

THE ETHICS OF ORGAN SALE

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Abstract

This research assesses the ethical conundrums that have arisen as to whether and under which circumstances the commercialisation of human body parts—precisely, kidneys—can be legally permissible. In consequence of organ trade being criminalised in almost all states in the world, proponents of ethical markets in human organs contend that legalising the organ markets would address the current dearth in organ supply, and mitigate the harms and risks that accrue from the abuses of illicit organ markets. Contra these somewhat seductive but ostensibly implausible argumentations, I advance a novel autonomy-based normative framework in defence of ethical markets in human organs. I contend that provided able-bodied persons are autonomous, that is, they are not completely bereft of (1) the minimum resources—income, housing, education and healthcare—to lead a minimally flourishing life, and (2) that they have the appropriate mental capacities and independence to choose amongst a meaningful range of options, they have the right to dispense their organs to those in need so as to pursue their conceptions of the good and ethically flourish. Autonomous persons have a claim-right against third parties—the state—not to interfere in the sale and purchase of their kidneys and the state has the correlative duty to recognise the transaction as legally binding and valid. Drawing on the idealised fulfilment of both conditions of autonomy, I address the myriad strands of critique of the commercialisation of human organs by pinpointing why they do not vitiate—or nullify—my autonomy-centred normative framework. I contend that the scepticisms regarding kidney sales lucidly hint at the necessity of regulation without undermining the individuals’ right to vend their kidneys. I thus make a case for “conditional commodification” whereby kidneys are vended exclusively by autonomous persons, and conclude with recommendations for the regulation of kidney sale in ways profoundly consonant with the autonomous person’s quest to lead an ethically flourishing life devoid of unjustified paternalistic interventions.

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Dedication

To my sweetheart Beauty Chinenye Eze,

the most trustworthy companion

and lover of learning

for being her through and through

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INTRODUCTION

A lot of people want to donate a kidney, but they're not in a position to because they have health issues of their own, and a lot of people need them. That's why the list is long and it takes a long time.

— Natalie Cole

Organ sale is one of the most vexing ethical conundrums in the world today. From corneas, lungs, and kidneys, to livers, pancreas, and hearts, there are invariably those who suffer from the failure of one or more of these organs, with kidneys being the most sought after organ for transplant. In 2014 alone, for example, 4,671 Americans died on the waiting list for kidney transplant (National Kidney Foundation, 2014). Because the failure of vital organs diminishes one's life span and ultimately leads to death, it is quite unsurprising that there is a profound interest in organ sales to ensure that those in need of organ transplant can have a second chance at life in order to pursue their variously defined projects and conceptions of the good.

Whilst kidney donation is legally permissible everywhere and everywhen, kidney sale is, by contrast, legally interdicted everywhere save Iran. To mitigate the supposed shortage in kidney supply, a debate has arisen regarding the moral propriety of permitting people to vend their kidneys in regulated markets. In fact, so polarising is the debate that it has surreptitiously attracted the attention of many bioethicists, public policy experts, medical practitioners, and the general public with the main aim of making organs available to persons in need even whilst holding fast to cherished moral principles. One incontestable fact is that there is no settled consensus—or to phrase it in the Nietzschean way, there is no consensus sapientium—on the moral acceptability of organ sale as the quandary has been stippled with multifarious tensions pro and contra the practice.

It is this incandescent dispute that has stimulated my enquiry into the ethics of organ sale. The question that drives this research is this: Under what conditions can the sale of organs within a regulated market be morally permissible? Put differently, whether and when can the sale of organs—kidney, in particular—by the able-bodied be morally right? Employing an autonomy-centred approach, I contend that kidney sale is morally permissible only when two conditions obtain: first, when the minimum resources—healthcare, housing, education, and income—are available for all; and second, the markets for organs are appositely divested of autonomy-constraining vices such as manipulation and coercion, that is, when full information for potential organ vendors are satiated. Provided these two conditions obtain, I contend that persons have a power-right to vend their organs to potential buyers and a claim-right against third parties—the state—not to interfere with the transaction but to acknowledge it as legally valid. Thus, what I defend in this research is a regulated market in human kidney sales based on these principles of personal autonomy under the rubric of the Hohfeldian rights framework.

