WHY WE SHOULD NOT PAY FOR HUMAN ORGANS

by Francis L. Delmonico and Nancy Scheper-Hughes

Abstract. The right to buy and sell human organs is challenged by the authors within the framework of a broad Christian perspective. Opposition to organ sales is argued in the light of the developing underclass of poor organ donors throughout the world who sell their organs to the rich. Very often neither the donors nor the recipients are fully informed about the medical risks involved in the procedure of organ transplantation.

Keywords: Christian perspective; demand; free market; gift; kidney donation; self-sacrifice; supply.

Organ transplantation is arguably the most intensely social of all medical practices. Its very existence relies upon a unique trust between society and its physicians, and it is dependent on the willingness of ordinary people to share their organs and tissues with a mortally sick loved one or even a stranger. From the outset, the language of organ sharing and transplantation has been extremely idealistic, strongly ethical, and (in an unrecognized, subliminal sense) also very Christian. While exhortations to altruism and heroic acts are found in all the world's religions, the emphasis of organ donation on bodily self-sacrifice and charity toward strangers resonates with the life, death, and teachings of Jesus. Indeed, the Last Supper and the Crucifixion offer the faithful a divine model of self-sacrifice and bodily sharing that to this day may motivate acts of organ sharing for transplantation. These strong symbolic equivalencies between secular transplantation

Francis L. Delmonico is Director of the Renal Transplantation Unit at Massachusetts General Hospital, the medical director at the New England Organ Bank, and Professor of Surgery at Harvard Medical School, Department of Surgery, Massachusetts General Hospital, 55 Fruit St., Wnt 505, Boston, MA 02114; e-mail francis_delmonico@neob.com. Nancy Scheper-Hughes is Director of Organs Watch and Professor of Medical Anthropology at the University of California at Berkeley; Medical Anthropology, 305 Kroeber Hall, Berkeley, CA 94720; e-mail nsh@sscl.berkeley.edu. This essay first appeared in *National Catholic Bioethics Quarterly* 2 (Autumn 2002), 381–89, and is reprinted with permission.

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ethics and a sacramental approach to life fostered an early acceptance of organ transplantation by the Roman Catholic Church, even though it necessitated the consideration of a new definition of death by brain criteria.[1]

More recently, the acceptance of brain death was made explicit by Pope John Paul II in his "Address to the XVIII International Congress of the Transplantation Society" (2000) while he simultaneously confirmed a principle of bodily integrity in stating that the "human body cannot be considered a mere complex of tissues, organs, and functions" (John Paul II 1991). He reinforced the transplant ethic of altruism and empathy for strangers that are the prerequisites for cadaveric organ sharing, and condemned an emerging commerce in human organs from live donors "because to use the body as an 'object' is to violate the dignity of the human person" (John Paul II 2000).

Today, the concept of the donated organ as a "gift" is under assault in many countries where payment for kidneys from living donors has become a lucrative business for clinics catering to wealthy nationals and foreign patients (Scheper-Hughes 2000; 2002; Finkel 2001). Consequently, organ donation from the deceased and genetically related living kidney donation are being supplanted by transplants using kidneys purchased from strangers. Though illegal in almost every nation, kidney commerce is not actively prosecuted because of the prevailing dominance of a market-oriented ethos and a growing sense that the older ideal of donor altruism is either utterly naive or exploitative of those who would donate freely that which is now sold by others. A utilitarian ethic of providing the greatest good for the greatest number has become a singularly important moral force supporting the right to buy or sell a human organ (Friedlaender 2002; Schlitt 2002).

Our objective is to bring a broadly Christian perspective to these unfolding developments, to delineate the problems inherent in a free (or even a regulated) market-based system of organ transplantation, and to reiterate an unequivocal opposition to organ sales. We are focusing here, in particular, on the buying and selling of kidneys from *living* donors, because commodified kidneys are today the primary currency—the gold standard, as it were—in global organ sales.

