Journal of Health Ethics

Volume 11 | Issue 1 Article 11

August 2015

Does the Iranian model of kidney donation compensation work as an ethical global model?

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1) Introduction

Growing out of a global health crisis, one of the biggest issues within bioethics today is the possibility of the establishment of a global system of compensated organ donation, and the issue has garnered a tremendous amount of arguments on both sides of the spectrum. Ever since organ transplants became a medical reality in 1954, the need for viable organs has been growing, and the development and perfection of transplant techniques only exacerbates an already critical problem (Tullius, 2013). In virtually every country in the world, the organ waiting list dwarfs the amount of viable organs available to use for transplantation, and it's clear that cadaveric organ donations are not able to fully supply the demanding market for organ transplant procedures (Satayathum, 2005). For these practical reasons, it has been suggested that countries, either individually or globally, develop a regulated system of organ donation compensation to help alleviate this global mass shortage of organs. Not everyone is on board with this idea, though, and critics argue that a system of this nature is an unethical commodification of the body and its implementation would lead to exploitation of the poor, violations of informed consent, and unjustified harm to the donor (de Castro, 2003).

Focusing specifically on the kidney organ, in this essay I examine the popular ethical arguments both for and against a global system of compensated kidney donation, and I analyze Iran's model of kidney donation compensation for its advantages and disadvantages as a model for a global system of kidney donation compensation. Furthermore, I suggest changes to Iran's model to avoid its disadvantages and come closer to establishing a model for a global system of kidney donation compensation. It must be noted that in this essay the term "compensated kidney donation" will go beyond mere reimbursement into actual payments, gifts, and/or benefits relayed from the donee to the donor in payment for the kidney donation itself. I begin by analyzing the ethical arguments for compensated kidney donation, including arguments from the global kidney shortage, organ trafficking, global ethical principles, and financial assistance of the poor. Next, the analysis transitions to the arguments against compensated kidney donation, and these arguments include claims of commodification, exploitation, violation of informed consent, and unjustified harm to the donor. Switching gears, I then examine Iran's model of kidney donation compensation through its satisfaction of the benefits of compensated donation and avoidance of the harms of compensated donation. Finally, I make suggestions regarding Iran's weaknesses as a global model for compensated donation and aim to come closer to finding an ethical and efficacious model to address the world's mass kidney shortage.

2) Ethical Arguments for Compensated Kidney Donation

Most likely the largest factor supporting compensated donation, the global mass organ shortage is one of the primary ethical arguments in favor of a global system of compensated donation. With an estimated global kidney waiting list of over 200,000 people, and hundreds of thousands more waiting on other organs, the mass organ shortage is a global crisis that provides a substantial reason to incentive live organ donations (World Health Organization, 2007). The presence of a vast network of organ trafficking has also been a reason cited by proponents of a system of compensated donation, because it is believed that a regulated system would be much more efficacious, safe, and less abusive and harmful than the current system of organ trafficking (Radcliffe-Richards et al., 1998). In addition to these two factors, it has been argued that restricting options of the poor is wrong and the ethical principles of autonomy, beneficence, and justice justify a system of compensated kidney donation (Rothman and Rothman, 2006).

2.1) Global Organ Shortage and Trafficking

Though exact numbers on global organ transplants and waiting lists are difficult to determine, it's clear that there is a massive global shortage of organs that affects virtually every country in the world. Globally in 2005, there were roughly 6,000 heart transplants, 21,000 liver transplants, and 66,000 kidney transplants throughout the year, and this number is expected to grow every year (Shimazono, 2007). Waiting lists are much harder to determine, but the World Health Organization estimates that over 200,000 individuals worldwide are on the kidney transplant waiting list (World Health Organization, 2007). Obviously, from these numbers it is easily noticed that the kidney is the organ with the most demand, and it represents a large majority of the global organ waiting list. Thus, naturally its high demand subjects it to the most forms of abuse and trafficking (Rothman and Rothman, 2006).

The number of kidneys in demand for the United States makes up approximately half of the global kidney waiting list. Roughly 101,000 Americans are already on the list, and every month 3,000 more join. In the United States in 2013, more than one-third of the kidney transplants were from live organ donation, but only 17,000 kidney transplants transpired throughout the year (National Kidney Foundation, 2015). Studies from 2003 even show that percentage-wise the United States has a much lower percentage of kidney patients on the kidney waiting list than other countries. For example, Spain and the United Kingdom both hover around fifty percent with half of their kidney patients being put on the kidney waiting list (Satayathum, 2005). These great disparities between the yearly number of needed kidney transplants and the number of actual kidney transplants highlights the great practical need for a global regulated organ trade. Proponents of an organ trade argue that adding incentives, such as monetary compensation, to kidney donations will dramatically increase the annual number of kidneys donated, and if enough individuals would participate the global kidney waiting list could be dramatically diminished. This way, roughly 200,000 people would have a chance at escaping organ waiting lists, and thousands more would not face preventable deaths (World Health Organization, 2007).

Although the global mass organ shortage is adopted as the main practical reason proponents support a regulated system of compensated donation, the existence of an organ black market and its organ trafficking system has to be a close second. In the *Declaration of Istanbul*, organ trafficking is defined as:

> …the recruitment, transport, transfer, harboring or receipt of living or deceased persons or their organs by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability, or of the giving to, or the receiving by, a third party of payments or benefits to achieve the transfer of control over the potential donor, for the purpose of exploitation by the removal of organs for transplantation (*Declaration of Istanbul*, 2008).

