BEYOND THE MARKET

A new approach to the ethical procurement of human biological materials

by

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Abstract

Supplies of human biological materials (HBM) for use in therapeutic procedures and research currently fail to meet global needs. Although the cause of shortages is multifactorial, the primary focus of ethical debate concerns strategies to motivate individual provision of HBM, in particular through the use of financial incentives. Despite the long history of trade in HBM from human teeth and bony relics to blood, organs, cells and tissues, contemporary ethical discussion is often fragmented, focusing on specific materials as representative of distinct issues. The approach of policy makers similarly highlights the apparent contextual differences of procurement and use of particular materials, producing multiple and often conflicting policies at the state, national and international levels. In contrast to the traditional orientation of debate, in which individual needs and choices are prioritized and the different features of procurement and use of particular materials are used to justify the adoption of different policies, I seek to outline a more consistent and comprehensive framework for policy making in this field by examining the commonalities of HBM procurement.

Setting the detachment of HBM from living and deceased human beings within the personal and social context of embodied moral agency, I suggest that the commodification of these materials will impair our ability to express important values in our bodies and may undermine cooperative efforts in pursuit of important public goods such as health. Reviewing the ethical issues of markets in HBM, I argue that more effective and ethical policies regarding procurement of HBM will be developed using a framework that emphasizes community goals and solidarity rather than individual priorities in a market setting, at both the national and international levels. I outline how the self-sufficiency model may be used by governments to develop more responsible practices in procurement and distribution of HBM while encouraging public participation not only in donation but also in efforts to reduce needs for these materials. In short, I argue that markets in HBM fail to capture the way we value our biological materials and to reflect the ways we wish to treat materials in the social realm. We must look beyond the market for a broader vision of the role that our bodies play in our lives, recognizing that the treatment of HBM is a rich and complex component of human flourishing that market norms cannot express.
Declaration

This is to certify that

i. the thesis comprises only my original work towards the degree of Doctor of Philosophy,

ii. due acknowledgement has been made in the text to all other material used,

iii. the thesis is less than 100,000 words in length, exclusive of tables, maps, bibliographies and appendices

Signed:

Dominique Martin
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The views expressed in this thesis are my own, and in no way represent those of the individuals noted above. Any errors contained herein are my own.
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Friends and Strangers

The duke cannot deny the course of law;
For the commodity that strangers have
With us in Venice, if it be denied,
Will much impeach the justice of the state;
Since that the trade and profit of the city
Consisteth of all nations. Therefore, go:
These griefs and losses have so ‘bated me
That I shall hardly spare a pound of flesh
Tomorrow to my bloody creditor.

The Merchant of Venice, Act 3, Scene 3, Lines 31-39 (Shakespeare 1948, 200)

1.1 Introduction

Trade in human biological materials*¹ (HBM), whether organs, gametes*, cells* or tissue, has become an important concern for states and societies nationally and internationally. While many countries continue to debate the merits of legalizing or regulating domestic markets in various forms of human flesh, a thriving cross-border trade continues to expand that remains largely unexamined, unregulated and surprisingly unknown to the general public. Antonio’s remarks in The Merchant of Venice, facing the consequences of having mortgaged a pound of his own flesh against a debt, highlight the difficulty of seeking mercy and protection from harm when the laws of commerce prevail and human bodies are treated as commodities. Shakespeare also points to the apparent impotence of governing authorities when individual human tragedies confront the implacable hand of the law and the importance of maintaining international trade. The justice of which Antonio speaks seems overly concerned with trade and profit. Despite the sympathy of the governing authorities to his plight, it is only through the wily intelligence of a fake lawyer that he escapes his death at the hands of the ruthless Shylock.

¹ See Appendix 1 for a glossary of terms used throughout the thesis. Terms included in the glossary will be italicized and identified with an asterisk when first introduced in the main text.
Trade in HBM poses many dangers to those who use their body as capital. For legislators and governing authorities, and for the citizens whose interests they represent, it raises a number of practical and ethical dilemmas, all of which appear magnified in the context of international markets. This thesis strives to clarify such issues, and in doing so to help guide policy development that will uphold the importance of human life – in its richest social conception – in the face of an increasingly individualized, commercialized and contractual approach to the procurement of HBM. Recognizing that trade in HBM is driven both by profit and fundamental human needs, I will present some relatively neglected strategies to meet the demand for such materials while advocating ethical principles of global relevance and validity that will guide sustainable development in supply without compromising social justice or concern for individual human wellbeing. As I examine the ethical issues raised by trade in HBM, it will become clear that the true task for policy makers is not simply to promote ethical trade and prohibit unethical practices, but to ensure that human needs for HBM are met in the most effective and ethical manner possible. Ultimately, I suggest that trade does not represent the best solution to this challenge.

1.1.1 Overview of the chapter

I begin this chapter by clarifying the definition of trade in HBM. I then briefly review the history of such trade before outlining the current state of affairs with respect to global trade in HBM and demand for various materials. In the following section, I outline the challenge for policy makers, who must determine how best to meet needs for HBM, and how to regulate commercial procurement practices both domestically and internationally in the context of societal concerns about poverty and injustice. I argue that the debate about trade in HBM has traditionally been hampered by a fragmented focus on different materials and an emphasis on trade as an individual concern rather than one of communities. I suggest that a more comprehensive and consistent approach to the issues will be achieved by resituating the debate in the context of social communities and shared human concerns for the procurement and use of HBM. Finally, I provide an overview of the thesis.
1.2 Defining trade in HBM

Biological materials may be detached from human bodies in a number of ways. They may be removed from a living individual (in vivo detachment*) or after death (post mortem detachment), and for a variety of purposes. In primary procurement*, materials are removed for the purpose of use by a third party – usually in therapeutic procedures involving other humans, or in research. In secondary procurement, materials are originally detached for the benefit of the provider – for example when diseased organs or tissue are surgically removed, or oocytes are harvested for personal use in assisted reproductive therapies (ART). Following removal, discarded or unwanted materials may be transferred to a third party for their use, for example when spare oocytes are donated to other infertile patients, or diseased tissue specimens are used in research.

Nearly all parts of human bodies now possess utility value as resources for use in therapeutic interventions or scientific research. They may also acquire a commercial value and become commodified. Commodification* occurs when HBM are exchanged within a market such that they are treated as fungible objects with monetary equivalence, and hence commensurability (Radin 1996, 118; see also Chapter 7). Markets include a variety of social systems in which goods may be exchanged between individuals or groups, subject to variable rules that may constrain trade interactions (see Chapter 4). HBM may be sold by providers* - the individuals from whom materials are procured either in life or following death - in cases of primary commodification of HBM. HBM may also be sold following detachment for another purpose, with or without remuneration of providers, in cases of secondary commodification.

Much of this thesis is concerned with the issue of primary commodification of HBM, that is, the question of whether individuals from whom materials are procured should be paid. This is because payment to providers is considered an important factor likely to enhance supplies of therapeutically useful HBM (see Chapter 5), and thus an important concern for healthcare policy makers. Nevertheless, secondary commodification must also be considered, in particular because it represents most of the existing trade in HBM. I will discuss the ethical issues of commodifying HBM in Chapter 7, however it is necessary to clarify briefly here what I mean by commodification, and hence trade in HBM.

1.2.1 Marx, commodification, and payment for labour

Marx, in his famed account of commodity exchanges in Capital, focused on products of human labour that acquire an exchange-value distinct from their use-value, becoming
commodities that may circulate within the “sphere of exchange” until such time as they “find a resting-place” and may be “consumed” (1936, 117). Marx regarded human labour as a vital element in the production of use-value, with “man’s activity” working upon “Nature’s material” to create useful products meeting “the wants of man” (201). Through the exchange of useful products in the social realm, these products become commodities, acquiring an exchange-value (or monetary equivalence) that expresses their value relative to other products at a particular time. “The existence of the things qua commodities, and the value relation between the products of labour which stamps them as commodities, have absolutely no connection with their physical properties and with the material relations arising therefrom (83).” Marx thus saw commodity exchanges as tending to obscure the true value (of human labour) in commodities. He criticizes the “fetishization” of commodities, in which the acquisition of commodities is motivated by the desire for greater exchange-value rather than for products with actual use-value to an individual, and which enables the exploitation of labourers. I shall argue below that although HBM must in general be transformed by labour in order to become useful products, they are not necessarily commodities, except where they acquire an exchange-value.

Although human labour is required to procure, modify and transfer or use HBM as therapeutic products or materials for research, it is the primary stage of commodification, in which individuals may choose to sell their own HBM by allowing removal of materials during or after their lifetime, which dominates public policy debate. Providers of HBM, especially living providers, may well incur time costs, inconvenience and suffer physical discomfort or injury as a result of HBM procurement procedures, but this labour – if it may be so called – is not particularly relevant to the production of HBM in the market setting except insofar as it may discourage potential providers of HBM or affects quality controls. Instead, the labourers who actively produce useful HBM include healthcare professionals and scientists. Paying these individuals for the cost of their labour does not constitute commodification of HBM, except where the HBM acquires an exchange-value, that is, where the transfer of HBM between individuals results in a cost of acquisition or profit in transfer that exceeds the cost of necessary labour. Where this occurs, the HBM becomes a true commodity because it has a price or exchange-value inherent to itself that is distinct from the cost of the labour potentially involved in its production. For example, where a salaried transplant surgeon receives an additional financial “bonus” for procuring and transplanting a kidney between patients, the kidney is commodified. Where the surgeon
simply receives her regular wage for the performance of duties including organ
procurement and transplantation, the kidney is not commodified despite its treatment as
a useful product that is transformed by human labour. It retains a utility-value but no
exchange-value as such. Similarly, the removal of a diseased appendix by a surgeon and
its subsequent examination by a pathologist, where both doctors are paid for their
labour, does not commodify the appendix in question. Where the kidney is sold to a
transplant patient, or the appendix is sold at a profit to a research institute, then
commodification occurs because the profitable transfer of organ for money involves an
exchange-value.

Once an object acquires an exchange-value, distinct from its intrinsic value – whether
that of utility or personal value as I shall discuss in Chapter 3 – it becomes
commensurable and hence potentially fungible with other objects that have a monetary
equivalence. Within the market, goods may be exchanged with other items in proportion
to their relative exchange-values, or price. The exchange-value is that which dominates
the market in commodities, obscuring other values that may be of immense personal
and social importance, as I shall argue is the case with respect to HBM.

A market in HBM is thus a system of commercial exchange in which providers,
recipients* or any individuals or organizations involved in the transfer of HBM between
different parties obtain a financial profit or fungible benefit as a direct result of their
involvement in this transfer. Such profit arises when recipients of HBM pay to obtain
materials at a price exceeding the costs of any services relating to HBM transfer,
storage, modification, or use. Although it is relatively straightforward to identify cases
of payment to HBM providers, it is often difficult to distinguish commercialism in
healthcare provision from practices in which HBM are treated as objects of trade
(commodities) (e.g. Heng 2007a). Although in existing markets for HBM, brokers or
medical professionals may directly profit from HBM by charging recipients of HBM a
higher price than that paid to providers, payment for HBM may also be disguised as
payment for services or reimbursement* of costs.

It may be difficult to distinguish cases of legitimate labour cost recovery from those in
which HBM are effectively commodified. For example, if a deceased organ provider’s
family is given a free funeral service2 or repatriation of the provider’s body3, this

2 A proposal to increase deceased organ donation in Pennsylvania by offering
reimbursement of funeral expenses has received considerable support in the United
States (e.g. Delmonico et al. 2002, 2003; Jasper et al. 2004; Rodrigue et al. 2009).
represents a profitable gain for the family and constitutes trade in organs (except where additional costs might be incurred as a direct result of organ provision). On the other hand, if the provider were maintained on life support for a longer period of time than would otherwise have occurred for the purpose of facilitating organ procurement, reimbursing the family for any additional hospital fees related to this period would not profit them and thus would not constitute trade in HBM.

Obviously, even where HBM are not regarded as possessing an inherent commercial value and treated as commodities, the availability of these materials enables a variety of people in the healthcare and affiliated industries to profit from the sale of other goods and services. For example, professionals involved in research or therapeutic use of HBM may obtain academic or professional credit, knowledge and experience that in turn enables them to achieve better-paid employment, or to profit from intellectual property rights. However, to suggest that HBM therefore inevitably possess commercial value is mistaken. The existence of treatable diseases enables and encourages the existence of profitable (and not-for-profit) healthcare systems that utilize a variety of commercially valued goods and remunerate a number of service providers. Although HBM may be traded and commercially valued, they otherwise contribute to healthcare profits simply by facilitating the treatment of diseases. Diseases contribute to profits in a similar way by creating the need for treatment. It is only where fees (or other commodities) are (directly or indirectly) exchanged for the materials themselves that they become articles of trade.

1.3 The current state of trade in HBM
The selling of body parts seems a particularly contemporary issue, given the apparently inexhaustible list of uses to which all kinds of HBM may now be put, and the extent of trade. However, the history of procurement, use and trade in HBM dates back at least two millennia. Recognition of this history, despite the scarcity of details or contemporaneous discussion of its ethical issues, is essential to any account of the current situation. Among the earliest evidence of use of HBM procured from another person is that of human teeth found in Etruscan dentures dating from the 7th century BC (T. Anderson et al. 2004, 862). Human teeth continued to be used in dentures until the late 19th century. In addition, during the 18th century, direct transplantation of human

3 Anecdotal evidence suggests relatives of foreign workers in Saudi Arabia may be motivated to permit deceased organ donation in order to pay for repatriation of the bodies (e.g. Estimo Jr. 2010).
teeth from living providers became popular among those who could afford this expensive treatment (Blackwell 2004, 22). George Washington for example, paid a number of his slaves a third of the going rate in return for teeth that were used to create his dentures (M. Thompson 1999). While this practice had largely ceased by the 19th century, there was continued demand for teeth from deceased providers with the corpses of young men killed in the battle of Waterloo looted to provide teeth for dentures (Woodforde 1983, 62). While many of the original “Waterloo teeth” were exported to America, teeth obtained from the dead of the American Civil War were in turn sent across the Atlantic in barrel loads some decades later (ibid., 63).

Prior to the advent of organ and tissue transplantation in the last century, the utility (and hence economic) value of human corpses was not so much therapeutic as educational, social or spiritual. During the medieval period, a large international trade in the relics of deceased saints thrived throughout Europe (Geary 1986), conferring status on owners of such treasures and providing spiritual succor to communities. The miraculous powers of some relics were also thought to provide therapeutic benefits for the ill or dying (ibid., 179). More pragmatically, corpses were used for anatomical dissection or scientific collections, enabling surgeons and physicians to develop and enhance their skills, a practice dating from the third century BC (Von Staden 1992, 223). Public exhibition of unusual specimens – so-called “freaks” – provided social entertainment rather than educational value (Barilan 2005). Whereas corpses for dissection were usually obtained from executed criminals and the poor (e.g. Lawrence 1998, 118; Hildebrandt 2008, 5-7), with the notorious exception of grave robbing or murder (Tward and Patterson 2002, 1183), skeletons were sometimes sold in advance by living individuals. These *futures markets* in corpses usually involved individuals with unusual anatomical variations. In Italy, one American commentator reported on this practice:

He is a mechanic, and for a pension of five pauls (fifty-five cents) per day, has sold his skeleton to the Academy of Medicine. They have bargained that he is not to leave Florence; but as he bids fair to live a half century more, his bones will cost them dear, and few of the present generation will see them. They call him the living skeleton, by virtue of the bond. There is one other such a giant at Pisa, a shrewder chap, who has sold his frame to two different corporations. Won’t there be a rattling among the dry bones when the two powers seek to enforce possession? (Jarves 1856, 133)

C. Thompson similarly writes of Owen Farrell, an Irish dwarf, who sometime before his death, “sold his body for a weekly pittance to a Mr Omrod, a surgeon, a not unusual
proceeding at the time” (1968, 212). In contrast, Charles O’Brien, the famed “Irish giant”, allegedly sought to prevent the sale and use of his skeleton. His death in 1783 sparked an astonishing battle among London surgeons to take possession of his corpse (Bergland 1965).

While futures markets in HBM are a thing of the past, at least temporarily, the following sections will demonstrate that needs for HBM are no longer exclusive to surgeons and anatomists and accounts of trade in HBM no longer belong to the realm of historical anecdotes. Instead, supplies and trade in HBM are critical issues for millions of people throughout the world whose lives may be dramatically affected by shortages of HBM or by involvement in HBM markets.

1.3.1 Human organs
Since the first successful human kidney transplant took place in 1954 (J. Murray 2005, 6-7), successful transplants have taken place using hearts, lungs, kidneys, pancreata, intestines and livers (both partial and whole), ovaries and testes from deceased and living providers. Approximately 100,900 organ transplants are performed worldwide (Global Observatory 2010, 4). This figure represents less than 10% of estimated global needs for organ transplantation (Global Observatory 2008). The number of patients waiting for organs continues to grow each year, with for example, 1,700 patients currently registered for transplantation in Australia (ANZOD 2010), and 110,000 in the United States (OPTN 2010). Waiting lists however, are not always the most accurate reflection of genuine needs for transplantation. Where needs for transplantation are defined in accordance with individuals for whom transplantation represents the best therapeutic option to improve or sustain health, official waiting lists are likely to be somewhat inaccurate for a number of reasons. Firstly, wait list eligibility criteria may be partially influenced by rationing concerns, excluding genuinely needy patients for whom the anticipated benefits of transplantation are thought likely to be relatively inferior to those of other patients. Other needs may not be identified at all, where individuals lacking access to healthcare are not recognized as suffering organ failure, at least until the final stages of disease, at which transplantation may no longer be a viable option. Thirdly, patients may be financially ineligible for transplantation in some countries, and thus not included on waiting lists. Fourthly, waiting lists may include patients unfit for transplantation. Analysis of waiting list data in the United States suggests, for example, that although renal transplant waiting lists may appear to be
growing exponentially, the rate of active candidates on the list remains relatively stable (Leichtman et al. 2008, 947).

The incidence and prevalence of organ failure, and the diseases that contribute to it, help to indicate potential needs for transplantation among particular populations. Thus, the Ministry of Health in China estimates that as many as 1.5 million Chinese need organ transplantation (J. Huang 2007, 195). The rapid increase in the global burden of chronic diseases contributing to organ failure, such as diabetes, hypertension, obesity and hepatitis (e.g. White et al. 2008, 229; Kemmer et al. 2008, 106), suggests that needs for transplantation will continue to outpace population growth and supplies of organs if current healthcare policies prevail.

Living provision of different organs carries a range of different risks, depending on the part, the provider’s own health, and the quality of provider care during screening, procurement and following provision. Carefully selected and treated living individuals can provide a kidney, or even part of their liver, with relatively minimal risks to their own health (Gai et al. 2007; Middleton et al. 2006). Unsurprisingly, renal transplants comprise the majority of organ transplants performed worldwide, roughly 69,300 annually, of which 46% are from living providers (Global Observatory 2010, 4). Living provision of partial lungs is more rarely performed and carries significant risks (Barr et al. 2006, 1374).

Living organ provision always requires burdensome screening procedures, painful and invasive surgery with peri-operative risks of morbidity and mortality and significant, if infrequent, long-term health risks. Furthermore, as Ommen et al. (2006) warn, knowledge of living provider outcomes may be incomplete and existing risk data may not be applicable to some potential provider groups. Where care and eligibility criteria fail to meet the stringent standards advocated by the Vancouver Forum on living organ donors* (Barr et al. 2006), for example in the setting of unregulated organ markets, organ providers may suffer significant short and long-term consequences to their health (e.g. Naqvi et al. 2008). Deceased organ provision is strongly advocated by the World Health Organization (WHO) as it minimizes the need for harmful living organ provision and supplies a wide range of organs. Furthermore, deceased providers can often supply more than three organs for transplantation (Devey and Wigmore 2009, 833), as well as tissue.

The advent of the immunosuppressant drug cyclosporine in the 1980s has enabled more people to receive transplants from unrelated providers, facilitating transplantation in general but also contributing to the increased use of living unrelated providers.
Although at present only Iran and Saudi Arabia have legalized payment for human organs, unofficial markets have flourished in the absence of legislation and illegal trade persists in many countries, including Colombia, the Philippines, Pakistan, India, China, and Egypt (e.g. Delmonico 2009a; Mendoza 2010a; Mendoza 2010c), and reports of trade in organs have involved citizens from all over the world as vendors*, brokers and buyers (e.g. Shimazono 2007; Scheper-Hughes 2008). While legal and illegal payments for organs often take place within national borders involving only domestic citizens, transplant travelers* comprise a large proportion of those illegally purchasing organs in developing countries, where their purchasing power is often a significant factor in driving the local industry\(^4\). The WHO estimates that more than 5% of organ transplants worldwide involve so-called transplant tourists who travel abroad to undergo transplantation using a purchased organ (Shimazono 2007, 959).

Transplant tourism* is perhaps the most notorious form of cross-border trade in HBM, as well as the most contentious form of international medical travel*. This is largely due to the tragic evidence of human trafficking and exploitation associated with the unregulated sale of organs from the poor in developing countries. Highlighted by research such as that of anthropologist Nancy Scheper-Hughes (e.g. 1998; 2004) and studies concerned with Indian and Pakistani kidney vendors among others (e.g. Chugh and Jha 1996; Goyal et al. 2002; Naqvi et al. 2007), global awareness of the harmful health and social consequences of living organ sales has led to international condemnation of the practice and ongoing efforts to eradicate it.

The WHO has played a large role in directing and implementing policy changes regarding organ donation and transplantation worldwide. In 1991 the World Health Assembly (WHA) endorsed the WHO Guiding Principles on Human Organ Transplantation, condemning trade in human organs and promoting ethical practice in donation and transplantation (WHO 2009c, 1). WHA Resolution 57.18 was passed in 2004, urging Member States to "protect the poorest and vulnerable groups from transplant tourism and the sale of tissue and organs” (WHO 2004). The updated Guiding Principles were approved by the WHA in 2010 (WHO 2010b). Similar guidelines, policies and legislation have been established at regional and national levels of governance and in the context of professional societies (e.g. European Parliament 2009; Department of Health 2005). Furthermore, in 2008, an international gathering of experts

\(^4\) For example, in 2007 over half of all renal transplants in Pakistan were purchased by foreign patients (Rizvi et al. 2009, 124).
lead by the International Society of Nephrology and The Transplantation Society produced the Declaration of Istanbul on Organ Trafficking and Transplant Tourism which outlines ethical practices in organ donation and transplantation and calls for the prohibition of organ trafficking, tourism and commercialism (Participants 2008).

Many countries have enacted legislation prohibiting payment for organs, most recently Pakistan in 2007, the Philippines in 2008 and Egypt in 2010 (Delmonico 2009a, 118; Natter 2010). However, despite global efforts to discourage trade in human organs, transplant travel continues, illegal and legal markets persist and a growing number of medical professionals and bioethicists have expressed support for the introduction of organ markets (e.g. Erin and Harris 2003a; Satel 2008; Cherry 2005; J.S. Taylor 2005; Matas et al. 2008).

1.3.2 Trade in bone, tissue and cells

The history of therapeutic transplantation of human tissue such as skin and bone dates from at least 2000 years ago (Hauben et al. 1982, 245). While there is a report of provision of skin by a slave to a master for use in nasal surgery from 1503 (ibid., 243), the successful and widespread use of therapeutic tissue allografts began in the early 20th century (Pfeffer 2009). Despite a relative lack of public awareness, many thousands of therapeutic procedures using human tissue are performed each year. For example, in Canada up to 62,098 tissue allografts are needed each year (Lakey et al. 2007a, 41).

In the UK it is estimated that bone is used in approximately 7,500 operations a year, compared to an annual rate of 3000 organ and 2,100 haematopoietic stem cell (bone marrow) transplants... [Whereas in] the US in 2006 the number of bone and tendon transplants was estimated at 1.5million with approximately 22,000 donors annually. (Hoeyer 2009, 242)

Evidence suggests that supplies of such tissue fail to meet demand in many countries; India, for example, needs an estimated 20 times more corneas in order to meet demand for 300,000 corneal transplants annually (Vajpayee et al. 2006, 554), while a Canadian study estimates the national shortfall for tissue allografts is between 31 and 66 thousand grafts annually (Lakey et al. 2007b, 135). A notable exception is that of Sri Lanka, which exports thousands of surplus corneas (Simpson 2004, 845). Estimates of needs for human tissue products* are largely confined to the market sector, which speaks in terms of potential revenue (e.g. Hüsing et al. 2003), rather than quantifying patients who might benefit from access to therapeutic procedures involving human tissue.
The first human tissue bank in the world was set up for corneal transplantation in Russia in 1929 (Pfeffer 2009, 3) and recent decades have seen a proliferation of such organizations, which are designed to help procure, store and process human tissue for use in research or therapeutic procedures including musculoskeletal transplants, skin grafting and heart valve transplants. The majority of human tissue used is recovered from cadavers, a process which is relatively straightforward as recovery can take place up to days later, leaving time for provider screening, consultation with relatives and so on. Various agencies may be involved at different stages in recovering, processing, storing and eventually using tissue. Along the way, many will incur significant costs, but “when treated and rendered transplantable by the tissue processors, this same raw material will gain enormous value” (Oberman 2006, 909). The total price for tissues originating from one cadaver may be as much as US$220,000 in the United States (Katches et al. 2000). It is claimed that the tissue trade generates up to one billion dollars annually in the United States alone (Keller and Grill 2009).

Distinguishing between trade in tissue and cells is in some respects misleading. After all, most HBM are composed of cells and much of the trade in tissue and cells overlaps. Cells are largely subject to the same regulations as tissue, and are incorporated into the same or often related biobanks. In some circumstances, the object of interest in research or therapeutic application is a particular kind of cell and one with specific genetic and/or immunological characteristics. For example, haematopoietic stem cells obtained from living bone marrow can be used to restore the bone marrow of cancer patients whose own marrow has been destroyed in chemotherapy. In the famous case of Moore v Regents of California (1990), cells from Moore’s spleen were used to create a cell line with great commercial value in research. References to cells thus tend to be associated with primarily qualitative benefits and uses, whereas tissue retains a significant quantitative value in transplantation. Where commercial value is associated with genetic material, intellectual property issues often become paramount (see Chapter 3). Umbilical cord blood (or rather its pluripotent stem cells) is also increasingly commodified with the potential for stem cell therapies to be derived from this (McGuckin et al. 2005). A burgeoning private industry encourages parents to bank their

In this thesis I will not address the issues related to procurement and use of embryos, embryonic cells or fetal tissue, whether in ART or research, as to do so would require considerable discussion of the moral status of human embryos and fetuses. (See for example A. Chapman (2009) on the complex issues of patenting human embryonic stem cells). Although important, this would distract unduly from the already sufficiently contentious issues related to materials procured from post-natal human beings. I hope to redress this neglect in another forum in the future.

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infants’ cord blood in case of future need, prompting organizations such as the American Academy of Pediatrics to advocate support for public cord blood banks and to caution medical professionals and patients about the uncertain nature of benefits in private banking (Cairo et al. 2007). Thirty-six public non-profit cord banks currently exist worldwide (Sullivan 2008, 554).

Like trade in other HBM, the tissue industry has been plagued by scandals, in particular those involving theft of partial or complete corpses from funeral homes (e.g. Rodgers 2003; Scheper-Hughes 2006). The most pressing dilemma for the tissue trade however, is how to reconcile the widespread prohibitions on paying providers or their relatives for tissue provision with the highly profitable secondary commodification of that tissue in the global industry.

While many countries have adopted legislation that reflects the spirit of the WHO Guiding Principles prohibiting payment for tissue (WHO 2009c, 3), there is increasing growth in for-profit tissue banks, and collaboration between not-for-profit banks and “pharmaceutical and biotech industries that help fund academic research and rely on human biological samples recovered and banked by these institutions” (Bauer et al. 2004, 113).

The problematic juxtaposition of non-commercial donation with extensive commercialization of donated tissue is aggravated by the immense potential for profits to be derived from research using human tissue. In particular, legal questions have arisen regarding benefit and profit sharing with providers and/or their communities, with legal decisions such as the Moore case and policy statements adopting a variety of positions. For example, the American Medical Association states that “profits obtained from the commercial use of human tissue may be shared with individuals who donated tissue” (Maschke and Murray 2004, 144).

1.3.3 Trade in gametes for use in assisted reproductive therapies (ART)

The first successful in vitro fertilization (IVF) procedures using donated oocytes occurred in 1983 (Buster 1998, 2), a century after the first recorded successful case of donor insemination took place (Daniels and Golden 2004, 8). Potential indications for the use of third party gametes include a variety of conditions contributing to medical infertility such as diminished oocyte stores or sperm quantity and quality, as well as

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6 That is, while tissue may be profitably traded, the secondary products of tissue research may create additional profits. Profitable sale of secondary products does not, in my definition, constitute trade in HBM.
social infertility* involving the absence of a suitable reproductive partner. For individuals whose fertility is socially or biologically impaired, use of third party gametes offers the chance to experience biological (in the case of female recipients of oocytes) or genetic parenthood (for individuals who use their own gametes with those of a third party).

In 2007, provider oocytes were used in roughly 12%, or 17,405 cycles of ART in the USA (CDC 2010); in 2006, over 12,685 cycles using provider oocytes and 24,339 using provider sperm took place in Europe (ESHRE 2010). In the United Kingdom in 2008, over 4000 cycles using third party sperm and 1400 using oocytes took place (HFEA, 2010). As access to ART in many countries is heavily influenced by capacity to pay for treatment, and need for gametes is not often distinguished from need for ART more generally (not all infertile patients require third party gametes), it is difficult to estimate demand for gametes, let alone to identify patients for whom use of provided gametes represents the most effective way to fulfill their desire for children. However, global supplies of human gametes for use in ART appear to fall far short of demand (e.g. Purewal and van den Akker 2009, 500; Bernstein 2009). Lengthy waiting lists in countries such as China (Gong et al. 2009) and France (Merlet and Sénémaud 2010), and increasing use of imported gametes and international reproductive travel* highlights national and regional shortfalls. Studies show that thousands of women travel abroad within Europe alone to access ova for use in ART (Martin 2010, 380), while 80% of provider sperm used in Canada comes from the United States (Collier 2010, 234). A recent survey suggests roughly 26% of reproductive travelers to the United States seek treatment using provider gametes (E.G. Hughes and DeJean 2010, e18; extrapolated from data in Table 2).

Gametes have been legally sold within a number of domestic markets for some time, with a significant proportion of trade occurring in the United States. The global market for sperm has been estimated to be worth over US$50 million each year (Zachary, 2000). While numerous countries have established prohibitions on payment for gametes, additional factors such as regulation of provider anonymity have made gametes from particular countries more appealing, as well as influencing prospective providers (Bernstein 2009; Chung 2006). Additionally, cross-border trade in gametes is stimulated both by increased supply in jurisdictions permitting provider payments and by variation in legislation determining who may have access to ART and to third party gametes (Ikemoto 2009b).
Oocyte provision is a physically invasive procedure that may have serious and long-term effects on provider wellbeing (Steinbrook 2006, 324-5; Bodri et al. 2008). The most serious risk of oocyte provision is that of ovarian hyperstimulation syndrome (OHSS), severe forms of which are potentially life-threatening and occur in up to 5% of ovarian stimulation cycles (Budev et al. 2005, S301). The risk of OHSS increases with higher doses of the drugs used to enhance oocyte production and with repeated stimulation cycles, thus there has been concern that in commercial provision, or where oocytes are procured for use in research, medical professionals seeking to obtain more oocytes may place providers at increased risk through higher doses (Dickenson and Idoiak 2009, 135; Prasad 2008). As yet, evidence of this occurring has been largely anecdotal, although the lack of transparency and disclosure in the private industry may well disguise such problems.

Sperm provision poses little physical risk to providers, although they too are usually required to undergo testing for infectious and genetic disease\(^7\) and may suffer inconvenience and social discomfort (Yee 2008, 6; Almeling 2007, 320). The perceived lack of risk and effort required is mirrored in the relatively low incentives offered for provision, usually US$50-$100 per “donation” (Almeling 2007, 302). Nevertheless, both sperm and ova providers may face emotional, psychological and social complications (e.g. Jadva et al. 2010, 4; Kramer et al. 2009, 4).

Oocyte providers may receive considerably higher payments than sperm providers, in what the American Society for Reproductive Medicine (ASRM) terms “compensation” for “time, inconvenience, and physical and emotional demands associated with the process” (2007, 308). Such payments usually involve lump sums that have no correlation with the actual financial costs that may be incurred through donation. In the US, compensated “donation” is a thriving industry. A 2005 survey found the US national average payment for donors at member clinics of the Society for Assisted Reproductive Technology (SART) was US$4,216, with a range from $1,500 to $15,000 and which demonstrated an obvious regional variation (Covington and Gibbons 2007). The ASRM advises that, “sums of $5000 or more require justification and sums above $10000 are not appropriate” (2007, 305). The ASRM also noted that providers are not necessarily protected in the event of incurring higher costs, and has recommended that providers be “covered for all health care costs resulting from the procedure” as well as being offered counseling (2007, 309).

\(^7\) See Daar and Bryzsky (2009) for a brief review of the potential issues of gamete provider screening.
1.3.4 Trade in oocytes for research

Human oocytes are also used in embryonic stem cell research, particularly in Somatic Cell Nuclear Transfer (SCNT) in which “the nucleus of an egg cell is removed and replaced by a somatic cell drawn from an adult person… [producing] a cloned human embryo” from which stem cells are eventually derived (Schneider 2009, 214). Stem cell research promises treatment for a wide range of diseases, and has thus created huge demand for oocytes (Waldby 2008). The nature of the research is such that a huge number of oocytes – and hence a vast number of oocyte providers – are required to produce relatively limited results (Dickenson and Idiakez 2009, 127). Largely due to concerns about the morality of human cloning and embryonic research, there are greater restrictions limiting trade in human oocytes for the purpose of research as compared with oocytes intended for use in ART. Thus in the United States, despite widespread payment for oocytes used in reproduction, a number of states including California and Massachusetts have legislated in order to restrict payments to reimbursement of expenses for donors contributing eggs for research - at least where such research is funded by the state (Spar 2007, 1290). Conversely, New York State has legalized the use of state funds to pay donors up to US$10 000 in order to increase the supply of oocytes for use in stem cell research (K. Harmon 2009).

Debate regarding the ethics of payment for oocyte provision for research (see Chapter 10.3.2) has been led by feminist bioethicists, who appear divided on the question of whether providers should be paid or not (see for example, Ballantyne and De Lacey 2009; Dickenson 2009; 2008, 68-89; Baylis and McLeod 2007; Widdows 2009b). Of course, all forms of HBM may be of value in scientific research, but oocyte provision currently represents the most significant area of research demand for HBM from living providers.

1.3.5 Trade in blood, plasma and derived products

Widespread use of blood transfusions and blood banking dates from the 1930s (Pfeffer 2009, 2). Blood is made up of fluid known as plasma, in which blood cells (erythrocytes, leucocytes and platelets) are suspended. Blood is procured from living individuals using venepuncture (the insertion of a large bore needle into a vein through which blood is drained). It is then screened for diseases and separated to obtain the various components. In specific plasma procurement, the blood cells are returned to the provider through transfusion after separation occurs.
Supplies of blood\(^8\), plasma and blood products for transfusion are generally sufficient in a number of developed countries, although both supply and demand fluctuates and constant effort is required to maintain supplies. Conversely, supplies in many developing countries are grossly inadequate. For example, Ethiopia reports supplies of only 43\% of estimated needs for blood, and Pakistan only half of estimated needs (WHO 2009a). Zhu (2006, 82) suggests that Chinese supplies are also grossly inadequate. In the South East Asian region, only 9.3 million units of blood are collected annually, compared with estimated needs of 15 million units (SEARO 2010). Like access to organ transplantation (White 2008), access to therapeutic blood supplies is subject to gross global inequity, with 20\% of the world’s population using up to 60\% of global blood supplies (Verma and Agarwal 2009, 146). Alarmingly, global demographic changes and emerging uses of blood products in diseases such as Alzheimer’s suggest that demand for blood may increase substantially (e.g. Greinacher et al. 2007; Robert 2009.)

Blood was the first HBM to become a widely traded and contentious commodity, prompting extensive debate in the 1970s and 1980s regarding the practical implications of paying blood providers (safety concerns being a paramount issue) and the ethical benefits of promoting altruism (e.g. Titmuss 1997). Numerous scandals regarding “contaminated” blood resulting in transmission of hepatitis and HIV to transfusion recipients were linked to commercial provision (Dukes 2009). Concerns about safety and the exploitation of commercial providers prompted the adoption of Resolution WHA 28.72 encouraging the voluntary, non-remunerated donation of blood and the pursuit of self-sufficiency in blood supplies at the national level (WHO 1975). Many countries have made progress towards this goal, with 57 countries collecting 100\% of their blood supplies from voluntary donors in 2007 (WHO 2009a). Nevertheless, “31 countries still report collecting paid donations in 2007, more than 1 million donations in total” and 31\% of all donations in developing countries, 24\% in transitional countries and 5\% in developed countries are collected from family/replacement and paid blood donors (ibid.). Additionally, some countries which claim to depend solely on altruistic donors offer “compensation” that may well constitute a financial incentive for providers, for example Germany (Healy 2000, 1640).

\(^8\) Note that while plasma is a component of blood, references to blood supplies henceforth refer to whole blood used to replace erythrocytes rather than plasma and its products, except where specified in the text. Thus for example where the WHO describes progress towards self-sufficiency in blood supplies, it ignores the use of imported or commercially derived plasma products.
Many countries that have adopted policies of altruistic blood donation have nevertheless continued to import commercially provided plasma products to supplement their domestic supplies. For example, in 2006, Australia imported an estimated 18% of its IVIg (a plasma product) needs from the United States, at a cost of US$25 million (Parnell 2008). Canada “typically imports from the US over 55% of its annual plasma needs” (Jones 1999, 77). The global plasma industry, more than 50% of which is supplied by the United States, is worth an estimated US$6.9 billion (Curling 2002, 16). In some cases, supplementation of altruistic supplies with imported commercial products is due to a lack of technological facilities able to produce the requisite products rather than an insufficient supply of altruistic domestic donors (e.g. Rautonen 2010, 99).

1.4 The challenge for policy makers
Although millions of people worldwide benefit from the therapeutic use of HBM each year, many millions more are currently unable to access these resources, due partially to insufficient supplies of HBM. Other factors such as the inadequacy of healthcare services may be the rate-limiting step in accessing HBM, but in general, shortages of willing HBM providers play a key role in many countries. Consequently, methods of procuring HBM and increasing supplies, as well as mechanisms for distribution of HBM in the setting of insufficiency, generate considerable interest and debate within societies concerned with meeting healthcare needs. Unlike other therapeutic resources, supplies of HBM are not entirely dependent on production facilities and financial investment, but on individual human beings who agree to detach their materials for use by others during their lives, or from whom materials are procured after death. The procurement of HBM thus impacts directly on individual human lives and societies.

The challenge of meeting global needs for HBM is threefold. Firstly, there is the practical problem of significant, widespread and increasing shortfalls in supply of HBM. Secondly, there are the many ethical concerns raised regarding procurement practices, in particular those associated with trade in HBM. These include: the risks of physical, psychological and social harm to providers; the potential for coercion and exploitation of providers; concerns about commodification of providers and violation of their dignity; and the potential injustice of procurement and distribution mechanisms. In addition, ethical concerns are raised about violations of autonomy and liberty in the setting of trade prohibitions and restrictions on access to HBM, particularly in the setting of cross-border travel by individuals seeking HBM. Thirdly, the globalization of trade and the inability of many countries to meet their own needs for HBM without
assistance or long-term collaboration with others places the procurement and
distribution of HBM in an inescapably global setting. Policy makers must therefore
consider and confront international diversity in policy and practice, as well as a plurality
of ethical values.

1.4.1 New markets, old issues
Just as procurement, use and trade in HBM are not new phenomena, the ethical issues
raised by contemporary practices are reflected in historical trade; the New York funeral
parlour scandal (Scheper-Hughes 2006) echoes an 1858 case in which the master of a
workhouse was indicted for trading in the corpses of deceased paupers after
fraudulently convincing relatives that the bodies were properly buried (MacDonald
2009, 393). The purchase of materials from living persons prompted concerns about
exploitation and harm to providers, as well as social justice. Blackwell suggests that the
practice of purchasing teeth from poor children or servants in the 18th century was
subject to negative social commentary in literature and art, depicting

a common period view of transplantation as a procedure in which elders prey on the
young, and the well-to-do on the indigent; in which social upstarts who would never
consort openly with chimney sweeps willingly take the sweeps’ teeth “piping hot”
into their mouths; in which body parts from the poorest and blackest of the poor are
magically transformed into precious ivory luxuries; and in which the consumption
of goods becomes indistinguishable from the consumption of people reduced to
commodities. (2004, 51)

Such concerns lend contextual colour to Kant’s oft-quoted objection to selling teeth:

To deprive oneself of an integral part or organ (to mutilate oneself), for example, to
give away or sell a tooth so that it can be implanted in the jawbone of another
person, or to submit oneself to castration in order to gain an easier living as a singer,
and so on, belongs to partial self-murder. (1996, 177)

Commentators sometimes imply that this objection to selling “even” a tooth is a little
absurd, and that ethical concerns about the sale of a tooth are surely minimal compared
with those of selling organs. Chadwick, for example, in comparing Kant with Harre,
who adopts a Kantian perspective to object to organ sales but not those of teeth, writes
that Kant wants “to go further and rule even this out”, (1989, 135). Even supporters of
Kantian arguments against selling HBM call the above example an “extreme”
comparison (Munzer 1993, 326). The apparent triviality of removing a tooth and
potentially selling it to another person is undermined when considered in the context of
systematic sales of teeth by the socio-economically vulnerable groups who provided
teeth for the wealthy elite of Europe and North America during the 18th century. Kant’s concern that the sale of body parts – even teeth - would violate respect for human dignity and constitute unethical treatment of one’s self or another human being seems less melodramatic when considered in the light of extreme inequity, exploitation and slavery that underpinned the historical market in teeth, although he doubtless did not intend such a reading of his argument. Similar injustices in global society today facilitate trade in HBM.

1.4.2 Current approaches to the challenge

The initial approach to the challenges of procuring HBM appears deceptively simple. Unethical practices should be discouraged or prevented while supplies of HBM must be increased. At the national level, states must decide how to regulate domestic practices and whether to facilitate, allow or prohibit cross-border trade. The rub lies in determining what constitutes unethical practices and developing effective and ethical ways to increase supplies. Despite the efforts of the WHO to promote unpaid donation of human blood, cells, organs and tissue (the WHO is silent on the issue of gamete procurement), international practices appear grossly variable. Even where trade is officially prohibited, terms such as compensation* and “reasonable profit” may be used deceptively to enable both payment for providers and secondary commodification of HBM (see Chapter 6.6.1).

Exacerbating confusion is the fact that different kinds of HBM are subject to variable and often conflicting policies, reflecting the generally fragmented academic debate surrounding procurement, distribution and trade of various materials. Consequently, even national policies may appear internally inconsistent, for example when trade in ova for research is prohibited while trade in ova for use in ART is permitted, or where altruistic domestic supplies of blood are supplemented by imported commercial supplies of plasma.

Commentators often focus on ethical issues related to specific HBM, with surprisingly little consideration of parallel debates with respect to other HBM. Recent literature concerning markets in human organs for example, rarely refers to trade in gametes, blood or even tissue, except where existing markets are cited as evidence of ethical validity (e.g. Friedman and Friedman 2006, 961; Matas 2004, 2009; Sobota 2004). Worse, the dominant issue of living kidney provider markets is frequently examined with scant consideration of the implications for sales of other organs. Narrowing discussion to specific materials not only fails to draw on and learn from the wealth of
useful debate in other contexts, it ignores the potential effects of policy governing these materials on the treatment of other HBM.

The piecemeal approach to both policy and debate is often justified according to the practical characteristics of specific materials. HBM may be categorized in a variety of ways, each of which tends to subtly shift debate. Adjectival dichotomies such as renewable and non-renewable, deceased and living, superfluous and essential are applied to various parts in efforts to justify the adoption of different approaches to their treatment. Obviously, meeting needs for particular kinds of HBM presents different healthcare priorities, just as procurement presents different risks according to the kind of material involved and whether the provider is living or dead. Nevertheless, the ethical values and principles at stake in each case should be consistent – although their implementation in practice may result in the adoption of different strategies. In this thesis, I strive to develop an ethical framework that will produce consistent and coherent policies with respect to the treatment of all HBM.

Another hazard of contemporary literature, at least so far as organs are concerned, is that the debate is curiously unbalanced, with an emphasis on group needs for HBM weighed against the possible impact of policy on individual providers. For example, advocates of living kidney markets highlight the imperative to save the lives of “thousands dying on the waiting list” as a strong justification for markets, but when considering market objections they focus on the autonomy of individual vendors (e.g. Friedman and Friedman 2006, 2009). The impact of markets in organs at the level of communities or societies is largely ignored. Further isolationism in debate is evident in the failure to consider needs for HBM in the context of competing or related needs for healthcare, and the alleged benefits of selling HBM in the context of social injustice and extreme poverty.

1.4.3 Different theoretical frameworks

Discussion of the issues surrounding the treatment of HBM - like much contemporary bioethical debate - tends to focus on specific ethical values and principles, and individual cases rather than social policies. The question of markets is often examined from the perspective of individual autonomy, beneficence, and non-maleficence. The fourth of Beauchamp and Childress’s (2001) famed principles of medical ethics – respect for justice – is less commonly appealed to, unless concerns about exploitation of individual vendors may be attributed to this. In an interesting issue of the Journal of Medical Ethics (Volume 29 (5), 2003), the issue of kidney sales was examined by a
number of authors in the light of the “principlist” framework. Among these, Beauchamp (2003) himself highlights the importance of distinguishing between the morality of individual acts and policies adopted at the societal level. Despite the concerns he expresses regarding societal injustice, he concludes that anticipated consequences of regulated markets will prove more ethical than the present non-market system of kidney procurement.

The ethical traditions on which current debate draws most heavily include utilitarianism – often subtly invoked in favour of markets as a win-win situation for both vendors and recipients (e.g. Berman et al. 2008, 1269; de Castro 2003) - or more rarely against markets as likely to result in greater harm; Kantian ethics – frequently cited as an objection to sales as inherently disrespectful of human dignity (e.g. C. B. Cohen 2002; Morelli 1999); and Mill’s classical liberalism – by virtue of which individuals are judged free to buy or sell HBM as they wish (e.g. Dworkin 1994).  

1.4.4 Introducing a neo-Aristotelian perspective
Although I shall endeavour to address the majority of arguments traditionally employed in the debate, my examination of the issues is influenced by neo-Aristotelian frameworks such as that of Martha Nussbaum (e.g. 1992; 2006), a largely neglected reserve of ethical theory within the context of HBM procurement. Despite the difficulty inherent in defining neo-Aristotelianism or the content of a neo-Aristotelian theory (see e.g. Wallach 1992, 621-623), some key features of a neo-Aristotelian approach to ethical issues may be identified. In particular, “a neo-Aristotelian ethics. . . sees human flourishing as always lived in some community and culture”, thereby offering a broad perspective with which to “explain how the possible relationships among persons who as yet share no common values and are strangers to each other can, nonetheless, be ethically compossible” (Rasmussen 2009, 13). Given “the open-ended character of human sociality” a neo-Aristotelian ethics enables us “to consider questions of frameworks and modern political issues” (ibid.).

This approach offers numerous advantages for examination of the treatment of HBM. Firstly, the emphasis on communal concerns and responsibilities is better suited to the

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9 As the examples here demonstrate, a disproportionate number of the references cited throughout this paper are concerned with the sale of organs rather than other HBM. Although many of the authors I quote apply their arguments specifically to organs (or simply kidneys), they are equally applicable to all HBM. Where they are not, for example where relevant differences in the procurement or use of particular materials would conceivably influence their application, I will clarify the scope of the argument.
procurement and distribution of HBM than the individualism of classical liberalism, for example. Practical constraints on matching materials with recipients, the unpredictability of both individual needs and opportunities to provide materials, and the need for considerable infrastructure to procure and deliver HBM require a minimum population of participating individuals to operate efficiently and to successfully meet more needs (see Chapter 8.1.1). Additionally, as I shall argue, the treatment of HBM is a fundamentally social concern, with the procurement and use of HBM affecting not only providers and recipients, but also their friends, relatives and community members.

Secondly, the grounding of ethical debate in the context of specific communities facilitates discussion that is relevant and valid to different societies. Thirdly, Aristotle’s teleological approach is well suited to policy making, in which the goals of procurement and distribution of HBM must be identified before determining how best to pursue them in the context of particular societies and their respective values.

1.4.5 Strangers, friends and moral communities

The procurement and distribution of HBM has global implications but begins in the context of smaller social communities. Individuals may provide materials for friends or family, and procurement – both living and deceased – may impact upon those related socially or biologically to the provider. Depending on the nature of particular health care systems and their features, such as population size and geographical extent, procurement and supply of various materials may take place in the context of municipal, provincial, regional, national or international communities. Community, in the context of the procurement and distribution of HBM, refers to a population of people between whom HBM may be exchanged or transferred. Communities may be defined in a variety of ways, and individuals may be members of a variety of disconnected or overlapping communities. Membership of the organ donation and transplantation community in Australia – which in theory includes all Australian citizens – consists, for example, of a number of different social, ethnic, religious and cultural communities.

Moral values are embedded in social communities and conflicts may arise when a culturally diverse political community such as that defined by Australian citizenship seeks to implement morally sensitive policies. Engelhardt argues that individuals who are members of distinct moral communities may be considered “moral friends” “who share a robust and full view of the moral world” (Hanson 2007, 207) or “moral strangers”, who can at best agree on a procedural account of morality in order to
facilitate their peaceful coexistence, free to “pursue their particular visions of the good and human flourishing with willing collaborators” (Engelhardt 2006, 41).

The friend-stranger dichotomy is, Loewy suggests, somewhat misleading. He argues that all moral communities are grounded in what he terms the “existential a prioris of ethics”, a shared natural framework for morality that includes:

1. the urge for being: all living creatures take the necessity for being for granted and under normal conditions will strive to maintain it;
2. biological necessities: all living things require that such necessities are met; if they are not, they will perish;
3. social needs: these may be starkly different among diverse cultures and diverse species but all higher self-knowing creatures have, at whatever level, some social needs;
4. an interest to avoid suffering…
5. a common sense of basic logic…
6. a desire to live our lives freely and to pursue our particular interests and talents as free from interference as possible.

This common framework ensures that where individuals do not share a robust moral friendship, they are nevertheless acquaintances rather than strangers. Loewy suggests that

the world of “moral acquaintances” sees a framework of shared capacities and interests which enable all to recognize that personal visions of the “good” (different as they may be) are realizable only in the context of a functioning and interactive community [in which]. . . all members, so as to realize their own goals and their own visions of the good, must embrace the goal of communal solidarity…. [In such a world] cooperation comes about not because common assumptions or common world views exist but because a common goal enabling other particular goals to flourish is recognized as necessary to that end. (1997, 89)

Although such theories of moral acquaintanceship are unable to resolve all cases of moral dissensus (Hanson 2007, 223), they offer a more substantive account of ethics with which to address many ethical dilemmas than that of the more individualistic and procedural approach of Engelhardt, for example. Our common biology, and hence shared needs for HBM and capacity to provide HBM to one another, makes a moral community of acquaintances engaged in meeting needs for HBM plausible. We cannot effectively meet our own needs independently, and must therefore cooperate in order to do so. I will argue in the following chapters that the treatment of HBM is a common moral concern of all societies and that drawing on our shared values and interests in HBM will enable us to flourish in this respect. I will argue that communities should strive to meet needs for HBM through solidarity, rather than in the socially disconnected environment of the marketplace that highlights “the ultimately corrosive effects on society of atomistic individualism” (Shannon 2001, 302).
1.5 Goals of the thesis

My aim in this thesis is to examine the ethical issues of procuring HBM in the light of arguments proposed in favour of allowing, enabling or encouraging sales of HBM. I focus on procurement strategies and issues - presupposing that equitable distribution of therapeutic resources such as HBM is desirable and largely uncontroversial, at least from the perspective of policy makers. Furthermore, I neglect the question of what constitutes ethical use of HBM in order to better address the issue of ethical treatment of human beings in HBM procurement, which should precede the question of ethical use. The purpose of this examination is to explore the question of when, if ever, markets in HBM are ethically justifiable, and in doing so to provide more consistent and comprehensive guidance for policy makers confronting the challenge of meeting needs for HBM. Given the global prevalence of needs for HBM, and the inevitable globalization of trade in HBM, the ethical issues of obtaining and distributing these materials have significant cross-border implications. In developing my account of the issues, I strive to formulate principles and to articulate values that are of global relevance and validity, in the hope of enabling national and international policy formation.

1.5.1 The burden of proof

Market advocates frequently argue that the prohibition of trade in HBM is an unjustifiable infringement of individual liberty, made worse by the supposition that prohibition impairs efforts to save lives (e.g. Kishore 2005). Patients in need of HBM, and individuals with no means of escaping poverty are prevented from engaging in mutually beneficial trade. Accordingly, many authors suggest that the “burden of proof” lies with those who wish to prevent trade. For example, J.S. Taylor writes:

Voluntary trades in human organs that take place between consenting adults, untainted by force or fraud, make all parties to them better off. As such, the burden of proof in this debate should rest with those who claim that such sales are immoral… To prohibit such transactions would… not only restrict voluntary commercial activity but also prohibit people from acting virtuously and expressing solidarity with strangers in virtue of their shared humanity. (2007, 202; see also Cherry 2005, 20)

With respect to trade in gametes, Robertson asserts:

If a ban on payments for gametes and embryos would interfere with the ability of infertile couples to obtain needed gametes or embryos, then the privileged status of procreative liberty would place on the state the burden of showing substantial harm from paying donors. (1988, 22)
Some arguments for trade in HBM seem buoyed by fears that moral pluralism precludes a universalizable global bioethics (e.g. Cherry 2006). Rather than engaging in “moral imperialism” by prohibiting trade on the speculative grounds that it may cause harm or that it may violate “non-universal” moral norms such as respect for dignity, market advocates suggest we allow individuals to choose whether they wish to participate in the market, and offer a variety of regulatory modifications that may minimize or eradicate pragmatic concerns about consent, exploitation and so on.

Although I will support the claims of market opponents who argue that in practice such harms will be inevitable, given the evidence of existing and past markets in HBM (see Chapter 5), I also suggest that liberal accounts err in presuming that the procurement of HBM is a primarily individual concern. While I agree that procurement of HBM from living individuals should be strictly voluntary, (given a universal principle of respect for bodily integrity which I outline in Chapter 2), I will argue that three factors make the procurement of HBM a fundamentally social concern and hence a liberty-based right to sell one’s own HBM should not take precedence over societal values. Firstly, HBM represent an important therapeutic resource for health, and thus for all humans. Secondly, HBM have unique personal value for providers and other living individuals by virtue of their relationship to providers. Thirdly, the treatment of HBM is inextricably connected to the treatment of embodied human beings. These facts mean that concerns about wrongful commodification, violation of human dignity and social justice that arise in the setting of HBM markets, should not be considered relativistic or secondary to concerns about individual liberty. Although trade may enhance individual liberty in some cases, the burden of proof when determining socially significant policies should first and foremost require evidence that it will promote the relevant social goals and protect important social values. Individual liberty represents an important social value, but it should not be considered in isolation or presumed to trump other potential concerns.

1.5.2 Overview of the thesis

In Chapter 2, I outline a minimal but universalizable moral framework from which to begin exploring the issues of HBM procurement. This consists in respect for the innate moral status of all living human beings; respect for bodily integrity; and respect for autonomy. I suggest that the universal importance of embodiment and detached HBM in human lives and morality and the nature of therapeutic HBM as an important requirement for human flourishing should guide our approach to the treatment of HBM.
In Chapter 3, I discuss personal value in HBM and explore the nature of the intimate relationship between HBM and living humans in more detail. I examine the conceptualization of HBM as property, both saleable and non-saleable, suggesting that personal interests in the treatment of our detached materials may be protected without establishing property rights in these materials. Rather than conceptualizing HBM as gifts, property or simply useful resources, I suggest we ought to first determine which systems of procurement, exchange and use best express the values we hold in HBM and most effectively promote our goals with respect to supply and use of HBM.

In Chapter 4, I discuss the role of morality in markets, identifying areas of potential ethical concern that may cause societies to exclude or block particular goods or resources from market exchange. I briefly review Aristotle’s distinction between oikonomia and emporium, arguing that systems of procurement and distribution of HBM should be framed like the Aristotelian oikonomia, in which essential requirements for human flourishing are shared among members of a community. Drawing on models of real and theoretical markets in HBM, I show that market advocates clearly recognize HBM as special goods*, which means that markets require careful regulation in order to protect the personal and social values at stake in the treatment of HBM. As markets are a mechanism of exchange designed to encourage supply and to facilitate the distribution of goods, I suggest that societies may find alternative mechanisms more effectively express the value of HBM and promote the goals of supply and distribution.

In Chapter 5, I explore the consequentialist arguments proposed for and against HBM markets. In particular, I critique the claim that markets are necessary to save lives and hence “ethically imperative”. I argue that effective alternative strategies are available, and that the vision of regulated markets is misleading. I also contest the Argument from Poverty in favour of HBM markets, arguing that markets will reinforce social injustice rather than reduce poverty.

In Chapter 6, I consider the main arguments proposed in favour of an individual right to sell HBM, which are concerned with autonomy, liberty and desert. Demonstrating that customary objections to markets regarding coercion or undue inducement of HBM vendors fail, I concede that the individual choice to sell one’s own HBM is not inherently immoral. However, I argue that a right to sell does not mean that individuals or society act rightly in purchasing HBM or in facilitating or promoting trade in HBM, particularly where alternative approaches to the treatment of HBM are more likely to promote the relevant individual and societal goals.
In Chapter 7, I seek to clarify objections to markets based on the issues of wrongful commodification and disrespect for human dignity. Although I conclude that the sale of HBM does not entail the (inherently immoral) commodification of living persons, I argue that it risks *partially commodifying* human beings and thus undermining valuable interpersonal and social relationships. In discussing the concept of human dignity, I argue that respect for dignity requires more than merely respect for bodily integrity or autonomy. Instead, I contend that treating people with dignity involves enabling them to pursue lives worth living, that is, promoting human flourishing through the protection of essential human capabilities. The commodification of HBM, I suggest, risks impairing respect for human dignity by emphasizing the instrumental value of embodied human beings at the expense of efforts to promote the requirements for human flourishing.

Regardless of whether trade in HBM is inevitably unethical or whether prohibition impairs individual liberty, I contend that non-commercial procurement strategies offer a more effective and less ethically problematic way to meet needs for HBM. Strategies which emphasize the shared value of HBM to all individuals and which highlight the potentially active role that individuals may play in contributing to shared resources of HBM are unlikely to instrumentalize providers. In Chapter 8, I argue that the Self-Sufficiency Model offers the best framework for policy makers seeking to address the challenges of HBM procurement.

In Chapter 9, I consider the three main options for policy makers confronting cross-border trade in HBM. Rejecting approaches that exclusively emphasize prohibition, and those that regard the cross-border market as a laissez-faire domain, I make a case for partial harmonization of national regulations to promote minimum standards of safety and quality of care of HBM recipients and providers. In conjunction with the promotion of self-sufficiency at the national or regional level, and efforts to eradicate the most harmful practices, I suggest this will encourage the evolution of global policies that better meet needs for HBM without compromising ethical values. Finally, in Chapter 10, I suggest some important areas for future work and review the main contentions of the thesis.
1.6 Conclusion

Rapid advances in medicine, surgery and science throughout the last few decades have discovered immense actual and potential therapeutic value in most, if not all human biological materials. Organ and haematopoietic stem cell transplantation, blood transfusions, assisted reproductive therapies and orthopaedic procedures using materials produced from human bone and tissue each offer individuals life saving or sustaining treatment, the restoration of physical function or the chance to create children. In addition, experimental stem cell procedures offer hope for curative treatment of a range of life threatening and debilitating diseases. Millions of people throughout the world suffering organ failure, infertility, chronic diseases and other illnesses may benefit from access to treatment using HBM, thus the increasing incidence of many such diseases, of the therapeutic potential of HBM and of social expectations of medicine and access to healthcare has been accompanied by increased demand for HBM.

The complex question of whether the sale of HBM is fundamentally immoral, and if not under what conditions it may be ethically acceptable, must be set in the wider context of human needs for HBM and healthcare, and the ethical treatment of embodied human beings. I shall argue that these two issues are inherently social as well as individual concerns, and thus cannot be satisfactorily addressed within ethical frameworks that prioritize individual preferences and rights at the expense of social concerns, values and public goods. I hope that my approach will not only enhance discussion of the social and ethical dimensions of value in HBM, but will contribute to more effective policy development for governments seeking to improve public access to HBM, as policy making – especially in the realm of healthcare – must primarily address the concerns of communities rather than individuals.

