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The Ethical Principle of Vulnerability and the Case Against Human Organ Trafficking

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ABSTRACT

An increasingly blurred understanding of the ethical significance of global "transplant transactions" - a curious combination of altruism and commerce, consent and coercion, gifts and theft, science and sorcery, care and human sacrifice - suggest a critical need to revisit the fundamental moral normlessness of the trafficking enterprise. This essay grounds its arguments in two, straightforward premises: (i) the ethical principle of respect for human vulnerability is an indispensable measure of the licitness of most, if not all, moral actions; and (ii) human organ trafficking violates the ethical principle of respect for human vulnerability. Drawing from this syllogism, the aim and proposal of this essay posits the argument that human organ trafficking cannot, in most, if not all, cases, be morally justified insofar as it violates the ethical principle of respect for human vulnerability.

Keywords: Transplantation Ethics, Human Organ Trafficking, Ethical Principle of Vulnerability, Case Against Organ Trafficking

1. INTRODUCTION

1.1 Overview

The widespread development of transplant capabilities has effected a global scarcity of transplantable organs.¹ Meanwhile, viable organs continue to be cremated and buried, and many individuals remain legally prohibited from participation in "organ trading," the buying and selling of human organs.² Some scholars contend that participation in trading is a morally licit means by which to address the widespread scarcity of organs.^{3,4} So long as the exchange is the product of fair opportunity – "fair" in the sense of an agreeable service provided for a reasonable fee, with no long-term negative effects – respect for autonomy suggests honoring the decisions of trading participants. Other scholars maintain that trading organs is an inherently unjustifiable

1. Nancy Scheper-Hughes, "Rotten Trade: Millennial Capitalism, Human Values and Global Justice in Organs Trafficking," *Journal of Human Rights* 2, no. 2 (June 2003): 197.

2. See D. A. Budiani-Saberi and F. L. Delmonico, "Organ Trafficking and Transplant Tourism: A Commentary on the Global Realities," *American Journal of Transplantation* 8 (2008): 925-29; see especially p. 925.

3. See Benjamin E. Hippen, "In Defense of a Regulated Market in Kidneys from Living Donors," *Journal of Medicine and Philosophy* 30 (2005): 593-626.

4. See Mark J. Cherry, "Embracing the Commodification of Human Organs: Transplantation and the Freedom to Sell Body Parts," *Saint Louis University Journal of Health Law and Policy* 2, vol. 2 (2009): 359-78.

moral action, no matter how benevolent the intended end or how “fair” the process.^{5, 6, 7} Selling one’s organs is contrary to human dignity inasmuch as it inescapably targets vulnerable populations and thereby proves impedimentary to the prospective donor’s capacity to give free, full, and informed consent.^{8, 9}

Human organ trafficking, the enterprise of organ trading and tourism that explicitly involves the coercion or deception of persons into exploitative, slavery-like practices,¹⁰ is a particularly notorious manifestation of organ trading. Today, trafficking remains a highly profitable global activity for organized crime,¹¹ and counts for five to ten percent of kidney transplants performed annually around the world.^{12, 13} The rise in global trafficking portrayed in the media features brokers, physicians, and hospitals engaged in the illegal trading of organs by way of explicit exploitation of poor populations in under-resourced countries, such as India,¹⁴ Pakistan,^{15, 16, 17} and Turkey,^{18, 19, 20} in which substandard medical care is normative. Such stories portray the reduction of once-commendable social acts to clandestine financial offers and incentives – ranging from \$1,000 - \$87,000 per organ, and \$35,000 - \$150,000 per “package deal” – that coerce donation from the world’s most thoroughly underserved. Moreover, trafficking

5. See Nancy Scheper-Hughes, “The Global Traffic in Human Organs,” *Current Anthropology* 41, no. 2 (2000): 191-224.

6. See Nancy Scheper-Hughes, “The Ends of the Body: Commodity Fetishism and the Global Traffic in Organs,” *SAIS Review*, vol. XXII, no. 1 (Winter-Spring 2002): 61-80.

7. See Scheper-Hughes, “Rotten Trade” *Journal of Human Rights* 2, no. 2 (2003): 197-226.

8. Shaun D. Pattinson, “Bioethics and Human Rights: Organ Trading, Tourism, and Trafficking within Europe,” *Medicine and Law* 191 (2008): 1.

9. R. R. Kishore, “Human Organs, Scarcities, and Sale: Morality Revisited,” *Journal of Medical Ethics* 31 (2005): 363.

10. Sarah Leevan, “Comparative Treatment of Human Trafficking in the United States and Israel: Financial Tools to Encourage Victim Rehabilitation and Prevent Trafficking,” *Cardozo Public Law, Policy, and Ethics Journal* 773 (Spring 2008): 1.

11. Pattinson, “Bioethics and Human Rights,” 1-8; see especially p. 1.

12. Budiani-Saberi and Delmonico, “Organ Trafficking and Transplant Tourism,” 925-29; see especially p. 925.

13. See Yosuke Shimazono, “The State of the International Organ Trade: A Provisional Picture Based on Integration of Available Information,” *Bulletin of the World Health Organization* 85 (2007): 995-62.

14. See Budiani-Saberi and Delmonico, “Organ Trafficking and Transplant Tourism,” 925-29.

15. See Farhat Moazam, “Pakistan and Kidney Trade: Battles Won, Battles to Come,” *Medicine, Health Care and Philosophy* (2012): 1-4.

16. See Farhat Moazam, Riffat Moazam Zaman, and Aamir M. Jafarey, “Conversations with Kidney Vendors in Pakistan: An Ethnographic Study,” *The Hastings Center Report* 39, no. 3 (2009): 29-44.

17. See Abidul Hasan S. Rizvi, S. Rizvi, Anwar S. A. Naqvi, Naqi M. Zafar, and Ejaz Ahmed, “Regulated Compensated Donation in Pakistan and Iran,” *Current Opinion in Organ Transplantation* 14 (2009): 124-28.

18. See Francis L. Delmonico, “The Implications of Istanbul Declaration on Organ Trafficking and Transplant Tourism,” *Current Opinion in Organ Transplantation* 14 (2009): 116-19.