Thus, organ trafficking necessarily involves the use of abuse, force, or coercion in the recruitment, harboring, and transfer of humans or their organs. Trafficking actually comes in two forms: human trafficking of organs and individual organ trafficking. The former involves trafficking humans in order to transplant their organs, and the latter involves trafficking the already excised organ (Budiani-Saberi and Columb, 2013). Organ trafficking then exemplifies one of the main objections to a global system of compensated donation: exploitation of the poor and violations of informed consent. This objection states that organ trafficking denies the right

of informed consent to donors and vulnerable populations that are exploited and unjustly taken advantage of by the use of abuse, deception, and coercion (Budiani-Saberi and Delmonico, 2008).

International studies suggest that roughly ten percent of the global yearly kidney transplants occur out of an organ sale system, and the vast majority of these involve organ trafficking of some kind (Budiani-Saberi and Columb, 2013). With roughly 66,000 kidney transplants in 2005, and this number surely growing since annually, this constitutes an average of around 6,000 cases of human organ trafficking yearly (Shimazono, 2007). So organ trafficking is a real problem that must be addressed. However, organ trafficking flourishes within the context of the prohibition of an organ trade, creating illegal economic incentives for the black market of organs. It is argued by proponents of a compensated donation that the best way to deal with organ trafficking is to remove the incentives and decriminalize compensated donation. They argue that this could be achieved by establishing a highly regulated system of compensated donation. Essentially, a globally agreed upon and nationally-ran regulated system could enact regulations and penalties to restrict hospitals and transplant centers from receiving organs outside of the regulated trade. If organs were only acceptable from approved agencies, this would decrease the incentives of organ trafficking and the practice could be greatly decreased, if not totally eliminated. Furthermore, regulations and processes can be enacted to ensure informed consent of patients, including the steps of disclosure of information, assurance of adequate understanding, and the attainment of express, formal consent, which are all essentials of the process of informed consent (ten Have and Jean, 2009).

Of course, one argument against this claim is that practical circumstances in some countries will not allow this type of strenuous regulation, and organ trafficking will still exist. To the extent that this might be a legitimate objection, it also applies to governance in many other areas where other types of governmental agencies aren't defunded and shut down due to this same possibility. Proponents of compensated donation emphasize that a regulated system would *at the very least decrease* the amount of organ trafficking cases, making it completely worthwhile. In response, an argument can be made that regulation wouldn't necessarily address the problem of exploitation, yet vulnerable populations are at a much greater risk for exploitation when there are no regulations. In a regulated system, exploitation can be addressed and attempts can be made to avoid or lessen it. Proponents then argue that a regulated system of compensated donation would likely involve fewer cases of exploitation and organ trafficking. Thus, it is no surprise that for proponents a great reduction in organ trafficking provides a substantial practical reason to support a global regulated system of compensated kidney donation (Radcliffe-Richards et al., 1998).

2.2) Argument from Ethical Principles

In addition to the practical reasons of the global organ shortage and organ trafficking, proponents also argue that common ethical principles justify the compensation of organ donation. In particular, the concept of principlism is commonly used to justify this act, because it contains the ethical principles of autonomy, beneficence, justice, and non-maleficence, all of which proponents use to argue for the ethical validity of compensated donation (Kelly, Magill, and ten Have, 2013).

Autonomy is defined as a concept of self-rule that is free from limiting constraints from others and impediments on meaningful choice. The autonomous person acts according to a self-chosen plan without interference or limitations upon that plan from other individuals. When one does not act autonomously, it is due to the incapability of realizing the plans and desires of the individual, and this incapability arises from some sort of hindrance upon the freedom of the agent (Beauchamp and Childress, 2013). Three conditions are necessary for autonomous action: intentionality, understanding, and noncontrol. For the act to be autonomous, the action must be intentionally willed, and the agent must adequately understand the action and its consequences. The agent must also not be under the controlling influence of another, because an agent can only act autonomously when the act is not directly affected by an impressionable factor or influence that affects the agent's plans (Beauchamp and Childress, 2013).

The principle of autonomy does have its limits, and restrictions upon autonomy are usually only justified to protect the autonomy of others (ten Have and Jean, 2009). This is in accordance with the negative obligation imposed by autonomy, which states that autonomous agents should not interfere in the autonomous actions of other agents. There is also a positive obligation imposed by autonomy, and it states that agents should foster autonomous agency for fellow agents, which includes the dissemination of information that is potentially relevant to an action they are deliberating on (Beauchamp and Childress, 2013). To support compensated donation, proponents argue that agents have the right to exercise their autonomy, and as long as it passes the obligations imposed by autonomy, it should be allowed (Rothman and Rothman, 2006). For them, compensated donation passes the negative obligation of autonomy, because no other agent's autonomy is restricted in individual organ sale. The point is that a strictly regulated system of compensated donation would have safeguards to foster autonomous decision making and informed consent, which reflects the positive obligation of autonomy. This argument then posits that respecting the principle of autonomy can justify regulated compensated donation (Beauchamp and Childress, 2013).

The second concept of principlism that supports the act of compensated donation is the principle of beneficence, and this principle basically states that one must act and do good towards others (Kelly, Magill, and ten Have, 2013). It imposes an obligation upon individuals to act in ways that benefit other people. Depending upon the context, there are differing types of beneficence, such as general, specific, obligatory, and ideal. General beneficence is beneficence towards strangers and those who we do not have emotional relationships with, and specific beneficence is the act of good towards those we do have emotional relationships with (Beauchamp and Childress, 2013).