Contemplating the prospect of markets in human organs Callahan surmises that we find the idea of a society where people may want, even freely, to sell their body parts to make ends meet – or even to have some extra money to do with as they please – is not the kind of society in which most of us would want to live. Part of the repugnance may be the belief that it could too easily lead to exploitation, part to the idea that our bodies are too important for our identity and a sense of wellbeing and too intimate to be turned into market items; and in part because we believe that – though we have yet to find it – there must be a better way to procure needed organs (we have no objection to altruistic donation). Some things should just not be put on sale, even if doing so might save life. (2003, 290)

In this course of this thesis, I hope to present a case in support of this intuition, and to outline a better strategy for procuring needed HBM than that of the market.
Key considerations for an ethics of HBM

There is something sacred in every man, but it is not his person. Nor yet is it the human personality. It is this man, no more and no less... It is he. The whole of him. The arms, the eyes, the thoughts, everything. Not without infinite scruple would I touch anything of this. (Weil 2005, 71)

2.1 Introduction

The goal of this thesis is to provide an account of human biological materials that will guide social practice and policy in their procurement, use and distribution, in particular by determining whether they ought to be bought and sold. Although the issue of trade is a central concern, it can only be satisfactorily addressed as part of a more comprehensive inquiry into the treatment of HBM by individuals and societies. To perform this inquiry, we must first explore the foundations of our ethical framework, clarifying the scope of morality and the core features of moral systems before considering their application to the treatment of people and their bodies. Understanding why the treatment of HBM is of ethical concern to individuals and society will help us to understand the implications of this concern. In this chapter, I sketch a minimal but universalizable set of requirements for moral systems, highlighting the importance of recognizing the inherently embodied and socialized nature of human existence. Morality, I suggest, begins with the recognition of one’s own moral agency and the moral status of other human beings. Furthermore, recognition of agency is inseparable from that of human embodiment. For morality to function, I argue that respect for individual bodily integrity and personal autonomy are necessary requirements. Finally, I show that the pursuit of human flourishing at the individual and societal levels – however conceived – provides purpose and meaning for participants in moral societies.
2.2 An account of morality

Attempts to provide a precise definition of ethics or morality are fraught with difficulty (see e.g. Wallace and Walker 1970). Gert suggests that “Morality is an informal public system applying to all rational persons, governing behavior that affects others, and has the lessening of evil or harm as its goal” (2008). The values embedded in a moral system form the basis of principles or rules by which the “right” course of action may be determined; the merits of particular goals for individuals or groups judged; the treatment of particular goods evaluated; and personal attributes and choices appraised as virtuous or not. Morality is a primarily social phenomenon. Most questions commonly regarded as of ethical concern are those in which the conduct of moral agents is likely to affect or involve other individuals. Thus, the origin of ethics is often located in “a natural phenomenon that arises in the course of the evolution of social, intelligent, long-lived mammals who possess the capacity to recognize each other and to remember the past behaviour of others” (Singer 1994, 5). While some of the content of moral systems may vary, their shared purpose and the commonalities of human social behaviour and experience contribute to common issues of moral concern and often similar if not universal moral values and principles. As Levy notes, moral systems have to play a distinctive role in human life; they have to facilitate the settlement of interpersonal conflicts and allow the reproduction of social groups over time; there are distinctive characteristics of human beings, as evolved rational animals, that constitute the human condition and that set powerful constraints on the contents of moral systems. (2002, 162)

He further identifies “universalizability” as a formal requirement of moral systems, by which members of any moral system are constrained “to ascribe to others whatever [they] recognize as appropriate in [their] own case” (ibid., 122).

This description of morality emphasizes its role in the resolution of interpersonal conflicts, an account reflected in the traditional framing of the issue of HBM procurement and use as a tension between risks to providers and benefits to recipients, as well as conflicts between different valuations of HBM – for example sacred and commercial. Negotiations concerning the rights of individuals to sell their body parts, or of relatives to withhold the bodies of relatives from public donation programs are fraught with opportunities for interpersonal conflict. While these issues are important, and will be considered in more detail in later chapters, this thesis ultimately pursues a more positive conception of morality as a guide concerned not merely with how individual people treat each other, but with the promotion of human flourishing. Chadwick (1989) describes these two approaches as alternatives, but I shall suggest that
although conditions for the treatment of others are necessary for any minimalist conception of morality, it is the active promotion of human flourishing which provides a more profound and realistic account of morality. Furthermore, where policy-making is concerned, I will suggest in Chapter 8.2.1 that states ought to actively promote the wellbeing of citizens, not merely to prevent internal conflicts.

2.2.1 Living human beings as moral agents

Human beings are recognized as moral agents and “subjects of significance” in all accounts of morality. Without rational agents capable of consciously formulating, recognizing and adopting principles of action, morality would be difficult to conceive, let alone implement. Agency also enables responsibility. As subjects of moral significance or concern, humans are recognized not only as possible agents, but also as individuals who may be affected by the moral choices of others. While only human beings are likely to be considered capable of agency within many moral frameworks, objects (or possibly subjects) of moral concern may include a variety of non-human entities, including the environment and non-human animals. However, responsibilities and obligations derive from the capacity to engage with and understand morality and to act with a degree of freedom, thus rationality is considered an essential attribute of agents. Although like Singer, some attribute moral agency to non-human animals, as this thesis is purely concerned with the use of human biological materials and the actions of humans in procuring, using and distributing them, I shall confine my discussion to human beings – although I hasten to add that other living beings such as animals and ecological systems may be of immense moral significance.

Not all living human beings are considered capable of full moral agency, for example children and mentally impaired adults. Furthermore, deceased human beings are no longer moral agents or subjects, although they may remain important objects of moral concern. Moral agency is often considered synonymous with personhood, however the potential distinction between living humans capable of agency and those who are not does not always correspond to distinctions between persons and non-persons. I shall distinguish simply between living human beings (referred to as persons in the ordinary sense of the term) and the deceased, with the former category consisting of moral agents and non-agents (those with impaired rationality).

10 Discussion of the potential implications of my account in this thesis for non-human species is unfortunately beyond the scope of this work. The most interesting of these will likely be the use of non-human biological materials in human science and medicine, for example xenotransplantation.
Most Western ethical traditions highlight the role of human rationality in moral agency, particularly in the work of Kant, who claimed that “moral laws have to hold for every rational being as such” (1950, 79). Rationality is a practical requirement for agency, however it is not necessary for recognition as a subject of moral significance or concern. The tendency to focus on rationality and agent decision-making when considering matters of morality sometimes occurs at the expense of equally, if not more important factors – the concerns of moral subjects. As MacIntyre notes, Western moral philosophy has historically neglected the importance of recognizing human “vulnerabilities and afflictions, but also our consequent dependences” (1999, 8). Basic human needs, practices and pursuits are foremost among the concerns of moral subjects, and these are generally situated in the context of social relationships and interactions. Over-emphasis on rationality also undermines recognition of the many ways in which human agency may be impaired. This concern is reflected in Nussbaum’s (2006) comprehensive account of social justice, in which she highlights the error of social contract theories which are premised on the idea of human beings as free, independent and equal in capacities and which thus exclude impaired or disabled humans, the poor and non-human animals.

2.2.2 Living human beings as subjects of moral significance

Charles Taylor explains that it is only by virtue of certain capacities, or potential capacities that a human may be a “moral agent” and a “subject of significance” (1985, 102). As a result, he argues,

there are matters of significance for human beings which are peculiarly human, and have no analogue with animals… matters of pride, shame, moral goodness, evil, dignity, the sense of worth, the various human forms of love, and so on… What it is to maintain and hand on a human form of life, that is, a given culture, is also a peculiarly human affair. (Ibid.)

This account of personhood explicates the nature of human beings as individuals with a particular status within moral frameworks. Without wishing to commit to a set of criteria for personhood, or an ontological claim that human beings possess a moral value as a result of their particular intellectual capacities or potential, I endorse Taylor’s conception of human beings as subjects of moral significance. Despite differing levels of rationality and hence moral agency, living persons are considered of equal moral significance. The implications of this moral status are perhaps best understood as corresponding to the requirements of respect for human dignity.
In describing the possible minimum content of the human dignity concept, McCrudden writes that it seems to have at least three elements. The first is that every human being possesses an intrinsic worth, merely by being human. The second is that this intrinsic worth should be recognized and respected by others, and some forms of treatment by others are inconsistent with, or required by, respect for this intrinsic worth. The first element is what might be called the ‘ontological’ claim; the second might be called the ‘relational’ claim… (2008, 679)

I shall discuss McCrudden’s last element, “the relationship between the state and the individual”, in Chapter 8.2.1; for the moment, let us consider this minimum core, or fundamental conception of human dignity, which he describes as “incomplete” but nevertheless important (ibid.).

The ontological claim that all living human beings are intrinsically valuable corresponds to their recognition as subjects of moral concern. That this intrinsic value is possessed equally by all living humans, is essentially uncontested in principle if not practice. For example, no one claims prima facie that HBM may be procured from some human beings – such as women, or the intellectually impaired - in a manner that would be unacceptable if applied to another particular group. The principles governing the treatment of HBM – which have yet to be determined – must apply equally to all human beings by virtue of their equal moral status.

The concept of human dignity will be examined further in Chapter 7, in which specific implications of respect for dignity and the so-called “dignitarian” objections to markets in HBM will be discussed. For the moment, the uncontroversial recognition of dignity as synonymous with the intrinsic moral worth of living human beings will suffice.

2.2.3 Embodiment and moral agency

I have already highlighted the tendency in moral philosophy to emphasize rationality at the expense of features of human existence that arise through our embodiment as human animals. The enthusiasm with which Cherry embraces “the possibility of driving a conceptual wedge between persons and their body parts” (2005, 28), is symptomatic of an ethical tradition that neglects the importance of physical embodiment in human lives and hence morality. Plato distinguished between the soul and the body, a separation that has been most influentially articulated by Descartes:

Thus the self, or rather the soul, by which I am what I am, is entirely distinct from the body, is indeed easier to know than the body, and would not cease to be what it is, even if there were no body. (1968, 61)
Cartesian dualism firmly locates moral agency beyond the reach of human flesh and thus distances concerns for the human body from the sphere of moral agency. The persistence of this dualist conception of human beings, particularly in the field of medicine, underpins practices that “treat the body as an assemblage of replaceable parts, a veritable machine, exactly what Descartes said it was” (Hacking 2006, 13).

Without exploring the metaphysics of moral agency, the self and human embodiment, it seems nonetheless safe to say that moral agents rely upon some degree of physical embodiment for agency. Cherry, for example, concedes the need for a physical brain, suggesting that in theory only

the higher brain is a necessary condition for being incarnate in the world. It is the seat of human consciousness, memory, and the cognitive capacities that sustain personhood… [Its removal]…demonstrably destroys the necessary conditions for the embodiment and existence of the person. (2005, 25)

Consider however, those suffering extensive physical dysfunction, for example people with quadriplegia, such that their moral agency appears limited to thought, and where possible the expression of preferences or communication of desires that must be fulfilled on their behalf by other agents. Not only do these individuals often depend on the persistent autonomic functioning of internal organs for the maintenance of their brain and hence higher cognitive functions, the very limitations of their physical agency and the survival of their material body – however functionally impaired – are intrinsically bound up in their identity, personal experience and interactions with the world. Such individuals, like all living persons, exist by virtue of their imperfect bodies, not merely their functioning brains, and their existence is defined by the actions and interactions of their bodies with the world.

Contemporary medical practice, it is claimed, tends to neglect the significance of human embodiment and fragment or compartmentalize moral agency from the experience of physical embodiment. Barilan, for example, argues convincingly that despite the emergence of ‘bio-psycho-social’ models of medicine, “the story of the body” and “the story of the person” are kept separate, most particularly in anatomical representations and study in which scientific neutrality has led to the “disavowal” of “any connection to the life of persons” (2005, 203).

In contrast, Svenaeus argues that Heidegger’s phenomenology offers a useful perspective on human embodiment that might provide a new framework for consideration of organ transplantation ethics. He highlights the centrality of embodiment to human existence: “embodiment is the mark, not only of interconnectedness (birth), but also of finitude (death)” (2010, 172). The commonality
of embodiment as a human experience is what connects human beings within social communities:

If the body is the central node-point of our being-together-in-the-world, which we have been surrendered to ever since the beginning of our lives, then the body is not only what separates us from other people – only I can feel my pain – it is also what connects us to them. I am attuned not only by things that happen to or in my body, but also by my being-together-with-others-in-the-world. (170)

Despite the influence of Cartesianism, human embodiment is inescapable and plays a central role in the universal foundations of morality. The inevitable embodiment of persons is important for two reasons. Firstly, embodiment entails constraints on actions – the ability to perform particular actions is determined to some extent by physical capacities. Secondly, it results in particular needs - such as those required to sustain life - and desires, such as physical pleasures and the avoidance of physical pain. The embodiment of other moral agents and non-agent human beings is likewise important in that these subjects of moral concern possess needs and the capacity to experience physical pleasures and pains. I have argued that any system of morality at the very least recognizes living humans as potential moral agents and as subjects of moral concern. Consequently, the treatment of humans by other moral agents is subject to some minimal but universal conditions. Foremost among these are the principles of respect for bodily integrity\(^\text{11}\) and for autonomy, without which there can be no meaningful moral agency and hence no meaningful system of morality.

### 2.3 Respect for bodily integrity

If people are to engage in social activities as subjects of moral concern and (in most cases) moral agents, they must be able to exercise some freedom of action. Without such freedom, they cannot make choices as moral agents. Whether capable of moral agency or not, human beings also require a degree of protection from interference by other agents such that they are able to distinguish themselves from other humans. The ultimate boundary of freedom, and of protection from interference is that of the physical borders of the human body.

Bodily integrity is a complex notion incorporating the idea of completeness as well as inviolability. In the former sense, which Dekkers describes as a recognition of

\(^{11}\) Note that I am specifically talking about \textit{bodily} integrity, which concerns the integrity of the physical or material human body, and not the more complex concept of integrity as outlined by Fjellstrom (2005), and as articulated by Rendtorff (2002), of which bodily integrity is merely a component.
“wholeness” in the body that may be biological, normative or subjective (2009, 340), any loss of component parts may be seen as compromising bodily integrity. Thus for example, Wilkinson and Garrard (1996, 337), suggest that loss of irreplaceable or unique body parts may be considered a greater violation of bodily integrity than that of blood.

However, the predominant conception of bodily integrity is that of an inviolable physical domain rather than a finite collection of integrated parts. Accordingly, the moral significance of bodily integrity is primarily concerned with the violation of boundaries, rather than the loss of parts, although violations may often be associated with destruction or removal of bodily components. After all, the components of living human bodies are constantly fluctuating in the course of various natural processes and social practices. All such processes involve a loss of bodily components (biological materials) and breach or impair bodily integrity, however there is little evidence to suggest that moral concerns about practices such as menstruation, the trimming of finger nails and the traumatic amputation of fingers, arise from concern for this impairment in itself. Rather, it seems that concerns about integrity arise due to the circumstances in which integrity is impaired.

Although Kant is often quoted as objecting to the removal of body parts on the grounds that it violates bodily integrity, his position on the subject is not entirely clear. While he condemns outright the sale of organs and teeth, he suggests that the sale of hair might be less problematic (1996, 177). He endorses the removal of diseased parts but appears opposed even to the gift of parts for another’s use (ibid.). Numerous attempts have been made to clarify and reconcile his position (e.g. Morelli 1999; Gerrand 1999; Kerstein 2009), from which it appears that Kant’s concern is not so much with the breach of bodily integrity, but with the procurement of part of an embodied moral subject, and particularly the mode and purpose of that procurement – an issue that will be discussed in Chapter 7.

2.3.1 Bodily integrity as inviolability

What then do we mean when we speak of bodily integrity in the sense of an inviolable human body? Wilkinson and Garrard (1996, 338), note that bodily integrity may be violated without literal loss of HBM, for example in cases of “spatial invasion” of the body such as rape. Rendtorff describes integrity in this sense as a personal sphere of self determination. . . . An untouchable core. . . . which should not be subject to external intervention… The personal body must be
Respect for bodily integrity is often expressed as the “right to bodily integrity”. It imposes a negative duty on moral agents to refrain from interfering with living human bodies, except where consent is given or may be presumed. Thus casual touching of other bodies in the course of daily social activities are not considered violations of integrity, where such practices accord with societal norms. Such norms are very much context dependent. For example, while for couples in a sexual relationship a kiss on the lips is usually consensual, a casual kiss on the lips of a stranger in the street may be considered a violation of bodily integrity. The recent case of an Australian ambassador who tried to impose a handshake on a female interpreter in Saudi Arabia highlights the cultural sensitivity of apparently minor infringements of bodily integrity (Zwart 2010).

On the other hand, consent to the disruption of bodily integrity is commonly presumed in the case of “incompetent” patients who are unable to provide consent for therapeutic interventions due to permanent or temporary mental incapacity. Surrogate decision makers in the form of persons deemed to be familiar with the preferences of the incompetent patient are often asked to provide consent on their behalf – further demonstrating how the limits of bodily integrity may be socially determined.

Violation of bodily integrity is most obvious when physical violence inflicts pain, damage (even death) or literally invades the space of a human body through use of rape, weapons or the application of restraints. Any non-consensual interference, regardless of the degree of harm it may inflict, is a violation of integrity and a wrong in itself. There are a limited number of justifications for violations of this fundamental principle. They include violations imposed: (i) in the belief that they are in the person’s best interests – for example coerced therapeutic interventions; (ii) as punishment for crimes; or (iii) in order to prevent immoral acts – such as restraining a murderer or fighting off an assailant.

2.3.2 Consent and respect for bodily integrity

Schicktanz and Schweda note that,

The body is a challenge for bioethics, because autonomy as the idea of the ‘unavailability’ of the body relies on various premises regarding the manner in which cultural and personal identity is built upon bodily practices, bodily constitutions and body images. (2007, 11)

I have emphasized that disruptions of bodily integrity are considered violations where
they occur against the wishes of an individual or in the absence of consent, where it may not be presumed. Does this mean that violations of bodily integrity are simply a particular category of violations of respect for autonomy? That is, is the disruption of bodily integrity wrong only where it violates autonomy? Archard (2008) provides a thorough analysis of this question in his examination of autonomy and self-ownership in the body, although rather than invoking bodily integrity he speaks of “bodily trespass”. He gives the example of a doctor who inserts a swab into the mouth of a patient without obtaining consent, without coercing or deceiving her or otherwise causing harm. The patient, he argues, has nevertheless been wronged and “the wrong of taking the mouth swab cannot be understood by appeal to the idea of respecting personal autonomy” (ibid., 22).

Archard argues that,

an autonomous decision is valuable insofar as it concerns a matter critical to the leading of a life. A critical decision in this sense is one that makes a substantial difference to the person’s life — what projects he can undertake, what he finds worthwhile and rewarding in life, what gives his life purpose and value. (Ibid.)

The doctor’s insertion of the swab, he suggests, is unlikely to impact upon the patient’s capacity to make and implement autonomous decisions in her subsequent life, thus to describe the wrong as a violation of autonomy is incorrect. Instead, he points to “bodily trespass”, a crossing or infringement of the physical boundaries of another person, which I consider synonymous with “violation of bodily integrity” as described by Rendtorff above.

Archard notes that “the idea of bodily trespass as a basic and distinctive wrong is best elucidated in terms either of property in one’s self, or of a jurisdictional domain over which the person exercises his will” (2008, 31). However he concludes that,

attempts to spell out what is wrong either by appeal to the idea that I own my body or by appeal to the distinct idea that I rule my body are of limited use. We still lack a proper appreciation of the differential wrongness of different kinds of bodily trespass, and may be committed by such spellings out to further contentious claims. (33)

Absent the principle of respect for bodily integrity, there are no alternative moral principles capable of precisely capturing its significance. As Archard shows, the wrong of bodily trespass is not the same as violations of autonomy, nor is it captured by accounts of coercion, deception or harm, “the wrong of bodily trespass is independent of any harm that is done in and by the trespass, and of the manner in which the trespass is achieved” (27).
To some extent, establishing grounds for the principle of respect for bodily integrity in a particular ontological conception of the human body may appear unnecessary. In the debate about markets in HBM, support for the principle of respect for bodily integrity appears unanimous, regardless of how the body is conceptualized. I believe however, that such a principle is a formal requirement of moral systems. Without the comprehensive protection of my personal physical domain afforded by the right to bodily integrity, I cannot exercise my full autonomy (a concept that I shall examine shortly). Furthermore, if the limits of interference with other moral agents are not set at the very least at the borders of their bodies, it is difficult to see where any meaningful limit can be set. Hence, procurement of HBM from living providers is a fundamental moral concern, and voluntariness of living provision must be an essential feature of any procurement system.

2.4 Defining autonomy

The principle of respect for autonomy has already crept into our discussion. Like respect for bodily integrity, it is a key feature of moral systems, for without autonomy there can be no moral agency. Unfortunately, as Onora O’Neill points out, “There are many distinct conceptions of individual autonomy in circulation, and even more views of the value and importance of these conceptions” (2003, 5). In Autonomy and Trust in Bioethics, O’Neill argues that individual autonomy is frequently subject to minimalist interpretation as no more or less than informed consent (2002a, 96). Situating the contemporary discourse on individual autonomy in the tradition of J.S. Mill, she notes its emphasis on independence of choice for moral agents, albeit with spectacular disagreement about what makes some choosing autonomous (ibid., 28). This conception of autonomy considers individuals

autonomous with respect to their desires if they arise from the self in some way – they are not implanted by another – and the person in some way reflectively accepts them, and is autonomous with respect to their actions if it is they, and not another, that controls the performance of them. (Ibid., 15)

J.S. Taylor draws on such “individual autonomy” in Stakes and Kidneys, describing it as “the non-Kantian approach…dominant within medical ethics… whereby a person is autonomous if he governs himself in accordance with his contingent ‘preferences and desires’” (2005, 15).
In contrast, O’Neill outlines a Kantian vision of *principled autonomy* in which autonomy in thinking is no more – but also no less – than the attempt to conduct thinking (speaking, writing) on principles on which all others whom we address could also conduct their thinking (speaking, writing). Autonomy in action is no more – but also no less – than the attempt to act on principles on which all others could act. (2002a, 94)

She argues that this conception “provides a basis for an account of the underlying principles of universal obligations and rights that can structure relationships between agents” (ibid., 96).

When I examine The Argument from Autonomy in Chapter 6, it is with the “non-Kantian”, narrow conception of individual autonomy that I shall be mainly concerned, due to the predominant role it plays in the market debate. However, in establishing a principle of respect for autonomy in the moral framework with which we shall address issues concerning the treatment of HBM, and which I shall claim is universalizable, a more comprehensive conception of autonomy is needed. A formal requirement of any moral system, I have suggested, is a principle that will enable moral agency through some degree of rational and reflective decision-making that engenders responsibility. Some version of the individual autonomy proposed by Taylor may fit this purpose, however as an essentially self-regarding concept focusing on an agent’s personal preferences and desires, it seems less fit when used in decision-making that affects other moral agents and members of society. This is particularly so when autonomous agents may be involved in complex webs of interpersonal relationships and shared pursuits, which may in turn impact on autonomy (see for example Baumann’s (2008) account of *relational autonomy*).

Respect for individual autonomy, despite the concerns expressed above, remains a key minimum component of moral systems at least in so far as self-regarding choices are concerned. In the setting of decisions regarding the procurement of HBM from living human beings, autonomy may be rightly valued as

> the fundamental interest all individuals have in making decisions in whatever concerns their own lives, free from external coercion and from manipulation — by such illicit means as brainwashing and involuntary intoxication — of their beliefs and preferences. The right of individuals to make such choices deserves respect for so long as the choices are, in a specified minimal sense, autonomous, that is to say, informed, voluntary and rational. (Archard 2008, 21)

The implications of respect for autonomy in the context of HBM procurement will be discussed in detail in Chapter 6, including the importance of considering a more social conception of principled or relational autonomy.
2.5 Moral pluralism and universal human flourishing

Thus far, I have identified three universal, necessary but insufficient features of morality: the recognition of human beings as moral agents and subjects of significance as a pre-condition for human morality, and the principles of respect for bodily integrity and individual autonomy as functional requirements for morality. These elements provide a minimal moral framework for examination of issues relating to the treatment of HBM, but offer limited guidance for policy makers concerned with developing and achieving societal goals. For some, this might seem an advantage, as it avoids the imposition of ethical values and principles that may not be valid in all societies. I shall argue however, that a minimal conception of human flourishing as a common goal for the members of all moral societies is universally valid and necessary if morality is to offer more than an impoverished contractual framework with which to regulate human interactions.

2.5.1 The problem of moral imperialism

The fear of wrongly imposing moral values on societies is a common concern in contemporary bioethics debates. It presents an enormous challenge for regulating the treatment of HBM in the global context, which I shall address in Chapter 9. Moral relativism is the theory that moral right and wrong are relative matters. A given act can be right with respect to one system of moral coordinates and wrong with respect to another system of moral coordinates. And nothing is absolutely right or wrong, apart from any system of moral coordinates. (Harman and Thomson 1996, 13)

Even if one allows for the existence of moral truths and a correct answer to all moral disagreements, “Each of those positions can explicate itself … [but] there is no independent intellectual location from which to evaluate or meta-critique those positions” (Capaldi 2006, 137). Attempts to impose a “universal” bioethics on multiple societies with potentially divergent moral frameworks are often described as “ethical imperialism”. Thus the selection of a particular framework to be implemented at a global level seems the height of either pragmatic arbitrariness – if all frameworks are recognized as equally valid – or “moral neocolonialism” (Widdows 2007) - where the prevailing powers impose their particular framework upon others. For example, in his critique of attempts to regulate “transplant tourism”, R. Evans writes:

The West is increasingly finding it fashionable to impose itself on the East with paternalistic and often self-serving policies. In other words, consistent with ethnocentrism, it is felt the East should conform with the West, which, in turn,
has become increasingly intolerant, overtly imperialistic and unacceptably antagonistic. (2008, 1092)

The predominant model of bioethics in international discourse has been described as “Western” (Chattopadhyay and DeVries 2008) or even “Euro-American” (Sakamoto 1999). There have been numerous attempts to outline alternative models, usually with a clearly geographical or cultural orientation (e.g. Peppin and Cherry 2003; de Castro 1999), however the language of documents such as the UNESCO Declaration of Bioethics (2005) undoubtedly reflect a more European tradition.

2.5.2 Moral pluralism

Concerns about the global imposition of a particular ethics are justifiable. They underscore the need to ensure that my framework, with its intended global scope, is both relevant and valid within the context of all societies and cultures if it is to have moral legitimacy. Fortunately, while I have noted considerable global variation regarding the legality of trade in particular kinds of HBM (see Chapter 1), this does not necessarily indicate the existence of a plurality of conflicting or even incommensurable ethical values concerning the treatment of HBM. Instead, the rapid practical evolution of HBM procurement and use has often outpaced ethical examination of the issues.

Such practices may represent new ethical challenges for many societies that have no precedents in terms of traditions or shared experiences that can provide a meaningful basis for ethical decisionmaking. Hence, rapid advances in medical biotechnology are posing a different kind of challenge to our authenticity and integrity not only as Asians, or Ibero-Americans, or Americans, but also as persons. (De Castro 1999, 233)

This is undoubtedly true of the procurement and use of HBM, which despite its extensive history remains in many respects a novel issue for most societies. In particular, the procurement of materials from living persons for therapeutic use and the possibility of commodification of these materials represent new procedures which are not embedded in longstanding ethical traditions, although they may be informed by them. As De Castro suggests, “More than ever, perhaps, this is the time for people of various nationalities and cultures to learn from one another’s mistakes and experiences” (ibid.).

We need not adopt the position of a radical relativist who holds “that no-one should ever pass judgment on others with substantially different values, or try to make them conform to one’s own values” (Wong 1993, 447). As Levy argues, a pluralist
need not think that because values are plural and conflicting, there is never any fact of the matter which of two judgements or practices is better. Very often values can be ranked; pluralism is entirely compatible with the rejection of radical relativism. (2002, 195)

The pluralistic approach is reflected in Nussbaum’s discussion of a universal capabilities approach to examining women’s quality of life in the context of Indian society. Nussbaum notes the importance of contextual considerations but argues that “certain very general values, such as the dignity of the person, the integrity of the body, basic political rights and liberties, basic economic opportunities, and so forth” are appropriate norms for the assessment of women’s lives (2000, 385). She argues that different cultural practices do not necessarily reflect the ethical values of a society, nor does recognition of cultural diversity preclude criticism of “unjust cultural practices” (401). She suggests that traditional practices [that] are harmful and evil, and … actively hostile to other elements of a diverse culture” should encourage the development of “a set of criteria against which to assess the practices we find, asking which are acceptable and worth preserving and which are not. (402)

In particular, Nussbaum writes,

when we make a concrete proposal for a universal framework… it will be suggested that the particular categories we choose are likely to reflect our own immersion in a particular theoretical tradition and may be, in some respects, quite the wrong ones for the assessment of Indian lives. We need to ask, then, whether it is appropriate to use a universal framework at all, rather than a plurality of different though related frameworks. And we also need to ask whether the framework we propose, if a single universal one, is sufficiently flexible to enable us to do justice to the human variety we find. (Ibid., 384)

2.5.3 Human flourishing as a varied but universal goal for morality

The principles of respect for bodily integrity and autonomy provide important constraints on the treatment of living human bodies. Nevertheless, morality is not merely concerned with prohibitions, but with the promotion of a variety of human individual and social goals perceived as necessary elements of, or desirable ends of human lives. The achievement and pursuit of such ends is often described as ‘human flourishing’, a term derived from Aristotle’s account of eudaimonia. Although Aristotle’s eudaimonia is a complex and much-critiqued concept, its interpretation as for example “a life, enjoyable and worth while all through” (Ackrill 1980, 19), grounds contemporary accounts of human flourishing such as Nussbaum’s.

Authors such as Engelhardt (2006, 41) have emphasized the pluralistic nature of accounts of human flourishing, which is commonly perceived as firmly embedded in
the context of particular societies. However, Nussbaum suggests that true human flourishing depends on a core set of capacities for functioning:

Legitimate concerns for diversity, pluralism, and personal freedom are not incompatible with the recognition of universal norms; indeed universal norms are actually required if we are to protect diversity, pluralism and freedom, treating each human being as an agent and an end. The best way to hold all these concerns together… is to formulate the universal norms as a set of capabilities for fully human functioning, emphasizing the fact that the capabilities protect, and do not close off, spheres of human freedom. (2000, 443)

The gradual emergence of virtue ethics\textsuperscript{12} or neo-Aristotelianism in contemporary bioethics has been largely confined to the realm of professional ethics (e.g. Oakley and Cocking 2001). When invoked in the setting of individual decision-making, virtue ethics appears to be contextually driven to help provide clear answers to bioethical dilemmas (Gardiner 2003, 301). Holland argues that virtue ethics may be useful in particular cases, but is problematic when applied to policy making at the societal level where it would require the imposition of a “determinate account of flourishing” by the state (2009, 9). Nevertheless, where the issue at stake is fundamentally social and grounded in universal features of human lives, such as the procurement and use of HBM, conceiving human flourishing as partially determined by universal elements such as Nussbaum’s capacities is very useful.

Where decision-making involves multiple individuals, and the decisions made will affect multiple persons, such as the development of policies governing the treatment of HBM, or the provision of public services such as healthcare, some conception of common goals is required. If morality is to provide guidance to members of society in their interactions in pursuit of shared goals, definition of these goals becomes part of morality itself. To avoid arbitrarily imposing a specific vision of ultimate goals on societies, or even individuals within societies, Nussbaum’s capabilities approach offers a way to promote the goals that will enable individuals to ultimately choose their own vision of the good life. Drawing on this, I will suggest that societies seeking to promote any conception of flourishing will not only desire to avoid harmful or involuntary HBM procurement practices but will actively aspire to a sufficiency of HBM to meet healthcare needs.

\textsuperscript{12} Although Nussbaum (1999) suggests that “virtue ethics” is a misleading category from which neo-Aristotelian ethics should be distinguished, I shall retain it here as accounts of human flourishing in bioethics often invoke “virtue ethics” when drawing on the neo-Aristotelian conception.
2.5.4 Flourishing, health and the body

Among the ten capabilities that Nussbaum lists, three are intimately related to the human body, namely,

1. Life. Being able to live to the end of a human life of normal length; not dying prematurely, or before one’s life is so reduced as to not be worth living. 2. Bodily Health. Being able to have good health, including reproductive health, to be adequately nourished; to have adequate shelter. 3. Bodily Integrity. Being able to move freely from place to place; having one’s bodily boundaries treated as sovereign, i.e. being able to be secure against assault, including sexual assault, child sexual abuse, and domestic violence; having opportunities for sexual satisfaction and for choice in matters of reproduction. (2000, 419)

Nussbaum also notes the importance of “being able to have pleasurable experiences, and to avoid non-necessary pain” (ibid.).

Pellegrino also highlights the centrality of health to flourishing in his review of markets in healthcare:

Human flourishing can and does occur in the presence of chronic illness, but it is certainly more easily attained when one is healthy. Chronic illness, pain, discomfort, or disability can constrain the most determined and best-adjusted person. For most people, it is difficult or impossible to do the things they want to do or enjoy when they are afflicted by illness. Health is a fundamental requirement for the fulfillment of the human potential and freedom to act and direct one’s life. To lack health and to need treatment is to be in a diminished state of human existence — a state quite unlike other deprivations which can be borne if one is healthy. (1999, 248)

The promotion of a minimum level of human health is likely to be a requirement for human flourishing in any society, as the inclusion of health in the United Nations Declaration of Human Rights (UN 1948) suggests. We should therefore identify the promotion of a minimum level of health as a universal goal for all moral systems. Given the potential for HBM to restore or sustain health, it is likely that contemporary societies with the capacity to use HBM therapeutically will seek to improve supplies of and access to HBM in pursuit of this goal. Thus, individuals and societies will not only seek to minimize or eradicate unethical practices (particularly those that pose risks to the health of providers or recipients) in procurement, but they will share an interest in the use and distribution of HBM and in the pursuit of a sufficient supply of HBM to meet healthcare needs.
2.6 Conclusion

I began this chapter with a brief account of morality and the role of embodied living human beings as “dependent, rational animals” who constitute important subjects of moral concern for morality, recognition of which status is often expressed as respect for human dignity. I argued that the social framework of all moral systems provides a universalizable foundation for a minimally conceived ethics of the human body. I discussed the principles of respect for bodily integrity and individual autonomy, which I claim are minimal requirements for any morality due to the embodied nature of moral agents. I examined the significance of consent to disruption of bodily integrity, agreeing with Archard that while consent is a necessary condition of respect for bodily integrity, it is does not sufficiently capture the idea of what is wrong with violations of integrity. I suggested that a minimal universalizable conception of autonomy with which to ground an ethics of HBM will require both the narrowly conceived individual autonomy required to protect bodily integrity and moral agency as well as a richer vision of autonomy by which morality strives to respect the interest that individuals have in directing their own lives and to enable members of society to live meaningful lives.

Finally, I introduced the concept of human flourishing as a goal of moral communities, the full implications of which will be outlined in Chapter 7. Although supportive of pluralistic conceptions of the good life, I endorsed Nussbaum’s claim that a set of universally valid capacities for flourishing should be protected and promoted by all societies. With this in mind, I highlighted the importance of human bodies and biological materials to the achievement of many universal requirements of and goals for human flourishing, in particular noting the significance of health, which will form a key theme throughout this thesis. Armed with this basic moral framework, the rest of this thesis will serve to further expand the universalizable content of morality with respect to the treatment of HBM, and its practical implications within the context of different communities.
3

Personal property?

_The compelling, even hypnotic fascination inspired by slave spectacles resides, I believe, in their violent triangular conjunction of money, property and flesh... money transforms flesh into property; property transforms flesh into money; flesh transforms money into property._ (Roach 1996, 215)

### 3.1 Introduction

The way in which HBM, or at least detached HBM, are valued and conceptualized in particular contexts determines to a large extent the norms of their treatment. Common practices or customs in which materials are treated as waste, precious gifts or saleable resources provide starting points for debate, from which formal codes of practice or legislation are often derived to guide future treatment. The social institution of property, with its attendant laws governing the potential sale, use, transfer or exchange of goods, inevitably influences and informs discussion of the transfer and/or valuable exchange of HBM within societies. The property paradigm may be used to frame codes of treatment of HBM, but it is also used to advocate the sale of HBM. Where HBM are already bought and sold, they are subject to a variety of property rights and laws that are variably enforced.

The Argument from Property claims that HBM are properly recognized as the property of their providers and hence – like many other kinds of property – can be sold at the will of the owner. I shall take issue with this claim, which is often justified by analogy with other forms of property, arguing that property is a socially determined concept rather than an intrinsic characteristic of HBM. I suggest that attempts to determine whether HBM _can be or are_ treated as property must be distinguished from efforts to determine whether they _ought_ to be. Numerous examples such as those discussed in Chapter 1 demonstrate that HBM can be propertised, and in many cases are treated as the property of providers, recipients or others involved in their treatment. Whether we ought to treat HBM as property depends on (a) whether HBM ought to be bought and sold – thus necessitating property rights in HBM in order to facilitate market exchanges – or (b) whether some property rights (beyond rights of sale) are required to enable ethical treatment of HBM, for example through voluntary transfer of materials or protection of personal interests in one’s own materials.
I shall argue here that the property concept fails to fully capture what is at stake in valuations of HBM, and thus offers at best a constraining and potentially damaging framework in which to govern the treatment of HBM. In contrast, I present an account of personal value in HBM that precedes concepts such as gift, resource, waste or property (whether saleable or not). Although property laws may be invoked to protect personal value, and hence interests in HBM, I suggest that alternative protective mechanisms may be established within societies, and thus that property rights in HBM are not necessarily justified or required for the ethical treatment of HBM.

3.1.1 Overview of the chapter

I begin by introducing the Lockean theory of natural property rights in the human body, arguing that while it fails to establish a right to sell one’s own materials, it highlights the centrality of individual personal interests in the treatment and disposition of HBM. Rather than endorsing an intrinsic right to property in the body, I suggest that a social constructivist view of property rights is more useful for examining the issue of how society should regulate the treatment of HBM. Conceptualizing HBM as property will be justifiable, I argue, if specific property rights are necessary to protect key personal interests or value in HBM, or if property rights offer better protection than alternative social mechanisms or conceptualizations of HBM. Accordingly, I next explore the different values that may be placed in HBM, focusing in particular on what I term “personal value”.

Following this, I discuss how personal value may be identified with personal interests in HBM and hence rights to determine the conditions of treatment of one’s own HBM – which are frequently construed as property rights. I argue that despite the ubiquity of property rights in legal debate regarding the treatment of HBM, such rights are by no means necessary to protect fundamental personal interests or important values in HBM. Rather, I suggest that recognition of property rights in HBM poses a number of ethical and practical hazards.

Next I briefly examine the two major alternatives to the propertised conception of HBM transfer and exchange, those of gift and public resource. I argue that these also pose practical and ethical dangers to the treatment of HBM. I suggest that attempts to formulate guidelines for the treatment of HBM that are directly derived from particular conceptions of HBM will be unsuccessful in upholding the variety of potential individual and social values and interests embodied in HBM. Instead, I argue that a pluralistic approach to value in HBM that prioritizes personal value but which sets such
value and the treatment of HBM in a social context will ultimately provide a more comprehensive framework for regulation of the treatment of HBM. Although in some societies, some form of property rights may be integrated into this framework, these should be considered a practical tool rather than a justification for particular forms of treatment of HBM, such as sale.

3.2 Property in the body – natural right or social construct?

Identification of something as property characterizes the relationship between that entity and a particular individual(s) as one of ownership, and thereby entails limits on how others may treat that entity. The property relationship incorporates a bundle of ownership rights that govern the use and transfer of goods by an individual (or groups in the setting of shared property). Limitations may be set on the use and disposition of particular entities even where these are recognized as private property. Although the definition of specific rights embodied in the property relationship is variable, Björkman and Hansson suggest that in modern capitalist societies “a person’s right to sell an entity [is] the core feature of ownership of that entity” (2006, 211).

Locke’s theory of natural rights holds that a previously unowned entity becomes the property of an individual when she mixes her labour with it, and further declares that “every Man has a property in his own person” ([1689] 1965, 328). For many, Locke’s account has been interpreted as a justification of property in one’s own body, and hence of one’s detachable HBM. Once something has been designated property, it may be given, bequeathed or sold to other individuals who then become legitimate owners.

Bray notes,

For Locke, an individual's ownership of his body and labor is the postulate that enables man to own things external to himself. Only because people have physical ownership of' their bodies do they have an ownership of their bodies' products. (1990, 212)

In contrast to the natural rights theory, Björkman and Hansson (2006, 210) term the major alternative, “the social constructivist view of ownership” by which the content of property rights is chosen by society in order to promote particular social goals, and formulated and implemented through the law. Both theories have been used to support recognition of property rights in HBM.
3.2.1 Natural property rights in the living body?

The natural rights theory is, I believe, inherently ill suited to the concept of saleable property in HBM. As Rao (2000, 368) and C. Campbell (1992) demonstrate, Locke himself views the human body as property held in trust for God. The relationship between bodies (and HBM) and individuals is essentially one of stewardship, with the “owners” of bodies obliged not only to care for themselves but also to provide mutual aid to others in order to help protect and preserve God’s property. Dickenson points out that “Self-ownership in the sense of ownership of the physical body is not the crux of [Locke’s] argument: rather, the claim that I own my actions, and therefore the resources or wealth produced by my actions” (2007, 38).

Nevertheless, even as stewards, individuals have proprietary rights over their bodies which entitle them to treat them largely as they will. The self-ownership model outlined by Arnesson (1991) and discussed by Campbell as an alternative framing of Locke’s property model is more consistent with contemporary accounts of the body as property. Campbell notes that we experience our living bodies “both as what we are and as what we have or possess” (1992, 34). When I stand up, I perhaps do not think of my legs as being used, however when someone kicks me in the leg, or my leg is amputated, I think of the leg as mine. Campbell describes the duality of such experiences as relationships of identity and otherness (37). He suggests that property rights in the body can be established without rendering persons property through the self-ownership paradigm, in which

self-identity is distinguishable from bodily existence and experience. Self-identity instead resides in the legislative will, the autonomous decision maker, the rationally self-interested chooser--the "self" and its choices that the principle of autonomy obliges us to respect. (40)

This results in a “loss of the embodied self, that is a sense that the body is incidental rather than intrinsic to self-identity and to understanding who we are” (ibid.).

Self-ownership requires a dualistic shift in order to distinguish between a person and the body she owns, thus avoiding “the stewardship implication that the person is [God’s] property by affirming that self-identity is distinguishable from bodily existence and experience” (ibid.). Unfortunately, treating the body and its parts as saleable, and hence effacing personal value in HBM has significant implications for the treatment of persons as embodied beings.

By uncoupling the body from the person and undermining the unity of the physical being, the property paradigm facilitates fragmentation of the body itself, both literally and figuratively. As a result, under property theory, body parts are severable from the person, who may give or sell these parts to others.
without loss of personal identity… Such fragmentation can result in instrumentalization, alienation, expropriation, and ultimately inequality. (Rao 2000, 429; see Chapter 7.)

Saleable property in the integrated human body facilitates the treatment of living human beings as financial capital, which endangers personal autonomy and bodily integrity by effectively enabling separate ownership of integrated materials. This risk is evident in the black market for organs, where human kidneys have become forms of debt collateral in some communities (L. Cohen 2003, 676). Rao notes that

Separate ownership of a body part within a living human being is at odds with the principle of personal autonomy because it affords one individual pervasive power over the body of another, while divided ownership of a person undermines individual equality. (2000, 455)

If we consider Locke’s intent in postulating bodily sovereignty, it is evident that natural property rights in the body itself are not required. He sought to uphold the right to bodily integrity and autonomy, which I have defended in the previous chapter, and further to entitle individuals to the fruits of their labour. On the other hand, some might argue that the latter claim entitles individuals to sell their detached HBM, for example in cases of secondary commodification where materials removed therapeutically hold commercial value. Applying Locke’s theory of property however, it seems that HBM which are deliberately removed from an individual – for example in therapeutic procedures – may more rightly be designated the property of the person who has laboured to remove them, or who modifies them for therapeutic use and/or commercial sale. The person from whom HBM originates adds little to its commercial value. Although arguably a person who deliberately cares for her health in order to ensure that her materials are in excellent condition for use by others performs some labour, such a claim will be difficult to prove against the visible and directed efforts of medical and scientific personnel\(^\text{13}\). Nevertheless, the intimate relationship between an individual and her body is such that when materials are detached, it seems natural to suppose that if they belong to anyone, they belong to her. Locke’s account of bodily sovereignty may thus inform our examination of the interests an individual may have in controlling the disposition of her HBM.

\(^\text{13}\) Dickenson argues that women’s labour in the case of oocyte provision justifies a Lockean property right in these materials (2007, 69). However, her intent seems rather to highlight the neglected role of women in providing valuable reproductive resources, and to promote their bodily rights, e.g. in controlling the treatment of extracted oocytes. Emphasizing the dangers of commodification, she advocates a bundle of property rights that does not include the right to sell (ibid., 70).
3.2.2 A social constructivist view of HBM as property

The social constructivist view of property offers a number of arguments with which to defend the treatment of HBM as property. Naturally, those who advocate markets in HBM will ultimately support a conception of HBM (at least detached materials) as property in order to facilitate trade. This of course pre-empts the question of whether HBM should be traded. I will argue in later chapters that it is not in the interests of societies to trade HBM, and therefore not to conceive of HBM as saleable property. However, in addition to the claims of market advocates, many have defended the propertisation of HBM as a way to protect certain fundamental interests one has in one’s body. Before considering these interests and how they may be protected, we must first explore the concept of personal value in HBM, from which such interests derive.

3.3 Personal value in HBM

Living persons have intrinsic moral status as subjects of moral concern, while detached materials possess moral value as special objects by virtue of their connection to living persons. To be recognized as a moral subject, an entity must be at the very least alive, sentient and possess the capacity for consciousness. Detached HBM, whether a kidney or a test-tube of sperm, may be alive but are not - strictly speaking - sentient and have no independent capacity for consciousness. The moral status of HBM and concerns about the treatment of HBM are therefore bound up in valuations of living people and principles governing their treatment, as well as personal value conferred upon detached materials by virtue of their relationship with living individuals. I will argue that this value is never entirely eliminable even where commercial or therapeutic valuations appear to dominate discourse and practice.

Some authors are quick to disconnect HBM and their potential moral value from that of living persons. Cherry, for example, suggests that even prior to physical removal, detachable parts may be considered differently from the rest of a human body as they can be “conceptually differentiated from the persons who possess them” (2005, 27). Such attitudes fail to recognize the plurality of values embedded in detached HBM and, I will argue, pose serious threats to the crucial valuation of living persons as subjects of moral concern.

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14 Gametes may be considered to have some kind of moral status as potential persons, however I agree with Reichlin (1997, 13) that this isn’t the same potentiality as human embryos. As noted earlier, I won’t address issues of embryo procurement or sale here.
3.3.1 Bodies and body parts as sacred

The value most commonly invoked in reference to HBM in the setting of opposition to purely instrumental or commercial valuations and treatment of HBM is that of sacredness. M. Evans (2003) distinguishes three broad uses of the term ‘sacred’: religious, transcendent and set-apart. In exploring the concept of the sacred as ‘set apart’, he writes that

the feature common to the set-apart sacred is its valuation beyond utility, and that this mental setting-apart of certain things, sometimes accompanied by a literal setting apart, is largely based on non-rational (which is not necessarily to say irrational) features, like their emotional value…. The concept motivates, shapes, constrains and justifies both individual and collective behavior and organization… it orients human behavior across contexts. (2003, 39)

The deceased human body is often described as sacred. Implicit in such descriptions are conditions of treatment such as conformity to funeral rites, avoidance of loss, injury, or use. Anthropology, history and archaeology provide a rich narrative of diversity in human practices with respect to the treatment of the dead. In an oft-quoted passage, the ancient Greek historian Herodotus highlights the importance that different cultures attach to the disposal of deceased bodies in accordance with funeral rites, despite the plurality of funeral customs (Strassler 2008, 224). Where dead bodies fail to receive the rites in accordance with the beliefs and customs of a particular culture, this failure is regarded as horrific and unethical treatment of the dead. Respect for the dead body appears a universal norm, but its practical implications are historically and culturally diverse.

That which is sacred is “set-apart” and may not be treated as non-sacred objects with similar properties might be. HBM detached from living people may also be regarded as sacred. For example, in some cultures parents may treasure baby teeth and locks of hair, while in others women may eat or bury placentas following childbirth in rituals designed to protect the child and mother (Birdsong 1998). Often, sacredness in HBM derives solely from the fact that the material is of human origin – regardless of whether the identity of the human is known, or whether the human is or was known personally to those valuing it. Thus the discovery of unidentifiable human remains nevertheless requires the fulfillment of traditional burial rites for the unknown, even in challenging circumstances such as natural disasters (e.g. O.W. Morgan et al. 2006, 814). However, designation as sacred does not inevitably preclude recognition of other forms of value in particular HBM. Although a relative’s body may be considered sacred, the removal and donation of organs for therapeutic use may be reframed as a sacred gift.
3.3.2 A plurality of shifting values in HBM

In contrast to sacred valuations of HBM, many materials are treated purely as waste. Thus human excreta and hair and nail clippings in contemporary Western societies are habitually discarded without further concerns about their treatment. Most other materials possess some utility value, either as diagnostic or research specimens or in various therapeutic modalities such as transplantation, transfusion and ART. While such valuations are often impersonal, highlighting the utility of specific materials rather than features of their provider, recognition of utility value does not preclude valuation as sacred or personal, and different values may be accorded to specific material by different individuals. In some cultures, the placenta is simply discarded after labour as a form of medical waste, while in others it forms part of elaborate childbirth rituals (Schneidermann 1998). Thus a placenta may have sacred value to a Hmong woman who believes it will help to guide the soul of her child (Birdsong 1998, 191), and therapeutic or commercial value to a scientist (Annas 1999).

3.3.3 The roots of personal value in HBM

The plurality of values and conceptions placed on particular HBM in a variety of settings makes the task of forming general principles of practice impossible if we attempt to draw general conclusions from particular cases. It is especially difficult to form definitive principles in this manner given the rapid evolution of science and medicine, with improved techniques reducing the risks of provision of some materials, and novel therapies creating demand for new materials and new ethical dilemmas. Throughout the many examples of historical and contemporary practice however, a common theme is visible. The way in which various HBM are non-instrumentally valued and conceived inevitably reflects back on the living person from whom they were derived. Historically,

> the ways in which humans have used body parts at any particular time and place depended directly on the meaning (status, power, value, etc.) attached to the human being from whom they came. The corpses of saints and the corpses of criminals in the medieval period had widely differing meanings, despite their apparent similarity as dead human beings. These meanings - whether taken literally or understood as symbolic of "higher" ideas - allowed pieces of the former to be venerated and pieces of the later to be reviled and "punished". (Lawrence 1998, 112)

Just as the treatment of the dead “is conditioned by [the survivors’] perception of death and their relationships with each other as much as by their relationship to the deceased whilst alive” (Pearson 2008, 203), the treatment of detached HBM is conditioned by the
living, either through posthumous expression of the provider’s preferences and values or through those of kin. I will use the term “personal value” to describe this potential non-instrumental value that is contained in all HBM and which may be expressed in particular conditions of treatment of detached HBM.

Although each material may have instrumental value, or may be regarded as sacred by virtue of being human tissue, it is personal value that connects each HBM to their original provider. There are varying degrees of connection between providers and their materials. Firstly, there are materials that are currently integrated components of a living human body. Secondly, there are materials that have been detached from a living person’s body. For example, a diseased appendix, or a kidney donated by a (still living) woman to her brother thirty years ago. Thirdly, there are integrated components of a deceased person’s body, or materials that have been removed from a body after death – such as organs – or which were detached from the living body of a person now deceased – such as a diseased appendix stored in a pathology museum. All materials within the second and third categories, including those still present within a deceased body, I refer to as detached. By detached, I refer to separation from a living human being, specifically its original provider. Thus a living person’s appendix is physically detached from her during appendectomy, and her corpse is detached from her following death in a more metaphysical separation.

Within the first category, HBM are traditionally understood merely as elements of living human beings with no distinct value of their own, only that inherent in the moral status of the person herself. The increasing commodification of HBM risks compromising that status and dissociating body parts before physical detachment, the implications of which I will discuss in Chapter 7. With respect to the second category, I will argue that the treatment of materials obtained from a person who is still alive is often of paramount importance to that person. The practical implications of a shared genetic identity and the extension of a personal interest in and potential ownership of such materials by an existing person suggest an intimate connection that has its roots in psychological, legal and philosophical understandings of the bodily integrity concept. Within the third category, while HBM are valued by virtue of their connection to a former living person, it is through the perspective of society, usually in the form of people known to the deceased, that this connection is upheld and the materials personally valued.

In each category, HBM are defined by their connections to and relationship with individuals and societies. Traditional distinctions between HBM, as noted in Chapter 1,
instead focus on biological or functional features, for example the physical ease with which a material may be detached, or the degree to which the loss of a particular material is perceived as a disfigurement of the person. Thus, Cherry argues that insofar as [some] body parts can be removed or replaced without a substantial loss in the range of embodied function usual to humans, claims that they should be considered as different from other types of property that can be given away or sold are less plausible. (2005, 28)

This is symptomatic of Cherry’s Cartesian approach to the body, in which “self and body are often both distinguishable and separable… a person’s body can be regarded as a collection of things with which the person is more or less intimately associated” (ibid., 25). Cherry suggests that HBM more intimately associated with personhood are those necessary for existence (such as higher brain function) and life (e.g. vital organs) with those responsible for important functions (such as limbs) preceding those that we might think supernumerary (the “spare” kidney, and oocytes) or replaceable (such as blood and renewable tissue). Wilkinson, however, recognizes that physical bodies and body parts are more than “mere objects”, being “intimately related to persons” (2003, 53).

3.3.4 Exploring personal value in HBM

The degree of connection between persons and particular body parts is often socially and culturally influenced. Karlsen et al. write that, “human biological material is intrinsic to human life, not only when they are parts of the living human body, but also in terms of how they are involved in human practices” (2006, 219). While the detachment procedures, cultural beliefs and circumstances in which HBM are procured influences the valuation of particular materials in different situations, the universal factor present is that of an intimate relationship between the material in question and its provider. This relationship confers personal value on all HBM.

Personal value has three dimensions. The first is a biological or genetic relationship of identity that has practical implications for the potential use of the material. A living individual and/or her genetic relatives will have an interest in the treatment of material that may impact on their lives – such as the revelation of health-related information. Secondly, individuals may feel a spiritually or psychologically mediated identity relationship with their detached materials. After all, our social identities are significantly shaped by our bodies from the moment of birth (or even before) until after death (Hockey and Draper 2005). Thus, the way in which materials are treated may be felt to reflect on attitudes to the provider or even to constitute symbolic treatment of the provider herself. For example, a Californian woman sued her gynecologist for
“branding” her uterus after it was removed for therapeutic reasons (Fantz 2010), echoing an earlier case in which a woman expressed emotional distress that her uterus had been branded with the initials of her doctor’s university during hysterectomy (Garay 2003). Thirdly, personal value involves an authoritative element regarding the treatment of the material. That is, the personal relationship between an individual and her biological materials entitles the individual to determine to some extent the use, storage or disposal of her detached materials.

In practice, like respect for bodily integrity, consent to particular forms of treatment of HBM is presumed. Although women who undergo hysterectomy are consented for the removal of their uteruses, and (probably) informed that the uterus will be subject to diagnostic pathology tests, it is unlikely that their consent is sought for the routine disposal of their pathology specimens and remaining tissue. In contemporary Western culture few women would be concerned to learn that their uterine tissue has been collected and incinerated, however, many would be upset to learn that their tissue had been “branded” or otherwise treated as a source of entertainment for medical staff. Such treatment is often described as “disrespectful” of the material in question and therefore of the person from whom it derives.

When valued personally in these ways, HBM is partially imbued with the identity of the person from whom it is derived. Identity in this sense may correspond merely to the memory of a deceased or distant individual – their personality and history as remembered by others. A kidney or lock of hair is not (or at least not merely) considered sacred because it belonged to a human being - in the ownership sense of belonging - but is valued specifically because it is connected to a particular individual. All HBM have the potential to preserve the biological or genetic identity of their provider due to the presence of DNA. As physical mementoes of, or genetic templates for particular individuals, HBM retain uniquely intimate associations with their providers. Like stones remaining from an ancient ruin, their identity is no longer synonymous with that of an integrated entity, but they nevertheless may serve to sustain the memory of that entity and to preserve its history. Some materials are also regarded as peculiarly personal even when unidentified, often causing transplant recipients to appreciate more fully the personal value of material received from unknown providers: for example, materials with more visually recognizable personal features such as faces or limbs15, or those traditionally linked to personality – such as eyes or hearts.

15 See e.g. Dickenson’s discussion of face and hand transplants (2008, 137-150).
Gametes, however, are personal in a more concrete sense. Gametes, when they are removed for use in ART, incorporate a personal connection to providers that is more than the symbolic value of what might be described as physical mementoes or relics of a deceased or living person. Gametes are used to create actual children who are biologically related to their provider. The bond of biological parentage between such children and their gamete providers may not always be expressed as an emotional or psychological interest in one another, however it preserves the provider’s personal value at least in so far as genetic identity is concerned, regardless of whether the provider is alive or deceased. Numerous studies demonstrating the mutual interest of gamete providers and their offspring confirm this connection often extends beyond the purely biological (e.g. Jadva et al. 2010).

3.3.5 Personal value in HBM may persist beyond death

The three dimensions of personal value in detached HBM may extend beyond the death of the provider, in the form of value conferred by living persons who were related socially or genetically to the deceased. Living persons may seek to uphold the wishes expressed by the provider prior to her death regarding the treatment of her HBM, and they may express approval or disapproval of treatment that is deemed to respect or disrespect the deceased (often expressed as “the memory” of the deceased.)

The persistent connection of HBM with their deceased providers is mediated by those living persons who regard the materials as intimately connected to the deceased. The strength of this perceived relationship or connection may be such that some people express reluctance to provide their materials after death, or to allow donation by relatives for fear that it will damage them. Like Ancient Egyptians who sought to preserve their bodies for the afterlife, even individuals who do not believe in an afterlife may express discomfort at the idea of “mutilation” of their corpse, particularly where visible body parts such as eyes and faces are concerned (e.g. Sque et al. 2008, 140). On the other hand, deceased donation rhetoric often encourages “donation as offering a redemptive chance for [a] loved one to live on in the body of another” (Crowley-Matoka and Lock 2006, 174). In addition, “Organ recipients often report powerful feelings of identification with their donors, describing new attitudes, tastes, personality traits, and bodily habits believed to have been acquired from the donor along with the implanted organ” (ibid.).
3.3.6 Effacement of personal value

Like other values, personal value in detached HBM is not always recognized or expressed. In general, it is more likely to be expressed in the setting of living donation of materials such as organ and gametes, or where the materials involved are visibly connected with identity – for example limb amputations or the removal of breasts or reproductive organs. The therapeutic removal of diseased internal organs or superficial materials such as skin cancers is more likely to be seen as the disposal of waste in which personal value is rejected. As visibly identifiable parts decompose or are broken down and transformed into useful products, personal value often diminishes. Anatomical displays such as the famous Body Worlds exhibition - in which plastinated cadavers are arranged in lifelike poses - are more easily personalized (Moore and Brown 2007, 242) than pathology exhibits of tissue specimen blocks or slides, although both may be anonymous. Those who receive tissue or plasma products may be less cognizant of the human origin of the treatment they receive, although this may be remedied by explanatory efforts on the part of medical professionals consenting recipients (Nicholas 2005). Blood transfusion recipients may think of the anonymous provider not as a specific individual but as a representative of the universal community of providers (Waldby et al. 2004, 1468), whereas organ recipients are likely to reflect significantly on individual donor identities (e.g. Sharp 1995, 365).

