observe that Meilaender, like many critics of the language of markets, incorrectly assumes that the exchange of organs for valuable consideration somehow *limits* the value of an organ to its exchange value. Conversely, so the argument goes, when organs are gifted, the value of the exchange is wholly determined by the fact that it is a gift. Yet consider some possible reasons why someone might sell or exchange his organs:

- for a \$25,000 donation in his name to a charity to which he is morally attached;
- for a \$50,000 deposit in his child's 529 tax-sheltered college account;
- to engage in an organ “swap” with another donor/recipient pair so that his loved one might receive a transplant;

- for a lifetime health care and prescription drug benefit, or a deposit in a health savings account, which he may or may not have had before;
- for \$50,000 to purchase a sports car.

Meilaender's categories (organs are either a commodity *or* a gift) brook no morally salient differences between these possibilities. Meilaender argues that the moral defensibility of living donation is predicated on the connection between the lived body and the donated organ *qua* gift, as a reminder (and remainder) of the embodied human being. Though vendors may sell or exchange their organs for any number of reasons, such reasons are, by his argument, morally irrelevant, if the only value attached to an exchange is its *material* value.

The position I endorse might *permit* any of these exchanges, but it would morally *endorse* fewer of them. Organ vendors might vend for a great many reasons, some of which represent a species of moral valor, some rather less so, and some not at all. The value of an organ can be assessed along many different axes of value, which include: the value to the recipient of the organ in terms of the quality and quantity of life gained; the value to the recipient's family, friends, and loved ones from his improved condition; and the value of the "valuable consideration" to the vendor, whether that consideration is destined for himself or others. It is simply inaccurate and uncharitable to reduce these varied means of valuing an organ in a market transaction to its "exchange value" alone; sometimes the exchange value is a means to much nobler ends.

Marcel Mauss observed that among the inalienable features of the gift relationship is a corresponding obligation of reciprocity, and that the identity of the gift-giver is inexorably bound up with the gift. But these facets of the gift relationship are refracted rather differently through the prism of desperation and shortage. This point was reiterated by Renée Fox and Judith Swazey in *Spare Parts*, their travelogue through transplantation. Fox and Swazey argued that the moral significance of a donated organ is not exhaustively understood by conceiving of donation as simply a gift. When the gift in question is the "Gift of Life," and the emotional relationship with the giver is complex, the reciprocal obligations on the recipient can be overwhelming, a phenomenon Fox and Swazey termed the "Tyranny of the Gift":

This psychological and moral burden is especially onerous because the gift the recipient has received from the donor is so extraordinary that it is inherently unreciprocal. . . . As a consequence, the giver, the receiver, and

their families may find themselves locked in a creditor-debtor vise that binds them one to another in a mutually fettering way.

If, by the expansion of the waiting list and waiting times for organs, the availability of a living donor becomes the only plausible means of receiving a transplant, the desperation of recipients will strain the gift relationship to its breaking point. Regardless of one's view of a market in organs, such a state of affairs is properly understood as a *crisis*. And in the years ahead, the situation will only get much worse, much more quickly, than most people now imagine.

To understand the scope of the problem, a brief review of some demographic trends in dialysis and transplantation would be helpful. By 2010, the number of patients with kidney failure is expected nearly to double to 650,000, and the waiting list for deceased donor organs will likely increase to between 100,000 and 120,000, nearly double the current waiting list of 65,000. Patients without a living donor with blood type O or B now face median waiting times that exceed their median lifespans: The average mortality rate of a patient who initiates dialysis is 60 percent at five years; the current national median waiting time for a kidney for recipients of blood type O is five years, while the median wait time for recipients of blood type B *exceeds* five years, though we don't yet know by how much.

By 2010, the waiting times for deceased donor organs will likely double, and short of a radical restructuring of the procurement system, this state of affairs will exclude the vast majority of potential recipients from ever receiving a transplant, simply by attrition from death. For those without a living donor, the list will degenerate into an equal opportunity to die waiting. By 2010, only about one in twenty patients with kidney failure will be able to receive a transplant, with the waiting time approaching nine or ten years, unless a privately arranged living donor can be identified. Those few still alive will have endured the physiologic toll of a decade's-worth of dialysis, making transplantation impossible or inefficacious.

In response to this looming crisis, the Institute of Medicine (IOM) recently issued the report Meilaender mentions on the current state of organ procurement, recommending various "Opportunities for Action." The report specifically ruled out the possibility of a regulated market in organs from living donors, at least for now. It focused instead on strategies to increase organ procurement from deceased donors without offer-

ing financial incentives of any kind—such as increasing the rate of eligible donors “converted” into actual donors or by establishing new procurement protocols that would expand the total number of eligible donors. Unfortunately, the IOM panel’s recommendations insufficiently address the current and future demand for transplantable organs; they are either too small or entirely impracticable.