It is noteworthy that the autonomy-based defence of markets in organ sales is not really novel. However, my strand of personal autonomy runs counter to those of other scholars like Cherry (2005), Dworkin (1994), and Taylor (2005), who comprehend the essence of autonomy in the Harry Frankfurt's hierarchical sense of agential identification with one's choice. Hence, for these pro-market exponents of commercial markets in human kidneys the background to the agent's supposed choice—whether the choice emanated from manipulation or coercion by conditions such as poverty—does not vitiate voluntary consent and choice once the agent's second-order desires is in synergy with the agent's first-order desires. Taylor (2005) strongly contends that “vendors would not necessarily suffer any impairment in autonomy when selling a kidney, even if they do so out of desperation” (p. 63) and it is paternalistic—call it “hard paternalism”—to prohibit markets in kidneys. But Taylor's seemingly fallacious adaptation

of the autonomism of Frankfurt is neither be right nor sound; it is just bland and vacuous. And, I think, for good reasons.

Hughes (2009) argues against the autonomy approach toward kidney sales by likening the unjust background conditions of the economically least-off members of society to duress and necessity that can vitiate criminal responsibility. Agents performing actions under duress or necessity are not fully autonomous in criminal law; the same could be said, Hughes (2009) contends, for people who—either due to necessity or duress stemming from their desperate economic circumstances—do not make autonomous—fully morally responsible—choices in relation to the vending of their kidneys (p. 609). Hughes therefore intimates that the personal autonomy approach cannot defend the sale of organs. Whilst I agree with Hughes that poverty is a constraint on personal autonomy, that does not mean the autonomy-centred approach is generally empty. Indeed, it seems to me that Hughes has pointed out the error in the conception of autonomy by pro-market scholars, but I disagree with his conclusion. In my conception of autonomy, poverty and desperation are antithetical to autonomy. So, if the minimum resources are there for all—and there is no poverty—would not that mean that organ sale is permissible?

Taylor (2005) does not seem to be of the same mind with Hughes: for him, coercion is an “intentionally characterised concept” present only when there is an intentional agent that causes a person to do the agent’s bidding against the person’s wishes and desires; thus poverty is not analogous to any intentional agent and cannot be said to coerce the economically least well-off into vending their kidneys. But this interpretation seems to me quite mistaken, given that poverty—at least most of the time—is the result of unjust economic circumstances and exploitation: it is a socially constructed unjust feature of the world that stems from the system we are embedded in that gives unfair advantage to some over others based on their arbitrary characteristics. In other words, poverty is engendered not so much by abstract entities as by intentional agents that are susceptible to investigation and charges. Where there is pervasive

corruption, it is some public officials who have acted against the common good which in turn generates poverty; when the international organisations—say, the Bretton Woods institutions such as the IMF and the World Bank—impose sanctions on developing countries, this triggers poverty. Poverty is the consequence of the unjust actions of some intentional agents. Personal autonomy, therefore, is incongruent with involuntary choices, for desperation is, I am inclined to think, a microcosm of the unjust world perpetuated by some intentional agents.

On my account of markets in human kidneys, the economically least well-off must be provided the minimum resources prior to their eligibility to participate in the market, lack of which they must be excluded from such market. A further reason the poor should be excluded from such market is the fact that having a low socio-economic status is itself an independent risk factor for organ diseases such as kidney failure (Hippen, 2005). If the economically least well-off are more susceptible to kidney diseases than the marginally well-off then it is, I think, morally imperative to restrict such market to those with the minimum basic resources requisite for a flourishing life.

In arguing for regulated market in human kidneys, I do not want to be construed as endorsing the view that there is a dearth of transplant kidneys that justifies kidney sales. I do not think shortage is a plausible ground for markets in kidneys. Rather, I want to defend organ sale from the perspective of personal autonomy independent of the allusions to curtailing shortage or the already pervasive black market in human organs that excruciatingly exploits the desperate. The method, then, is analytical—drawing upon the tools of rigorous logical and philosophical analysis to comprehend whether and when the individual has the right to vend kidneys. In other words, this research is essentially theoretical, engages with arguments, and makes a synthesis of opposing sides to the debate to generate theses from which an antithesis and further synthesis will be ultimately engendered.