Unlike other valuations of HBM, personal value is only completely obliterated when the material itself is destroyed or irretrievably lost. Even where unrecognized, it remains latent within materials and may be triggered by a variety of circumstances such as being treated in a manner deemed disrespectful or inconsistent with the wishes of the provider. For example, when the Californian woman inadvertently learned her uterus had been “branded”, the tissue that had been effectively dismissed by her as waste became highly important. Similarly, when Moore learned that his splenic tissue had been developed into a profitable cell line, it was his personal interest in this tissue that underpinned his main legal claim, namely that his personal property in the form of his detached splenic tissue had been “converted” by the researchers: used without his consent for a purpose which he had not authorized (Moore v Regents of California 1990, 5). Moore theorized “that he continued to own his cells following their removal from his body, at least for the purpose of directing their use” (ibid.). Therapeutic, commercial or even sacred valuations of HBM may be expressed at different times but

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16 Cremated human remains, for example, may be personally valued until such time as they are dispersed and no longer physically tangible.
attempts to impose specific valuations at particular times – and hence to influence the
treatment of materials – will require extensive debate and ultimately are likely to be
most heavily influenced by the personal value or interest claims that individuals may
make with regard to their materials.

3.4 Personal interests in the treatment of HBM

Personal interests in HBM are shaped by three main concerns. First, the possibility that
use of detached materials may be directly harmful to the living provider (or others), for
example by the revelation of sensitive genetic or biological information in the course of
research or screening for transplantation. Second, providers frequently wish to
determine the use or disposal of their materials, for example by donating for the benefit
of specific areas of research. Third, particular forms of treatment of detached materials
may be emotionally distressing to the provider or their relatives, for example disposal of
materials in a manner contravening religious customs.

With respect to the first concern, existing frameworks to safeguard research
participants and providers of HBM for therapeutic use are well established in the
absence of a property right to HBM, through the medium of informed consent protocols
and research ethics. Although growth in biobanks and the rapid evolution of
biotechnology may engender new threats to provider privacy interests, these are likely
to best protected through institutional safeguards and transparent systems of data
collection rather than the recognition of property rights. The same measures will be
required in both a donation and a market system of procurement to protect providers.
The interest in controlling the disposition and use of one’s detached materials is that
which dominates the property debate.

3.4.1 Personal interests in controlling the treatment of one’s HBM

A personal interest in one’s HBM is reflected in the idea that if anyone owns material
detached from my body, it should be me, by virtue of my genetic, biological and
emotional or psychological connection to this material. This interest drives much of the
support for recognition of property rights in HBM. The desire to determine what
happens to one’s detached materials may be motivated in various (sometimes
overlapping) ways, each of which reflects a particular right of control:

(i) Right of transfer: e.g. to give one’s kidney to a relative;
(ii) Right of sale: e.g. to transfer for payment;
(iii) Right of pecuniary interest: e.g. to share in profits arising from research;
(iv) Right to determine recipients: e.g. directed donations to individuals;
(v) Right to determine use: e.g. by ensuring tissue is used in particular kinds of research and not others;
(vi) Right to ultimate disposal: e.g. to guarantee destruction or burial of materials.

Some of these rights reflect the traditional bundle of property rights outlined by Honoré, in particular the rights to use, transmit, and manage and the rights to the income from and capital in the materials (M. Quigley 2007, 631). A number of authors have discussed how traditional bundles of property rights may be used to shape property rights in HBM (e.g. Björkman and Hansson 2006). Rather than presupposing that the rights listed above are both valid and best framed as property rights, we should first explore the rationale for these rights and their potential limitations.

Individuals may seek to control their detached HBM in the above ways in order to (a) profit financially; (b) benefit known or unknown individuals or society through therapeutic or research contributions; (c) ensure their materials are not used by (particular) others in particular ways; (d) ensure their materials are ultimately disposed of in a manner consistent with the provider’s preferences. However, society also takes an interest in the treatment of HBM, given its potential value and the hazards it may present to society through dangerous use or disposal. These interests may conflict, for example where a person seeks to dispose of materials in a manner hazardous to public health, or where the sale or directed transfer of materials fails to maximize therapeutic benefits. While a property right is implicit in the right to trade or otherwise profit from one’s HBM, interests in disposal and beneficial donation of materials do not necessarily require protection in the form of property rights. The degree to which personal interest in materials is upheld by law will vary according to the balance struck between personal and societal interests.

Although it is conceivable that a society may decide to consider all detached HBM res communes omnium or “the common property of all humans” and thus open to property claims by anyone (Marusyk and Swain 1989, 383), upholding a degree of personal value and hence individual rights over one’s HBM is likely to meet with greater consensus. While materials are integrated within a living body, they form part of the autonomous individual and their disposition and use (if it may be so called) is the expression of bodily autonomy. The strongest claim to a personal interest in one’s HBM lies therefore at the moment of detachment, at which a person may autonomously choose to detach material for a particular purpose. Respecting this choice implies
upholding the provider’s wishes regarding the disposition and use of the material once detached. For example, if Alice chooses to donate a kidney to her brother, it would be wrong for a transplant surgeon to remove the kidney and then sell it to another patient or throw it in the bin. Naturally, respect for the provider’s wishes is likely to be tempered by societal concerns. For example, a provider’s wish to sell his heart or to have his diseased appendix mailed to an ex-girlfriend would generally be disregarded.

3.4.2 Protecting personal interests through property rights

Failure to acknowledge and protect some degree of personal interests in HBM will undermine important social relationships such as those between individuals and healthcare providers. It will also create a void in which detached HBM may be subject to arbitrary treatment, making it difficult for any of the potentially interested parties (e.g. providers, patients, researchers) to achieve their HBM-related goals effectively. Thus society must impose some conditions of treatment on HBM, for example rules regarding custodianship duties, disposal procedures, secondary commodification and so on. Does this mean some kind of property rights in HBM is required for societies wishing to ensure appropriate treatment of HBM?

Björkman and Hansson note that

A person’s legal rights with respect to a biological material (from her own body or that of someone else) can be constructed in many different ways, depending on what types of legal relations are included in the bundle [of rights]. The primary normative issue is what such a bundle of rights should contain. It is only a secondary issue whether the chosen bundle of rights should be called a property right. (2006, 212)

Even where legal rulings have been made supporting personal property rights, these are frequently overturned. The case of Moore, who claimed property in his detached splenic cells, demonstrates the legal (and hence social) uncertainties and anxieties concerning property rights in HBM. The first ruling in the Moore case argued that

“property” refers not to a particular material object but to the right and interest or domination rightfully obtained over such object, with the unrestricted right to its use, enjoyment and disposition. ... The rights of dominion over one’s own body, and the interests one has therein, are recognized in many cases. These rights and interests are so akin to property interests that it would be a subterfuge to call them something else. (Marusyk and Swain 1989, 352)

However, following appeal, the ruling was overturned:

The majority expressed a reluctance to extend property rights into the situation, and seemed to prefer that Moore's rights be protected by upholding his claims for breach of fiduciary duty and lack of informed consent which the court felt offered adequate protection. (Boulier 1994, 703)
In a recent case in the United Kingdom (Yearworth 2009), a storage system failure resulted in the destruction of sperm stored on behalf of patients. In order to claim damages, the patients needed to establish a proprietary interest or property in their own sperm. The Court of Appeal ruled that the sperm was indeed owned by the men. Commenting on the case, Quigley argues that it shows “there are situations in which it is necessary to appeal to proprietary notions in order to offer remedies for wrongs committed” although she acknowledges its implications for future cases remain unclear (2009, 466).

The law regarding property rights in deceased bodies is less ambiguous, with a variety of examples from Anglo-American law suggesting the absence of a property right in corpses, although anatomical or museum specimens from deceased bodies have been recognized as legal property (Boulier 1994, 705-7). Rao describes corpses as “quasi-property”, not able to be bought and sold but “over which individuals retained a limited array of rights” (2000, 382; see also Wagner 1994, 934). The absence of a property right in corpses has not impaired respect for personal interests in deceased bodies. Families are generally able to dispose of bodies in accordance with cultural beliefs (subject to sanitary conditions imposed for the benefit of society) and individuals are able to bequeath their HBM to science or society for therapeutic use. The only element lacking is the capacity to profit from the sale of the body.

Similarly, a variety of systems are already in place, or have been proposed, to protect personal interests in the treatment of other detached materials. Altruistic living donation of blood and organs has raised little concern about property rights, with informed consent procedures helping to ensure that the preferences of providers are respected. Directed deceased organ donation remains a contentious issue (see e.g. Ankeny 2001; Pennings 2007; Cronin and Price 2008). The complexities of donation to research and secondary commodification of human cells and tissue remain ongoing issues for regulators seeking to determine and protect personal interests of providers. Numerous models have been established or proposed in response to these, such as that according usufructuary rather than wholesale property rights (Lenk and Hoppe 2009) and various forms of charitable trust (Mullen 2009), each of which seeks to respect personal interests except that of financial profit.

Rao presents “privacy rights” as an alternative to property rights in the body, arguing that property and privacy constructions of the body converge to the extent that they secure identical interests - namely, the right to possess one's own body and the right to exclude others from it. The two diverge, however, in their concept of the
relationship between the person and the body. Property envisions a person who "owns" and is thus distinct from his or her body, while privacy views the person as embodied and the body as personified. (2000, 364)

In 2010, the settlement of a dispute between the Havasupai tribe and Arizona State University regarding the unauthorized use of donated blood samples recognized the rights of donors in determining the use to which their materials are put, without any property claim arising (Havasupai v ABOR 2008). Although the case highlights the challenges of obtaining informed consent for future uses of donated HBM (Mello and Wolf 2010), it demonstrates the importance of personal value in detached HBM, and the fact this may be protected without recourse to the language and legal constructs of property rights, grounding them in this case in “privacy rights” (Havasupai v ABOR 2008).

Boulier argues that recognition of property rights is necessary to establish consistency in the legal approach to the treatment of HBM (1994, 722), however if agreement can be reached on the appropriate treatment of HBM, legislative consistency (without necessarily incorporating property rights) will be more effectively attained. Steinbock notes that “it is only after we determine the moral question of what may permissibly be done with something that we can determine [the legal question] if it is properly treated as property” (1995, 57). Or, one might add, whether the individual rights governing the treatment and disposition of one’s own HBM are termed property, privacy or another kind of right.

3.4.3 Intellectual property in HBM

Worryingly, while few legal systems as yet support property rights in HBM, there is extensive protection granted to intellectual property in the body in the form of patents upon human genes and cell lines. Moreover, even courts that reject ownership claims on the part of those who supply body parts appear willing to grant property rights to scientists, universities and others who use those body parts to conduct research and create products. (Rao 2007, 371)

Intellectual property in the human genome and the alleged commodification of human genes are issues of enormous importance and public concern, as authors such as Dickenson (2007), Hoeyer (2007) and Resnik (2001a) note. In this thesis I have chosen to focus on the issues pertaining to the procurement and sale of “raw” HBM, rather than those of genetic data that may be obtained from these materials or intellectual property that may be derived in turn from the use of the materials or genetic information. For example, I am concerned with the issue of whether the cells removed from Moore’s
spleen ought to be considered his property, rather than whether the cell line derived from these cells is rightfully his property. Patents on human genes, for example, give patent holders the right to replicate particular genes and use them in research or in the manufacture of therapeutic products. The original material used in research that results in patents is not, strictly speaking, commodified, except where it has been bought or sold by the provider or other parties involved in its transfer, modification or storage, until the point of its final use. Nevertheless, where the product patented is a clone of the original material – whether a cell or a DNA sequence - or where it closely resembles that material it is to all intents and purposes, rightly considered as a “human body part” (Resnik 2001a).

Patenting human DNA poses numerous social and ethical issues, including the implications for genetic privacy (e.g. Everett 2003, 55) and potentially negative effects of patents on scientific research or public access to therapeutic products derived from such research (e.g. Parthasarathy 2005). Where the DNA in question is obtained from particular social or ethnic groups, such as Tongan citizens or Maori communities (Dickenson 2007, Ch.8), or groups suffering from specific genetic diseases (e.g Novas 2006), the potential impact on provider communities – whether positive or negative - may be extreme.

However, although the use of genetic material may have especially significant personal implications, any research using HBM may be equally problematic. For example, pharmaceutical research and patents on life saving medicines currently pose far greater threats to the health of research subjects and those in need of therapeutic products. Within the confines of this thesis, I have chosen therefore to focus simply on the issues of commodifying HBM in general, including material from which DNA may be isolated and intellectual property in the human genome derived. Although commodification of cloned human genes might encourage commodification of HBM, or indeed of living persons, especially given the tendency of society to equate such patents with literal commodification of genes integrated within living persons, intellectual property in human DNA or indeed in other HBM should not be confused with actual commodification of original HBM within or detached from actual persons. In the future, it may be possible to synthesize precise replicas of human organs using cell lines derived from actual human cells. While trade in such organs is likely to pose ethical issues, these should be distinguished from trade in “original” human organs.
3.4.4 Rights for all – but what kind?

The imbalance between intellectual property rights or property rights in original materials held by those who receive HBM for use in research (or indeed those responsible for services involving HBM such as transport, storage, modification and distribution) compared with the simple right to donate altruistically accorded to HBM providers provokes many concerns. In particular, the lack of more extensive rights may impair opportunities to express altruism through donation of HBM. As Dickenson argues in the context of the UK Biobank, “That same altruism which impelled donors to give in the first place… naturally and rightfully implies that they will prefer altruistic rather than narrowly profit-making uses to be made of their gift” (2007, 132). A system in which people are accorded a right to donate their HBM for altruistic purposes, but which does not ensure that such donated HBM is then used to achieve goals consistent with this, does not truly respect the right to donate. Allowing public biobanks to secondarily commodify donated tissue is as unacceptable as allowing surgeons to sell donated kidneys to the highest bidder. Allowing for intellectual property rights in products derived from research using HBM should not mean that providers have no right to determine how their materials are used, or to influence, or even prevent the establishment of commercial interests in derived products.

The potential property rights of recipients, as well as mechanisms to protect the personal interests of HBM providers should be re-evaluated, rather than using current recipient rights to justify the extension of property rights (often including that of sale), (an argument I will explore in Chapter 6). As Björkman and Hansson suggest (referencing Felix Cohen),

> [On his view.] property rights have their origin in the law, and historically laws express the interests of those who write and promulgate them. Ethically, on the other hand, the merits of any law or legal arrangement should be judged according to how well it promotes the good life of those affected by it. Therefore, property rights should be arranged such that they promote a proper combination of social goals such as justice and economic productivity. (2006, 210)

Although authors such as Munzer and Smith (2001), Dickenson (2007, 22) and Bray (1990) advocate specific limited property rights in HBM without seeking to establish a right to sell, in order to protect personal interests in determining the use or disposition of detached materials or to enable liability claims in the treatment of detached materials (Quigley 2007), recognition of property rights may well result in additional problems for the procurement, use and distribution of HBM that will negatively affect society’s ability to meet needs for HBM.
3.4.5 Potential hazards of recognizing property rights in HBM

Drawing on Radin’s (1987) account of personality, property and market *inalienability*¹, Bray (1990), suggests that the body, being “central to the individual’s sense of identity” should be considered property in order to protect “the individuals’ interests” in it. However, she argues on the same grounds that

the living body is the physical manifestation of the individual's unique personality and self identity, and because universal commodification threatens to undermine the uniqueness of each body by treating all bodies as fungible commodities… property interests in human bodies should be market-inalienable. (Bray 1990, 240)

Hence, Bray advocates only a quasi-property right in the human body as “the right of use and control, but a limited right of disposition” (244).

Bovenberg discusses the problem of inalienable property rights in human tissue in the context of biobanks, warning that (besides other concerns) according individual property rights - rather than a shared interest in the common resource of the biobank - to these materials might result in a “tragedy of the anticommons” with the pursuit of individual rights “potentially blocking, delaying or restricting the collection, storage and use of large-scale collections” of material and thereby impairing the progress of research and the ability to share its benefits with society (2004, 579).

Other practical concerns about recognition of individual property rights in HBM include the challenge of obtaining consent for transfer of such rights in the context of umbilical cord blood (Dame and Sugarman 2001); the risk that commercialization of dead bodies may encourage heirs to dispose of corpses in profitable ways that conflict with the preferences of the deceased; and the possibility that healthcare systems might be overburdened by legal paperwork designed to minimize disputes over HBM. In order to protect against these and other ethical concerns about saleable property rights, many commentators seek to define limited property rights, such that Bovenberg notes,

as a result of imposing all desirable limitations, the bundle of property rights would be stripped of a number of core rights. Just how many of the standard incidents may be removed from the bundle before we stop calling it property, is a contentious issue. (2004, 567)

3.4.6 HBM as common property?

In Chapter 8 I will advocate a communitarian approach to the provision of HBM, with members of communities sharing materials with others in need. In this sense, detached HBM might be regarded as the common property of societies, to be distributed in accordance with predetermined values and principles agreed upon by community members. Current examples of public organ, tissue and blood banks reflect such a model, and the term “public property” may even be used to describe them. Dickenson,
for example, advocates a Hegelian model for biobanks, in which “property mechanisms can be used to enhance agency and subjectivity, to encourage a Hegelian interaction with the world and to transcend selfish individualism” (2007, 139). In Philosophy of Right, Hegel (2001) emphasizes the role of social interactions in property ownership and contracts that require mutual recognition of subjects to enable the transfer and exchange of property. “The means by which I hold property, not by virtue of the relation of an object to my subjective will, but by virtue of another will, and hence share in a common will, is contract” (ibid., 76 s71). Dickenson (2006) argues that a Hegelian contract model for oocyte providers in research would facilitate ongoing relationships between providers and researchers in which the respective interests and rights of both parties could be considered.

Although models of shared or common property such as this and existing public biobanks or trusts may be termed property and include various rights for individuals and group members while excluding the right of sale, I do not wish to endorse a particular model or even to advocate the conception of donated HBM as property per se. The complexities of formulating legal frameworks in which individuals may provide materials and influence - to a greater or lesser extent – their future disposition or use lies beyond the scope of this thesis. Different materials provided for particular purposes, whether transplantation, reproduction or research banking, will require different models with particular bundles of rights to reflect the range of possible interests of providers and recipients. If we begin our examination of whether HBM should be bought or sold by presupposing that our interests in HBM are best understood within a property framework of some kind, we risk limiting our understanding of the values and principles that should be considered, and potentially overlooking other frameworks, and novel models that are free of the historical weight of law and custom that is inevitable in propertised conceptions.
3.5 The impact of different conceptions of HBM

The conception of HBM as property is not the prevailing public paradigm, despite its ubiquity in legal discourse. Instead, even where HBM are extensively commodified, for example in the global market for oocytes, materials are usually described as “gifts”. Whether described as personal property, gift or public resource, the way in which HBM are conceptualized is highly influential in – and potentially hazardous to - the market debate.

3.5.1 HBM as individual gifts

The altruistic donation of HBM is a dominant paradigm in policy and social practice throughout the world. The gift of blood or organs is celebrated in the media and identified by numerous authors as the ideal mechanism for obtaining and distributing HBM, most famously by Titmuss (1997). Such is the influence of the gift metaphor that even where a commercial trade effectively operates, for example in the procurement and sale of ova in the United States, women are still described as “donors” rather than vendors, and their altruism is heavily emphasized in advertising, and even in surveys of the women themselves (e.g. Almeling 2006; Kalfoglou and Glittelson 2000).

The solicitation of (paid) gamete providers is highly gendered, with women framed as altruistically motivated while men are encouraged to see sperm provision as a job (Almeling 2007). Krawiec (2009a) suggests that the emphasis on altruism enables the reproductive industry to profit financially. In Property in the Body, Dickenson (2007) argues that the traditional devaluing of women’s labour and objectification of (embodied) women has contributed to practices in which women’s bodies (and increasingly men’s) and their HBM are expropriated and commodified. This is due, she suggests, to reliance on informed consent and the gift model of HBM provision, in which rather than the traditional practice of altruism in which ongoing social relationships bond donors to recipients, “one-way altruism” enables recipients to make use of donated HBM without regard for the donors’ interests in treatment of their HBM (ibid., 18-19).

Skepticism about altruism is not confined to the oocyte market. In reviewing the rhetoric of the “gift of life” often applied to deceased organ and blood donation, Simpson notes that more often than not [these gifts] are expected to pass between individuals who are unknown to one another. …. [They] are a particular expression of the social contract, given to people ‘just like us’, and linked to rewards that will be appreciated in a life beyond this one. Propelled by abstract notions of altruism or
charity, they are expected to circulate in, and indeed be constitutive of, larger entities such as society, state, or nation. (2004, 841)

And yet, this conception remains problematic, with the intended purity of the gift inevitably contaminated through its interactions with the world. The gift may be considered tainted by the fact that, as many proclaim, “everyone but the donor profits from the gift” or by the possibility of compromised altruism, in the setting of donor coercion or donors seeking a direct return on their gift. Furthermore, Simpson suggests, once pressed into the service of society, the bodies within which ‘gifts of life’ originate will no longer act as the locus for extraordinarily powerful gestures of kindness, compassion, and commitment to the greater social good but will become sites for the production and extraction of fungible commodities. (2004, 841)

This is perhaps evidenced in the case of living kidney donors who have retrospectively sought financial compensation for their gift when their relationship with the recipient has broken down (F. O’Neill 2009, 157).

Thomas Murray describes the benefits of gift giving as follows:

Gifts help to create and sustain intimate personal relationships. In the face of impersonal bureaucracies, gifts to "strangers" affirm a number of vital social values including our solidarity with others in our community, and our vision of human flourishing, individual and social, that require more than the thin relationships established by markets and contracts. (1987, 37)

The giving of gifts is a practice found in most societies, and one that, while usually described as virtuous or morally laudable, may also be a component of complex interpersonal reciprocal obligations.

Scheper-Hughes warns of problematic gifting practices, particularly in the context of living related organ donation. She notes that, “Every gift is both altruistic and indebting, spontaneous and calculated. Gifts demand counter-gifts, even though time may elapse and the return gift may or may not be in kind” (2007, 508). Not only can potential living donors be pressured to “sacrifice” themselves for relatives, the recipients of their gifts may in turn be subjected to the “tyranny” of those who have given so generously what may be never be repaid (ibid., 509).

The reality of gift giving as an exchange or relationship between people – with its attendant expectations and potential tensions – is distinct from the ideology of donation. As Shaw notes, referencing Tutton, “the gift is typically conceptualised by ethics committees, medical councils, and research institutes interested in fostering the donation of body tissues as a one-way transaction” (2008). Hence, the language of “gift relationship” “conflates altruism and the pure gift as unconditional with the gift
relationship and gift-exchange, which is construed and understood as a part of a chain in a social system of prestation and counter-prestation” (ibid.).

Yet the moral virtue and social benefits of gift giving, and of giving body parts for therapeutic use by relatives or strangers remains globally relevant. The altruistic model is widely applauded, even by those who regard it as an inadequate motivation for procurement systems (e.g. Satel 2009, 9). There is considerable support among major world religions for the donation of at least some body parts, such as organs, tissue and blood17 (Gillman 1999; Simpson 2004). The gift conception of HBM is perhaps the least ethically problematic of procurement paradigms, as it incorporates altruism and beneficence, two important values found in most moral systems. Unfortunately, this does not ensure that gift models will best protect the interests of providers and societies, as Dickenson points out (2007, 18-22), or that they will be the most effective in facilitating sufficient supplies of HBM.

3.5.2 HBM as public resources
The relatively recent conception of HBM as a type of public resource seems intended to provide a neutral model that reflects the utility value of HBM without the ideological agendas or emotional influence of the gift and property models. It is popular in policy discussions, and within the small but emerging literature that seeks to reframe donation as a public or civic obligation rather than a supererogatory act of altruism. For example, as altruistic donation becomes systematized, and the introduction of “opt-out” systems of organ donation presuppose a norm of giving, the gift ideology becomes replaced with the idea of HBM as a public resource to which people are expected to contribute. In this spirit, Tutton notes the emerging use of “participation” to describe the involvement of providers of tissue to biobanks (2009, 56).

The resources model more accurately captures the issues at stake in debate about the procurement and distribution of HBM – in which the need for better supplies of HBM reflect needs for healthcare resources in general. Thus, the WHO refers to human organs, cells and tissue as “a vital community resource” (2010b, 1). However, the term masks the unique nature and personal value of HBM as elements of human bodies that set them apart from all other kinds of healthcare resources.

17 Donation of gametes is considered problematic in some religions e.g. Inhorn (2006); Simpson (2004, 854).
3.6 From value to practice and paradigm

Just as living human beings are accorded equal moral status through recognition of their human dignity, detached HBM may be accorded personal value distinguishing them from other objects. Thus the treatment of HBM, like the treatment of human beings, is an important moral concern for societies. Not only may the lives of persons be revealed in their death and the treatment of their bodies after death (Klinenberg 2002, 133), but the treatment of HBM can reflect how the living are and will be treated. Walker (2000, 20), for example, argues that human remains should be treated with respect because it might desensitize people to disrespectful treatment of the living and because the intimate association between the person deceased and their physical remains warrants respect.

The ethical conditions governing treatment of HBM are yet to be determined, including whether they ought to be traded as commodities. In evaluating the various arguments for and against the sale of HBM, we must take care to avoid imposing a particular value or conception on HBM – whether sacred, instrumental or commercial – recalling that the value of HBM which should primarily ground our discussion is personal - the intimate relationship between detached materials and the individuals from whom they are derived, and the broader relationships that exist between providers and recipients of HBM and other members of their societies. After all, as Keat argues, “although the acquisition of consumer ‘goods’ takes place through exchange within the market (or economic) domain, the realisation of their value typically takes place in non-market (non-economic) domains” (2008, 248-9). Similarly, C. Campbell notes that “our images of the body can influence policies regarding the method of procuring valued body tissues, and correlatively, adopting a particular policy can reflect a certain understanding of the moral status of the body” (1992, 34).

3.6.1 Anderson’s pluralistic theory of value

In her pluralist theory of value, Elizabeth Anderson recognizes “a plurality of evaluative attitudes” towards goods:

A plurality of values or standards… by which we evaluate different goods and adjust our attitudes toward them… A plurality of different kinds of goods, distinguished by the complexes of attitudes it makes sense to take up toward them and by the distinct social relations and practices that embody and express these attitudes. Finally,… a plurality of contestable ideals, by which we try to govern the development of our attitudes, character, values, and aspirations. (1993, 14)
She notes that sometimes the plurality of modes of valuation may be incompatible, and that different valuations may be appropriate for different people according to their personal relationship with particular goods. Rather than advocating a rigid classification of goods and how they ought to be valued, Anderson rejects a monistic approach to the valuation of different goods as “inherently defective, because it cannot make sense of the phenomena of values and valuation that any theory of value must account for” (ibid., 16).

I will draw on Anderson’s pluralist account of values throughout this thesis, which is especially suited for a normative inquiry into the appropriate treatment of HBM as highly personal yet unavoidably social goods.

An ideal-based pluralistic theory of goods does not concern itself exclusively with the qualities of the goods people enjoy. It also focuses on the realization of distinct ideals of the person and community, and it views goods as mediating these relations among people. Ideals require people to care about goods in particular ways, by embedding them in appropriate relations of production, protection, distribution and enjoyment. Treating a good as a particular kind of good is as much a way of realizing and expressing appropriate relations among people as it is a way of properly valuing the good itself. (Ibid., 14)

3.6.2 A pluralistic conception of HBM

Rather than struggling to ensure that our treatment of HBM conforms to existing forms of the property, gift or public resource models, and despite the weight of historical customs, practice and legislation, we should strive to develop conceptions of HBM that will best meet the goals and values of contemporary societies. Recognizing the rapid evolution of medical and scientific use of HBM, the emerging challenges of meeting needs for HBM throughout the world and the potential hazards of HBM provision to individuals and societies, we should think beyond traditional paradigms where necessary in order to uphold the plurality of values and interests that may be placed in HBM.

Consideration of personal value in HBM will benefit the development of social policy by highlighting the close relationships between individuals and their own materials, as well as the importance of broader social relationships between individuals and other members of their social communities. The provision and use of HBM has implications not just for providers and recipients, but also for those connected by bonds of genetics, family, friendship, or shared needs for HBM. Each may have an interest in the disposition or use of particular HBM. Nevertheless, respect for personal value, and recognition that it stems from the intimate connection of detached HBM with an individual person should remind policy makers that the treatment of such material
impacts upon providers. How we procure, use and dispose of HBM cannot be considered without taking into account the role of providers and the importance of their interests. Failure to do so may lead to divisive or even conflicting policies. Although the treatment of particular HBM will differ in specific contexts, the underlying values that guide all treatment should be consistent.

T. Murray suggests:

The system chosen for obtaining human biological materials will carry whatever symbolic weight attaches to the relationship to the "strangers at our door," as Ignatieff calls our fellow inhabitants of mass society. These gifts of the body, ministering to the needs of strangers, connect us in our mutual quest to relieve suffering and to pursue our good, separately and together. (1987, 38)

Scheper-Hughes and Lock deconstruct the anthropological discourse of the human body and reveal “the interaction among the mind/ body and the individual, social, and body politic in the production and expression of health and illness” (1987, 31). They conclude that, “The individual body should be seen as the most immediate, the proximate terrain where social truths and social contradictions are played out, as well as a locus of personal and social resistance, creativity, and struggle” (ibid.). Likewise, Herring and Chau (2007) argue that our bodies are of concern to others as well as ourselves, being interconnected with other bodies and the world in a manner that makes the legal categorization of our bodies problematic, particularly with respect to propertisation.

Thus, our treatment of HBM is likely to be informed by and to influence social interactions that go beyond the procurement and use of these materials. In this chapter, I have argued that personal value in HBM, which in turn derives from the inherent value of living persons, should guide societies as they seek to determine how best to govern the treatment of HBM. Just as payment cannot capture personal value in HBM, property rights do not precisely reflect the personal interest we have in the treatment of our detached materials. Although some form of limited property rights may prove useful in protecting these interests, we must take care to ensure that legal instruments facilitating contractual disposition of HBM do not undermine recognition of the intimate connection between people, their bodies and their detached materials. The popular conception of property as synonymous with saleable means that public expression of property rights in HBM may be interpreted as endorsement of trade. If we wish to avoid scenarios such as that quoted at the beginning of this chapter, in which flesh is rapidly transformed from persons into parts, from parts into property and from property into money and so on until all traces of individual persons are obliterated in the marketplace for HBM, we must hang on to our sense of personal value in these materials.
Markets and morals

Social communities – that is culture - precede commerce. Throughout history, human beings have always established social communities first. They develop rules of social exchange, embed their members in complex reciprocal relationships, and build social trust. Only when these relationships, and the trust that is built from them, are firm can communities enter into commercial trade and set up markets for exchange. That’s because markets, by their very nature, deplete trust. (Rifkin 2001, 243)

4.1 Introduction

In this thesis, I seek to determine the place, if any, that human biological materials may have within markets. After exploring the social and philosophical conceptions of these materials in the previous chapters, as well as the important place of HBM within moral systems, it is appropriate that we do the same for markets themselves. Both lawful and unlawful markets in various HBM have flourished for centuries, with the medieval market in saintly relics forming an international economy with complex and variable mechanisms of exchange (Geary 1986, 174), reminiscent of the contemporary global system of procurement and distribution of HBM. Societal condemnation of “black markets in body parts” stretches from the infamous murders and grave-robbing for anatomical dissection in 19th century Edinburgh (Tward and Patterson 2002), to the New York City funeral parlor scandal of 2005, in which bone and tissue was secretly removed from bodies and sold to brokers, and international trafficking of human organs (Scheper-Hughes 2006; 2004). Both sides of the HBM sales debate have been greatly influenced by the evidence of black markets, particularly with respect to the sale of human organs. Those against markets fear that legalization will only enhance the extent of the harms identified in black markets, while those in favour argue that legalization will prevent such harms and eradicate the black market itself.

For some market advocates, the language of economics appears to offer a more rational, less emotionally driven account of procurement and distribution of HBM, free of the potential conflicts of moral debate in pluralistic societies. A common misconception in the debate is that once something has been judged a marketable commodity, no further ethical evaluation is required regarding its treatment and the “laws of the marketplace” will determine the conditions of its procurement and
distribution. This contributes to contemporary neoliberal perceptions of the market as a moral-free zone, in which the laws of supply and demand enable all participants to obtain that which they desire, free of the influence of “abstract moral concerns” (Hippen et al. 2009). Yet the rhetoric of market advocates paints an idealized vision of legal markets in which reason dominates emotion, healthcare professionals are finally permitted to save lives, and everyone, so to speak, wins. The legalization of organ markets, for example, is often described as a “simple” solution to the problems of black markets, waiting lists and enforced altruism, with opponents chided for maintaining their repugnance for markets at the expense of human lives (e.g. Matas et al. 2009, 384).

The marketplace is thus paradoxically conceived both as a refuge from morality and as a triumph of moral values. While pro-market arguments directly addressing the concerns of opponents tend to endorse a number of market regulations in order to minimize the harmful consequences feared to result from the sale of HBM (see Chapter 5), numerous authors have suggested that an (autonomy based) moral right to buy or sell HBM is not just necessary but sufficient for both the justification of markets and the content of market norms. Onora O’Neill’s critique of dominant conceptions of individual autonomy in bioethics highlights the dangers of consumer choice (manifesting as informed consent) as “a complete basis for all ethical justification… in bioethics and beyond” (2002a, 48). This approach to markets in HBM will be discussed in Chapter 6.

The isolation of markets from morality and social (as opposed to individual) concerns is an unfortunate characteristic of both sides of the debate. Market advocates and opponents neglect the social and hence moral framework of markets at the expense of solutions to the question of how HBM ought to be procured and distributed that will reflect both the values and the practices of contemporary societies. Markets play a key, but not unique role in producing and distributing goods within societies. Given that the issue for societies is how best to procure and distribute HBM, consideration of markets – how they may be structured and how their operation is evaluated – is inevitable, pertinent and useful. In this chapter, I explore the relationship between markets, societies and morality in order to define the questions we must ask when considering the possible role of markets in the treatment of HBM. This will inform my eventual discussion of alternative systems of procurement and distribution of HBM.
4.1.1 Overview of the chapter

The chapter begins by reviewing the Aristotelian origins of economics as a political and ethical discipline grounded in social communities, and confirming the place of markets as embedded within moral society. I suggest that the distinction made by Aristotle between oikonomia and emporium offers useful insights for our debate. I then turn to the question of which goods should be excluded from market exchanges, what Walzer (1983) terms blocked exchanges. I argue that most candidates for exclusion are special goods, considered essential requirements for - or components of - human flourishing. Despite variable conceptions of human flourishing, I argue that HBM are universally considered special goods because they are necessary for health; scarce and often irreplaceable with synthetic alternatives; and because they are of unique personal value to human beings and societies (see Chapter 3). Using the example of markets in healthcare – the issues of which partially resemble those concerning markets in HBM - I suggest that special goods elicit multiple challenges for policy makers where commercial values conflict with social and moral values. Five categories of potential concern regarding the role of special goods within markets are identified, from each of which justifications for market inalienability or regulation may be drawn.

Next, I review theoretical and practical models of free and regulated markets in HBM, showing how economic perspectives and various concerns about HBM as special goods may underpin evaluation of these models. I reveal the continuum between strictly regulated markets and truly free markets and introduce the Myth of the Regulated Market, which will be more closely examined in Chapter 5. I conclude by reviewing Anderson’s approach to the evaluation of ethical limits to markets.

4.2 Aristotle’s economic ethics

In order to give due consideration to the potential place of HBM within markets we must first determine the place of markets within societies. The study of markets from both a practical and ethical perspective is the domain of economics, a social science for many centuries considered a branch of moral philosophy (Alvey 1999, 53). The Oxford English Dictionary defines economy in part as the “(administration or condition of) concerns and resources of a community” (Sykes 1976). The modern separation of economics from ethics neglects the traditional understanding of economy as a socially oriented and organized system for the production and distribution of resources for the community, to the detriment of economic science itself (Sen 1988, 7; Alvey 1999). This neglect is especially significant where specific markets are considered in isolation – a
trend that is notable in economically oriented discussions of markets in HBM, or markets in healthcare more generally. Markets, whether regulated or not, are inevitably subject to the (necessarily reciprocal) influence of other markets and non-market social forces. We cannot speculate on the likely features of a market in HBM without considering, for example, the influence of employment markets, healthcare markets, and social values and beliefs about the sale of HBM on such a market (e.g. Roth 2007). Moreover, by choosing to foster markets in HBM through legislation permitting the sale of HBM, society must be able to identify the goals of markets with respect to the broader goals of society itself – those deemed consistent with or expressive of human flourishing. For example: are markets in HBM intended to promote individual liberty, health, wealth or some combination of all three? Market design should then strive to ensure the promotion of these goals in practice.

The word economy has its roots in the Ancient Greek oikonomía, meaning household management (Sykes 1976, 328), and economic moral philosophy owes much to Aristotle’s account of economy and markets (Sen 1988, 3). In *The Politics* (1996) Aristotle argues that where trading or exchange of goods and services occurs within the oikonomía – understood as the community of the polis engaged in the common pursuit of human flourishing - the point of trading is not to obtain wealth but to ensure that all members of the polis have that which is needed to flourish. Wealth may consist of actual currency or simply goods that are surplus to the needs of the household - “the amount of available property [that] exceeds the capacity of the citizen for proper use” (Lewis 1978, 79). In contrast to the oikonomía, in which money is simply a mechanism to facilitate mutually beneficial exchanges of necessary goods, Aristotle’s emporium (market) is a place outside the polis, where individuals lacking common goals and the bonds of civic relationship trade with the purpose of acquiring individual wealth for its own sake.

The world of the market and money-making is anarchical, ataxia, something without order, in brief, a corruption of community and, accordingly, a perverse moral location of the economy. For the money economy (or one version of it) is a great homogenizer, rendering things and persons the same and removing them from their natural places, their proper use in the case of things, their status in the rank ordered community of human beings. (Booth 1994, 213)

Lewis (1978) clearly explains Aristotle’s economic theory, showing that for Aristotle, in the absence of the polis community structure, individuals are doomed to pursue the acquisition of wealth for its own sake through anxiety concerning their livelihood.

Exchange takes place either in an environment of potential enemies – those who have previously been in a weak bargaining position and have been obliged to
accept tough terms now being constantly on watch to get their own back – or it is impersonal – with neither buyer nor seller acquainted with or caring about the other, but simply determined to further their own interests by obtaining the most favourable prices. (82)

Where might HBM fit in the Aristotelian scheme of markets and economy? Where materials are conceived of as public goods, as is frequently the case for deceased donor organs and blood, providers may be seen as possessing materials surplus to their actual needs and therefore able and perhaps duty bound to share these with those suffering from a deficiency of such materials, who will put them to their proper biological use. In the Aristotelian oikonomia, however, money is legitimately used to facilitate exchanges of needed goods, thus those with a deficiency of particular materials might possess a surplus of other goods which might be needed by HBM providers. Applying Aristotle’s economic model to the procurement and distribution of HBM does not preclude a commercially mediated exchange of materials with other social goods, merely a particular kind of market. The sort of market that Aristotelian economics would condemn would involve free trade in HBM by socially disconnected individuals who would fail to consider the needs of one another or the potential commonality of goals inherent in procurement and use of HBM. Where market participants are members of a polis-like community, trade in HBM would be designed to further the healthcare needs of all members, requiring careful regulation to ensure mutually beneficial exchanges. Free trade between individuals lacking a shared understanding of human flourishing with respect to health and a common goal of ensuring access to necessary healthcare resources would likely result in the egocentric pursuit of personal gain, possibly at the expense of effective procurement and distribution of HBM.

The sheer diversity of the many different modern markets and economies precludes any direct correlation between them and the models of oikonomia and emporium developed by Aristotle. Nevertheless, contemporary economic theory and practice appears more closely aligned with the emporium, and many societies are characterized as “market societies”, “increasingly dominated in all [their] aspects by the monetarized exchange of goods” (Slater and Tonkiss 2001, 6).

Slater and Tonkiss describe the development of market societies as introducing a new principle of social order, of social integration and co-ordination, that was both specific to modern societies and tied to its most profound values... [promising] new patterns of political, social and cultural organization....in which social order emerges from the independent actions of autonomous individuals. The individual’s sphere of action was circumscribed solely by their material means and the rationality with which they could deploy their market
power. Such a transition could be understood either as the liberation of reason, freedom and progress from the irrational constraints of tradition, or else as the erosion of communal life and the decline of all social values that might stand above the merely economic measure of price. (2001, 6)

Contemporary debate has distinguished between individualistic (predominantly emporium-style) markets in HBM and the procurement and distribution of HBM as a common social or political concern (oikonomia). As we reflect on market values and models throughout this chapter, it will become clear that the exchange of HBM within society, whether commercial or otherwise, would be better conceived within the framework of the oikonomia.

4.3 Blocked exchanges and special goods

Markets, however much they may invade “every other sphere… [or dominate] every other distributive process” (Walzer 1983, 119), are in practice limited, their boundaries identifiable – if often blurred – at the points at which the market sphere abuts particular social or private domains deemed sacred – set apart from the commercial valuations and relationships of the market. These bounds are recognizable because the relationships or goods at stake are deemed inappropriate for the market sphere. Walzer terms these blocked exchanges. In Spheres of Justice, Walzer (1983) defines three different domains within which goods should be justly distributed according to a particular principle reflecting the value and nature of the goods in question. Thus goods may be freely exchanged, distributed according to need, or finally to desert. Goods that ought not be freely exchanged are thus blocked from the market sphere.

In his critique of Walzer’s theory of justice, which he characterizes as a form of institutional pluralism, Claasen (2009, 423) suggests that rather than focusing on the plurality of principles of justice, institutional pluralism should instead consider the different mechanisms of provision of particular goods within society. He argues that this reformulation will more realistically capture the nature of provision of goods, which often occurs via a plurality of mechanisms. Using this account, Claasen argues that counteracting processes of commodification is a way of ‘limiting the market’. Blocked exchange refers to prohibiting markets, incomplete commodification refers to regulating markets, and complex pluralism refers to making non-market alternatives available in addition to markets, so that the market does not take up the whole field of provision for a certain good. (2009, 428)
Before determining whether goods should be fully or incompletely commodified, prohibited from market exchange, or whether dual systems of provision of particular goods should be promoted, one must determine whether the good in question is special. If a good is not considered a special good, then it usually qualifies for full commodification in a free market. Special goods are those whose procurement, use or distribution is deemed of sufficient importance or value to society that their exchange within markets may be inappropriate (market inalienable) or subject to limitations (incompletely commodified). Conditions imposed upon market exchange of such goods should in theory reflect the perceived value of the goods to society. While different societies may accord special value to a variety of goods – for example a culture that highly values art may wish to prevent distribution of art via the market and confine art to publicly accessible institutions – some goods are likely to be universally recognized as special, such as essential requirements for or components of human flourishing, for example health, food and education or friendship, love and justice.

### 4.3.1 HBM as (universally) special goods

As discussed in Chapter 2, Nussbaum (2000, 418-421), identifies ten capabilities as universally required for human flourishing, thus requiring their just distribution within societies. The goods required to secure these capabilities are likely to prove universally special. As goods that are instrumentally valuable to health, and of universal personal or indeed sacred value to all human beings and societies, HBM are undoubtedly special goods. In the next sections outlining various examples of and proposals for markets in HBM, we will see that market advocates focus almost exclusively on the instrumental or therapeutic value of HBM. The personal value of HBM, of course, is not something that is amenable to trade - from the practical point of view it is a blocked exchange. The blindness of the market to this dimension of value in HBM is what renders treatment of HBM within the market framework particularly challenging.

Consider this typical example of economic discourse on HBM from Becker and Elias:

> When an economist sees a persistent gap between demand and supply - as in the demand for and supply of organs for transplants - he generally concludes that there are obstacles to equilibrating that market. And the obstacles are obvious in the market for transplants since no country allows monetary incentives to acquire organs either from living individuals or from cadavers. (2007, 3)

This quote demonstrates a dissociation of HBM not only from morality but also from the reality of HBM use and procurement as socially embedded, with the only obstacle to
market success identified as the prohibition of trade. It highlights the dangers of commodification rhetoric noted by Radin, who notes that “Reasoning in market rhetoric, with its characterization of everything that people value as monetizable and fungible, tends to make it easy to ignore [less monetizable costs]”, such as impairment of personal and community wellbeing (1996, 85).

The therapeutic value of HBM, and the direct relationship between procurement of HBM from living persons and their health provide ample reasons to categorize these materials as special goods, whether their other dimensions of value are recognized or not. Thus I will preface my review of different HBM market models with an account of the commodification of healthcare, which offers valuable insights into the goals and limitations of markets in goods that are essential for the promotion of health, and therefore human flourishing.

4.3.2 Healthcare as a special good

Pellegrino argues that if health care is fully commodified – that is, not recognized as what I term a special good -

then it is something we possess and can sell, trade, or give away at our free will. This implies that, like any commodity, ownership of medical knowledge upon which health care depends resides with health professionals or those who employ or invest in them (Nozick, 1974, p.160; Engelhardt, 1996, p.381). No one else can lay claim to their medical knowledge or skill unless they were acquired unjustly. In this view, there would be no duty of stewardship over medical knowledge which would require its use on behalf of those who need it but cannot pay for it. Nor can there be any valid moral claim by the sick on society for its allocation or distribution. (1999, 247)

Even in highly commercialized systems, health care is rarely treated purely as a commodity. For one thing, doctors are expected not to simply sell “products” to those willing to pay, but instead to refuse provision of services or goods that risk impairing the health of prospective buyers. More importantly, a society that fails to prioritize healthcare distribution in the setting of scarce resources and urgent needs would gravely threaten both individual and social wellbeing. Failure to provide free care to the indigent might result in catastrophic disease outbreaks affecting even the wealthiest members of society, while prioritization of wealthier patients might ultimately jeopardize market efficiency by wasting limited resources. This does not preclude markets in healthcare, it simply means that unfettered free markets are likely to collapse and result in unprecedented numbers of preventable deaths, diseases and disabilities, impairing the flourishing of individuals and communities. “Health care is both an
individual and a social good. A good and well-functioning human society requires healthy members, and healthy members require a good and well-functioning society” (ibid., 260).

Interestingly, Aristotle compares the inappropriate acquisition of wealth (in the market) with the practice of the art of medicine (Politics 1257b, 18-31). In both cases, he suggests, the aim is to maximally (“without limit”) produce goods (wealth and health). As Lewis points out, pursuing the good of health as an end in itself is dangerous (1978, 74). Health is good because it contributes to human flourishing more generally. If health is pursued at the expense of other goods, flourishing may be impaired. For example, an individual who devotes their entire life to fitness activities and intensive medical care may well achieve better health but may miss out on all the other social and personal goods that make life meaningful and enjoyable. This is clearly a risk in healthcare markets that regard health as an isolated good, or indeed in HBM procurement systems that neglect broader social goals in favour of increased supplies of HBM.

4.3.3 Five categories of concern about commodification

Concerns about the complete or incomplete commodification of special goods may be categorized as follows:

(i) **PRACTICAL BARRIERS** to commodification: Some goods cannot be bought and sold because they cannot be made “products” or transferred as property; for example: abstract ideas, clouds, and life. In addition, the production and distribution of some goods may be deemed ineffective or inefficient through market mechanisms, and likely to result in market failure;

(ii) **CORRUPTION of VALUE**: Some goods risk corruption through sale, such that they would be transformed into different goods, or effectively obliterated. For example, friendship would become paid companionship, and sexual love would become provision of a sexual service. Commodification of a good might also corrupt its innate value to society, for example the sale of criminal justice, political power, and public honours might ensure that such goods were valuable to individuals seeking to avoid justice, or seek power and acclaim but would eliminate their true value as goods awarded according to merit and desert;
(iii) VIOLATION of MORAL NORMS: Commodification of some goods may be regarded as an inevitable or probable violation of a moral norm; for example the sale of living human beings is seen as violating respect for human dignity as well as respect for liberty and autonomy. More contentiously, trade in some goods might be regarded as violating moral duties. For example, if parents have a moral obligation to spend time with their children, charging their children a fee for “quality time” might be viewed as immoral. Where society recognizes a duty to provide citizens with particular goods, such as healthcare, food and education, the market may nevertheless be considered an appropriate mechanism of producing and distributing these goods, but in order to ensure that everyone has access to a minimum quantity of these resources, regulation is required;

(iv) VIOLATION of SOCIAL NORMS: Goods which are considered socially inappropriate for production, use or exchange may be viewed as special and considered eligible for market exclusion. Radin (1987:1854) terms such cases examples of “prohibition-alienability”, e.g. heroin and alcohol;

(v) HARM PREVENTION: Goods that pose risks of harm to individuals or society may be identified as special and subjected to market prohibition or regulation; e.g. the sale of nuclear weapons, poisons and guns.

Depending on the concerns elicited by particular goods, and the opportunities available for effective market regulation, goods may be excluded from market exchange, judged suitable for incomplete commodification and thus incorporated into regulated markets, or - in rare cases - established within complex pluralistic mechanisms of provision such as hybrid systems of both altruistic and commercial procurement. Methods of market regulation include exclusion of goods (e.g. nuclear weapons) or participants (such as legal minors); price fixing; imposition of monitoring (e.g. mandatory reporting of gun sales) and transparency mechanisms (e.g. procedural requirements for informed consent of vendors and purchasers); imposition of quality standards or rationing through acquisition quotas.
4.4 Modeling markets in HBM

Numerous arguments from each of these categories of concern about commodification have been made in opposition to complete (free market) or incomplete (regulated market) commodification of HBM. As objections to and arguments for the market, they will be explored in detail throughout the next three chapters. In this section I review the free and regulated market models and identify their respective issues. The free market model that dominates the economies of Western democratic societies reflects the liberal tradition supporting individual freedom in the pursuit of personal conceptions of the good life. It is manifested in arguments for the sale of HBM that prioritize both the anticipated practical benefits of free markets – in which supply will increase to meet demand for HBM – and the alleged moral benefits of enabling individuals to dispose of their body parts as they choose and to sell them in pursuit of their own goals. Nevertheless, much of the pro-market literature regarding HBM is moderated by concern for values that the free market model can less effectively protect or promote, such as harm minimization, avoidance of exploitation, and fairness in the distribution of goods. Many market advocates thus support a degree of market regulation, in particular with respect to state control of the distribution of HBM according to medical need, rather than ability to pay. The preponderance of regulated market advocates highlights recognition of HBM as special goods that ought not be treated as “mere commodities”, at least by virtue of their therapeutic value and hence importance to the promotion of health. I will now consider two broad conceptions of the free market and regulated market models of trade in HBM. In comparing the theoretical models with real examples I discuss the conditions under which HBM might be recognized as market inalienable, or if marketable, whether regulation of trade might be deemed necessary, and what form such regulation might take.

4.4.1 The free market

Perhaps the best-known example of free markets in HBM is that of the United States gamete trade. Although the US regulates certain forms of use of gametes (in particular discouraging payment for HBM used in stem cell research (Korobkin 2007, 45), the sale and purchase of ova and sperm for use in the reproductive healthcare market is largely unregulated – with the exception of three states (Chung 2006, 278). The 2005 introduction of federal regulation mandating screening and testing of gamete providers appears designed to prevent the spread of communicable diseases rather than to influence the market (see ASRM 2010). Baum notes that regulation in the US is
essentially limited to “1) gamete donor medical screening guidelines, 2) clinic reporting requirements, and 3) insurance coverage guidelines” (2001, 108). Payments to gamete providers – commonly referred to as “compensation” – are determined by independent clinics, which also select and reject potential vendors and purchasers. Access to gametes is thus governed not by rationing criteria developed by legitimate government authorities, nor entirely by ability to purchase, but by purchasing power and the potentially discriminatory criteria of the clinic in question (J. Daar 2008). Conditions of sale, such as provider anonymity or restrictions on the number of children produced per provider are also determined within the market itself rather than through external regulation (Chung 2006, 277). Furthermore, gametes provided within the US may be freely sold to foreign patients.

Chung praises the US free market in gametes because it ensures a wider supply of “quality” gametes with “popular” characteristics such as healthy genetic histories and avoids gamete shortages (2006, 294-5). In addition, the absence of regulation governing provider anonymity “caters to the diverse desires of its own population and those abroad” (ibid.). Baum similarly advocates free alienability of oocytes within the market as necessary for supply to meet the demand from infertile couples. He argues that the procreative liberty enabled by the market should prevail in the absence of “identifiable threats to individual or public health”, and criticises market prohibition as a paternalistic exclusion of women from the market that restricts their reproductive autonomy (2001, 162).

Free market models of trade in other forms of HBM are also typified by an emphasis on improved supply of materials, a willingness to accept economically influenced inequalities in access to and provision of materials and a tendency to frame market prohibitions as unjustifiable infringements on the autonomy of both providers and recipients (e.g. Block et al. 1999). Thus, Nelson proposes a free market in transplant organs in which they may “be bought and sold like any other commodity” (1991, 64). In advocating a free market in organs, Block et al. identify the benefits of a supply and demand system as greater organizational efficiency, more lives saved, relief of financial burdens following the death of relatives and positive boosting of the economy (1999, 105). R. Epstein argues that an unregulated market will not only perform better in meeting demand for organs but will also protect the interests of vendors (2009, 87).

Ryan advocates a free market “balanced by using the least amount of restrictions as ethically and legally possible” (2009, 446). He notes that the use of an organ procurement agency to facilitate the transfer of organs between vendors and recipients
is likely to be a practical necessity given the complexities of testing, screening and matching organ transfer pairs (437). Although Ryan advocates minimal regulation, he refers to the possible role of regulation in helping “with issues of bargaining power” (446) and “ensuring that neither party is being unconscionably taken advantage of” (437). Without explicitly supporting a free market, Savulescu argues that individuals should be allowed to sell organs regardless of their financial motivation, and irrespective of the impact of markets on organ supply, but nevertheless warns of the “need to ensure that the risk involved is reasonable compared with the benefits it will offer to the person undertaking the risk and society” (2003, 139).

Free market advocates, it seems, are sometimes better characterized as proponents of minimally regulated market systems. The nature of HBM as therapeutic products that pose risks of infection and illness to recipients appears to warrant regulation designed to minimize social harm to purchasers through screening and quality control. Interestingly, the same degree of concern is not shown to potential vendors of HBM with little support evidenced for exclusion of vendors at risk of harm through procurement procedures. (Just how Savulescu would determine “reasonable” risks in an organ market is unknown.) One rationale for this discrepancy may be that market efficiency requires the provision of adequate information to all participants, and information about the quality of materials (including the presence of infection) is necessary for purchasers to make informed decisions. Vendors, it is presumed, will be provided with adequate information about the risks of procurement procedures. However, an inequality stands out. Regulatory processes such as the FDA order on ART in the United States (ASRM 2010) effectively strive to exclude materials that pose particular risks of harm to recipients. A potential purchaser cannot, we presume, choose to purchase gametes that are infected or undergo procedures that fail to meet minimum quality standards. Potential vendors on the other hand, are allowed to determine their own degree of acceptable risk and are not prevented from making dangerous decisions.

4.4.2 The regulated market

The arguments of regulated market advocates and the concerns they identify as necessitating regulation reveal considerable overlap with the concerns of market prohibitionists. Market regulators seek to justify markets not only by appeal to the claims of free marketers, but also by demonstrating that the concerns of opponents can be addressed through regulation and by arguing that regulation will enhance the anticipated benefits of free markets.
The best-known example of regulated markets in HBM is that of the Iranian national market in kidneys from living vendors. The “compensated and regulated living unrelated donor renal transplant program” was introduced in 1988 (Ghods and Midhavi 2007, 649). The market model is characterized (in theory at least) by a number of key features including:

(i) **Citizenship limitations of the market**: Sale of kidneys from Iranians to foreigners and from foreigners to Iranians is prohibited;

(ii) **Minimization of harm to providers**: Prospective vendors are excluded if deemed medically unfit and providers are given free life-long health insurance;

(iii) **Removal of intermediaries**: Transplant teams are prohibited from soliciting kidney providers and brokers are discouraged;

(iv) **Market oversight**: a non profit organization and government and professional bodies oversee the procurement process to ensure regulations are enforced;

(v) **Civic recognition**: state and charitable organizations promote a positive view of vendors by celebrating kidney provision as “altruistic”; payment to providers is thus characterized as a gift or reward (Haghighi and Ghahramani 2006, 138).

The first objective of regulated markets in HBM, like that of free markets, is to increase supply. Secondary objectives reflected in the Iranian system include: (i) minimization of harm to vendors and recipients; (ii) promotion of vendor benefit through payment; and (iii) to ensure the benefits of the market accrue mainly to providers and recipients, rather than to brokers or intermediaries. In the case of Iran, it is clear that the primary objective has been achieved. Supply has increased such that 1642 renal transplants were performed in Iran in 2006, (from 245 in 1988), of which 243 were from deceased providers (Ghods and Midhavi 2007, 649). The success of the market has perhaps been exaggerated, with claims that the waiting list for kidney transplants was eliminated in 1999 now proven incorrect (see Griffin 2007, 505).

Claims regarding the success of regulation efforts are also somewhat dubious. Haghighi and Ghahramani imply that profiteering through brokerage of kidney sales is effectively eliminated, claiming that 96% of vendors are referred through the nonprofit organization DTPA (2006, 139). However, while all vendors receive a payment of approximately US$1100 for their kidney (Nourbala et al. 2007, 928), vendors are also entitled to accept additional money from recipients, enabling a freer market system in
which prices fluctuate according to the perceived quality of goods, and the respective needs of vendor and purchaser for money or goods. The efficacy of government oversight has also been questioned, as well as the rigor with which regulations are enforced (Griffin 2007, 505).

How effective are the systems designed to prevent harm to vendors and recipients? Independent empirical data available regarding the Iranian market is limited (Hippen 2008) and sometimes contradictory. One study reported 91% satisfaction by vendors, but concluded that follow-up care was inadequate and vendors were underpaid (Malakoutian et al 2007, 825), while another concluded that the majority suffered psychosocial complications:

The majority of vendors stated that what they obtained from vending did not compensate them for what they lost. None were able to remove themselves from poverty and debt or change their lives radically. Quality of life was impaired in all aspects. (Zargooshi 2001b, 1796)

According to Hippen (2008, 5), research of recipient outcomes suggests that poorer outcomes may be associated with the use of purchased kidneys compared with those donated by relatives in Iran. Although he speculates this may be due to the poorer health of impoverished kidney vendors, he concludes it is not statistically significant (ibid.).

Despite the imperfections and uncertainties regarding the efficacy of regulation in the Iranian model, many authors cite this model as evidence to support the introduction of similarly structured markets in a variety of countries (for example Hippen 2008; Major 2008; Friedman and Friedman 2009). Furthermore, many dismiss concerns about the imperfections of the Iranian system, expressing confidence that the advantages of wealthier, more developed countries would result in better systems. For example Becker and Elias, having noted the evidence of poor outcomes for vendors in Iran and in the Indian black market declare:

The experience in these two poor nations is hardly comparable to what would happen in the United States or other advanced nations that began to pay for organs. The quality of the surgery would be far superior, as would be both the pre and post care, especially since some of the Indian cases occurred during periods when paying for organs was illegal, and occurred in the underground medical economy. (2007, 14)

Alternative models of regulated kidney or organ markets (more or less defined) include those of Erin and Harris (1994; 2003a), de Castro (2003, 146), Matas et al. (2008), Omar et al. (2009), and the various models proposed in When Altruism Isn’t Enough (Satel 2009). While some models include all forms of organ procurement, others
distinguish between in vivo markets from living organ vendors, futures markets in which prospective deceased providers receive some payment while alive, and post mortem markets where heirs are entitled to sell organs from the deceased. Some authors express support for a dualistic system akin to Claasen’s complex pluralism, for example Goodwin recommends 

a transparent, hybrid system that supports altruistic procurement… [yet also] embraces a transparent but limited market approach… restricted to posthumous harvesting (after death)… Individuals would not be compensated for providing a live donation. Rather, this proposal would allow for individuals to negotiate for organ transfer upon death. Family members or a decedent’s estate could be compensated for organ donations, as well as charitable organizations. (2006, 22)

Common features of regulated market models reflect those of the Iranian model, namely:

(i) protection of vendor autonomy through informed consent and prevention of coercion by third parties;
(ii) minimization of harm to live vendors through
  a. exclusion of unfit vendors as defined by current live donor eligibility criteria;
  b. provision of adequate and free post-operative care and follow-up (J.S. Taylor argues this is necessary to protect vendor autonomy (2005, 110-12));
(iii) oversight to ensure regulations are enforced through
  a. use of central governmental organizations to purchase and distribute organs;
  b. exclusion of foreigners from participation in national markets.

In addition, many of those who support a regulated market mechanism of organ procurement veto the use of market mechanisms in the distribution of organs thus purchased, instead arguing that access to organs should be made equitable through a state market monopoly that provides equitable access to transplantation:

(iv) equitable allocation system of organs (in which equity precludes consideration of prospective recipients financial status18).

