ORGANS FOR SALE

The subject of this chapter is the sale of human organs for transplantation. Many of the arguments it addresses apply equally to all body parts and, indeed, to all body products. The chapter, however, will focus almost exclusively on the sale of kidneys. There are a number of practical reasons for this, including the fact that, in the ethics literature, kidney sale is very extensively discussed, and the fact that (as we’ll see in a moment) illicit kidney trading appears to be practised on a large scale:

Thousands of [Chinese] prisoners are executed every year in order to provide fresh organs for transplantation in the times and places where they are most needed. First prisoners are shot through the back of their heads, but drugged, IV’d, and occasionally even respiration so that their hearts will keep beating until they are adjacent to the organ recipients. Then the doctors cut the functioning organs out of the prisoners and transplant them to the waiting patients – often either high-paying foreigners or members of the communist elite. Since brain death is not recognised in China, prisoners’ organs are usually removed while they are technically alive, and there is no concern for the pain or death which this causes the prisoners.¹

¹ Organ sale, as it’s popularly known, can occur in a number of very different forms. The most troubling is where living people have their organs stolen for their cash value or, even worse, are killed so that their organs can be ‘harvested’ and sold. Becker’s disturbing account of the execution of Chinese prisoners (above) appears to fit into this category.²

There have also been worrying reports (from several countries including Brazil, India, Israel, and the Philippines) of body parts being stolen both from cadavers and from living hospital patients. These parts are said to include whole eyes (not just the cornea), bone, skin, pituitary glands, and heart valves.³

¹ A less disturbing – but still, some would argue, unethical – practice
would be for us to use a commercial market to distribute the, organs usable for transplantation from people who die 'naturally' from accidents, age, or disease.

A third practice is one in which living individuals volunteer to sell one of their own organs (one which they can live without, such as a kidney) in order to satisfy their need or desire for money. My main interest is in this category: cases in which an organ for sale comes from a paid living donor who, in some sense, volunteers. From an ethics point of view, these cases are much more interesting than those in which people are murdered so that their organs can be 'harvested'. For in 'harvesting' cases, it's pretty obvious what the moral objections are, as the opening quotation from Becker illustrates. Saying what exactly is wrong with voluntary paid donation, on the other hand, isn't easy despite the 'feelings of outrage and disgust' that it often arouses. For organ sale of this sort appears to be both consensual and beneficial to the donor, once financial benefits are taken into account. So why would anyone object?

During the course of this chapter we'll see that there are a number of ethical arguments against this sort of commerce. Many utilise the moral concepts analysed in Part I. For example, people argue that paid organ donors would be harmed, or exploited, or commodified - and that organ vendors' consents would be invalid. Objections like these are the principal concern of this chapter. For this reason, there's a sense in which the chapter (and indeed the whole of Part II) is negative. What I mean by this is that it aims not to provide a comprehensive account of all the arguments for and against organ sale, but rather just to provide a critique of the case against. One reason for this narrow focus is simply lack of space. As always, it's not possible to cover everything that one might wish to cover. Another is that the arguments against organ sale tend to be more ethically interesting than those in favour. For the latter tend either to be practical and/or utilitarian arguments, focussing solely on the ability of a market in organs to save the lives of people on transplant waiting lists, or to be 'doctrinaire' libertarian arguments which have little to do with the specific moral standing of organ sale and a lot to do with an entirely general commitment to 'individual liberty' and the 'free market'. A third reason is that, given the very obvious advantages of permitting organ sale and the fact that it is illegal almost everywhere, it's important to scrutinise very carefully the moral arguments against the practice. For as Janet Radcliffe-Richards et al. remind us, banning the sale of kidneys is harmful and so there should only be a prohibition if there is a very convincing moral case against the practice:5

The well-known shortage of kidneys for transplantation causes much suffering and death. Dialysis is a wretched experience for most patients, and is anyway rationed in most places and simply unavoidable to the majority of patients in most developing countries. Since most potential kidney vendors will never become unpaid donors, either during life or posthumously, the prohibition of organ sales must be presumed to exclude kidneys that would otherwise be available. It is therefore essential to make sure that there is adequate justification for the resulting harm.6

This quotation from Radcliffe-Richards et al. leads us nicely onto another preliminary distinction: between those arguments which purport to show that trading in human organs is immoral and those which purport to show that it ought to be criminalised. In general - and especially in such hotly contested areas as abortion, censorship, and euthanasia - this law-morality distinction is important.7 For there may, of course, be moral arguments against doing x which, even if successful, don't justify banning x. However, in the context of the present chapter, this is a distinction that, in practical terms, collapses. What I mean by this is that, although I'll be concerning myself exclusively with moral arguments and concepts, my findings will inevitably have implications for the law in this area. This is because, given the very substantial practical benefits that a commercial market in human organs would deliver, the case for legal prohibition must inevitably be a moral one (and, almost certainly, a non-utilitarian moral one).8 Hence, by critically assessing the moral objections to organ sale, I'll in so doing be assessing the case for legal prohibition (or at least the most important part of that case). If these moral objections turn out to be flawed, then not only is the case for legal prohibition undermined, but - given the above-mentioned practical advantages - we will have a strong prima facie case for allowing (encouraging even) a commercial market.

To turn now to the substantive assessment of the arguments, Chapter 7 will proceed as follows. First, section 7.1 will give a brief overview of contemporary regulation and practice. Then, five objections to organ sale will be considered in turn. These are:

1. That it would cause harm (or excessive harm) to organ vendors.
2. That free donation expresses or promotes altruism and social solidarity, while (allowing) paid donation damages these things.
3. That organ vendors' consents would, in many cases, be invalid.
4. That (prospective) organ vendors would be coerced into selling their organs.
5. That organ vendors would be exploited.

These seem to me to be the best - and the most widely accepted - arguments against organ sale. However, this list isn't exhaustive and there are further objections that I don't consider here. One notable omission is
what, in Chapter 3, I called commodification arguments. There certainly are commodification arguments against organ sale (indeed, I’ve published a paper on such arguments). However, I don’t discuss them in this chapter, chiefly because they are dealt with both in Chapter 3 and in Chapters 8 and 9. While there are undoubtedly things to be said about commodification arguments against organ sale, to say them here would generate too much repetition. Also, it seems to me that commodification arguments (insofar as they work at all) work better against commercial surrogacy and DNA patenting than they do against organ sale and, hence, it’s more sensible to consider them in these other contexts than to consider them here. (The fact that commodification claims about kidneys look less plausible than those about surrogacy and DNA patenting is, I suspect, attributable to the widespread belief that childbirth, gestation, reproduction, and all things genetic are intimately related to persons or ‘to personhood’ in ways that particular solid organs, such as kidneys, aren’t.)

7.1 Contemporary regulation and practice

The buying and selling of human organs for transplantation purposes is a criminal offence in nearly all countries. Furthermore, it has been rejected by most relevant professional organisations since the 1980s. Interestingly, though, there’s some Canadian evidence indicating that public attitudes to organ sale are much more ‘permissive’ than those of healthcare professionals and legislators, and a survey conducted by Guttman and Gutmann in the early 1990s found that, in response to a particular case study, more than 70 per cent of the general public, but less than 30 per cent of healthcare professionals, said that they would support kidney sale. The World Medical Association issued the following Statement on the Live Organ Trade as far back as 1985:

In due consideration of the fact that in the recent past a trade of considerable financial gain has developed with live kidneys from underdeveloped countries for transplantation in Europe and the United States of America. THE WORLD MEDICAL ASSOCIATION condemns the purchase and sale of human organs for transplantation. THE WORLD MEDICAL ASSOCIATION calls on the governments of all countries to take effective steps to prevent the commercial use of human organs.

This policy was replaced in 2000 with the more wide-ranging Statement on Human Organ and Tissue Donation and Transplantation. Section 34 states:

Payment for organs and tissues for donation and transplantation should be prohibited. A financial incentive compromises the voluntariness of the choice and the altruistic basis for organ and tissue donation. Furthermore, access to needed medical treatment based on ability to pay is inconsistent with the principles of justice. Organs suspected to have been obtained through commercial transaction should not be accepted for transplantation. In addition, the advertisement of organs should be prohibited. However, reasonable reimbursement of expenses such as those incurred in procurement, transport, processing, preservation, and implantation is permissible.

This more recent statement mentions what the WMA takes the main moral objections to be: that organ vendors’ donations aren’t truly voluntary, and that organ donation ought to be motivated only by altruism. We’ll be assessing both of these arguments shortly.