The Move toward Live Organ Donation

The pioneer surgeon Dr. Francis Moore, chief of the first transplant program, predicted many years ago that the pressures of successful transplantation would alter our ethical assumptions about the basic tenet of the medical profession: *primum non nocere*—first do no harm (Moore 1988). The first successful live-donor transplant performed in 1954 by Dr. Joseph Murray in Boston was between siblings who were identical twins. Since that historic procedure, the transplantation of a kidney from a living do-

nor has evolved from the early requirements of an identical twin, to the selection of a human-leukocyte-antigen (HLA)–matched family member, to the current situation in which virtually any living person willing to do so, and judged medically and psychosocially suitable, can be a kidney donor ("Consensus Statement" 2000). Because of improvements in immunosuppression, an excellent HLA match between the donor and recipient is no longer required to achieve a successful outcome (see Terasaki 2000).

The stunning success of kidney transplantation in relieving human suffering has created an unprecedented demand for a very limited supply of donor organs. As the demand for treatment by organ replacement has increased each year, the number of donated organs has remained essentially unchanged. Transplant professionals now accept that the cadaveric source of organs will never be able to resolve the ongoing shortage nor the problem of expanding waiting lists of frustrated patients. As a result, and for the first time in 2001, the number of live kidney donor transplants has exceeded the number of transplants from deceased donors in the United States.[2] Over 20 percent of the donors were genetically unrelated spouses, friends, and coworkers who donated their kidney for love or friendship. Nevertheless, a new, extremely troubling, and abundant source of transplantable organs has been found among the world's poor and refugee populations. The new global economy has produced a large "supply" of displaced and desperate people willing to trade or sell a kidney in exchange for food, work, shelter (including shelter for refugees from deportation), and medical care for themselves or other family members, or to get themselves out of crippling debt.

The Black Market for Organs

The search for living donors is fueled in part by desperate dialysis patients. Increasingly, medically sophisticated patients are learning from their doctors, from the experiences of others, and from recent reports in the medical literature that organs transplanted from living donors offer the " best quality" and best prognosis for an excellent outcome. They also are keenly aware that kidney transplantation provides a survival benefit to dialysis at every age and by every cause of kidney failure (Wolfe et al. 1999; Najarian et al. 1992). And so, increasing numbers of patients are willing to travel, sometimes a great distance, to secure the organs they need.

For several years, one of us (Nancy Scheper-Hughes [2003]) has been actively involved in multi-sited, ethnographic field research in nine countries on the global traffic in human organs. The pattern of organ distribution follows established routes of capital: from South to North, from Third to First World, from poor to rich, from black and brown to white, and from female to male recipients. Residents of Japan, the Gulf States in the Middle East (Kuwait, Saudi Arabia, and Oman), Israel, Western Europe,

and North America now travel in individually tailored or in organized group packages to medical centers in India, China, the Philippines, South America, Turkey, and Eastern Europe to purchase kidneys that are not available locally or legally. They are aided in their quest by a new class of organ brokers, some of whom operate on the Internet.[3]

Scarcities drive the new business in transplant tourism. A dearth of cadaver organs exists in the Middle East, partly because of orthodox and fundamentalist religious beliefs that permit organ transplantation but question the removal of organs from brain-dead donors (Steinberg 1996; Gorgin, Zand, and Recknagel 2000; Al-Mahdi 1987). Hence, one solution to the problem of long waiting lists of patients has been the formation of highly organized transplant tourism packages arranged, in some instances, with the support of government-sponsored medical insurance programs. These programs carry affluent patients from Israel, Saudi Arabia, and the Gulf States to nearby countries, including Turkey, Russia, and Iraq, where kidney sellers are recruited from prisons, unemployment offices, flea markets, shopping malls, and bars in urban shantytowns and new slums for immigrants.