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18 Some authors imply that the fairest distribution mechanism would be that of a competitive market system, for example on the grounds that “the higher bidders would be [most likely] those who stood to gain most from the use of the organs” (R. Epstein (2009, 87).
Advocating a regulated market in oocytes, Resnik (2001b) highlights similar values to those of organ market regulators, such as the protection and promotion of liberty, health, safety and human rights. Resnik (ibid., 24), identifies ten potential areas of regulation in oocyte markets, however in reality the regulation of gamete markets is considerably less comprehensive. Although more regulated than the US market, with a fixed price payment and national legislation governing the use of ART, the Spanish model of oocyte procurement – not officially recognized as a market – delegates responsibility to private clinics and distribution of oocytes is essentially market driven.

Spain, as a member of the European Union, is subject to Directive 2004/23/EC of the European Parliament, which urges member states to ensure that “the procurement of cells and tissue as such is carried out on a non-profit basis” (European Parliament 2004). However, the Directive permits “compensation” of donors for “inconveniences” (ibid.). The flexibility of this language has enabled member states such as Spain to provide a varying degree of financial payment to oocyte providers.

Spanish Law 35/1988, Article 5 states that donation of gametes should be a formal, secret, and free of charge contract between the center and the donor and should under no circumstances have a lucrative or commercial nature. (Boada et al. 2003, 275)

Nevertheless, payment of €900 to oocyte providers is routine in Spain and endorsed by authorities as a just compensation for the inconveniences and potential costs incurred by ‘donors’. While this sum, equivalent to GB£740, may simply remove the disincentives or financial barriers to donation, it is more likely that in many cases it exceeds the actual financial costs incurred and thus constitutes a financial incentive for provision. One oocyte provider in Spain, a recent immigrant from Chile, reported she was able to live on her payment for three months (S. Carney 2010). Research suggests that financial motivations often play a role, albeit ambiguous, in the decision to ‘donate’ eggs in Spain (Orobitg 2005, 45) and in other countries that offer compensation (see e.g., Purewal and van den Akker 2009). Regardless, Spain offers a plentiful supply of eggs in comparison to other European nations which either prohibit donation (e.g. Italy) or ‘compensation’ altogether, or offer significantly less, for example GB£250 in the United Kingdom. With Spanish ART clinics operating privately, and no restrictions on access to oocytes by foreign patients, significant numbers of reproductive

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19 Interestingly, the UK’s current restriction of compensation to GB£250 for providing oocytes for use in ART contrasts with policies allowing the payment of GB£1500 for oocytes to be used in research (D. Campbell 2010).
travelers purchase ART procedures that include ‘donated’ oocytes in Spain (Shenfield et al. 2010, 1367). In 2008 nearly 400 patients traveled from France - where oocyte donors do not receive payment - to other European countries to access oocytes, including 66% to Spain (Merlet 2009, 38).

Waldby describes the US and Spain as having a vigorous and privately controlled internal trade in reproductive oocytes, in each case linked to unregulated transnational trade. Nations that attempt to protect oocyte donation from free market forces find that nationally based regulations are being increasingly undermined by tissue trading between states, facilitated by medical tourism, global medical commerce and the ever-expanding demand for oocytes. (2008, 22)

She reports that “[Spanish] clinics recruit through beauty parlors, supermarkets, colleges and by word of mouth, and pay oocyte suppliers about £1000 per procedure, with a premium paid to fair, “northern looking” donors” (ibid., 23).

4.4.3 Introducing the Myth of the Regulated Market

J. Chapman (2008, 1343) and Rothman and Rothman (2006, 1526) have declared the vision of regulated organ markets a myth. Numerous market opponents express similar worries that the implementation of regulated market models will either fail to successfully enforce regulations or will gradually devolve into less regulated systems. Rothman and Rothman warn:

Whatever the proposed system, regulation may not be readily accomplished. Once a market is lawful, half-way measures that allow for sellers but not for buyers might prove inoperative. Effectively regulated markets typically involve so-called ‘natural monopolies’ wherein entry points can be effectively policed… By contrast, in kidney sale, with almost everyone eligible to enter the market, oversight will not be easily established or maintained. So too… change almost inevitably carries unintended consequences… (2006, 1527)

In Chapter 5 the claims of regulated market advocates and their opponents will be assessed in detail. The greatest challenge for market regulators, I will argue, is the likelihood of deregulation and the fact the strongest arguments for the removal of market prohibitions are those that will also preclude all but the most minimal of procedural forms of regulation designed to ensure efficiency and protect the freedom of market participants. Thus in her commentary on Erin and Harris’s proposed market model, Radcliffe-Richards argues

If it is presumptively bad to prevent sales altogether, because lives will be lost and adults deprived of an option some would choose if they could, it is for the same reason presumptively bad to restrict the selling of organs. Once you recognize that the default presumption is in favour of any such transaction, you should be reluctant to prevent any more sales than necessary. (2003, 139)
Visions of the free market are often made less explicit, perhaps for fear of the likelihood that they will prompt repugnance and objections. A typical nightmare of the free market is that tentatively envisaged by J.S. Taylor (2005, 200) in which the poor sell their biological materials for use by the rich – whether in therapeutic procedures or for more frivolous purposes such as the production of cosmetics or even cannibalism. In the truly free market in which only the autonomy (conceived minimally as informed consent or as autonomous desires) of participants is guaranteed, vendors may be literally hollowed out of body parts. I shall consider this possible implication of the argument from autonomy in Chapter 6. While some express hope that market forces will promote fair prices and good vendor care, the evidence of unfettered black markets suggests otherwise. I will argue in Chapter 5 that black markets may plausibly be considered representative of legal markets, at least to some extent.

4.5 Common values in pluralistic societies

Market advocates may judge the ethical concerns of objectors valid but disagree with their conclusions, or find them grounded in emotions of repugnance rather than reasoned arguments (e.g. White 2006, 319; Roth 2007, 53-4). Others suggest that disagreement about particular market issues such as respect for dignity simply reflect the plurality of moral values and argue that those who object to the market need only ignore it and pursue their own non-market mechanisms of procurement and distribution. In the context of multicultural societies, the opportunity to voluntarily participate in HBM markets may be presented as a solution to moral dissent, with some individuals choosing to sell that which others choose to donate. Hippen argues the market offers individuals the opportunity to clearly express altruism by “explicitly rejecting compensation” (2005, 597). This reflects a more general perspective of market economies as a crucial feature of liberal democracies in which individuals may freely pursue their own moral preferences within the neutral arena of the market. Keat (drawing on and critiquing MacIntyre) notes that “Neutralist liberals often claim that only market economies are consistent with the principle of neutrality and hence with the exclusion of ethics from political reasoning” (2008, 243). Such claims ignore the reality of markets as embedded firmly within societies.

20 While the possibility of maintaining multiple mechanisms of procurement has yet to be examined (see Chapter 5), there is significant concern that a legal market would ‘crowd out’ altruistic procurement mechanisms in particular (e.g. Danovitch and Delmonico 2008, 390).
Market relationships can only be sustained by being embedded in certain types of local nonmarket relationships, relationships of uncalculated giving and receiving, if they are to contribute to overall flourishing, rather than, as they so often in fact do, undermine and corrupt communal ties. (MacIntyre 1999, 117)

Keat suggests that MacIntyre’s account – which he largely endorses - is not applicable to large nation states but nevertheless resolves the dilemma of how then to regulate markets within modern societies. He suggests:

We can conceive of ‘instituting markets’ in large-scale societies as a (possible) collective, ethically-based decision about how to secure the institutional conditions for certain kinds of goods, a decision that would be accompanied by recognising the need also to secure and protect the existence of other domains in which very different kinds of goods are likewise made available to all members of the political community. (2008, 254)

Critical to Keat’s defense of ethically framed market economies is that “markets are conceived as the institutional means adopted to promote (certain sources of) wellbeing” (ibid.). Significantly, he notes that where market mechanisms cannot effectively promote the collective goals of society, or where markets endanger important social goals, market regulation or alternative mechanisms for the distribution of goods must be implemented (ibid.).

4.6 Evaluating the ethical limits of markets

The rationales for establishing markets in particular goods include the hope that market mechanisms will optimally enhance the supply of goods; that market mechanisms of procurement and/or distribution of a particular good will be optimally fair; and that market mechanisms will optimally facilitate the exchange of particular goods and thereby enable participants to express their individual preferences and obtain their personal desires.

In evaluating real and theoretical markets in HBM, we must therefore begin by asking what good(s) we are concerned with. While the potential for market mechanisms to enhance supplies of HBM – conceived as therapeutic goods – is genuine, it is the correlation between supplies of HBM and the promotion of health that lends normative support to market advocates. Although markets in HBM may also enable vendors and recipients to pursue their respective personal goals, especially by providing vendors with a fungible good (money), the enhancement of vendor liberty may prove a less important concern from the perspective of society than the promotion of health (see Chapter 6). The examination of HBM market models strongly suggests that while strict regulation may ensure justice in distribution of HBM, it is unlikely to promote fairness
in the procurement of HBM, with the poor more likely to bear the burden of provision – a concern that should be balanced against the anticipated benefits of markets.

Reference to optimality in market rationales suggests that the market’s primary value is as a mechanism of social exchange. If alternative mechanisms are better able to achieve the aims of the market, it is absurd to suppose that societies should promote markets instead. Therefore, in considering the moral benefits and social advantages of markets in HBM, it is crucial to also consider the comparative benefits and efficacy of alternate mechanisms of exchange. The emphasis of market advocates on the failure of altruistic mechanisms (see Chapter 5) demonstrates awareness that the possibly superior efficacy of market models plays a key role in the debate. Evidence of superior non-market systems of procurement and distribution should likewise impair support for the market.

The idea of particular goods as necessary to human flourishing and thus important to all members of society underpins the possibility of social consensus in framing the treatment of such goods with respect to marketing or market inalienability. Similarly, E. Anderson notes that Walzer’s distinction of different social spheres of distribution relies on “a society’s shared understandings of the meanings of goods” (1993, 143). She highlights the fact that such understandings depend on the equality of the participants, “so as to avoid a false consensus achieved by force or domination” (ibid.). This is crucial when considering the development of HBM markets within the context of gross socioeconomic inequities.

Anderson suggests that two questions should be asked in defining the “proper limits of the market”: 

First, do market norms do a better job of embodying the ways we properly value a particular good than norms of other spheres? ...Second, do market norms, when they govern the circulation of a particular good, undermine important ideals such as freedom, autonomy, and equality, or important interests legitimately protected by the state? (1993, 144)

Anderson identifies five features of the “norms structuring market relations that govern the production, circulation, and valuation of economic goods”: “they are impersonal, egoistic, exclusive, want-regarding, and oriented to “exit” rather than “voice”” (145). Do such attitudes inform market norms with respect to trade in HBM?

In general, HBM markets are impersonal and egoistic, with vendors and buyers intent on achieving their own desires rather than a common goal. It might be claimed that vendors are indirectly united with purchasers in the promotion of health – by participating in HBM markets the supply of HBM is theoretically enhanced with
benefits for all those with access to these goods. This would depend on the conditions of
distribution of HBM, but would also be somewhat dubious – it is equally probable that
vendors would be simply pursuing their own commercially mediated goals without
concern for the benefits of their participation to recipients, let alone society more
generally. Although altruistic donation systems may be impersonal in the sense that
donors and recipients are sometimes unknown to one another, there is a social
relationship of solidarity and common purpose as well as the potential for recognition of
reciprocal obligations between society members. Donor contributions to society are
complemented by other goods that society may provide to its members - excluding
those that might be specifically tied to ‘donation’ as incentives.

HBM are goods that may be characterized as exclusive in that “access to [their]
benefits [are] limited to the purchaser” (E. Anderson 1993, 145); this also applies to
HBM when exchanged outside the market, except where materials are used in public
health research. Free markets in HBM are ‘want-regarding’ in the sense that materials
are distributed according to the desire and purchasing power of consumers, rather than
discriminating between urgent needs or other allocation criteria that may promote
justice. Anderson’s fifth feature concerns the fact that individual participants in the
market “influence the provision and exchange of commodities mainly through “exit”,
not “voice”… The counterpart to the customer’s freedom to exit a trading relationship is
the owner’s freedom to say “take it or leave it”” (146). Although the structure of HBM
markets may be influenced by the preferences of society and may evolve in accordance
with opinions expressed by market participants, it is possible if not probable that market
forces may suppress the voices of both customers and vendors. Customers desperate to
acquire materials critical for their health, and sometimes requiring specifically matched
materials, will lack alternative options. They may lack even the option to exit. Vendors
may likewise be constrained by poverty, and as Anderson remarks, “where the good
being sold is embodied in the person, voice may be alienated to the buyer” (ibid.).

4.7 Conclusion

Markets cannot, and ought not to be morally neutral - in the sense of purely amoral -
social domains. The very fact that markets in HBM are invariably intended to promote
health and individual autonomy shows that they are morally framed. The inevitable
impact of procuring and distributing HBM within any system – economic or otherwise
– on social practices, values and individual human beings means that markets cannot be
kept separate from society. Attempting to draw a line between economics and ethics
where the treatment of HBM is concerned is as foolish as distinguishing between my “surplus” left kidney and myself.

Drawing on Anderson, the goal of this thesis may be reframed as follows: to determine whether markets in HBM are likely to promote the goals of society, in particular that of enhancing access to therapeutic materials necessary for health; whether markets will promote or instead undermine central values such as freedom, autonomy and justice; and whether market norms better express the ways we value HBM than the norms of alternative systems of procurement, use and distribution of HBM. I have suggested that economy, and hence the provision and distribution of HBM, should be understood in the Aristotelian sense of “an ensemble of things we do, together, in interaction with nature and for a purpose or end within the overarching framework of our ends, social and individual” (Booth 2001, 233).

The question “what good is thereby served?” is essential to understanding what we do when we do the things called economic, much more essential than grasping the most efficient way of doing them. Not our income levels or purchasing power, but a knowledge of the good life, of virtue individual and political, is the true standard of living. (Ibid.)
Anticipate the worst or hope for the best?

Prosperity and depression hinged not on the state of production in the neighbourhood, but on the remote occurrences in remote places. Like the forces of nature, therefore, the market was unpredictable, no more to be known or controlled by the individual than the weather. (Handlin 2002, 79)

5.1 Introduction

The weight of debate regarding the sale of human biological materials has long rested on the likely practical consequences of legalizing or prohibiting the sale of particular HBM. The evidence garnered from contemporary markets in organs, blood and gametes by anthropologists, doctors and sociologists has made an enormous contribution to ethical discussions, often as an illustration of the perils of sales (e.g., Goyal et al. 2002; Scheper-Hughes 2004; Chugh and Jha 1996; Nahman 2008; Jing 2006; Titmuss 1997). Despite this, the pervasive assumption that payment of HBM providers will dramatically increase supplies elicits strong support for the development of markets. Irrespective of the arguments examined in the following chapter regarding whether individuals have a prima facie right to sell their HBM, or those to be examined in Chapter 7 regarding its potentially inherent immorality, a number of arguments concerning the likely consequences of markets in HBM are often employed to justify prohibiting or promoting markets. Thus, Resnik writes, “Because the commodification of human oocytes is not inherently wrong, consequentialist and prudential arguments should guide our policy-making in this area” (2001b, 4).

In this chapter, I examine the relative merits of consequentialist arguments in the market debate, identifying three key points of neglect. Firstly, I argue that emphasis on the impact of financial incentives for providers underestimates the potential of non-commercial provider motivations and overlooks the influence of procurement infrastructure and other factors on supplies of various HBM. Secondly, I suggest that prioritization of the healthcare needs of prospective HBM recipients, in particular those seeking organs or gametes, occurs at the expense of individuals and communities suffering from more urgent healthcare needs and thus undermines claims that markets in HBM are “ethically imperative”. Thirdly, the idea that “regulated markets” represent the best method of minimizing the harms associated with illegal or unregulated markets is, I
will argue, inherently flawed: (a) because efforts thus far to eradicate black markets have been suboptimal; and (b) because a procurement system that effectively prevents such harms will be so regulated it hardly resembles a market, minimizing the potential impact of financial incentives.

5.1.1 Overview of the chapter

I begin by reviewing the complex interactions between financial incentives and rates of HBM provision, warning their impact may be overestimated. I then examine the Argument from Life-Saving Necessity (ALSN), which is commonly invoked in reference to markets in organs, and then consider similarly structured arguments concerning the right to health and reproduction. Such arguments claim that markets are the best or only way in which to enhance health through improved supplies of HBM.

Next, I examine a major consequentialist objection to markets in HBM, which claims they will inevitably exploit the poor. Following this, the myth of the regulated market introduced in Chapter 4 will be explored in more detail. The potential impact of trade in gametes on children produced will also be briefly discussed with an emphasis on the challenges of cross-border trading and vendor anonymity.

I will also explore the argument that markets are justified because they reduce poverty. Finally, the Argument from Harm Minimization will be examined, which claims that markets are necessary to prevent the harms associated with black markets in HBM. I contend that these harms will in many instances be replicated or aggravated in the setting of legal markets, concluding that non-market mechanisms for enhancing supplies of HBM and eliminating black markets will more effectively and sustainably support the values and promote the goals identified by both market and anti-market commentators.

5.1.2 A caveat regarding consequentialism

The speculative nature of consequentialist arguments for and against markets in HBM means that any conclusions drawn here are of limited practical value and cannot be used to formulate definitive answers to the questions posed in this thesis. On the other hand, examination of these arguments helps to identify important points for consideration in policy development. Although the real consequences of establishing particular kinds of markets in particular HBM will be specific to particular places and times, and thus predicted with difficulty, the general considerations and arguments discussed here will be relevant in some form to most markets in most contexts. A further, important
rationale for including this chapter in my discussion is that much of the debate, as I have noted, consists in claims and counter-claims about the benefits or hazards of markets in HBM. It will at the very least highlight the importance of empirical research into the factors that influence supplies of HBM and the effects of HBM provision and sale on providers and their communities.

5.2 Financial incentives and supplies of HBM

Although advocates of markets in HBM offer numerous arguments that do not depend on the presumption of improved supplies - such as the “right to sell” claims outlined in the next chapter - where policy making is concerned, the key motivation for consideration of markets in HBM involves the anticipated improvement in supply. There is undoubtedly evidence that financial incentives are influential in motivating HBM provision\(^{21}\). At face value, the economic equation appears straightforward: offer payment for HBM provision and supplies will increase. However, the influence of financial incentives on supplies of HBM is more complex than examples like that of the Iranian kidney market might suggest. Not only do paid providers of HBM sometimes express additional (non-commercial) motivations (e.g. Kalfoglou and Glittelson 2000; Kenney and McGowan 2010; Zargooshi 2001a, 387), the efficacy of financial incentives is likely to prove proportional not only to the level of payment but also to the degree of financial desperation suffered by potential vendors. Thus the successful impact of the Iranian model, for example, may prove difficult to replicate in countries with better socioeconomic equality and higher living standards for the poorest groups\(^{22}\).

Optimistic views of the potential impact of financial incentives also tend to underestimate or neglect the significance of numerous barriers to HBM procurement beyond that of provider motivation. Unless such factors are addressed, financial incentives are likely to have limited impact. Finally, emphasis on payment underestimates the impact and potential of non-commercial motivations to donate HBM. Non-commercial procurement strategies have successfully motivated the

\(^{21}\) The introduction of payments for live kidney provision in Iran dramatically increased the supply of kidneys for transplantation (Ghods and Midhavi 2007). The relative abundance of ova for use in ART in countries offering donor “compensation” compared with those that do not also strongly suggests supply is heavily influenced by payment. For example, see Shenfield (2010, 1367) on reproductive travel within Europe.

\(^{22}\) 62% of living kidney providers in Iran, for example, live below the poverty line (Malakoutian et al. 2007, 825).
provision of supplies of blood in many regions\textsuperscript{23}, altruistic living kidney donors are increasing in many countries (see Horvat et al. 2009) and studies demonstrate high levels of support for participation in altruistic deceased organ donation programs in many countries, such as Australia and the United States (West and Burr 2002, 27).

Three questions must be considered when estimating the likely effects of financial incentives on supplies of particular HBM. Firstly, what level of financial incentive is required to motivate provision of HBM? Secondly, will incentives result in a sustainable increased supply of HBM? Thirdly, will financial incentives be more effective than alternative motivations?

\textbf{5.2.1 Determining adequate incentives for provision of HBM}

The level of incentive required to motivate the HBM provision varies according to the material in question, the anticipated risks and discomfort of particular procurement procedures, and the socioeconomic and cultural context in which potential providers are situated. For example, in the United States people are motivated to sell plasma in return for US$40 (Monti 2009), and in Lithuania €11.6 [roughly US$15] (Buciuniene et al. 2006, 166). In China on the other hand, providers of blood are sometimes offered over US$200 (Adams et al. 2009, 415). The amount offered in China appears to reflect cultural perceptions of the physical and psychological costs of providing blood (ibid.). However, it may also reflect awareness of the very real consequences to some blood providers in Chinese markets who have contracted HIV and other diseases through unsafe practices (e.g. Jing 2006). In contrast to sales of blood, the money offered to living kidney or liver vendors is usually much higher, with the discomfort and pain of procurement, inconvenience, and risks to health considerably higher than those associated with blood provision. In the black market however, it is clear that the incentive required to motivate sale depends largely on the economic desperation of potential vendors, as well as the market rate for purchasing organ transplants. Thus prices range from averages of about US$1500 in Bangladesh (Moniruzzaman 2007) and US$2000 in the Philippines (Mendoza 2010a) to reports of as much as US$15 000 in Peru (Schepers-Hughes 2008, 115). With respect to legal organ markets, in Iran the government pays kidney vendors US$1100 (Nourbala et al. 2007, 928) and in Saudi Arabia relatives of deceased providers are paid about US$13000 (Garwood 2007, 6).

\textsuperscript{23} The WHO (2009a) reports that 51 countries collect 100\% of their blood from unpaid donors, and that 32 countries have doubled their altruistic donations between 2004 and 2007.
Payment for oocytes reflect the same variation, with women from poorer countries motivated to sell at lower costs. For example, the GB£250 offered as compensation to oocyte providers in the United Kingdom may well be inferior to the actual costs incurred through provision. It appears to offer little incentive to women to donate and consequently supplies of oocytes are low in the UK (D. Campbell, 2010). However the US$200 paid to oocyte vendors in Romania is worth a couple of months’ salary (Nahman 2008, 71). In other cases, poor women are flow from the Ukraine to Cyprus for oocyte procurement in return for US$500 (Barnett and Smith 2006), while in India oocyte vendors may receive as little as GB£70 (Prasad 2008). In contrast, the average payment in the US is at least US$4200 (ASRM 2007).

In the United States, a recent study suggests individuals will be more likely to provide kidneys in vivo in return for payment, although it found that the “probabilities of donating to a family member increased only marginally and nonsignificantly with increasing levels of payment” (Halpern et al. 2010, 363). Of the poorest respondents (annual income ≤ US$20 000), 29% of participants were willing to consider altruistic donation, 44.1% willing to provide in return for US$10 000 and 47.9% in return for US$100 000 (ibid.). Members of this group were more willing to sell a kidney than those of the wealthiest (annual income ≥ US$100 000), with 27.5% of the latter willing to sell for $10 000 and 31.3% for US$100 000 (ibid.). With only 15.2% of the wealthiest respondents willing to donate without payment, these figures suggests that kidney providers in a US market might be disproportionately drawn from the poorest groups 24.

Although conceivably significant increases in supplies of all HBM will occur in the setting of financial incentives, it is possible the relative poverty of potential vendors will be more influential than the amount offered in motivating sales. For example, a Swiss study of medical students indicated that while a third would never consider selling a kidney, two thirds of those who would, would do so only if confronting financial difficulties (Rid et al. 2009, 563). If the purpose of incentives is simply to motivate more providers, quite small payments may be successful. If markets extend across national borders the relative poverty of other societies will enable wealthier countries to obtain HBM at lower costs than if payment is provided to domestic citizens. Of course, concerns about the fairness of payment amounts may encourage market regulators to set

24 Interestingly, it also suggests that the poor are more altruistically inclined to donate kidneys – although in practice studies have shown living kidney donors less likely to be from poorer groups – probably due to the potential financial disincentives to donation (e.g. Laurentine and Bramstedt 2010, 181).
a minimum price for particular HBM, but poorer groups are still likely to constitute a majority of vendors. If global market forces are allowed to determine prices, the flow of HBM from countries such as Bangladesh, Pakistan, and Egypt towards the United States, Western Europe and Saudi Arabia for example, is likely to mirror the dynamics of existing black market trade.

5.2.2 Factors influencing supplies of HBM

Although in practice a proportion of potential deceased organ donors are lost due to the refusal of relatives to consent to organ procurement, multiple other factors contributing to failure to actualize potential deceased donors have a significant impact on cadaveric organ supplies, including failed identification of potential donors and inadequate healthcare infrastructure (Matesanz and Dominguez-Gil 2007). For example, Van Gelder et al. conclude that, “the main cause of organ donor loss in Belgium is donor underdetection and not family refusal” (2008, 29). Matesanz (2003) argues that refusal rates in Spain have remained stable at approximately 25% despite increasing improvements in organ procurement numbers. Spain’s unprecedented success in deceased donation should therefore be attributed not to better motivation of potential organ providers, but rather to more effective and efficient systems of procurement, a fact which should be carefully considered by policy makers hoping to improve procurement solely by focusing on consent legislation for example (M. Quigley et al. 2008). Given the evidence of widespread support for deceased donation in many countries, this suggests that although financial incentives might increase consent rates, other barriers to donation will play a potentially greater role in improving supplies of organs. Focusing too much attention on potential provider motivation risks neglecting the influence of other factors on rates of HBM supply.

The same argument applies to procurement of other HBM. The location of procurement facilities and the ability to store and transport materials within countries, for example, plays a key role in enabling or disabling supplies of various HBM. While provider motivation is an important influence on supplies of HBM, other factors may be equally, or more so. They include:

(i) Removal of financial barriers to HBM provision:

For example, reimbursement of costs incurred through living provision of HBM such as costs of diagnostic testing, screening, provision procedures, follow-up health care, related insurance costs, lost wages and travel costs (e.g. Participants 2008, 5);
(ii) Removal of cultural or social barriers to HBM provision:
    For example, education regarding procurement procedures; engagement with religious beliefs and practices regarding deceased organ provision; public campaigns to combat stigma; legislation facilitating provision of gametes through regulation of provider anonymity, and articulation of rights and responsibilities of providers;

(iii) Removal of practical barriers to provision of HBM:
    For example, establishment of legislation and healthcare infrastructure necessary to maximize the potential of deceased organ provision (Matesanz and Dominguez-Gil 2007); facilitation of paired exchanges of organs from living donors who are willing to donate to a friend or relative but who are not a match; enhancement of surgical expertise and technological infrastructure to improve efficacy of procurement and utilization of organs (e.g. de Goyet 2009); creation of regional blood and bone marrow provision facilities to enable rural participation in provision; creation of national facilities to store and process blood and tissue products.25

The removal of barriers to provision of HBM will not only have a significant impact on rates of provision, it will also contribute to the sustainability of HBM supplies. If these barriers are not addressed, financial incentives (like any other motivations) will be limited in their efficacy. A rapid increase in supply produced by offering financial incentives will last only so long as the level of incentive outweighs the financial and personal costs of provision or the degree of economic desperation in society persists. In a society with improving social welfare and economic equality, incentives may become increasingly ineffective as the pool of disadvantaged providers diminishes. In addition, the possible “crowding out” of altruistic donors may compromise overall supplies, with those previously willing to donate to relatives or society reluctant to do so if (a) materials can alternatively be obtained in the market system or (b) commercialization of provision is seen to corrupt or contaminate altruistic procurement. The evidence to support “crowding out” theories is ambiguous, sometimes conflicting and often speculative, but most studies indicate a need to structure incentive systems for HBM provision carefully if non-commercial motivations are to be preserved (e.g. Lacetera and Macis 2010; Satel 2009; Mahoney 2009).

25 See for example efforts to enhance Korean plasma product supplies (Park et al. 2010).
5.2.3 Estimating the efficacy of motivations to provide HBM

The presumed superiority of financial payments as a motivation to provide HBM is largely untested. As I noted earlier, the efficacy of altruism as a motivation for blood donation is well proven in many countries, and studies demonstrate extensive support for altruistic deceased organ donation. Evidence also shows many people are willing to donate organs to relatives or friends in need. The efficacy of financial incentives for various forms of HBM provision compared with alternative models of motivation is subject to considerable speculation. For example, the factors that discourage deceased donation, such as religious concerns and distrust in the integrity of death diagnosis, may well prove less susceptible to financial influence, except where conditions of economic desperation prevail. Education about the procurement process, communication of support for donation from religious leaders and promotion of trust in healthcare systems through transparent procedures and development of equitable access to public healthcare are likely to be more effective in addressing these concerns. Where religious objections are held, it is unlikely that financial incentives will override them, particularly as numerous faiths endorse donation but object to commercial use of the human body.

International comparisons of provision rates in the setting of various incentives, as well as attitude surveys provide useful indications of the possible impact of markets, as do pilot studies, however it is difficult to anticipate the effects of long term cultural changes and practices in both commercial and non commercial procurement systems. In Chapter 8, I will suggest a variety of motivational alternatives to payment for provision of HBM, such as civic duty, reciprocity and solidarity, arguing that in conjunction with enhanced procurement and distribution systems they are likely to produce more sufficient and sustainable supplies of HBM. For the time being, however, I shall allow that financial incentives are more likely to increase HBM supplies, at least in the short term. This granted, we may usefully explore the consequentialist arguments for markets in HBM, beginning with the arguments from life saving necessity and the promotion of health which both depend on the establishment of increased supplies of HBM.

26 Data from the Global Observatory (2010) shows that in 2009 there were 982 living kidney donations in the United Kingdom, 235 in Spain, 417 in the Netherlands, 623 in Germany, 6388 in the USA and 324 in Australia for example. None of these countries offer financial incentives to donors. Similarly, in 2009 the Sindh Institute of Urology and Transplantation in Pakistan performed 544 renal transplants using unpaid living related donors (SIUT 2010).
5.3 The Argument from Life Saving Necessity

The expression “moral imperative” is used by a number of authors to lend impetus to the movement to establish markets in organs, for example:

As death and suffering mount, the construction of an incentive-based program to increase the supply of transplantable human organs – and to suppress unauthorized markets for human organs overseas – has become a moral imperative. (Satel 2009, 129; see also J.S. Taylor 2005, 202)

Similarly, in advocating a trial of incentives for deceased donation involving payment of funeral costs, Arnold et al. claim, “The ethical imperative of saving further lives necessitates an attempt to reconcile the good that might be achieved by a more effective system… with the ideal of the purely altruistic system” (2002, 1367). The emphasis on saving lives is echoed by numerous authors, such as Goodwin: “If saving terminally ill patients is the ultimate goal of organ transplantation, there may be limited virtue in foreclosing compensation alternatives for cadaveric organ donations” (2006, 211).

While market advocates often accuse their opponents of relying on feelings of repugnance towards the sale of organs, and emotional rather than rational arguments (e.g. Satel 2009, 3; Mortinger 1990, 499), they are no less guilty of appealing to emotions and intuitions. Mirroring the rhetoric of market opponents who reference the “desperately poor” threatened by harm, coercion and exploitation, market advocates highlight the “thousands dying on the waiting lists”. Thus, Satel writes that prohibition of payment, or reliance on altruism, “is the cause of too many unnecessary deaths” (2009, 9). This shorthand version of the Argument from Life-Saving Necessity (ALSN) implies - or explicitly declares (Block et al. 1999, 110) - that those reluctant to endorse the creation of organ markets are at least partially responsible for the death of those waiting for transplants.

The ALSN is founded on a largely unexceptionable moral premise – that the saving of human lives is in general morally good, and that societies ought therefore to facilitate systems that will save more human lives where possible. Its second premise is an empirical claim – that only the introduction of financial incentives can ensure a sufficiency of organs to save the lives of those in need of transplants – or at least to save substantially more lives than alternative methods. Given the obligation to save lives where possible, and the claim that only through the establishment of an organ market can more lives be saved, proponents conclude that markets are morally justifiable and indeed obligatory.
In response to the ALSN, three key objections should be noted. Firstly, markets may not be a practical necessity to save lives. Secondly, if the imperative is to save lives, addressing alternative healthcare priorities, rather than that of end-stage organ failure might save more lives. Thirdly, most organ market advocates highlight the role of living kidney providers as a solution to the shortage of kidneys for transplantation. They are more reluctant to wholeheartedly endorse in vivo markets in partial livers and lungs despite the practice of altruistic donation of these organs (Aronsohn et al. 2010, 932). This hints at a qualification of the life saving imperative, namely a concern for the risks incurred by providers. As I shall argue below in the context of market regulation, defining the limits of acceptable risk-taking in the market is more problematic than in non-commercial systems. If the imperative to save lives is so overwhelming, it seems that only where the risk of death from procurement outweighs the likely number of lives saved would provision be limited.

5.3.1 Are markets necessary to save lives?

Although blood and bone marrow are often used to save lives, it is organs for transplantation that are most prominently invoked in the ALSN, in particular kidneys. However, many patients with renal failure may be kept alive for some time using renal dialysis, whereas those suffering end stage liver, respiratory or heart failure can ill afford to await transplantation. Deceased organ provision must thus be a priority of those who support the ALSN, and given the evidence that healthcare infrastructure and systems play a vital role in determining the availability of deceased provider organs (see 5.2.2) it seems that addressing practical barriers to provision should take precedence over the introduction of financial incentives that will be useless in the absence of adequate procurement systems. Furthermore, simply because current altruism based procurement systems have failed to meet demand for organs does not mean that markets offer the only effective solution. Alternatives, which I shall discuss in Chapter 8, include a range of options for motivating living and deceased donation such as civic duty, reciprocity and solidarity and novel strategies such as the establishment of mandatory deceased donation. In addition, I will emphasize the fact that far more lives will be saved through prevention and treatment of diseases contributing to organ failure than efforts to increase supplies of organs in the presence of ever-growing demand.
5.3.2 Inconsistencies in the endorsement of markets as a life-saving imperative

By invoking the ALSN, market advocates expose themselves to a number of competing claims to save lives. Despite the much-touted economic efficiencies of renal transplantation over dialysis (e.g. E.S. Huang et al. 2009), addressing basic health care needs in developing countries will quickly and cheaply save more lives (e.g. Laxminaryan et al. 2006). Furthermore, it is anticipated that the costs of treating end stage renal failure with renal replacement therapy (whether dialysis or transplantation) will prove unbearable even for the wealthiest countries, if the incidence continues to grow (Dirks et al. 2005). Consequently, those intent on saving lives from organ failure should prioritize investment in prevention strategies.

Market advocates proclaim an imperative to save lives, but effectively limit the requirements of such an obligation to the removal of a single perceived barrier to the saving of lives - organ market prohibition. Ironically, although such a move might save more lives, most of those responsible for saving lives in the market system will be motivated by self-interest in the form of financial incentives rather than the desire to save the lives of others. We justify market systems on the grounds that there is a moral duty to save lives, yet the pursuit of a market system is practically justified on the grounds that appeal to a moral virtue in (or obligation) saving lives by donation has failed. Furthermore, despite the conviction with which the ALSN is invoked as a kind of universal moral mandate, its application to HBM markets is peculiarly selective in terms of those whose lives are prioritized for saving. Benatar, in his critique of “blinkered bioethics”, highlights this discrepancy:

> While attention to potentially preventable deaths through organ transplantation is praiseworthy, it is striking and of concern that there is no mention in all these debates in most bioethics journals of the many millions of people dying prematurely every day because of lack of food or access to even the most basic health care. (2004, 291)

The emphasis on saving the lives of those suffering end-stage organ failure - with the implication that these lives warrant unprecedented measures and (possibly) moral compromises by society – neglects the pressing healthcare needs of those most likely to be called upon to contribute as organ vendors.

Snyder argues that in many cases participation in deceased donation constitutes an “easy rescue” and that “we all have a duty to rescue others from great harm when we can do so and at little or no cost to ourselves” thus many communities would “be justified in promoting a norm of participation and in removing hurdles against participation” in deceased donation (2009, 48). While not endorsing mandatory
donation, Snyder’s argument paves the way for more rigorous expectations of society and its members to contribute to supplies of life saving HBM, particularly through deceased donation. I will return to this concept in Chapter 8. Here, I wish simply to make the point that if the imperative to save lives is so urgent, the argument should be applied to alternative strategies to enhance organ availability, including the possibility of mandatory deceased donation.

5.3.3 Public policy should think beyond cases of individual emergency

Invocation of the ALSN usually occurs in association with a “strategy of last resort” attitude. The implied or attested failure of altruism and other non-market strategies is cited as a justification for markets as if the latter’s anticipated success in saving lives will outweigh any hypothetical or actual ethical problems that may result27. Thus Arnold et al.’s claim that saving lives may require a “reconciliation” with the “ideal” of altruistic systems (2002, 1367). This naturally invites the question: How far ought we to compromise on other ethical concerns in order to save lives? Despite the virtue inherent in saving lives, it is clear that few if any societies endorse the saving of lives at any cost. The global outrage expressed in response to evidence of prisoners being executed “on demand” in China in order to facilitate organ transplantation (J. Parry 2009), is evidence that trading one life for others – irrespective of the net number of lives gained – is not regarded as an ethical policy choice, despite the fact that the voluntary sacrifice of a life in order to save others is often celebrated. Furthermore, as widespread disapproval of the black market in HBM demonstrates, saving some lives at the expense of the ill health, exploitation or coercion of other individuals is not considered justifiable.

Commentators on the market debate often reflect on individual cases of donation or sale to inform arguments. After all, individuals are lauded, if not actively encouraged to incur some risk of harm in order to save lives. While an individual might perform heroic acts such as entering a burning building or jumping into a river to save a life, the state – which is obliged to promote policies that consider the needs and interests of all citizens – must seek to prevent the incidence of house fires, to ensure the availability of trained firemen with safety equipment and to teach people to swim. This doesn’t mean that those who sacrifice themselves to save others are wrong, simply that the best way to save people from burning to death in house fires or drowning in rivers is not to

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27 Consider for example, the title of one pro-market paper: ‘Saving Lives Is More Important Than Abstract Moral Concerns: Financial Incentives Should Be Used to Increase Organ Donation’ (Hippen et al. 2009).
encourage others to take risks (whether motivated by altruism or payment) but to develop the best practical solutions to saving these lives without endangering others.

The imperative to save *one’s own life* is implicitly recognized as a strong justification for engaging in harmful practices (albeit short of murder). Sometimes, both organ vendors and buyers are motivated by the desire to save their own life or that of a loved one. Market advocates suggest that trades which are mutually life-saving are surely justifiable (e.g. Sever 2006, 1355; Matas et al. 2007, 17-19). Surely, one might add, the purpose of morality is to enable individuals to collaborate and interact for mutual benefit. However, as I noted in Chapter 2, morality is not simply concerned with negotiation and conflict resolution, but with promoting human flourishing. Social institutions, including markets, should therefore strive not to create minimally pareto-efficient cooperation between individuals but to establish systems that will present optimal benefits for all, without incurring avoidable harms. There are surely better ways to meet the life saving needs of the poor and those suffering organ failure, than to encourage desperate exchanges between them. While we might excuse or even approve the actions of desperate individuals lacking more ethical alternatives, we may nevertheless criticise societies who endorse such actions or who fail to promote access to better alternatives.

Kishore writes that, “Society owes a duty to save the life of a dying man and in the event of failure to do so, it is absolutely immoral to interfere with his own arrangements by making unrealistic laws” (2005, 365). The failure of society to meet needs for HBM may well be deserving of criticism or condemnation, however it does not follow that society’s attempts to prevent harmful alternatives through the prohibition of dangerous or otherwise unethical trade in HBM are immoral. Prohibition may well prevent greater harms occurring than that of unmet needs for HBM, by fulfilling society’s obligation to protect vulnerable citizens from abuse and exploitation.

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28 For example, Danovitch (email message to the author March 8, 2010) reports a living unrelated kidney “donor” in Egypt whose 11 year old daughter was suffering from cardiac disease: The donor “denied that any cash payment had been made but told [him] that the recipient family have helped out the donor family with medications for their daughter when these were not covered by insurance.” There have been other reports of parents selling kidneys to obtain money for medical treatment of their children (e.g. Finkel 2001).
5.3.4 Thinking beyond organs for transplantation

The ALSN may also be applied to other HBM. Blood and bone marrow transfusions may save lives and the potential value of other materials such as oocytes used in stem cell research may well prove life saving. All HBM may enable the promotion of health by improving or restoring function and thus enhancing quality of life, if not directly saving lives. Increasing global recognition and support for a right to health therefore appears to lend impetus to claims that markets in HBM are necessary for the promotion of health. However, the right to health (UN 1948), applies universally to all individuals, and thus is unlikely to be effective as an argument for markets in which health benefits for some are traded against risks of impaired health to others.

In the setting of gamete markets, reproductive rights (often expressed as reproductive freedom or autonomy) are sometimes invoked as a justification for allowing sales: “Paying gamete donors is not inappropriate because financial incentives increase supply and thus access to gametes, which in turn enables ART-seeking individuals to safely exercise their inherent right to procreate” (Chung 2006, 287). Similarly, in the setting of market prohibitions or restrictions on access to gametes for use in ART, appeal is made to reproductive freedom to justify or allow travel abroad to obtain gametes in less regulated systems of provision (Pennings 2002, 341).

Deech suggests in response that

it cannot be practically or theoretically acceptable to recognize a human right for every man and woman to a baby… [Such a right] would entail a duty contingent on other people to make it possible. Even between married persons there is no duty to cooperate in fertility. When procreation includes third parties beyond the confines of husband and wife, then accountability and medical ethics contribute to the decision. (2003, 430)

Rights based justifications of markets in HBM advocating the promotion of health encounter the same problem as the ALSN with respect to competing claims between vendors and buyers of HBM. Promoting the buyer’s right to improved health or reproduction may conflict with the obligation to protect and promote the health or reproductive freedom of HBM providers (e.g. Storrow 2006, 329).

5.3.5 Defining the limits of acceptable risks when promoting health or saving lives

The physical procurement risks faced by living HBM vendors are in theory equivalent to those faced by donors. In practice, however, it is feared that markets will result in greater risks to HBM vendors, either because the market is deemed more likely to ignore obligations to protect and promote the health of HBM vendors (see 5.6.1 below)
or because the justifications for markets may entail acceptance of greater risks to vendors (see Chapter 6). In non-commercial procurement systems, the principle of respect for the right to health may be applied equally to all individuals concerned, without consideration of individual wealth or willingness to incur risks in exchange for other goods. Procurement policies that are grounded in respect for a universal right to health may well involve trade-offs between risks and benefits to living providers of HBM and recipients, but the only considerations need be the availability of resources, evaluation of needs and determination of acceptable risks with respect to the health of all participants. Commercially based procurement systems conversely, are to some extent driven by non-health related goals on the part of HBM vendors and industry (in the setting of for-profit procurement systems). As difficult as it may be to weigh the health risks for a provider against the anticipated health benefits to a recipient of HBM, it is considerably more difficult when incommensurable non-health related values are added to the equation. In non-commercial systems, the primary goal of the provider is, after all, the promotion of the recipient’s health.

5.3.6 The anticommons as an impediment to the saving of lives?
A final practical objection may be made to the argument from life saving or health promoting necessity, namely that legitimizing the sale of some HBM may result in market failure or what Bovenberg (2004) refers to as an anticommons scenario. As noted in Chapter 3, Bovenberg suggests that with individuals seeking to profit from and protect their rights to their own tissue, biobanks for research may be unable to operate effectively, to the detriment of research that might otherwise benefit populations. A similar issue may apply to other materials such as organs for transplantation. If individuals seek to obtain the highest possible price for their organs, for example if provider characteristics render them more valuable, they may postpone provision in order to seek out better conditions of sale, compromising supply flows and efforts to meet needs equitably and efficiently. The pursuit of higher profits may also direct materials towards areas of research less likely to promote public health goals.

Despite the globally recognized value inherent in saving lives and promoting health, arguments for the establishment of HBM markets that are grounded in these goals prove ineffective. Not only must they provide sufficient evidence that the creation of markets

29 Such characteristics may include general features of the provider (including age, sex and exposure to various infectious and chronic diseases) as well as specific genetic features that may facilitate matching with potential recipients.
is the only way to effectively enhance supplies of HBM – a claim that remains in doubt – but the very values invoked in their support will also serve as a considerable restraint on markets. At the very least, markets will require regulation to ensure equitable distribution of HBM according to healthcare needs. In addition, where societies seek to promote health through societal institutions and policies, competing healthcare claims are likely to take precedence over markets in HBM, particularly where important gains in population and individual health may be won at lower economic and moral costs than those of HBM markets. Of note, competing health care concerns may in some circumstances warrant the deferral of some forms of HBM procurement altogether, in order to address more pressing or economically accessible public health issues. For example, treating infectious diseases may take precedence over the establishment of ART or organ transplantation in some societies. Where HBM procurement and use is feasible and desirable however, moral concerns about the consequences of markets may justify prohibition, particularly where alternative procurement strategies are possible. I shall now consider some of these moral costs that are cited as consequentialist objections to markets.

5.4 Exploitation and injustice in HBM markets
Concerns that sales of HBM are necessarily or “inevitably” exploitative of vendors are one of the most common objections to the establishment of markets (e.g. Danovitch and Delmonico 2008, 387). The Objection from Exploitation holds that sales of HBM are likely to or inevitably exploit all or some vendors, and are therefore inherently immoral. Exploitation in the normative sense implies a wrongful usage or utilization of a resource, person or situation, in which advantage is taken of the exploitee by the exploiter. Wilkinson, in his comprehensive account of exploitation, defines it as “wrongfully using...in one or more of a limited set of ways” (2003, 12). This limitation acknowledges the semantic ambiguity in the term “wrongful use”. Wrongfully using, in the broad sense of unethically acting towards or treating a person or thing, incorporates the range of immoral actions involving others. The fundamental feature of exploitative actions however, is that actual usage of the other is involved, meaning that the exploiter successfully obtains some benefit or value through her interaction with the exploitee. Wilkinson thus argues that in all cases of exploitation, exploiters “necessarily use others to foster the achievement of their own goals” (ibid.).

30 Note that all references herein to exploitation concern the normative connotation of the term as prima facie unethical (see Wilkinson 2003, 10).
5.4.1 Defining exploitation

Common to all cases of exploitation is the idea that the advantage obtained by the exploiter, that is the degree to which she intentionally succeeds in promoting her own interests, exceeds in some respect the advantage to which justice entitles her. In other words, exploiters obtain some degree of unmerited benefit as a result of using a situation, object or person. This knowledge allows us to identify the importance of specific features that enable exploitation. An unmerited benefit may arise through an accident of fate – for example, a door happens to swing open as I pass by during the course of a private conversation, enabling me to eavesdrop – or as a result of a particular attribute of the exploitee enabling me to obtain an undeserved benefit – for example, I might exploit a person’s visual impairment to eavesdrop on his conversation. In the case of the open door, I do not exploit the speakers (although I perhaps harm them by eavesdropping on their conversation); I simply exploit the situation. In the latter case, however, I exploit the speaker’s visual impairment to my own advantage in order to eavesdrop, which adds an additional wrong to that of the eavesdropping itself – the wrong of exploiting people.

That which is exploited in a person is often described as vulnerability - an actual or relative weakness in a person that enables another person to use them in a particular manner consistent with exploitation. For example, poor people in developing countries who lack access to basic human needs such as food and shelter are commonly described as vulnerable or susceptible to exploitation and harm in labour markets and research trials (Kottow 2003). However, Logar argues, “If exploitation must involve taking advantage of genuine vulnerabilities, such as basic needs, then the criterion is too restrictive and doesn’t allow for criticism of cases where one’s wants and desires are being exploited” (2010, 344). In many cases, the feature of the exploitee that enables exploitation cannot rightly be characterized as a vulnerability, whether relative or not. For example, I may exploit a friend’s generosity and wealth when I repeatedly borrow money without repaying it. My generous and rich friend, Alice, is not vulnerable as such - she may even consent to my using her in this way to obtain money that I do not deserve. Exploitation may seem more or less immoral depending on the nature of the vulnerability or other personal attributes being exploited, on the benefits gained by the exploiter and on the loss or injury potentially suffered by the exploitee. Exploiting Alice in this way may seem less objectionable than exploiting my friend Brendan’s blindness in order to steal from him. This is due to the fact that Alice voluntarily agrees to loan me money, and that she presumably obtains some satisfaction in acting on her generous
desire. Brendan on the other hand, does not consent and suffers a loss of money, so is worse off after exploitation. Nevertheless, in exploiting Alice’s generosity, I act wrongfully.

5.4.2 Benefit disparity exploitation

How may we determine what constitutes an undeserved or unmerited profit, and in particular, whether the sale of HBM is likely to involve vendor exploitation? The sale of HBM after all involves some degree of benefit provision to vendors in the form of whatever incentives are offered. In this context, the ‘unmerited benefit’ obtained by buyers of HBM is that which is not completely balanced by the benefit obtained by the vendor. Wilkinson describes “disparity of value” exploitation as situations in which one person takes advantage of another’s vulnerability in order to produce an unfair distribution of benefits between the two parties (2003, 34). In order to avoid disparity of value exploitation in the setting of HBM markets, we must determine a “fair” price for the sale of various materials.

A number of authors have suggested prices for living kidney (and sometimes liver) provision in the United States, drawing on cost-benefit analysis theory used in health and life insurance policy making to estimate fairness (e.g. Becker and Elias, 2007)31. Accounts of “fair compensation” for the provision of gametes and blood use estimates of actual costs incurred by providers with the addition of nonspecific payment for “inconvenience” or “suffering” (Boada et al. 2003, 275; ASRM 2007, 306; Ballantyne and De Lacey 2009; Simon 1998, 885). In order to avoid charges of exploitation, some authors have suggested offering as much as the market or the healthcare system can support to pay, for example US$250 000 has been suggested as an affordable sum for living organ providers in the United States (Matas and Schnitzler 2004, 220).

Setting a market value on the saving of a human life or the opportunity to create a child is inherently problematic given the incommensurability of some economic and social goods, and gross benefit disparities between vendors and buyers are likely to prevail.

31 See also Aronsohn et al. (2010) for a survey of physician estimates of fair prices for liver and kidney provision.
5.4.3 Exploitation of unfair vulnerabilities

Those in favour of less regulation propose allowing market forces to dictate the “going rate” as a fair price for particular body parts\(^32\). This suggestion highlights the importance of recognizing the role that vendor vulnerabilities play in exploitative markets. Where market prices are determined simply by supply and demand, the desperation of both buyers and vendors may drive market participation and acceptance of market conditions in a manner that undermines their respective bargaining capacity and ability to abstain from unfair deals. If the vulnerability of potential vendors is unfair, for example if their economic circumstances are due to local or more widespread economic injustice, those who take economic advantage of this vulnerability are guilty of exploitation even where the vendors are considerably advantaged by the trade. This is particularly so if the exploiter is in some way implicated in the unjust conditions in which vendors must act.

Of note, although a trade may be exploitative, this does not mean it is unjustifiable. Exploiting the vulnerability of poor HBM vendor may indeed be the best option in a bad situation. Although benefit disparity exploitation is *prima facie* wrong, Wilkinson argues that, “mutually advantageous exploitation… will often be less morally objectionable than other forms” (2003, 71). The opportunity to improve one’s life by selling HBM may be deemed preferable by a vendor despite the injustice of the sale. At the level of society and policy making however, such an argument would result in widespread and systematic exploitation by the relatively powerful or wealthy. If governments permit, let alone encourage mutually advantageous exploitation, this will at best promote minimal survival gains for the disadvantaged. It would fail to promote flourishing by effectively eradicating any expectation of cooperation for optimal mutual advantage, instead advocating egocentrism. Consequently, markets that seek to avoid exploitation will require regulation to promote fairness in benefit distribution, in particular by ensuring minimum prices for HBM. Furthermore, social vulnerabilities such as poverty that contribute to exploitation should also be addressed (see below).

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\(^{32}\) Various reasons are given to justify a free market approach to HBM prices. For example, Krawiec (2009) argues that price fixing in the US gamete market allows the industry to obtain greater profits by minimizing payments to oocyte providers. Chung on the other hand implies that vendors ought to be allowed to charge higher prices for more desirable oocytes (such as those with less common genetic attributes) to better meet the needs of consumers (2006, 294). Nelson (1991, 67) and Block et al., (1999) similarly advocate free markets in organs in order to promote market efficiency.
5.4.4 Wrongful use as a form of exploitation?

Drawing on Harris’ account, Wilkinson (2003, 13) distinguishes ‘wrongful use’ exploitation from ‘disparity of value’ exploitation. He equates the former kind with the inappropriate instrumentalization or objectification of a person in which the exploiter treats the exploitee “merely as a tool for, or a means of, achieving [her own goals]” (2003, 33). While Wilkinson associates this kind of exploitation with use that is inherently immoral, regardless of the degree of benefit obtained by the exploiter, it also fits within my account of an undeserved (because immorally acquired) benefit through use. It reflects the Kantian account of instrumentalization of persons, which I will discuss in the following chapter.

Sample describes “morally bad exploitation [as] interaction for the sake of advantage in a way that fails to respect the value of our interactor – that is, in a way that degrades her” (2003, 84). In this sense, certain vulnerabilities may be identified as relevant when judging potential cases of exploitation. Although my desire to purchase a television is exploited when I sell my blood in return for one despite my preference not to provide blood, other things being equal, this desire is hardly a relevant vulnerability. The blood buyer who takes advantage of this desire is exploiting it but does not fail to respect my value as a human being. On the other hand, a buyer who takes advantage of my need to earn money to feed my children fails to respect this value. This is because the vulnerability in the latter case consists of a fundamental human need, recognition of which should entail a duty to offer assistance rather than to extract advantage (see Chapter 7.4.3).

5.5 Vendor poverty as an argument for and against markets

The likely prevalence of HBM provision among the poor in the setting of markets is frequently raised as an objection to markets. Poverty renders individuals and communities vulnerable to exploitation and harm as HBM vendors. It is often associated with poor education and inequitable access to healthcare which makes obtaining informed consent difficult, and means that vendors may not only fail to share in the benefits of improved HBM supplies but may lack suitable follow up care after HBM provision. In the absence of an equitable distribution of HBM supplies – which requires equitable access to those healthcare services using HBM – those most likely to sell HBM are those least likely to receive them. In non-market systems of HBM procurement and use, while some inequities in the distribution of donation and access to HBM may exist due to a variety of factors (e.g. Ladin et al. 2009; Courtney and
Maxwell 2008), they will be considerably less significant. One of the justifications of encouraging all members of society to donate blood and to participate in deceased donation of HBM is that donors themselves -or at least their relatives, friends and members of their social groups- may benefit directly from their provision of HBM. The value of donated HBM is thus shared directly, rather than being exchanged against payment that may not offer commensurable value.

The issue of inequitable access to HBM provided through market mechanisms is addressed by many market advocates who support a monopsony in which central (usually state governed) organizations obtain materials and then distribute them equitably to the population according to need (e.g. Erin and Harris 2003). Regulation cannot promote equity in HBM provision, however, where financial incentives are offered in the setting of economic inequities.

5.5.1 HBM markets as a solution to poverty

Despite these concerns, numerous authors argue that markets are morally justifiable, and prohibitions unethical, as they offer the poor an opportunity to improve their economic situation by selling HBM. I will argue in Chapter 6 that societies and possibly some individuals have a moral obligation to address poverty, such that offering the poor money for their HBM may constitute an act of omissive coercion. Markets, I have already argued, are also likely to prove exploitative of the poor. Nevertheless, cases of mutually beneficial exploitation, or even omissive coercion, in which the poor are economically advantaged and the wealthy are able to meet needs for life saving HBM, may seem consequentially justified where all participants are trade are left better off than they would be in the status quo ante. Although the evidence of existing markets – both legal and illegal – suggests that HBM vendors are more likely to be left worse off rather than better, in theory a regulated market might be able to guarantee that HBM vendors gain a clear economic benefit, particularly when selling materials with greater commercial value such as organs and oocytes. Taylor, for example, argues that the wholesale international export of kidneys by developing countries could have “positive health benefits” and improve the living standards of the poor if governments taxed the purchase of kidneys and used “the money thus raised to (for example) provide clean drinking water for their citizens, or to improve the provision of basic medical care” (2005, 196).

33 Given the lower prices of blood, plasma and sperm, it is likely vendors of these materials will need to sell regularly to achieve any significant or sustainable benefit.
Establishing financial capital in the living bodies of human beings may nevertheless have significant negative repercussions for the poor. Debt collectors may effectively expropriate biological materials, as has already occurred in the setting of black markets in kidneys (e.g. L. Cohen 2003, 676). Zutlevics suggests that wealthier countries might be reluctant to provide financial aid to poorer countries if doing so would alleviate poverty and thus reduce the pool of poor people willing to sell organs (2001, 299). Not only is it implausible to think that poverty might be eradicated through the sale of HBM, we should also think twice before promoting a system of HBM procurement that relies for its efficacy and sustainability on the continued poverty of at least some groups as a motivating factor for HBM provision.

However, discussing markets in ova and surrogacy, Crozier argues:

We should be hesitant to intervene in a market for the sake of protecting a vulnerable group from undue inducement or exploitation unless the following conditions have been met:

1. The outcome of the offer (and/or others of its type) will deepen the oppression of the vulnerable group in a manner that is self-perpetuating; and
2. We are actively pursuing an agenda designed to give the vulnerable group more palatable options, and this agenda is hampered by the acceptance of these offers. (2010, 301)

With respect to the first condition, I suspect that most markets in HBM, which typically rely on marginalized and economically and socially disempowered groups within society are likely to reinforce vulnerabilities. The stigma attached to selling HBM within poor communities noted by Crozier (ibid., 302) and others (e.g. Moazam et al. 2009, 42; Kretzmann 1992) contribute to social marginalization and political disenfranchisement of HBM vendors. As I will discuss in Chapter 7, HBM vendors are frequently rendered invisible, disconnected from recipients because the commercial nature of their transaction entails a severing of social bonds and an effacement of personal value in the HBM provided. Non-commercial procurement conversely depends on the promotion of communal goals and shared responsibilities of HBM providers and recipients, as well as a celebration of personal value. Rather than providing the poor with satisfying employment opportunities that can bolster self-esteem, or educating them so that they acquire valuable skills, the opportunity to sell simply takes materials of value and replaces them with money that may or may not enable vendors to attain financial security or improve their lives.

The second condition, which echoes Veatch’s claim that markets are justified where societies have failed to address poverty using better strategies (2003, 32), is similar to the argument that “Altruism has failed, and therefore markets are necessary”. Both
arguments claim that markets are justified because more ethical strategies to achieve public goals (whether eradicating poverty or meeting needs for organs) have failed. Again, while I would argue that in individual cases such failures might excuse or even justify mutually advantageous transactions, this is not an acceptable approach for policy makers seeking to promote the interests of all members of society. Despite Taylor’s suggestion (2005, 196), I suspect most, if not all countries would have more attractive revenue sources than the export of human kidneys in order to provide safe drinking water for citizens. Policy makers should be advocating the most ethical and practically effective solutions to both shortages of HBM and to global poverty, using sustainable rather than short term, high cost strategies. I will propose an approach to the issue of HBM shortages in Chapter 8, while with respect to the problem of global poverty, numerous experts have proposed and implemented successful strategies for improving the condition of the poor.

Although opportunities for safe and rewarding employment are crucial for economic progress, so too are strategies which address factors contributing to gender inequality and poverty - such as inadequate healthcare and education (J. Thompson 2007). Measuring income alone does not adequately capture the extent of poverty’s effects or the success of efforts to address them (Baruah 2009). The claim that markets in HBM offer a solution to poverty is at best disingenuous, and at worst a devious attempt to give carte blanche to wealthier societies to exploit the poor. I shall discuss the Objection from Poverty further in the context of omissive coercion in the next chapter.