The difference between obligatory beneficence and ideal beneficence is a little more practically obscure, but theoretically the difference involves the act's obligation. In obligatory beneficence, acts of beneficence are morally imposed and required; whereas, ideal beneficence only includes non-obligatory acts of beneficence that are nonetheless virtuous, heroic, and noble. From the perspective of compensated donation, acts of beneficence will either be ideal/general or ideal/specific, depending upon whether or not the donor had an emotional relationship with the donee, though it stands to reason that in organ sale it would mostly be ideal/general. Thus, this approach argues that the principle of beneficence supports a regulated system of compensated donation and opposes its prohibition, which would dramatically decrease acts of beneficence (Beauchamp and Childress, 2013).

The third concept of principlism is the principle of justice, and it is also used by some to support compensated donation. Justice cannot be restricted to a singular definition. In the context of organ donation, it usually refers to matters of distribution of scarce resources, and it provides a guide to areas of concern for specific normative theories to address (Gert, Culver, and Clouser, 2006). One of the most influential theories of justice is Martha Nussbaum's capabilities theory, and it provides the principle with normative content. Many proponents of a system of compensated donation use this normative theory of justice as evidence for this type of system's ethical justification (Beauchamp and Childress, 2013).

Martha Nussbaum's capabilities theory of justice is premised on the fact that all humans are equal in worth, value, and dignity due purely to the fact that they are human. For Nussbaum, this value stems from the human's inherent ability to make moral decisions in order to plan a unique, individual life that is in accordance with one's own plan and conception of the good. This value then entitles each individual within a state to certain rights and types of treatment that allows them to realize their personal conception of the good (Nussbaum, 1999). Nussbaum considers the types of treatment that individuals are entitled to as essential capabilities that must allow individuals to realize their own personal conception of the good. She argues that there are ten essential capabilities that a state must provide for its citizens, and without these capabilities individuals are not living a truly dignified human life (Beauchamp and Childress, 2013). With these capabilities available, individuals will not be constrained by fear, hunger, or the absence of opportunity (Nussbaum, 1999).

Obviously, the availability of autonomous choice is crucial to Nussbaum's capabilities theory, and this crucial factor is emphasized by proponents of compensated kidney donation. One essential feature is the capability of bodily health and integrity whereby individuals should be "…able to have good health, including reproductive health; being adequately nourished; being able to have adequate shelter" (Nussbaum, 1999).

To justifiably be denied a capability in this approach, the capability must be unattainable. For example, mortality is not a denying of the essential capability of life, because immortality is unattainable. However, if an essential capability is attainable, then Nussbaum argues it must be available. In renal failure and other conditions that require a kidney transplant, the shortage of organs (and, as argued by proponents of compensated kidney donation, the prohibition of compensated donation) denies hundreds of thousands of individuals the essential capability of good bodily health. Proponents argue that such a capability is attainable through a system of compensated donation and its prohibition would therefore be unjust in this normative theory of justice. Individuals with renal failure have their inherent dignity violated by the absence of opportunity, and allowing those individuals on the kidney waiting list to die also denies them the essential capability of life and the right to not die prematurely (Beauchamp and Childress, 2013). It should also be noted that Nussbaum developed her approach to emphasize an international or global context. Thus, proponents argue that the prohibition of compensated kidney donation is contrary to the principle of justice as espoused in Nussbaum's capabilities theory of justice (Garrett, 2008).

2.3) Assistance of the Poor

Proponents of compensated organ donation also emphasize the potential financial benefits it could offer to poorer individuals. It is argued that individuals should be able to

exercise their autonomy and improve their life chances by selling their organ, namely the kidney, for economic relief if they so choose (Rothman and Rothman, 2006). Yet the majority of objections to compensated donation focus on the factors involving this practical reason in support of compensated donation, because these objections aim at protecting poorer populations from evil practices and exploitation. However, proponents of compensated donation argue that these objections and prohibitions unnecessarily limit poorer populations' ability to better their situations and ultimately *harm* them in an unnecessary, unjustifiable way, which brings us to the last component of principlism: non-maleficence (Kelly, Magill, ten Have, 2013).

The principle of non-maleficence is used to support an organ trade in an indirect manner. This principle basically obligates individuals to not harm others, or at least to employ the least harmful act that can be employed. Basically, it obligates humans to avoid harm when possible and perform the least amount of harm when necessary (Beauchamp and Childress, 2013). Proponents then use this ethical principle to argue for a system of compensated organ donation in two ways. First, similar to one of the first pro-compensation arguments discussed above, proponents argue that the principle of non-maleficence obligates us to act in ways that produces the least amount of harm when possible, which they believe can be associated with the development of a system of donation compensation. Since organ trafficking has been shown to thrive in a prohibition and other attempts to curb its occurrence have failed, proponents argue that the principle of non-maleficence obligates us to legalize and regulate the trade in order to produce the least amount of harm possible. It is argued that there is much more risk for abuse, exploitation, and harm when the trade is illegalized and forced underground rather than openly regulated; thus, by the principle of non-maleficence a system of compensated donation can be ethically forged in the name of reducing harms from organ trafficking and the black market (Radcliffe-Richards et al., 1998).

The second way proponents use the principle of non-maleficence to justify compensated donation is by claiming the prohibition *harms* poorer populations by taking away an option for them to better themselves financially (Radcliffe-Richards et al., 1998). This is actually the position of the famous bioethicist Robert Veatch, who has recently taken up this position due to a continual neglect of the well-being of the poor (Rothman and Rothman, 2006). According to Veatch, it is unethical for the state to prohibit the opportunity of compensated donation while simultaneously refusing to provide the goods of life to our poorest peers. Proponents claim this is a violation of the principles of autonomy and non-maleficence due to the harm caused by the prohibition (Veatch, 2003).