Criminalisation and condemnation by professional associations notwithstanding, stories about the buying of kidneys from live donors continue to appear frequently in the news media and there is evidence that organ trafficking from ‘developing’ countries to ‘developed’ countries still goes on. One notable example here is India, which, despite making organ sale illegal in 1995, remains one of the parts of the world where organ purchasing is rife. A kidney from a live donor can be bought in India for less than $2,000 – a bargain for a rich American or European, but a sizeable sum considered from the perspective of a slum dweller living in poverty. Amritsar in northern India is reported to be a major centre for the organ trade, and it is alleged that its local government and health authorities collude with traffickers. Middlemen, who tell them that they will be given good jobs, bring many organ sellers to Amritsar under false pretences. Victims find themselves imprisoned in private houses and ‘persuaded’ to donate their kidneys, sometimes being subjected to torture if they don’t ‘consent’. In other cases, moneylenders, who subsequently pocket most of the fee, force people who are heavily in debt into selling organs. So there is – and this understates the point – a consent issue here. For many of these Indian donors are coerced, or misled, or under-informed, or forced by poverty to surrender their kidneys. Such practices aren’t confined to India. A recent English newspaper report describes how organ trafficking from Moldova (in Eastern Europe) to Israel via Turkey is rife. The case of Sergei (a Moldovan man) is given as a graphic illustration:

an agent in the Moldovan capital, Chisinau, tricked him [Sergei] into surrendering a kidney . . . after luring him to Turkey with the promise of a job. When the job failed to materialise, the agent . . .
said Sergei would have to sell blood to raise the bus fare back home. She guided him to a private hospital on the outskirts of Istanbul and a jab in the arm followed… As the anaesthetic wore off… the agent simply walked into the room and said; ‘We’ve taken your kidney. There’s nothing you can do. I’ll give you £1,800 for it.’

Not all potential organ sellers come from comparatively poor countries, though, as an interesting story from the UK illustrates. Early in 2000, Mick Taylor, a 26-year-old from Halifax (England) won £4,100,000 on the National Lottery. Mr Taylor was a kidney patient who had been suffering from kidney disease since the age of 11. He had already had two kidney transplants, but both had failed (one after a year, the other after three and a half years). At the time of winning the lottery, he had to attend St Luke’s Hospital in Huddersfield three times a week for renal dialysis treatment. When interviewed about his lottery win by the press, Mr Taylor remarked, ‘I’d exchange my millions for a new kidney. I was more excited when I got my transplant than when I won this money!’

Subsequently, dozens of calls were made to English newspapers by people who wanted to sell Mr Taylor one of their kidneys in exchange for all or part of his lottery winnings. According to the Guardian newspaper, organisations dealing with dialysis patients were ‘outraged’ at the behaviour of these callers. Nick Turkentine, (then) head of charity affairs at the National Kidney Research Foundation, was quoted as saying:

I am speechless. I can’t believe that people would offer to sell their organs for the chance of some lottery cash. What this man was trying to say was that he would give up everything to have his health – he wasn’t saying he wanted to buy a new kidney. Words cannot express how we as a charity feel about people trafficking in human organs.

This, of course, is no more than anecdotal evidence, but it does suggest that even in relatively affluent countries such as the UK, there are people who would be willing to part with one of their kidneys if the price were right.

Similarly anecdotal evidence from the US suggests that there are plenty of willing buyers around too, buyers who are willing to part with very substantial sums of money. In 1999, the world’s largest internet auction house, eBay, discovered (and removed) the offer of a kidney for sale posted on its website. The seller, known simply as ‘hero’ from Sunrise, Florida, offered a ‘fully functional kidney for sale’. His (or her) advertisement read:

You can choose either kidney. Buyer pays all transplant and medical costs. Of course only one for sale, as I need the other one to live. Serious bids only.

By the time eBay intervened to stop the proceedings, bidding had already started at $25,000 and risen dramatically to more than $5,700,000. eBay representatives said afterwards that it wasn’t possible to tell whether or not the offer was genuine, or the bids serious.

We can, then, sum up the state of contemporary regulation and practice as follows. In spite of being almost universally criminalised and condemned, a ‘black market’ in organs persists, particularly in developing countries like India. That this is so should hardly be surprising given the desperation which exists on both sides of the transaction: the desperation of Americans and Europeans who urgently need (and can afford to pay for) kidneys and that of the organ vendors who need the money.

In the next few sections, we’ll scrutinise the ethical arguments against organ sale to see if any of them are successful.

7.2 Harm

The most straightforward way of objecting to organ sale is to say that it’s wrong because it involves unnecessarily subjecting organ vendors to pain and risk. In other words, it’s wrong because it’s harmful. This argument (the ‘harm argument’), however, faces a number of obvious objections – some of which, it seems to me, are decisive.

The first (an empirical point) is simply that kidney removal isn’t terribly dangerous if performed in good conditions. Nicholson and Bradley, for example, claim that ‘donor nephrectomy [kidney removal] is generally very safe, with a perioperative mortality of about 0.03%’ and that with ‘careful donor selection and rigorous prophylactic measures it should be possible to reduce mortality further’.

The second objection, which is directed specifically at the legal prohibition issue, says that, if our concern is exposing the organ vendor to risk, then the last thing we should be doing is banning sale since, as Cameron and Hoffenberg put it:

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. It is the marginalization of paid organ donation that leads to its performance in less than ideal circumstances. Paid organ donations need be no more risky than unpaid.
In other words, the best way of avoiding harm to organ vendors is not to criminalise and drive sale underground but rather to accept and regulate it. This style of argument is familiar from other contexts, notably debates about the legalisation of abortion, drugs, and prostitution.

The third objection goes as follows. No matter how dangerous paid donation is, it needn’t (if carried out in the right conditions) be any more dangerous than unpaid donation, since the mere fact of payment doesn’t add any danger. So if paid donation is wrong because of the danger to which the donor is subjected, then free donation must also be wrong on the very same grounds. Free donation, though, is not wrong; on the contrary, we tend to regard it as commendable, heroic even. Therefore, paid donation isn’t wrong either — or, if it is wrong, it’s wrong because of something other than the danger to which the donor is subjected.

At this point, it might be argued that what’s wrong with organ sale isn’t danger per se but rather the fact that someone is being paid to endanger herself. There are two readings of this argument. One is as a worry about consent, the idea being that payment somehow invalidates the vendor’s consent. We’ll be returning to this in section 7.4. The other is as an expression of a moral principle according to which (quite independently of concerns about consent) it’s wrong to pay someone to endanger herself. Quite what the basis for such a principle might be is hard to see. Furthermore, the principle is almost certainly false. Or if it’s not, then many different widely accepted occupations would fall foul of it. For, as Cameron and Hoffenberg put it,

The actual risk of loss of life during donation of a kidney has been estimated to be approximately 0.03%, 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.

Common forms of ‘risky labour’ are often more dangerous than organ sale, but are regarded as heroic, rather than condemned; it is seen as quite proper to reward those who undertake them. And this difference in attitude can’t be justified in terms of the good consequences that ‘risky labour’ produces, since the consequences of an organ sale (often, saving a life) may be just as good or better.

The view that organ sale is wrong because it involves subjecting organ vendors to pain and risk, then, seems untenable. This is because organ sale is too similar in relevant respects to other widely accepted practices: in particular, unpaid donation by living donors and ‘risky labour’ of various kinds. So it’s hard to see how we could, without inconsistency, condemn or ban organ sale, while at the same time not condemning or banning these other practices. There are also a number of less straightforward objections to the harm argument. One of these is that organ sale often isn’t harmful all things considered; in particular, once we weigh the financial benefits that the vendor gains against the modest health disadvantages that she suffers. Another is that banning organ sale in order to protect the health of potential vendors is unduly paternalistic. However, there’s no need to deploy such objections in order to show that the harm argument is flawed, so I won’t be saying anything more about them here.

7.3 Altruism

The idea of altruism figures prominently in the debate about whether or not we should pay people for their renewable body products: especially blood, but also sperm and ova. John Keown, for example, in a paper arguing against paid blood donation, claims that

A major argument for exclusive reliance on unpaid donation is that, unlike paid donation, it promotes altruism and social solidarity.

And Brazier notes that the UK’s HFEA (Human Fertilisation and Embryology Authority) issued a consultation paper on payment for gamete donations in 1998 in which they reiterated their support for a “culture of altruism”. Similarly, the HFEA’s 1999 annual report stresses

its commitment to altruistic donation and its belief that the donation of sperm or eggs to create new life should be a gift, freely and voluntarily given.

When it comes to organ sale and the ethical debate surrounding it, the concept of altruism has a similar, if less foregrounded, role to play. Thus, Siminoff and Chillag describe for us an anti-market transplantation culture in which the organ is seen as ‘the ultimate gift’. This ‘dominant metaphor for organ transplantation’, they tell us, ‘directly reflects the ethic of voluntarism and altruism on which the entire donation system is predicated’. Similarly, we find statements like the following in numerous places:

Organs are priceless and should be donated for altruistic reasons... provision of an organ should be seen as a donation or gift... freely given in the spirit of altruism.

This section critically assesses altruism arguments against organ sale (i.e. those arguments against organ sale that rely heavily on the idea of
altruism). These arise in a number of different forms, but most of them have the following underlying structure:

1. Altruism is a good thing, either intrinsically or because of its positive effects (or both).
2. Permitting and/or practising organ sale would reduce the amount of altruism in the world.
3. Therefore, we oughtn't to permit and/or practise organ sale.

In what follows, I'll briefly assess each of this argument's premises (1 and 2) and then ask whether its conclusion (3) follows from these premises.

(A) Is altruism a good thing?

Altruism is usually defined as acting out of disinterested concern for the well-being of others. Why might one think that such actions are morally good? Two main answers are available. The first says that altruism, acting beneficently, acting so as to promote others' welfare, etc., are intrinsically good – and are to be contrasted with morally bad characteristics and motivations, in particular selfishness. The second answer (which isn't incompatible with the first) says that altruism is good because of its positive effects, not only its direct effects on the person to whom the altruism is directed (for example, an individual organ recipient), but also its indirect effects on wider society (for example, what Keown calls 'social solidarity'). Both of these answers have got a lot going for them. Many examples of acting out of disinterested concern for the well-being of others do seem to be paradigm cases of moral goodness, especially where there is substantial self-sacrifice on the part of the altruist. And it seems plausible to suppose that, other things being equal, a society with more altruistic acts would be better than one with fewer, both in terms of 'solidarity' and in other ways.