5.6 The Argument from Harm Minimization

The Argument from Harm Minimization (AHM) holds that in the absence of legal markets in HBM, shortages will persist and therefore demand for HBM will sustain illegal markets in which providers and recipients are at risk of serious harm. Thus, they argue, introducing legal markets in which vendors and recipients can be protected through careful oversight and regulation and which will minimize demand on the black market will reduce harm overall. While I have noted that various commentators support a free market approach to procurement and/or distribution of HBM, most advocate market regulation in order to ensure that harms are eradicated or minimized. The AHM is usually employed as a supplementary argument for markets (e.g. Matas 2008; Taylor 2005, 198-9). In contrast, the Objection from Inevitable Harm holds that regulated markets will simply replicate or indeed exacerbate the harms of illegal or unregulated markets.
5.6.1 Harms of the unregulated market

Illegal or unregulated markets in HBM are associated with a variety of harms such as coercion and deception of vendors, inadequate consenting procedures and medical care, as well as exploitation. Poor quality care may expose vendors to far greater risks of injury, death or infection than are found in altruistic donation programs. Larger profits may be sought at the cost of higher, avoidable risks to vendors. For example, oocyte vendors may be exposed to higher doses of hormone stimulation – increasing their risk of potentially life threatening ovarian hyperstimulation syndrome – in order to maximize the number of oocytes procured (Dickenson 2008, 81; K. George 2008, 286; Barnett and Smith 2006)\(^\text{34}\). Plasma vendors in China were notoriously reinfused with remaining blood components pooled from multiple providers in order to enable more frequent provisions, resulting in high rates of provider infection with diseases such as HIV, hepatitis and syphilis (Anagnost 2006, 517).

Exploitation in the form of low payments to organ vendors in desperate economic situations is typical, and vendors are frequently paid less than the promised amount (Goyal 2002, 1591; Padilla 2009, 121). Studies suggest that living kidney vendors receive grossly suboptimal care, with ineffective screening, minimal post-operative care and no follow-up (Padilla 2009,122; Mendoza 2010a). Furthermore, multiple studies from India, Iran, Pakistan and the Philippines show kidney vendors are frequently left worse off financially and in poor health (Goyal 2002; Malakoutian et al. 2007; Moazam et al. 2009; Mendoza 2010b). Many suffer social stigmatization, compromising marriage prospects and employment (e.g. Scheper-Hughes 2004, 49). In addition, isolated cases of murder for organs (e.g. Xiaohua 2009) as well as theft of organs and oocytes from the living (Scheper-Hughes 2002, 69; Sforza 2007) and bones and tissue from the dead (Scheper-Hughes 2006; Bauchner and Vinci 2001) have been reported.

Vendors are not the only ones at risk in unregulated markets. Inadequate screening and medical care also exposes recipients of HBM to infection and disease. Studies confirm higher rates of graft failure and post-operative complications in those who have traveled abroad to purchase organs on the black market (e.g. Alghamdi et al. 2010; Canales et al 2006). Transplant “tourists” may also be exploited, with reports of travelers being charged last minute “fees” to obtain their operation (Echevarria 2010).

\(^\text{34}\) Sauer suggests third party oocyte providers may be less likely to experience OHSS than women who undergo ovarian stimulation for their own IVF treatment, as pregnancy increases the risk of OHSS (2006, 157). However, to my knowledge there have been no comparative studies examining the rates of OHSS in paid versus altruistic providers, or the levels of hormone doses.
Unethical market practices have wide reaching consequences for societies. Spread of infectious disease has been a particular concern for markets in blood products (e.g. Feldman 2000). Conflicts of interest for medical professionals seeking to profit from their patients (both providers and recipients of HBM) may contribute to lack of trust in healthcare systems and the medical profession. In the setting of unregulated gamete markets, lack of efforts to safeguard personal information may threaten the privacy of providers (Yuen 2007). Finally, the use of third-party gametes, usually from anonymous providers, has important and long-term implications for children produced who may be unable to exercise their rights to trace their genetic heritage\(^{35}\). This challenge is exacerbated in the setting of cross-border markets where geographical distance, language barriers, poor record keeping, inter-jurisdictional differences, private clinics and the socioeconomic position of providers may render future tracing of information nearly impossible. Furthermore, in cross-border gamete markets, children may face major legal difficulties relating to citizenship and recognition of parentage\(^{36}\).

Many of the harms associated with the market are attributed to the use of brokers and “middle-men” who seek to extract maximal profits by overcharging recipients of HBM, underpaying vendors and cutting costs by providing suboptimal medical care to both groups. In addition, lack of legal safeguards, oversight and transparent reporting on unregulated market practices makes adoption of responsibility by all markets participants problematic and impairs the capacity of vendors and buyers to make informed choices that protect their interests.

5.6.2 The myth of market regulation
An effectively regulated legal market in HBM can, in theory, minimize or prevent many of the harms outlined above. Standards of care may be enforced, minimum prices fixed and regulatory safeguards enacted to protect market participants against breach of contract, deception, fraud or injury and guarantee their benefits. Insurance coverage can offset long-term risks and enable appropriate follow-up care for patients. Most importantly, market advocates claim that the enhanced supply of HBM in regulated markets will diminish demand in black markets and offer the poor a safe environment in which to sell. In practice however, market regulation is likely to prove difficult. The idealized vision of regulated markets in which both vendors and buyers trade to mutual advantage represents a dangerous albeit attractive myth.

\(^{35}\) See e.g. Ravitsky (2010).
\(^{36}\) See e.g. the case of ‘Baby Manji’ in Palattiyl et al. (2010, 691).
Firstly, the creation of regulated markets will not necessarily diminish sales in less regulated markets. Demand for HBM, in particular organs and gametes, is rapidly growing (see Chapter 1). Improved availability of these materials may divert some customers from the more dubious zone of the black market but features of the latter may continue to attract some customers unless:

(a) supplies within the regulated market exceed demand;
(b) access to the regulated market is readily available to all those seeking HBM;
(c) conditions applied to the use of HBM in regulated markets do not affect perceived quality or desirability of HBM compared with that available in less regulated markets.

Chung for example suggests that regulation of the gamete market would impair supplies from more “desirable” providers (2006, 294), leaving the possibility that “higher value” materials could be profitably exchanged in the black market. Similarly, Voo et al. argue that organ black markets may provide “higher quality” organs for a higher price than regulated markets, or opportunities for high-risk providers to sell if they are excluded from the regulated market (2009, 563). Furthermore, definition of acceptable levels of risk and payment, and standards of patient care may be subject to significant variation between countries or even within them. In this setting, the ability of medical professionals and policy makers to effectively influence international practices in pursuit of universal minimum standards may be significantly impaired.

Secondly, a degree of injustice and exploitation may prove inevitable in regulated markets. Financial incentives will be more effective among economically vulnerable groups, placing a disproportionate share of the burden of HBM provision upon the poor. Although minimum prices may be set to minimize benefit disparity between vendors and buyers of HBM, determination of “fair prices” will be difficult, if not impossible in the setting of cross-border trade. Furthermore, the market might not be able to support a truly “fair” price, or may be rendered inefficient, with decreased demand due to higher costs of obtaining HBM. Many regulated market advocates conceive of equitable distribution mechanisms of HBM, which depend on the establishment of public healthcare systems to ensure equitable access to HBM. The development of such infrastructure and equitable distribution systems must precede the introduction of payment for HBM if regulatory efforts are to be effective.

See also Fox (2008) for a discussion of the way gamete markets prioritize particular provider characteristics.
Thirdly, the biggest challenge for market regulators is that of risk minimization. The idea is that the safeguards of non-commercial procurement systems will simply be transposed to the market setting, enforcing the same procedures of informed consent, excluding unfit providers and ensuring the same standards of medical care for all participations. The only anticipated difference is that providers may be differently motivated and will exit the market with an additional benefit in the form of payment. However, additional arguments used to justify the introduction of payment for HBM are likely to conflict with, or at least undermine paternalistic protection mechanisms. Consideration of the potential economic benefits to vendors or their right to sell freely must be weighed against the level of risk deemed acceptable for HBM provision.

The market should be held to a higher standard of risk minimization than altruistic procurement systems, given the distinct possibility of conflicts of interest for both healthcare professionals and providers of HBM seeking to maximize profits to the potential detriment of provider health. Although donors of HBM may seek to trade health benefits for their relatives at the expense of their own health, the primary value guiding policy and practice within non-commercial procurement systems should be that of health promotion and protection. A regulated market system may espouse the same goals, but by explicitly endorsing financial incentives to motivate provider participation, it compromises the ethos of health promotion and will undermine the strength of paternalistic regulations.

The anticipated failure of market regulation to minimize black market harms is compounded by the possibility that legalization will create additional harms. These include concerns about medical professionalism and conflicts of interest that may impair trust in healthcare systems and even families. For example, desperately poor relatives and/or profit seeking doctors may seek to facilitate deceased provision of HBM by compromising the integrity of death diagnoses. Although doctors in altruistic procurement systems may have incentives to compromise death diagnosis, such as enhanced opportunities to offer transplants to other patients, it is less likely that potential donor families and their advocates will be inappropriately influenced by this incentive.

Finally, the regulated market is likely to prove unsustainable as it will be persistently undermined and eroded by the realities of globalization, in particular cross-border free trade agreements and patient and provider mobility. Unless uniform regulations are implemented worldwide, less well regulated markets will persist in some countries and offer relatively easier access to desired HBM, undermining efforts to enforce
regulations elsewhere and possibly encouraging evolution of regulated markets to less stringent regulations (Pennings 2004; Deech 2003, 430). For example in Europe, some fertility clinics take advantage of regional mobility to entice women from poorer countries to sell oocytes to wealthier local patients. “Reasonable” compensation amounts for citizens of one country may be excessive for those from poorer economies. While unethical markets may persist in the setting of non-commercial procurement systems, evidence suggests that market prohibition can be effective not only in reducing black market activity but in promoting non-commercial procurement (e.g. Abbud-Filho et al. 2006; Chua 2010). In the setting of regulated markets, where market infrastructure and commercial considerations in HBM procurement (and possibly distribution) are endorsed, it is easier for downwards regulation to occur than in a non-market procurement system. Danovitch and Delmonico (2008), for example, cast doubt on the capacity of the United States to enforce regulations of a domestic kidney market.

5.6.3 Non-market mechanisms for harm minimization

A well-regulated market that effectively minimizes the dangers of HBM sales will be so constrained as to approximate in many respects the non-commercial procurement systems. These constraints, as Radcliffe-Richards (2003) has suggested, will compromise the efficacy of the market in increasing supplies of HBM, for example by limiting the number of HBM providers through the exclusion of high-risk individuals. A true commitment to the values identified as concerns in unregulated markets should eventually prompt regulated market advocates to reconsider non-commercial procurement systems. Pursuit of these non-market alternatives does not mean acceptance of the harms of black markets. Not only will more effective procurement systems (just like hypothetical regulated markets) increase supply and possibly diminish black market demands, but coordinated efforts to minimize demand for HBM and discourage black market practices will be more effective in the non-commercial setting, a claim I shall outline in Chapter 8.

Enforcement of national and international policies and legislation concerning illicit trade in HBM has yet to receive the attention it deserves. Despite the growing influence of the WHO Guiding Principles (2009b) and international consensus statements such as the Declaration of Istanbul (Participants 2008), it seems that the major factors supporting ongoing black markets (in addition to persisting HBM shortages), are the existence of extreme poverty, the reluctance of governments to address the issue, the willingness of some health professionals to facilitate and/or profit from the market and a
tendency to justify individuals purchasing HBM on the black market on the grounds of urgent health or reproductive needs. The effect of prohibitory legislation introduced in a variety of countries such as Pakistan, Brazil and the Philippines noted above, the impact of the acknowledgment by Chinese authorities regarding the practice of transplant tourism using organs from executed prisoners (Delmonico 2009) and the criminal prosecution of individual surgeons, brokers and hospitals involved in organ trafficking in India, Nepal, Indonesia, South Africa, the United States, Turkey and Kosovo (e.g. Roy 2008; AFP 2009; Smith 2010; Scheper-Hughes 2008; Press 2010) shows that a variety of solutions exist and should be pursued if the harms of illegal and unregulated markets are to be prevented.

5.7 Conclusion

While the saving of lives is globally relevant, admirable and desirable, the moral obligation to save lives and for governments and societies to enable systems in which lives will be saved cannot be used as a trump card for markets in HBM. Not only are the likely effects of introducing market systems uncertain at best, there are alternative, less ethically problematic methods for meeting needs for HBM that should also be considered. However, while the ALSN fails to establish that markets in (some) HBM are morally imperative, it by no means demonstrates that markets in organs are unacceptable. As an effective way of improving availability of even some organs, markets that save lives might be seen as morally valuable, other things being equal, unless we can demonstrate that conflicting arguments about the intrinsic immorality of sales are effective, or prove that in practice, markets will not save more lives than non-market systems.

From the perspective of policy makers and societies, it must further be demonstrated that the saving of lives through market mechanisms is consistent with the healthcare priorities of the society in question and with other key values such as social justice. While saving lives is morally virtuous, it is not a universally paramount moral obligation, nor is the right to save one’s own life unconditional. The obligation to save lives requires society to facilitate provision of HBM, especially where it constitutes life-saving treatment, however this obligation will be limited by competing obligations to provide other forms of treatment to those suffering life-threatening conditions.

The potential consequences of establishing a market in HBM include a variety of effects regarded as undesirable and potentially immoral. Many, if not most of these are - theoretically at least - preventable in the context of a carefully regulated market.
Estimating the validity of consequentialist claims for and against markets will not definitively resolve the question of whether markets in HBM are ethically justifiable, as the inevitable uncertainty of empirical results provides at best an approximation of the likely consequences. However, a justifiable individual action does not always correspond to a justifiable social policy. Systematically taking advantage of the poor, failing to introduce strategies to minimize and eradicate social injustices that contribute towards exploitation and hence deliberately reinforcing a state of affairs that is only marginally better than the status quo is a deliberate failure to promote human flourishing.

Those who advocate potentially harmful practices on the grounds that they will produce some improvements on current circumstances - particularly where these practices are primarily motivated by their anticipated value to a select group – should be regarded with caution. Consequentialist arguments for markets in HBM appear at best naïve, and at worst hypocritical and opportunistic. Regardless, they embrace defeatism, implying a moral surrender to the market that fails to consider the untapped motivations of societies, which may seek to promote health and to save lives more effectively by investing more resources in public healthcare and encouraging public contributions to shared goods.
6

The right to sell?

*I sold my kidney for 32,500 rupees. I had to; we had run out of credit and could not live... Yes, I would do it again if I had another to give. I would have to. That money is gone, and we are in debt. (L. Cohen 2003, 666)*

6.1 Introduction

In the previous chapters, I have argued that the treatment of HBM is an important moral concern of human societies. In Chapter 4, I discussed the role that markets play within societies, arguing that the goals and practices of markets are subject to the moral norms and values of society. I have argued that it is in this context that proposals for the sale of HBM must be considered. The fundamentally social and pluralistic nature of procurement, use and distribution of HBM requires an ethical approach to policy making that is inherently communal rather than individualistic. However, many market advocates adopt an individualistic approach to the debate, emphasizing the interests that individuals may have in selling or purchasing HBM. Supporters may claim that markets offer the fairest or most effective system in which moral “strangers” may express their moral preferences and pursue their own goals, producing an optimal allocation of goods without imposing moral values. For example, Cherry argues that, “Freely chosen, market-based, health care financing, procurement and distribution, respects the liberty of persons to pursue their own deep moral commitments” (2006, 116). In this chapter I shall focus on the claim that individuals have a right to sell their own HBM and hence market prohibitions are unethical, regardless perhaps of the consequences.

The first two arguments I consider are typical of the contemporary Western approach to bioethics. Prioritizing individual autonomy and liberty over other ethical values, they highlight individualism and a contractual, minimally demanding conception of ethical policy intended to avoid ethical imperialism by enabling individuals to pursue their own vision of the good life. While upholding the ethical values embodied in these arguments, I will show that when applied in isolation, they offer such an impoverished account of the ethical issues inherent in the treatment of HBM as to be practically meaningless when applied to public policy in this area.
In the second part of the chapter, I consider another argument claimed to intrinsically justify the establishment of payment for providers: the Argument from Desert. The justice-based claim that providers of HBM are entitled to rewards, including financial payments, has been invoked in the establishment of living renal markets in Iran (Simforoosh 2007) and payments for deceased and living organ providers in Saudi Arabia (Garwood 2007). It also underpins the compensation model used in many allegedly noncommercial procurement systems for oocytes, sperm and blood. The Argument from Desert, although relatively neglected in the literature, is highly influential in pro-market sentiment and merits closer attention. I will also discuss the Argument from Analogy, in which provision of HBM is equated with ordinary employment and thus remuneration justified.

I will argue that such arguments are not sufficient to establish the case for markets in HBM, due to their neglect of the social context of markets and the plurality of values embodied in HBM. Although establishing an intrinsic right to sell will lend significant weight to the case for markets, it does not mean that a person who purchases that HBM is behaving morally, or that societies that endorse such trade are pursuing ethical public policy. Nevertheless, the values and ethical principles articulated in these pro-sales arguments are essential for the development of a comprehensive moral framework concerning the treatment of HBM, and procurement of HBM in particular.

6.2 Bodily autonomy – The foundation of a right to sell?

Dworkin equates respect for a right to dispose of one’s own organs and other bodily parts with respect for “the bodily autonomy of individuals, that is, their capacity to make choices about how their body is to be treated by others” (1994, 156). In his rather brief argument for the morality of live organ sales, he presupposes the legitimacy of sales of other HBM (such as gametes) and argues “the primary good achieved by such a right [to sell one’s HBM] is the recognition of the individual as sovereign over his own body…” (ibid.).

The all-encompassing notion of “bodily autonomy” or “sovereignty” in one’s body forms the basis of the main arguments for an intrinsic right to sell one’s own HBM, including the Argument from Property (see Chapter 3). The opportunity to participate as vendors in HBM markets, it is claimed, rightly enables individuals to “dispose of” or “use” their bodies “as they see fit”. The language of property is thus inextricably tied with the exercise of personal liberty, grounded in a particular conception of the unique relationship between an autonomous human being and her body. This relationship has
already been discussed in the context of personal value in HBM in Chapter 3. Here, I review the relationship between persons and their detached materials from the perspective of autonomy and its implications for a right to sell.

I have already highlighted the importance of embodiment to the moral agency and status of living human beings, advocating respect for bodily integrity as a fundamental right to determine the conditions of treatment of one’s living body by other moral agents. It is clear that Dworkin’s concept of “bodily autonomy” is similar, if not identical to the concept of “bodily integrity” outlined in Chapter 2. Respect for bodily integrity, I argued, conceptualizes the bodies of living persons as physically inviolable. One may not interfere with the body of another individual without her consent, whether directly expressed or justifiably presumed. This negatively conceived right limits the use or disposition of our living bodies by others, but it does not in itself clarify our own rights to use or dispose of our bodies. Respect for bodily integrity is not the same thing as respect for physical liberty. The former constitutes a negative right not to be interfered with physically, whereas the latter implies a right to express oneself physically.

But surely, one might argue, the right to use one’s living body is self-evident. My embodied existence seems to presuppose such a right, as every moment of my life involves my use or disposition of my body. I “use” my body and its various parts to perform essential physiological functions or specific tasks – for example, I use my lungs to breathe, and I use my fingers to play the piano. Such use might be conceived as instrumentalizing my body for the accomplishment of my own ends, however this “instrumentalization” is the natural function of my body. I may also choose to (literally) dispose of parts of my body in the sense of detaching them, for various purposes. I will argue however, that while one has the right to remove parts, this does not entail a right to subsequent use, sale or disposal of these parts.

A hiker famously cut off his hand in order to escape when trapped by a rock (Press 2003); people choose to excise body fat, trim hair and nails and have diseased body parts removed. Although others may feel an obligation to prevent acts of detachment which physically injure a person, (especially where the person may not be acting autonomously as a result of mental impairment), other things being equal, respect for autonomy entitles each person to treat her living body as she wills, so long as this treatment will not negatively affect other living persons. This is the case because a living human body is inseparable from an embodied moral subject, as I have argued in Chapter 2. In order to exercise the most basic form of autonomy, individuals should be
able to “use” their own bodies – while these bodies are integrated components of the individual moral subjects - without interference by others.

My actions as an embodied being should be distinguished from those in which I might use detached body parts or materials. Once detached, although my HBM may retain important personal value (see Chapter 3), they are no longer an intrinsic component of my living identity and self, and hence no longer intrinsically involved – however incidentally - in the physical expression of my autonomy. If I use the bones from my amputated hand to strike the keys of a piano, I am no longer using my fingers to play in precisely the same way as when my hand was an integrated part of myself, although the effects may be similar. My right to act as an embodied being – by breathing, using my legs to run or my fingers to play piano – should be distinguished from a right to use detached HBM or other objects to accomplish various purposes. My detached parts become objects, and as such may be used by myself or others, transferred, destroyed or otherwise altered, subject to norms that have yet to be determined. The treatment of these detached objects, while morally relevant, is not precisely the same as treatment of me as a living embodied subject (see Chapter 7). Similarly, my right to use my body as an expression of my autonomy is distinct from my right to use detached body parts, or other objects, which may be influenced by concerns about ownership, rightful forms of use and potential implications of use with respect to other individuals.

In short, it is the as yet undetermined content of a right to use, transfer or sell body parts that is at stake in the market debate, that is, the implications of personal value in one’s detached HBM: in particular, whether a personal interest in the control of one’s detached materials constitutes a right of sale. This is distinguishable from - albeit closely concerned with - the right to bodily autonomy, and the negative right to avoid nonconsensual trespass upon one’s body, including the detachment of one’s body parts by others, which forms the content of a right to bodily integrity.

Despite my distinction between bodily autonomy and autonomous actions concerned with the treatment of detached HBM, it is possible that respect for individual or personal autonomy entails the right to sell one’s HBM. Bodily autonomy is the core of individual autonomy, for all autonomous actions are necessarily embodied, but autonomous actions may not be specifically concerned with the body as such. Thus while my right to detach body parts is a matter primarily of bodily autonomy, my right to use detached parts or other objects, to interact in particular ways with other moral subjects and so on are matters concerned with the broader conception of autonomy. It is this I have in mind with respect to the Argument from Autonomy.
6.3 The Argument from Autonomy

Dworkin’s conflation of a property-style right to bodily integrity with autonomy is ignored by J.S. Taylor, who fleshes out Dworkin’s argument from the perspective of individual rather than bodily autonomy in *Stakes and Kidneys* (2005), in which he clarifies and refutes the major objections commonly made to the Argument from Autonomy. These are: the Objection from Coercion, which claims that in practice vendors will be coerced and thus not autonomously agree to sell, due either to inadequate informed consenting procedures or to the ‘coercion’ of their circumstances, in particular extreme poverty; and the Objection from Impaired Autonomy, which claims that selling HBM is in fact a constraining option which leads to diminished autonomy. In his defence of Dworkin, and organ markets more generally, Taylor draws on a conception of autonomy that is “the non-Kantian approach… dominant within medical ethics… whereby a person is autonomous if he governs himself in accordance with his contingent ‘preferences and desires’” (2005, 15). He defines an individual as autonomous with respect to their desires if they arise from the self in some way – they are not implanted by another – and the person in some way reflectively accepts them, and is autonomous with respect to their actions if it is they, and not another, that controls the performance of them. (Ibid.)

This conception of autonomy is undoubtedly useful when considering the issue of coercion and violation of bodily integrity. Respect for autonomy, in this sense, requires the prohibition of activities that involve violations of autonomy, for example through the coercive removal of body parts. It also requires that *in vivo* detachment of HBM should be fully informed, free of deception or manipulation to ensure that voluntary providers of HBM make truly autonomous decisions. Thus the objections to markets cited above would preclude sales if it could be shown that vendors would not act autonomously (in the “non-Kantian” sense) in alienating their materials. I will discuss these objections shortly, showing that where individual autonomy (as described above) is concerned, the Objection from Autonomy fails. However, the Argument from Autonomy is not yet won. That is, establishing that the sale of one’s HBM does not violate respect for individual autonomy fails to establish a right to sell. The fact that I might autonomously wish to sell my television or the last animal of an endangered species does not mean I have a right to do so.

Fortunately for market advocates, the Argument from Autonomy may be consolidated, drawing on a richer conception of autonomy as for example, “the fundamental interest all individuals have in making decisions in whatever concerns their own lives” (Archard 2008, 21). I will begin by considering whether the sale of HBM
can be autonomous in the sense of voluntariness of action, that is, autonomy-based objections to HBM markets. I will then consider whether the prohibition of sale impairs autonomy by preventing individuals from expressing the interest they have in determining their own lives through the use or sale of their HBM.

6.3.1 Coercion, incentives and undue influence
The decision to sell one’s HBM is considered autonomous (in the “non-Kantian” sense) if it is informed, voluntary and represents the provider’s authentic desire. Major objections are raised against markets on the grounds that even legal markets may replicate the conditions of black markets in which coercion, manipulation and deception are used to obtain materials from providers who are particularly vulnerable to such practices due to socioeconomic factors such as illiteracy and extreme poverty.

Coercion occurs when an individual is forced to adopt a particular course of action, such as selling a body part, under threat of a worse fate being imposed upon them (Wilkinson 2003, 91). Coercion may also occur in non-market settings, for example if an individual is forced to “donate” an organ to a relative under threat of violence or familial sanctions (Schepers-Hughes 2007). While in practice it may be difficult to exclude coercion in some HBM markets, in theory there is no reason to suppose that individuals will not freely and authentically choose to sell their HBM after receiving appropriate information about procurement procedures and risks. The sale of HBM may offer some individuals the prospect of a much better life, or the ability to save the life of loved ones by obtaining money for urgent medical treatments, for example. Such motivations may be comparable to those motivating some altruistic donors.

Although the purpose for which one provides HBM may be relevant when judging the ethical virtue of a decision, it seems less relevant to the authenticity of decisions to detach one’s HBM. Nevertheless, it is often argued that the purpose motivating decisions may impair decision-making quality. That is, the anticipated benefit of providing HBM – whether egocentric or altruistic - is considered potentially influential in a manner that impairs rationality. This represents the Objection from Overwhelming Incentives.

The lure of a substantial financial reward is sometimes described erroneously as a “coercive offer”. As Veatch notes,

Attractive offers may be perceived as offers that exert pressure or inducement, but they are neither coercive nor unethical offers simply because they are very attractive. In fact, offers are not necessarily unethical even if they are perceived as irresistibly attractive. (2003, 28)
Ordinary decision-making usually involves a calculation of the anticipated benefits, virtues and possible negative effects of particular choices. The term “incentive” is often used interchangeably with “motivation”, and in this sense it may seem that an incentive is present when routine decision-making calculations find in a favour of a particular option. Thus “saving my brother’s life” may be described as an incentive for me to donate my kidney to my brother, or the generous holiday leave package of a particular job prospect may constitute an incentive to take that job over one with a shorter leave policy.

Grant points out that while incentives today are commonly regarded as “innocuous”, “when the term first came into general use, incentives were highly controversial” (2002, 130). It is the original sense of the term “as an inherently suspect form of manipulation and control” that underpins anxiety about the use of incentives for providers of HBM. Incentives, Grant writes,

are only necessary to move people to do what they would otherwise not want to do, either because there are no good reasons inherent in the situation to do it or because they do not understand those reasons and it would be too costly or ineffective to apprise people of them. (2002, 130)

Thus, although the advantages and disadvantages of different holiday leave entitlements of different job offers may play a key role in my motivation to pick a particular offer, the offer of a free house or an annual all-expenses paid vacation attached to a particular job will exert a somewhat different influence on my decision-making. Although it can be difficult to determine when a bonus offer is indeed designed to act as an incentive, rather than simply constituting a feature of decision-making, in many cases the difference is intuitively obvious. An incentive is intentionally “added value” rather than value that naturally forms part of the advantages of a particular choice.

If provision of HBM is conceived as employment, payment for HBM may be framed as “compensation” akin to wages for the time and inconvenience of procurement procedures, and individuals choosing between “job” offers may be motivated to sell HBM not because the payment acts as an incentive as such, but because payment for that particular kind of work is perceived as a better option than payment for an alternative form of work. While payment for HBM in this case motivates sale, it is not quite an incentive in the second sense outlined above. I will discuss this further below.

Consider however, where payment for HBM is regarded as a (goods) market transaction in which the opportunity to obtain money in return for HBM motivates sale. Incentives are used in markets to encourage purchasers or vendors to buy or sell items that they would otherwise not choose to sell. Thus we buy two shirts in order to “get
Incentives encourage us to do things we would never have done in the absence of the offer – I only wanted one shirt, and I had no desire to sell my house.

Decision-making may be influenced by persuasion, education, inventive offers or coercion. Each form of external influence, as well as the quantity of relevant information available to decision makers and their individual capacity to understand and process such information will affect the degree of authenticity or, possibly, the quality of their decision-making. Such factors are an inevitable component of human life, particularly where decision-making affects the interests of multiple individuals.

Incentives, especially those of a financial or fungible nature, are at work in markets and other social domains. Parents offer incentives to children to encourage good behaviour; teachers and governments vis à vis students and citizens respectively do likewise with respect to other goals. Incentives are offered in the employment market to attract workers to rural areas, dangerous jobs or simply to increase the supply of workers in particular fields.

In contexts where the autonomy of an individual is considered paramount, procedures may be set in place to minimize the impact of external influences and to enhance the quality of decision-making by provision and explanation of relevant information, for example in health care settings. As Onora O’Neill (2003) points out, however, it is not necessarily the degree of information offered or specificities of consent procedures that enable patient autonomy, but relationships of trust between patients and doctors, and procedures that prevent deception and coercion.

As many have noted, the goal of saving a loved one’s life can be as overpowering as a large payment in terms of producing unreflective decision-making.

38 Of course, many instances of coercion prevent decision-making (abduction for example, in which someone is physically restrained and transported under protest), but not all. While I am subject to coercion if A threatens to make me worse off if I choose to X rather than Y, I may nevertheless choose to X and suffer the consequences imposed by A, although this threat is likely to have weighed heavily on my decision-making.

39 Given the dynamics of supply and demand of goods within markets, which influence price, it is questionable whether price increases to encourage (the production and) the sale of more goods should be regarded as incentives. In the market setting increased price is a reflection of current market value, whereas attaching additional goods or benefits to sales to encourage purchase may be seen as an incentive or “added value” for buyers.
Frequently, a prospective [organ] donor, particularly a parent or sibling of the prospective recipient, will experience the decision to donate as automatic. They frequently report feeling that they had no choice but to donate, and proceed to offer their organs willingly and without hesitation, sometimes even before hearing of the risks involved in such a donation. Disclosure of risks frequently has no effect on the decision to donate. (Sauder and Parker 2001, 403)

Procedures can be designed to promote reflection and enhance the decision making process for HBM providers, but it is difficult to argue that the use of payment itself is necessarily more problematic for autonomous decision making than any other forms of persuasion or motivation.

Nevertheless as Grant suggests, incentive offers, where strictly defined as “An extrinsic benefit or a bonus, neither the natural or automatic consequence of an action nor a deserved reward or compensation” are “usually made in the context of an authority relationship” (2002, 135). This is undoubtedly the case where healthcare professionals and/or government representatives are involved in soliciting HBM.

Although an incentive offer doesn’t necessarily impair the rationality or quality of decision-making, as Grant warns,

When incentives are understood within the horizon of market economics, first, the concept becomes so broad as to lose its distinctive character and analytic utility, and second, the ethical problematic involved in the use of incentives becomes obscured. (Ibid.,136)

Where an incentive is required to lead individuals to adopt a particular choice, particularly where incentive offers are made in the setting of power imbalances, the motivations of both parties (decision makers and incentive providers) as well as the circumstances of the choice in question are likely to merit particularly close attention from an ethical perspective. Nevertheless, the use of incentives to encourage HBM provision should not be regarded as violating respect for autonomy.

6.3.2 Omissive coercion and “economic coercion”

In addition to concerns about outright coercion and overwhelming incentives impairing vendor autonomy, a third autonomy-based objection to sales of HBM is that of so-called “economic coercion”, or the coercion of circumstance (J.S. Taylor, 2005, 51). This objection, usually raised against living organ markets, is described by Taylor as the claim:

A current market in human kidneys would enable the poverty of destitute people to coerce them into selling the kidneys, and would provide the necessary conditions for the poor to suffer from impaired autonomy in a way that they would not have otherwise suffered. (53)
In other words, establishing a market will make the desperately poor worse off by creating the undesired opportunity to sell their organs, an opportunity they will be compelled to take, given the desperation of their economic circumstances. Taylor contests this objection on the grounds that “a person’s economic situation is not an intentional entity” (61), and therefore cannot be viewed as coercing a person (with intention being a necessary condition for coercion to take place). However, as P.M. Hughes points out, a person’s “economic circumstances are at least sometimes the consequence of the intentional actions of other economic agents” (2009a, 613), suggesting the possible argument that where those responsible for extreme poverty stand to profit from markets, coercion or at least exploitation (see Chapter 5) may be involved.

Wilkinson’s account of coercion (2003, 82-97) supplies grounds for a more convincing rebuttal of the Argument from Economic Coercion. Establishing a market in HBM in which the poor may be offered the opportunity to sell is not a threat. The opportunity to participate in such a market will not necessarily make the poor worse off. Threatening to kill a man if he does not give me his kidney is coercive, as both these options risk making him worse off than he was previous to the threat. Offering to purchase his kidney is not a threat. He may choose to sell his kidney (becoming better or worse off depending on the conditions of sale and so forth), or he may choose not to sell (maintaining the status quo ante). Where his pre-existing circumstances consist of dire poverty, selling HBM may make him worse or better off, but he is still free to choose to sell, given that not choosing to sell leaves him no worse off. It seems likely that many suffering extreme poverty would choose to sell HBM precisely because they believe the opportunity to sell is likely to benefit them. Hence, the argument from economic coercion fails.

Wilkinson adds an extra dimension to this issue by discussing the possibility of “omissive coercion” (2003, 127). Rather than overtly threatening a person, one may make fulfillment of prior obligations to him conditional on provision of HBM, leaving him in a position where to obtain what he is rightly owed he has no option but to provide his HBM. The coercer threatens not to perform a duty unless she obtains what she desires, effectively threatening to make him worse off (than he would be if the duty were appropriately fulfilled). For example, if Alice has a pre-existing ethical duty to provide Brendan with life-saving nourishment, she cannot make fulfillment of this duty dependent on Brendan selling her his kidney.
If markets are prohibited on grounds of omissive coercion, it will be necessary to define the relationships between potential vendors and other participants in the market as well as those who may have obligations towards potential vendors of which the fulfillment may influence the decision to sell. For example, in the case of a private transaction between a father and daughter, where the father offers to purchase his daughter’s kidney, and the daughter chooses to sell because she has no other means of paying for her college education, this may constitute omissive coercion if provision of a college education is deemed an obligation of (sufficiently wealthy) parents to children. Similarly, if a state that has failed to provide human rights such as access to food, basic healthcare and education to its poorest citizens establishes a market in organs, it may be omissively coercing the poor. Of course, this objection will not obtain in the case of all markets. For example, if a daughter chooses to sell her kidney to her father in order to obtain money for a new plasma television, this is unlikely to count as omissive coercion.

Noting the possible application of this line of argument to trade in HBM between rich and poor nations, Wilkinson warns that, “we face serious difficulties in making sense of group responsibility and of the way in which group-actors’ responsibilities are connected to those of individuals” (2003, 129). Setting this aside, he argues that there’s a further serious problem with it – or, rather, there’s a serious problem with attempting to use it specifically as an argument for the legal prohibition of organ sale… The argument works equally well against all trade between rich nations and the poor ones…if the rich nations have a duty to give resources to the poor nations, then any time that the rich nations insist on trading rather than donating, they will be practicing omissive coercion – threatening to withhold money that they should be giving anyway, unless they’re provided with goods of one sort or another. (Ibid.)

Wilkinson suggests that if the omissive coercion argument succeeds, it “‘proves too much’ and gives us no reason to single out organ sale for condemnation and/or prohibition” (130).

To this, one might object that there are morally relevant differences between particular kinds of goods that make demanding specific goods - such as HBM - in exchange for the fulfillment of pre-existing duties worse than others. For example, a mother may offer to purchase clothes for her son on the condition that he performs some household chores. Given she has a duty to provide her son with clothes anyway, insisting that he clean the house, prepare dinner or chop wood for the stove may appear to constitute omissive coercion. However, performing such chores may in fact be beneficial for the child, who thereby learns useful skills.
In setting up a clothing reward system for fulfillment of chores, a mother may be actively fulfilling her parental duties. Similarly, when a wealthy nation trades essential food or medicines (or the money to purchase them) with a poor country in return for goods produced or labour services, the poor are creating goods, learning skills or providing services that may continue to act as a source of revenue. Trading HBM, on the other hand, involves a permanent transfer of capital in the form of human flesh, often entails direct injury (however minimal) to providers and a loss of personal value in HBM. The benefit to poor nations in the case of trade in HBM is purely instrumental, lying solely in the financial profit obtained and the good to which it may be put, and must be balanced against the losses incurred through HBM provision; whereas trade in labour or produced goods may not only result in financial benefits but also sustainable advantages for industry and development of other trading opportunities. Thus the lack of extraneous benefits of trade to those who are omissively coerced may help to “single out” objectionable markets.

Interestingly, Veatch appears to support the argument from omissive coercion in the sense that he claims it is immoral to offer to buy organs from the poor when society has the resources to provide for their urgent needs, however he claims that the consistent and persistent failure of society to address poverty using these resources justifies the introduction of markets.

If we are a society that deliberately and systematically turns its back on the poor, we must confess our indifference to the poor and lift the prohibition on the one means they have to address their problems themselves. (Veatch 2003, 32)

This argument supports the idea that markets may (omissively) coerce the poor, but suggests that the consequences of markets will be more beneficial to the poor than market prohibitions (see Chapter 5). Of course, even where markets do not – omissively or otherwise – coerce the poor, this does entail a right to sell.

### 6.3.3 Impaired autonomy through constraining options?

Market opponents also object that the opportunity to sell body parts may impair autonomy by providing a “constraining” option. For the poor, selling an organ or other body part may be undesirable for a variety of reasons – for example, it may be associated with social stigma or physical injury. In the absence of a market, the poor suffer the harmful consequences of poverty, but not the harms of sale. If a market is established, this new opportunity to make money may seem unavoidable. Debt collectors may call in debts sooner, knowing that debtors could obtain money by selling
HBM (L. Cohen 2003, 676); families may also exert pressure on unemployed individuals to contribute to household finances through sale of HBM (e.g. Zargooshi 2001b, 1795). Although sale may appear to represent the best option available to the poor in some circumstances, it may ultimately leave them worse off - with fewer options due to ill health, recurrent debt and social stigma compromising important life choices such as marriage and employment (e.g. ibid.; L. Cohen 2003; Mendoza 2010c; Padilla 2009). However, contrary to objections concerned with vendor poverty and coercion, market advocates argue that markets enhance the autonomy of the poor by providing them with new opportunities that enable them to improve their lives (e.g. Veatch 2003; Savulescu 2003).

Much of the debate regarding the likely impact of HBM markets on the autonomy of the poor rests on the features of markets and their likely consequences, (see Chapter 5) as well as how poverty may be understood to undermine autonomy. P.M. Hughes, for example, argues that the lack opportunities available to the poor means that although they may voluntarily choose to sell organs, they do not endorse the economic constraints that limit their option sets, hence such choices are not truly autonomous (2009a). E. Anderson makes a similar case with respect to workers who choose to accept hazardous employment, arguing that workers “often lack the internal conditions for fully autonomous choice” because they may fear to seek information or to question or refuse particular tasks (1993, 198-199). Such fear relates not merely to potentially coercive harassment by employers, but to the potential loss of vital income. She notes that, “The opportunity to earn a living is not merely another commodity, like a toaster. It is both a need and a responsibility” (ibid., 199). This is reflected in the many accounts of organ vendors who seek money to provide for families.

6.3.4 The Argument from Autonomy

Despite concerns about the authenticity of rational, voluntary decisions to sell HBM in the setting of poverty, respect for autonomy is not in theory incompatible with HBM markets. Where autonomy is conceived as a fundamental interest in critical life choices (Archard 2008, 21), respect for autonomy may require societies to respect or indeed enable individuals to act on their autonomous choices, such as the decision to sell HBM. Similarly, a more Kantian vision of respect for autonomy, founded in the idea that individuals should be treated as ends in themselves rather than means to our own ends, suggests that we should strive to some extent to promote the autonomous ends of others.
This intuition is behind some claims that the poor should be permitted and/or enabled to sell their HBM in order to make significant changes to their lives. Personal value in detached HBM, as I noted in Chapter 3, includes a personal interest in the use, transfer and disposition of one’s HBM. This may well include an interest in the sale of HBM, and potentially forms the grounds for a right to sell in circumstances where financial profit from sale is of significant importance to critical life choices.

If my personal interest in my own HBM is such that its use, transfer or disposition constitutes an important life choice, I may be granted a right to determine whether my HBM is used or discarded, how it is ultimately disposed of, or even to select who makes use of it. This would reflect my right to determine how, as a living person, others treat me. However, such rights are directly concerned with the intrinsic personal value of my HBM. Where payment for my HBM is involved, I essentially trade that personal value for money. My potential rights to determine use or disposition of my HBM are impaired by the transfer of property rights in the material. If I exercise a right to sell, I make personal value secondary to fungible value. Respect for my autonomy, in the case of respecting my right to sell HBM, concerns a primary interest in obtaining money rather than a primary interest in the treatment and disposition of my HBM. This is not to say that obtaining money is an inappropriate interest, or that obtaining money is not a key feature of exercising autonomy, simply that the sale of HBM in itself is not an expression of a critical life choice regarding the treatment of HBM, except in so far as it is instrumentally valuable.

Where payment for HBM may successfully enhance autonomy (and human flourishing) by contributing to the attainment of fundamental capabilities, markets appear inherently attractive and it seems plausible to suppose that society has an obligation at the very least not to hinder trade, and possibly to actively facilitate HBM markets. However, this appeal depends on the absence of better alternative options. Those seeking to enhance human flourishing and to protect and ensure fundamental capabilities for flourishing must consider the range of ways in which these may be promoted. Not only are markets in HBM unlikely to achieve these goals in practice, as I

40 Of note, a key objection to HBM markets is that sales violate the (Kantian) autonomy of vendors by instrumentalizing them and their bodies, using them purely as a means to acquire HBM. The standard rebuttal of this claim is that the consent requirement, by implicitly recognizing the subjectivity of a vendor, acknowledges the vendor as possessing ends of her own and being an end-in-herself and thus respects her autonomy (Wilkinson 2003, 54). I shall return to this in Chapter 7.
have argued in the previous chapter, but I shall also argue in Chapter 7 that markets in HBM can at best be considered a strategy of last resort and that a range of alternative methods to enhance autonomy and promote human flourishing are far better equipped to do so.

6.4 The Argument from Liberty

Again referencing Dworkin, J.S. Taylor writes, “Allowing a current market in human organs … will enhance personal autonomy through removing a prohibition that currently restricts persons’ control over their own bodies” (2002, 275). The prohibition of markets does not impair autonomy in this sense so much as it impairs liberty. My autonomous control over my body, I have argued, consists of a right to bodily integrity and to choose whether to detach some of its materials. My autonomy may be impaired when my bodily integrity is violated or when my ability to choose autonomously is impaired through coercion or deception, or where my capacities to think and act autonomously are impaired. Liberty, on the other hand, concerns my freedom to act on particular autonomous choices - including those that directly concern my body – especially those that may involve or affect other people. Denying someone an opportunity to do something is not usually regarded as a violation of their autonomy, although markets may arguably be instrumentally useful in enhancing autonomy (as discussed above). Prohibitions on trade in HBM however, are likely to impair liberty, that is, the freedom to buy and sell HBM. Respect for individual liberty is highly valued in many societies, and in many cases may be regarded as a natural extension of respect for autonomy.

The Argument from Liberty draws on the work of J.S. Mill, who famously declared that, “the sole end for which mankind is warranted, individually or collectively, in interfering with the liberty of action of any of their number, is self-protection” (1948, 73). The widespread legal prohibition of many HBM markets and restrictions on sale imposed in regulated markets interfere with the liberty of potential vendors as it prevents individuals from selling their HBM. Assuming that markets involve only voluntary vendors, “To ban a market in organs is, paradoxically, to constrain what people can do with their own lives” (Savulescu 2003, 139).

Mill makes a strong case for allowing individuals to determine what is best for themselves, arguing that individuals are best equipped to understand their own circumstances and preferences, have their own interests at heart and may thus pursue their own vision of the good life in their own way (1948, 133, 75). Nevertheless, he
outlines two general circumstances in which society is justified in restricting the liberty of individuals, each of which may have broader applications than the simplicity of their formulation at first suggests. The harm principle offers the broadest scope for restriction of individual liberty, as it justifies the exercise of power “over any member of a civilised community, against his will… to prevent harm to others” (ibid., 73). The second, more controversial condition placed on liberty, is that one is “not free not to be free,” that is, one cannot permanently abrogate one’s liberty by voluntarily entering into a slavery contract. These two limitations on the right to liberty form the basis for potential objections to the Argument from Liberty in favour of a right to sell HBM.

6.4.1 Mill and the Harm Principle

The harm principle may be used to justify varying degrees of market regulation in order to prevent harm to society members. For example, vendors wishing to profit from their HBM may conceal important medical information that might disqualify them from provision, such as infections, leading to inferior or dangerous materials being procured and distributed among society. This practical objection was instrumental in discouraging the sale of blood (Keown 1997, 98). Furthermore, the creation of a legal market might discourage altruism, leading to indirectly harmful effects on societal attitudes towards helping others or directly affecting those in need of HBM, if the decrease in altruistic donation is not compensated for by the number of new vendors (e.g. Danovitch and Leichtman 2006, 1134). Additionally, if selling HBM is indeed harmful to vendors, then by legalizing sales, more people will be encouraged to sell and vendors may thereby indirectly harm others by setting an “injurious example” (Mill 1948, 137). Of course, if the harm to vendors is obvious, it may have a beneficial deterrent effect on prospective market participants.

Finally, if a market participant is harmed, he may also indirectly harm society by increasing societal burdens, or by incapacitating himself and preventing the fulfillment of his duties towards others – such as employers, family members and so on (ibid., 138). For example, recipients of HBM purchased in the market may inflict significant healthcare costs on their societies if they suffer complications as a result of inappropriate or dangerous treatments.

Archard (1990, 454) suggests that Mill did not object to people entering into such contracts, merely that he felt society should not enforce them.

Higher rates of complications have been noted, for example, in patients who have purchased organs abroad (e.g. Alghamdi et al. 2010; Sever et al. 2001; Krishnan et al. 2010). Patients who purchase gametes for use in ART may also be at greater risk of
6.4.2 Freedom not to be free?

Mill further argues that, “the principle of freedom cannot require that [an individual] should be free not to be free” (1948, 158).

[By] selling himself for a slave, he abdicates his liberty; he forgoes any future use of it beyond that single act. He therefore defeats, in his own case, the very purpose which is the justification of allowing him to dispose of himself. (Ibid.)

Although Mill’s prohibition of slavery is sometimes condemned as inconsistent, Archard defends it on the grounds that “the slavery contract is a clear example of a positive self-abrogating exercise of liberty by one of its parties” (1990, 460), and that Mill’s ‘liberty principle’ is justified by the fact that it guarantees the exercise of something which Mill holds valuable, namely the exercise of individual freedom subject to the harm principle. It would be inconsistent with holding that principle justified to permit behaviour which denied the exercise of freedom. (Ibid.)

This claim would appear to preclude the in vivo sale of vital organs, and possibly limit the extent of HBM that one might provide. The sale of limbs or both kidneys, for example, while not necessarily incompatible with life, would undoubtedly permanently limit the range of opportunities one might have for exercising one’s liberty. This is not to say that amputees or others with significant physical disabilities are slaves, merely that deliberate and permanent abrogation of physical capacities may limit the range of future opportunities for action, thus impairing liberty. This applies equally to the in vivo detachment of HBM for altruistic purposes.

6.4.3 Respect for liberty as a constraint on markets

Granting a right to sell one’s HBM on liberal grounds would not necessarily legitimate markets. For although the risks attendant in selling HBM might in some cases (e.g. within an effectively regulated market) be limited to those of voluntary vendors and hence ‘self-regarding’, purchasers, brokers and professionals involved in the incurring subsequent healthcare or societal costs. Although the most significant pregnancy complications associated with the use of commercially acquired gametes are likely to be due to transfer of multiple embryos rather than the use of third party gametes (see for example McKelvey et al. 2009), a recent study suggests that women who undergo ART using provided oocytes are at higher risk of hypertensive complications of pregnancy (Klatsky et al. 2010). Such risks apply to the use of altruistically donated gametes also, however where older patients use the market to circumvent gamete allocation age criteria, they may be at a higher risk of pregnancy complications, given the strong association between advanced maternal age (>45 years) and complications for both offspring and mother (Yogeve et al. 2010).
procurement and sale of HBM would be to some degree responsible for any harms incurred by vendors. Mill asks,

In cases of personal conduct supposed to be blamable, but which respect for liberty precludes society from preventing or punishing because the evil directly resulting falls wholly on the agent; what the agent is free to do, ought other persons to be equally free to counsel or instigate? (1948, 153)

He further suggests “the case of a person who solicits another to do an act is not strictly a case of self-regarding conduct” (154). Finally, although Mill declares that “over himself, over his own body and mind, the individual is sovereign” (173), and argues that the good of an agent “either physical or moral, is not a sufficient warrant” to interfere with his liberty, he shows a reluctance to encourage or facilitate actions that might jeopardize that good, whether they are expressive of liberty or not. He suggests that if, “in the opinions of others” an individual’s prospective actions appear potentially harmful to himself, “these are good reasons for remonstrating with him, or reasoning with him, or persuading him, or entreating him” (ibid.).

6.4.4 Market prohibition as the promotion of liberty?

Besides consequentialist concerns about of HBM markets, it is also possible that markets may impair rather than enhance liberty. Ruger, in her capabilities account of healthcare markets, argues that because health is necessary for human flourishing and freedom, it has a non-instrumental value which requires protection of health in the marketplace, whereas money or income does less so (2006b, 168). If health is necessary for liberty, then liberty cannot be used to justify a free market in healthcare, except on mechanistic grounds. Similarly, Radin notes that the claim that market prohibitions or “inalienabilities involve a loss of freedom also assumes that alienation itself is an act of freedom, or is freedom-enhancing” (1996, 42). She contrasts the view of ‘negative’ freedom or interference with liberty, by which prohibitions are regarded as paternalistic, with “a positive view of liberty that includes proper self-development as necessary for freedom”, arguing that in the latter context, market prohibitions required to foster self-development “will be seen as freedom-enhancing rather than as impositions of unwanted restraints on our desires to transact in markets” (1987, 1899).

If markets in HBM are to avoid impairing liberty, strict enforcement of regulations will be required to protect the health of HBM providers and to ensure that markets offer a greater range of life choices, including opportunities for obtaining income, in the long term, rather than constraining options through impaired health and socioeconomic development within provider communities.
6.5 The Argument from Analogy with Labour

The right to sell one’s own HBM is often defended using the analogy of dangerous forms of employment. The freedom to sell at personal risk is no different, it is claimed, than the freedom to take on a dangerous job. In both cases, financial incentives are often provided to attract individual participation in important activities benefiting society. HBM provision and ordinary labour are described as analogous because providers must usually travel to procurement centres and undergo screening investigations and eventually procurement procedures. In doing so, they expend time, suffer inconvenience and discomfort, incur costs and risk injury in the way that many people do in the course of employment. These similarities may be used to ground three different claims in favour of payment to HBM providers. Firstly, that materials constitute the products of labour and hence are the rightful property of the providers and may be sold (see Chapter 3). Secondly, that providers deserve payment as either a reward or compensation for these efforts (see section 6.6 below). Thirdly, that because no objection is made to paying people for their labour, there can be no objection to paying people to provide HBM. This last claim constitutes the Argument from Analogy with Labour (AAL), which in many respects is a rebuttal of harm-based objections to the Argument from Liberty. In this spirit, J.S. Taylor argues, “since it is morally permissible for a person to be employed in certain dangerous jobs, it is also morally permissible for a person to sell one of their kidneys, given that the levels of risk involved are similar” unless outweighed by additional moral considerations (2005, 139).

6.5.1 Standard objections to the Argument from Analogy with Labour

Taylor provides considerable reassurance to those concerned about the dangers of live kidney provision by comparing the mortality and morbidity rates of the latter with those of commercial fishermen and “dangerous jobs in the construction industry” in the United Kingdom (2005, 127-130). Other authors have likewise compared selling organs to paying soldiers, fireman and others employed in dangerous public services (e.g. Monaco 2006, 956; Steinbuch 2010, 40). The AAL builds on the argument that if one is allowed to voluntarily incur risks through altruistic donation, it is inconsistent to prohibit commercial provision of HBM that presents equivalent risks, by recognizing the role that financial remuneration (and incentives) play in commercial provision and dangerous employment such as mining, fishing or service in the military.

Five common objections to the AAL may be noted. Firstly, there are empirically based arguments about relative risks which I shall not attempt to address, conceding that
in some cases, the risks of employment will undoubtedly exceed those of HBM provision, especially when provision occurs in the setting of optimal care. Secondly, it is argued that the quality of informed consent in employment markets may be better than that of HBM markets. I have already concluded that payment does not preclude the possibility of providers giving valid consent to sell HBM. However, we should take note of Anderson’s discussion of cost-benefit analysis in employment markets, in which she warns such analysis “is mistaken in thinking that people can adequately and autonomously express all their valuations through market relations” (1993, 200). Although informed voluntary HBM vendors may consent to accept the dangers of provision, one might argue “this does not imply that they find these risks acceptable, fair, legitimate, or worthwhile” (ibid., 201).

Thirdly, Taylor notes Zutlevic’s objection that sales of HBM may be associated with social stigma but suggests that such disanalogies do not “seriously weaken the pro-market argument by analogy” (2005, 135). After all, social stigma may be equally present in some forms of incentivised employment, such as the military. Fourthly, there is the fact that by providing HBM, individuals not only incur risks of harm but also, in many cases, inevitably suffer harm in the form of lost and irreplaceable organs or gametes. The discomfort and inconvenience of procurement procedures and the temporary or permanent loss of biological materials are sometimes unavoidable. However, many forms of labour similarly impose physical burdens on workers and potentially substantial harms that in some cases may outweigh the harms of HBM provision.

Finally, there is the objection that the sale of non-renewable materials such as kidneys and oocytes is irrevocable (Taylor 2005, 135-7). Where labour generally consists of a service provided by workers that can be replicated on a regular if not frequent basis, the provision of non-renewable HBM is more aptly described as the sale of goods. Once supplied, they are permanently lost to the provider. Although the sale of labour involves an irrevocable loss of a particular period of time, the labourer in general possesses more time that he may choose to sell as labour or to expend on his personal desires. Having sold one’s non-renewable biological material, it is usually impossible to regain this

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43 Examination of the question whether sperm should be considered renewable is beyond the scope of this thesis. Although usually classed as renewable because men continue to produce sperm throughout their lifetimes, the fact that each sperm (like each oocyte) contains subtly different genetic material means that each gamete is “irreplaceable” in the sense it could in theory be used to create a unique child, unlike blood or liver cells which are functionally interchangeable.
material if one regrets the decision to sell. Taylor rebuts this concern on the grounds that donation of these materials is likewise irrevocable yet considered morally permissible (137). Even if irrevocability did undermine the AAL in the case of some HBM, the provision of renewable materials such as blood and liver segments could still be considered analogous to labour. Nevertheless, this objection brings us closer to the fundamental difference between selling labour and selling HBM.

6.5.2 Payment for HBM provision is payment for goods, rather than services

When I purchase bread, I am not directly paying the baker for the time he spent baking, the inconvenience of his early morning and the discomfort he experiences working among the hot ovens. Although the price he sets on his bread may reflect the extent of his efforts – a more time consuming loaf may cost more, for example – I pay for the bread itself, not his labour. Likewise, payment is offered to HBM providers not because the efforts they may incur in procurement procedures are intrinsically valued, but because the products of these efforts are valued. This contrasts with payment for those employed in the military, police or fire department services, in which the work that these people perform is intrinsically valued. Although better public security may be described as a “product” of such services, policemen no more sell “security” than the electrician I pay to install my lighting sells “light”. It is thus mistaken to argue that payment for HBM will promote respect for the labour of HBM providers because payment for public service reflects recognition of its value.

The distinction may appear subtle, but it has important ramifications. The labour of the baker, unlike that of the policewoman or even the electrician, is often invisible to those who purchase bread. Our consideration of the baking industry tends to stop at the point of sale. We treat the bread purely as a commodity, ignoring the efforts of the baker. Whether the bread is valued and enjoyed or discarded as waste is entirely up to the consumer. Without engaging with the long history of ethical concerns about the treatment of workers who, like bakers, produce commodities, it is important to note that the commodification of HBM creates more significant issues. Although treating bread as a commodity without recognition of the baker’s labour may impair his self-esteem, treating HBM as commodities not only risks devaluing the efforts of HBM providers

44 In some cases, it may be possible to repurchase sold materials such as oocytes frozen in storage. At present, the recovery and auto-transplantation of procured organs such as kidneys or liver segments is unfeasible on many levels.

45 It may also contribute to failure to consider the working conditions of bakers, leading to harmful treatment of those employed in the baking industry.
but also obliterates the personal value inherent in these materials. The negative repercussions of this will be discussed in the following chapter.

Construing payment for HBM provision as a labour market distances these materials from their central place in human lives: they become simply products or commodities like bread baked by bakers, or coal produced by miners. Looking more closely at the “labour” of HBM provision, we should also note that providers do little that actively contributes to creation of the “products”. Providers enable other individuals such as healthcare professionals to procure, modify and use materials by passively submitting to investigations, treatments and procedures. Providers may voluntarily travel in order to facilitate removal of their “products”, but in reality their major contributions to the “production” of HBM consist in possession of the raw materials and a willingness to allow their removal and use. I do not intend by any means to diminish the efforts, suffering and risks that HBM providers may incur, simply to emphasize that in the context of HBM markets, the provider is rather like a farmer who allows a mining company to enter his land and extract minerals from the soil, except that in this case, the provider is both farmer and land. The analogy with labour distracts from the fact that what is really being sold are materials from living human beings. Considering the ethical issues of dangerous or physically demanding employment may usefully inform our examination of living HBM provision, but we must remember that HBM markets are not truly labour markets if we are to comprehensively explore all the issues of paying for HBM provision.

Furthermore, simply because people choose and are allowed to engage in many forms of dangerous employment does not mean such employment is ethically justifiable. Efforts to minimize risks to employees, including through the provision of alternative means of employment are welcomed by workers and often mandated by society, despite potential losses in profitability or market efficiency. This suggests that where alternatives to the in vivo provision of HBM are available, these should be exhausted prior to encouraging sales, for example by preventing needs for HBM and using alternative therapies, (see Chapter 8).

46 This is evident in the fact we use the term “provision” or “donation” to describe the procurement of HBM, rather than production. Bakers, on the other hand, “produce” bread.
47 See for example Stout and Linn (2002); Nieto and Duerksen (2008); Jagger et al. (2008); regarding efforts to reduce occupational hazards. See Wilson (2010) regarding the role of worker cooperatives as safer alternatives for immigrant workers in Canada.
6.6 The Argument from Desert

The AAL is often bolstered by reference to forms of dangerous employment that are celebrated by society and which citizens are encouraged to support or participate in, such as the military, fire brigade and police work. Analogy with such careers, it is claimed, renders payment for provision of HBM not merely acceptable but obligatory: those who voluntarily risk harm in order to contribute necessary goods to society deserve compensation or reward for their efforts. The Argument from Desert may take one of two forms. Firstly, it is claimed that those who provide HBM for the benefit of others should be compensated for the loss of their HBM. Secondly, it is claimed that providers of HBM merit a reward in recognition of the virtue of their act. Whether reward or compensation, the primary intent of providing financial payments to providers that exceed the financial costs they may have incurred (which would simply constitute reimbursement) is to incentivise provision. In most cases, the ambiguity of the language used to describe reward or compensation policies appears symptomatic of discomfort with their underlying purpose and of reluctance to articulate what is, strictly speaking, a payment for provision of HBM. Hence we find the Iranian organ market described as follows: “the Iranian government undertook to reimburse a reward to donors… This gift is given as a reward from society to compensate the donor for the sacrifice, although undoubtedly an human organ is invaluable” (Larijani et al. 2004, 2540).

Nevertheless, the Argument from Desert is intuitively appealing. Many authors indignantly point out that in organ transplantation, everyone but the donor of organs benefits substantially from the process (e.g. ibid.; Friedman 2006, 748; Matas 2004, 2009). Although a provider may derive personal satisfaction from altruistic donation, the recipient gains enormous health benefits and health care professionals involved in transplantation at least partially earn their living using the gifts of organ donors. The presumed injustice of this distribution of benefits has two elements. Providers of HBM at the very least ought not to be left worse off, and ought perhaps to be left better off. The former claim concerns compensation, whereas the latter concerns rewards for HBM provision.