The use of these ethical principles of principlism as an argument for a *global model* of compensated donation is strengthened by their existence in global ethical principles, too. A branch of the United Nations known as the United Nations Educational, Scientific, and Cultural Organization (UNESCO) has developed a global ethical standard complete with a list of global ethical principles spelled out in their *Universal Declaration on Bioethics and Human Rights* (ten Have and Jean, 2009). Included in these global ethical principles are the following relevant components:

> Article 4 - Benefit and Harm: In applying and advancing scientific knowledge, medical practice and associated technologies, direct and indirect benefits to patients, research participants and other affected individuals should be maximized and any possible harm to such individuals should be minimized.

> Article 5 - Autonomy and Individual Responsibility: The autonomy of persons to make decisions, while taking responsibility for those decisions and respecting the autonomy of others, is to be respected. For persons who are not capable of exercising autonomy, special measures are to be taken to protect their rights and interests.
>
> Article 10 - Equality, Justice, and Equity: The fundamental equality of all human beings in dignity and rights is to be respected so that they are treated justly and equitably (ten Have and Jean, 2009).

Articles 4, 5, and 10 of the *Universal Declaration on Bioethics and Human Rights* all refer to the ethical principles of beneficence, non-maleficence, autonomy, and justice, respectively. Thus, the ethical principles of principlism are inherent within these global ethical principles, and these arguments from ethical principles for compensated donation are then relevant for a global model of compensated donation. However, this global ethical standard also discusses principles of human dignity, consent, and human vulnerability, which turns our attention to the arguments against systems of compensated donation (ten Have and Jean, 2009).

3) Ethical Arguments against Compensated Kidney Donation

For as many arguments as there are for the development of a system of compensated donation, there are just as many arguments saying the exact opposite. There are three main types of arguments used against compensated donation: arguments from commodification, arguments from exploitation and informed consent, and arguments from harm (Wilkinson and Garrard, 1996). Each of these arguments claim to justify the prohibition of compensated donation by themselves, and they are each intrinsically related to one or more of the global ethical principles, including human dignity, harm, consent, and respect for human vulnerability (ten Have and Jean, 2009).

3.1) Human Dignity and Commodification

The argument from commodification is based on the very first principle of the *Universal Declaration on Bioethics and Human Rights*, human dignity, which states: Human dignity, human rights, and fundamental freedoms are to be fully respected (ten Have and Jean, 2009). As a concept and principle, human dignity refers to the intrinsic value every single human being contains, and this value is an inherent dignity that must be respected unconditionally (ten Have and Jean, 2009). This is an ideal which is very prominent in Kantian philosophy, because Kant posited that humans contain an inherent value that makes us intrinsically valuable. Thus, part of his Categorical Imperative for ethical action is to always treat people as ends in themselves and never merely as a means (Kant, 1997). This means that people should always be treated as valuable individuals and never merely as a means towards some other end. Opponents of compensated donation argue that providing monetary compensation for a person to donate their organ treats that individual merely as a means, a collection of useful parts, rather than a valuable individual that is to be respected wholly, and it is to change that individual from a "person" to a "thing." This treats someone merely as a means rather than an end in themselves, thus making it an unethical action (Marway, Johnson, and Widdows, 2014).

This process then attempts to turn "persons" into "things" by objectifying their parts into commodities, i.e. goods that can be sold on the market (Cherry, 2008). To commodify something is to take something with intrinsic value and objectify it, and once it is objectified it must be commercialized to give it an exchange value, which allows it to be sold for a price. This

completes the transition from a "person," or thing with intrinsic value, to a "thing" that is subject to market relations (Marway, Johnson, and Widdows, 2014). Michael Sandel describes this process as corruption of the human person, and he believes it promotes an objectifying and degrading view of the human person. He argues that this corruption is caused by adding market relations to a non-market product, so to place the human body in this market situation is to corrupt the very integrity of the human person (Sandel, 2012).

It might be argued that organ donation as a whole treats "persons" as "things," because it necessarily treats parts of individuals as interchangeable. Technically this latter clause is true, because for organ donation and transplantation to be a viable method for addressing organ failures and needs, differing organs of differing people must be interchangeable. So, organs are technically *objectified* in organ donation. However, they are not *commercialized* in organ donation, but rather they're given out of altruism. In altruistic organ donation, individual parts aren't thought of as "saleable," so they are not given an exchange value and, consequently, not commodified. Further, the language of donation itself distances this act from market relations and commodification. Thus, though both organ donation and organ sale deal with objectifying parts of "persons" to use in another, only the sale of organs unjustifiably commercializes the body and unethically treats it as a commodity (Marway, Johnson, and Widdows, 2014).

3.2) Exploitation and Informed Consent

The argument from exploitation and informed consent is actually based on two global ethical principles: consent and respect for human vulnerability. These principles require people to gather consent from the patient for any medical intervention and to take into special account human vulnerability, especially traditionally vulnerable populations (ten Have and Jean, 2009). Throughout history, vulnerable populations have traditionally been taken advantage of, so it has been a priority in modern times to pay special attention in one's dealings with these vulnerable populations. One vulnerable population that has been consistently taken advantage of throughout history is the poor, and that is the population the argument from exploitation and informed consent focuses on. This argument basically has two main components: 1) exploiting the poor, and 2) doubting the voluntariness to sell an organ (Marway, Johnson, and Widdows, 2014).