That said, two reservations about the claim that altruism is a good thing should be noted. First, altruistic acts aren't always morally good. Indeed, they're not always permissible. Hugh McLachlan makes the point as follows:

Actions can be altruistic and wrong and worthy of discouragement . . . Altruism can be good in some contexts and can be bad in others. It can have good effects as well as bad effects. It can be done for good motives as well as bad ones: altruistic motives are not always good; self-interested motives . . . are not always bad.35

How can an altruistic act be wrong? This is best answered by simply listing some types of case. Perhaps not all of these will be accepted as possibilities – but I think that it is pretty hard to maintain that all of the following are impossible.

1. The altruist is culpably mistaken about what's really in the interests of the person she's trying to help and ends up harming rather than helping.
2. The altruist benefits the person she's trying to help, but her intervention is wrongfully paternalistic.
3. The altruist benefits the person she's trying to help, but in so doing wrongfully harms innocent third parties.

McLachlan provides what seems to be a compelling example of (3) (or perhaps of something even worse than (3) if we think that these 'altruists' didn't even manage to benefit anyone):

Often, altruism results in extremely wicked actions because people can, wrongly, be prepared to do for other people things which they would, rightly, be too ashamed to do solely for themselves. The recent suicide bombers in Israel, who killed over a dozen bystanders in a crowded marketplace and injured many more were not – or possibly were not – lacking in altruism.36

To generalise, it's easy to think of more everyday cases in which A loves B, so much that A is prepared to do bad things to a third party, C, in order to benefit A. Such cases range from minor wrongdoing to serious evil. So, as McLachlan points out, while many acts of altruism are paradigm cases of moral goodness, it's clear that others can be 'extremely wicked'.

My second reservation about the claim that altruism is good is that, as it stands, it ignores an important distinction between cases in which altruism is obligatory (such as where there's a duty to rescue) and cases in which altruism is supererogatory (which means morally good, but not morally required – going 'above and beyond' one's duty). This distinction is important for the following reason. If (say) altruistic blood donation were morally obligatory, then to demand money for one's blood (and, arguably, to accede to such a demand) would be wrong. But if, on the other hand, altruistic blood donation were supererogatory, then to demand money for one's blood wouldn't be wrong. Rather, it would be merely non-supereorogatory: not good, but not wrong. So, with this distinction in place, one might (at least of some cases) accept that altruistic donations are good while also saying that there's nothing wrong with non-altruistic donation – the point being that non-altruistic donation, while not as good as altruistic donation, is nonetheless permissible. This has implications for the sort of altruism argument which can be made against organ sale. If it could be shown that altruistic donation is obligatory then the argument...
In other words, the best way of avoiding harm to organ vendors is not to criminalise and drive sale underground but rather to accept and regulate it. This style of argument is familiar from other contexts, notably debates about the legalisation of abortion, drugs, and prostitution.

The third objection goes as follows. No matter how dangerous paid donation is, it needn’t (if carried out in the right conditions) be any more dangerous than unpaid donation, since the mere fact of payment doesn’t add any danger. So if paid donation is wrong because of the danger to which the donor is subjected, then free donation must also be wrong on the very same grounds. Free donation, though, is not wrong; on the contrary, we tend to regard it as commendable, heroic even. Therefore, paid donation isn’t wrong either—or, if it is wrong, it’s wrong because of something other than the danger to which the donor is subjected.

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would be stronger, or at least more straightforward, because it would follow that selling was wrong. But if all that could be shown was that altruistic donation is good, then it wouldn’t follow from this, or at least wouldn’t follow directly, that selling is wrong. For, as we’ve seen, it might be merely non-supererogatory.

(B) Would organ sale reduce the amount of altruism in the world?

[.] If to a voluntary blood donor system we add the possibility of selling blood, we have only expanded the individual’s range of alternatives. If he derives satisfaction from giving … he can still give, and nothing has been done to impair that right.37

As the quotation from Arrow (above) suggests, there’s a puzzle about why permitting payment for blood or organs should be thought to reduce the amount of altruism in the world. After all, it seems obvious that (at least in principle) paid and unpaid donation systems could peacefully coexist, with people who want to give freely continuing to do so. Furthermore, paid donations may even add to the amount of altruism in the world. For there can be cases in which a person sells an organ not for ‘selfish’ reasons, but in order to pay for someone else’s medical care.38 Such cases aren’t merely a philosopher’s thought experiment, but perfectly real. One example is England’s 1989 ‘kidneys-for-sale’ scandal, in which39

it was revealed that a human kidney transplanted into a private patient at the Humana Wellington Hospital in London had not been donated, but rather had been sold by an impregnous Turkish peasant.40

One of the less well-known facts of the case is that one of the Turkish organ vendors was offering his kidney for sale in order to be able to purchase lifesaving medication for his daughter, who was suffering from tuberculosis. Since this man had ‘no employment and no other saleable assets’, stopping him from selling his kidney prevented an act of altruism and deprived his daughter of her best chance of being saved.41

Given cases like these, we’re every right to ask: how exactly will allowing organ sale lead to there being less altruism in the world? The main answer given is that it would (we’re told) undermine the practice of free donation.42 Abouna et al., for example, claim that there’s

considerable evidence to indicate that marketing in human organs will eventually deprecate [sic] and destroy the present

willingness of members of the public to donate their organs out of altruism.43

But is it really true that kidney sale would undermine the practice of free donation? There are a number of reasons for answering no to this. The main one is that it’s far from clear that there is a significant practice of free donation to be undermined. As Harvey points out,

it is doubtful that there is a great number of willing, non-related potential organ-donors who will give without payment.44

Given the pain, risk, and inconvenience involved, free donation (except by relatives) is very unlikely to take place anyway. This is borne out by some of the available statistics. If we take a look, for example, at the UK regulatory body ULTRA (the Unrelated Live Transplant Regulatory Authority), which was established under the Human Organ Transplants Act 1989 to approve all transplant operations involving a living donor who is not a close ‘blood’ relative of the organ recipient, we’ll see that throughout the whole period from 1990 to 1998 it approved only eighty-five kidney transplants from unrelated live donors.45 This is a drop in the ocean compared to the 5,000 or so British patients who were waiting for transplants throughout that period, and it’s clear that (as Cameron and Hoffenberg put it) ‘the blunt fact is that altruism alone has failed to supply enough organs to meet demands’.46

(C) Is the altruism argument successful?

Earlier, I suggested that altruistic acts aren’t always good, that they are sometimes wrong, and that sometimes altruistic motivations can lead people to do terrible things. These are potentially serious problems for the altruism argument. But, these reservations notwithstanding, let’s grant for the present that there’s something good about encouraging altruism and see where it takes us.

Can this assumption underpin an argument against organ sale? The answer to this depends partly on how we answer the question we’ve been addressing in the last couple of pages: would permitting sale reduce the amount of altruism in the world? Ultimately, this is an empirical question to which a definite answer can’t be given here. That said, there do seem to be some pretty strong reasons for answering ‘no’ in the case of kidney sales from live donors. The most powerful of these is that there isn’t a substantial pre-existing system of free donation to be undermined. In other words, allowing paid donation is hardly likely to reduce the number of altruistic donations, since these just aren’t happening anyway. Another reason for answering ‘no’ is that allowing kidney sales
may bring into existence opportunities to be altruistic which don’t presently exist (or exist only outside the law). This was demonstrated by the case of the Turkish man who offered his kidney for sale in order to buy medicines for his daughter.

Kidneys may then be importantly different from (say) blood. For, as we’ve seen, if there’s no substantial system of free donation in place, then (of course) free donation can’t be undermined by permitting sale. But if a substantial system of free donation does exist (as, in most countries, it does with blood), then there is at least a possibility of its being undermined. Thus, the argument which says that what’s wrong with sale is that free donation would be undermined might well work for blood, even if it doesn’t for kidneys.

This difference between kidneys and blood reveals a general structural difficulty for altruism arguments against sale. For what we’ve seen is that altruism arguments (insofar as they work at all) work much better for those things which are already freely donated on a large scale than for those things which are hardly freely donated at all. Hence, they will tend to be most successful where they are needed least – because if there’s already widespread free donation, then commercialisation will be simply unnecessary. This isn’t a decisive objection, since there are (of course) things which are in short supply in spite of widespread free donation. But it is a problem for this style of argument because there will be a tendency for it to be least successful where it’s most needed. Wilkinson and Moore make a similar point about paying biomedical research subjects:

If hardly anyone would volunteer for research without pay, then refusing to allow inducements would not promote the gift relationship and it would, moreover, cause a shortage of research subjects. If, on the other hand, people would generally be willing to volunteer for free, even if inducements were allowed, then prohibiting inducements would be redundant; the desired attitude would already exist.46

I’ll end this section by raising a pair of interrelated problems for the altruism argument. One is a concern about uncertainty; the other, a doubt about the value of encouraging altruism, relative to other goods. The following comment from Gillon provides a good way into these objections:

When benefits in altruism and social solidarity can be obtained along with the maintenance of optimal health care we can all cheer. But should the pursuit of altruism and social solidarity impair the provision of health care many would give priority to

Gillon’s point, which seems to me to be a good one, is that while attempting to promote altruism and social solidarity may be all well and good, it’s not clear that these laudable aims give us sufficient reason to deliver sub-optimal health care. Or to put it more starkly, it’s far from clear that the pursuit of altruism and social solidarity justifies the implementation of anti-commerce laws and policies which (in effect) kill kidney patients who need transplants (those who may well get lifesaving transplants if organ sale were allowed) – not to mention the harm done to prospective organ vendors, some of whom will be deprived of money that they desperately need.