It is true that recent national efforts, initiated by the so-called Organ Donation Breakthrough Collaborative, have successfully improved the procurement rate of organs from eligible deceased donors to 70 percent or higher in a number of regions. But even if the procurement rate were 100 percent, the increased number of organs from the deceased is far outstripped by the growth in demand for organs. The vast majority of deceased organ donors are those declared dead by neurological criteria—most typically, patients who suffer sudden head trauma. The bodies of these “brain-dead” individuals can be sustained on ventilators while permission to procure organs is requested from the families and a procurement team is assembled. The problem is that only 10,500 to 13,000 people die annually in this way, meaning that the rate of growth of the waiting list far outstrips even the most successful efforts to improve organ procurement from the deceased. Higher conversion rates, while surely welcome, are not an answer to the current crisis or the looming mega-crisis.

This leads to the second IOM recommendation: expanding the donor pool to include those who die in other ways. Already, a small percentage of deceased donors are those who are declared dead by cardiac criteria, almost always in controlled circumstances, when a decision has been independently made by family members and doctors to terminate life-sustaining treatment. Unlike the condition of brain death, in which the request for organs is typically made *after* death is declared, potential donors after cardiac death need their final moments of life to be managed with precision: The individual dies in the surgical suite; once the heart stops beating for two to five minutes, the procurement team is on the scene ready to remove. Yet even the most enthusiastic proponents of so-called “controlled” donation after cardiac death (DCD) estimate that the additional annual number of such donors available by the year 2013 would be only 2,018. This would represent an important contribution, but it is quite small compared to the coming demand.

The IOM’s boldest recommendation is to expand so-called “uncontrolled” donation after cardiac death, which it claims might lead to an

additional 22,000 donors per year. Uncontrolled DCD involves the harvesting of organs from patients who have died unexpectedly outside the hospital, and in whom cardiopulmonary resuscitation has been unsuccessful. While in theory this might expand the pool of eligible donors, the moral and logistical difficulties with harvesting organs from uncontrolled DCD candidates are legion. First, successful uncontrolled DCD involves correctly identifying a candidate for donation under circumstances of significant stress, such as a witnessed cardiopulmonary arrest in the field, with near-immediate initiation of CPR, hopefully by someone with formal training. Only about 7 percent of all out-of-hospital cardiopulmonary arrests meet this standard. A potential donor must be transferred to an emergency room, with the right personnel standing ready to identify an uncontrolled DCD candidate. Immediately, the next-of-kin need to be contacted to secure permission for organ harvesting, all within the scope of approximately 90 to 120 minutes after an arrest. (In many cases, the surviving family would learn of a loved one's unexpected death and field a request for organ procurement in the same urgent phone call, making the careful deliberation and sensitive conversation that have been hallmarks of the organ donor collaborative impossible.)

Assuming that already resource-strained emergency rooms will have such personnel available on a 24/7 basis, one must also assume a round-the-clock availability of organ procurement teams, including transplant surgeons, operating room technicians, nurses, and operating rooms, all ready to be mobilized for activity within an hour of cessation of circulation. In essence, this would require a continuous presence of such personnel in the hospital at all times, a state of affairs that would financially strain all but the most tertiary of transplant centers. For outlying emergency rooms, this would necessarily entail a rapid transfer of an uncontrolled DCD candidate almost immediately after being identified.

Alternatively, uncontrolled DCD candidates could be put on cardiopulmonary bypass after cessation of CPR within the allotted time frame, adding substantially to the cost and manpower required to harvest the organs. Consideration would also have to be given to the appearance of the donor candidate to the family, arriving to the emergency room, only to find their now-deceased loved one on cardiopulmonary bypass, with a transplant surgical team anxiously standing by.