In China, a lucrative form of transplant tourism has been developed with the participation of Chinese doctors in medicalized executions ("Testimony" 2001). The condemned prisoner is reportedly (Smith 2001a, b) intubated and surgically prepped for organ harvesting minutes before execution, and executions are planned to coincide with prepaid transplant tours. In India, trading a kidney for a dowry is a strategy for parents to arrange marriage for an otherwise economically disadvantaged daughter (Cohen [1999] 2003). Debt peonage also contributes to the formation of veritable "kidney belts" in the South of India where pauperized agricultural and domestic workers exchange a kidney for job security (Ram 2002). The United States has not been isolated from this global business. Transplant tourism packages, arranged mostly in the Middle East, have brought kidney patients to U.S. centers for transplants performed with kidneys purchased from donors allegedly posing as relatives and friends of the recipient (Friedlaender 2002).

The Case That Is Made for Kidney Sales

A market system of living donor organ sales (of kidneys, but also parts of livers) has been proposed and defended from many different perspectives (see Radcliffe-Richards et al. 1998; Mahoney 2000). Some proponents of legalizing sales note that everyone in the organ transplant process (other than the live organ donor or next of kin who gives consent for cadaver donation) is compensated in some tangible way. A salary is provided to the Organ Procurement Organization (OPO) coordinator who obtains family consent, the OPO then charges an acquisition fee for the recovery

of organs, the transplant surgeons and physicians who care for the patient are paid for their service, and finally the transplant center charges for the hospitalization. Those who are opposed to monetary compensation for organ donation respond by pointing out that compensation or services rendered to the transplant recipient is ethically different from the compensation that would be provided for an organ. Providing compensation to the transplant center physicians and OPO staff is accepted by our society because these transplant professionals provide a service to patients in the exercise of their responsibilities; it is this professional service for which they are compensated.

Others advocate for payment for organs because they hold a libertarian view in which the autonomy of individuals is paramount, including the freedom to buy or sell organs. In these transactions, the body is understood as a valuable commodity that belongs to the individual and which they can dispose of as they see fit. In the rational-choice language of contemporary bioethics, the conflict between nonmalfeasance ("do no harm") and beneficence (the moral duty to perform good acts) is increasingly resolved in favor of a consumer-oriented approach to human freedom, the "right to choose." To wit, those able to broker or buy a human organ, it is said, should not be prevented from doing so. The resulting landslide toward living, unrelated, and paid kidney "donation" is thereby constructed as a win-win situation that can benefit both parties. Physicians or social scientists who decry the intrinsic exploitation of the bodies of the most vulnerable are criticized as inappropriately paternalistic and as excluding the poor from a valuable new source of income.

Finally, there are those, like Michael Friedlaender (2002), who argue from a more fatalistic position that, idealistic arguments aside, and as unsavory as the commerce in human organs may be, Pandora's box has already been opened, and the only responsible and pragmatic response to existing "black markets" is to replace them with "white markets"—government-controlled and -regulated systems of "compensated gifting" of living donor organs. Currently, the Ministries of Health in the Philippines and in Israel are considering various proposals to regulate the sale of organs by living donors in those countries. But to date only Iran has instituted such an officially sanctioned system of kidney sales, and it has generated its own share of controversy within the Iranian medical community (see Zargooshi 2002).

Opposition to Organ Sales in a Secular Society

Arguments against organ sales from live donors are difficult to defend in a secular and free-market–dominated society such as ours, because they cannot be referenced by a traditional Christian morality that holds as first premises the integrity, value, "goodness"—indeed sacredness—of the body

and the dignity of all human beings. Nonetheless, there are established societal norms that restrict the entry of the market into certain protected spheres of human life. For example, our society does not endorse the selling of a person into slavery or the buying of children through black-market networks in international adoption, even if these are defended in terms of rescue and life saving, as they often are.