This point – which, in essence, boils down to ‘even if promoting altruism is good, is it good enough to justify the loss of thousands of lives?’ – is bolstered by what I just called a ‘concern about uncertainty’. Proponents of the altruism objection often talk confidently about the positive social effects of the ‘culture of voluntarism’. However, it’s not obvious that voluntary donation really has these effects – or, if it has, that they are as positive as is assumed. As we saw earlier, these are complex and highly contested empirical matters. Altruism (or, at least, the altruism level of a whole population) is hard to measure accurately. One reason for this is that any downturn in observed ‘public’ altruism (blood donation, donations to charities, etc.) could be easily outweighed by an upturn in unobserved ‘private’ acts of altruism (for example, acts of generosity to friends or colleagues). Another reason is that altruism is fundamentally a matter of people’s motivational states. Hence, we can’t infer with certainty from (say) the mere fact that someone is giving something away for free that she is acting altruistically, for there may be other motives (for example, making herself appear and/or feel generous). Conversely, it would be naive to hold that just because someone asks for a fee, she is not acting non-altruistically. (Think back again to the Turkish man who wanted to sell his kidney to save his daughter.)

What follows when we combine this point about uncertainty with Gillon’s point about the price we sometimes pay when we ban commerce is a powerful objection to the altruism argument against organ sale. The objection goes as follows. Admittedly, many people believe that banning organ commerce encourages altruism and social solidarity. But this belief is shaky on a number of counts. There are doubts about whether altruism and social solidarity are as good as they’re portrayed as being. But, more importantly, it’s far from clear that there’s firm empirical evidence for the view that banning organ commerce encourages altruism. So the altruism objection to sale is built on rather wobbly foundations. Against this uncertainty, we have to weigh a certainty: that thousands of people will
PRACTICES

die if they don't get transplant organs. In the US alone, 76,000 people were waiting for transplants in 2000 (up from 18,000 in 1989), but there were only 6,000 donated organs (including from cadavers). The figures indicate that 5 per cent of Americans need a transplant at some point in their lives and half of these die while on waiting lists. As Nancy Kay, executive director of the South Carolina Organ Procurement Agency, puts it: 'they are needlessly dying because we have the knowledge and ability to save them'. 49 So we’ve to choose between an ‘anti-commerce’ policy which might have some long-term social benefits but which certainly condemns thousands to die and a ‘pro-commerce’ policy which would certainly save thousands and might lead to the loss of some rather intangible social benefits. When it’s put in these terms, it’s hard to resist the conclusion that the altruism argument is inadequate.

7.4 Inducements and consent

This section considers the consent argument against organ sale: the claim that what’s wrong with organ sale is that the vendor’s consent (if she consents at all) is likely to be invalid. In Chapter 5, we saw that in order for a consent to be valid, three main elements must be present (and present in sufficient quantities): information, competence, and voluntariness. The consent argument against organ sale focusses mainly on the last of these, voluntariness. That’s not to say that there are no instances in which lack of information and competence are at issue, for there clearly are such cases. Nonetheless, consent arguments against organ sale in general, against the whole practice, tend to focus almost exclusively on the voluntariness element and, in particular, on the relationship between voluntariness and financial incentives.

Before proceeding with an assessment of the consent argument, we should first note that there are obviously many particular cases in which organ donors (paid or otherwise) don’t provide valid consent. Some examples were mentioned early on in the chapter: Chinese prisoners, Brazilian hospital patients who had parts of their bodies stolen, Indian organ sellers who were subjected to torture or forced to sell by money-lenders. Horrific though these cases are, they don’t contribute much to the consent argument, because what makes them so objectionable (and non-consensual) isn’t payment, but rather some other factor (for example, assault, coercion, murder, theft, torture). So to use cases like these in a general argument against organ sale would be rather like arguing against all employment on the grounds that there are some cases of slavery, or arguing against property because there are some cases of theft.

To turn now to our analysis of the argument, a good starting point is the World Medical Association’s assertion that we should ban organ sale because ‘a financial incentive compromises the voluntariness of the choice’. 50 Why might someone think this? And how exactly are monetary incentives supposed to reduce the extent to which a decision is voluntary? There are three main answers:

1. Financial incentives encourage (‘make’) people do things that they wouldn’t otherwise do.
2. Financial incentives are (or can be) coercive.
3. Financial incentives, even if not coercive, can make people’s actions and decisions less free and/or autonomous.

In what follows, I’ll briefly dismiss (1), which is a very weak answer. The rest of section 7.4 will then analyse, and ultimately reject, (3). Argument (2) (coercion) receives a separate treatment in section 7.5. Both (2) and (3) are really about autonomy and could in principle be merged. I’ve kept them apart just because they give rather different accounts of the way in which commercialisation compromises autonomy. These accounts aren’t, however, incompatible, and one could hold that financial incentives erode autonomy both by being coercive and in other ways.

To turn first to (1), the reason why this is inadequate is simple: the fact that payments encourage people to do things that they otherwise wouldn’t clearly doesn’t, in and of itself, generate any sort of consent problem. For, if it did, then consent problems would be endemic and would occur every time someone was ‘encouraged’ by payment to go to work for wages or to hand over property in return for a fair price. So while it’s conceded on all that sides that most organ vendors wouldn’t have given up their organ if it weren’t for the money (indeed, the whole point of the market is that more people give up their organs than otherwise would), this fact alone in no way invalidates their consent.

Answer (3) is more promising. As I’ve just suggested, the first problem that any answer must overcome is that there’s a puzzle about why payment is held by many people to be incompatible with valid consent. Wilkinson and Moore (in a paper about paying research subjects) make the point well:

the idea that inducement undermines consent is surprising. People receive inducements all the time to do things they otherwise would not do, such as parting with their goods or working under particular conditions for particular employers. There is no suggestion in the vast majority of these cases that their being paid undermines the voluntary nature of their actions. 51

Clearly, then, neither the mere fact of payment nor the mere fact that someone is influenced by payment is enough to ground a consent argument against organ sale. The thought rather must be that certain sorts
of payment, or payments in certain circumstances, exert 'undue influence on a participant's decision'. So what counts as undue influence? The central ideas here are autonomy and freedom. An influence is 'undue' insofar as it erodes or fails to respect the consentor's autonomy and/or freedom. It's no accident that accusations of undue inducement almost always occur in one of two different contexts. The first is where the 'victim' of the inducement is in desperate need of money because of poverty, or because she has some special need — such as to purchase costly medical treatment. The second is where the 'victim' isn't in desperate need of money, but is offered such a huge amount of money to do X that doing X becomes, in some sense, irresistible. (It's also possible for both these contexts to be present at the same time: I.e. for the 'offeree' to be desperate and for the offer to be enormous, but such cases don't require special consideration.)

We've already seen plenty of examples of the first context: Indian organ sellers being forced into the sale by moneylenders or the like. Cases of the second are less common in real life, but we can nonetheless easily envisage top sports stars being offered multi-million-dollar deals to transfer from one team to another, or more generally employees being 'headhunted' by rival employers who offer to triple their salaries. A good fictional example is provided by the film Indecent Proposal, in which David and Diana Murphy (Woody Harrelson and Demi-Moore) do a deal with billionaire financier John Gage (Robert Redford) under which he pays them $1,000,000 in return for a one-night sexual encounter with Diana. Here, one might argue that the amount of money offered by Gage is so great, compared to what is after all only one night of Diana's life, that the offer becomes irresistible to them. Incidentally, perhaps the Indecent Proposal scenario isn't as far-fetched as one might think. UK surveys have suggested that 65 per cent of people would sleep with a complete stranger for £1,000,000, and furthermore that:

16% of men would sleep with someone for £100 or less. A quarter of men ... would have sex with someone for £1,000, 35% for £10,000 and 51% for £100,000. Of women interviewees asked the same question, 3% would do it for £100, 8% for £1,000, 16% for £10,000 and 29% for £100,000.

We now need to ask what morally relevant features (if any) these two types of situation have in common. Let's, for convenience, call them desperate offeree cases and enormous offer cases. One notable thing that they have in common is that there's a huge gap between (a) the offeree's level of welfare if she doesn't accept the offer and (b) her level of welfare if she does accept the offer. In desperate offeree cases, this is because the offeree needs what's offered and will be substantially harmed if she doesn't get it, while in enormous offer cases, it's simply because of the offer's sheer size that the offeree stands to gain a lot by accepting. Of course (as viewers of Indecent Proposal will know) whether an enormous offer is worth accepting, all things considered, depends on what's demanded in return and on the side-effects of accepting the offer. But let's focus, for the time being, just on cases in which the net gains for the offeree are vast.