The first of these components of this argument states that compensated donation unjustifiably exploits the poor, because the relationship between "donor" and "donee" pits the poor against the rich. It is argued that it is unethical that rich donees who are willing to pay for an organ should be allowed to exploit vulnerable populations who are more in need of the money than the organ at the particular time. Opponents argue that the globally rich would be pitted against the globally poor, and the market would almost necessarily operate under these conditions. For opponents, then, inequality would be a defining piece of the organ market, and a market based on this concept cannot possibly be ethically justifiable (Marway, Johnson, and Widdows, 2014).

The second component of the argument states that compensated donation would force upon poor individuals an almost impossible dilemma: keep an integral part of one's body or sell it to pay the bills. Basically, this argument states that informed consent can never be achieved in this context due to the voluntariness of the decision, the third step in the process of informed consent, never being real (ten Have and Jean, 2009). Sandel labels this component of the argument the "fairness objection," and he also points to the injustice of inequality being the basis

of the market. He states, "…market exchanges are not always as voluntary as market enthusiasts suggest. A peasant may agree to sell his kidney or cornea to feed his starving family, but his agreement may not really be voluntary. He may be unfairly coerced, in effect, by the necessities of his situation" (Sandel, 2012). Thus, the argument from exploitation and informed consent states that it is unethical for the globally rich to exploit the vulnerable populations of the globally poor, and the decision to sell one's kidney is a coerced response due to financial influences, making it an unethical and unjustifiable practice (Marway, Johnson, and Widdows, 2014).

3.3) Harm: Physical, Emotional, Social

A third and final argument against compensated donation involves the amount of physical, emotional, and social harm the act of selling one's kidney involves, and this is related to the global ethical principle of "Benefit and Harm" that states that "any possible harm…should be minimized" (ten Have and Jean, 2009). This argument is actually an argument from non-maleficence, the ethical principle that obligates us to do no harm when possible. When arguing against physical harm, this argument from non-maleficence pertains insofar as it can be argued that organ transplantation, donation, and sale are too harmful to justify any amount of good that comes from them. When analyzing the evidence, though, studies show that there is limited short-term and long-term medical risk involved in kidney donation. In fact, one particular study discovered an 85 percent survival rate over 20 years after the donation of a kidney, and the mortality of the group was not related in any way to factors associated with kidney donation or decreased kidney function (Fehrman-Ekholm, 1997). In terms of short-term risks, other studies suggest only a 0.03 percent chance of mortality and 20 percent chance of morbidity shortly after the donation, and there is fairly conclusive evidence that there is no higher rate of renal failure amongst kidney donors than in the normal population. However, opponents argue that these statistics are only valid for ideal, sterile conditions, and virtually all transplants that come from compensation systems are not ideal. This is especially true in cases of organ trafficking and transplant tourism where many transplants take place in back-alley clinics and clandestine transplant centers (Erin and Harris, 2003).

The more damning arguments from harm, though, come from arguments of emotional and social harms. Certain recent studies have shown that donors who have sold their kidneys exhibit high signs of anxiety, despair, and a sense of hopelessness, and many reported that these emotions started post-nephrectomy. Many also reported withdrawing from their friends and family due to a feeling of "wrongness" and "shamefulness" about what they had just done, which seems to suggest an inherent ideation that this practice is intrinsically wrong. Body image issues also inflicted those who sold organs, because they commonly reported feeling as if their body was somehow "fragmented" and damaged now. Furthermore, many recent donors also reported a certain stigmatization from others for selling their kidney. Many felt socially isolated, and a large percentage reported that they were unwilling to share with others that they were an organ donor. Others have been excommunicated from their churches, excluded from marriages, and told to hide their scars whenever possible to avoid being known as an organ donor. Opponents argue that these harms are a far cry from the feelings of well-being, respect, and self-worth that many proponents claim come with compensated kidney donation, and the minimal benefit that this practice provides is not worth the physical, emotional, and social harms that it afflicts upon the donor (Koplin, 2014).

4) The Iranian Model of Kidney Donation Compensation

Now that the arguments for and against compensated donation have been thoroughly discussed, it is now prudent to focus on an actual model of kidney donation compensation to analyze its capability as a global model and how well the model is attaining the benefits and avoiding the harms of compensated donation. Though compensation for organ donation can occur in many forms, including medical benefits, funeral incentives, tax benefits, and many other avenues, direct cash and financial benefits naturally garner the most attention and discussion. The most notable example of this type of system of cash-compensated organ donation is Iran, and they have one of the most successful transplant systems in the world that has erased their kidney waiting list since late 1999 (Larijani, Zahedi, and Taheri, 2004).

4.1) The Iranian Model

Iran's kidney donation and transplantation system has evolved drastically in the last thirty years. It began in the 1980's as an unregulated international market that was welcome to anyone willing to pay the price and do the work of finding a suitable organ match. Beginning in the late 1980's and early 1990's, this began to change as the Iranian Ministry of Health began to get involved with the practice. After noticing that many donors and recipients were scared off by the potential exploitation, manipulation, and unfair treatment involved with the process of buying and selling a kidney, the Iranian Patients' Kidney Foundation (IPKF) took over and started regulating the process of arranging kidney pairings, writing contracts, and other essential services of the kidney compensation system (Frye-Revere, 2014).