19. See A. I. Reed, R. M. Merion, J. P. Roberts, G. B. Klintmalm, M. M. Abecassis, K. M. Olthoff, and A. N. Langas, “The Declaration of Istanbul: Review and Commentary by the American Society of Transplant Surgeons Ethics Committee and Executive Committee,” *American Journal of Transplantation* 9 (2009): 2466-69.

20. See Rick Luscombe, “The Declaration of Istanbul on Organ Trafficking and Transplant Tourism,” *The CANNIT Journal* 20, no. 2 (April-June 2010): 6.

practices, past and present, have failed to provide even the most elemental post-operative care for donors. As such, trafficking exemplifies a stark violation of human rights, particularly for those vulnerable groups for whom participation may seem the only way to realize and secure those fundamental rights.²¹

Unfortunately, this is just the beginning of a global account, much too long and winding, of a problem of tremendous domestic and international moral concern. These “transplant transactions,” as it were – a curious combination of “altruism and commerce; consent and coercion; gifts and theft; science and sorcery; care and human sacrifice”²² – suggest a critical need to revisit the fundamental moral illicitness of the trafficking enterprise. To be sure, the issues of immediate import to the trafficking conversation are manifold, and any singular analysis of topics, no matter how sweeping, will unavoidably fall short of adequacy. This essay thus aims to briefly address but three: (i) the principle of respect for human vulnerability, (ii) the contemporary enterprise of human organ trafficking, and (iii) the case in favor of a regulated market in organs.

1.2 Analytical Method

The present essay grounds its argument in two, straightforward premises: (i) the ethical principle of respect for human vulnerability is an indispensable measure of the licitness of most, if not all, moral actions; and (ii) human organ trafficking violates the ethical principle of respect for human vulnerability. Drawing from this syllogism, the aim and proposal of this essay is to examine the principle of respect for human vulnerability in the context of human organ trafficking with the intention of positing the argument that human organ trafficking cannot, in most, if not all, cases, be morally justified insofar as it violates the ethical principle of respect for human vulnerability. To secure the justification of this thesis, the current essay moves in three parts. First, it will address the ethical principle of respect for vulnerability, including a more specific analysis of the ontology of vulnerability, its place in contemporary bioethics, and its application in the context of organ trafficking. Second, it will sketch a general outline of the contemporary practice of organ trafficking, including a specific analysis of its global status and the trends and regulations with which it corresponds.

Third, it will address the case in favor of a regulated market in human organs, including a specific analysis of the relationship it shares with both the personal freedom and genuine – i.e., “full” – consent to commoditize the human body, as well as the logistical plausibility of safeguards as institutional methods by which to combat vulnerability. Finally, it will forward a persuasive argument, grounded in the analysis of Parts 1-3 (delineated as Sections 2, 3, and 4, respectively, in the essay), against the general practice of organ trafficking, highlighting the incongruity of bodily

21. Tazeen H. Jafar, “Organ Trafficking: Global Solutions for a Global Problem,” *American Journal of Kidney Diseases* 54, no. 6 (December 2009): 1145-46.

22. Scheper-Hughes, “Rotten Trade,” 197.

commodification²³ with social moral responsibility and personal integrity, as well as the broader illicitness of a regulated approach to compensated donation and its inescapable violation of the ethical principle of respect for human vulnerability.

Before proceeding, however, a note of clarification is in order. The purpose of this essay is not to illuminate the general moral illicitness of organ trafficking. Insofar as the practice relies explicitly on deception, coercion, and manipulation, that much is already clear. Rather, against the backdrop of a growing scarcity of organs globally, the aim of the current essay is to underscore the ethical principle of respect for vulnerability as the linchpin of the practice's refutation. Contemporary economic globalization, simultaneously effecting an increasing amount of displaced persons around the world,²⁴ suggests that revisiting the principle and its place as a safeguard in bioethical endeavors and analysis pertaining to issues of global justice – such as is found in the present context – is a task more timely than ever.

2. THE PRINCIPLE OF RESPECT FOR HUMAN VULNERABILITY

2.1 *The Ontology of Vulnerability*

The term “vulnerability,” derived from the Latin *vulnus*, meaning “wound,” might best be understood in the current context as “the susceptibility of being wounded.” Arising in the field of bioethics in the 1978 *Belmont Report*, its conceptual meaning has today become nebulous to the extent that it is often considered to lack meaning and is subsequently found to be of little practical use.²⁵ In the *Report*, vulnerability is addressed and mentioned in relation to both individuals and populations as a whole, in the sections on “voluntariness,” and “the systematic assessment of risks and benefits,” respectively. Of particular importance in the *Report* is the need for protection of vulnerable populations, particularly in biomedical research endeavors. The *Report* singles out particular populations – including “racial minorities, the economically disadvantaged, the very sick, and the institutionalized,”²⁶ – who should be protected against the possibility of being included in research solely for the purpose of convenience.²⁷

The ontological origins of the notion of vulnerability as present bioethical discourse were first introduced in the sphere of human experimentation, as characteristic

23. See Mark Schweda and Silke Schicktanz, “The ‘Spare Parts Person’? Conceptions of the Human Body and Their Implications for Public Attitudes toward Organ Donation Sale,” *Philosophy, Ethics, and Humanities in Medicine* 4, no. 4 (2009): 1-10.

24. Scheper-Hughes, “Rotten Trade,” 197.

25. Agomoni Ganguli-Mitra and Nikola Biller-Andorno, “Vulnerability in Healthcare and Research Ethics” in *The SAGE Handbook of Health Care Ethics: Core and Emerging Issues*, eds. Ruth Chadwick, Henk ten Have, and Eric M. Meslin (Thousand Oaks, CA: SAGE Publications, 2011), 239-50; see especially p. 240.

26. National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research, *Belmont Report: Ethical Principles and Guidelines for the Protection of Human Subjects of Research*, <http://ohsr.od.nih.gov/guidelines/belmont.html> (accessed December 15, 2012).