6.6.1 The ambiguity of compensation for HBM provision

Compensation is intended to rectify the potential disadvantages of providing HBM, restoring as far as possible the status quo for providers. Grant notes:
Compensation means ‘rendering equal’, a ‘recompense or equivalent’, ‘payment for value received or service rendered’, or something which ‘makes up for a loss’ - as in the term ‘unemployment compensation’. Compensation equalizes or redresses a balance, and so, to speak of ‘fair compensation’ is entirely sensible. 

(2002, 134)

Precise reimbursement of costs incurred through provision of HBM, such as diagnostic tests, procurement procedures, time off work, travel, necessary follow up care and insurance to protect against post-provision complications will ensure that providers are not financially worse off without offering surplus payment that would render provision a sale (see Chapter 1).

However, the loss of HBM, particularly non-renewable materials, and the discomfort or “inconvenience” of providing HBM is not so easily equated with financial losses. Attempts to set a price on suffering or inconvenience draw on traditional cost benefit analysis that sets a monetary value on human life according to what E. Anderson terms, “the ‘willingness-to-pay’ scale” (1993, 191). In this sense, the willingness of individuals to provide particular HBM in return for a minimum level of payment may be seen as approximating the value that they place on their welfare and the risks or suffering that provision may entail. Setting aside Anderson’s reservations about the validity of cost-benefit analysis, estimating fair compensation for HBM provision remains challenging. In seeking to balance the disadvantages of physical suffering and inconvenience, how are we to measure the benefits of altruism and social solidarity that may also compensate providers? Putting a price on the non-financial burdens of HBM provision is difficult to do without creating genuine financial incentives that do more than restore the status quo for providers. Surely these burdens are incommensurable with payment? Although a large payment might promote willingness to undergo a painful or inconvenient procedure, it cannot obliterate the actual pain or inconvenience that I experience and thus does not, strictly speaking, make up my loss. Accordingly, the Argument from Desert based on genuine compensation implies that all providers of HBM should be reimbursed for costs incurred and protected against future costs related to provision, that efforts should be made to minimize incommensurable burdens such as pain and inconvenience, but cannot be regarded as making a strong case for “compensation” that involves additional payments to providers.

6.6.2 Rewarding HBM providers

The reward variation of the Argument from Desert is more demanding than that of compensation. It claims that the unique value of HBM provided and the burdens
The practice of rewarding meritorious actions such as saving lives is not exclusive to Western society, with a strong place in Islam (Rady 2009, 186) and other religions, although such rewards are more traditionally expressed as God-given rather than material. Nevertheless, the framing of payments for organ provision as “rewarded gifting” in Iran (Simforoosh 2007) and Saudi Arabia (Shaheen et al. 2005) reflects Monaco’s account.

The difficulty inherent in rewarding provision of HBM is that the meritorious action that engenders reward should in theory be distinguished by the purity of its motivations. The decision to provide HBM is deemed worthy of reward precisely because it is motivated by a desire to contribute to the wellbeing of others, not by the desire to obtain a personal benefit such as payment. Knowledge of a reward systematically attached to HBM provision is likely to compromise the virtue of motivations and transform rewards into simple payments or incentives for action. This does not mean that all virtuous actions must be exclusively motivated by altruism. A fireman who regularly endangers his life to save others is likely to be motivated both by the desire to earn a living and to help society. His regular salary is not, however, strictly speaking a reward but fair compensation for his employment. On the other hand, if a fireman acts above and beyond the normative expectations of his profession – for example by defying the protocols designed to minimize risks to firemen in order to attempt an extremely dangerous rescue – such actions may be considered particularly meritorious and deserving of a reward – such as a medal or public commendation.

Norman (2001) contrasts the expression of praise or gratitude for meritorious actions with material rewards, suggesting that in many cases where reward is deserved, we are not entitled to material reward in a way that engenders a justice claim. For example, if I offer to donate a kidney to my brother, I most likely deserve his gratitude and the praise of my family and friends. This does not mean that I am entitled to a material reward or that my brother does me an injustice if he fails to reward me with a significant sum of
money or other valuable commodity. Instead, Norman argues that entitlements to material reward arise in the setting of socially cooperative relationships in which “what creates the entitlement is not the idea of “desert” but the idea of social co-operation, the idea that those who contribute to a common enterprise should share equally in the fruits of that endeavour” (2001, 125).

He regards such cooperation as embodying reciprocity, with individuals contributing to common goods and thus deserving of an equal share of benefits. While Norman notes that some activities may be seen as more valuable to society and thus more deserving perhaps of reward, he suggests that quantifying or qualifying the respective contributions of individuals will be difficult in practice and instead claims that “justice requires that all participants in a scheme of social co-operation should benefit equally overall” (2001, 134). Although in reality it is difficult -if not impossible - to ensure that all participants in social endeavours benefit equally, it is at the very least possible to ensure that an equitable system of benefit distribution is promoted.

Providers of HBM undoubtedly deserve gratitude, recognition and reimbursement of their financial costs. The value of their gifts to society will have a claim on justice where provision occurs in a non-market context in which their contributions are made to the common good of HBM supplies within society. The implications of such a claim include rights of access to the benefits of increased supplies of HBM. It also suggests that those who provide HBM to society should be entitled to access other public goods such as education and healthcare more generally – in other words, in a society in which there are few public goods and little social cooperation, provision of HBM is unlikely to be just. A market system will preclude such claims on justice, especially where HBM are provided by those excluded from society such as non-citizens.

In considering the sort of “fixed-amount specific reward or honorarium” that Monaco proposes for organ providers, it is difficult to see how such systematic rewards could be differentiated from ordinary payment for supply of needed goods, although Monaco emphasizes that “this would not be the buying or selling of organs; it would be a specific, fixed-amount reward for organ donation” (2006, 957). He further notes that “a reward of $40 000 to $80 000 has been suggested as financially feasible” (ibid.). Such fundamentally material ‘rewards’ should be properly characterized as payments and incentives for the supply of goods within a market, rather than disguised as an entitlement of altruistic individuals.
6.7 Unpaid donation, profits and injustice

The commercial value of HBM to those engaged in procurement, transport, modification or professional use (therapeutic or research) services is often cited as a reason to pay providers (see for example Aziz 2009, 104). After all, if everyone else profits financially from HBM, why not the people from whom it is obtained? A distinction must be made, however, between profits obtained from trade in HBM and profits obtained from the provision of professional services involving the treatment of HBM

6.7.1 Payment for HBM will not rectify unjustified fees for service

It would certainly be hypocritical to allow trade in HBM by doctors or other professionals engaged in the treatment of HBM but not to pay providers of the materials. If trade in HBM is unethical, however, simply because trade occurs among some parties would not justify extending trade to others. Instead, greater efforts should be made to prevent trade, wherever it occurs. I have argued in Chapter 1 that paying providers of services related to the procurement, modification, or use of HBM does not constitute trade in HBM. However, although the professional financial benefits of working with HBM do not justify payment for HBM providers, this does not mean that the profits received by service providers are always fair or justifiable. As noted in Chapter 4, where commodification and pursuit of profits impairs the capacity of society to provide important healthcare services to its members, and thus to flourish in the exercise of their fundamental human capabilities, this should be condemned and corrected. Paying HBM providers will not correct the injustice of undue fees for healthcare services.

6.7.2 Secondary commodification and shadow markets in HBM

In cases of secondary commodification of HBM where HBM has been provided by unpaid donors and is then sold by third parties, it is difficult to determine when payment to service providers that exceeds the reimbursement of costs directly incurred constitutes effective payment for the material itself. For example, if a transplant surgeon charges an exorbitant fee for performing a kidney transplant, she may be accused of profiting excessively from provision of transplantation services, but not of profiting from sale of the transplanted kidney itself. However, if a manufacturer pays the costs of transporting a container of donated femoral heads from an orthopaedic unit, then processes these materials into a bone product and sells it to another orthopaedic clinic
for use in surgery, how is a price for these products to be determined that does not constitute an effective profit from the material itself? The same problem applies to most HBM that are ultimately sold to healthcare institutions, for example blood products.

In reality, the price paid for a unit of blood at the point of service delivery is comparable to whatever payments a hospital or healthcare system makes to those involved in the recovery and delivery of human organs to the point of transplantation. Although hospitals pay a fee for a product, they are effectively paying for services involved in the procurement, transport and modification or examination of the material. The primary product is made commercially valuable only through these services. It is not the place here for a discussion of what constitutes a justifiable fee for provision of particular healthcare services or goods. However, where HBM are provided altruistically for the purpose of benefiting others in healthcare services, it is obvious that profits are expected to be minimized. For example, profits for service provision should correspond to the minimum required to ensure effective service provision. This idea is reflected in the WHO Guiding Principles on Cell, Tissue ad Organ Transplantation, in which “profiteering” from HBM is repeatedly condemned, and Principle 8 declares that, “All health-care facilities and professionals involved in cell, tissue or organ procurement and transplantation procedures should be prohibited from receiving any payment that exceeds the justifiable fee for the services rendered” (WHO 2009b, 9).

Nevertheless, exploiting the allowance of fees for service provision, HBM are in some cases being effectively commodified, with enormous profits obtained by service providers. While this secondary commodification does not automatically justify payment to providers, it remains an important issue. B. Parry describes the (secondary) commodification of altruistically donated tissue in tissue banking as follows:

Having passed through several iterations of partial or incomplete commodification they may, as they do in the US, eventually enter something that looks remarkably like a formal resource economy or market. It is prevented, however, from being designated as such by the fact that the transactions that occur within it, while explicitly monetized, are not characterized as ‘sales’ but rather as “exchanges” that attract ‘fees’ in ‘compensation’ for services. It operates therefore, not as a black market, for these transactions are not technically illegal, but rather in an interstitial zone as a type of shadow economy. (2008, 1144)

I shall briefly discuss how this issue might be addressed in Chapter 10.
6.8 Conclusion

It is apparent that the main arguments for a right to sell HBM are inspired by the individualism inherent in a particular conception of the intimate relationship between persons and their bodies, and hence biological materials. Although I claimed in Chapter 2 that morality is founded on an individualized conception of human beings as embodied moral subjects with the right to bodily integrity and autonomy, I also emphasized the social nature of morality. Moreover, I have highlighted the importance of personal value in HBM and hence the significance of its treatment for individuals and society. Arguments for the sale of HBM that prioritize individualism at the expense of social values and relationships concerning HBM and the treatment of other human beings may produce results that are unacceptable to both individuals and communities and may fail to express and uphold the equally fundamental human concern for flourishing. As Hughes notes, the prioritization of autonomy “as the controlling value in the organ market debate” is associated with lack of genuine concern for the wellbeing of organ vendors except for “considerations of their potential temporary economic gain… [and] the impact on their autonomy of legalizing or prohibiting such markets, or on how denying them the opportunity to sell is misguided paternalism” (2009a, 608). Such arguments are also unlikely to be accepted in societies in which respect for individual autonomy and liberty are outweighed by community and family concerns.

Unsurprisingly, autonomy, liberty, property and desert based arguments for markets are habitually supported by appeal to more communal concerns and values. The needs of people requiring HBM and those of the poor are invoked to qualify respect for autonomy or liberty. Respect for liberty is important, for example, where it contributes to human flourishing by enabling people to escape poverty, and it may be constrained by concern for the wellbeing of other members of society. Similarly, market advocates usually argue that providers deserve rewards because they contribute to communal goals, rather than private rewards from the individual beneficiaries of their HBM.

If the ultimate value of the right to sell HBM is dependent upon its promotion of human flourishing, generally conceived, we must ask if selling HBM is the best way to achieve this goal, or whether alternative strategies might be not only effective but less ethically problematic. Even granted a right to sell, a right to buy HBM or to endorse and facilitate markets in HBM will nevertheless require more ethical justification. If we endorse markets in HBM solely on the grounds that they are consistent with minimal respect for autonomy and liberty, then we must commit ourselves to the acceptance of minimally regulated markets, the hazards of which were noted in Chapter 5.
Suddenly there were all these new possibilities laid before us, all these ways to cure so many previously incurable conditions. This was what the world noticed the most, wanted the most. And for a long time, people preferred to believe these organs appeared from nowhere, or at most that they grew in a kind of vacuum. ... They didn’t want to think about you... they wanted you back in the shadows. (Ishiguro 2005, 264)

7.1 Introduction
In Kazuo Ishiguro’s 2005 novel, Never Let Me Go, cloned children are raised in isolation from society awaiting the time when they begin to “donate” organs. The central characters grow up at Hailsham, a special facility at which they are encouraged to express themselves creatively as part of a project aimed at showing society that the clones have souls (Ishiguro 2005, 260). In this bleak dystopia, Hailsham is eventually closed because society “didn’t want to be reminded how the donation programme really worked” (ibid., 264). Society wants the clones “back in the shadows.” The discomfort that society feels vis à vis the organ providers in the novel remains largely unexplored. Reluctance to lose the life saving benefits of a perfect supply of HBM compels society to deny the quintessential humanity of the clones – a fiction that can be maintained only through their systematic exclusion and concealment from society. When confronted with the reality of their humanity, Ishiguro suggests that society is frightened. “‘We’re all afraid of you’ [A teacher remarks to the clones] ... ‘There were times I’d look down at you all... and I’d feel such revulsion...’” (ibid., 269). An obvious moral to be drawn is that the treatment of the clones is wrong because it deliberately denies their manifest humanity. Prevented from leading normal human lives - the relatively enriching education provided at Hailsham constituting an exceptional attempt to provide the semblance of childhood – the clones enter the “donation” programme and “complete” at a young age, with completion representing the end of their utility and hence existence.

The invisibility of Ishiguro’s clones echoes Scheper-Hughes’ description of organ providers in contemporary society. By exploring and reporting on “transplant tourism”, Scheper-Hughes notes that she is “breaking a long-standing taboo against ‘knowing’
the organ donor or acknowledging the invisible sacrifice of those whose gifted, bartered or sold organs gave new life or increased vitality to others” (2004, 64). She continues,

In positioning myself on the ‘other side’ of the transplant equation in order to represent the silent or silenced organ donors, I am attempting to reconstitute living donors as rights-bearing individuals and persons rather than as faceless organs ‘suppliers’, ‘vendors’ or living cadavers and medical material for transplant procedures. (Ibid.)

Ishiguro’s book reveals two interrelated concerns about the treatment of the clones, both of which are frequently invoked as objections to the sale of HBM. Firstly, the clones are instrumentalized, their subjectivity is denied as they are used purely as the means to the ends of others. Their own hopes and dreams of a future are ignored, because their perceived value to society is purely instrumental: they ensure that people no longer need die from various diseases. Secondly, their humanity is denied in order to facilitate this instrumentalization: “People did their best not to think about [the clones]. And if they did, they tried to convince themselves [the clones] weren’t really like us. That [the clones] were less than human, so it didn’t matter” (Ishiguro 2005, 263).

These concerns are reflected in two of the most significant objections to markets in HBM, the objection from commodification and the objection from human dignity. While the two concerns are intimately related, it is a mistake to presume that they are synonymous, or that commodification of human beings is simply a subset of disrespect for human dignity. It is the objective of this chapter to unpack both the terminology and the arguments concerning human dignity and commodification and to examine how the sale of HBM from both living and deceased providers may wrongfully commodify human beings or fail to respect their dignity. In doing so, I hope to demonstrate that policy makers who seek to promote human flourishing and to ethically enhance access to HBM should eschew market systems in favour of alternative procurement strategies such as those I shall outline in Chapter 8.
7.1.1 The importance of defining concepts

The objections from dignity or commodification underpin much of the ethical opposition to markets in HBM, constituting *prima facie* arguments against markets regardless of their anticipated consequences. They also earn the most scathing criticism from market advocates. Unfortunately, such criticism is sometimes well founded. Invocation of human dignity or reference to commodification, are frequently used as trump cards in the market debate. Although the concept of human dignity is enshrined in documents such as the Universal Declaration of Human Rights (UN 1948) and thus carries normative weight, its content is by no means uncontested, nor are the implications of respect for human dignity universally recognized, let alone endorsed. Accordingly, while claims that markets in HBM violate human dignity and should therefore be prohibited are influential, they can only be effective in debate where the content and import of respect for human dignity in the context of sales of HBM are clearly defined. Opponents dismiss such claims on the grounds that it is a vague notion that at worst reflects an irrational repugnance for markets or at best represents shorthand for other ethical values such as respect for autonomy. Famously, Macklin (2003) declared dignity to be “a useless concept”, while Brownsword (2003) warns of a “dignitarian alliance” for whom it serves as a conservative constraint on science and biotechnology.

On the other hand, the failure of dignity advocates to clarify their arguments enables market supporters to invoke dignity in their own claims, such as Satel’s contention that dignity

> [can] be seen as a potent justification for supporting [organ sales], because compensation promotes vital features of human dignity as commonly understood: the advancement of freedom, the amelioration of suffering, and the preservation of human life. (2009, 78)

Although the definition of commodification is largely uncontested, its use in bioethical debate has become as value-laden as that of dignity. As Wilkinson points out, commodification has both descriptive and normative connotations (2003, 44). It is usually cited in the context of allegedly wrongful or inappropriate commodification of particular entities “which aren’t (proper) commodities (notably persons)” (ibid., 46). However, confusion is created when authors such as Cherry speak of donated organs, for example, as proper commodities (2009a, 360). If this were the case, then it would be absurd to critique the sale of organs as improper commodification as compared with the donation of organs. Thus, we encounter debate about whether payment for HBM necessarily commodifies the material in question, and/or its provider, and also whether
such commodification is itself necessarily immoral. To avoid linguistic ambiguity, M. Epstein for example instead employs the term “commoditisation” to distinguish the value-neutral process of “turning an object, which has not previously been a commodity, into a commodity” from “commodification, a value-laden term denoting any particular kind of commoditization of which the speaker is critical” (2010, 2).

Despite the failure of market opponents to fully capitalize on the strength of objections from dignity and commodification, these arguments should not be considered synonymous with irrational market repugnance, or dismissed as “knock-down” claims by the “enemies of medical and scientific progress” (Dickenson 2008, 167). Instead, the discomfort elicited by visions of global markets in which the poor systematically provide biological materials for use by the wealthy should be recognized as symptomatic not of defunct social mores but of the fundamental principles that shape human morality.

7.1.2 Overview of the chapter

I will begin by discussing the issue of commodification. Clarifying both the terminology and concerns inherent within the scope of this concept, I agree with market advocates who argue that the sale of HBM does not entail commodification of living human beings. However, I highlight a variety of ways in which markets in HBM risk commodifying living persons – an inevitably immoral practice. I further argue that only secondary commodification of materials obtained from deceased providers avoids this risk. I argue that commodification of HBM encourages the instrumentalization and objectification of HBM providers in a way that labour markets do not, despite claims that the latter should be seen as analogous to HBM markets (see Chapter 6.5). Further, in agreeing that commodification of HBM may occur in altruistic procurement systems, I show that this represents a problem with such systems, not a justification for commercial procurement. Commodification of HBM in general, usually in association with commercialization of healthcare and scientific research, may have significant negative consequences for individuals and societies.

In the second part of the chapter, I explore the concept of human dignity in greater detail, arguing that while respect for dignity implies respect for a number of moral principles governing the treatment of human beings, it is best understood as an active injunction to promote individual human flourishing rather than as a simple constraint upon actions. Thus, for example, while respect for autonomy requires us to obtain consent for provision of HBM from living persons, respect for human dignity obliges us
to address the needs of desperate prospective vendors without demanding biological materials in return. The third part of the chapter accordingly outlines an approach to the procurement, use and distribution of HBM that first and foremost seeks to promote human flourishing, thereby respecting human dignity and addressing the needs of all. I argue that markets will conversely drive HBM providers into the shadows, with commercialization and commodification of healthcare programs and human bodies encouraging the prioritization of financial concerns at the expense of efforts to meet fundamental human needs.

7.2 The Objection from Commodification

To “commodify is to fungibilise through, or because of, commerce” (Wilkinson, 2003:48). Wilkinson notes three components of commodification, “denial of subjectivity, instrumental valuation and fungibility” (2000, 94), while Radin outlines the following characteristics of “literal complete commodification”:

(1) Exchanges of things in the world (2) for money, (3) in the social context of markets, and (4) in conjunction with four indicia of commodification in conceptualization. Those four conceptual indicia characterize complete commodification in rhetoric. They are (i) objectification, (ii) fungibility, (iii) commensurability, and (iv) money equivalence. (1996, 118)

Radin further clarifies the term objectification as “ascription of status as a thing in the Kantian sense of something that is manipulable at the will of persons” (ibid.). As Wilkinson notes, treating certain things as commodities is not inherently problematic, but when used in the normative sense, commodification is “the inappropriate application of [the commodifying attitude] to entities which aren’t (proper) commodities (notably persons)” (2003, 46).

To understand and assess the Objection from Commodification, we must examine the following questions, which are frequently confused:

(i) When are HBM commodified?
(ii) What might be wrong with the commodification of detached HBM?
(iii) Does the commodification of HBM entail commodification of living human beings?
(iv) Is the commodification of human beings intrinsically immoral?
7.2.1 When are HBM commodified?

Primary commodification of HBM occurs when a living provider voluntarily receives a payment (or a fungible commodity) in return for her HBM. This includes both in vivo paid provision, and so-called “futures markets” involving a pre-mortem arrangement with the prospective post mortem provider, who may receive a payment while alive in return for bequeathing the use of some of components of her corpse, or the entire body to another person or company. Alternatively, the pre-negotiated payment may take place after death, with the profits being awarded to the vendor’s heirs.

Secondary commodification of HBM occurs when:

(a) payment is negotiated with the provider after the HBM has been removed, i.e. payment is not a motivating factor in the decision to have the material in question removed (voluntary secondary commodification); or

(b) the provider has not voluntarily negotiated a payment in return for her HBM but the material is traded or otherwise commodified by another agent, (involuntary secondary commodification).

An example of voluntary secondary commodification is that of the purchase of so-called “spare” (Ikemoto, 2009) eggs (and embryos) remaining after their donors have undergone fertility treatment, for use in either ART or research. The original donor may be offered an outright payment, or reduced costs for subsequent fertility procedures.

Cases of involuntary secondary commodification may involve voluntary or involuntary provision of HBM. Examples of the former include (informed and consensual) agreements to altruistically donate tissue that is subsequently commodified. For example, patients often agree to donate tissue that must be removed in the course of therapeutic procedures such as hip replacement. This tissue may later be sold to tissue banks that in turn sell the (modified) tissue for use in allografts or research (Hoeyer 2009). Similarly, hair donated by pilgrims to temples has been sold on the international market in vast quantities (Berry 2008, 65). In some cases, secondary commodification may be involuntary with respect not only to the sale of HBM but also to their procurement, for example organ procurement from executed prisoners, illicit procedures such as cadaver theft (e.g. Powell and Segal 2006) or the removal of organs or tissue during routine surgical procedures (e.g. Schepet-Hughes et al. 2000, 204).

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48 See Roberts and Throsby (2008) for a review of the complexities of oocyte “sharing” programs in the United Kingdom.
7.2.2 Are donated materials inevitably commodified?

Authors such as Cherry have argued that even altruistically provided materials are necessarily commodified, stating that donated kidneys are “as a matter of fact commodities” (2009a, 260). Wilkinson (2000, 194) also claims that the organ removed from a provider, whether freely given or voluntarily sold, becomes commodified in the sense that it is interchangeable with other organs, or potentially with money; that it has a primarily instrumental value for the recipient; and that it has no subjectivity. Of course, detached HBM are necessarily objectified. Once my appendix has been removed, my tooth pulled out, or my blood donation taken from me, these materials are all objects that may be used to a variety of ends. It also seems true that where detached HBM are used therapeutically, they are to some degree interchangeable and commensurable. For example, with the exception of rare immunological types, most blood provided is suitable for use by a range of recipients and each recipient is able to use blood obtained from a large number of providers. One provider’s blood is usually as therapeutically valuable as another’s and is hence functionally interchangeable. Organ matching is more specific, but from the perspective of many transplant recipients a number of organs would be of equivalent therapeutic value and hence interchangeable.

Interchangeability and commensurability of therapeutic value does not, however, constitute complete fungibility of value in HBM. From the perspective of a patient in need of HBM, only a therapeutically useful material can meet that need. Provision of money or other goods cannot fulfill the need for HBM. One transplantable kidney might be approximately equivalent to another, but neither is fungible with even a dialysis machine. They are only fungible where they may be exchanged for money that can purchase a therapeutic equivalent – which depends on the existence of a market in HBM, thus begging the question. From the perspective of providers, their relatives and even recipients, the personal value inherent in HBM means donated HBM are not fungible at all. Although my unit of donated blood may be functionally interchangeable with thousands of other units, for me it represents the fulfillment of a unique decision to help others. A deceased donor’s organs are also uniquely valuable to the donor’s relatives, despite their potential interchangeability with other organs received by an organ bank at the same time. Where payment occurs, however, the vendor deliberately renders the provided blood or organs fungible, making the material interchangeable with any other commodity in accordance with its exchange-value, and regardless of any personal value it may hold.
With respect to monetary equivalence, Cherry (2009a, 365-6) argues that kidneys for transplantation are exchanged in a commercial setting in which a variety of individuals profit from each organ transplanted. In addition, he suggests, transplant recipients who pay for their operation effectively purchase the organ itself. From the perspective of society, the cost of transplantation or the healthcare costs saved by transplantation further facilitate a monetary evaluation of organs, and other biological materials. This issue was discussed in Chapter 1, in which I argued that commercial provision of services involving HBM does not necessarily attach a commercial value to materials except where trading or brokering is involved. Only where altruistically donated materials become fungible in a monetary sense and tradable objects rather than simply exchangeable objects, acquiring an effective price rather than a cost of acquisition, do they become commodities.

Monetary evaluation of goods or services does not entail true fungibility or monetary equivalence, as attempts to commercially evaluate loss of life or injury for insurance purposes demonstrate. Those who can afford higher premiums may appear to set a particular economic value on their life – but this does not mean that their lives are literally more valuable (whether financially or personally) than those of the uninsured. The rhetoric of commodification may encourage actual commodification of HBM but does not entail it (Radin, 1996, 14).

Nevertheless, the commercial culture surrounding the procurement and use of HBM should not be dismissed as irrelevant, even where it does not involve the “literal and complete commodification” of HBM. Commercialization of healthcare, and of processes surrounding HBM procurement and distribution in particular, is likely to undermine efforts to prioritize the most urgent healthcare needs as well as equity in access to scarce resources (see Chapter 4.3.2). Rothman and Rothman (2006) and others have suggested that payment for organ or blood provision risks “crowding out” altruistically motivated providers and eroding societal altruism more generally (e.g. Titmuss 1997, 263-4). Mellstrom and Johannesson on the other hand, suggest that this problem could be overcome by offering providers the chance to donate their payment to charity (2008, 857). However, Dickenson further warns that increasing public awareness of commercialism in procurement and use of HBM will undermine support for altruistic HBM provision (2008, 39), especially I would suggest, in the setting of outright secondary commodification.
7.3 What’s wrong with the commodification of HBM?

In Chapter 4.3.3, I identified five categories of concern about commodification. These were: (i) practical barriers to commodification; (ii) corruption of value; (iii) violation of moral norms; (iv) violation of social norms; (v) harm prevention. Practical barriers to the commodification of HBM include opposition from potential participants in an HBM market, such as prospective vendors and healthcare professionals, as well as the difficulties in establishing and enforcing legislation governing property rights in materials such as human tissue that may be used in research. Although such problems may impair the efficiency of markets, it is likely that the actual commodification of HBM would be easily implemented into the already commercialized systems of healthcare delivery in many countries. Detached HBM, as I have noted, are already considered as objects and transferred between individuals with relative ease. With respect to concerns about harm prevention, I have already discussed the potential for commodification of HBM to reduce or increase the risks of harm to both individuals and societies in Chapter 5, concluding that although the evidence suggests markets will more harmful than beneficial, this claim is inevitably speculative. Finally, although in many contemporary societies the commodification of HBM violates social norms, this descriptive fact should not factor in our ethical examination of the issues of commodifying HBM, which essentially seeks to define appropriate social norms in this area. It should nevertheless inspire efforts to determine the validity of moral norms that may underpin social condemnation. Setting aside these categories of concern, therefore, I will now examine the remaining two: how the commodification of HBM may corrupt the value of these materials, and how it may violate moral norms.

7.3.1 Corrupting the value of HBM through commodification

As Chapter 3 demonstrated, a variety of values may be embodied in HBM, for example: therapeutic, symbolic, or personal value. Commodifying HBM - by according them commercial value and enabling their exchange within the market – does not necessarily impair therapeutic value, although if it results in an inefficient market it may do so. Also, I will argue, it does not necessarily obliterate the potential symbolic value accorded to materials. Symbolic valuations of HBM include that of the altruistic gift and that of the sacred. The corruption of the gift conception of HBM is sometimes identified as a concern for market opponents (e.g. Fox 2008; Sandel 2000). If HBM acquire commercial value through sales, it is claimed, those who wish to donate materials altruistically will find their gift corrupted, as it will be inevitably associated
with a price. However, as Mack points out, many gifts exchanged or offered have a commercial price that does not detract from their symbolic value (quoted in J.S. Taylor 2005, 158). Selling a kidney to provide for one’s family, or purchasing human tissue to perform research into diseases may well be inspired by altruism, for example.

Furthermore, although markets in HBM may negatively impact on altruistic donations in a “crowding out” effect, this is not inevitable. Although I am able to purchase a cake for my mother’s birthday, I prefer to bake one in order to demonstrate my affection. Similarly, I might choose to donate blood rather than to pay someone else to provide blood, demonstrating my willingness to make a personal effort to meet societal needs for blood. If HBM are commodified, a person might still choose to donate their HBM rather than to receive a payment, or may give the payment received for HBM provision to a charity, sustaining the altruistic symbolism of HBM provision (Mellstrom and Johannesson 2008).

Arguably, the sacred value sometimes accorded to HBM may also be preserved in the setting of commodification. After all, we buy and sell gravestones, religious paraphernalia and other objects that may acquire a sacred value. Of course, once accorded sacred value, such items are rarely – if ever – considered or treated as commodities. It is more difficult to preserve the sacred in the setting of commodification than it is to preserve altruistic value. Although some sacred items are commercially produced and sold – such as rosary beads and religious statues - the sacred value accorded to HBM arises by virtue of their origins as part of human bodies. They may be commercially acquired or transferred, but it seems incongruous to speak of commercial production of HBM. To do so would involve the commodification of living human beings – an issue I shall discuss shortly. Sacred valuation of HBM is usually grounded in personal value. For example, a woman who believes her placental tissue is essential to the spiritual wellbeing of her child may disregard any potential commercial value in the tissue. No other item, not even another woman’s placental tissue can ensure the safety of her child’s soul (Birdsong 1998, 191). To commodify this tissue would corrupt its sacred value, however this does not necessarily preclude the commodification of potentially sacred materials. Although some members of society may be horrified to witness the commodification of HBM deemed sacred, as long as their own materials may be excluded from the market, their value will be preserved.

Commodification of HBM likewise does not necessarily obliterate the personal value of HBM, although it may impair efforts to respect all dimensions of such value. These dimensions are (i) biological or genetic identity; (ii) personal or social identity; (iii) a
controlling interest in the disposition and treatment of one’s HBM (see Chapter 3). Procurement of HBM - whether commodified or not - risks impairing each of these aspects of personal value in HBM. Genetic and biological information requires protection, and the rights of an individual to determine the conditions of transfer and use of their detached materials will vary according to circumstances such as the use to which it is put, the conditions of provision and the extent of information provided when obtaining consent to procurement and use of HBM. When materials are transferred and used by others - or even discarded – the provider or their relatives may experience this as a surrender of personal value, regardless of whether commodification occurs. Nevertheless, commodification is more likely to obliterate or corrupt personal valuation of HBM, as a commercial transfer of goods – like most forms of property sale – implies a permanent relinquishment of interests in the commodity.

Whereas other forms of exchange or good provision often imply a reciprocity in social relationships and some degree of obligation on the part of the recipient to honour the interests of the provider, for example by preserving a gift or using the good for the purpose intended by the provider, trade usually discharges mutual obligations at the point of sale. Recipients are free to treat their new property as they wish because the vendor’s payment has effectively effaced her interests in the commodity. Although conditions of sale may be imposed to limit the set of property rights in traded commodities, for example by prohibiting destruction of the commodity, the exchange relationship between vendor and buyer customarily ends at sale, unless a temporary loan rather than a permanent sale is involved. Consequently, although an organ recipient might feel equally grateful to a vendor or to a donor, and each provider may preserve an interest in the outcome of the transplant and feel that the recipient should strive to ensure the organ is not wasted or destroyed through inadequate care for their health, such feelings and obligations are eroded in the market setting. My mother, for example, is more likely to appreciate and store carefully my home made birthday cake than she would an equally delicious commercial bakery product.

Commodification of HBM, by obscuring the personal value of the body, contributes to its dehumanization. Dickenson argues that the commodification of HBM ignores the inherent “strangeness” of the body – its unique value or nature:

The body both is, and is not, the person. But it should never be only a consumer good, an obscure object of material desire, a capital investment, a transferable resource: merely a thing. Our consciousness, dignity, ngeia and human essence are all embodied, caught up in our frail human bodies. The body is indeed like nothing on earth: not no one’s thing, but no thing at all. (2008, 168)
Subtracting the historical narrative of HBM providers leaves behind only objects of therapeutic or commercial value. Sharp (2001) and others (e.g. Schepers-Hughes 2002; Barilan 2005, 201) have warned of the dangers of such fetishization or commodification of the body in medical practice. Denaturing, as it were, the deceased organ provider, helps to facilitate the work of medical professionals who might otherwise struggle with the emotional impact of their tasks (Sharp 2001, 123), but it may also obscure important facts about donor populations. Gender, age, socioeconomic or ethnic bias in risk factors for accidents that contribute to the availability of deceased providers, for example, may be disguised when only the organs and their recipients are noted. For example, in Saudi Arabia approximately 30% of the population are non-Saudi citizens and this group represents 54.1% of potential deceased providers (SCOT 2009, 54), likely due to a higher proportion of foreign workers engaged in high risk employment activities such as driving and manual labour. However the number of non-Saudi citizens receiving transplants is unknown, as well as the exact number of actual organ providers who are non-Saudis. Although 16.5% of haemodialysis patients in the Kingdom are non-Saudis (ibid., 37), some of these may be fee paying foreign patients rather than resident workers.

Despite the depersonalization of organs in even non-commercial transplantation programs, Sharp notes that, “Donor kin … in contrast to professionals… persistently view donors’ bodies not as objects, things, or commodities, but as lost loved ones” (2001, 123). Sharp (Ibid., 125) describes the efforts that kin may make to preserve personal connections with the deceased, including tracing transplant recipients and creating public memorialization projects. Similarly, living providers of biological material, particularly gamete providers, may feel a need to preserve connections by maintaining contact with recipients of the materials or by receiving reports on their progress (Kalfoglou and Gittelsohn 2000, 803; Kenney and McGowan 2010, 464-5).

Where primary commodification or voluntary secondary commodification of HBM occurs, in which materials are sold by the provider, personal values may remain, but practices that maintain or reinforce such value may be discouraged or disabled. By engaging in a contract to sell, vendors typically sever the legal and social rights which personal value in biological materials normally accord them. To sell something of personal value is usually to surrender it completely. In the case of involuntary secondary commodification, those for whom the HBM sold has personal value may see commodification as disrespectful of that value, or as a violation of the personal interest the provider had in determining the treatment of her own material. Where involuntary
procurement is involved, the violation of bodily integrity will be compounded by the commodification of the stolen material.

7.3.2 Distinguishing between commodification and instrumentalization

As discussed in previous chapters, the commodification of HBM may result in the violation of moral norms, for example by exploiting, coercing or otherwise harming vendors. I have argued that markets in HBM do not inevitably violate such norms, thus I shall not revisit them in the context of the objection from commodification, although they fall within the scope of the broader commodification argument against markets. Instead, we must now consider whether commodification may intrinsically violate moral norms. Although commodification may be judged unethical if it impairs important values or results in unethical practices, it is intrinsically immoral only where it entails treating that which should never be treated as a commodity. This concept is often expressed using Kant’s maxim (1950, 96) that we should always treat others (and ourselves) as ends, never solely as means to another’s ends (e.g. Davis and Crowe 2009, 597). Consequently, some authors dismiss the objection from commodification on the grounds that where (in primary commodification) providers consent to the sale of their HBM in order to accomplish their own purposes or where (in secondary commodification) the sale of the material has no (obvious) impact at all upon the treatment of providers, no providers are wrongfully instrumentalized or objectified and are therefore not commodified.

For two reasons, it is important to distinguish concerns about commodification from the Kantian injunction. Firstly, conflating the two risks neglect of unethical practices that might instrumentalize providers without literally commodifying them. Secondly, the ease with which Kantian-framed concerns about commodification are dismissed by appeal to the autonomy (or voluntariness) of providers detracts attention from the broader concerns about commodification such as those identified in the previous section. Nevertheless, the commodification objection shares common ground with that of Kant’s maxim. The wrongful commodification of a particular entity entails the denial of its intrinsic moral status. At least in so far as living persons are concerned, I have argued that each should be considered a unique subject of equal moral concern (Chapter 2). To commodify a living human would inevitably deny this moral status not only by treating them as an object and effectively instrumentalizing them (thereby violating Kant’s maxim) but also by treating them as fungible, which effectively erases any concern for them as a unique subject.
In Chapter 2, I discussed the moral status and value of living persons, arguing that the core of morality consists in recognition of individual living human beings as moral subjects of concern. Irrespective of the broader content of different moral systems, I argued that each person possesses a place in the moral framework of society with fundamental rights to autonomy and bodily integrity, and a fundamental interest in flourishing as an individual and as a member of society. To commodify a person would be to deny her moral status, to treat her as no more significant, in a moral sense, than any tradeable object.

The institution of slavery exemplifies the commodification of human beings. To engage in outright commodification of human beings would require either trade in entire living human bodies or the nonconsensual procurement and sale of biological materials from living humans, which would be a violation of bodily integrity on a par with slavery. Any in vivo involuntary procurement of HBM for the purpose of using that HBM for monetary or therapeutic gain constitutes commodification or instrumentalization of the provider respectively, by treating the body of a living person as a source of capital or therapeutic resource without regard for her status as a moral subject. For example, a debt collector who forces a farmer to sell a kidney treats him as a commodity for he views the farmer’s body as an object with monetary equivalence.

Commodification of persons is intrinsically wrong because it denies the moral status of living persons. Any (pure) instrumentalization of a person denies her moral status and enables her unethical treatment, but commodification – by ascribing a fungible value to persons – obliterates all concern for the human being in question. Treating someone only as a means effectively ignores their moral status as a human being, but commodifying them may go further: instrumentalization is compatible with recognition of a unique identity (albeit objectified), but commodification removes even that possibility by rendering the individual interchangeable with any other commodity.

However, as I noted in Chapter 3, detached HBM do not possess the same moral status as living persons. They are not moral subjects of concern, although they usually possess important personal value of concern for moral subjects. Commodification of detached materials does not, therefore, wrongfully treat these materials – as they are already objects rather than moral subjects. Commodification of HBM is consequently

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49 Trafficking in human beings for body parts is a contemporary example of such commodification. See Francis and Francis (2010) for a review of coercive organ provision in the context of human trafficking.
not intrinsically immoral, except where it may involve the commodification of living human beings.

7.3.3 Does the commodification of HBM entail commodification of living persons?
Most proposed schemes of commercial HBM procurement do not involve the commodification of persons – the sale of entire living human beings or the involuntary in vivo procurement of HBM – but only voluntary sales of HBM. Would the commodification of HBM in such circumstances result in the commodification of vendors? Obviously if one were to sell a part of oneself which is necessary for personhood, such as life-sustaining organs including one’s brain, one would be commodifying oneself – or rather destroying one’s capacity to be a person through a process of commodification. However, as Wilkinson argues, “it is possible in principle for a person’s body to be commodified without the person herself being commodified” (2000, 196):

I might buy an organ from a friend for a ‘generous’ fee (because she needs the money and I need the organ), fully commodify her organ, but nevertheless not commodify her: i.e. I could continue throughout to regard her (qua person) as (a) having morally important subjective preferences etc. (b) non-instrumentally valuable, and (c) a unique and incommensurably valuable individual. (Ibid.)

This possibility hinges on the issue of vendor autonomy and on the attitude that buyers adopt towards vendors. I have argued in Chapter 6 that autonomous sale of HBM is possible. Objectification, or the failure to recognize an individual’s moral subjectivity, occurs when a person’s autonomy is not respected – for example when a vendor is coerced or not enabled to provide free informed consent. By respecting the vendor’s desire to pursue her own interests by selling her own HBM, purchasing her HBM is no more objectifying her than engaging in any other voluntary market transactions. Although I may think of the material in question as an object with instrumental value to me, by ensuring that the vendor wishes to sell me the material I am respecting her moral status as a person.

However, although the consent requirement may diminish concerns about pure instrumentalization or objectification of vendors, it is probable that in the impersonal context of markets the necessarily procedural nature of the autonomy requirement will minimize appreciation for vendors as individual subjects with their own interests. (This may be true of many suppliers of market goods, or even of altruistic HBM donors). Providers are often invisible to the ultimate recipients of their goods, and intermediaries or other brokers are interested purely in the quality or price of the goods and while
respecting supplier voluntariness, make no further effort to value them in the manner described in Wilkinson’s idealized example. Nevertheless, so long as valid consent is obtained, vendors will not, strictly speaking, be completely commodified\(^{50}\).

However, commodification of HBM may result in harmful effects on societies at the individual level – for example, where persons feel degraded by selling their own materials, or where children produced using purchased gametes feel degraded (e.g. Fox 2008, 165) – or in the context of interpersonal relationships – for example, where the bodies of loved ones are sold. Selling HBM may be experienced as symbolic sale of a person. Selling one’s own materials, like buying those of another person, or selling a relative’s body after their death, may be viewed as tantamount to selling people.

### 7.3.4 The dangers of partial commodification

It seems peculiar to claim that I can commodify my kidney, liver or blood, without commodifying my embodied self. My kidney, as an integrated component of my living body, is part of the “me” that has a unique moral value and subjectivity – commodification of which would violate the most basic tenet of morality. And yet from the moment I agree to have this kidney detached in exchange for a sum of money or equivalent good, it becomes a commodity, no more or less than its monetary equivalent, no more valuable or meaningful than an expensive television, a bathroom renovation or year at college. In effect, where primary commodification occurs, the living human body is partially commodified. While the mere possibility of markets makes HBM and human bodies potential commodities in theory, where commodification of detached materials occurs the body literally becomes partially commodified. I prefer the term “partial commodification” to that of “incomplete commodification” because the latter implies that the object being sold is not yet entirely considered a commodity. Partial instead refers to the fact that not the entire human being but only a part of the physical body of the individual is commodified. The material that is commodified however, is truly, not incompletely, commodified.

What might happen if we begin to think of our bodies as collections of parts that might be cashed in for money? The depersonalization sometimes witnessed in deceased organ provision would then extend into the lives of living human beings. Cherry argues that

\(^{50}\) By commodifying his friend’s organ while it is presumably an integral part of her living body, Wilkinson performs a Cartesian sleight of hand. He distinguishes between his friend and her detachable organ, although at the time of his offer this organ is no more properly thought of as a commodity than the entirety of her body. (See 7.3.4)
the more body parts are like other replaceable objects… the more it becomes plausible that they should also be open to being bought and sold on the market. A necessary condition for the legitimacy of a market in organs will be that the organs bought and sold are not integral to persons but can be conceived of as outside of the essential core of personal embodiment. (2005, 28)

The potential impact of such thinking on societal practices, social relationships and personal identity is likely to be profound. While K. Smith (1999) outlines the changes to legislation in the United States necessary to facilitate a securities market in which HBM might be used as debt collateral, a few authors have expressed concern about the possible implications of identifying financial capital in the human body, and how this may transform financial and social welfare institutions, healthcare services and insurance, to name but a few51. Should eligibility for welfare be partially determined by the extent of detachable materials that individuals could use to secure basic needs? Will the stigma of sale be attached to the poor? Could a healthy young man use his body as collateral against a house mortgage? Will doctors be held responsible for medical care that fails to optimize the value of particular parts? Should people considering marriage or children factor the potential commercial value of their respective genetics and health into their decision-making? At a more personal level, how many people will be unable to resist contemplating their body’s commercial potential and perhaps gradually to dissociate from parts that risk being sold?

A response to such questions may be that the increasing therapeutic potential of HBM means that we might already consider ourselves to be collections of potential resources or “spare parts” (e.g. Schweda and Schicktanz 2009b). From the perspective of public health policy, this may well be the case. Concerns about optimizing procurement and enhancing public participation in donation programs encourage the adoption of an attitude towards the body as an object that may or should be partially fragmented for use by others. The key difference however, is that in the absence of commercial procurement, the potential objectification and fungibilisation of HBM is heavily mediated by appreciation of social and personal value in HBM. The ‘gift’ of HBM involves a sharing between donor and recipient – however anonymously - while participation in public activities for mutual benefit unites all potential donors and recipients. Although individual personal value may be subsumed, it is transformed into a social value that connects rather than disconnects individuals. The relationship bonds

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51 See e.g. Fox (2008) on the “eugenics” of commercial gamete provision. Note that while Demme (2010, 48) considers the possibility of kidneys being called in when debtors default on loans, Cohen (2003) describes this very practice in Chennai, India.
of giving and sharing are usually socially cohesive (T. Murray 1987), whereas those generated by trading are contractually terminated.

Fears about the commodification of HBM are, in many respects, merely hypothetical. Furthermore, in practice the effects of commodification are likely to be subject to significant contextual variation. B. Parry, for example, warns that

In thinking through the very pressing question of how [transactions in HBM] might be understood, characterized and regulated we must learn to look beyond the dominant orthodox model of economics and towards other more imaginative and diverse formulations. These ought ideally be highly plural and diversified approaches that are responsive to the very local, geographically specific, and highly differentiated modes of bodily commodification that currently inhabit the realm of tissue circulation in this bio-political age. (2008, 1144)

We must turn therefore to related concerns about respect for human dignity in the setting of sales of HBM. I will show that commodification of living persons is an instance of violation of human dignity, but that the implications of respecting dignity consist of more than a prohibition of commodification.

7.4 The Objection from Dignity

Respect for human dignity may be invoked as an objection to markets in HBM in support of a variety of more explicit arguments. Although I shall argue that respect for dignity does indeed incorporate a wide set of principles governing the ethical treatment of human beings, it is more than the sum of these parts. The various conceptions of human dignity, for example as an ascription of moral status, a prohibition against instrumentalization of persons, or even a purely psychological phenomenon, contribute to the astonishing degree of confusion, conflict and controversy found in debate. Many of these different perspectives are valid and important components of the dignity concept. The implications of the dignity principle are not, however, overly complex. When understood as an injunction to acknowledge the moral subjectivity of living human beings and to therefore promote human flourishing, respect for dignity becomes a simple first principle of moral systems that will inform and guide the development and implementation of ethical practice in the treatment of HBM. I will begin with a review of the main criticisms of the dignity concept, particularly as it is invoked with respect to the sale of HBM, in order to better avoid these pitfalls in my own account. Having outlined a clearer conception of dignity, I will reconsider the objection from dignity.
7.4.1 The problem with ‘human dignity’

Three major complaints are made concerning the invocation of human dignity in bioethics debate. Firstly, it is claimed that dignity is introduced in debate as a sort of trump card, without any attempt to substantiate the concept or the argument it supposedly represents. Secondly, as Macklin (2003) argues, dignity at times may seem to be simply an umbrella term or synonym for better-defined ethical values such as autonomy. Thirdly, dignity is described as a vague or nebulous concept that at worst… [is] used as mere rhetorical dressing, adding little weight to the policy debate than the weight or cachet of the concept. In such circumstances, dignity conveys a sense of general social unease, but with little explanation of how, exactly human dignity is threatened. (Caulfield and Chapman 2005, 737)

Such criticisms are well founded in the context of debate regarding markets in HBM. All too frequently, market opponents refer simply to the “fact” that sale “violates dignity” without attempting to defend or explain this claim. While it may be supposed that audiences are familiar with the content of the dignity objection, or at least with the principle of respect for dignity, this is unlikely to be the case. Even the UNESCO Declaration of Bioethics and Human Rights, which repeatedly refers to the need to respect human dignity, makes no attempt to outline an account of this value (UNESCO 2005).

The failure of market opponents to articulate comprehensive accounts of the objection from dignity lends weight to the claim that the “dignitarian” stance is indicative of “repugnance” towards markets that has no foundation in rational argument. On the contrary, however, I will show that consideration of human dignity informs not only the issue of organ sales, but also much broader questions regarding the procurement, use and distribution of all HBM within societies.

7.4.2 Reframing human dignity

In Chapter 2, I described human dignity as the moral status or worth of living human beings. Respect for dignity, in this sense, consists in acknowledgement of that status and recognition of the obligations that derive from it. Failure to recognize other human beings as subjects of moral concern means that we risk treating them like ordinary objects. Respect for bodily integrity and autonomy, for example, have meaning only because of the characteristics of moral subjects. Respect for dignity therefore prohibits, at the very least, the outright commodification of persons on the grounds that commodification denies moral subjectivity. The non-instrumentalization of human beings as outlined by Kant, is another element of this core content of respect for dignity.
To treat another merely as the means to one’s own ends denies her inherent moral status: the recognition that the other has ends of her own.

Of note, dignity is not simply a badge that entitles the bearer to have their autonomy respected. If I walk past a man dying in the street, I do not violate his bodily integrity or his autonomy, nor do I instrumentalize or commodify him, but I fail to respect his dignity. Without actively mistreating him, I fail to treat him as I ought. If I were to toss my banana skin at the man this would also violate his dignity. Both my failure to act – to offer comfort or assistance - and my action – throwing rubbish – constitute treatment inconsistent with respect for human dignity. Although, as I will shortly discuss, it can be difficult to determine exactly what is required of us by respect for human dignity, it is relatively easy in many cases to identify actions that are inconsistent with respect for dignity.

An objector might suggest that my failure to act is merely an instance of failing to act beneficently by helping a fellow human in need. In throwing rubbish, likewise, I am simply violating the principle of non-maleficence. But these principles fail to adequately capture what is at stake when human dignity is invoked. For example, application of the principle of beneficence to everyday life is exceptionally problematic. Must I spend my entire day identifying opportunities to help other people? While I might be particularly virtuous if I did so, it is absurd to suppose that a well-functioning human society will require its members to act beneficently at all times. It would also be difficult to provide a universalizable rule for beneficence in practice. Imagine, for a moment, if the man I pass on the street has merely dropped a shopping bag and is struggling to collect its contents. It would be kind of me to help him. My failure to do so, however, is not a violation of his dignity. I can see that he is able to repack his bag: I would simply be helping him to save time and effort by assisting.

Recognizing the dying man as a person requires me to treat him as such, to relate to him as a fellow member of human society, like myself, with needs and desires. Nussbaum quotes Grotius when she writes that

> when we think about fundamental principles, [the way to begin] is to think of the human being as a creature characterized both by dignity or moral worth and by sociability: by “an impelling desire for fellowship, that is for common life, not of just any kind, but a peaceful life, and organized according to the measure of his intelligence, with those who are of his kind.” (2006, 36)

She describes human dignity as being inextricably entwined with certain capabilities,

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52 Although in my example the subject of my ethical obligation is in my immediate vicinity, the same principle may be applied to distant others.
Dignity is not defined prior to and independent of the capabilities but in a way intertwined with them and their definition… The guiding notion therefore is not that of dignity itself, as if that could be separated from capabilities to live a life, but, rather, that of a life worth, or worthy of, human dignity, where that life is constituted, at least in part, by having the capabilities on the list. (Ibid., 162)

Respect for dignity therefore requires us to help ensure that each human being is able to pursue a life worth living: one in which the individual is able to exercise the typical capabilities of human beings, (for example those proposed by Nussbaum (2000, 418-21)); to have basic human needs met and thereby to flourish, to some extent, as a member of human society. Although we cannot define for each society, let alone for every individual, the content of human flourishing, by promoting the essential human capabilities we can help to ensure that all human beings are minimally equipped to pursue their own ends and life goals. Even though I may be unable to save the life of the man on the street, he is not presumably enjoying a life worth living. To offer him the personal contact of another human being if he desires it, to try and meet his immediate needs – perhaps for comfort or shelter – would be to provide the very minimum that one would expect in order to respect his dignity.

The obligations implied by respect for human dignity, because they seek to guarantee the most urgent of human needs and to secure the most fundamental objectives of (a minimally conceived) flourishing human life, should be priorities for society. Furthermore, the obligation to respect the dignity of others by securing these fundamental needs must be largely unconditional. If, for example, I offer to assist the dying man on the condition that he gives me his wallet, I am not truly respecting his dignity because such an offer implies that his refusal would absolve me of the obligation to assist. This does not mean that respect for dignity would justify a society in which the wealthier members systematically provide for the poor without any reciprocating efforts. Where the poor are enabled to live lives worthy of human dignity through the securing of basic capabilities, they will be better able to participate in common societal endeavours and activities.

7.4.3 Reviewing the objection from dignity
The objection from dignity claims that sales of HBM fail to respect the dignity of vendors and are therefore unethical. Based on the above account of dignity, I suggest that sales would violate dignity where payment for HBM constitutes omissive coercion (see Chapter 6), that is, where it makes fulfillment of the prior obligations of respect for dignity conditional on provision of HBM. For example, purchasing HBM from
communities that have no other means of providing for their needs with respect to basic healthcare, education, food or shelter, violates respect for their dignity. Surely, one might suggest, trading with such communities in any form is therefore disrespectful of dignity. If I offer to pay a very poor man in exchange for his labour or his remaining property, so that with my payment he can purchase necessary healthcare – is this not equally objectionable? Two factors will determine the answer to this question. Firstly, will the offer undermine the vendor’s ability to flourish? That is, where the sale of labour, property or HBM physically, financially or socially impairs the vendor’s capabilities, it is likely to be disrespectful of human dignity. Secondly, trade in this context should be primarily aimed at enabling vendors to secure the requirements for flourishing. While trade may in some circumstances be a necessary mechanism to promote the wellbeing of individuals and communities, for example by providing them with a sustainable source of income, only trade that offers the best available method for securing the requirements for flourishing can be deemed respectful of dignity. In some cases this may be mutually beneficial, promoting the interests of both vendors and purchasers, but it ought to maximally advantage the least well off from a capabilities perspective. Minimal advantages to those lacking the basic requirements for a life worthy of dignity cannot be used to justify transactions that maximally benefit the more fortunate, as respect for human dignity requires the former to be prioritized.

Where markets in HBM are concerned, this means that purchasing organs from those suffering extreme poverty would be disrespectful of human dignity except where such a market offered the best or only way to provide for the basic needs of the poor. It is difficult to imagine a real world scenario in which organ markets would fulfill either of these criteria. Thus perhaps, as M. Epstein declares, “it is not transplant commercialism that violates human dignity but rather the society that forces many of its members to consider transplant commercialism as a viable option” (2009:136).

On the other hand, purchasing organs or other HBM from people who possess the full range of capabilities for flourishing would not necessarily violate human dignity, in so far as respect for dignity imposes an obligation to ensure the capabilities of others. However, with respect to the recognition of the moral status of human beings, purchasing HBM may still violate dignity. Where sales of HBM commodify or partially commodify living human beings, depersonalizing or objectifying them, this violates

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53 Note that this may be the case even where the deal is not exploitative. For example, if the social stigma attached to acceptance of the offer impairs the vendor’s ability to engage in rewarding social relationships.
respect for dignity. Throwing rubbish at a person lying on the street denies their status as a human being – regardless of whether it hurts them, or even whether they are aware of it. It is something that simply is not done to human beings. Violating the social norms of treatment of living human beings, or deceased human bodies for that matter, contributes to stigmatization of certain people as somehow less than human, and hence may legitimize or encourage treatment inconsistent with other moral norms such as non-maleficence, justice, and so on. Thus in a society in which all members have their basic needs met, the sale of blood may nevertheless stigmatize groups more likely to sell – such as the relatively poor – creating a social divide in which vendors are identified as less worthy of respect; their lives less valuable (e.g. Kretzmann 1992).

Visions of regulated markets in the context of idealized societies may be consistent with respect for the dignity of HBM vendors in some cases. In practice however, the realities of markets and the features of modern society, in addition to the gross inequities currently prevalent in even the most fortunate nations, appear to offer little hope for markets that will respect the dignity of all participants. Taylor’s proposal (2005, 196) regarding the possibility of large-scale exportation of HBM from extremely underprivileged societies throughout the developing world, to be used by wealthy foreigners, should provoke discomfort. Less dramatically, the knowledge that the already neglected and near invisible members of underprivileged groups within societies are to shoulder the burden of HBM provision should prompt careful reflection. The politically and socially silent expatriate workers within Saudi Arabia who provide organs for Saudis upon dying are not the worst off of organ vendors in the world, but they are eerily close to the clones of Hailsham who live separated from the society they supply with HBM.

7.5 Beyond the market

The arguments and objections regarding markets in HBM discussed in this and previous chapters paint a challenging picture for policy makers concerned with improving access to HBM without violating fundamental ethical principles. Although consideration of market mechanisms to improve HBM supplies is understandable in the context of contemporary market-based societies, policy makers and ethicists may err in prioritizing these. That is, market strategies appear to be the default practical setting in the debate, with the presumption that unless insuperable opposition to the market is established, markets offer the best solution to meeting needs for HBM. I reviewed this claim in Chapter 5 in the setting of the Argument from Life-Saving Necessity, arguing that
markets are not the only possible solution, nor the best. Efforts to develop more effective strategies to meet needs for HBM are hampered by the predominant focus on individualized policies and the presumption that the market model must be excluded before seriously considering alternative strategies. In the following chapters, I will outline an alternative vision of ethical policy making with respect to the treatment of HBM. By reframing the concerns and challenges of procuring HBM as a shared social issue that should prioritize respect for human dignity rather than a set of conflicting human needs that can be met only through a market based system of individualized trading, I suggest that more universally acceptable and effective solutions will be developed. In the remainder of this chapter, I review the ethical principles and values that have been identified throughout the debate as important priorities for societies.

7.5.1 Moral, social and policy priorities for the treatment of HBM

The procurement, use and distribution of HBM represent a major practical and social issue for contemporary societies. A significant proportion of therapeutic needs for HBM are currently unmet in many countries (see Chapter 1), and many of the existing markets in HBM – both legal and illegal – are characterized by inequity, exploitation and harm to both vendors and recipients (see Chapters 4 and 6). In addition, “shadow markets” in which donated HBM are secondarily commodified risk impairing support for altruistic donation by undermining the ethos of public contributions to shared public benefits.

I suggest that the following principles and values should be used to guide policy-making regarding the treatment of HBM:

(i) **Respect for human dignity:**
By recognizing “the equal dignity of each and every human life” (Nussbaum 2006, 270), therefore prohibiting commodification of living persons, and prioritizing efforts to provide all with the capabilities for flourishing;

(ii) **Respect for bodily integrity:**
By prohibiting involuntary procurement of HBM from living providers;

(iii) **Respect for liberty and autonomy:**
By enabling individuals where possible to pursue their own ends and to make decisions that are influential in their lives;

(iv) **Promotion of health:**
By enhancing equitable access to therapeutic resources and minimizing the risks of living HBM provision;
(v) **Promotion of social justice:**
By discouraging practices that exacerbate socioeconomic inequities, and by equitably promoting contributions towards and access to public goods;

(vi) **Recognition of the personal value of HBM:**
Through efforts to protect personal information and to prevent the expropriation and use of HBM where such treatment conflicts with the values of living providers; and through efforts to uphold and promote the expression of such personal value where desirable in the context of procurement and use of HBM, for example through practices that commemorate HBM providers.

In addition to this minimal set of conditions, I suggest that efforts should be made to promote human flourishing at the societal level by encouraging social solidarity, altruism and other values that will support mutually beneficial interactions between society members and participation in activities that contribute towards common goals.

### 7.5.2 Universalizability?

These principles and values are universalizable in the sense that human societies that recognize the equal moral worth of all members, and which therefore seek to protect and promote the wellbeing of all members, will be likely to endorse them. In practice, of course, there is room for considerable variation in the implementation of policy. For example, a society that regards the use of donor gametes or the destruction of placental tissue as immoral may seek to prevent such treatment of these materials. In practice, this means that some of the principles may conflict. Although respect for human dignity, bodily integrity and autonomy (negatively construed) constitute fundamental requirements for all moral systems, the other values may be subject to different prioritization in the context of different individuals and societies. The biggest challenge is likely to consist of conflicts between individuals who seek to purchase or sell their HBM and societies that judge trade in HBM to be unethical. Respect for liberty will be appealed to in these contexts as a right that should take priority over the mores of society.