The research is orientated around four different chapters. The first chapter sets the stage for the enquiry by critically reviewing the literature on organ sales to decipher the contentions pro and contra markets in human kidneys. The arguments for regulated markets in kidneys include the following—namely, that there is shortage in supply of kidneys; that the illicit or illegal trade in human kidneys can be curtailed through regulated markets; that risky labour and nephrectomy are synonymous, implying that there is no reason the one should be accepted and the other cast-off; that individuals are autonomous and should be allowed to do whatsoever they wish with their bodies; and finally, that there should be consistency in our moral principles, for if we allow people to sell body tissues—say, blood and egg—then we should similarly permit them to vend their kidneys. Conversely, the arguments against kidney sale include the following—namely, that it commodifies the human person; that it exploits the poor; that there is no genuine consent in kidney sales; that it causes harm and risks to vendor; and finally, that it kidney sale crowds out altruism.

The second chapter delves into the ethics of organ sale to defend the individual's right to kidney sale in the absence of autonomy-limiting conditions such as manipulation, coercion, or desperation due to certain unjust circumstances. In this chapter, the normative framework will be presented by first discussing the minimal conditions of personal autonomy. I will contend that autonomy requires not just agential identification with one's desires but a divesting of the many autonomy-limiting background conditions, including poverty, deception, manipulation, and coercion. After exploring the conditions of personal autonomy, I shall then elaborate the Hohfeldian jural relations—Hohfeld's analytical scheme of rights which includes powers, liberties, immunities, and claims—to comprehend what it entails to posit that the autonomous person has right over their bodies and organs, including to sell them in order to make more money—or profit—in their search for eudaimonia, that is, for flourishing.

The third chapter interrogates the several critics of organ sales, especially from the vantage points of exploitation, commodification, the teleology of medicine, and the putative morally repugnant nature of the practice of organ sales. I shall contend that despite the force of these arguments against the legalisation of kidney sale, they cannot withstand the strength of my autonomy-centred approach. Indeed, I will argue that these contentions only pinpoint the reason why regulated markets in human kidneys are indispensable to address the issues that stem from kidney sale. To be committed to precluding exploitation and commodification, for example, is to put a regulated system of organ sale in place that ensures the respect of the dignity of persons.

And in the fourth—final—section I sketch some plausible ways kidney sale can be regulated. I shall contend that state-controlled price-fixing, long-term postoperative care for vendors, informed autonomy, and geographical constraints are of utmost significance in the apposite regulation of kidney sale. These recommendations, I shall suggest, are not the final word on the regulation of kidneys, but should act as a starting point for fruitful discussion on the problematic of the regulation of organ sale in general, and kidney sale, in particular.

In consequence of this research being a work of ethics, I do not wish it to be construed from the perspective of public policy: though ethics obviously has implications for public policy, they are not coterminous. Thus, I would advise those interested in quick fixes to the problematic of kidney sale to discard this research and read policy papers. I am interested not in cures but in diagnosis, and I am sure those interested in cures would not find my approach illuminating. Be sure that I scarcely care if you think this work benighted.

I present this research with the intention that it will cast the discussions about kidney sales in a novel light—it cannot be the termination of the discourse, but indeed its starting point. Most of us come into this world with two kidneys, but due in part to our diverse human

frailties, lifestyles, and unforeseen circumstances, some members of our species suffer from kidney failures that pits them against life. Today it is Attila's kidney failure; tomorrow it is Csenge's; last year it was Zoltan's: so mysterious is the functioning of kidneys that anyone can be the victim of kidney failure. This work is meant not so much to encourage kidney donation but, when certain conditions are satiated, to accentuate the necessity of permitting kidney sales so that persons who think vending their kidneys will enable them flourish would do so without any constraints from the state's coercive powers.