27. Contemporarily, this explicitly extends to children, pregnant women, prisoners, and people with intellectual and physical disabilities. See Ganguli-Mitra and Biller-Andorno, “Vulnerability in Healthcare and Research Ethics,” 240.

of particular individuals and populations most susceptible to maltreatment and abuse and who were typically the most poorly defended against historically.²⁸ The designation of population groups as vulnerable implies a positive duty to protect and defend them against the possibility of being maltreated or, as the original Latin implies, “wounded.” Since its birth, bioethics has attempted to justify this principle by underscoring the vitality of the principle of respect for autonomy and the consequent mandate of informed consent, which continues to grow increasingly inclusive and strict, for all persons making moral decisions in the clinical context. The principle of respect for autonomy²⁹ is not merely the acknowledgement of the capacity of persons to possess worldviews, make choices, and take actions based on idiosyncratic values; it also includes the effective effort to create the conditions, personal and social alike, within which to act on such worldviews, choices, and values.³⁰

While neither the 1978 *Belmont Report*, nor the WHO’s 1996 *Declaration of Helsinki*, nor the 2005 UNESCO *Universal Declaration on Bioethics and Human Rights* includes a specific philosophical definition of what is meant by “vulnerability” or “human vulnerability,” the best ontological understanding of the subject remains to be found in the 1972 text of Emmanuel Levinas, titled *Humanisme de L’autre Homme*, or “Humanism of the Other Man.” Levinas was the first to treat vulnerability as an important philosophical theme. Levinas begins his analysis of vulnerability by interpreting it as manifestation of “subjectivity.” For Levinas, the individual, subjective self always proceeds “otherness.” Thus, when the subjective self is made manifest, it is born into relationship with a preexistent other, which awaits its arrival. In this sense, the self is inescapably dependent upon this other and, hence, is vulnerable.³¹ As Levinas writes: “The Self, from head to feet, until the bone marrow, is vulnerability.”³² “Vulnerability” thus enters the philosophical scene as a state intrinsic to subjective phenomenology and as the fundamental condition of humanity insofar as the possibility of the self can exist only to the extent that it is in relationship with the other.³³

Hans Jonas, in his 1979 work *Das Prinzip Verantwortung*, or “The Principle of Responsibility,” adds to the philosophical understanding of the ontology of vulnerability. First, Jonas identifies vulnerability as the “perishable characteristic of what exists.” As such, vulnerability extends to all corners of nature and human experience, and thus renders human persons ontologically vulnerable at their core. As the natural state of the human condition, vulnerability is inerascably inherent to the finitude and fragility of

28. Hasan A. Khamash and Robert S. Gaston, “Transplant Tourism: A Modern Iteration of an Ancient Problem,” *Current Opinion in Organ Transplantation* 13 (2008): 395-99.

29. For an astute and detailed analysis of the principle of respect for autonomy, see Tom L. Beauchamp and James F. Childress, *Principles of Biomedical Ethics*, 6th ed. (New York: Oxford University Press, 2009), 99-148.

30. Maria Patrão Neves, “Article 8: Respect for Human Vulnerability and Personal Integrity,” in *The UNESCO Universal Declaration on Bioethics and Human Rights: Background, Principles and Application*, eds. Henk A. J. M. ten Have and Michèle S. Jean (Paris: UNESCO Publishing, 2009), 156.

31. Patrão Neves, “Article 8: Respect for Human Vulnerability and Personal Integrity,” 157-58.

32. Emmanuel Levinas, *Humanisme de L’autre Homme* (Paris: Fata Morgana, 1972), 104; translated from French by Patrão Neves, “Article 8: Respect for Human Vulnerability and Personal Integrity,” 158.

33. Patrão Neves, “Article 8,” 158.

human experience. Hence, it is unable to be eliminated or erased, and requires the care of others as manifest in their solidarity with, and non-exploitation of, that vulnerable condition. In this sense, vulnerability can be seen to constitute a major theme in bioethics as well as a core principle to be respected. This point was iterated in the 1998 *Barcelona Declaration*,³⁴ counting the vulnerability among its four fundamental principles of joint European policy related to ethics and law. As the *Declaration* describes it, vulnerability is a twofold notion expressive of (i) finitude and fragility of human life, which (ii) grounds the possibility to act morally for those who possess autonomy. Those most deserving protection are persons whose autonomy, dignity, or integrity are threatened.³⁵

2.2 The Principle and its Place in Contemporary Bioethics

The principle of respect for human vulnerability is both complex and confusing. It therefore invites curiosity over whether the principle is ipso facto futile or useful, particularly as applied in concrete biomedical circumstances. Growing attention to the concept of vulnerability in health care as manifest in policy documents, medical research, and the academic literature from which each are developed offers competing, and at times contradictory, understandings of the principle, issuing a conflicting impression of the place of the principle in contemporary bioethics. A first flawed approach is a much too broad notion of principle. This is the case, for example, of the first serious attempt to develop a normative justification and consolidation of the principle, launched by a group of European scholars in 1995. The aim of the research initiative was to examine the “great principles of bioethics and biolaw” with the help of continental European philosophy and theology to develop a theoretical and principle-based framework that could compete with the fourfold principled-approach of Georgetown University’s Tom Beauchamp and James Childress. This alternative approach coupled one of Beauchamp and Childress’ principles, namely, autonomy, with the principles of dignity, integrity, and vulnerability.³⁶

Of the four principles listed by the group, vulnerability is understood to be ontologically prior to the others. This is due to its presumed ability to express the fragility of the human populous more concretely than its complimentary principles. Hence, vulnerability should be viewed as an inherent aspect of human persons and not, as mentioned above, something that might be done away with through scientific and medical research. As such, it may be viewed as a principle that unites moral strangers, bridging the gap and regulating ethical discourses within the global community. For these reasons, the principle of respect for human vulnerability can be understood as a principle that serves as the biopolitical nucleus of contemporary global welfare.³⁷

34. *Barcelona Declaration*, <http://www.ethicslaw.dk/publication/THE%20BARCELONA%20Dec%20Enelsk.pdf#search=%22Barcelo na%20Declaration%20Bioethics%22> (accessed December 15, 2012).