Even the high premium placed in U.S. society on personal autonomy is not allowed to be the final arbiter of behavior if it can be shown that the social fabric of society would be threatened or weakened. A civil-rights law that restricts the rights of property owners to discriminate against races and classes of individuals seeking to rent or purchase a home is an obvious case in point. Furthermore, our society still subscribes to a fundamental principle that all humans are created equal and that each individual life has an intrinsic value, so that the person cannot be sold or physically dismantled or bartered away.

Although class distinctions are an almost naturalized part of social life in all complex societies, in this particular instance the exploitation of organ sellers veers dangerously close to human slavery, as argued by Giovanni Berlinguer (Berlinguer and Garrafa 1996). The pressures put by organ brokers upon the desperation of the world's dislocated, refugee, and poorest populations to provide the scarce commodities reveals the limits of arguments based solely on individual autonomy. Yes, even the poorest people of the world "make choices," but they do not make these freely or under social or economic conditions of their own making. Further, the pressure of organ brokers upon the poor makes their decision to sell an organ anything but a free and autonomous choice. These secular arguments reach a conclusion similar to one derived from Christian morality—that the sale of human organs is unethical.

The most disturbing issue of organ sales to both Christian and secular ethicists is the formation of an economic underclass of organ donors throughout the world to serve the wealthy. This is not to suggest that proponents of organ sales are in favor of exploiting the poor but, rather, that they are indifferent to the social and individual pathologies that markets in kidneys and other body parts produce, such as the documented evidence of postsurgery medical complications, chronic pain, psychological problems, unemployment, decreased earning power, social ostracism, and social stigma faced by kidney sellers in many parts of the world (see Zargooshi 2002; Jimenez and Scheper-Hughes 2002a; Ram 2002).

Proponents of organ sales suggest that a distribution system regulated with government oversight would prevent these widely known abuses from occurring, at least in the United States. However, the debate then moves to another arena for public policy makers to consider. Would a system regulated by the Department of Health and Human Services (DHHS) accomplish its objectives and become the only route of organs for pay-

ment? This is doubtful in view of the futility of regulated control of donor payments suggested by current practice elsewhere. The global market sets the value based on social, economic, and consumer-oriented prejudices, such that in today's kidney market an Indian kidney fetches as little as $1,000, a Filipino kidney $1,300, a Moldovan or Romanian kidney $2,700, while a Turkish seller can command up to $10,000 and an urban Peruvian as much as $30,000 (Scheper-Hughes 2002a, 73; 2002b).

Brokering in the United States would likely be no different. If the current policy of prohibition of organ sales was rescinded, there would be little justification, legally or ethically, to prevent donors from circumventing the DHHS system and using the Internet to solicit a better price. A regulated system would either have to outlaw Internet bidding and set a controlled price or would have to continuously modify the price to outbid Internet brokers and to keep up with emerging kidney markets elsewhere.

Medical and Social Considerations

Living organ donation has medical risk. In a survey of transplant centers of approximately ten thousand live donor transplants performed between 1999 and summer 2001, the transplant community was made aware of at least two live kidney donor deaths in the United States and one donor who developed an operative procedure complication that left the donor in a persistent vegetative state (Matas, Leichtman, Bartlett, and Delmonico 2002, 138). A national registry of donor events is urgently needed to inform potential donors of the risks and complications of live organ donation.

When the living donors are sellers, poor and trapped in life-threatening environments, they may face complicated recoveries without access to medical care. In the village of Mingir and in the city of Chisinau, Moldova kidney sellers reported that they were unable to sustain the demands of heavy agricultural or construction work, the only labor available to men of their skills and backgrounds. They experienced deep shame and resentment, they were stigmatized as male "prostitutes," excommunicated from their local Eastern Orthodox churches, alienated from their families and coworkers, and, if single, excluded from marriage. Even their families were affected; their children were ridiculed as "one-kidneys" (Jimenez and Scheper-Hughes 2002a).