And for those of us with two healthy kidneys, it is worthwhile to attend to the wisdom of the Akan—an ethnic group in Ghana—which says: *Së mframafa adeë ma wo a, fa boö to so*. Construed in its literal configuration, this implies that we should put a stone on top of any present or gift that the wind brings to us. Penetrating this at a more-than-literal—figurative—understanding it is recommended that one should take care of whatever one is given or it may go missing (Appiah & Appiah, 2000, p. 126). Precisely because our kidneys constitute a vital part of our existence devoid of which we cannot possibly attend to our individual plans and projects that conduce to our own flourishing, it is ultimately up to us to take care of them through our lifestyles lest they fail.

CHAPTER 1: SETTING THE PROBLEM

Are those living under conditions of social insecurity and economic abandonment on the periphery of the new world order really ‘owners’ of their bodies?

— Nancy Scheper-Hughes

Imagine that you were diagnosed with a certain renal disease—say, pyelonephritis—that later alchemises to an end-stage renal failure, and that you were placed on a long waiting list due to the dearth of kidney donors. Imagine, too, that you had the resources to purchase a kidney but the laws of your state interdict the sale of kidneys. Suppose, finally, that the laws of your state became lenient regarding kidney sales and that there is a kidney vendor available to mitigate your excruciating health predicament. Would you purchase a kidney from the available organ vendor? Or, let us assume the inverse of this idealised scenario. Imagine that you had two well-functioning kidneys and, *ceteris paribus*, that you had the minimum material resources—say, basic income, healthcare, housing—to pursue your own conception of the good life. Imagine, too, that it comes to your notice that there is a patient with failed kidneys—perhaps the patient undergoes dialysis—who needs a kidney to prolong his life. Suppose, finally, that the laws of your state became accommodative of kidney sales, and that you were—ideally—uncoerced to vend your kidney. Would you vend your kidney to the diseased in order to raise your income?

Like in all matters at the intersection of law, policy, and ethics, these are not facile conundrums to be resolved by a sleight of hand; for insofar as there are jeremiads of individual preferences awaiting satisfaction within the constraints of available resources, it would be utterly foolhardy, I think, to presuppose that there be would be a sole, immutable, answer under all circumstances. It is thus the uncertainties implicit in our moral problematics that drive this endeavour not so much in consequence of the ostensible disequilibrium in supply and demand

of kidneys that characterises our contemporary spatio-temporal reality but because the quandaries posed to us as members—denizens, nay citizens—of the liberal community are ones that cannot possibly be defenestrated in our varied unflinching quests to pursue our diverse conceptions of the good and lead flourishing lives in the prevailing liberal ethos.

This chapter is geared toward setting the pace for a long journey of exploration concerning one of the most contested and emotion-charged ethical problems in our time—namely, organs sales, in general, and kidney sales, in particular. I am inclined to suppose that the task of the explorer—or the adventurer—is to excavate the inscrutabilities surrounding specifically miscomprehended facticities. But it is noteworthy that this decipherment of the putatively indecipherable does not, so it seems to me, portend an enquiry devoid of a prior apprehension of the problematic, the various cues that stimulate the animus between parties to the problematic, and the method of examination.

This chapter is orientated around four sections. The first section distinguishes between organ donation and organ sale, and the focus of this research is the latter rather than the former. The second section highlights the rationale behind the clamour for regulated markets in organs. The third section provides a gloss—that is, a brief review—of the traditional arguments marshalled for and against kidney sales. And, finally, the fourth section draws implications for ethical enquiry that these unsettled deliberations bring to the limelight in respect of autonomy and the right to do whatever one desires with one's body.

1.1. Organ Donation Versus Organ Sales

The difference organ donation and organ sales lies, I think, in the distinction between market and non-market (altruistic) transactions. Whereas organ donation is the removal of an organ

from a person—living or dead—for transplant into another without any financial motives or rewards involved, organ sale involves some financial payment to the person who sells his or her organ to the organ recipient. Whether it is cadaveric organ donation or cadaveric organ sale the consent of the deceased donor or vendor is sought prior to removing the deceased donor's or vendor's organs: this consent is usually derived either from the donor or vendor prior to his death or through the consent of the deceased donor's or vendor's relatives for transplant rights over the body parts of the deceased. In cadaveric organ sales, in particular, the payment could be made to the living person prior to his death for rights over their body once they are dead; or the payment could be made to the relatives for transplant rights over the body of the deceased.