35. Patrão Neves, “Article 8,” 158.

36. Solbakk, “Vulnerability,” 229.

37. Solbakk, “Vulnerability,” 230.

However, this understanding of vulnerability continues to receive mixed reviews with contemporary scholars. One critique, mentioned above, is the broadness of its scope, rendering the principle too vague to provide clear and comprehensive moral guidance. Another centers on the fact so many groups, particularly in the context of international research, are now considered to be vulnerable that it seems to bankrupt its moral force. On the other hand, even an overbroad understanding can be interpreted as too narrow to be helpful, risking such attention to the minute details of specific groups as to ignore the broader, basal needs of non-vulnerable participants in research. This last element also runs the risk of proving a manifestation of stereotyping. Even if the broad needs of the particularly vulnerable groups are met, that might be insufficient to meet the more specific needs of the most vulnerable persons belonging to generally vulnerable groups. The more imminent failure still of the European research initiative is the principlist language with which it couples vulnerability, namely, autonomy, integrity and dignity. Such language unavoidably fall victim to the “deontic and purports to represent moral requirements rather than the anthropological hallmarks they really are.”³⁸

A second flawed approach is an intentionally narrow conception of vulnerability. This is the approach, for example, reflected in both the *Belmont Report* and the *Declaration of Helsinki*. This restrictive, minimalist, consent-based approach justifies protection of vulnerable persons on the basis of their inability to provide free and informed consent to participation in treatment. Such a conception, however, is too narrow in terms of its actual ability to cover the entire enterprise of vulnerability in biomedical research and clinical practice. For this among other reasons, the concepts of fairness, harm, wrong, and power have been interjected to address complex situations within which additional safeguards to protect vulnerable groups – such as those related to consent and the upholding of other ethical standards – are required. In this sense, vulnerability can be understood and identified as that likely occurrence of additional or greater wrong than can otherwise be expected in a particular scenario.³⁹

The question remains of how the principle of respect for human vulnerability ought to best be applied in light of the aforementioned critiques. Within the field of clinical medicine, the principle of respect for human vulnerability helps, if nothing else, to reinforce the autonomous rights of individual patients. Simultaneously, it appeals to the health profession generally by establishing a “symmetrical relationship” with patients and forces individual health care organizations to protect persons even when they do not issue a complaint. The needs and interests of vulnerable populations should therefore never be underestimated, which means that the principle that commands respect for vulnerable groups, both socially and internationally, exemplifies that the benefit of some should not be secured through the exploitation of others. It also signifies that improvements in the well-being of some will only render the rest – those who find themselves excluded – more vulnerable still. Moreover, the principle also signifies a new understanding of the human body and disease in that, in light of the principle, the body is no longer an object but a subject inseparable from the human person with whom it attaches. At the level of experimentation, it demands a new level of communication

38. Solbakk, “Vulnerability,” 230-31; quotation from p. 231.

39. Solbakk, “Vulnerability,” 231-34.

between patient and physician, forcing the latter to focus more on the person treated than the corresponding illness. In short, then, the principle of respect for human vulnerability commissions a new logic into moral reflection “which no longer implies the claim of persons’ rights by the solicitude of obligations that are due to all. . . .”⁴⁰

3. THE ENTERPRISE OF HUMAN ORGAN TRAFFICKING

3.1 *Status Quaestionis*

Countries that have voluntarily facilitated organ trafficking, such as Pakistan⁴¹ and the Philippines, do not release specific data related to the amount of foreign patients that travel to these countries in hope of securing transplantable organs. According to one report coming out of the Philippines, “a quota of foreign nationals was intended but there has been no report of data to indicate that such a stipulation has been fulfilled.”⁴² Despite its secretive nature and the frequent difficulties obtaining pertinent data, the extent of organ trafficking has become vividly evident through visits by researchers and by reports prepared for presentation at the WHO. According to data collected by the Sindh Institute of Urology and Transplantation, at least 2,000 kidneys transplants have been performed in Pakistan to “transplant tourists” participating in trafficking practices. One esteemed nephrologist in Port of Spain Trinidad reported to have witnessed some 80 patients traveling from Trinidad to Pakistan to purchase organs. In the Philippines, a February 2007 newspaper account reported that some 3,000 kidney sales had been transacted that year, leading the WHO to hold a regional consultation in Manila to call attention to its objection to trafficking and the rampant commercialism being practiced globally. The Cebu Province of the Philippines is now reported to be seeking out new organ sale endeavors to increasing commercial transplants in the Philippines.⁴³

Egyptian transplant professionals have estimated that Egypt performs at least 500 kidney transplants annually, a majority of which are performed from commercial living donors. One study reports that transplant tourists participating in trafficking have underdone kidney transplantation with tsunami victims in Chennai, India. Meanwhile, at the WHO regional consultation in Slovenia, a Moldovan representative reported the request of Israeli physicians to bring tourism to their country. The request was ultimately denied but, at current, there is no penalty for Israeli insurance companies who facilitate transplants to occur beyond the country’s borders.^{44, 45} As many as twenty Israeli patients may undergo kidney transplantation in the Philippines each month. The consequence for

40. Patrão Neves, “Article 8,” 162-63; quotation from p. 263.

41. For a superb analysis of state of organ trade in Pakistan, see Mozam et al., “Conversations with Kidney Vendors in Pakistan: An Ethnographic Study,” *The Hastings Center Report* 39, no. 3 (2009): 29-44.

42. Budiani-Saberi and Delmonico, “Organ Trafficking and Transplant Tourism,” 926.

43. Budiani-Saberi and Delmonico, “Organ Trafficking and Transplant Tourism,” 926.

44. See Susanne Lundin, “Organ Economy: Organ Trafficking in Moldova and Israel,” *Public Understanding of Science* 21, no. 2 (2012): 226-41.

45. See Leevan, “Comparative Treatment of Human Organ Trafficking,” 1-35.

Israel manifests itself in the lost expertise of Israeli transplant surgeons.⁴⁶

At the Second Global Consultation of Human Transplantation at the WHO headquarters in Geneva in 2007, one scholar⁴⁷ assembled a sampling of the trafficking by the analysis of medical databases such as Lexis/Nexis, MEDLINE, PubMed academic journal articles, and Google searches that included media sources related to transplant tourism. He found that some five to ten percent of kidney transplants performed annually around the globe were the product of organ trafficking. The credibility of his estimate was supported by the following data: at least 100 nationals from countries such as Saudi Arabia (700 in 2005), Taiwan (450 in 2005), Malaysia (131 in 2004), and South Korea (124 in the first eight months of 2004) went abroad to participate in transplant commercialism. Additionally, approximately twenty nationals from countries including Australia, Japan, Oman, Morocco, India, Canada, and the United States traveled as tourists to participate in trafficking. More striking still is the observation of the data coming out of China⁴⁸ in the summer of 2007. In 2006, 11,000 transplants were performed from executed prisoners. Of the 11,000 organs, 8,000 were kidneys, 3,000 were livers, and 200 were hearts. The 8,000 kidney transplants in China in 2006 would account for ten percent of the total number of transplants performed globally in trafficking programs. China's recently adopted Human Transplantation Act, which bans commercialism, has reduced the number of transplant to foreign patients by fifty percent. Nonetheless, the reduction in Chinese transplant activity has presumably been replaced by an increase in Philippine organ trafficking.⁴⁹