Is this, then, the morally relevant feature: that in both kinds of case the difference between accepting and not accepting is simply so great that it's psychologically impossible (or almost impossible) to resist? We should certainly concede immediately that, in both desperate offeree and enormous offer cases, it's tremendously hard for offerees to decline. Whether it's strictly impossible for them to do so raises difficult questions about free will and about the nature of temptation. However, we don't need to tackle those questions here, because there are independent reasons for thinking that the consent worry in such cases can't be justified by reference simply to the size of the gap between the offeree's level of welfare if she doesn't accept and her level of welfare if she does. To see why, consider the following remark:

If the sole alternative to death is some lifesaving treatment, then one is unfree to turn it down, but this does not rule out autonomous choice of the treatment. All the features of autonomous choice might be present: careful deliberation, correct understanding of the options, no manipulation, and so on. If informed consent is possible, despite the dire choice one faces, it cannot be because one is free to refuse the treatment. It must be because one can nonetheless act autonomously.

Wilkinson and Moore (quoted above) are surely right about this. Even if we grant that there's a sense in which the recipients of enormous offers and desperate offerees aren't free to decline, this doesn't mean that they can't autonomously accept and (hence) validly consent. This must be so. Otherwise, it would be impossible for anyone ever to consent validly to lifesaving operations, not to mention lottery 'jackpot' wins or large salaries; the mere fact that a proposal is tremendously attractive clearly doesn't mean that it can't be validly and voluntarily accepted by the offeree.

This may, however, seem a bit swift, and a little more needs to be said about the distinction between freedom and autonomy. In particular, in what sense is a person offered lifesaving medical treatment 'unfree to turn it down' (as Wilkinson and Moore claim)? There clearly is a sense in which people are free to turn down these treatments, for there are plenty of cases in which people explicitly refuse life-prolonging therapy. It seems to me, though, that what Wilkinson and Moore have in mind here
isn't freedom in that sense, but rather lack of choice relative to one's fundamental goals. What does this mean? The thought is that A can be unfree to decline X (an offer) in that in order to achieve A's fundamental goals (which, typically, include or require staying alive) A has to accept X — A has, we might say, no alternative to X as a means of achieving her fundamental goals.\(^6\) On this understanding of freedom, we can say that someone who wants to stay alive and is offered necessary lifesaving treatment isn't free to refuse it. She has no choice, unless she abandons her fundamental goals. But if someone who doesn't want to stay alive is offered the same treatment, she is free, because (let's assume) her fundamental goals don't include or require staying alive.

I've proposed so far (following Wilkinson and Moore) that one doesn't need to be free (in the sense just outlined) in order validly and voluntarily to consent, and that what matters as far as consent is concerned isn't freedom but autonomy. So what exactly is autonomy? I suggested in Chapter 6 that something like Gerald Dworkin's account of autonomy is correct. According to this account, autonomous persons are those who have 'the capacity to raise the question of whether [they] will identify with or reject the reasons for which [they] now act', while autonomous choices are those which are made by autonomous persons who are (sufficiently) free from 'distorting' or 'controlling' influences.\(^6\) So a person may autonomously consent to something, even in the absence of tolerable alternatives, provided that she has the capacity to reason and reflect, the capacity to make (many of) her desires 'line up' with the outcomes of her reflections, and freedom from distorting or controlling influences. One important implication of this is that while desperate offerees are almost by definition not free to decline an offer (by which I mean that they have no practicable alternative), they may still be capable of making a fully autonomous choice, provided that they meet the conditions just mentioned. Hence, the Turkish man who wants to sell his kidney in order to buy medical treatment for his daughter, or the woman who wants to sell her kidney for £1,000,000 to a National Lottery winner may well be acting autonomously, particularly if they have deliberated rationally about the decision, and have reflectively endorsed the relevant desires ('to save my daughter'; 'to become a millionaire').

Does this mean that the consent argument against organ sale is unsuccessful? We've so far looked at the possible possibilities for grounding the argument: (a) the fact that donors are influenced by payment, (b) the fact that payment makes accepting hugely attractive compared to declining, and (c) the fact that 'desperate offerees' aren't free to decline (in the sense just discussed). And we've concluded that none of these will suffice. However, there may still be a version of the consent argument which is at least partially successful, one which focusses on the donor's non-autonomously held desires.

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Desires can be more or less autonomously held. As a useful shorthand, we might say that some desires are more autonomous (more autonomously held) than others.\(^5\) (Like most philosophers, I use 'desires' here as a general term covering not only what people ordinarily call 'desires' but also such things as aspirations, cravings, ends, goals, objectives, wants, wishes, etc.) What makes a desire autonomous? A full answer to this could occupy a whole book, but a reasonably accurate (if incomplete) answer is that a desire is autonomous insofar as it is susceptible to elimination by reflection.

The idea of elimination by reflection can be 'cashed out' as follows. Some desires, like wanting to go to the library on Tuesday afternoon to return a book, can be easily got rid of by rationally considering new evidence, or by reconsidering priorities. So if, say, I discover that there's a bus strike on Tuesday, or that the library is closed on Tuesday, or that my book isn't actually due back until Thursday, there's a good chance that — just by thinking about this evidence — I'll eliminate the original desire and replace it with another (say, wanting to go to the library on Wednesday morning). Alternatively, even if no new evidence comes in, I might — just by reflecting — eliminate the original desire by deciding that I don't care about returning my library books on time, or that I care about other things more (going on holiday, going to the pub, participating in 'anti-globalisation' protests, or whatever). My desire to go to the library on Tuesday afternoon, then, is easily eliminable by reflection, and as such is highly autonomous.

Wants of this sort should be contrasted with those which are hard, or impossible, to get rid of just through deliberation. Addictive desires (those which constitute addictions) are the most obvious candidates. For example, people who smoke cigarettes and want to give up, but can't because they are addicted, have a desire for cigarettes which they can't get rid of just by rationally reflecting. The smoking addict's position is often described in terms of first- and second-order desires. A first-order desire is a desire for something that is not itself a desire (for example, wanting chocolate cake), whereas a second-order desire is a 'wanting to want' or 'wanting not to want' (for example, 'I wish I didn't want chocolate cake'). Thus, the smoking addict may rationally reflect, decide (on some level) that she no longer wishes to smoke and, in the process, form a second-order desire — something along the lines of 'I want not to want cigarettes.' However, if she's an addict, then just doing this is unlikely to be enough, because her relevant first-order desires (for example, wanting a cigarette now) will be fairly unresponsive to what happens at the second order. The first-order desires are, we might say, immune to elimination by reflection, meaning that even if the smoking addict reflects and decides that smoking isn't a good policy, that won't be sufficient to rid her of these desires. And so the desire to smoke is, for this person at least, non-autonomous.
Before this is applied to the case at hand, several further clarificatory remarks need to be made. First, this is not an anti-smoking point; the idea isn’t that the desire to smoke is non-autonomous because smoking itself is irrational (for example, because of its health effects). Indeed, it’s undoubtedly possible in principle for the desire to smoke to be entirely autonomous (though only for people who aren’t addicted). This is because what matters (for autonomy) isn’t so much the nature of the object of desire as the relationship between the desirer and the desire – in particular, is the desire immune to elimination by reflection? So it’s possible in principle for wanting to go to the library on Tuesday afternoon to be just as non-autonomous as wanting the next cigarette, or the next ‘fix’ (although, if the library-desire were non-autonomous to this extent, then we’d probably say that the person in question was afflicted by some kind of irrational, maybe even pathological, library-compulsion).

Second, we should remember that it’s of course possible even for addicts to give up smoking and (eventually) to stop wanting cigarettes. So immunity to elimination by reflection needn’t be total and, more generally, such immunity is a matter of degree. Some non-autonomous desires are harder to get rid of by reflection than others.

Third, while all addictive desires are to some extent non-autonomously held, not all non-autonomous desires are addictions – or, at least, not all non-autonomous desires would normally be called addictions. One reason for thinking this is that some non-autonomous desires simply aren’t powerful enough to be termed addictions: for example, a desire for chocolate cake, which, although eliminable by reflection, only has very mild effects on the desirer’s behaviour. Another reason is that, as I’ve already hinted, there might be compulsions that aren’t addictions, such as ‘having to’ go to the library on a Tuesday. That said, many people might consider labelling such a compulsion a ‘library addiction’, for people these days do tend to use the term ‘addiction’ quite loosely to cover a wide range of things (including exercise, gambling, internet usage, masturbation, overeating, pornography, ‘relationships’, sex, shopping, stealing, and work). The most compelling reason for thinking that not all non-autonomous desires are addictions, though, is that many entirely normal ‘bodily’ desires (including sexual desire, the desire to avoid pain, wanting to sleep, and wanting to eat) are non-autonomous, since they can’t generally be eliminated by reflection. Of course, such desires can be influenced both by social forces and by the will-power of individuals. Thus, I may (for example) be able to wean myself off hamburgers and fries and onto fresh fruit and vegetables in response to health information, or may manage to change my sexual behaviour after taking an ethics course. However (a small number of heroic exceptions notwithstanding), the extent to which individuals can modify (and, a fortiori, the extent to which they can eliminate) their bodily desires just by thinking about them is very limited indeed. Thus, people usually can’t help desiring things like food, sex, and sleep, in one form or another. One interesting implication of this is that, insofar as these desires are an inevitable consequence of embodiment, embodiment itself is autonomy-limiting. (This, though, doesn’t mean that embodiment is bad, since autonomy isn’t the only thing we value.) Another implication is that normal bodily desires and addictions are, in some respects, very similar (and the same might be said about strong emotional attachments).