My focus in this research is on organ sales rather than donation as it is one of the most sensitive ethical issues in contemporary time. Whilst it is rare to find opponents of organ donation, the same cannot be said of organ sale which happens to be disconcerting to many for some reasons I will consider later in this chapter. Following Wilkinson (2003) I would like to emphasise that organ sale refers not to the sale of body products—for example, sperm, hair, eggs, and blood—but to organs like kidneys, hearts, lungs, pancreas, liver and so on. This is in consequence of the fact that in the case of body products there is less harm involved compared to organs, though these all attract ethical issues in terms of exploitation, commodification, and consent.

Organ sale is generally discussed with the endorsement of a regulated market rather than a free or unfettered market (Taylor, 2005; Wilkinson, 2003). This is due to the assumption that a free market might be exploitative of people—particularly, the poor—and that the regulated market will rid organ sales of exploitation and address the problematic of organ shortage. In the next section, I explore the rationale for regulated markets in human organs.

1.2. The Rationale for Regulated Markets in Human Organs

It is profoundly incontrovertible that organ transplantation—the removal of an organ from one person and the placement of that organ in another person in order to replace a malfunctioning organ—saves and even prolongs the lives—and quality of life—of patients with end-stage renal disease. In fact, patients with end-stage renal disease who benefit from a transplant rather than undergo haemodialysis tend to live much longer than those who undergo haemodialysis (Matas, 2004). Furthermore, according to Kerstein (2016), a kidney from a living donor usually lasts, on average, from 12 to 20 years, relative to the duration for a kidney from a deceased donor which lasts approximately 8 to 12 years. Exactly because early transplantation provides better results, the worst results accrue from late transplantation for people who wait on haemodialysis.

But the fundamental conundrum with organ transplantation is that there is at present a putative shortage of organs—particularly from living donors. In the US alone—according to recent statistics cobbled together by Organ Procurement and Transplantation Network (OPTN) in January 2019—there are over 113,000 patients on the national waiting list; and whereas the number of people requiring organ transplant has steadily increased, the number of donors and transplants has remained constant without any corresponding increase in either the number of deceased donors or living donors (OPTN, 2019). More flummoxing, moreover, is the fact that living donors are lesser in number compared to deceased donors: in 2018, for instance, there was a total of 17,553 donors—6,831 were living donors whilst 10,722 were deceased donors (OPTN, 2019). These data imply—at least in the case of the United States—that, each year, more patients are placed on the waiting list for transplants from a deceased donor than there are organs available for that purpose. Accordingly, the waiting list gets longer each year so that not only are patients added every 10 minutes to the waiting list, about 20 people die each day waiting for organ transplant (OPTN, 2019).

Kidney accounts for 82% of the patients awaiting organs transplant (OPTN, 2019). In 2016, over 100,791 awaited kidney transplants; and 3.6 years is the median wait time for a patient's first kidney transplant (National Kidney Foundation, 2019). Again, in 2014, 4,761 patients gave up the ghost whilst awaiting a kidney transplant; and a further 3,668 patients could not receive organs because their medical condition degenerated (National Kidney Foundation, 2019). And, finally, to complicate the kidney issue further, it has been estimated that, on average, over 3,000 patients are added every single day to the waiting list for a life-saving kidney transplant; and whereas a new patient is added each and every 14 minutes to the kidney transplant waitlist, 13 people die each day whilst awaiting a kidney transplant (National Kidney Foundation, 2019).

The statistics presented above are, of course, about the state of affairs of organ transplantation in the United States. But this does not nullify the ubiquity of organ shortage across regions and states in the globe, save for Iran which—for reasons I shall be discussing later in this research—has efficaciously eliminated the problem due in large part to its unique organ allocation system. From Spain, Brazil, and Wales, to Hungary, Italy, and India, organ shortage is a vexing issue that has polarised physicians, bioethicists, lawyers, philosophers, policymakers, and political scientists, amongst others, not least because it raises the question of what could be done to deal with, rather than circumvent, the conundrum and to salvage a plethora of human lives.