3.2 Trends and Regulations

With these statistics in mind, this essay now moves to consider the trending medical effects and reactive regulations on the emerging worldwide population of live kidney donors who travel to participate in tracking practices.^{50, 51, 52} In Pakistan, medical follow-up data suggests that long-term outcomes for patients – if such patients are among the select few who receive the novelty follow-up care – is very troubling. The majority of donors in Pakistan – approximately ninety-three percent – who sold a kidney to repay a debt reported that they remained unable to pay their debt and received no economic improvement in their lives. Their objective in selling their organs for a profit proved, therefore, practically useless, painful, and unfulfilling. Such a disturbing report is not only a record of Pakistani experience but also serves as an indictment of the international transplant community inasmuch as it drastically overlooks the vulnerable plight of the

46. Budiani-Saberi and Delmonico, "Organ Trafficking and Transplant Tourism," 926-27.

47. See Shimazono, "The State of the International Organ Trade," 995-62.

48. See Allan M. Concejero and Chao-Long Chen, "Ethical Perspectives on Living Donor Transplantation in Asia," *Liver Transplantation* 15 (2009): 1658-61.

49. Budiani-Saberi and Delmonico, "Organ Trafficking and Transplant Tourism," 927.

50. For a more specific and comprehensive view of this issue, see Jafar, "Organ Trafficking," 1145-57.

51. For another, more comprehensive vision of the scope of the issue, see Eytan Mor and Hagai Boas, "Organ Trafficking: Scope and Ethics Dilemma," *Current Diabetes Reports* 5 (2005): 294-99.

52. For a sociological perspective on the issue, see Miran Epstein, "Sociological and Ethical Issues in Transplant Commercialism," *Current Opinion in Organ Transplantation* 14 (2009): 134-39.

donor whose interests remain equally valid to that of the recipient. Moreover, research out of Egypt, where it is prohibited to transplant organs from deceased donors, indicates that seventy-eight percent of commercial living donors reported a significant deterioration in their general health condition. This is likely the result of insufficient medical donor screening for donation, examination of preexisting medical conditions, and the labor-intensive conditions into which the donor often returns immediately following surgery. Follow-up studies suggest that eighty-one percent of donors spent the money received within five months after nephrectomy, most typically to pay off financial debts rather than investing the money in socio-economic tools to improve quality of life.⁵³

Studies from Pakistan and Egypt are consistent with findings in India, Iran, and the Philippines that reveal deterioration in the health conditions of commercial living donors. A long-term financial disadvantage is also evident following long-term nephrectomy due to inability to generate an adequate income level prior to donation. Common experience in these countries therefore suggest social rejection and regret about participation in trafficking. Such reports are consistent with interviews with donors who explain clearly and emphatically that a cash payment does not solve the vulnerable state of destitution.⁵⁴ Conversations with kidney vendors in Pakistan are the most revealing regarding the manifold plights suffered following nephrectomy. One ethnographic study includes the narratives and conversations of researchers and donors. Among the numerous issues identified are those related to surgical pain, incision “prickling,” and muscle spasms, which continued to recur in some individuals three years after surgical scars had healed.^{55, 56}

Other issues reported from the Pakistani experience suggest feelings of inhumanity (surgical incision scarring left some feeling they were half the person they once were), fear about the remaining kidney (including what will happen if the kidney fails to thrive in the future), a sense of hopelessness (as many as fifty percent of those interviewed experienced severe anxiety and profound sense of lost meaning in life), feelings of regret (related to the despair that the act did not help their financial lot and feelings of betrayal to the divine via participation in the exchange), and feelings toward the medical profession and medical professionals, generally of curiosity over whether individual patient’s lives were valued as much as the next (the impetus of which includes a lack of sympathy and general engagement by the medical staff). The conversations in the study include many who would not recommend anyone to sell a kidney – for any reason. When petitioned why the subjects had themselves participated, the most common response was “extreme poverty.”⁵⁷

Against this background, the imminent need for thoroughgoing regulation of national organs allocation is clear. The question of what alternatives exist is therefore

53. Budiani-Saberi and Delmonico, “Organ Trafficking and Transplant Tourism,” 927-28.

54. Budiani-Saberi and Delmonico, “Organ Trafficking and Transplant Tourism,” 928.

55. Mozam et al., “Conversations with Kidney Vendors in Pakistan,” 33.

56. For other physiological complications related to participation in trafficking, see Shimazono, “The State of the International Organ Trade,” 995-62.

57. Mozam et al., “Conversations with Kidney Vendors,” 33-37.

necessarily raised. While little regulation exists in the countries most culpable for exacerbating the vulnerable plight of those who participate due to conditions of poverty, this essay will here attempt to issue some reasonable suggestions for improvement. Among them is that each country would do well to consider establishing a system of deceased organ donation. At a WHO Regional Consultation on Developing Organ Donation from deceased donors, held in Kuwait City in 2007, transplant professionals from Bahrain, Iran, Jordan, Kuwait, Lebanon, Libya, Morocco, Oman, Pakistan, Qatar, Saudi Arabia, Sudan, Syria, Tunisia, United Arab Emirates, and Yemen supported such an expansion. Each opposed commercialism, trafficking, and transplant tourism, including the use of brokers and medical professionals who advertise such services for economic benefit. The Statement from Kuwait suggested that each country (i) develop a legal framework and national self-sufficiency in transplantation, (ii) must have a transparency of transplantation practices, (iii) should disallow their insurance companies to supporting such illegal practices as organ trafficking and transplant tourism. In addition to this list, countries would also do well hold pharmaceutical and insurance companies accountable for their engagement in the process, imposing fees and penalties.⁵⁸