Fortunately, in many cases the conflict between individual liberty and market prohibitions can be overcome. Liberty is often invoked in these circumstances solely as a means to justify actions that will result in access to HBM or financial payment. If
these needs can be met within non-market systems of HBM procurement, the freedom to participate in the market is no longer desired. Thus societies that strive to meet needs for HBM and to provide employment opportunities for its members without creating markets in HBM will circumvent these issues. On the other hand, where some individuals are explicitly denied access to particular HBM or subjected to allocation systems (in the setting of ongoing scarcity) that are considered unfair, the right to liberty may become an unavoidable issue. For example, homosexuals denied access to ART using third party ova, or alcoholics denied access to liver transplantation may argue that their right to liberty entails a right to access such materials if a provider is willing to sell them. I shall examine this issue and how it may be addressed in both national and international policies in the following chapters.

7.6 Conclusion – human flourishing as a social enterprise

The treatment of HBM is, I have argued, a particularly social concern, as the treatment of human beings and their bodies inevitably occurs in the context of social relationships. Furthermore, the extent of needs for HBM affects many people in most societies and effective efforts to meet these needs will depend on the maximal participation of society members in procurement programs. Although ad hoc commercial exchanges of HBM between individuals may in some cases be consistent with the ethical principles outlined above, and may help to meet the needs of specific individuals for HBM, they will not be practically effective in meeting needs and will expose participants to a variety of harms.

Similarly, although individuals pursue their own personal life goals and strive to flourish in unique ways consistent with their individual circumstances, talents and desires, the basic requirements for human flourishing, as defined in Nussbaum’s (2000, 411-426) account of capabilities, are best secured through societal efforts to provide and promote common conditions for flourishing. When pursued at the societal level, for example, efforts to eradicate extreme poverty and ensure universal access to basic healthcare will be more effective than free market systems in which individuals seek to secure their own advantage through private transactions.

Many advocates of trade in HBM dismiss concerns about commodification, even as they emphasize its dangers, by appeal to the consent criterion. For example, Dworkin declares:

The danger we want to avoid at almost all cost is that people start to be treated as property by others. But this is avoided by leaving all decision about their organs, tissues and so on to the person themselves, and insuring that their decisions are voluntary. (1994, 160)
The misguided emphasis on consent to sales of HBM promotes a conception of human society and morality as a temporary association of independent strangers who intermittently contract for (possibly) mutual advantage. Situating the procurement and distribution of HBM in the context of cooperative social communities will avoid the moral hazards of rivalrous individualism that thrives within markets peopled by desperate patients and vendors. Moazam et al. note that, “the international debate on organ commerce generally highlights the predicament of patients who die while waiting for transplantation. In contrast, the would-be providers of kidneys appear as faceless individuals merely exercising their right to sell an organ” (2009, 31). Their description of the miserable consequences of merely respecting voluntariness reveals the need for recognition of a rich conception of human dignity and a rigorous account of the effects of even partial commodification in the debate.

Finally, the tendency to highlight minimal gains for vendors of HBM should not be mistaken for the promotion of human flourishing. Far from respecting the dignity of those who may seek to sell their HBM in order to secure basic needs, as a justification for markets in HBM the alleged benefits to vendors simply take the edge off our discomfort at sales. It reflects the self-justification of the Hailsham staff in Ishiguro’s novel, one of whom while attempting to comfort a young man facing his final donation or “completion”, comments,

“You’ve had good lives, you’re educated and cultured. I’m sorry we couldn’t secure more for you than we did, but you must realize how much worse things once were.” (2005, 261)

As a strategy addressing the issue of poverty, or promoting liberty and autonomy, markets in HBM ring hollow. Furthermore, to suggest that markets enable us to better express our personal value and interest in our bodies and detached materials is misleading, given the customary effacement of such value by commodification. As a policy to meet needs for HBM, markets are ethically problematic and do not offer the most effective methods of improving access to HBM. In the next chapter I will outline a model of procurement that does.
The pursuit of self-sufficiency

The individual, when isolated, is not self-sufficing; and therefore he is like a part in relation to the whole.
(Aristotle 1996, 14 (1253a 26-9))

8.1 Introduction

The challenge for policy makers is to address needs for HBM while respecting the ethical values and principles outlined in previous chapters and, ideally, promoting additional social goals such as health and solidarity. In this chapter, I will introduce and outline the self-sufficiency model as an ethical and practical solution to the challenges of HBM shortages as well as harmful markets in HBM. Although imperfect, I argue that it offers the best approach for policy makers and is suited to a variety of different practical and socio-cultural contexts.

In The Politics, Aristotle’s account of autarkeia, or self-sufficiency, describes the importance of communal living, in which members of the polis are better able to flourish together than alone. I will argue in this chapter that the social nature of HBM procurement and use requires an approach by policy makers that is inherently communal rather than individualistic; in which social relationships rather than market contracts should be used to support the complex web of interactions involved in the provision and receipt of HBM within the state.

Humans are not self-sufficient since they need the company of other people and membership of the state if they are to achieve a life that is self-sufficient [in the sense of having all the goods that make life worth living]. Since that life must be complete, and so must not lack determinate types of goods, and since not all goods are economic goods, the state’s self-sufficiency requires more than that it meet the economic needs of its citizens. (Aristotle 1996, xxiv-xxv)

8.1.1 Defining self-sufficiency in HBM as a practical goal

The goal of self-sufficiency in HBM (or a specific kind of HBM) represents:

The achievement of a sufficient supply of HBM provided by the members of a given population, to meet the needs of that population.

In ordinary usage, the term self-sufficiency refers to an independent capacity to provide for one’s own needs without help or reliance on others. Self-sufficiency in HBM similarly implies self-reliance and independence in meeting needs for HBM at the level
of a population or community. In practice this means avoidance of outsourcing\(^*,\) and efforts to sufficiently meet population needs. The pursuit of self-sufficiency in HBM has also traditionally been qualified by the prohibition of payment for providers, a feature which will be discussed further below.

*Populations* pursuing self-sufficiency may be defined as groups of individuals functioning as self-governing communities, where individual members possess an equal right to have their potential needs for HBM met. Although any group or community might choose to pursue self-sufficiency with respect to a particular HBM, numerous practical factors will determine the feasibility of specific populations. These include population size, the degree of genetic heterogeneity, and the incidence of needs for particular HBM, which will influence the likelihood of suitably matched materials being available to those in need within the population. Other factors include the availability of shared or cooperative medical and political infrastructure so as to organize and oversee the integration of requisite healthcare services. In practice, such populations will be bound by geographical and jurisdictional limits, usually defining membership as residency or citizenship of a nation state. It must be noted that the intent of this definition is not to limit the number of people whose needs will be considered, but to identify those who are responsible for meeting needs; that is, the same people. In addition, it aims to ensure that the population considered is a structured society equipped with governing authorities able to oversee the implementation of policy.

True self-sufficiency should be defined in an empirically consistent manner, enabling international comparisons, systematic evaluation of progress and transparent assessment of efforts to meet all genuine needs. I have already highlighted the ambiguity of current estimates of need for HBM, (see Chapter 1), which may be influenced by rationing criteria or barriers to accessing health care. With respect to the therapeutic use of HBM, excepting gametes, I suggest that satisfaction of (therapeutic) needs\(^{54}\) be defined as follows:

> The provision of timely access to therapeutic procedures, including the provision of suitably matched human biological materials, for individuals for whom access to such treatment represents the optimal method for restoring health\(^{55}.\)

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\(^{54}\) By *therapeutic need*, I refer to an immediate individual need for HBM in order to overcome current ill health or disease, rather than potential *research needs* for materials that might be used to develop therapies for disease.

\(^{55}\) This definition was originally developed with Dr Luc Noël at the WHO in 2009.
8.1.2 Defining needs for gametes

Therapeutic needs for gametes are more difficult to define. Although medical infertility represents a pathological deviation from normal human functioning parameters, so-called “social infertility” arises because individuals or couples seek to procreate outside of the normal biological parameters of the human species. Evolving social customs in many societies have resulted in increasing support for single people and homosexual couples seeking to create children, although legislation in many countries continues to exclude non-traditional patients from access to assisted reproductive therapies (e.g. Storrow 2007, 2290). However, the desire to create a child is not always rightly considered a genuine need. For example, how should we regard the desire of a man who has already produced three children to have a child with a new partner, or that of a woman who has never produced children who wishes to do so at the age of seventy?

The opportunity to reproduce or to raise children is an important biological and social element of human flourishing for many people. In some cases, meeting needs to reproduce requires medical or surgical prevention or treatment of infertility without recourse to third party gametes. In cases where access to gametes from third party providers is desired, it may be difficult to determine whether use of such gametes is in fact the optimal treatment for the infertile couple or individual. While the ultimate purpose of treating infertility is to enable people to become parents, the secondary aim of treatment using third party gametes in some cases may be to produce a partly genetically related child; to carry a (genetically unrelated) child through pregnancy; or to produce legally recognized offspring when alternative methods such as adoption are denied or unavailable. For some, the secondary advantages of reproducing use third party gametes may drive demand for gametes even where alternative opportunities for parenting are available, and access to gametes may represent the optimal treatment from the patient(s)’ perspective.

Given the additional social complexities of defining infertility, and of determining when, if ever, access to third party gametes represents the optimal treatment of infertility, the definition of therapeutic needs for gametes will vary between particular social communities. Methods of defining needs and distributing available gametes, like those employed in the allocation of other HBM in the setting of insufficiency, must at the very least be transparent, open to community debate and revision and should strive to maximize both justice and efficiency. The goal of self-sufficiency with respect to therapeutic needs for gametes might be best defined as follows:
The provision of timely access to parenting opportunities, including therapeutic procedures for the treatment of infertility and access to donor gametes where necessary, for individuals for whom such access represents the best way to fulfil their reproductive goals and parenting potential.

8.1.3 Assessing research needs for HBM

For HBM used in research, in particular oocytes or other materials used in stem cell research or unproven experimental treatments, it is difficult, if not impossible to quantify needs. Even where a relative abundance of raw material such as human bone or tissue may be available to researchers, specific areas of research may require material from individuals with specific genetic or disease characteristics, creating significant demand for relatively rare materials. Furthermore, given the difficulty inherent in predicting the benefits of many forms of research, in particular stem cell research, efficient allocation of available materials to optimize ultimate therapeutic benefits will remain a challenge. The potential application of research benefits to distant populations additionally complicates the definition of research needs for HBM. Also, as scientific research increasingly takes place through international collaborations, the most effective use of scarce materials is likely to involve extensive sharing and exchange of materials across borders. Thus where research needs for HBM are concerned, while different communities should strive to contribute their own materials where needed rather than outsourcing demand to other populations, self-sufficiency may be best pursued on a much larger scale. Each population should take responsibility for contributing resources and protecting HBM providers and their materials, but where possible collaboration and sharing should take place to optimize the benefits for all (see 8.6.1).

8.2 The history of self-sufficiency

The concept of national self-sufficiency dates from the mid 1970s when the World Health Organization first began to advocate the promotion of national blood supplies from voluntary unpaid donors, and to discourage commercial outsourcing that posed quality and safety risks for recipients and possible exploitation of the poor in foreign countries (WHO 1975; Mayr 2005). Decades later, the most recent World Health Assembly resolution on blood again specifically encourages member states to pursue self-sufficiency in blood and blood products (WHO 2010a). Despite the dramatic progress made towards national self-sufficiency in blood and blood products, many countries are as yet unable to meet their own needs for plasma products and must rely
on commercially imported products. The United States supplies 70% of global plasma, of which it uses 40% within the US domestic system (Lamb 2009, 1520). The US plasma industry relies primarily on remunerated “source plasma” providers (T. Anderson et al. 1999, 139-40).

The failure to meet needs for plasma products within many countries is not wholly due to a shortage of willing plasma providers and will therefore not be resolved by offering payment to plasma providers. Instead, Rautonen (2010) identifies two factors impeding self-sufficiency in this area (within the European Union). Firstly, he notes that almost all plasma products and production processes are covered by intellectual property rights (IPR). . . . Due to IPR issues and the economies of scale, many low-volume products are manufactured by only one or at best a few producers. This means that even if a country were self-sufficient in some plasma products, it would nonetheless be completely dependent on free trade in meeting the domestic demand for the remaining products. (Ibid., 99)

Secondly, he points out that the differing productivity of plasma processors influences the amount of raw plasma required to meet needs (ibid.).

Other authors highlight the impact of transfusion protocols in minimizing inappropriate (and therefore wasteful) use of blood. In a Malawian hospital, for example, the use of guidelines decreased transfusion rates by 75% (Roberts et al. 2009, 259). The impact of such factors on efforts to achieve self-sufficiency in blood should not be underestimated, although the motivation of donors remains an important issue.

**8.2.1 The prohibition of payment**

A key element of the self-sufficiency model with respect to blood was that of unpaid voluntary donation. This condition was imposed on the self-sufficiency model for two reasons. Firstly, blood from paid providers was for a long time associated with higher rates of transmissible disease (Eastlund 1998). This was likely due to a number of factors, including higher rates of disease among the poorer populations more likely to sell blood and a tendency among paid providers to conceal risk information that might exclude them from selling (Buyx 2009, 332), less effective screening mechanisms in commercial procurement systems and infection of repeat blood vendors during procurement as a result of unsafe practices (e.g. Eastlund 1998, 878). Similarly, providers from prison populations were more likely to be infected with HIV and hepatitis for example (Ibid.). Contaminated blood scandals have consequently affected numerous countries including the United Kingdom, France, Japan and the United States (Dyer 2009; Feldman 2000). The second rationale for prohibiting payment of blood
providers was that it risked harming or exploiting vulnerable populations (WHO 1975), or imposing an unfair burden on those members of society least likely to benefit from supplies of blood (e.g. Titmuss 1997, 288).

Improved screening procedures have decreased the risk of contaminated blood supplies in many countries (Buyx 2009, 332), although Murphy and McSweeney suggest that unpaid donors are still up to 10 times safer than paid providers (2009, 191), and a recent study of paid providers in Lithuania confirms ongoing risks (Kalibatas 2008).

8.2.2 Extending the self-sufficiency model to other HBM
In recent years, self-sufficiency in organs for transplantation has also emerged as an ethical and practical goal for policy-makers (e.g. WHO 2009c, 3; Participants 2008, 855). Again, the emphasis has been on improving domestic supplies and avoiding the ethical and safety hazards of outsourcing manifest in “transplant tourism”. Again, the prohibition of payment for providers has been a feature of the self-sufficiency model. I had the privilege of attending the WHO Third Global Consultation on Organ Transplantation, held in Madrid, Spain in March 2010, the theme of which was the pursuit of self-sufficiency in transplantation. During the consultation and the discussions among participants leading up to it, a number of concerns were expressed about the viability of applying the self-sufficiency model to organs for transplantation. The most important of these were as follows:

(i) Self-sufficiency in organs is unachievable (in most, if not all countries), and therefore useless as a practical goal;

(ii) Simple sufficiency or self-sufficiency in organs will be unachievable if payment for organ provision is prohibited;

(iii) Restricting access to organ transplantation to members of specific populations such as nation states will (selfishly) hurt patients in need of transplants who belong to countries that are unable to provide transplantation services for various reasons.

In this chapter, I will begin by outlining the ethos of pursuing self-sufficiency, before identifying the key practical features of the self-sufficiency model using the example of organs for transplantation. I will address the above concerns as well as others that may be anticipated, arguing that the self-sufficiency model offers the most practical and ethical approach for countries seeking to enhance access to organ transplantation. I then
consider the application of the self-sufficiency model to other forms of HBM and potential issues that may arise in the context of specific materials.

8.3 The ethos of self-sufficiency

The key motif of the self-sufficiency model is perhaps best described as communal responsibility. Embracing the goal of self-sufficiency implies an adoption of responsibility by a population for meeting its own needs for HBM, in particular by taking responsibility for provision of HBM, rather than relying on outsourcing. Given the nature of needs for HBM, this responsibility must be shared by all members of the population, every one of whom may be required to contribute to HBM supplies, or may develop a need for a particular HBM. Overriding this communal responsibility is that of the governing authorities charged with developing and implementing policies designed to achieve self-sufficiency.

8.3.1 The role of the state

The role of the state in the procurement, use and distribution of HBM (and hence self-sufficiency policies) arises naturally from the conditions of political authority and function. The state is a political entity incorporating a number of institutions through which a defined spatial territory and its population are governed. States derive power and legitimacy from the people they represent. This relationship between state and citizens may arise from the functions the state performs for the people, from the means by which the state is chosen or approved by the people, or from a combination of the two (Dunleavy 1999, 611). The nominal – and frequently the actual – ultimate source of authority, the state “effectively monopolizes the legitimate use of force within the given territory”, controls membership within and travel to and from the territory, and is recognized as sovereign, with a right to non-interference in its domestic activities by other states (ibid.). While in practice the legitimacy of the state in part derives from its capacity to defend that sovereignty and to exert its authority over its population, its ethical claim to legitimacy depends on the means by which the state is chosen or approved by the people and/or the extent to which it succeeds in performing certain functions for the people. While the importance of particular functions may vary according to the priority of needs in particular contexts, they may be summarized as follows: (i) defense of citizens from foreign threats; (ii) prevention of internal conflict, maintenance of social institutions and development and enforcement of legislation; (iii) establishment and maintenance of infrastructure required to ensure provision of
individual requirements for achieving a good life, as determined by societal values. This last task includes such social goods as food, shelter, education and health care, in short, the needs that are frequently cited as basic human rights.

In his discussion of human dignity, McCrudden describes a third element of the dignity concept evident in the policy and constitutional language of national and international governance. This element concerns

the relationship between the state and the individual. This is the claim that recognizing the intrinsic worth of the individual requires that the state should be seen to exist for the sake of the individual human being, and not vice versa (the limited-state claim). (2008, 168)

Where the treatment of human beings and their bodies is concerned, the state undoubtedly plays a key role in protecting the interests of individual persons and promoting respect for their dignity. Given the therapeutic value of HBM, and the duty of states to promote the health and wellbeing of citizens, the state must take responsibility for helping society to access vital healthcare resources, including HBM.

The treatment of HBM, involving as it does both the removal of materials from the bodies of living individuals and from the very recently deceased, requires careful government oversight. Legislation is necessary to protect citizens from violations of bodily integrity and to ensure that the diagnosis of death is not abused to facilitate murder or unethical procurement of materials. The treatment of HBM also represents a public health concern beyond that of the benefits derived from therapeutic use of materials. Disease transmission and harmful procurement practices endanger patients and other members of the community, requiring careful monitoring to ensure safeguards are implemented appropriately. Finally, government authorities must be responsible for ensuring equitable access to HBM.

8.3.2 The role of the public

Given the volume of needs for HBM and the challenges of ensuring suitable matches of material for recipients, in particular organs and bone marrow for transplantation, the more individuals who provide materials, the more likely it is that self-sufficiency will be achieved. Ideally, this means that all members of society should take advantage of opportunities to provide HBM where needed. Not all members will be eligible to provide particular materials: while all members of society should be regarded in theory as potential providers, in practice many will be excluded. For example, individuals may be deemed unfit to provide materials due to risks to their own health and wellbeing, or ineligible on the grounds that their materials may expose recipient to risks such as
transmissible diseases. In addition, not all individuals die in circumstances conducive to deceased organ and/or tissue procurement.

In order to optimize the (voluntary, unpaid) provision of HBM, three issues must be addressed. Firstly, barriers to participation in donation opportunities must be eliminated: for example disincentives to donation should be removed through reimbursement of financial costs potentially incurred, measures taken to ensure donors are not subjected to health or life insurance penalties and wages guaranteed during time off work for provision (e.g. Participants 2008, 855-6). Secondly, the practical infrastructure required to facilitate donation should be extended to maximize opportunities, for example by establishing more readily accessible blood banks (e.g. Harrington et al. 2007, 366) and by providing organ retrieval teams to hospitals that are geographically distant from transplantation centres. Thirdly, all members of society must be engaged as participants in self-sufficiency endeavours. I will discuss methods for promoting such engagement shortly.

8.3.3 Reorienting transplantation policies

Research suggests that trust in healthcare systems, a sense of belonging to communities and social responsibility, as well as awareness of community needs play a key role in motivating altruistic donation of HBM (M. Morgan et al. 2010; Shaz et al. 2009; Harrington et al. 2007; Hoeyer and Lynöe 2006; Alessandrini 2007). The successful implementation of self-sufficiency policies in blood donation highlights the importance of emphasizing social solidarity and common public health goals in motivating public support for donation. The reciprocity inherent in the pursuit of self-sufficiency – in which all potential recipients of HBM are also potential donors of HBM – relies on promotion of equitable access to HBM. This focus on social goals and shared endeavours will require a paradigm shift in the ethos of organ donation and transplantation in many societies. Individual needs and virtues have often taken precedence in discussions of organ donation and transplantation. Whether described as the unique gift of an altruistic donor or the fulfillment of a particular recipient’s desperate need, the transfer of an organ from one person to another has contributed to a prevailing view of transplantation as a series of individual operations, access to which is often the exclusive privilege of the wealthy. This conception has lent weight to proposals for market-oriented approaches to transplantation, however the success of HBM procurement and transplantation programs depends on the recognition of transplantation as an inherently public health project.

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8.4 Features of the pursuit of self-sufficiency

As noted in Chapter 5, there are multiple practical barriers to enhancing procurement of HBM beyond that of motivating more providers. Progress towards self-sufficiency in organs for transplantation for example, will require a comprehensive strategic approach to minimize the need for transplantation within a population and to maximize the efficiency, efficacy and quantity of its resources. In short, the implementation of the self-sufficiency model consists in minimizing needs, maximizing resources and the efficiency of their use, providing the requisite infrastructure and promoting justice and solidarity in the application of these strategies.

8.4.1 Practical requirements

The efficacy of self-sufficiency strategies will depend on the careful organization of HBM procurement and distribution programs in conjunction with the provision of quality primary healthcare to all members of society. The following points briefly summarize the practical requirements for pursuing self-sufficiency, using specific examples for organ transplantation:

(i) Legislation:

This is required to regulate procurement practices and allocation criteria and mechanisms; e.g. death diagnosis criteria and procedures; waiting list operational structure;

(ii) Organization:

The creation of a specialized entity through the ministry of health, a governmental agency or a contracted organization, to oversee and coordinate national transplantation activities; e.g. the Australian Organ and Tissue Authority (DonateLife 2010b);

(iii) Healthcare infrastructure:

Procurement, transport and storage facilities, as well as transplantation services are required. In addition, basic healthcare services to identify needs for HBM and to facilitate procurement opportunities such as intensive care units to enable deceased organ donation will contribute to self-sufficiency efforts;

(iv) Public health programs and education:

Prevention of needs for HBM, for example by treating chronic diseases leading to organ failure, and encouragement of donation will operate most
effectively through public health campaigns, services and education programs targeting all members of society;

(v) **Registries and data collection:**
The creation of donor and recipient registries will help to monitor the efficacy and quality of programs, while research into needs for HBM and the efficacy of self-sufficiency strategies will encourage improvement;

(vi) **Community consultation:**
In order to ensure that self-sufficiency strategies are endorsed and embraced by society, community consultation is necessary to assist in development of policies that reflect community values and priorities and address potential public concerns.

8.4.2 Minimizing needs for HBM
Rather than focusing solely on increasing supplies of HBM, the self-sufficiency model takes a multilateral approach to policy making. Firstly, efforts must be made to minimize HBM requirements by (a) prevention of needs; (b) use of alternative methods to meet needs; (c) efficient use of HBM. Preventing needs for organ transplantation should be a key health care priority, not only because it reduces demand for transplantation but because prevention or treatment of the diseases contributing to organ failure – such as diabetes, hypertension, alcoholism and hepatitis – will promote better health and reduce costs of healthcare provision within society. The importance of prevention of renal failure in low resource settings such as sub-Saharan Africa for example, is highlighted by Persy et al. (2010). A major factor contributing to the incidence of end stage renal disease in various countries may be that of inequitable access to primary and secondary prevention of disease. For example, a study by Hallan et al. (2006, 2279), shows that despite comparable rates of chronic renal disease prevalence among whites in Norway and the United States (10.2% and 11.5% respectively), the United States has as much as three-fold higher prevalence of end stage renal failure in some age brackets. Prevention of end stage organ failure should therefore be an integral component of national strategies to minimize demand for organs and thus reach self-sufficiency in transplantation.

Optimizing alternative methods to meet needs for HBM is an important goal for research. Although dialysis offers an alternative to kidney transplantation for the treatment of end stage renal failure, transplantation is in most cases the best treatment option and is usually less expensive in the long term (E.S. Huang et al. 2009). Efforts to
create synthetic organs, use animal organs or repair failing organs that would replace the need for human organs for transplantation remain in most cases a distant hope, however the products of such research may offer temporary alternatives to patients in the setting of organ shortages, for example through the use of artificial hearts as a bridge to transplantation (Copeland et al. 2004), and may eventually help to reduce needs for human organs.

Strategies to promote efficient use of HBM are essential to self-sufficiency efforts. HBM should not only be allocated in order to promote efficient use and avoid wasting resources unnecessarily, but procurement and distribution systems should also be designed to minimize discards of useable materials. For example, studies show that while so-called “expanded criteria” kidneys from older donors are usually of inferior quality, they may nevertheless offer older recipients better outcomes than dialysis (Foss et al. 2009). Rates of organ discard as high as 15% of recovered kidneys in the United States in 2007 (Tuttle Newall et al. 2009) have prompted widespread efforts to minimize wastage through revision of both donor criteria and allocation policies (e.g. Vinkers et al. 2009). For example, organs that have previously been rejected on the grounds of infection with transmissible diseases may nevertheless be useful. In a world first, Mueller and colleagues in South Africa recently reported on the transplantation of kidneys from HIV positive donors to HIV positive recipients (2010), which offers hope to such patients previously excluded from donation and transplantation opportunities. Similarly, organs from donors with hepatitis have also been successfully transplanted into hepatitis positive recipients (Lau and Bunnpradist 2010b). Finally, paired exchange systems and domino exchanges can facilitate donation where prospective living related organ donors are not suitable match for their intended recipient (Akkina et al. 2011; Hwang et al. 2010).

8.4.3 Promoting justice in the self-sufficiency model

Justice must be a key priority in self-sufficiency policies, as the integrity of the self-sufficiency model is predicated on an equitable sharing of responsibility and benefits of HBM provision among the members of society. Achieving equity requires particular attention to a variety of factors that may influence access to, and support for donation and transplantation. For example, Axelrod et al. (2010, 2287), found that even despite “near-universal insurance coverage” for organ transplantation in the United States, patients in the highest socioeconomic groups have significantly better access to transplantation as well as better long-term outcomes, particularly where existing barriers
such as geographical distance from transplant centres may be partially overcome by wealthier patients.

While in practice some subsets of a population may receive a disproportionate share of the actual benefits of donation – for example where the prevalence of end stage organ failure is higher in some social or ethnic groups – this should not necessarily require a corresponding increase in the burden of donation for members of such groups. While an increased risk of becoming an organ recipient - or knowing someone who will require an organ - should undoubtedly motivate more to become donors, equitable distribution of the burden of donation should be sought at a societal level. Possessing an increased risk of requiring a transplant is after all a burden, not a benefit. However, underrepresented ethnic donor groups, or members of groups with higher rates of need may be encouraged to donate by appeal to reciprocity, and by reminding them that suitably matched HBM are more likely to be found for their relatives among members of these groups (e.g. Shaz et al. 2009, 1446; Grassineau et al. 2007). In particular, marginalized ethnic minorities may suffer inequitable access to healthcare, undermining their trust in the integrity of procurement and distribution systems and thus willingness to donate (M. Morgan et al. 2006). Efforts to address general healthcare inequities and to engage with minority groups in culturally sensitive ways may enhance participation in donation opportunities (Grassineau 2007).

It is important to remember that HBM procurement and use take place in the context of public healthcare systems that are inevitably subject to their own resource constraints. As a public service, the need for therapeutic procedures involving HBM must be considered in the light of competing claims on healthcare within the population. The challenge of meeting needs while progressing towards self-sufficiency must be addressed with rigorous attention to transparent justice in the allocation of scarce resources. While a population should strive to achieve complete sufficiency by meeting all needs for HBM, in practice careful examination of data concerning the burden of disease within the population and the costs and benefits of particular treatments will be required to establish real benchmarks for success and priorities for intervention. For example, the first priority in a particular population may be to supply sufficient organs and transplantation services to meet the needs of individuals with end-stage organ failure between the ages of 25 and 45, in order to maximize the benefits of transplantation for the population as a whole. Addressing the needs of particular age groups may have additional benefits such as preserving essential members of the workforce and care-givers for children and the elderly.
8.4.4 Enhancing supplies of HBM

A key factor with respect to the optimization of resources in organ transplantation is the prioritization of deceased donation. Deceased donation is indisputably a safer alternative to live donation, as it risks no harm to donors, and it also provides considerably more organs for transplantation including those such as hearts that cannot be taken from living providers. A single deceased donor can provide more than three organs for transplantation (as well as other materials) (DonateLife 2010a), although numerous factors will influence this number (Olson and Cravero 2009). For all HBM, however, a major challenge for increasing supplies of materials is that of donor motivation. Respect for bodily integrity and autonomy at the very least requires that procurement of HBM from living persons should be voluntary, and respect for personal value in the deceased body usually requires pre-emptive consent by prospective deceased donors or posthumous approval of donation by their relatives. Accordingly, strategies to encourage donation forms a major component of the self-sufficiency model for organ transplantation.

8.5 Motivating donors

For a population pursuing self-sufficiency in HBM, all members are considered potential donors of materials. The prohibition of payment limits the range of incentives that may be offered to potential donors (excluding any fungible incentives) however a number of important motivations for donation remain, as well as various strategies to optimize donor numbers.

8.5.1 Altruism

I suggested in Chapter 5 that altruism is an underestimated factor in the market debate, with reports of its failure to motivate donors at odds with the evidence of millions of altruistic blood, tissue and organ donors (both deceased and living), in societies all over the world, irrespective of race, culture and religion. Despite numerous claims that altruism has failed to motivate sufficient numbers of organ donors (e.g. Satel, 2009:3), evidence suggests that other factors play a greater role in organ procurement than actual donor motivation (see Chapter 5.2.2). I have already suggested a variety of ways in which public support for donation may be converted to actual consent rates and participation in altruistic donation, for example by enabling donation opportunities, removing disincentives to donate and by educating individuals and groups about HBM needs and procurement processes. Numerous studies confirm that
Altruism, or the desire to help others, plays a key role in motivating donors of HBM (e.g. Titmuss 1997, 302; Siminoff et al. 2007, 927), and further efforts to reinforce altruism can be made by publicly recognizing and celebrating altruistic donors for example through events such as World Blood Donor Day and World Organ Donation Day, as well as by ensuring that potential donors of HBM are informed of the value of their materials and appreciation for their gift shown (e.g. Axler et al. 2008, 327). Nevertheless, other non-commercial motivations may serve to enhance support for donation and participation in self-sufficiency efforts.

### 8.5.2 Solidarity

Solidarity is increasingly identified as an important value in global bioethics and is inherent to the concept of self-sufficiency. The Universal Declaration on Bioethics and Human Rights states that, “Solidarity among human beings and international cooperation towards that end should be encouraged” (UNESCO 2005). Interestingly, Wilde describes “the call for solidarity on a global scale [as] a response to a deeply divided world which has failed to realize the promise of the United Nations Declaration of Human Rights” (2007, 174). The extensive literature on the subject conceptualizes solidarity in a variety of ways. Common to most accounts is the idea of solidarity as an expression of concern for the wellbeing of others and of willingness to contribute to that wellbeing, extending beyond simple empathy. Baylis et al. emphasize the importance of “communal welfare rather than self-interest” in solidarity, describing relational solidarity as

> a shared interest in survival, safety and security – an interest that can be effectively pursued through the pursuit of public goods and through ongoing efforts to identify and unravel the complex webs of privilege and disadvantage that sustain and foster an ‘us’ versus ‘them’ divide. (2008:205)

Promoting donation of HBM as an act of social solidarity may well enhance the motivation of potential donors. Etzioni provides a comprehensive description of how solidarity or a communitarian ethic might work in the context of organ donation, suggesting that we make organ donation

> a part of one’s sense of moral obligation, something one cannot look in the mirror or face friends without having lived up to. It reflects a complex combination of an inner sense of what is right and social pressure to do what is right, the core elements of moral culture. (2003, 6)

Respect for solidarity should encourage members of a population to contribute to the common welfare of society by acting as donors when eligible to do so, and promote
respect for donors and concern for the potential risks of live donation. Solidarity, as Baylis et al. (2008) note, engenders particular concern for vulnerable populations who risk exclusion from the benefits of therapeutic procedures involving HBM while sometimes bearing a greater share of its burdens. Thus efforts should be made to ensure the burdens of HBM provision are equitably distributed, as well as access to healthcare services and procedures involving HBM. Where HBM are used in research, efforts should likewise be taken to ensure benefits are equitably shared, an approach that Chadwick and Berg (2001:320) suggest might be usefully adopted in DNA banking for genetic research, rather than the traditionally individualistic approach to participation.

8.5.3 Reciprocity

Reciprocity has been variously described as an ethical norm of behaviour in which people ought to act towards or for others as they would wish others to act towards them; an evolutionary social strategy that encourages altruistic behaviour for mutual benefit; and a manifestation of justice in social behaviour by which individuals receive and return benefits or punishments in kind and proportion as they are merited or deserved. With respect to self-sufficiency, concern for reciprocity should encourage those who stand to benefit from use of HBM to earn this benefit by sharing the burden of donation. Siegal and Bonnie (2006), however, advocate a reframing of organ donation as a collective responsibility for society based on “reciprocal altruism”. Their account of such an approach mirrors the fundamental ethos of the self-sufficiency model: “Everyone is a potential recipient as well as a potential donor” (ibid., 416). They highlight the fact that reciprocity has been neglected as a motivation for organ donation, and suggest that promoting public awareness of the benefits of increased donation and thus the importance of greater public participation in donation will stimulate support: “The gap in organ supply can be substantially closed only if most members of society, regardless of class or race, are willing to participate” (ibid.). Of note, a recent study suggests reciprocity may well be an effective motivator for organ donation (Schweda et al., 2009), although the best method for its application in procurement strategies remains undetermined.

One model advocated by a number of authors is that in which individuals who have previously registered a willingness to donate are given a degree of priority if they develop a need for organ transplantation (e.g. Gubernatis and Kliemt 2000a; Nadel 2005; Trotter 2008). Most such models specify that urgent cases will be given waiting list priority regardless of whether the patient was willing to donate. Variations on this
model can already be found in practice, most recently in Israel (Lavee et al. 2010). The (limited) priority given to living organ donors in the United States in the allocation of deceased kidneys (ibid., 1132), also reflects the idea of rewarding merit, but does not directly disadvantage those unwilling to donate. More demanding reciprocity models suggest that only those willing to donate should be entitled to access transplantation (e.g. Jarvis 1995). Although such a rigorous interpretation of reciprocity in practice may be deemed unacceptable in many societies, there are other ways in which individuals and groups might be able to contribute to self-sufficiency efforts, even where they remain unwilling to act as donors, thereby qualifying for access to transplantation. For example, participation in public health programs to identify and treat conditions contributing to needs for HBM may significantly reduce the likelihood of individuals requiring organ transplantation, thus balancing refusal to donate. Alternatively, those reluctant to donate blood, for example due to a fear of needles, might be encouraged to sign up as potential deceased donors. Because its scope extends beyond donation of a specific material, the self-sufficiency model offers a range of activities in which members of the community may be included and goals to which they may contribute.

Of note, Pennings proposes a system of “needs adjusted reciprocity” to enhance supplies of gametes for use in ART, suggesting that in suitable cases couples who require ova for example, could donate sperm in exchange and vice versa (2005). In such a system those who need gametes would have an obligation to help contribute to the needs of other couples where possible. It is possible that couples or individuals engaged in ART might also introduce altruistic donors who, although unable to donate to their relatives or friends as a result of genetic or social concerns, may be willing to donate to strangers who reciprocate in kind. Although there may be limited occasions in which this would help to increase supplies of gametes, creating a system akin to the domino and paired exchanges of living organ donation could have beneficial effects.

8.5.4 Civic duty
A variant on the reciprocity or solidarity models of donation is that of civic duty, in which donation is framed as an obligation of citizens to contribute to the vital healthcare resources of their society, as they do through taxation, volunteering in times of war and other forms of social contribution. Evidence shows that public participation in blood donation may increase dramatically in the setting of public emergencies (Glynn et al. 2003; Liu et al. 2009). Greater public awareness of life-threatening HBM shortages may be effective in motivating more donors. In this spirit, or that of solidarity, members of
society should also be encouraged to take responsibility for preventing needs for HBM by addressing personal health issues that may contribute to needs. For example, public health campaigns highlighting the importance of preventing and treating hypertension, diabetes and obesity could emphasize the contribution these conditions make to organ failure. Individuals could be urged to consider improving their own health as a way to minimize the burden of these diseases on healthcare systems and procurement systems of HBM in particular.

8.5.5 The duty to rescue – a rationale for mandatory donation?
Different societies will determine how best to frame motivations for donation among the various members of their communities. While the idea of reciprocity or solidarity may embody a degree of self-interest by reminding society members that they will benefit from greater public participation in self-sufficiency efforts, and appeal to altruism highlights the virtue of helping others, the duty to rescue may be invoked as a more abstract moral appeal to potential donors. I have already touched on this topic in Chapter 6, in the context of the Argument from Life Saving Necessity.

Commentators such as Hester (2006) and R. Howard (2006) have argued that the charitable gift conception of deceased donation should be replaced in favour of one that identifies donation as a strong moral obligation of human beings to save the lives of others. Reflecting this, Snyder notes that, “A variety of ethical traditions and theories can agree that, at the very least, we all have a duty to rescue others from great harm when we can do so at little or no cost to ourselves” (2009, 28). He argues that in many societies, deceased organ donation imposes little burden on donors and may save lives; therefore members of society have an obligation to donate where possible. This obligation may be expressed in policy in a variety of ways, and framed in accordance with the particular religious or ethical values and principles of different communities.

There continues to be considerable discussion of the practical merits (Rithalia et al. 2009) and moral hazards (e.g. P. Hughes 2009b) of presumed consent policies with respect to deceased donation, suggesting that it will be some time, if ever, before policies which effectively mandate deceased donation of organs (or even blood) in return for access to these materials become viable. Nevertheless, authors such as Harter (2008) and Spital and Taylor (2007) have presented a variety of arguments in favour of deceased donor conscription\textsuperscript{56}. While acknowledging the potential practical challenges

\textsuperscript{56} Other terms for mandatory donation include “routine recovery” (Spital and Taylor 2007) and “mandatory cadaver organ procurement” (Harter 2008).
of ethically implementing such policies, for example the need to preserve the integrity of death diagnosis and procurement (Harter 2008, 171), and the primary moral objection that the system would impair individual autonomy, mandatory donation advocates argue that the imperative to save lives should outweigh concerns about liberty and religious preferences. These authors further clarify that individuals would not be entitled to opt out of such mandatory programs, on the grounds that to allow “conscientious objection” as it were, would “dilute the value” of the proposal (Spital and Taylor 2007, 302).

While a rigorously enforced system of presumed consent would be consistent with the ethical values outlined in earlier chapters, including respect for dignity and the personal value inherent in HBM, a mandatory procurement program which does not allow objectors to “opt out” would effectively deny personal value in deceased bodies, which may in some cases have harmful repercussions. On the other hand, the reciprocity based “club” system proposed by Jarvis (1995), in which those who elect not to be registered as potential donors are simply excluded from the group of potential organ recipients, would reflect the self-sufficiency ethos. As Robertson (2007, 26) points out in his own account of a “cooperative system”, the so-called “free-rider” problem is avoided, and justice enhanced, by excluding those who wish to benefit from public goods without contributing to them. The injustice of free-riders who exploit the donation system may discourage others from donating to the public pool, as a recent survey suggests is the case with citizens of the United States reluctant to share organs with foreign patients (Volk et al. 2010).

Without delving further into the complex issues of enforced reciprocity and mandatory donation, I suggest that the self-sufficiency model should continue to be based on the principle of voluntary donation. While all members of community should be considered potential donors and recipients of organs (or other HBM), with an equal moral obligation to contribute to self-sufficiency efforts where possible (except if they choose to exclude themselves from the pool of potential recipients), they should retain the right to refuse donation opportunities. For one thing, there are multiple ways in which individuals may contribute to public goods, and while the burden of HBM donation should not be regarded as fungible with other contributions (e.g. volunteer work or political participation), it may be seen as commensurate with these in some cases. The condition of voluntariness, on the other hand, does not preclude the introduction of strong measures designed to encourage public participation in self-sufficiency efforts, such as advertising campaigns critiquing “free riders”.

Even policies that frame donation as a strong duty of members of society may be
regarded as an infringement of liberty or an unacceptable imposition of moral values. If such an approach is likely to discourage rather than encourage donation, it should be avoided. However, a gradual evolution of motivation strategies may help to reframe donation as a social norm rather than an exceptional virtue of altruistic individuals. The self-sufficiency model, by emphasizing the importance of communal efforts and the value of public contributions to all members of society, will help to explore these additional strategies and thereby increase donation of HBM.

8.6 Potential concerns about the self-sufficiency approach

The specific policies that might be adopted as part of a self-sufficiency model in practice may vary greatly while still retaining the key features and supporting the ethical values and principles outlined in this chapter. Nevertheless, a few points of clarification should be made in order to address the potential concerns highlighted earlier.

8.6.1 Cross-border solidarity or selfishness?

A possible objection to the self-sufficiency model, for example in organ transplantation, is that it risks excluding patients whose only hope of accessing life-saving transplantation is to travel abroad, such as members of nations that are too poor or too small to sustain a transplantation program or to offer patients reasonable chances of finding a suitable donor match. Self-sufficiency, it may be feared, could serve as a justification for excluding foreign citizens from accessing healthcare while living abroad, or detract from the humanitarian obligations of nations to assist neighbours in the setting of healthcare crises.

However, striving to meet domestic needs using domestic resources does not preclude the sharing of these resources with foreign patients in need. For example, in the setting of public health crises that impact on supplies of HBM such as the outbreak of blood borne diseases, neighbouring states may assist with emergency relief in the form of HBM supplies (e.g. Liumbrono et al. 2008). Bilateral agreements should help to ensure that such aid is reciprocated. The United States, for example, has a quota of 5% of organs to be used for transplantation of foreign patients, however only 0.9% of transplants in 2008 went to non-resident aliens, a group that also contributes significantly to the United States donor pool (Delmonico et al. 2010). Where foreign citizens contribute to donation of HBM, for example the resident expatriate workers of Saudi Arabia or the isolated cases of tourists abroad who suffer injury and become
deceased organ donors\textsuperscript{57}, these people should be regarded as members of the potential donor and hence potential recipient communities. Thus expatriate workers in Saudi Arabia should be granted equitable access to organ transplantation and foreign tourists should be granted access to organ transplantation in life threatening emergencies (e.g. TSANZ 2010, 3). However, such humanitarian assistance should not be used as a loophole for systematic outsourcing in which foreign patients seek entry to organ transplant waiting lists abroad under false pretences.

The self-sufficiency model should encourage nations to collaborate and assist one another in promoting better access to HBM in order to minimize potential foreign demands on resources. Certainly the effective and ethical use and donation of HBM requires organization, oversight and a minimum number of participants, thus self-sufficiency will be more effectively pursued by a population that shares a common governing authority responsible for coordinating and regulating the activities of the group, and possibly, common values and customs regarding the treatment of HBM. In practice, this will likely correspond to nations, and sub-regional or regional associations of states such as the European Union. While nations might strive to achieve self-sufficiency within their own borders, this does not preclude collaboration with neighbouring states in an exchange of resources to avoid wastage, maximize efficient use of resources and address life threatening cases. For example, the Trans Tasman Exchange agreement between Australia and New Zealand enables the sharing of organs between these nations’ respective populations. The agreement (TSANZ 2010, 22) is mutually beneficial, with organs that cannot be used in one country being offered to the other, and in cases of urgent need, the saving of a life is prioritized without concern for national borders. From an ethical perspective, the concern for equity in distribution is reflected in the distributional methods employed between the countries. The key feature of the self-sufficiency concept, in which all members of the population are potentially both recipients and donors, is reflected in the reciprocity of the bilateral agreement. Both Australians and New Zealanders may act as donors and recipients of the shared organs. This agreement may be seen as extending the boundaries of the population seeking self-sufficiency to include both Australians and New Zealanders, in an expression of regional solidarity. Similar agreements can be found in Europe and other parts of the world (e.g. Pretagostini et al. 2007).

\textsuperscript{57} For example, in 2009 an Australian tourist in Greece became a deceased organ donor (D. Murray), while an Irish tourist in Australia also became a donor (Dart 2009).
In theory, there are no upper limits to the scope of self-sufficiency. In practice, pursuit of self-sufficiency at a global level is unfeasible with respect to most forms of transplantation due to practical limitations on the safe storage and transport of detached HBM, in particular organs. However, the most effective donation and transplantation program for bone marrow cells will operate globally, as difficulties finding suitable donor-recipient matches are best overcome by maximising the genetic diversity of the donor pool (see BMDW, 2010). The constraints on membership of a given population pursuing self-sufficiency in HBM are designed to minimize unilateral outsourcing of HBM provision, promote operational efficiency and to draw on existing social relationships and values to motivate participation in self-sufficiency efforts. This avoids the risks inherent in outsourcing (see Chapter 9). Avoidance of outsourcing through the pursuit of self-sufficiency is in itself an expression of solidarity with distant vulnerable populations that are placed at risk through practices such as transplant tourism.

Gunson notes that,

The expression of solidarity takes the form of a relation between people — between group members, between groups, between individuals and groups, or even between individuals — based on the willingness to take the perspective of the other seriously, and it seems on the face of it that solidarity has no obvious limits (2009, 8).

It is evident that the expression of solidarity in HBM provision is not exclusive to self-sufficient populations, and concern for others may be extended to include potential HBM providers and recipients throughout the world.

8.6.2 Viability and the prohibition of commercialism

Doubt that self-sufficiency in various HBM can be achieved may engender concerns that adoption of an impossible goal will impair efforts to meet achievable priorities or to minimize harm by establishing more ethical policies regarding outsourcing of HBM. In particular, one might argue that payment for HBM is the only way to achieve self-sufficiency and that the prohibition of payment in the self-sufficiency model is accordingly unrealistic and impractical. In response, I offer two arguments. Firstly, reiterating the points explored in the context of the ALSN in Chapter 5, the efficacy of non-commercial motivations, as well as the importance of non-consent related factors in the success of procurement programs are often underestimated. With the exception of supplies of gametes, which I shall address shortly, self-sufficiency remains an authentic goal for HBM in many countries, although due to the limitations of current healthcare
resources, geography and population sizes, self-sufficiency may take considerable time and may need to be pursued in collaboration with neighbouring nations.

Despite the doubts of market advocates, there is evidence to suggest that renewed and novel efforts to promote and facilitate non-remunerated organ donation, in particular deceased donation, may significantly improve organ availability (e.g. Lacroix et al. 2004; Danovitch and Leichtman 2006; Matesanz and Dominguez-Gil 2007). Expansion of the donor pool to include donation after circulatory death (Lacroix et al. 2004); the use of extended criteria organs; and the optimization of organ recovery and utilization will enhance organ availability. Additionally, reorienting public perception of organ donation from individualized altruism to a fulfillment of ethical obligations towards one’s society may well contribute to higher donation rates. New motivations of reciprocity, solidarity and civic duty as outlined above may prove more effective in the long term than financial incentives. Pursuing self-sufficiency encourages comprehensive and multifaceted efforts to meet needs for organs, and to minimize them by preventing and treating diseases that contribute to organ failure. These complementary strategies will help to enhance the success of the self-sufficiency model.

The second objection to the claim that self-sufficiency cannot succeed in the absence of financial incentives for HBM provision is that it is by no means certain that payment for HBM provision would offer a more effective or sustainable supply of HBM than the self-sufficiency model. The conditions that render financial incentives most effective in motivating HBM provision (i.e. economic inequalities within society) are unlikely to co-exist with conditions of equal access to HBM and healthcare services, which is a feature of the self-sufficiency model. Populations that seek to progress towards self-sufficiency in HBM will strive to develop the requirements for success identified earlier in this chapter, for example the establishment of strong and equitable public health programs. As societies seek to minimize the socioeconomic inequities that render communities and individuals susceptible to financial incentives for HBM provision, the alleged efficacy of HBM markets is likely to diminish.

In addition, payment for HBM provision inherently conflicts with the ethos of self-sufficiency by promoting an inequitable distribution of the burden of provision. Payment creates an inequality in the potential recipient population by targeting members of a subset (the poor) as potential providers. The use of targeted incentives should not be employed except where these seek to eliminate bias in donor distribution. For example, framing obligations to donate in the language and traditions of particular religious groups may facilitate participation, ensuring representation of these groups in
the donor pool. Offering financial incentives, conversely, will unfairly target those with socio-economic vulnerabilities, diminishing the burden of donation for the wealthy. Furthermore, payment may compromise the reliability and sustainability of HBM procurement programs, as well as increasing harm to providers. Evidence from current markets suggests communities from which paid providers originate tend to be socially marginalized (e.g. Kretzmann 1992). Payment tends to further divide societies between those who provide and those who do not, regardless of whether stigma is attached to the sale of HBM. Thus Moazam et al. (2009, 35) report that kidney vendors - themselves frequently invisible within society - perceive the recipients of their organs as “faceless strangers”. The communal ethos of the self-sufficiency model cannot be authentically embraced and effectively pursued in the setting of commercialism.

8.6.3 The approach to ongoing outsourcing

In the context of persisting HBM shortages, societies pursuing self-sufficiency (or their individual members) may be tempted to engage in outsourcing, either through the importation of HBM or by traveling abroad to access procedures involving HBM. Unilateral outsourcing, whether on a large or individual scale, is associated with a variety of issues including those attached to the commercial provision of HBM, which I shall discuss in the following chapter. In particular, it should be noted that outsourcing frequently impairs self-sufficiency efforts in the exporting country.

8.6.4 Qualifying needs for particular HBM

Although the urgency of meeting needs for life-saving organ or bone marrow transplants or blood transfusions is widely recognized, qualifying needs for donated gametes in ART or stem cells in experimental therapies is less straightforward, as noted earlier. The degree to which a society feels motivated to help individuals or couples create children using donated gametes will depend on complex interactions between attitudes towards parenthood and infertility, levels of societal altruism, concerns about the risks and potential impact of gamete donation on both donors and children produced by ART, and the extent of available alternatives for parenthood such as fostering and adoption. However, applying the self-sufficiency model to gamete procurement would at the very least provide for fruitful examination of policy and, in the absence of a recognized communal obligation to donate gametes, should encourage and facilitate altruistic donation, promote efforts to address preventable causes of infertility and enhance access to parenting alternatives.
Novel strategies to address needs, such as the mirror donation system proposed by Pennings (2005), merit careful consideration. On the other hand, focus on the needs of patients requiring third party gametes should not take place at the expense of efforts to address infertility that do not require donor gametes. Many couples lack access to assisted fertility services altogether, and many more individuals suffer from preventable diseases that contribute towards medical infertility (e.g. Ombelet 2009). As always, the single-minded pursuit of better supplies of HBM risks distracting attention from equally urgent needs for healthcare. Access to HBM should be part of an equitable healthcare system, not a parallel system for privileged communities. Policy makers should consider these issues as they strive to determine how best to regulate procurement and distribution of gametes and how to implement self-sufficiency policies with respect to gametes.

Until we are better able to estimate the likely benefits of particular research, societal obligations to contribute to meeting these needs cannot be determined. Ongoing debate about oocyte donation for research and literature concerned with potential societal obligations to contribute to research (e.g. Harris 2005; Siegal et al. 2009) will be useful in exploring this issue, and offers interesting parallels for further discussion of societal obligations to provide HBM in the pursuit of self-sufficiency.

8.7 Conclusion

The self-sufficiency model I have described in this chapter is not an entirely novel concept, nor does it incorporate any novel strategies to improve access to various HBM. However, despite international recognition of self-sufficiency as a goal for policy makers, it remains relatively neglected. Closer examination of the ethos of pursuing self-sufficiency, the various practical elements that it requires (e.g. Kim et al. 2010), and the ethical values and principles that it implies, will provide a more comprehensive framework for policy making at the national level. Rather than adopting particular strategies in isolation, such as the traditional approach to the promotion of altruistic organ donation, the self-sufficiency model integrates strategies in order to maximize their respective success through mutual reinforcement. Thus for example, prevention programs can be used to highlight the importance of donation, and the development of healthcare infrastructure can be designed to address multiple aspects of the model.

See for example Bennett and Hany’s (2009) comprehensive review of the requirements for enabling renal transplantation and addressing chronic renal failure in Indonesia.
Above all, promoting reciprocity and solidarity among the members of society and presenting the challenge of HBM shortages as a shared public responsibility will help to unite support for all aspects of the solution to this challenge. Reframing needs for HBM in the context of the pursuit of self-sufficiency will help to avoid the narrow focus on supply issues, and specifically provider motivation, that often leads to consideration of “quick-fix” solutions such as the use of financial incentives for HBM provision.
Meeting needs in the global context

In our ever-more globalised world, cultural and regional variations in what counts as dead, in how relations between body, self, and identity are understood, and in the particular forms of and possibilities for bodily commodification are not merely an issue of quaint or exotic interest. Rather the cultural meanings and social organisation that shape organ donation and transplantation in any one place may be both profoundly connected to and enormously consequential for the existence of this biotechnology elsewhere. (Crowley-Matoka and Lock 2006, 179)

9.1 Introduction

The common biology of members of the human species enables us to share many of our biological resources with others. Blood, organs, cells, tissue and gametes may cross the borders of gender, religion, ethnicity, race, and nationality. They may restore sight and sustain life after crossing the frontier of death itself. Although the universal features of human lives and societies mean that all moral systems have common elements and shared concerns, morality and social practices have long been regarded as embedded in particular communities or societies.

Moral concepts are embodied in and are partially constitutive of forms of social life. One key way in which we may identify one form of social life as distinct from another is by identifying differences in moral concepts. (MacIntyre 1995, 1)

As globalization facilitates travel, trade and migration between the diverse communities of the world, interactions between individuals and societies extend the borders of localized moral concern and different communities must determine how these new relationships are to be governed. In the context of global needs for HBM, and the ability to transfer these materials across borders, the procurement, use and distribution of HBM has become a key issue for the global community.

In Chapter 1, I noted that many countries face shortages of various HBM. Furthermore, while some countries have established collaborative relationships in which HBM resources are shared, a vast and growing cross-border trade in HBM has

59 For example, see the exchange of organs between Australia and New Zealand (TSANZ 2010) and the Bone Marrow Donors Worldwide organization, which aims to facilitate global matching of bone marrow donors with recipients (BMDW 2010).
developed. Despite the failure to meet domestic needs for HBM such as organs for transplantation, a number of countries allow - if not encourage - the export of their HBM to foreign patients. While outsourcing of HBM improve supplies for some patients, it usually occurs at the expense of others – in more ways than one. In this chapter, I review the ethical issues of cross-border trade in HBM and consider how these may be addressed at the national and international levels.

9.2 What’s wrong with cross-border trade in HBM?
Cross border trade in HBM essentially raises the same concerns as trade that occurs within states or smaller communities, which have been highlighted in earlier chapters. In the cross border setting however, these issues are often magnified due to the following factors:

(i) International trade in HBM frequently occurs in the setting of private hospitals and clinics and may thus be less subject to jurisdictional safeguards and regulatory oversight, exposing providers and recipients to increased risks;
(ii) Global economic inequalities facilitate exploitation of poorer communities by wealthier individuals and corporations;
(iii) Cross-border trade contributes to social distancing of providers and recipients, limiting awareness of agent responsibilities, and diminishing respect for personal value in HBM;
(iv) Trading on the claim that international regulatory differences represent genuine cross-border moral diversity, international outsourcing of HBM may encourage unethical domestic policies through foreign revenue;
(v) Outsourcing may undermine sufficiency and equity of access to HBM within both domestic and foreign societies.

9.2.1 Risks to HBM providers in the cross-border setting
Supplies of HBM that are sold to foreign patients or otherwise exported generally depend on commercial provision, with the exception of tissue products that are usually derived from altruistic donors. This is because altruistic donors are likely to be reluctant to donate materials that are sold for profit, especially to foreign citizens, and because few altruistic donation systems have surplus HBM after meeting domestic needs. Commercial procurement systems on the other hand, are usually not associated with
equitable distribution systems and are thus comfortable with allocating HBM according to the purchasing power of would-be recipients. The relative wealth of patients from more developed countries renders export of HBM from developing countries a highly lucrative venture for brokers and industry involved in HBM procurement and use, with low payments to HBM providers often associated with very high payments from HBM purchasers. For example, a study of the kidney black market in the Philippines showed that vendors received roughly US$2133 for a kidney (Mendoza 2010b, 258), while foreign patients might pay as much as US$85 000 for a kidney transplant (Turner 2009, 193). Similarly, Romanian women have been reported to earn US$200 for providing oocytes while foreign patients may purchase a variety of procedures involving these oocytes for a few thousand dollars (Nahman 2006, 77; Ellis and Colcutt 2005).

Although domestic markets in HBM often supply local consumers, the purchasing power of foreign citizens may encourage and sustain such markets, thereby contributing to the impact of markets even where they are not solely responsible for them. Thus the hazards of markets identified in Chapter 5, such as poor care of providers, exploitation and even coercion are exacerbated by cross border trade. Conversely, for example, following the prohibition of transplants for foreign patients in the Philippines the number of organs sold to foreigners decreased by 94%, while living related donation and deceased donation within the country improved (Chua 2010). Cross border trade on the fringes of legality or within illegal markets also encourages human trafficking, as different participants such as surgeons, patients and HBM vendors seek profits, anonymity or cheaper prices in third party countries which may offer little protection for providers (e.g. D. Smith, 2010; Press, 2010; Geis and Brown 2008; Yagna et al. 2009).

In some cases, foreign patients who travel abroad to purchase gametes or organs unfairly take advantage of lax standards of care for HBM providers. Patients may rationalize their decision to travel on the grounds that access to these materials is cheaper in the destination country, or more readily available due to the absence of payment prohibitions, and that their own right to health and the possibility of HBM vendors benefiting from trade justifies their action. In reality, the restrictions in their own countries are frequently designed to protect HBM providers from harm, and the better availability of HBM abroad represents poorer safeguards for providers. Cheaper costs may also be a sign of cost-cutting measures that negatively impact on provider care, for example higher doses of ovarian stimulant drugs produce more oocytes per procurement cycle but place providers at greater risk of ovarian hyperstimulation syndrome (Barnett and Smith, 2006)
9.2.2 Risks to HBM recipients in cross border trade

Patients traveling abroad to purchase HBM, or those using imported materials in the domestic setting may be at greater risk than when supplies are locally procured. A number of studies highlight the poorer outcomes of transplant tourists, particularly with respect to post-operative infectious complications (Alghamdi et al. 2010; Gill et al. 2008; Sajjad et al. 2008), which may be due to inferior standards of patient care in foreign transplant markets; difficulties inherent in providing continuity of care across borders especially where elements of such care occur in an illegal setting; and inferior quality materials from paid providers. Patients traveling abroad may also be exploited financially (Echevarria, 2010), and may be caught up in legal conflicts, particularly in the setting of reproductive travel60 If international medical travelers encounter difficulties, they may have little avenue for legal redress, limited insurance coverage and may face further costs and challenges on returning home (e.g. Terry 2006:465). Injured patients may also impose healthcare costs on their domestic systems when they return with complications (Lunt and Carrera 2010, 30).

9.2.3 The impact of outsourcing on domestic healthcare systems

Although outsourcing supplies of HBM may offer a rapid solution to domestic shortages in some cases, reliance on systematic outsourcing undermines the ability of domestic programs to meet needs for HBM. Access to HBM from foreign providers depends, after all, on the willingness of foreign communities to export these resources and cannot be relied on. Changes in legislation or practice, and improvements in social welfare in some countries may swiftly and dramatically alter the volume and accessibility of HBM for foreign patients. For example, the prohibition of organ sales in Brazil contributed to a decrease in the number of patients traveling there to access transplants and improved domestic access (Abbud-Filho et al. 2006, 603). Enforcement of similar legislation in other countries may produce similar results, as is hoped in Pakistan for example (Bile et al. 2010). Equally, a crisis such as the contamination of blood supplies may render export of resources unacceptable.