Today, the Iranian Model of Kidney Transplantation (IMKT) is a tightly regulated system that is seen as a good, but not perfect, model of a functioning organ compensation system. The IPKF registers the statistics and information of both candidates for kidney transplants and willing donors into a database to find a match for each party. After obtaining the proper consents, the IPKF introduces the matched pair to each other, and the pair comes to an agreement on an acceptable price to be paid from the recipient of the kidney to the donor of the kidney (Aramesh, 2014). The role of the IPKF and other charity organizations that also work in matching potential donors with recipients, such as the Dialysis and Transplant Patients Association (DATPA), cannot be overstated, because their involvement cuts out the "middle-man" of organ brokering. This greatly lessens the chances of corruption, favoritism, and exploitation, because no conflicts of interest will occur if these organizations and the transplant teams have no financial ties to the matching of the pair (Larijani, Zahedi, and Taheri, 2004).

After the IPKF has matched the two parties and they've agreed on a fair payout from the recipient to the donor, the kidney transplant takes place. Once completed, a nongovernmental organization known as the Charity Foundation for Special Diseases rewards the kidney donor for their gift with further monetary compensation in addition to a yearlong, free medical insurance. To ensure proper protocols, fair payment, and ethical application, all transplantation centers and compensated kidney donations are located and performed in university hospitals under close supervision of the Ministry of Health and Medical Education. Iranian compensated kidney donation is further exclusively limited to Iranian citizens, and foreigners must provide a donor from their own nationality in Iran (Aramesh, 2014).

4.2) The Iranian Model's Benefits

Being one of the very few countries in the world allowing some sort of compensated kidney donation, the Iranian model provides a plethora of benefits. First and foremost, the model's greatest benefit and success has been the unquestionable termination of the kidney transplant waiting list since 1999. The addition of financial incentives for kidney donation in the late 1980's and a lower rate of patients with End Stage Renal Disease combined to make short work of the kidney waiting list in the 1990's (Ghods and Savaj, 2006). Iranians in need of a kidney transplant regularly receive an organ in a speedy manner, so long as they're able and willing to pay for it. This is generally not an issue, though, because the lower demand for kidneys compared to their much higher supply has kept the prices relatively low, which has consequently made them affordable for *virtually* every Iranian patient in need (Aramesh, 2014). Furthermore, charitable organizations usually step in to help aid with the finances of the transplant if the recipient is too poor and unable to pay for the transplantation and costs themselves (Ghods and Savaj, 2006).

A close second benefit is the eradication of organ trafficking in Iran. Since the Iranian Patients' Kidney Foundation matches kidney donation pairs and organizes all the payment and procurement details of the transplant, kidney brokers and organ brokering agencies, who are the usual suspects and catalysts of organ trafficking, can play no role in the transplant process. Transplants only occur though this governmental foundation, and they're also only allowed in university hospitals in Iran, which are under strict scrutiny from the Ministry of Health and Medical Education (Aramesh, 2014). Furthermore, this model also eradicated organ trafficking in the form of transplant tourism, too. This practice is one of the biggest bioethical issues within global ethics and transplant ethics, and it usually involves individuals who need a kidney transplant coming over from a country that doesn't allow organ sale to a country where they can legally buy themselves a kidney for transplantation. These individuals are usually motivated by long organ waiting lists in their home country and the lack of an opportunity to buy an organ from another due to their country's prohibition. This is an extensive process that usually involves organ brokers and other health care professionals to manage the procurement of the organ, the exchanging of money, and the scheduling and location of the transplant (Shimazono, 2007). When this practice started to become noticed by government officials, the Iranian Ministry of Health banned all foreign recipients from receiving kidney transplants from Iranian donors, which essentially prevented the practice of transplant tourism in Iran (Ghods and Savaj, 2006).

What makes this benefit even more impressive is the fact that this model is thriving as a deterrent to organ trafficking within a developing country with a poor corruption index and reputation. Transparency International is a global organization with the purpose and aims of locating, broadcasting, and destroying corruption throughout governmental agencies throughout the world. This organization puts out an annual Corruption Perceptions Index (CPI) that ranks each country according to its corruption prevalence, perception, and control. Iran ranks low in every factor of corruption, scoring a mere 27 points out of a total of 100 points and ranking 136 out of the 175 nations that this organization surveyed. Furthermore, they rank in the 20^{th} percentile when it comes to controlling corruption. Thus, the fact that this model has avoided rampant corruption while simultaneously meeting its goal of alleviating the kidney waiting list and halting organ trafficking within the country is a great testament to this model's effectiveness, ability to be implemented and evade corruption, and overall promise as a global model (Transparency International, 2015).

Other benefits of the Iranian model include the promotion of autonomy and control over one's body via the allowance to donate one's kidney for compensation and the promotion of justice via elimination of the kidney waiting list, organ trafficking, transplant tourism, and financial assistance of poorer population. Even acts of beneficence are on the rise, because organ donation is essentially an act of beneficence towards another, with the government even referring to their organ compensation as a "gift for altruism" (Aramesh, 2014). One last major benefit of this model is its ability to address notions of commercialism and exploitation within systems of compensated organ donation. Though a component of the exploitation objection argues that a system of compensated donation would only benefit the rich who are wealthy enough to pay for these organs, studies within Iran's model show this is clearly not the case. For example, one study of over 500 renal transplant recipients found that over fifty percent of the kidney donation recipients were poor, and only a little over thirteen percent of the recipients were rich. An essential part of Iran's model is the active role played by charity organizations, which help pay for the expenses of the transplant surgery for poorer patients who cannot afford. Thus, this model of compensated donation benefits the sick of both the rich and the poor (Ghods and Savaj, 2006).