Having spent a while looking at the nature of autonomy and, in particular, at the concept of non-autonomous desire, we’re now in a position to apply these ideas to the consent argument against organ sale. What they generate is a version of the argument which claims that we’ve reason to be suspicious about the quality of any consent given by organ vendors, because the financial incentive involved will, in many cases, incite them to act on non-autonomously held desires. It’s my contention that this argument won’t work, but, before saying why, it’s worth first saying that there are particular contexts in which this style of argument seems to be at least partially successful. Consider, for example, those sex-workers who are driven into prostitution by drug addiction. If such people also attempted to sell their kidneys, there would be an extremely serious autonomy worry about the quality of their consent, since they would be motivated by a highly non-autonomous desire (for drugs). Similar concerns would be raised if a so-called ‘shopoholic’ (shopping addict) tried to sell her kidney to fund her habit. Again, the objection would be that she was motivated by an addictive desire (for shopping). Whether these autonomy worries are sufficient to make buying an organ in such circumstances wrong remains an open question. Nonetheless, what is clear is that (in these cases) those propounding this autonomy argument have a point. The prostitutes and shopoholics, however, are special cases because they are addicts, and it’s not so clear that the autonomy argument applies to organ sale in general, or even to its most prominent forms. As before, it will be useful to consider enormous offer cases separately from desperate offeree cases, since slightly different problems arise.

In enormous offer cases, the argument is that such sinister forces as greed and cash-lust will unduly influence prospective kidney vendors. So, for example, when people tried to sell their kidneys to Mick Taylor (the £4,100,000 lottery winner), many of them, it could be argued, weren’t acting autonomously because they were overwhelmed by a non-autonomous lust for money. Whether this is true is really an empirical psychological question, not one to which I know the answer with any certainty. However, it does seem that there are some ‘armchair’ reasons for thinking that it isn’t that likely to be true of these prospective vendors. The main one of these is that, even for an averagely well-off British
person, desiring £4,000,000 seems eminently sensible, as does selling one's kidney for £4,000,000, especially given the data discussed in section 7.2, which suggest that the level of risk involved is quite low. Getting £4,000,000 for one of your kidneys is, basically, a very good deal compared to, say, working for a living — for (if we use UK figures as a reference) it would take someone with an average salary several lifetimes to earn such a sum. So while, of course, it's possible non-autonomously to desire something which it would be rational and sensible to desire, there seems not to be any reason for being especially suspicious about the motivations of people like those who tried to sell a kidney to Mick Taylor. And even if there are reasons for being suspicious, these will surely be equally applicable to (say) well-paid jobs.

To turn now to 'desperate deferee' cases, the concern here isn’t so much about greed and cash-lust but about the desperation and poverty of prospective donors. Paul Hughes, for example, says:

one common objection to allowing a market in organs is that the economically worst off members of society will be exploited, since they will be the least likely to resist the temptation to profit financially in this manner.66

It's notable that Hughes, like many who speak and write on this subject, thinks in terms of poor people succumbing to temptation — suggesting that their plight is rather like that of the addict or of the person overcome by cash-lust. But is this the correct model? And why should we think that desperation renders people's desires non-autonomous? Again, the problem for the anti-sale argument is that — given dire circumstances — wanting (say) to sell one of your kidneys for $2,000 seems very sensible. So why view such a want as non-autonomous? Furthermore, it seems fair to assume that most 'desperate' organs sellers' desires to sell and desires for money are in fact eliminable by reflection. For if the vendor discovered that she (miraculously) no longer needed the money, then (presumably) her desire for money would fade. Or if she found out about a more attractive way of earning the money, then (presumably) her desire to sell the organ would vanish. So the relevant desires (to sell, and for money) appear pretty autonomous, because they are vulnerable to elimination by reflection.

It may, though, be objected (understandably) that the relevant desires have been misidentified: that in the case of the sex-workers and the shopoholics, what was focussed on wasn't the desire for money but rather an underlying desire (drugs, shopping), so that's how we should view other organ sellers. At this point, generalising becomes hard because there are a wide variety of different reasons why one might want to sell an organ. Two common ones, though, are (a) to save one's own life and (b) to save the life of a close relative. So perhaps these are the kinds of desires on which we should be focussing. And they do indeed seem to occupy the same motivational position as do drugs and shopping in the other cases. So are desires like (a) and (b) autonomous or not? Whether they are depends on the individual concerned. However, to generalise, it does seem that such desires are likely not to be autonomous. This is because, for most people, desires like wanting to carry on living and wanting one's loved ones to carry on living have a high degree of immunity to elimination by reflection. Indeed, people often talk about such desires ('survival', 'protection of the young', etc.) as instincts, suggesting that they're innate and hard or impossible to get rid of just by reasoning.

(Nota, however, that I'm not suggesting here that wanting to survive and to protect one's offspring is irrational, or even non-rational — rather, the idea is just that such desires may be non-autonomous insofar as they're immune to elimination by reflection.)

If we grant, at least for the sake of argument, that desires like 'survival' are (for most of us at least) non-autonomous, what follows from this? One possibility — the one required by the argument against organ sale — is that organ vendors can't validly consent when they are motivated by such desires. Surely, though, this conclusion can't be right. For, if we were, we'd be left (again) with a position according to which it's almost impossible for anyone validly to consent to lifesaving medical treatments — since (bizarrely) one could only do so if not motivated by the desire to survive! It's clear, then, that either desires like 'survival' aren't really non-autonomous or it's possible for a person validly to consent even when she is motivated by such non-autonomous desires. Either way, this particular argument against organ sale fails.

Section 7.4 has assessed the claim that financial inducements, or undue financial inducements, compromise the voluntariness of people's choices and render their consents invalid. There appear to be two main reasons why one might believe this. The first is that an undue financial inducement works by making the offer it supports seem, as it were, too attractive — perhaps even irresistible. The second is that undue inducements incite people to act on non-autonomously held desires. However, as we've seen, both of these (putative) reasons are flawed — or, at least, neither is sufficient to ground a consent argument against organ sale. The problem with the first is that it's clearly possible for people validly to consent to extremely attractive offers — notably offers of lifesaving medical treatment. And it's hard to see what (in this respect) differentiates the 'desperate' organ seller from the 'desperate' patient who wants a lifesaving treatment. Given that desperation doesn't (I take it) invalidate consent in the latter case, why should it in the former? The problem with the second reason is a little more complex. We saw that inducements can sometimes incite people to act on non-autonomously held desires.
person, desiring £4,000,000 seems eminently sensible, as does selling one’s kidney for £4,000,000, especially given the data discussed in section 7.2, which suggest that the level of risk involved is quite low. Getting £4,000,000 for one of your kidneys is, basically, a very good deal compared to, say, working for a living – for (if we use UK figures as a reference) it would take someone with an average salary several lifetimes to earn such a sum. So while, of course, it’s possible non-autonomously to desire something which it would be rational and sensible to desire, there seems not to be any reason for being especially suspicious about the motivations of people like those who tried to sell a kidney to Mick Taylor. And even if there are reasons for being suspicious, these will surely be equally applicable to (say) well-paid jobs.

To turn now to ‘desperate offeree’ cases, the concern here isn’t so much about greed and cash-lust but about the desperation and poverty of prospective donors. Paul Hughes, for example, says:

One common objection to allowing a market in organs is that the economically worst off members of society will be exploited, since they will be the least likely to resist the temptation to profit financially in this manner.66

It’s notable that Hughes, like many who speak and write on this subject, thinks in terms of poor people succumbing to temptation – suggesting that their plight is rather like that of the addict or of the person overcome by cash-lust. But is this the correct model? And why should we think that desperation renders people’s desires non-autonomous? Again, the problem for the anti-sale argument is that – given dire circumstances – wanting (say) to sell one of your kidneys for $2,000 seems very sensible. So why view such a want as non-autonomous? Furthermore, it seems fair to assume that most ‘desperate’ organs sellers’ desires to sell and desires for money are in fact eliminable by reflection. For if the vendor discovered that she (miraculously) no longer needed the money, then (presumably) her desire for money would fade. Or if she found out about a more attractive way of earning the money, then (presumably) her desire to sell the organ would vanish. So the relevant desires (to sell, and for money) appear pretty autonomous, because they are vulnerable to elimination by reflection.

It may, though, be objected (understandably) that the relevant desires have been misidentified: that in the case of the sex-workers and the shopoholics, what was focussed on wasn’t the desire for money but rather an underlying desire (drugs, shopping), so that’s how we should view other organ sellers. At this point, generalising becomes hard because there are a wide variety of different reasons why one might want to sell an organ. Two common ones, though, are (a) to save one’s own life

and (b) to save the life of a close relative. So perhaps these are the kinds of desires on which we should be focussing. And they do indeed seem to occupy the same motivational position as do drugs and shopping in the other cases. So are desires like (a) and (b) autonomous or not? Whether they are depends on the individual concerned. However, to generalise, it does seem that such desires are likely not to be autonomous. This is because, for most people, desires like wanting to carry on living and wanting one’s loved ones to carry on living have a high degree of immunity to elimination by reflection. Indeed, people often talk about such desires (‘survival’, ‘protection of the young’, etc.) as instincts, suggesting that they’re innate and hard or impossible to get rid of by reasoning. (Note, however, that I’m not suggesting here that wanting to survive and to protect one’s offspring is irrational, or even non-rational – rather, the idea is just that such desires may be non-autonomous insofar as they’re immune to elimination by reflection.)