4. THE CASE IN FAVOR OF A REGULATED MARKET IN ORGANS

4.1 Personal Freedom and Genuine Consent to Commodification

A first argument in favor of a regulated market in organs grounds itself in the refutation of organ donation for profit as an illicit means of treating the human body – namely, treating its parts as commodities to be bought and sold. As the argument goes, the effort to avoid recasting spare human body parts or hoarding scarce medical resources is not a challenge idiosyncratic to financial transactions, and is not, therefore, a legitimate objection to offering financial compensation to increase the occurrence of living organ donation. Such a concern is one to be addressed under any system of organ procurement. In this light, kidney donation, viewed as an altruistic gift, whether the product of trafficking or not, is seen to be entirely illusory rhetoric insofar as it applies to actors in the system rather than just the specific donor.⁵⁹

Donors, surgeons, organ procurement agencies, and recipients each objectify organs, treat them as convertible objects, and charge fees for access to organs. In other words, a significant amount of money changes hands within the walls of hospitals. If this is so, a regulated market in organs can be seen as no more harmful. Ongoing discussions regarding the moral permissibility of financial compensation, or other valuable incentives, do not concern whether human organs should be commoditized, but rather who should receive valuable health care and who should bear the astronomical costs. In this vein of thought, the very act of legally prohibiting financial compensation for donation renders organs a highly constrained commodity, where donors are required to

58. Budiani-Saberi and Delmonico, “Organ Trafficking and Transplant Tourism,” 928.

59. Mark J. Cherry, “Embracing the Commodification of Human Organs: Transplantation and the Freedom to Sell Body Parts,” *Saint Louis University Journal of Health Law and Policy* 2, vol. 2 (2009): 365-66.

part with their physical property without material compensation while others (including physicians, hospitals, procurement agencies, and the like) benefit financially, in terms of both quality and quantity of life, being able to successfully and healthily return to work, a drastic reduction in medical bills, and the like.⁶⁰

The awarding of college scholarships is used in one author's⁶¹ argument to drive home the aforementioned points. In this logic, castigating raw financial incentives for kidney donation in favor of the more rhetorically acceptable college scholarship award – because college scholarship incentives might be seen as a means by which to preserve altruism (even though altruism in the current context is denounced as illusory and overly rhetorical) – strikes this proponent as a manifestation of deceptive marketing. In fact, it might be viewed as a policy that specifically designed to seduce healthy members of society into parting ways with what is their very valuable property in the name of altruism, within what is otherwise known to be a commercial transaction, thereby further complicating what ought to be a transparent and honest medical process.⁶²

The author finally suggests that even college educations – in absence of the aforementioned scholarships – might licitly be purchased through compensation for kidney donation, and that both federal and state governments may even be convinced to treat the “purchase” as a non-taxable transfer of resources. However, regardless of this hypothetical suggestion, the public has already discovered the commercialization of human bodies. Moreover, the argument goes, financially compensating donors would also significantly enhance the fairness than the current prohibition on payments. That human organs might be transferred at a price of zero does not ipso facto reduce the significance of their value to zero. Rather, it straightforwardly transfers the value of the organ from donor to recipient. College scholarships are surely one type of compensation, but prospective donors may welcome the opportunity to improve their financial status even if they do not possess a desire to attend college, or to support another through college. Failing to acknowledge that human organs are a valuable commodity that can be shared at a price encourages the continuation of a dishonest society and public policy in what is otherwise a very financially valuable commercial transaction.⁶³

4.2 Institutional Safeguards as Combating Vulnerability

A second argument in favor of a regulated market in human organs grounds itself in a vigorously regulated approach. In this line of thinking, a defensible market in commercialized organs should minimally have the following four characteristics: (i) the priority of safety of the vendor and the recipient; (ii) transparency regarding risks to the vendor and recipient, and regarding institutional outcomes and follow-up care; (iii) institutional integrity with regard to establishing guidelines that broadly reflect the conditions under which a given institution will and will not participate in organ vending, including a mechanism of mediating institutional financial conflicts of interest; and (iv)

60. Cherry, “Embracing the Commodification,” 366.

61. See Cherry, “Embracing the Commodification,” 359-78.

62. Cherry, “Embracing the Commodification,” 366.

63. Cherry, “Embracing the Commodification,” 366-67.

operation under a rule of law, providing an avenue of enforceable redress if contractual obligations are violated.⁶⁴

Regarding safety and transparency, one argument suggests that, along with moral value, safety and transparency have market value. If it is true that the desperation of vendors and recipients motivates them to overlook the manifold risks that accompany participation in trafficking practices, an alternative without hazards might become increasingly more appealing, and would therefore be more likely to be socially accepted. In fact, the market value of safety itself would succeed where moral prohibition and legal sanction may have previously failed in reducing the practice of trafficking. In this view, one might correctly object that viewing safety and transparency merely as market values actually opens up the possibility that safety might be compromised in exchange for a reduction in cost for the recipient, or, conversely, an increase in compensation to the vendor. However, when safety and transparency are also viewed as concrete moral obligations on the part of transplant professionals, standards of proof regarding safety become clearer and the burden of proof lies firmly within transplant centers to be transparent regarding safe practices.⁶⁵

Regarding institutional integrity, one author⁶⁶ suggests that, because nothing obligates vendors, donors, recipients, transplant professionals, or transplant centers to participate in organ markets,⁶⁷ by fashioning a policy on an institutional level, vendors, donors, and recipients with compatible moral commitments can cooperate with one another, and, unlike the current system, the rights of each can remain respected in full. A regulated approach will also ensure better medical care, such as allocating kidneys based on precise HLA-matching. Alternatively, in conjunction with willing transplant organizations, some waiting-list recipients may choose to bargain with the state, offering Medicare an opportunity, for example, to save the cost of lifetime dialysis welfare in exchange for acting as a purchasing agent for a transplantable kidney and decades of coverage for immuno-suppression medication. The more specific content of individual institutional policy would be of less relevance than the more general requirement for institutions to formulate policy that adequately articulate the moral commitments of the institution's members.⁶⁸

Regarding rule of law, the author suggests that legislative oversight of an organ market would ensure that standards of safety are met, ensure good-faith enforcement of contracts between vendors and other entities, and serve to protect against fraudulent behavior. In the context of the organ market, this argument suggests that the law should play a twofold role. First, rule of law should have a productive function that facilitates freely consented-to arrangements between individuals and individual institutions. Second,

64. Hippen, "In Defense of a Regulated Market," 611-612.

65. Hippen, "In Defense of a Regulated Market," 612-13.

66. Hippen, "In Defense of a Regulated Market," 593-626.

67. For an interesting perspective on organ markets and the ends of medicine, see F. Daniel Davis and Samuel J. Crowe, "Organ Markets and the Ends of Medicine," *Journal of Medicine and Philosophy* 34 (2009): 586-605.