4.3) The Iranian Model's Drawbacks

Though the Iranian model provides quite a few advantages and benefits, it also has some disadvantages that are inherent within the objections against a system of compensated donation. First and foremost, the Iranian model does nothing to address the commodification objection to compensated donation, and, in fact, it tends to take an extreme regard in this matter. For example, there are two separate direct monetary transactions that take place within each individual kidney transplant within Iran. The first transaction is a direct monetary negotiation between the donor and the potential recipient that decides how much the potential recipient will pay the donor for donating their kidney. The second monetary transaction comes from a nongovernmental organization known as the Charity Foundation for Special Diseases, and this organization provides monetary compensation to the donor that is known as the "gift for altruism" from the state. Though the donation is an act of beneficence that will help another, it definitely is a payment directly for the kidney donation that is not technically altruism. This arrangement really tends to commodify the donation to a nearly unacceptable level (Aramesh, 2014).

A second potential disadvantage with this model is its reliance on poorer populations for the supply of organs. Though studies suggest that over half of the kidney donation recipients in Iran are poor, an even larger percentage, 84 percent, of the kidney donations came from poor Iranians (Ghods and Savaj, 2006). This is somewhat to be expected, though, since financial incentives of this nature are going to appeal much more attractive to poorer populations. This brings into question the voluntariness of the decision with the main drive behind kidney donation being the financial aspect (Aramesh, 2014). A related disadvantage of this system is the lopsided reliance of financial incentives over non-financial incentives in this model. In the "gift for altruism" package from the Iranian NGO charity is included a 1-year free medical insurance for donors, but generally there is no other non-financial health incentive for donation, in addition to a lack of health support in the years following donation (Pajouhi, Zahedi, Pajouhi, and Larijani, 2014). Further disadvantages of this model include a stigmatization of donors and the suppression of altruistic donation (Aramesh, 2014). Many donors have felt stigmatized and

socially isolated by both foreigners and some in their own country for donating their organ for compensation, because it is sometimes viewed as improper or inhumane to donate one's kidney for compensation (Koplin, 2014).

5) Addressing the Weaknesses

Though the benefits and advantages of the Iranian model seem to outweigh the disadvantages, there are certain steps and revisions that can be made to further address these disadvantages. Furthermore, even though some fundamental objections, such as objections from corruption (commodification) or fairness (exploitation), to this practice will always remain, perhaps there is some middle ground that can be reached for these objections where it can be agreed by all that the advantages of a certain model of donation compensation outweigh the disadvantages. This is my attempt to address Iran's model's weaknesses and reach this point (Sandel, 2012).

5.1) Tax Deductions

To address the weakness of, *extreme*, commodification in this model, a revised model must pass two conditions: (a) the notion of donation must be retained, and (b) there must be no direct payment for organs. Using moral or nonfinancial incentives would be consistent with these conditions, but, practically it appears not to provide enough incentives to meet the need for viable organs (Veatch, 2003). Other systems have been proposed using indirect methods of payment, such as scholarships, but they ended up being disguised versions of the traditional organ sale (Cherry, 2008).

One system suggested by proponents of an organ trade that meets these conditions is a system based on tax benefits received for charitable donations one made throughout the year. In the United States and most other countries, individuals are allowed to deduct charitable donations that they made off of their taxable income. When one makes any sort of donation to a religious organization, non-profit organization, charity, or government agency, the amount of the donation is a tax write-off that one does not have to pay taxes on. For example, if Shelly made $150,000 annually and she was in the 33 percent tax bracket, a $10,000 donation to UNICEF would actually only cost her $6,700, because she'd be able to deduct that $10,000 off of her taxable income of $150,000, making it $140,000 of taxable income. These incentives are promoted by nations to encourage charitable giving to charities and other organizations (Charity Navigator, 2015).

Since governmental agencies are allowed to accept charitable donations that are tax deductible, the Iranian Ministry of Health or the Iranian Patients' Kidney Foundation could then make donations eligible to be considered tax deductible. Once achieving this status, then donations could be incentivized without any, or at least as minimally as possible, bodily commodification, because this practice could pass the two conditions. There is no payment for a donation, and, obviously, the notion of donation is retained. These deductions are incentives for charitable giving, so the tax deduction is technically a benefit for one's charitable gift. Some, like Veatch, might argue that this is just semantic manipulation, and tax deductions constitute an indirect organ payment. But analogously this would mean that tax deductions for monetary donations would be a payment for the actual cash or check involved in the donation, which doesn't make sense (Veatch, 2003).

This system would allow incentivized kidney donations that pass the two conditions of avoiding, or minimalizing, commodification of the body. The deduction amount would have to be a large figure, because there's a rather ungenerous exchange rate between actual tax savings and the dollar amount of the deduction. For example, let's say this year Shelly decided to sell her kidney instead of making monetary donations, and let's posit that the tax deduction for a charitable kidney donation is $50,000. Shelly would then be paying taxes on only $100,000 of that income rather than her annual salary of $150,000. In her tax bracket with the progressive income tax of 2011, she would pay roughly $35,600 in income taxes without the deduction. When the deduction is added, she saves roughly $14,000 by paying only $21,125 in income taxes (Charity Navigator, 2015). Thus, this is an effective way to incentive organ donation and address the vast global organ shortage, while not making the body a commodity or subject to the commercial market ideology (Wilkinson and Garrard, 1996).

5.2) Lopsided Compensation Incentives, Stigmatization, Suppression of Altruism

There are also fairly obvious solutions for the disadvantages of lopsided compensation incentives, stigmatization, and suppression of altruism as well. For example, if there's an evident need to offer more non-financial incentives such as longer periods of free health insurance rather than merely one free year, then the obvious answer would be to scale back some of the financial incentives for more non-financial incentives of longer periods of free health insurance. In fact, this works well with the use of tax deductions rather than direct monetary payments (Pajouhi, Zahedi, Pajouhi, and Larijani, 2014).