If we grant, at least for the sake of argument, that desires like ‘survival’ are (for most of us at least) non-autonomous, what follows from this? One possibility – the one required by the argument against organ sale – is that organ vendors can’t validly consent when they are motivated by such desires. Surely, though, this conclusion can’t be right. For, if it were, we’d be left (again) with a position according to which it’s almost impossible for anyone validly to consent to lifesaving medical treatments – since (bizarrely) one could only do so if not motivated by the desire to survive! It’s clear, then, that either desires like ‘survival’ aren’t really non-autonomous or it’s possible for a person validly to consent even when she is motivated by such non-autonomous desires. Either way, this particular argument against organ sale fails.

Section 7.4 has assessed the claim that financial inducements, or undue financial inducements, compromise the voluntariness of people’s choices and render their consents invalid. There appear to be two main reasons why one might believe this. The first is that an undue financial inducement works by making the offer it supports seem, as it were, too attractive – perhaps even irresistible. The second is that undue inducements incite people to act on non-autonomously held desires. However, as we’ve seen, both of these (putative) reasons are flawed – or, at least, neither is sufficient to ground a consent argument against organ sale. The problem with the first is that it’s clearly possible for people validly to consent to extremely attractive offers – notably offers of lifesaving medical treatment. And it’s hard to see what (in this respect) differentiates the ‘desperate’ organ seller from the ‘desperate’ patient who wants a lifesaving treatment. Given that desperation doesn’t (I take it) invalidate consent in the latter case, why should it in the former? The problem with the second reason is a little more complex. We saw that inducements can sometimes incite people to act on non-autonomously held desires.
However, serious doubts were raised about whether the desires on which organ sellers normally act are non-autonomous and about whether, even if they are non-autonomous, they are the sort of motivations that should be counted as consent-invalidating. Leaving aside the coercion issue, which is to be dealt with in the next section, I conclude therefore that the arguments for the view that financial inducements compromise the voluntariness of organ sellers' choices and render their consents invalid are weak.

7.5 Coercion

If organ sale were permitted, would (prospective) organ vendors be at substantial risk of being coerced into selling their organs? If so, this may underpin an additional argument (the coercion argument) against the practice, as well as bolstering the consent worries discussed in the previous section.

As we've seen, there are undoubtedly particular cases in which people are coerced into selling their organs by threats of violence or death. Clearly, such coercion is wrong. But if accusations of coercion are to underpin a more general argument against organ sale, these accusations themselves need to be more general. They must also be capable of withstanding two immediate objections. The first is that coercion worries are by no means confined to commercial transplantation and so it may be hard to construct a coercion argument which doesn't 'prove too much'—i.e. one which doesn't entail the condemnation or prohibition of both free donation and sale. Harvey makes the point well:

> there is financial pressure when the potential [paid] donor is in poverty. And perhaps it may be argued that this alone is sufficient for banning all paid-for donations. But then, in consistency, the same reasoning should be applied to related donors: since some of them are open to heavy psychological and emotional pressure (for example, perhaps by being the submissive and 'guilt-ridden' offspring of an extremely domineering and now ailing parent).

The second objection is that we could screen out most cases of coercion by decriminalising organ sale and using a regulatory body, perhaps rather like the UK's ULTRA (the Unrelated Live Transplant Regulatory Authority). Part of ULTRA's remit is to ensure that

> a doctor has explained to the donor the nature of the procedure and the risks involved in the removal of the organ in question... the donor's consent was not obtained by coercion... the donor understands that his or her consent can be withdrawn at any time.

...and the donor and the recipient have been interviewed separately by a suitably qualified independent person, who is not part of the transplant team, and that person is satisfied that the above conditions have been met.

Of course, ULTRA exists partly to screen out cases in which there have been inducements, but there's no reason in principle why the checks outlined above couldn't be carried out within the context of a properly regulated commercial market in human organs (i.e. within a context in which inducement was permitted, but not coercion).

Let's turn now to the question of what a coercion argument against organ sale in general might look like. The standard opening move is to claim that poor people will be forced by poverty into selling their organs. But what does this mean? One interpretation is that poor people are 'forced' insofar as they don’t have any viable alternatives. But under this interpretation, the 'forced by poverty' claim just collapses into the kind of the things that were discussed in the previous section — the effect of lack of options on freedom, autonomy, and so on. How else, then, might 'forced by poverty' be understood? Perhaps the main difficulty with making sense of this, in relation to coercion, is that (on the account of coercion defended in Chapter 6) only agents can coerce. This is because to coerce is to threaten (more specifically, to threaten harm relative to a normative baseline), and obviously only agents can threaten. Given this, it's clear that poverty per se can't coerce, even though (like other deprivations) it can be used as a method of coercing. So in order to make sense of coercion arguments against organ sale we'll need to ask who is supposed to be doing the threatening.

As just suggested, poverty can be used as a method of coercing. What this means is that people can be threatened with poverty (including the continuation of existing poverty) if they don't comply with the coercer's demands. An obvious example of this is the behaviour of exploitative employers during times of high unemployment. They can threaten workers with unemployment — and, hence, poverty — if they don't comply with their demands. People can be made poor by action or by omission, actively or passively. If a person has all of her possessions stolen then she has been actively impoverished; while if a person isn't given assistance to which she has a right then she has been passively impoverished. This distinction corresponds to a distinction made in Chapter 6 between active and omissive coercion. To coerce actively is to threaten active harm, while to coerce omissively is to threaten omissive harm. More specifically, A omissively coerces B to do X when

1. A has a duty to do Y for B and A's failing to do Y would cause or constitute omissive harm (harm by omission) to B; and
PRAXIS

2 A proposes (threatens) not to do Y for B unless B does X; and
3 the existence of A's duty to do Y for B does not depend on B's doing X (i.e. A's duty is freestanding).

In the light of these distinctions, it seems that the most plausible version of the coercion argument against organ sale is one which focuses on omissive coercion. But who is doing the omissive coercing? In order to answer this, we need to know who has a freestanding duty to alleviate the prospective organ seller's poverty, because having such a duty is a necessary condition for practising this particular form of omissive coercion. Moore and Wilkinson make the point as follows:

...it is a necessary condition of an offer's being coercive that the offerer is also responsible for the bad circumstances of the offeree. For example, if we poison you and then offer to provide the only available antidote in exchange for your stamp collection, that is coercive. If you are poisoned in a way for which we are not responsible, and we make the same offer, that is not coercive... as long as those making an offer are not responsible for the circumstances of the potential subjects, their offer is not coercive.

Coercers are only coercers, then, insofar as they're responsible for the coercee's situation - although, as I've already suggested, this responsibility can include both negative and positive duties, and so coercers can be responsible for (alleviating) the coercee's situation even if they haven't themselves caused it.

Returning to the case in hand let's, as a shorthand, call people with a freestanding duty to alleviate the prospective organ seller's poverty 'rescuers'. If a rescuer proposes to alleviate the prospective organ seller's poverty but only in return for an organ, she is omissively coercing the organ seller (in accordance with the tripartite account of omissive coercion outlined above). Such a situation is comparable to Nozick's drowning case discussed in Chapter 6, in which P (the occupant of a boat) offers to save Q (who is drowning close to the boat), but only if Q promises to pay P $10,000 within three days of reaching shore. The view defended in Chapter 6 was that, in this case, P coerces Q if and only if P has a freestanding duty to save Q without remuneration - i.e. only if P is a rescuer.

It's not hard to see how, in principle, this style of coercion argument could work against organ sale. What's much harder is working out who the rescuers are. For, at the level of individuals, pinning down plausible candidates is tricky. The standard case about which accusations of coercion are made is one in which the purchaser is a rich Westerner and the vendor is someone desperately poor from the 'developing' world. The Westerner, it is said, uses poverty to 'force' (coerce) the poor person into giving up the organ. On the picture sketched so far, this coercion claim is true only if the Westerner in question is responsible for the vendor's poverty. But is she responsible? This question is simply too big to be taken on in any detail here, raising as it does fundamental issues in political philosophy about the distribution of goods and about the duties of the rich to the poor. However, what we can say is that this kind of argument seems to work much better at the level of groups than it does at the level of individuals. The problem with attributing responsibility to individual organ purchasers is that the extent to which they are rescuers may vary enormously depending on their own positions of wealth and power, and on the extent to which they have already done virtuous things in an attempt to act on their duties towards the poor. For example, a Western organ purchaser could have already devoted a large part of her income and time to charitable projects aimed at the alleviation of poverty and may herself have relatively little money - just enough to buy a kidney. Do we really want to say that such a person has a freestanding duty to give her money to the prospective organ vendor without receiving a kidney in return, and that she is responsible for the vendor's poverty? Maybe we do, but insofar as the answer to this question isn't obviously yes, the coercion argument against sale remains weak.