68. Hippen, "In Defense of a Regulated Market," 613.

rule of law should be so designed as to protect the contractual and personal rights of vendors, donors, recipients, professionals, and institutions. The productive functions of law might include provisions for a common market in which individuals can negotiate terms, as well as opportunities for vendors to bargain with the State regarding value of exchange rates. The protective functions include designing sample contracts that satisfy the side-constraints of safety and transparency, offering mediation mechanisms by which to resolve conflicts pertaining to financial inducements to increase vending through the breaching of safe practices.⁶⁹

5. THE CASE AGAINST HUMAN ORGAN TRAFFICKING

5.1 *Against the Commodification of the Human Body*

As is clear above, arguments favoring regulated sales of organs⁷⁰ argue against social science paternalism and on behalf of individual rights, bodily autonomy, and the right to sell one's organs, tissues, blood, or other body products⁷¹ continue to gain currency in contemporary academic circles. Moreover, some have argued from a pragmatic position that regulation rather than prohibition or moral condemnation is the more appropriate response to a practice that is already widely established in numerous parts of the world.⁷² What is needed, the argument goes, is rigorous oversight and the adoption of donor bills or rights to inform and protect prospective organ sellers.⁷³ However, the problem with markets generally is that they reduce everything – including human beings, their labor, and their capacity to reproduce – to the status of commodities that can be bought and sold, traded, and stolen.⁷⁴ Nowhere is this more dramatically visible than in the market for human organs and tissues.⁷⁵

As this essay has attempted to underscore through the delineation of statistics, trends, current regulations, and patient narratives, in the developing world, vulnerable populations, particularly those most poor, cannot really “do without” their extra organs. Transplant surgeons have disseminated an untested hypothesis of so-called “risk-free” live donation in the absence of any published, longitudinal studies regarding the effects of organ removal on the poor. Organs Watch, a medical human rights group affiliated with the University of California, Berkeley, has found that living kidney donors from slums, inner cities, or prisons face extraordinary threats to their health and personal security through violence, accidents, and infectious diseases, which can all too often easily

69. Hippen, “In Defense of a Regulated Market,” 613-14.

70. See Cherry, “Embracing the Commodification,” 359-78.

71. For a fine introduction to the boundaries of personhood, equity, and community in biomedicine, see Patricia A. Marshall, “Introduction: Organ Transplantation – Defining the Boundaries of Personhood, Equity, and Community,” *Theoretical Medicine* 17 (1996): v-viii.

72. See Hippen, “In Defense of a Regulated Market,” 593-626.

73. Nancy Scheper-Hughes, “The Global Traffic in Human Organs,” *Current Anthropology* 41, no. 2 (2000): 197.

74. For an interesting perspective concerning the “dignity” of trafficking participants, see Kishore, “Human Organs, Scarcity, and Sale,” 362-65.

75. Nancy Scheper-Hughes, “The Ends of the Body: Commodity Fetishism and the Global Traffic in Organs,” *SAIS Review*, vol. XXII, no. 1 (Winter-Spring 2002): 62.

compromise their remaining kidney. As the use of live kidney donors has moved from the industrialized West, where it typically takes place among relatives who are themselves highly privileged, to areas of risk in the developing world,⁷⁶ transplant surgeons have become complicit in the needless suffering a hidden and vulnerable population.⁷⁷

In all these transactions, the integrity of the body, so far as it can be known, is radically transformed. The integration of the body and its parts as naturally given is exchanged for a divisible body in which individual organs and tissues can be detached, isolated, and, worse still, sold. This points to the demise of classical humanism, holism, and the personal responsibility with which each corresponds, eventuating in an “ethics of pieces” – part histories, part truths, and now divisible bodies in which detached organs emerge as market economies, as “fetishized objects of desire and consumption.”⁷⁸ Contemporary bioethical arguments concerning the right to sell an organ or other body part are based on Western notions of contract and individual, autonomous “choice.” But the social and economic contexts in which organ trafficking is practiced makes the “choice” to sell a kidney anything but “free” and “autonomous.” The idea of consent is deeply problematic when one has no other option to sustain one’s family than to sell an organ to do so.⁷⁹

Assigning a market price to body parts – even a potentially fair one – unavoidably exploits the desperation of the poor, suddenly transforming suffering into what seems like opportunity. Moreover, asking law to negotiate a fair price for a living human kidney flies in the face of everything contract theory stands for. When concepts like individual agency and autonomy are invoked to defend the “right” to sell organs, ethicists might rightly suggest that certain “living” things are not alienable or proper candidates for commodification. Further, the surgical removal of non-renewable organs is an act in which medical professionals, given their ethical standards, should not be asked to participate. In this sense, even the argument for regulation proves to be out of touch with the social and medical realities operating in many parts of the world, and especially in developing nations. Statistics alone suggest that tools developed to monitor organ harvesting and distribution through trafficking practices is often dysfunctional, corrupt, or compromised by the power of organ markets⁸⁰ and the exemption of organ brokers and maverick surgeons willing to violate the first premise of classic biomedical ethics: first, do no harm.⁸¹

Clarity is hence needed amidst the tension between donors and recipients, between physicians and patients, between individuals and the State, and between the illegal and the merely unethical about whose values and which notions of the body and embodiment are being represented. Transplant surgeons must pay more attention to where organs come from and the manner in which they are procured. There must be firm

76. Rashad S. Barsoum, “Trends in Unrelated-Donor Kidney Transplantation in the Developing World,” *Pediatric Nephrology* 23 (2008): 1925-29.