As for stigmatization, it seems fairly obvious that once the system would be expanded to a global perspective and brought into the open the stigmatization of donors would be dramatically decreased. There are even historical precedents for this in America with the legalization of abortion and relegalization of alcohol, because stigmatization of those partaking in these two things has dramatically decreased, with the exception of certain religious groups, since it was legalized, normalized, and brought into the open. There's even evidence from two recent studies in Iran that this is the case, though prior studies have said differently (Koplin, 2014). However, it's been well documented that the studies and literature used to suggest this stigmatization in Iran, as well as falsely give evidence for Koplin's arguments, are outdated and were performed before Iran's "renovation" of their transplant system, which brings their validity and accuracy very much into question (Frye-Revere, 2014).

Addressing the weakness of suppression of altruistic donation is difficult, because it's difficult to know exactly where the problem lies. It's well-documented that patients' families often times prefer to compensate another donor rather than donate their own kidney (Aramesh, 2014). However, as long as kidneys are readily available and procured in an ethical manner as described above, it's not obvious why this should necessarily be a problem. Of course, in a perfect world altruistic donation is much more preferable than compensated donation, but it's not a perfect world and altruistic and cadaveric donation simply cannot meet the demands of the global organ waiting lists. Furthermore, since live kidney donation is a morally supererogatory act, there should be no expectance of these types of situations anyways. Instead, we should be prioritizing our attention to increasing the number of *altruistic cadaveric organ donations*, because these are types of altruistic acts that are more likely to have widespread effects without requiring too much sacrifice from people.

5.3) Harming or Helping the Poor?

As for addressing the last weakness of the Iranian model, i.e. exploitation or the using of poorer populations for kidney donations, it is similar to the problem of commodification in that it is a fundamental objection to the practice and will always be present in one way or another. It has been suggested that this objection is a particular weakness for the Iranian model specifically, because study statistics show that roughly 84 percent of organ donors are poor with the final 16 percent coming from the middle class of Iran. This suggests that these populations are being "exploited" due to their financial status, and their decisions might be unfairly skewed by the financial incentives involved (Ghods and Savaj, 2006).

It must be noted that this objection is subject to a claim of arbitrariness, though, because there are many other instances of "exploiting the poor" that are never mentioned by these opponents. Critics say that there's a necessary connection between discrimination and compensated donation due to the greater response shown by vulnerable poor populations to the financial incentives of organ sale. The greater effect that the financial incentives put on vulnerable populations is discriminatory and unethical. Robert Veatch makes this point, recognizing it as a radical idea. Every financial transaction would be exploiting the poor under such broad, wide-ranging criteria. Things like risky, low-paying, or unpleasant jobs would also be exploitation of the poor, because they disproportionately affect and influence poorer populations, which is seen by these jobs' employee demographics. Thus, analogically speaking, these types of jobs should also be prohibited under this objection due to their disproportionate influence on poorer, vulnerable individuals. Of course, this is an absurd claim to make, thus showing the skeptical and arbitrary nature of this objection when it is only applied to compensated donation (Veatch, 2003). Furthermore, the exploitation objection also contains notions that systems of compensated donation exploit the vulnerable poor only to help the rich. However, as previously mentioned this isn't true within the Iranian model, because studies suggest that over half of kidney recipients are poor, which further weakens the strength of this perceived weakness (Ghods and Savaj, 2006).

Nevertheless, though informed consent is taken from all kidney donors prior to transplantation in Iran's model, further steps can be taken to ensure that patients are making a truly free decision without being unduly pressured by their financial situation (Aramesh, 2014). This could be completed by following a set protocol that coincides with the four steps of informed consent: disclosure, understanding, voluntariness, and formal consent (ten Have and Jean, 2009). Pre-operation counseling sessions would be able to meet the first several steps of the process. During this session, a transplant specialist, and maybe even an ethicist, would disclose all of the relevant information about the procedure to the patient, including side effects, risks, success rate, etc. They would also have to check for an adequate amount of understanding of that information, and this could be completed via an informative quiz similar to loan counseling. After the initial counseling session, there would be a waiting period of one to two months for the donor to reflect upon the decision and make sure it is what they really desire. If it is, the donor would come back for a final counseling session where express written consent would be attained. A protocol of this nature would ensure informed consent, respect the donor's autonomy, and ensure that finances aren't an unduly and overly-influential factor in the patient's decision (Hansmann, 1989).

6) Conclusion

To conclude, though the Iranian model of kidney donation compensation isn't perfect, there are some simple, subtle changes that can be made to make it a more practical and ethical model for a global system of kidney donation compensation. It will never be a perfect model, and both proponents and opponents of compensated organ donation will raise issues with one component or another. However, this revised model provides a nice compromise for both proponents and opponents of a system of compensated donation to meet in the middle for a global solution to a massive problem. The model favors proponents' arguments in that it has the potential to reduce global kidney waiting lists and organ trafficking, promote the global ethical principles of autonomy, justice, beneficence, and non-maleficence, and provide both financial and non-financial assistance to those who need it most. On the other hand, the model favors opponents' arguments in minimizing commodification, exploitation, and associative harms, all while placing a high priority and interest in ensuring informed consent. As a whole, this revised model is a great start towards addressing the global problems of kidney shortages, organ trafficking, and transplant tourism, and it sets a great precedent of solidarity and cooperation to come together to propose a model that speaks to and addresses the arguments of both sides.

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