A more promising option is to focus on groups rather than individuals. One might argue, for example, that the rich nations have a duty to alleviate poverty in the poor nations. With this (plausible) assumption in place, it could then be argued that when the rich nations 'offer' the poor nations money for organs, this isn't really an offer, but rather an instance of coercion. This is because the rich nations should be giving the money anyway, not demanding organs in return for it. So what the rich nations are doing is threatening to withhold resources to which the poor nations have a moral right, unless the poor nations hand over organs: a classic case of omissive coercion.

As I've already mentioned, we face serious difficulties in making sense of group responsibility and of the way in which group-actors' responsibilities are connected to those of individuals. These theoretical problems left aside, though, much of the argument just outlined seems believable. However, there's a further serious problem with it - or, rather, there's a serious problem with attempting to use it specifically as an argument for the legal prohibition of organ sale. The problem is simply that the argument works equally well against all trade between the rich nations and the poor ones. For (in simplistic terms) if the rich nations have a duty to give resources to the poor nations, then any time that the rich nations insist on trading rather than donating, they will be practising omissive coercion - threatening to withhold money that they should be giving anyway, unless they're provided with goods of one sort or another. And, as far as the coercion argument is concerned, there's no reason to single
out the trade in organs for special treatment. This is a decisive objection to the coercion argument. Either it doesn’t work at all, or it works but ‘proves too much’ and gives us no reason to single out organ sale for condemnation and/or prohibition.

7.6 Exploitation

The last argument that we’re going to look at in Chapter 7 is that, if allowed, organ sale would cause or constitute exploitation. This claim occurs frequently in the ethics literature, as the following examples illustrate:

[One of the] compelling reasons to object to the sale of organs ... is exploitation, that is, when one person takes advantage of the misfortune of another for his or her own benefit. 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 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 poor will be exploited by a market for organs because their comparatively limited range of viable options (i.e. their limited real autonomy) is being taken advantage of.

The first thing to note is that there’s clearly a lot of overlap between the kind of exploitation arguments that people put forward in the literature and the arguments that we’ve been considering in the last few sections. In particular, it’s common for writers to group together exploitation claims with what are distinct claims about defective consent and/or coercion. So, having already provided separate treatments of consent and coercion, in this section I’m going to focus narrowly on the idea that organ purchasers would wrongfully take advantage of organ sellers, since this is what seems to me to be the main thing which differentiates the exploitation argument from the arguments previously discussed.

People who put forward the exploitation argument against organ sale are usually thinking about the exploitation of the poor. Thus, Kahn (quoted above) talks about taking advantage of others’ misfortune, while Hughes (also quoted above) talks of taking advantage of people’s comparatively limited range of viable options. Although poverty isn’t the only thing that can render someone vulnerable to exploitation, this concentration on economic disadvantage is probably right, just because in practice it is the lack of and need for money which are most likely to motivate people to sell parts of their bodies for relatively modest sums. The focus on economic disadvantage does, however, immediately present a difficulty for the exploitation argument. For if the main concern is that organ purchasers will take advantage of other people’s economic misfortune, the obvious solution is not to ban organ sale altogether, but instead just to prohibit the purchase of organs from people below a certain level of wealth – thus precluding the possibility of exploiting the misfortunes of the poor. Under such a system, the poor would be treated in some respects as like children and mentally incompetent adults, as a vulnerable group which needs to be protected from exploitation.

Most readers will find this proposal preposterous. But while there may well be sound arguments against it, appealing to exploitation won’t suffice. For the exploitation argument, as we’ve seen, is about the maltreatment of the poor and so, if the poor are excluded, our exploitation concerns should vanish. One practical objection to a system which excluded only the poor is that it would deliver no (or hardly any) organs, because only people who are desperately poor would be willing to sell a kidney. However (as we saw in section 7.1), this is probably false if the price is right, and a system which excluded only the poor would certainly deliver more organs than outright prohibition. One likely effect of excluding the poor is that organ prices would be much higher, since (for example) a middle-class American is unlikely to sell an organ for $1,000, but may well sell it for $100,000. In this respect, the exclusion of the poor would be rather like having a regulated labour market and strict immigration controls in order to stop wages from falling and unscrupulous employers from exploiting. This is perhaps why people feel so uncomfortable about allowing sale from the rich while banning sale from the poor. For it seems at best ironic and, more likely, patently unfair to exclude from an organ trading system the very people who most need the money it could provide and who would be the most willing participants. How will a poor person who is willing to sell a kidney for $2,000 to buy medical treatment for her daughter feel when she’s told that (to protect her from exploitation) she isn’t allowed to sell – while, at the same time, a relatively rich neighbour is allowed to sell her kidney for $100,000 to fund home improvements?

There is, however, another, far preferable, way of permitting organ sale, while at the same time eliminating exploitation (or, at least, keeping it to a minimum) – the setting of a minimum fee. This would rule out exploitation, not by excluding the poor from the system altogether, but instead by ensuring that organ purchasers don’t take unfair advantage of the poor. It’s crucial that we include the word ‘unfair’ here, because taking advantage of other people’s misfortune per se is neither wrong nor exploitative. What’s exploitative is unfairly taking advantage of people’s misfortunes. Hence, there’s nothing necessarily exploitative about setting up in business as an emergency plumber, or a roadside vehicle-repair service, or – for that matter – an emergency-room doctor. Each of these
services could be exploitative, but only if it overcharged desperate customers and/or provided them with a shoddy service. The same goes for organ purchasers. They only exploit vendors if, taking advantage of their poverty, they offer them an inadequate fee and/or maltreat them in other ways. Thus, it seems hard to escape the conclusion that the setting up of a regulatory regime which enforced a fairly generous minimum fee not only would neutralise the exploitation argument, but may result in a considerable level of benefit for some of the poorest people in the world. As Cameron and Hoffenberg put it,

"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."

7.7 Summary and conclusions

At the start of this chapter, it was (I hope) made clear that all or most of the organ trade, as it is practised today, is morally unjustifiable. Its unpalatable features include the complete absence of regulation and supervision, the coercion and underpayment of vendors, and in the most appalling cases — the theft of organs and murder of 'donors'. Nothing that I state here should be construed as an attempt to excuse or justify the actions of those presently involved in organ trafficking. The awfulness of present practice, however, doesn't get us very far when we attempt to answer questions such as: is organ sale per se morally wrong and should it be criminalised? This is mainly because what makes present practice so objectionable isn't payment per se but additional factors — for example, assault, coercion, murder, theft, torture, and underpayment — factors which could, in principle, be removed from an organ trading system. Furthermore, when it comes to the legal prohibition issue, it has been plausibly argued that banning organ sale is partially responsible for the awfulness of present practice. Cameron and Hoffenberg, for example, claim that it's the 'marginalization of paid organ donation that leads to its performance in less than ideal circumstances'. Hence, far from being a reason to continue the ban on sale, the dreadfulness of present practice may be a reason to discontinue prohibition, so that the organ trade can be brought 'overground' and properly regulated.

Given this, the main body of Chapter 7 was concerned not with an analysis of present practice, but rather with ethical arguments that attempt to show that the act of paying a person for a part of her body is somehow objectionable in itself. Five anti-sale arguments were considered, focussing respectively on harm and risk to the vendor, the role of free donation in promoting altruism and social solidarity, valid consent, coercion, and exploitation.

In section 7.2, the harm and risk argument was rejected (a) because donating a kidney isn't (or needn't be) terribly harmful, and (b) because it certainly isn't any more harmful than other widely accepted forms of 'risky labour'. In section 7.3, I conceded that altruism arguments may have some force if there is already a successful and predominantly free system of donation in place, such as the UK's free blood donation service — or if there is a realistic prospect of such a system being brought into being. However, altruism arguments won't work against practices like kidney sale, because free donation between non-relatives is very rare indeed and is unlikely to become much more common in the foreseeable future. Where we have a choice between an altruistic system and a commercial system, then the altruistic system will normally be preferable. But where an altruistic system is not a practical possibility and the real choice is between a commercial system and (virtually) no system at all, it makes little sense to opt for not having a system at all just because an altruistic system, if possible, would have been better than a commercial one. Section 7.4 assessed the view that financial inducements invalidate organ donors' consents: the claim that financial inducements make the offers that they support irresistible to (certain kinds of) offeree and/or that inducements incite people to act on non-autonomously held desires. Such views were found to be either implausible, or plausible but insufficient to ground a consent argument against organ sale. Section 7.5 discussed the coercion argument, the idea that organ sellers would be the victims of coercion. It was conceded that many actual organ vendors are coerced. However, it was concluded that there's no reason to suppose that a properly regulated market in human organs would involve any more coercion than a properly regulated system of free donation — or that it would be any more coercive than capitalism in general. Finally, section 7.6 examined exploitation arguments against organ sale. As with coercion, it was conceded that many actual organ vendors are exploited. It would, however, be possible to make a suitably regulated market in human organs non-exploitative, or comparatively non-exploitative. In particular, the imposition of a generous minimum fee could help to alleviate poverty and save lives, while at the same time all but eliminating exploitative kidney purchases.

The overall conclusion in this chapter, then, is that the moral case against the establishment of a properly regulated commercial market in human organs is weak. As I stated at the outset, this has direct implications for criminal law in this area. Permitting organ sale would deliver very substantial practical benefits (the saving of lives). Hence, in the absence of a defensible moral argument for prohibition, the case for decriminalisation looks compelling.