77. Scheper-Hughes, “The Ends of the Body,” 77.

78. Scheper-Hughes, “The Ends of the Body,” 78.

79. Scheper-Hughes, “The Ends of the Body,” 78.

80. See Shimazono, “The State of the International Organ Trade,” 995-62.

81. Scheper-Hughes, “The Ends of the Body,” 78.

assurances that donations everywhere is voluntary and uncoerced, especially among vulnerable populations. Finally, the risks and benefits of organ transplantation ought to be more equally distributed within nations, ethnic groups, genders, and social classes. The division of the world into organ buyers and sellers is a medical, social, and moral tragedy of immense and as yet unrecognized proportion.⁸²

5.2 Against the Regulated Approach to Compensated Donation

As mentioned above, some have argued⁸³ from a pragmatic position that regulation rather than prohibition or moral condemnation is the more appropriate response to a practice that is already widely established in numerous parts of the world.⁸⁴ However, several problems remain for this view of organ markets. The first concerns the ambiguity of “safe practices” and conflicts of interest. The limitations and controversies in the current literature on the evaluation of long-term outcomes should be of critical concern in the moral evaluation of the licitness of a regulated market in organs. In the context of abuses of organ trafficking, the burden of proof lies within transplant institutions to prove that organ donors have been properly evaluated and that vendors can safely vend. Though donors are routinely notified of the risks as they arise, the unique position of the donor role can conspire both potential donors and transplant professionals to judge that the benefits outweigh the burdens that do not rise to the level of absolute surety. This problem is only complicated by the dynamics of the organ market itself, which may influence a number of vendors and transplant professions – even acting in good faith – to modify judgments about which risks are acceptable and which are not. Moreover, financial incentives are likely to motivate either vendors or professions to act in bad faith by deliberately setting aside data indicating greater risk. Hence, a slippery slope to the exploitation of the vulnerable becomes vividly clear.⁸⁵

A second problem regards vendors from nations that do not afford protections which fulfill side-constraints, such as transparency. As is clear by now, organ trafficking operates outside the law of most countries. The success of a legalized organ market governed by side-constraints therefore already rests on fragile trust. It requires trust in transplant professionals and institutions operating according to a moral and professional commitment to place the safety of the vendor first, and in accord with rules of law that protect the contractual rights of vendors that is credibly enforced. When some vendors, even apart from the pressures of organ brokers of the severe constraints of poverty, might be prepared to bypass the standards of safety, transplant professionals have a moral obligation not to participate in the vendor relationship that violates the side-constraint of safe practices. It is possible that some vendors, frustrated at being turned away by transplant centers that take the side-constraints seriously, will turn to organ brokers and organ trafficking. This much would only contribute to the abuse of already vulnerable

82. Scheper-Hughes, “The Ends of the Body,” 78-79.

83. Hippen, “A Regulated Market,” 593-626.

84. Scheper-Hughes, “The Global Traffic in Human Organs,” 197.

85. Hippen, “A Regulated Market,” 615.

populations.⁸⁶

A third problem concerns limits on the fungibility of organs as a commodity. As the previous subsection states, viewing organs as “things” that can be permissibly bought and sold raises the question of whether entities other than the buyer and seller can legitimately claim property right over an organ. In the case of deceased donor organs, this question is partially addressed by the model of a market whereby the organ of a living person is purchased in advance, and the property right is transferred upon death to the possessor of an “organ future.” This is by no means an idle concern. Hospitals in numerous developing countries have conspired to dispose of transplantable organs from potential deceased donors to avoid damaging the underground trade in organs from live vendors. Other commentators in India have observed that the presence of organ trafficking ultimately dilutes the political will to institute a robust program for deceased donor procurement. This is conceptually identical to the owner of an organ future destroying an organ to manipulate the value of competing financial interests. Even if the absence of such a robust program is clandestine, the lack of a program that results in an increase in demand for organs from living vendors is a system that benefits organ trafficking, which in turn inescapably preys upon the poor.⁸⁷

A final problem explicitly involves the selling of organs as commodities. Since the vendor is selling an organ while alive, an organ, viewed as a commodity, could also be viewed as a valuable asset by third parties who have other financial relationships with vendors. As noted above, vendors may choose to sell their organs for a wide variety of reasons, including, most commonly, the repayment of accumulated debts. If this practice is permissible, and absent alternative means of payment, the question of whether a creditor may require the sale of an organ – either for living vendors or after death – for the purpose of debt repayment is raised. If an organ, viewed as property, is part of the estate of the living or deceased vendor, this question tests the limits of a vendor’s “right to vend” and a forbearance right. If it is permissible to allow vendors to sell their organs and use the exchange to benefit their own ends, it seems arbitrary to prohibit third parties from insisting that vendors requisitely fulfill a financial obligation by selling a kidney. This much proves to be yet another slippery slope to exploitation of the most vulnerable in society.⁸⁸

6. CONCLUSION

The principle of respect for human vulnerability, including the ontology of vulnerability, its place in contemporary bioethics, and its application in the context of organ trafficking; the contemporary enterprise of human organ trafficking, including its global status and the trends and regulations with which it corresponds; and the case in favor of a regulated market in organs, including the relationship it shares with both personal freedom and genuine – i.e., “full” – consent to commoditize the human body, as well as the logistical plausibility of safeguards as institutional methods by which to

86. Hippen, “A Regulated Market,” 616.

87. Hippen, “A Regulated Market,” 617-18.

88. Hippen, “A Regulated Market,” 618.

combat vulnerability, are but three issues of principle significance in the debate over the moral licitness of human organ trafficking. Drawing from the twofold premises that (i) the ethical principle of respect for human vulnerability is an indispensable measure of the licitness of most, if not all, moral actions; and (ii) human organ trafficking violates the ethical principle of respect for human vulnerability, the aim and proposal of this essay has been to examine the principle of respect for human vulnerability in the context of human organ trafficking with the intention of positing the argument that human organ trafficking cannot, in most, if not all, cases, be morally justified insofar as it violates the ethical principle of respect for human vulnerability. To this syllogistic end, it has been successful.

The implications here are significant. To be sure, the reality of organ trafficking and the abuse of vulnerable populations through participation in compensated donation is a genuine and growing fear. But rather than allowing it to terminate human progress, may it instead serve to remind that while the benefits of transplant capacities are important, how and how far they are utilized is more important still. On a conclusory note, it is worth underscoring again that the principal thesis pursued herein has been an inexhaustive attempt to nail down an argument in favor of the general moral prohibition of participation in organ trafficking – or for any participation in a compensated donation program whereby vulnerable populations are unavoidably targeted. Hence, exceptions may exist. Still, the impetus to continue the exploration of transplant techniques and related therapies therapy to assist individuals to donate and receive organs uncoerced and free of manipulation should remain a priority of contemporary biomedical research.

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