Apart from correctly identifying this small fraction of patients with out-of-hospital cardiac arrest, the results of serologic testing (e.g., HIV,

hepatitis) are unlikely to be completed prior to the warm ischemia time deadline of one hour. Conditions such as cancer, absent a readily available medical record or reliable historian, would also likely go undiagnosed. Consequently, an untold number of potential donors will undergo expensive procurement procedures while awaiting the results of these necessary tests and the gathering of necessary medical information, only to be ruled out as eligible donors in the end. The financial loss of prospectively procuring or preserving any organs later lost due to serologic contraindications would be non-trivial. Recipients and physicians would also have to be prepared to accept substantially more complications in the post-transplant period. A recent study from UCLA of known uncontrolled DCD cases showed that the incidence of primary non-function (i.e., a kidney that is transplanted but never functions) and delayed graft function (i.e., a kidney that is transplanted, but the patient requires dialysis while waiting for the transplant to recover function) were double the rates of those from donors after brain death—2.7 percent vs. 1.4 percent and 51 percent vs. 25 percent, respectively. The result of relying excessively on such organs, even if it were logistically possible and morally defensible to procure them, would be kidney transplants with higher complication rates, longer hospitalizations, and poorer long-term outcomes. The IOM's signature solution is almost certainly a non-starter.

The inherent limitations of addressing the organ shortage by increasing the rate of procurement from deceased donors should point us toward a different solution—namely, a regulated market in organs from the living. Morally, such a policy would ameliorate terrible suffering by dramatically increasing the organ supply. Politically, it would respect the plurality of views in the nation about the meaning of one's own body. And medically, it would mean not only more organs but better organs—healthier and longer lasting, better matched to their respective recipients, and transplanted earlier in the disease process, often before dialysis is even necessary. Compared to the IOM's recommendations, the comparative advantages of such a market are many and varied, including:

- An increase in the number of available organs for transplantation on a scale that more plausibly approaches the current and future demand;
- A concomitant reduction, possibly even elimination, of the root causes of international organ trafficking and unregulated Internet solicitation;
- The opportunity for truly altruistic living donors to donate, largely

free of the incessant moral and emotional pressures of the desperation of their designated recipients;

- An increase in the frequency of pre-emptive transplantation, which confers a graft survival benefit that exceeds transplantation after any amount of time on dialysis;

- The identification of a cohort of living vendors who are at the very lowest risk for long-term adverse outcomes, eliminating another competing pressure on current and future living donors with co-morbidities that are relative contraindications to donation;

- Organs which, on the whole, are transplantable with fewer operative or immunologic complications, as well as vastly improved long-term outcomes;

- The leisure of *time* to carefully undertake all forms of vendor screening, whereas organs from deceased donors are procured, screened, and allocated under non-trivial time pressures;

- The opportunity for highly sensitized patients, who are immunologically ineligible for the vast majority of available living and deceased donor kidneys, to receive transplants without undergoing a highly morbid procedure of desensitization;

- For the organ vendor, an opportunity to improve the lives of others through an agreed-upon exchange for a consideration that the vendor deems valuable, in a manner that is both as safe as altruistic donation and fully respectful of the vendor's moral agency.

Of course, an organ market would not dissolve the deep moral differences that exist between those who find organ vending acceptable and those who judge it a grave moral violation. Just as there will always be physicians who will not cooperate with vendors under any circumstances, there will also be recipients who will hold similar moral commitments. The salient difference in a market system is that both altruistic donation and commercial exchange are allowed to flourish side-by-side, without the conditions of desperation fostered by shortage.

To be morally defensible, a market in organs from living vendors needs to meet four specific conditions: safety, transparency, institutional integrity, and respect for the rule of law.

First, a kidney market must be safe for both the vendor and the recipient. Safety has both moral value and market value. Morally, it extends the commitment of medical professionals to avoid causing harm to those under their care. Meeting this obligation entails treating donors, recipi-

ents, and vendors in a manner consistent with accepted standards of care. Individual physicians are under no moral or legal obligation to participate in a vendor exchange if they believe that either the vendor or the recipient is medically or psychologically unsuitable. Absent compelling evidence to the contrary, guidelines regarding the pre-transplant evaluation of vendors should parallel those that now apply to donors.

Second, organ markets need to be transparent, which is an extension of the physician's obligation to truth-telling. Transparency includes forthright disclosure of the risks involved to donors, vendors, and recipients, insofar as they are known, as well as disclosure of what is pertinent, but still not known. It also includes an ongoing commitment to expand our knowledge of long-term outcomes for donors, vendors, and recipients, so that all parties can make informed decisions.

Third, as a matter of institutional integrity, every hospital, transplant center, and physician needs to establish clear conditions for participating or not participating in organ vending. As a matter of policy, a health care institution might abjure any cooperation with living vendors, with perhaps modest exceptions for emergency situations. Alternatively, an institution may cooperate with vendors on a limited basis, and individual practitioners might be given the choice to cooperate or not with living vendors, similar to current arrangements with living donors. The specific content of individual institutional policies would be less relevant than the fact that individual institutions would formulate policies that accurately articulate their respective moral commitments, so long as these commitments are consistent with the universal standards of safety, transparency, and legality.