Transplant patients relying on paid donors are also at risk. Paid donors who have an economic need for compensation may conceal aspects of their medical history that would disqualify them. Systemic infection transmitted by a donor organ can result not only in a loss of the transplant but also in the death of the immunosuppressed recipient. Even as new technology is being used to detect viral antigen in the blood of a donor within days of exposure, the issue of accurate and honest medical history remains critical

to assuring the safety of the organ transplant. In Manila, minors (those under the age of eighteen) inflate their age so that they are not excluded from the sale of their kidneys. In the covert kidney market of Istanbul, sellers may angrily insist on the transaction with a kidney broker who questions their heath (Jimenez and Scheper-Hughes 2002b). Physicians, whose primary responsibility is to provide care, should not enable a practice that degrades a poor person, that compels anyone to sell his or her body parts, or that encourages anyone to take a medical risk of death for the sole purpose of securing a monetary payment.

A Return to the Gift

"The material needs of my neighbor are my spiritual needs."
—Immanuel Levinas, Nine Talmudic Readings
(cited by Donoghue 1996, 39)

We end this essay with a reminder of the original ethical challenge implied in organ sharing. What is essential here is to retain the ultimate value of the body as a gift to the donor, meaning also that it is a gift to the self. The body and its parts remain inalienable without free and informed consent. It is through the body that humans experience and live in the world as conscious subjects.

In his 1970 classic, *The Gift Relationship*, Richard Titmuss anticipates many of the dilemmas now raised by the global human organs market. His assessment of the negative social effects of commercialized blood markets in the U.S. could also be applied to the global markets in human organs and tissues.

> The commercialism of blood and donor relationships represses the expression of altruism, erodes the sense of community, lowers scientific standards, limits both personal and professional freedoms, sanctions the making of profits in hospitals and clinical laboratories, legalizes hostility between doctor and patient, subjects critical areas of medicine to the laws of the marketplace, places immense social costs on those least able to bear them—the poor, the sick, and the inept—increases the danger of unethical behavior in various sectors of medical science and practice, and results in situations in which proportionately more and more blood is supplied by the poor, the unskilled and the unemployed, blacks, and other low income groups. (Titmuss 1997, 314)

A broader conception of medical ethics, including attention to social justice, underscores the violation of trust in the buying and selling of human organs. Transplant physicians should be attentive to the motivations of organ donors and receive assurances that an organ donation is voluntary and uncoerced. Finally, the risks and benefits of organ transplantation need to be more equally distributed among and within nations, ethnic groups, genders, and social classes. The division of the world into organ

buyers and organ sellers is a medical, social, and moral tragedy of immense and not yet fully recognized proportions.

NOTES

1. Within a year following Christiaan Barnard's first heart transplant, the Dean of Harvard Medical School appointed a committee to examine the definition of brain death. This Harvard Ad Hoc Committee, composed of ten medical specialists, one lawyer, one historian, and one theologian, produced "A Definition of Irreversible Coma" (1968), a report published in the *Journal of the American Medical Association*. Following a discussion of the diagnostic procedures to be used in establishing a diagnosis of brain death and a legal commentary suggesting that the judgment of the criteria for establishing brain death is a medical, not a legal, issue, the report cites an address by Pope Pius XII to an International Congress of Anesthesiologists in which the Pope declared that it was not within the competence of the church to determine the moment of death, that this was a task appropriate to the attending physician, and that, moreover, it was not obligatory for the physician to continue to use extraordinary measures in obviously hopeless cases (Pius XII [1957] 1958:398). Thus, from the outset, the establishment of a radically new definition of death escaped the kind of acrimonious debates that have followed the abortion question and euthanasia.
2. Information from The United Network for Organ Sharing, Richmond, Virginia (*www.network17.org/pservices/ unos.htm*).
3. A Web site called "Liver4You" (*www.liver4You.org*, last visited 25 June 2003) promises speedy liver transplants from living donors to transplant patients willing to travel to Thailand or the Philippines. "Want a Living Organ Next Week or a Morgue Organ in 5 Years?" the site asks provocatively.

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