Although countries may influence the domestic policies of other countries, they cannot guarantee the reliability and sustainability of international trade in HBM. Reliance on domestic resources is more easily controlled and monitored, thus local

60 For example, a child produced in India using provided oocytes and a surrogate became caught up in a citizenship and parental rights wrangle, with his intended (genetic) Japanese father unable to legally claim him and return to Japan (Palattiyil et al. 2010, 691-2).
investment to promote self-sufficiency offers a better solution in the long term. In Israel, for example, which has long been a source of transplant tourists, efforts have recently been made to review domestic policies in order to promote a more ethical and effective supply of organs for transplantation within the country while discouraging transplant tourism and commercialism (Jotkowitz 2008; Lavee et al. 2009).

In the majority of cases, the countries from which HBM are procured to supply foreign needs are those in which progress towards self-sufficiency is significantly less advanced. For example, China provides some thousands of organ transplants to foreign patients each year and would undoubtedly provide more if global condemnation of Chinese organ procurement practices had not contributed to a ban on transplants for foreigners and a reduction in transplant activity using organs from executed prisoners (Delmonico 2009, 117; Budiani-Saberi and Delmonico 2008, 927). China could in theory help neighbouring countries such as Singapore or Japan to better meet the needs of their citizens for organ transplantation. Disregarding the ethical issues of the Chinese procurement program, such outsourcing would be at the expense of the many millions of Chinese citizens in need of organ transplantation (J. Huang 2007:195). To avoid exacerbating existing inequities in access to HBM, unilateral outsourcing should only be considered in the setting of surplus supplies of ethically procured HBM in a source country, such as occurs with the Sri Lankan Eye Bank (Simpson 2004, 845).

9.2.4 Potential advantages of cross border trade in HBM

Although needs for HBM will ideally be met domestically, cross border exchange or transfer of HBM offers some benefits. As I noted in Chapter 8, collaboration between countries can help to provide emergency supplies of HBM and to maximize the efficient use of resources. The challenge of bone marrow matching requires a global exchange of materials to meet patient needs, and patients with rare immunological characteristics or those who belong to ethnic minorities may be able to find optimal matches for organ transplantation or blood transfusion only in foreign communities. Immigrant or ethnic minority patients seeking third party gametes for use in ART may prefer to obtain ethnically matched gametes from foreign populations, while concerns about gamete donor anonymity may also cause patients to seek donor gametes from distant populations. As societies strive to develop the necessary healthcare infrastructure to provide therapeutically useful HBM, neighbouring countries may represent the only way to provide for domestic needs. Outsourcing needs for HBM in the setting of emergencies, such as disease outbreaks that reduce supplies of useful materials or crises
that provoke urgent needs such as earthquakes or war also offers a temporary solution. Conceivably, where two societies offer better access to different HBM, an exchange of resources may enable the populations of both to meet needs in a more timely fashion. Finally, where particular individuals are deliberately denied access to HBM in their own country (with the exception of equitable rationing) the opportunity to travel abroad to obtain HBM may enhance liberty and minimize the impact of unjust policies. Patients who suffer social discrimination, or those who cannot afford to access healthcare services using HBM locally, may be able to purchase such access abroad.

Although the preceding benefits of cross-border exchange or sharing of HBM are possible in the absence of markets in HBM, other advantages may arise in the setting of an international market in HBM. These include financial benefits to countries that are able to export materials on a large scale, which may in turn be used to foster important domestic social or healthcare goals. Secondly, an international market allows patients or HBM providers to travel abroad to purchase or sell materials in accordance with their individual preferences, where satisfying such preferences is condemned and/or prohibited in their own countries. The existing infrastructure and mechanisms of cross-border exchange of HBM are largely commercial in nature – as multinational trade in blood and tissue products demonstrates – and would thus facilitate a rapid expansion of global interactions to optimize the availability of HBM on the global scale. However, such market benefits are likely to accrue only to those societies or individuals who are able to pay for access to HBM, just as those most likely to provide materials will be from poorer countries less able to negotiate favorable trading agreements.

9.3 Global policy regarding payment for HBM provision

Respect for state sovereignty entitles governments to regulate the activities of their citizens within their own borders without fear of interference from other states. The procurement, use and distribution of HBM within national borders are thus primarily the concern of national governments. Nevertheless, the World Health Organization (WHO) provides health-related guidance and recommendations for all countries, and through the World Health Assembly (WHA) issues resolutions that are highly influential in policy making for the 191 member states of the organization. Other regional organizations such as the European Union may also issue policies or legislation

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61 Possible exceptions to this principle include international interventions justified by concern for gross violations of human rights or for activities that threaten the security of other states, however these are inevitably highly controversial.
governing practices within member states. More generalized ethical guidance is available in the form of United Nations Declarations on Human Rights and Bioethics (UNESCO 2005). Common values and principles are notable within the various documents available, however in reality the policies, legislation and practices within different countries are highly variable with respect to the treatment of particular HBM.

9.3.1 UNESCO Declaration of Bioethics

The aims of the UNESCO Declaration on Human Rights and Bioethics include

(a) to provide a universal framework of principles and procedures to guide States in the formulation of their legislation, policies or other instruments in the field of bioethics; (b) to guide the actions of individuals, groups, communities, institutions and corporations, public and private. (UNESCO 2005)

The scope of the Declaration is clearly global and due to its lack of specificity it may be applied to all HBM. However, while it refers frequently to respect for human rights, fundamental freedoms and human dignity, and notes the importance of consent, equality, justice, and equity, it offers little meaningful guidance for those seeking to apply such values to practices concerned with the procurement and use of HBM.

The Declaration does state, “States should take appropriate measures, both at the national and international levels, to combat bioterrorism and illicit traffic in organs, tissues, samples, genetic resources and genetic-related materials” (ibid.). This prohibition of illicit trafficking fails to acknowledge that the concerns of illicit trade might be replicated in legal trade. While potentially useful in its identification of important global ethical values - although authors such as Cherry (2009b) have contested their validity - the Declaration is too generalized to provide clear guidance on the specific issues of procurement, use and trade in HBM. Furthermore, it has little, if any, influence on international practice and law as yet (Harmon 2008).

9.3.2 WHO Guiding Principles on Human Cell, Tissue and Organ Transplantation

Like the UNESCO Declaration, the WHO Guiding Principles (2009c) are addressed to a global audience (member states of the United Nations). In contrast however, they are directly concerned with specific human biological materials – organs, cells and tissue with the exception of blood and reproductive cells – and offer clear guidance for the development of regulations and policy at a national level. The eleven principles are accompanied by explanatory text and a preamble in which a number of issues may be identified. These can be grouped as concerns about deceased and living donation, the
role of the state, the organization of donation and transplantation programs and commercialism.

The importance of legislation, independent physician determination of death, prioritization of deceased donation and consideration of known donor preferences regarding deceased donation are noted. Live donation is declared acceptable if informed consent and appropriate care of donors is ensured, and minors and legally incompetent persons are excluded from donating, except in exceptional cases consistent with national legislation. Commercialism is explicitly condemned, with prohibition of fungible rewards for donors or their next of kin and of profiteering from recovery or transplantation of materials by health insurers and professionals. Allocation of cells, organs and tissue must also be in accordance with “equitable, externally justified, and transparent” criteria and without financial consideration. Advertising or brokerage of a commercial nature is additionally prohibited, but promotion of altruistic donation encouraged. Finally, the Principles emphasize the need for quality control systems to ensure the “safety, efficacy and quality” of materials and procedures used in transplantation and donation, and advise that “organization and execution of donation and transplantation activities… must be transparent and open to scrutiny” (ibid., 13).

The Guiding Principles also note the importance of self-sufficiency in transplantation (ibid., 3), which reflects the WHO policy on self-sufficiency in human blood and blood products (WHO 2010c; 2010a). Concerns for donor wellbeing, consent, equitable allocation and quality controls are also manifested in WHO blood policies.

Unfortunately, the WHO frameworks fail to include mention of reproductive cells. The WHO has published no ethical guidance on the procurement, use and potential sale of ova or sperm for research or use in fertility treatments. Thus while the position of the WHO on organs, tissue and non-reproductive cells including blood is both consistent and clear, a vital category of HBM is conspicuous by its absence from policy. Otherwise, the Guiding Principles offer policy makers a comprehensive framework for regulation of practices regarding the procurement and distribution of HBM. Although instrumental in promoting ethical policies in organ transplantation throughout member states, a number of countries have failed to implement policies consistent with the spirit and the letter of the text, as previously noted examples of illegal markets and “compensated donation” models demonstrate.

9.3.3 European Union (EU) Directives

Unlike the WHO, the European Union has confronted the challenges of regulating all
forms of HBM. The EU approach exemplifies the difficulties and advantages of applying policies within a regional context. The European Parliament has produced a number of policy statements governing blood and blood products, human organs, tissues and cells and also reproductive cells.


This Directive outlines requirements for ensuring the safety and quality of cells and tissue, as well as principles governing “donor selection and evaluation” that emphasize consent and non-commercialism. However, while urging member states to ensure that “the procurement of cells and tissue as such is carried out on a non-profit basis”, it notes that “Donors may receive compensation, which is strictly limited to making good the expenses and inconveniences related to the donation. In that case, Member States define the conditions under which compensation may be granted” (ibid.).

As noted in Chapter 4.4.2, the flexibility of this language has enabled member states to provide variable sums of money for oocyte and blood provision throughout Europe. Where “compensation” exceeds the actual financial costs incurred from donation, it becomes a profitable enterprise and constitutes trade in HBM (see Chapter 1), violating the spirit of the Directive.

The most recent EU Directive concerned with blood, 2002/98/EC, is similarly ambiguous in its references to payment for provision, and leaves room for outsourcing. Article 20 advises that “Member States shall take the necessary measures to encourage voluntary and unpaid blood donations with a view to ensuring that blood and blood components are in so far as possible provided from such donations” (European Parliament 2003). The EU has not as yet issued a Directive concerned with human organs for transplantation, however the 2007 Communication on this issue to the European Parliament by the European Commission suggests one is forthcoming (European Parliament 2009). This Communication highlights concerns about transplant tourism, the importance of deceased donation, the challenges of organ shortages and points out the EU Charter of Fundamental Rights in which “making the human body and its parts a source of financial gain” is prohibited (ibid., 8).

The EU directives are heavily focused on procedural requirements and practical standards, however they do include ethical values and principles, with a particular
emphasis on non-commercialism and voluntary donation. They demonstrate the
difficulty of articulating regulation for a variety of member states that may have vastly
different national policies and practices, with diplomatic language allowing for flexible
interpretation. While this may facilitate harmonious relations between member states, it
has resulted in a burgeoning trade in HBM within the EU, particularly with respect to
reproductive travel involving the use of gametes from “compensated donors”. Similar
effects are noted within federalized states such as Australia and the United States of
America, in which regulatory differences encourage interstate medical travel despite the
existence of federal guidelines (Blyth and Farrand 2005, 104).

9.3.4 Variation between national guidelines and policies

Numerous states have developed ethical guidelines, policies and legislation governing
procurement and use of human biological materials. These may be specifically devoted
to blood, organs or tissues, and to living or deceased donors (e.g. NHMRC 1997, 4).
Variation in practice determines flows of HBM between different jurisdictions, usually
in the direction of lower costs, better supplies, fewer restrictions on access or use, or
less rigorous enforcement of legislation prohibiting trade. For example, cross-border
trade in ova is largely driven by differences in regulation that affect access to and
supply of oocytes rather than by cost differentials in accessing fertility treatments –
although this does play a part. The European Union is a bewildering labyrinth of
regulations regarding access rules, “compensation” for gamete donation, provider
anonymity and the use of pre-implantation genetic diagnosis (Jean Cohen 2006, 145;
see also Chapter 4.4.2).

Inconsistencies within national policies and international policy variation enabling
cross-border trade may undermine existing legislation and policies domestically and
abroad. Firstly, apparent inconsistencies in domestic policies (such as paying gamete
providers but not kidney providers, or paying egg providers for use in ART but not in
research or vice versa) may decrease public support for particular practices. Although it
is possible that inconsistencies may encourage the adoption of more widespread
restrictions, it is more likely that liberal policies will be used to justify “down
regulation” in other areas. This is evident from a number of articles calling for the
removal of prohibitions on organ markets in the United States on the grounds that
oocyte and sperm providers are remunerated (e.g. Friedman and Friedman 2006, 961;
Matas 2004, 2009). Secondly, individuals who can afford to travel abroad to access
commercially procured HBM when payment for provision is forbidden in their own

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country, effectively circumvent national legislation. This may be unfair to other citizens too poor to seek HBM abroad, but it also points to a potential responsibility on the part of governments to consider the impact of domestic policy on foreign citizens. Hence, some governments have adopted legislation that partially extends jurisdiction of HBM procurement and use beyond territorial borders. For example, Israel prohibits surgeons traveling abroad to procure organs from paid providers, a practice which played a key role in commercial transplant travel from Israel (Jotkowitz 2008, 3927).

Thirdly, countries that import HBM or HBM derived products procured in a manner inconsistent with national policies may undermine the integrity of existing legislation, for example where importation of commercially obtained plasma products conflicts with altruistic donation policies. This is particularly insidious where such practices are unacknowledged, no attempts are made to develop procurement strategies more consistent with official policy, and where governments misrepresent their success in achieving sufficiency in altruistic supplies. Without transparent disclosure, when such practices become known, public faith in procurement systems may be significantly damaged.

9.4 Addressing global trade in HBM
Numerous authors have highlighted the problems of national or international legislative diversity, with some offering suggestions for how these issues might be addressed (e.g. Pennings 2004; Morris 2007). A degree of global consensus on the treatment of organs and blood is taken for granted, with most commentators suggesting that global trade in organs should be discouraged by increasing domestic supplies (using a variety of methods including markets). Little has been said about how ongoing cross-border trade in HBM ought to be approached, however. With respect to organs, states have been encouraged to prohibit trade domestically (thereby indirectly minimizing export opportunities) and urged to discourage outsourcing by the WHO and professional organizations (e.g. Participants 2008). Francis and Francis (2010) also recently reviewed the possibilities for international regulation of organ trafficking.

Cross-border trade in blood and plasma products has been identified as both an ethical and practical issue, but the significant progress made towards self-sufficiency in many countries means that international trade is not considered an urgent priority for the global community. Farrugia, for example, claims that Australia should be less concerned with outsourcing some plasma products to the commercial sector, arguing that “the regulated plasma sector” does not involve “exploitation of developing world
The WHO and others have sought to increase global supplies of safe blood from unpaid voluntary donors, acknowledging the issue of commercial plasma trade but apparently judging it a secondary priority given the challenges of achieving sufficiency in plasma products from unpaid donors (WHO 2009b). On the other hand, significant concerns have been raised about biobanks and the regulation of trade in cells and tissue products. Thus far, product safety, provider consent, benefit sharing and profiteering have been the main issues identified as requiring regulation (see e.g. Scanlon 2006; Capron et al. 2009, 118-120). Rather than variation in legislation, it is a lack of legislation and policy at the national and international level that presents concerns. However, although there are multiple issues that must be considered and addressed with respect to domestic governance of biobanks (Gibbons 2009), cross-border issues should not be forgotten in the meantime, especially given the global scope of research in human tissue.

In contrast, there has been extensive discussion of how best to regulate cross-border trade in gametes, particularly in the context of the European Union, which provides a unique model for consideration of more globalized regulation, and in the United States where the federal-state relationship in some ways resembles that of the EU-member states (e.g. Hunter and Outram 2008; T. Davies 2010; D. Adamson 2005; Merchant 2009). In his discussion of the challenges of European regulation of reproductive services (including travel abroad to access gametes), Pennings (2004) examines three different options for prospective regulators. Firstly, he suggests, national policy makers might prohibit cross-border trade, for example by taking measures to prevent reproductive travel abroad and/or to punish citizens who return after traveling abroad to access procedures that are prohibited domestically. Secondly, international harmonization of legislation that eradicates cross-border differences may reduce or eliminate motivations to travel or trade across borders. Thirdly, the status quo could be preserved, with policies adopted and enforced domestically in accordance with national norms while individuals are permitted to travel abroad. Although Pennings’ discussion
is concerned with reproductive travel, his points may be equally applied to other forms of medical travel and to cross border trade in HBM. I shall explore each of these approaches to cross border trade in HBM more generally in the following sections.

A common thread of most accounts of regulatory issues is that regulatory voids present the greatest threats to ethical practice, which applies to both national and international policy making. For example, in the context of oocyte procurement for stem cell research, Isasi and Knoppers write,

[Given] the international realities of stem cell research, global recognition is necessary to prevent “ethical arbitrage” or forum shopping. Several jurisdictions, albeit with different conceptualizations of monetary payments, have led the way by prohibiting the importation of gametes and stem cell lines that have not been procured in accordance with the local laws governing monetary payments and consent rules (e.g. California, 2006; Czech Republic, 2006). These jurisdictions, by setting political and ethical boundaries, demonstrate that a society is capable of making ethical assessments, encouraging consistency, and establishing priorities... regulatory vacuums and the lack of adequate procedural and substantive safeguards undeniably lead to abuse. (2007:42)

9.4.1 The prohibition model
Nations seeking to enforce domestic policies regarding the procurement, use and distribution of HBM may choose to prohibit any cross border trade or travel by patients that would involve practices inconsistent with domestic policies. For example, as payment for organ provision is prohibited within Australia, importation of organs from paid providers or travel abroad for transplantation using commercially procured organs could be legally prohibited. This would effectively make the purchase of human organs an extraterritorial crime akin to legislation governing child sexual abuse by Australians overseas (see Perrin 2009, 203). Currently, although brokers of organs are subject to criminal penalties in many jurisdictions and have been prosecuted in a number of cases (e.g. Roy 2008; Smith 2010; Press 2010), patients known to have illegally purchased human organs both domestically and abroad have not been prosecuted62.

The prohibition model may be effective in discouraging some of the cross border trade in HBM, however it has major disadvantages. If domestic policies are unfair or inappropriate, criminalizing those who seek to access HBM abroad – particularly where they do so in order to access life saving treatment – may seem unduly harsh, if not an unethical restriction on liberty. Pennings cites the historical example of European travel for abortion, in which Irish women were prevented from seeking abortion in England,

62 With the exception of a Singaporean man who sought to purchase an organ via a broker, who was fined $11 850 and sentenced to a day in jail (Loo 2008).
and German women were arrested after traveling to the Netherlands to access abortion services (2004, 123). In some cases, criminalization of travel abroad to access HBM may not be concerned with trade itself, but with particular usage of HBM. For example, if the purchase of gametes is permitted in Country A, but homosexual couples there are denied access to provider gametes, such couples might travel to Country B where they may purchase gametes. In such a context, the issue would be one of prohibiting homosexual access to third party gametes rather than prohibiting trade in HBM.

The criminalization of travel for transplantation involving purchased organs may seem extreme, however when we consider that the decision by an Australian to travel to China for a liver transplant may directly result in the execution of a Chinese prisoner, the stakes are considerably high. Prohibiting travel abroad that involves individuals engaging in activities either alone or in company with consenting adults is indeed an infringement of personal liberty. Prohibiting travel that might result in harm to an involuntary provider of HBM in a foreign country may well prove a justifiable restriction on liberty in some cases.

9.4.2 The laissez-faire model

In the laissez-faire model, states are left free to regulate practices within their borders, and individuals are permitted to travel abroad to engage in practices that contravene domestic policies. This represents the current state of global affairs: although there are signs of increasing efforts to harmonize some elements of policy regarding the treatment of HBM, patients are essentially free to seek HBM in foreign jurisdictions if they are financially and physically able to do so. Penning suggests that this approach is the most advantageous of the three models. He writes

In a democracy, the majority has the political right to express its moral position in legislation and regulation. However, tolerance, respect for the ethical position of others and recognition of their autonomy as rational persons should prompt the majority to look for ways to take into account the view of the minority… (2004:127)

He notes that despite efforts to please everybody, legislation cannot “completely accommodate the minority” and thus reproductive travel abroad will allow “minority members to obtain the treatment they desire”, acting as “a safety valve that avoids moral conflict” (ibid.).

At first glance, this indeed appears to be a win-win scenario. Governments may congratulate themselves on upholding moral standards within their borders while ensuring that everyone is happy, because dissidents (at least those sufficiently wealthy)
may simply go abroad to exercise their moral preferences. Again, however, I must point out that some regulations are designed to prevent substantial moral harms. I shall argue that on some points of policy regarding the treatment of HBM, efforts should be made to enforce regulation in both the nation and international settings. Tolerance or the avoidance of moral conflict must not be used as an excuse to avoid taking responsibility for the potentially harmful actions of citizens abroad or the impact of domestic policies on foreign populations.

9.4.3 The harmonization model

Harmonization refers to the revision of conflicting legislations such that differences are eliminated or minimized. Three variations of the model are identifiable. Firstly, harmonization may trend towards the more restrictive of legislation or policies considered. Within the European Union, for example, adoption of the Italian legislation regarding gamete procurement by neighbouring countries would result in widespread prohibition of gamete donation (Boggio 2005, 1153). Conversely, harmonization might be liberal. For example, with the Spanish approach to gamete procurement embraced by other countries, generous “compensation” might be allowed for oocyte providers and few if any restrictions placed on access to gametes and ART. Thirdly, harmonization might be partial, seeking cross border consensus only on general principles or safety issues (Pennings 2004, 124).

In the case of restrictive harmonization, the impact of inappropriate restrictions risks being extended to more societies and some citizens may still be able to circumvent domestic regulations by traveling further abroad to more liberal jurisdictions. Where restrictions are appropriate however, more widespread harmonization will help to eradicate harmful practices.

The adoption of the least restrictive legislation governing the treatment of HBM would doubtless minimize demand for law enforcement, but would risk the promotion of “lowest common denominator” policies (ibid.). Assuming that some degree of regulation is ethically necessary, harmonization in either liberal or restrictive directions must be carefully considered. Where harmonization enables the general adoption of the most ethical policies, it represents the ideal situation – the challenge lies in determining the best policies and then obtaining international support for their adoption. For example, there is widespread support for the WHO Guiding Principles on Cell, Tissue and Organ Transplantation, as demonstrated by their adoption at the World Health Assembly (WHO 2010b). Although substantial variation persists in both policy and
practice, the legislative changes over the last few years in Pakistan, Egypt, the Philippines and Israel (Delmonico 2009a, 118; Natter 2010; Jotkowitz 2008) suggest that with sustained efforts at the national and international level, global policies with respect to organ transplantation and procurement at least, have some hope of achieving substantial harmonization.

Partial harmonization offers a compromise in the setting of (at least temporarily) irresolvable disagreement regarding best practice and policies. Agreement on some points may be achieved, for example in the setting of minimum standards for HBM provider care and consenting practices, or in the prohibition of payment for HBM provision. Different nations may then agree to enforce such policies while continuing to pursue different policies with respect to other aspects, for example allocation criteria. Where partial harmonization is confined to endorsement of ethical guidelines, its impact is likely to be minimal. The evidence of considerable variation in the implementation of compensation policies for gamete and blood donation within the European Union - despite consensus on the EU Directive noted above – highlights the limitations of this approach. Nevertheless, partial harmonization offers significant improvements on the laissez-faire model. In the absence of the EU Directive for example, the differences between EU member states might be far greater.

**9.5 National self-sufficiency & global solidarity**

In the previous chapter, I argued that the pursuit of self-sufficiency in HBM using procurement from unpaid donors offered the best approach for policy makers at the national or regional levels to meet domestic needs for HBM in an ethical and effective manner. The pursuit of self-sufficiency will not only minimize demand for cross border trade in HBM by improving domestic supplies but will actively discourage outsourcing by highlighting the importance of local responsibility for the burdens of HBM provision. Realistically, even as more countries embrace the WHO Guiding Principles and progress towards self-sufficiency in various HBM, other countries will still offer opportunities for societies and individuals seeking to purchase HBM abroad. The international community and individual states must therefore determine how to address the issue of cross-border trade, if we are to avoid the hazards of a laissez-faire approach.

The first step, I believe, is to encourage national adoption and implementation of the self-sufficiency model, subject to whichever practical variations are necessary in the context of specific countries.
The second step requires the international community to consider the issues of cross-border trade in various HBM and to identify priorities for regulation. The principles and values guiding such regulation should be the same as those that underpin the self-sufficiency model, the WHO Guiding Principles and the UNESCO Declaration of Bioethics. Global solidarity should inspire recognition of our responsibilities for distant others, particularly in the context of practices that may be influenced by our own actions and policies in the domestic setting. It should also prompt concern for those communities and individuals most at risk of harm from cross-border trade, namely those suffering from extreme poverty who may lack the essential capabilities required for human flourishing and the effective protection of their own governments from exploitation, coercion and harm. Others at risk, such as patients seeking access to HBM should also be protected. In order to identify individuals at risk, and to determine the extent of potential concerns about cross border trade and how they may be addressed, research and monitoring will be required. Policies should be developed in consultation with those likely to be affected by them, engaging vulnerable groups so as to decide not only how best to help, but also how to address vulnerabilities so that these communities may be empowered to act autonomously and make “decisions in whatever concerns their own lives” (Archard 2008, 21).

The priorities for global regulation of cross-border trade in HBM should be as follows:

(i) Protection of HBM providers;
(ii) Protection of HBM recipients;
(iii) Engagement with vulnerable groups;
(iv) Collection of information regarding cross-border trade, its contributing factors and its impact.

9.5.1 Strategic approach to cross border issues

Protection of providers and recipients begins with the identification of minimum standards of care for patients, criteria for informed consent and legislation governing the diagnosis of death and protocols for the procurement of HBM from deceased providers. A variety of international instruments developed by professional organizations are already available, which will facilitate this task (see e.g. Barr et al. 2006; Delmonico et al. 2005; Participants 2008; Mainland and Wilson 2010). Although countries that engage in HBM procurement and use should be encouraged to meet minimal requirements in this area, not all will do so, and private healthcare providers may be
able to exploit legal loopholes in order to avoid such requirements. Efforts to minimize unacceptable practices may then target the industry itself. For example, international accreditation of clinics that conform to minimum standards may be used to influence consumers. The governments of countries from whom transplant or reproductive travelers originate may then choose to criminalize overseas travel that involves unaccredited services rather than all medical travel for HBM, allowing a degree of liberty to citizens while preventing or discouraging the most harmful elements of the trade.

The imposition of international standards of patient care will require careful reflection. Differing levels of infrastructure and resources between countries means that best practice in Country A may be inferior to that of Country B. For example, Country A may be unable to provide health insurance to living organ providers for any possible complications of their surgery, while Country B is able to do so. This does not mean that organ provision in Country A should therefore be prohibited. Best practice in Country A may reflect general standards of health care provision and offer the best way to meet local needs for HBM. However, where HBM are exported from country A to country B, it seems unfair that recipients in B are benefiting at the expense of risks to providers in A that country B could prevent. This is an issue that will require further examination and debate to determine the fairest method for determining minimally just standards in the cross border setting. It should be distinguished from the issue of developing minimal standards corresponding to the level of protection for HBM providers below which provision cannot be justified at all.

Quality and safety standards in patient care should also apply to recipients of HBM. Accreditation, data collection and monitoring of trade will also be required to help enforce standards, quantify risks to participants and encourage market evolution towards more ethical practice.

With respect to engagement with vulnerable groups, policy makers at the international level should draw on the work of anthropologists, sociologists and medical professionals researching cross border trade who describe the realities of the industry and identify potential vulnerabilities. Greater efforts should be made to discuss policy with those groups likely to be affected by cross border trade, helping to give potential HBM vendors a voice in decision making. More importantly, international efforts to address poverty and other sources of vulnerability should target regions where trade in HBM is endemic and seek to provide communities with resources and opportunities that will make selling HBM an option rather than the only choice available.
9.6 Conclusion

International variation in the regulation of access to and use of HBM, particularly the regulation of payment for HBM provision, facilitates medical travel by providing alternative locations in which patients may more easily access procedures involving HBM than in their own countries (Carbone and Gottheim 2005). Trade in HBM in the form of export and import of HBM products also flourishes as a result of cross-border policy variation and regulatory gaps. Despite its predominantly commercial nature, the globalization of HBM provision revealed in cross-border trade demonstrates the capacity of human beings to exchange biological materials with distant others regardless of race, religion and nationality. Many providers can share their materials with one of hundreds or even thousands of compatible strangers both domestically and abroad, while human tissue products or the benefits of research using HBM may be shared with many. Although for individuals in some cases it can be challenging to find suitably matched biological materials for transfusion, transplantation or reproduction, global networks enable matches to be found in distant countries (eg. BMDW 2010).

A new approach to global demands for HBM is urgently required, in which community is emphasized and sharing rather than trading of HBM is promoted. Governments must take the lead in pursuing self-sufficiency in HBM and promoting HBM donation in accordance with societal values and healthcare priorities. Ethical practices that address domestic priorities will minimize travel abroad, avoiding the exploitation of vulnerable foreign communities. Members of the international political and professional healthcare communities should work together to establish guidelines for national regulation of medical travel involving HBM. The efficacy of regulations is determined by their application within countries, thus while international instruments are valuable to guide cross-border interactions, it is national policies and regulations that will most effectively impact on practice. Although each country must debate their domestic issues of HBM procurement and use and develop legislation and policies in accordance with the values of their societies, the international community should strive to achieve agreement on minimal standards of care for providers and recipients, and on globally unacceptable practices such as trafficking and coercion of HBM providers. In addition, the international community should work together to prevent unacceptable practices, to share knowledge and resources that will enhance global access to HBM, and to establish systems of data collection that will facilitate research and guide the development of more effective systems of HBM procurement and use.
9.6.1 Defining community in the global context

Engelhardt has argued that the irresolvable differences elicited by global moral pluralism and the absence of an independent universal moral authority means that, a global bioethics can at best provide a thin moral framework, a space within which individuals and moral communities can peaceably pursue divergent understandings of morality and bioethics within limited democracies and within a global market. Such a global bioethics cannot provide a content-full understanding of the right, the good, virtue, or human flourishing. Content will have to be found within particular moral communities and the moralities and bioethics they sustain. (2006:40)

While Engelhardt seems to suggest that moral communities are born rather than made, and that individuals may therefore choose to join whichever community best reflects their personal values and beliefs, Hester advocates a processive conception of community:

Community, then, is not shared values but shared valuing and shared evaluation. Though communities do have shared values, those values are the result of processes which are themselves already instances of community(ing), and further, the shared values of a community can only be claimed as “shared” if the activities of the members demonstrate shared commitment. (2004, 432)

In the context of the procurement and distribution of HBM, the limits of community should be defined by the individuals between whom HBM may be exchanged. Although in theory this applies to the entire human species, for policy making in practice it may be better defined by the actual exchanges of HBM. Where international trade or non-commercial exchange of HBM occurs, “HBM-sharing communities” will therefore extend beyond national borders. Although the concept of an HBM-sharing community may seem thin compared with the more cohesive communities bound by multiple shared features such as religion, ethnicity or locality, given the personal, social and therapeutic importance of HBM, it should not be undervalued.

Those like Pennings (2004) who argue that patients seeking purchased materials abroad are simply expressing their own moral preferences in a like-minded community, are often mistaken. Communities providing these materials frequently do not endorse (socially or morally) the commercial procurement of HBM, as the stigma attached to paid provision demonstrates. Instead, they may be coerced, or unable to avoid participating in sales of HBM due to lack of alternate options for economic survival in the absence of local government protections. If international trade is to be defended on the grounds of cross-border communities sharing moral values, advocates will need to demonstrate genuine commitment to these values and also a sharing of other values and
practices regarding the treatment of HBM. Moral communities, I have argued in Chapter 2, seek to promote human flourishing together, rather than as purely self-interested individuals. Patients seeking HBM abroad should have a vested interest in the impact of their travel on HBM providers and other members of the local community in destination countries. This interest should not be limited to financial transactions; it implies taking greater responsibility for mutual benefit.

Rather than viewing cross-border exchange of HBM as a moral free marketplace, effectively endorsing an anything-goes approach to practice under the false guise of respect for liberty and moral pluralism, the shared biology of humanity that enables such exchanges should be viewed as an opportunity for sharing and a rationale for the promotion of universal human values and goals with respect to the treatment of HBM.
Marketplace or community?

Hath not a Jew eyes? hath not a Jew hands, organs, dimensions, senses, affections, passions? Fed with the same food, hurt with the same weapons, subject to the same diseases, healed by the same means, warmed and cooled by the same winter and summer, as a Christian is? If you prick us, do we not bleed?

The Merchant of Venice, Act 3, Scene 1, Lines 59-62 (Shakespeare 1948, 196)

10.1 Introduction

I began this thesis with a quote from The Merchant of Venice in which the unfortunate Antonio has foolishly mortgaged a pound of his own flesh and must face the fatal consequences of its collection by the merchant Shylock (ibid., 200). Antonio recognizes that little can be done to save him, for the contract that he freely entered was legal, and the laws of trade dictate its fulfillment. He notes the importance of maintaining public faith in the integrity of the Venetian market, in which profits depend on trade with all nations. In contemporary markets in HBM, trade likewise extends beyond the borders of the city-state and across the world. In modern markets, individuals less fortunate than Antonio may also freely contract to sell various parts of their bodies. The circumstances that contribute to sales, and their consequences, may produce much grief and loss, but not all modern vendors will be saved at the eleventh hour by Shakespearean machinations. In this chapter, I review the themes and arguments of the preceding chapters and summarize my conclusions, highlighting avenues for further work and priorities for immediate action.

Policy, legislation and debate regarding the treatment of HBM have traditionally been fragmented. Different rules for different materials, uses and recipients have applied within and between states at the national, regional and international levels. Discussion that starts at a specific practical end point – for example, the shortage of kidneys for transplantation in a particular country – and traces back to determine questions such as whether payment for living or deceased organ donation is ethical, may produce solutions to specific problems, but will fail to provide comprehensive and consistent accounts of related issues and to establish the most effective solutions to all issues.
10.2 A new approach to the treatment of HBM

Although Shylock was eager to take his pound of flesh from Antonio, the quote at the beginning of this chapter shows that he was well aware of the central role that embodiment plays in human lives and morality. The therapeutic value of HBM is made possible by shared human biology. Blood, tissue and organs may be transferred between individuals of different religion, gender, race and age. Children may be created through gametes provided by strangers in distant countries. In Chapter 2, I began my examination of the ethical treatment of HBM by discussing the role that human bodies play in moral and social communities. I defined some universal moral principles that apply to the treatment of living persons by virtue of their nature as dependent social animals with rational capacities. I argued that at the very least, moral systems must incorporate recognition of all living humans as subjects of moral concern with rights to bodily integrity. Further, in order to act as moral agents, the autonomy of living persons should be respected, including recognition of the fundamental interest people have in influencing the course of their own lives. Without proposing a specific account of the good life for individuals or societies, I suggested that the capabilities approach to human flourishing described by Nussbaum (2000, 411-426) identifies key elements necessary for all human beings to pursue lives that would be considered worth living. Given the potential violation of bodily integrity in HBM procurement and the importance of health and hence the availability of therapeutic HBM for human flourishing, I concluded that the provision and the procurement of HBM ought to be a key moral concern for all societies.

In Chapter 3, I discussed the different values that individuals and societies may place on HBM. Examining the question of whether HBM should rightly be considered the property of providers, I argued that while the intimate relationship between living persons and their detached biological materials confers an important personal value upon these materials which may require legal protection, conceptualization of HBM as property is not necessarily required to protect personal interests in HBM. Shifting valuations of HBM, and their implications for the treatment of these materials, are an important concern for society. Variations in value between cultures and societies, not to mention individual people, make identification of a primary immutable valuation impossible. Instead, throughout the thesis, I have sought to demonstrate how concerns about the treatment of living individuals underpin concerns about the treatment of HBM – reflecting the manner in which personal value in detached materials is derived from personal relationships and valuations of living individuals. In order to decide how
society ought best to regulate the treatment of HBM, we must look to the potential impact of different policies on individuals and society and ask which values and ethical principles will best serve to secure and nurture the capabilities required for human flourishing and to promote relationships between individuals and societies that will produce the kind of world we would all wish to live in.

10.2.1 Reconsidering markets in HBM

Although the modern marketplace is sometimes viewed as devoid of ethical influence and thus a forum in which individuals are free to trade goods in accordance with their personal moral preferences, in Chapter 4, I argued that markets instead reflect the values of the communities in which they develop and operate, and should thus be designed to promote the goals of society. In this context, potential ethical concerns about markets and in particular markets in HBM were introduced, and various proposals for market regulation examined. When the goals and concerns of market advocates are articulated, they reflect many of the goals and concerns of market opponents. I suggested that societies considering how best to procure and distribute HBM would do well to consider Aristotle’s distinction between the oikonomia and the emporium. The former model exemplifies a way of thinking about goods as shared resources for communities that reflects both the way HBM are valued personally and the way the treatment of HBM is recognized as socially significant. Conversely, the emporium style marketplace is reminiscent of contemporary markets in HBM, in which goods are traded between individuals without concern for the needs of the community or the possible impact of trade on society. In Chapter 5, I discussed the possible consequences of markets in HBM, arguing that markets are unlikely to achieve the priorities of market advocates and that alternative, non-market mechanisms may more effectively and ethically meet the goals of societies in procuring and distributing HBM. Importantly, I sought to rebut the claim that the imperative to save human lives justifies markets in organs.

10.2.2 A right to sell HBM?

Setting aside the more popular arguments for markets in HBM that focus on increasing supplies of HBM, in Chapter 6 I explored the claims that focus on individual rights to sell. Despite the importance of respecting individual liberty and autonomy, I argued that where these principles are invoked to justify sales of HBM, their value is primarily instrumental. An individual may wish to sell her own biological materials in order to improve her life, opening up opportunities that may enhance the expression of
her autonomy and liberty. The sale itself is merely a means to this end. Being able to choose employment, to seek out relationships with different people, to travel and to develop one’s talents is an expression of autonomy or liberty. Being allowed to sell parts of one’s body does not in itself further one’s autonomy. Again, I suggested that there are better ways to enhance the autonomy and liberty of the poor. Although in some communities, prohibitions on the sale of HBM may be regarded as an unacceptable restriction on individual liberty, the endorsement of sales by society and the development of a market based system to provide for society’s HBM needs may be nevertheless unethical. Allowing a right to sell should not be mistaken for a moral mandate to purchase HBM.

With this in mind, in Chapter 7, I discussed the issues inherent in commodifying HBM. Foremost among these is the fear that commodification of HBM will impair the personal value of these materials, and damage individuals' conceptions of themselves and others as embodied persons or subjects of moral concern. Commodification attitudes towards living persons risk engendering denial of their human dignity; commodification of HBM *per se*, by depersonalizing the procurement and distribution of HBM, promotes disregard for the social context in which markets may operate, which itself may result in disrespect for human dignity. In other words, the procurement and distribution of HBM should provide individuals and societies with the opportunity to consider not only needs for HBM, but also other important human needs required to live a dignified life. Trade in HBM will in many cases depend on conscious neglect of such needs, which should take precedence over commercial priorities in any society that truly aspires to flourish.

**10.2.3 The self-sufficiency model**

Having critiqued the various arguments and models proposed for markets in HBM, in Chapter 8, I presented my alternative strategy for procuring and distributing HBM. Elaborating on the goal of national self-sufficiency advocated by the WHO, I argued that the development of effective and ethical policy will depend on societies embracing responsibility for meeting HBM needs without outsourcing HBM provision. Not only should the burden of providing HBM be shared by those who receive the benefits of HBM supplies, I suggested that a non-commercial domestic procurement system will motivate the development of fair, efficient and safe policies that minimize risks to community members. Reviewing a range of ethical values such as solidarity and reciprocity, I argued that these, in addition to altruism, might be used to enhance
potential donor motivation, for example by placing a stronger emphasis on individual duties to contribute to shared public goods. The self-sufficiency model will require extensive investment in infrastructure and will take time to achieve the necessary support from society members and hence to produce optimal results. However, it offers the best chance for countries to achieve sustainable and reliable supplies of HBM without taking advantage of vulnerable foreign communities.

The issue of how to address ongoing cross-border trade was then reviewed in Chapter 9, in which I argued pragmatically for a partial harmonization approach to international regulation. Encouraging the pursuit of national self-sufficiency while prioritizing the protection of HBM providers and recipients through implementation of minimal standards of care will be most effective when industry, healthcare professionals, individual medical travelers and societies are informed, educated and encouraged to take responsibility for their actions and policies. Both cross-border and national activities with respect to the treatment of HBM should be regarded as a common concern of all human beings. Global solidarity rather than a purely procedural framework for the independent pursuit of individual goals should ground the development of policy. This will “enable us to do justice to the human variety we find” (Nussbaum 2000, 384).

10.3 Future avenues for research

Only limited data is available regarding the extent of global needs for HBM and the relative success of various societies in meeting their domestic needs, but it is certain that millions of needs remain unmet (see Chapter 1). The number of living and deceased individuals who provide materials each year is known to number in the millions, but how many of these provide blood, organs, gametes, cells or tissue, and what proportion of providers are remunerated is unknown. Empirical research is urgently needed so that policies can be developed which best address current needs and anticipate future requirements. More importantly, by determining (and addressing) the factors that contribute to increasing needs for HBM, policy makers will be able to limit if not reduce the growing demand. Although organ market advocates have argued pilot studies of regulated markets are needed (e.g. Matas et al. 2008, 284; Halpern et al. 2010, 364), a variety of alternative mechanisms to motivate potential HBM providers merit closer attention and possibly trials. Some of these have already been successfully implemented in some communities. They include promotion of deceased donation as a social obligation rather than an exceptional gift; removal of barriers and disincentives to living
organ, cell and blood donation; active encouragement of gamete donation; and efforts to address concerns that may contribute to deceased donation refusal rates despite approval in principle. Setting aside these more practically oriented issues, in this section I will briefly introduce some areas in urgent need of consideration by ethicists and policy makers concerned with the treatment of HBM.

10.3.1 Secondary commodification of human tissue

The rapid growth in biobanks appears to have left scientists, jurists and policy makers struggling to establish standard operating procedures, regulatory safeguards and legislation to govern practice in the procurement, use, storage and transfer of human tissue for research. The WHO has sought to establish international consistency in coding of cells and tissue to facilitate data collection and enable donor and recipient tracing, and issued guidelines for safe procurement and use of cells and tissue (2006). As regulatory frameworks evolve, a key issue that must be addressed is that of secondary commodification of altruistically donated materials. Despite prohibitions on profit (WHO 2009c, 3), the tissue industry represents a source of immense profit, particularly to private biobanks (e.g. Andrews 2005, 26). I have argued that such profiteering should not be seen as a justification for paying HBM providers. Rather than viewing secondary commodification as an injustice because providers receive no share of the financial benefits of their donation, it should be seen as a violation of the donors’ trust, and of societal values. The aim of altruistic donors who agree to provide materials for use in research or for the creation of therapeutic products is to promote the health of society. Where research is conducted by public institutions and the benefits are made available to society, the donor’s wishes are essentially fulfilled. Where tissue is instead sold to private institutions and the financial profits of research are channeled into the pockets of shareholders rather than public healthcare systems, this betrays the donors’ wishes.

Regulation of cell and tissue donation is required to ensure not only that prospective donors are informed of the potential uses of their materials, but to minimize opportunities for profiteering and secondary commodification. The challenge for policy makers and ethicists is to determine what constitutes profiteering as opposed to recovery of reasonable operating costs, and how to ensure that the benefits of public donations, whether in the form of scientific knowledge, therapeutic products or financial profits, are channeled into public healthcare systems and shared equitably among the members of society who contribute to them.
10.3.2 Considering needs for oocytes in research

As the growing body of literature from feminist bioethicists demonstrates, the use of oocytes in stem cell research requires closer attention. A number of authors have advocated paying providers of oocytes for use in research on the grounds that:

(i) Providers of oocytes for use in ART are paid, thus it would be inconsistent or unfair to refuse payment for oocytes used in research (e.g. Angel 2007, 202; Klitzman and Sauer 2009);

(ii) In the absence of payment, there will be insufficient supplies of oocytes for use in research (e.g. Foohey 2010, 908-9);

(iii) Provision of oocytes for use in research is analogous to participation of human subjects in research trial. As the latter are paid, oocyte providers also deserve payment (Ballantyne and De Lacey, 2009; Angel 2007, 222).

Although I am unable to fully address this issue here, I will briefly review the last claim, which harks back to the Argument from Analogy with Labour discussed in Chapter 6.

Providing oocytes (or other HBM for that matter) for use in research ought to be distinguished from “ordinary” participation in human research. In the latter, men and women are treated and observed as research subjects, whereas individuals are simply providers of material that is used in research. Despite the fact they may undergo screening, receive hormone stimulation and suffer invasive oocyte procurement, these steps do not benefit the women, nor are they intended to provide valuable research information, they are simply necessary to obtain the materials required for research. Although Dickenson argues that this represents women’s reproductive labour (2006, 48; 2007, 68, 102), this labour is not truly analogous to the work of human subjects in research trials. Dickenson (2006, 47) and K. George (2008, 288) also point out that the usual ethical standards of care for participants in research trials are not always applied to oocyte providers.

As Dickenson (2006) and others have argued, the efforts of women in providing oocytes (or other forms of reproductive labour such as surrogacy) have been grossly neglected. The emphasis on altruism has tended to undermine women’s control over their reproductive resources, undervalue their contributions and underestimate the risks they face in providing oocytes. However, payment for oocyte provision may further exacerbate these issues by commodifying women’s biological materials and objectifying providers. Instead, those who choose to donate oocytes should be
reimbursed for costs they may incur; greater efforts should be made to minimize the risks of oocyte provision for research and to enable women to have more control over the use of their donations, for example by providing comprehensive information about the purpose of research and its anticipated benefits; and to celebrate the contributions of women in this field.

Furthermore, if lack of financial incentives results in insufficient supplies of oocytes for research, this should not necessarily be cause for distress or policy revision. The sheer number of oocytes needed to achieve the desired goals of research (Dickenson 2009, 127) may render oocyte provision a pointless task – even with financial incentives it is possible that supplies of oocytes will remain insufficient. If we remember that oocytes are not just raw materials for research, but unique HBM obtained through personal effort and risk and with personal value for their providers, the costs of obtaining them may far outweigh the (as yet) speculative benefits of their use in research.

10.3.3 Neglected issues

Unfortunately, I have been unable to address a number of additional important issues related to the treatment of HBM in this thesis. Firstly, I have not considered the parallels between providing HBM and the provision of services intimately connected with the human body such as prostitution and surrogacy. Secondly, I have not discussed the ethical issues that arise from particular forms of use of HBM, such as the use of gametes in ART or stem cell research. Thirdly, I failed to explore the complexities of deceased provision of HBM, and the role that social and scientific conceptions of death play in this. A final neglected issue concerns the allocation of HBM. Concerns about equitable distribution of HBM, especially human organs, have been raised by numerous authors (see McCarrick 2009). I trust the lack of discussion of this subject does not detract from the overall points of concern addressed in the thesis or those arguments in which equitable distribution of HBM is invoked. I have avoided engaging these important questions despite their relevance to the subject of ethical treatment of HBM because they raise substantial and complex issues that could not be adequately addressed within the scope of the thesis. I hope to examine these questions in the light of the work of this thesis at a later opportunity.
10.4 Conclusion

It is likely that debate will continue regarding the merits and hazards of markets in HBM in the context of specific markets and societies. In the meantime, needs for HBM continue to grow throughout the world and thousands of people are at risk of harm in poorly regulated and illegal markets. Fortunately, many countries have already laid the foundations for safe and reliable systems of procurement and distribution of HBM. Renewed and novel efforts to promote donation, to minimize needs for HBM and to protect those at risk of harm will further advance the goals identified here and invoked by many commentators, governments, professional societies and international organizations such as the WHO.

I would like to make a final point about the challenges of meeting needs for HBM and the importance of setting needs in the context of broader requirements for healthcare and existing socioeconomic inequities. Although my arguments here have often focused on the dramatic stakes of organ procurement and transplantation, they are equally applicable to the procurement of materials whose sale is often regarded as less ethically problematic. Thus, I will return briefly to the example of human teeth, which I introduced in Chapter 1.

10.4.1 Reconsidering trade in teeth

It may be supposed that the therapeutic or commercial value of human teeth expired with the demise of tooth transplantation in the 19th century. Like many elements of global trade and use of HBM, needs for teeth and commercial trade in teeth are largely invisible to the public eye. Nevertheless, there is considerable demand for human teeth for use in dental research and an ongoing trade, the extent of which is essentially unknown. This represents an important issue for policy makers and merits closer consideration.

Dental pathology imposes a significant social burden on many societies. The WHO reports:

Oral diseases are major public health problems in all regions of the world. Their impact on individuals and communities as a result of the pain and suffering, impairment of function and reduced quality of life they cause, is considerable. Globally, the greatest burden of oral disease is on the disadvantaged and poor population groups. (Petersen 2005, 667)

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63 See e.g. Waldeck’s (2002) advocacy of markets in breast milk, and Berry’s (2008) review of markets in human hair.
A shortage of human teeth available for use in dental research is partially mitigated by the use of bovine teeth, however researchers suggest that access to more human teeth for research would be beneficial (Oesterle et al. 1998; Dominici et al. 2001). A literature search reveals no evidence of contemporary debate regarding the procurement of human teeth for use in research. However, a variety of online forums show that dental students are encouraged to obtain teeth for educational use by calling on practicing dentists and oral surgeons to collect teeth on their behalf. The casual comments on such forums show how easily HBM may be disconnected from their providers, instrumentalized and objectified. In response to an online query regarding how to acquire the necessary teeth, a student at the University of Pennsylvania writes,

I just searched Google for the nearest oral surgeons - dropped off jars with diluted bleach at 5 different offices and picked them up about 6 weeks later. This gets you a ton, but lets you really pick out some quality teeth. (SDN 2010)

The following week, another student comments

A great place to get teeth is a "denture mill", these guys pull teeth all day. Every time I go to one I get at least a jar full of teeth. Granted alot [sic] are in poor condition but some are in great shape. (ibid.)

At the level of research institutions, two different methods of obtaining needed teeth are likely to be practiced. Firstly, public dental hospitals conducting research may procure teeth removed therapeutically from patients. Secondly, private dentists who remove teeth for therapeutic reasons may provide these to research institutes. In both cases, consent to donation of teeth for research may be obtained from patients, and it is unlikely patients will be offered payment for materials that would customarily be discarded. In the second case, dentists may charge a fee to supply teeth to researchers, or brokers might collect teeth for resale. With respect to research itself, the therapeutic benefits may target healthcare priorities or more cosmetic concerns, and any financial profits may or may not be channeled into further research. In most countries, the absence of public access to dental care is likely to limit equitable distribution of the benefits of research. The teeth providers from the “denture mill” may well have poor quality dentition precisely because they lack access to early dental intervention and have poorer nutrition due to poverty. Whether the students who use these teeth to learn will later share their skills with poorer communities is uncertain.

Markets in teeth will not help address the global burden of dental pathology. Instead, investment in equitable access to dental care and public research facilities in dentistry, in conjunction with systematic procurement systems that would ensure appropriate
consent procedures of all dental patients would help to supply the necessary resources for research and promote better health for all members of society.

10.4.2 Beyond the market

The focus on supply and demand of HBM has naturally led to considerations of market procurement mechanisms. This has limited both the scope of ethical concern and practical solutions to the problem of meeting needs for HBM. Loewy highlights the need to take a broader picture of ethical issues in his discussion of just institutions,

One cannot hope to build a truly just institution within the context of an unjust society anymore than one can practice truly ethically in an institution which is basically not ethically just. Therefore, we must strive to affect the social structure of the society in which we live. Within a framework of shared interests and capacities, using compassionate rationality and proceeding by democratic process we must seek to reconstruct society itself. (1997, 94)

Rather than asking whether we should pay people for their biological materials, policy makers, ethicists, health care professionals and all members of society must look beyond the market and ask what sort of society we wish to live in, and how we can better promote the conditions for human flourishing, including better access to HBM, without trading in our bodies or our ethical values.
Bibliography


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Haddow, G. 2006. "”Because You’re Worth It?” the Taking and Selling of Transplantable Organs." *Journal Medical Ethics* 32 (6): 324-328.


Havasupai v ABOR (Arizona Board of Regents). 2008. 204 P.3d 1063 Arizona Appeals. Division 1. Available at: [www.cofad1.state.az.us/opinionfiles/cv/cv070454.pdf](http://www.cofad1.state.az.us/opinionfiles/cv/cv070454.pdf)


Howard, R. J. 2006. "We Have an Obligation to Provide Organs for Transplantation after We Die." American Journal of Transplantation 6 (8): 1786-89.


Transfusion Alternatives in Transfusion Medicine 10 (2): 53-60.


Lawlor, R. O. B. 2010. "Organ Sales Needn't Be Exploitative (but It Matters If They Are)." *Bioethics* Published online February 10, 2010.


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Appendix 1

Glossary

Alienation

See detachment; inalienability

Cells

Although cells constitute most elements of the human body, I follow the traditional distinction between blood (and its cellular constituents), reproductive cells or gametes, and other cells obtained from more complex human tissue, as members of these different categories are associated with different markets, therapeutic uses and issues.

Commodification (complete)

The market exchange of things (commodities), such that these things are treated as fungible objects with monetary equivalence and hence commensurability (Radin 1996, 118).

- Incomplete commodification

Describes attempts to regulate the market exchange of special goods, for example by setting limits on their fungibility or monetary equivalence.

- Partial commodification

Describes the commodification of integrated elements of a living person’s body, such that the person is not herself wholly commodified, but a component of her body is ontologically distinguished as a prospective commodity. This renders the person herself a potential commodity.

- Primary commodification

The voluntary sale of HBM by providers, where the HBM is detached for the specific purpose of sale.

In a current market, (in vivo) detachment is from living providers.

In a futures market, (post mortem) detachment is from deceased providers who have contracted to sell while alive. Providers in this case may receive complete
or partial payment for their materials during their lifetime, or payment may be made posthumously to their heirs upon procurement of the materials.

- **Secondary commodification**
The sale of HBM by *providers* or third parties, where the materials sold were originally detached from the provider for a non-commercial purpose.

*Voluntary secondary commodification* occurs when the provider consents to the sale of their detached materials. For example, the provider contracts to sell placental tissue to a research bank following delivery of a baby.

*Involuntary secondary commodification* occurs in the absence of consent to sell from the provider. The provider may be unaware of the commercial transfer of their detached materials, for example when tissue banks sell altruistically donated materials to third parties. Alternatively, the provider may be coerced, for example where materials are detached for the purpose of sale against the provider’s wishes.

**Commodity**
An “article of trade, especially a product as opposed to a service” (Sykes 1976, 203). A commodity is in essence fungible, in that it has a price equivalent and may be exchanged with a variety of other products or goods of monetary equivalence.

HBM are treated as commodities where they are transferred or exchanged between two parties in return for a financial or fungible benefit that exceeds the costs incurred through *procurement* or modification of the material for use.

**Compensation**
A term widely used to describe a variety of payments to *providers* of HBM. In many cases, compensation payments represent financial *incentives* for HBM provision, rather than the *reimbursement* of costs incurred through provision.

**Detachment**
Refers to the separation of HBM from a living person64. *In vivo detachment* occurs when materials are removed from a living human being. *Post mortem*

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64 Note living person here refers to the original provider of the material, not a recipient from whom materials might later be physically removed (e.g. following a failed organ transplant.)
**Detachment** is the removal of materials (including the use of an entire body) after the provider’s death. In the latter case, the materials are metaphorically separated from the living person by death. While the term *alienation* is sometimes used to describe the detachment of materials for the purpose of sale, I have tried to employ the more neutral term detachment to refer to the process of separating materials physically from persons regardless of the purpose involved. Detachment may occur naturally, for example when hair or skin is shed, or through invasive procedures such as nephrectomy or venepuncture.

**Donor**

See *provider*.

**Futures market**

See *commodification*.

**Gametes**

Human reproductive cells, including sperm and oocytes. The latter are also known as “eggs” or “ova”.

**Human biological materials (HBM)**

Any original physical component of a human body, living or deceased. They include organs, tissue, cells, fluids composed of cells or other matter and various forms of tissue at the cellular or sub-cellular level.

This definition includes materials that are produced using modified human tissue such as *products* derived from plasma or bone. It does not include purely synthetic prosthetics that may be implanted in human bodies such as artificial joints, pacemakers, surgical clips, wires, coils, staples and sutures, orthopaedic rods and fixators, bionic ears and robotic devices, except where such devices may include components produced from human tissue.

**Inalienability**

Entities described as **market inalienable** are deemed inappropriate for sale. Conversely, **alienable goods** are those that may be transferred via commercial exchange.
Incentive

Except where otherwise specified, in this thesis the term “incentive” refers to benefits offered to prospective HBM providers in return for their materials, where such benefits constitute a payment or fungible commodity the value of which exceeds any costs directly incurred through provision of the material.

Infertility

- Medical infertility refers to the impaired ability of a woman to become pregnant and safely deliver a child, as a result of biological factors on her part and/or that of her male partner, where the biological impediments or dysfunction is considered pathological or abnormal. For example, premature ovarian failure causes medical infertility, whereas ovarian failure occurring after the age of 50, is not considered abnormal and hence causes natural biological infertility rather than medical infertility.

- Social infertility refers to the impaired ability of an individual or couple to become parents of a child, as a result of social rather than abnormal biological factors. For example, lack of a sexual partner; older age with naturally impaired biological fertility; impaired access to parenting opportunities such as fostering or adoption.

International medical travel

The voluntary travel of individuals (medical travelers) beyond their national borders for the purpose of accessing health care services in another country. Familiarly known as “medical tourism”.

Medical travel may be distinguished by its particular markets such as transplant travel or reproductive travel.

Market inalienable

See inalienability.

Medical tourism

See international medical travel
Outsourcing

In this thesis, “outsourcing” refers to the practice of deliberately obtaining HBM from foreign providers, except where providers and recipients are related by social or familial bonds. Examples of outsourcing include the systematic importation of plasma products from foreign countries where the plasma is obtained from foreign citizens and transplant travel involving unrelated providers and recipients of different nationalities. Unplanned cases in which travelers receive or provide HBM in emergencies do not constitute outsourcing.

Procurement

The removal and transfer of human biological materials for the purpose of use by a third party.

- In primary procurement materials are removed from an individual specifically for the purpose of use by another. For example, blood donation.
- In secondary procurement materials are originally removed for the provider’s benefit, but later transferred to a third party for their use. For example, a tumour may be excised as part of oncology treatment and then donated to a tissue bank for research.

Although the term “recovery” is increasingly used to describe the removal of organs from deceased donors, I prefer the more neutral and accurate term “procurement”.

Products of HBM

HBM may be modified to produce therapeutic goods, such as plasma products or tissue products derived from bone. Where such products include material originally detached from human bodies, these are primary products of HBM.

Secondary products of HBM are goods that are derived from research using HBM but which do not contain original human biological material. They include intellectual property and cell lines.

Provider

An individual from whom biological materials are detached either in life (living provider) or following death (deceased provider), where these materials are transferred for use by other individuals either immediately following detachment or at a later date.
Providers may also be described as **donors**, where the provider receives no fungible benefit in return for providing materials.

The term **vendor** refers to providers who voluntarily agree to the transfer of their materials in exchange for fungible benefits including payment.

**Recipient**
Individual or entity (such as a tissue bank) that receives **HBM** for the purpose of use.

**Reimbursement**
Refers to payment of costs incurred in the **provision** or **procurement** of **HBM** where such costs are actual and unavoidable, and where payment is not an approximation but strictly equal or inferior to the amount incurred.

**Reproductive Tourism**
See **reproductive travel**.

**Reproductive travel**
A subset of **international medical travel**, also known as **reproductive** or **fertility tourism** and **cross-border reproductive care**, in which patients travel abroad to access reproductive healthcare services in a foreign country.

**Reward**
Term which may be used to disguise payment for HBM, often treated as synonymous with **compensation**. Genuine rewards refer to benefits offered to individuals in recognition of meritorious (usually virtuous) actions. (See Chapter 6.6.)

**Special goods**
Special goods are those whose **procurement**, use or distribution is deemed of sufficient importance or value to society that their exchange within markets may be judged inappropriate or subject to specific limitations (see Chapter 4).

**Transplant tourism**
See **transplant travel**.
Transplant travel

A subset of international medical travel, in which patients travel outside their healthcare jurisdiction to access transplantation services abroad. May include public condemned cases known as “transplant tourism”, but also includes legitimate cases, for example when a patient with a related altruistic donor must travel abroad for transplantation due to a lack of surgical services in their own country.

Transplant tourism is a frequently employed, negatively connotative term used to describe international transplant travel that involves the purchase of human organs (obtained from voluntary living organ vendors or executed prisoners for example.) Many accounts of “transplant tourism” have incorporated the elements of illegality, trafficking and commercialism into definitions, thus failing to provide for the more ethically acceptable cases of transplant travel.

Treatment of HBM

Refers to the use, procurement or distribution of human biological materials.

Vendor

See provider.
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