One should note that recipient candidates are not neutral on the subject of organ vending, and some will find it inconsistent with their own moral commitments. The genius of an organ market is that it permits like-minded donors, recipients, and health care professionals committed to donation and opposed to vending to cooperate freely, mutually attaching moral value to certain ways in which organs are or are not procured, commensurate with their common moral commitments. Of course, individuals and institutions constitutive of "donor only" communities would benefit indirectly from an organ market, by reducing the overall demand for organs. Still, recipients who choose to abstain from cooperating with organ vendors for moral reasons could do so, even unto death. Conversely, recipients who *are* willing to cooperate with organ vendors would also be

entitled to know, *a priori*, the position of their transplant institution on the subject of organ vending, since a failure to disclose this would be a violation of respect for the moral agency of the recipient in question.

Finally, organ markets need to be governed by the rule of law. The law oversees the application of safety standards, stipulates criteria for tort liability in contracts between vendors and other entities, and reinforces institutional integrity by defending the accrediting authority of professional organizations with voluntary membership. To borrow a distinction made by the political theorist James Buchanan, the rule of law should have a *productive* and a *protective* function. The productive function provides regulatory structure to mutual agreements between individuals and institutions, such as a regulated common market. The protective function preserves the contractual and forbearance rights of all participants through the development of sample contracts, and creates mechanisms for adjudicating disagreements and conflicts of interest between various parties, such as financial inducements to subvert standards of safety.

If all of this sounds rather legalistic, so it is. Ideally, the rule of law permits those with the best intentions to cooperate without interference, and sharply proscribes the activity of those with the worst intentions. Such legal constraints in no way exhaust the moral obligations that physicians rightly owe to donors, vendors, and recipients, but they at least prescribe the bare minimum of permissible practice.

While there is every reason to believe that organ markets would create a vast new supply of organs, it is important to make clear that what is meant by a “right to vend.” The “right” to vend an organ is a right of *forbearance*, which is to say, a non-interference right. Understood in this way, the right to vend does not imply a correlative obligation on the part of individuals or institutions to cooperate with any individual vendor. In instances where cooperating with a vendor would, in the judgment of a transplant professional, violate the side constraint of safety, the obligation is explicit: no cooperation.

Concerns have been raised in many quarters about who organ vendors would be, and specifically, whether vendors would inevitably come from the poorest or otherwise most vulnerable among us. As just stated, however, the forbearance rights of vendors cannot supersede the side constraints of safety and institutional integrity. There is ample evidence in the medical literature that the poorest among us are also at higher risk for the development of kidney disease, as well as risk factors for cardiovascular disease, which would

be accelerated in the setting of unilateral nephrectomy. This epidemiologic fact may be morally sufficient to exclude most poor people from being organ vendors. The justification for such an exclusion is not that poor people are somehow rendered *incapable* of autonomous decision-making by virtue of their poverty. It is that cooperating with them as vendors will often violate the standards of safety that govern the whole system. In a regulated market, unlike a black market, exploitation is not a legitimate concern.

In 1955, Richard Herrick received a kidney transplant from his identical twin, Ronald, at the Brigham and Women's Hospital in Boston, Massachusetts. Fifty years later, Richard, still with normal kidney function, addressed a congregation of transplant professionals, a living testament to the promise of kidney transplantation. As the field enters its sixth decade, it is clear that one tragedy, inevitable death from uremic poisoning, has been exchanged for the tragedy of a collective desperation fostered by shortage. As the waiting list and the waiting times expand, the hopes of transplant recipients are fading—not the extravagant hope for death denied, but the modest hope that they might be spared lives cut short. It is a hope that was dashed for the 3,500 who died on the list last year waiting for a kidney that never came, as well as for all who cared about them and cared for them.

No alleged benefit justifies treating human beings as mere repositories of organs for barter or sale. The moral agency of vendors is not on the auction block. On the contrary, the defense of a regulated market in organs from the living is predicated on treating human beings as thinking, embodied moral agents, more than the sum of their parts, capable of choosing between right and wrong, and thus capable of deserving praise and blame for their decisions. There is a straight line from the premise that all organ vendors are hapless pawns, exploited by avaricious advocates of the technological imperative, to the conclusion that such persons are neither fit for the blessings of liberty nor the responsibilities of citizenship. To understand organ vendors as worthy of both is to understand them as fully capable of reflecting on and acting on their own moral commitments, hopes, and aspirations. It is to say that organ vendors, like the rest of us, are full participants in the moral life.

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