Different states have responded in multifarious ways to assuage organ shortage. One frequently mentioned model is the presumed consent—variously dubbed the opt-out or deemed consent—system wherein all citizens are potential donors unless they specifically retract their consent, that is, unless they choose to opt-out. Thus, in this particular model of organ donation, the mere fact of not formally objecting to organ donation is an attestation that the citizen

acquiesces in the confiscation of his organs after the citizen is deceased. The Welsh Human Transplantation (Wales) Act 2013 is a paradigmatic example of an opt-out system. The Act accentuates that the deceased is presumed to have consented to donation unless (1) the deceased had a decision in force with regard to donation, (2) the deceased had appointed someone to decide on their behalf regarding donation, and (3) the relative—as well as some longstanding friend—objects to the donation based on the views that the deceased is believed to have held (Human Transplantation (Wales) Act, 2013). Other states with the presumed consent model include, but are not limited to, France, Spain, Turkey, Sweden, Greece, Chile, Argentina, Colombia, Austria, and Norway.

In the United States, however, the opt-in system happens to be the norm. This system means that anyone who wishes to donate can opt in to deceased donation either by signing donor cards during, for instance, driver's licence renewal or, conversely, families and relatives can consent to the donation of the deceased's organs in the event of one's brain death. States such as Brazil, Israel, and the United Kingdom, amongst others, champion the opt-in system of organ donation. The Israeli opt-in model—colloquially termed “don't give, don't get”—differs, to some extent, from others because it prioritises patients who have consented to donating their organs. In this model, if there are two patients with the same medical need in respect of organ transplant, the priority would go to the patient who has hitherto signed an organ donor card or whose relatives and family members have previously donated an organ. There are also, additionally, financial reimbursements to living donors to compensate for the medical expenses incurred as a result of their donation.

Despite the promises of the opt-in and opt-out systems of deceased organ donation, the problem of organ shortage is far from being resolved. Indeed, the fact that these two systems are modish does not necessarily translate to their being divested of their blandness. Patients

still die each on the waiting list, and even the increase in deceased donation does not—and cannot possibly—match up with the number of people on the waiting list for transplant (Matas, 2004). The Welsh system—like similar systems of organ donation around the world—has profoundly fallen short of expectations (Parsons, 2018). The same thing could be said of the Chilean system (Zúñiga-Fajuri, 2015). And, even if the number of the deceased donors corresponds with the number of patients awaiting transplant, we would still, I think, be faced with the problem of survival since, as I have already pointed out, donations from living donors prolong the life of organ recipients compared to deceased organ donations. The pervasive organ shortage has led to some scholars clamouring for a regulated market for living human organs so as to address the shortage (Fabre, 2006; Matas, Adair, & Wigmore, 2011). A regulated system, so the argument goes, emblematised by compensation for living donors would increase the number of organ transplants, thereby decreasing death due to waitlists and haemodialysis.

Whilst the proposal for a regulated market in human organs seems promising, it has been met with criticisms and fierce national and international legislations against the commercialisation of human body parts. The Convention on Human Rights and Biomedicine (Oviedo Convention) which has been signed and ratified by 29 states prohibits financial gains that arise from organs. Again, Scheper-Hughes (2000)—an anthropologist with expertise in the anthropology of the body—has summarily dismissed organ shortage by contending that it is nothing but an artificial construct engendered by those who have vested interest in encouraging organ transplant. True or not, the contention for a regulated market in human organs triggers ethical questions about whether the body should be commercialised in order to attend to the current dearth of organs around the world. In the next section, therefore, I review the traditional arguments that have been rendered in favour of and against a regulated system for payment to kidney vendors.

1.3. Review of Traditional Arguments

Is there anything ethically inapposite or wrong with permitting people to sell their kidneys for transplantation purposes? Intellectuals mostly support the (free) donation of kidneys devoid of financial compensation as is the case in a market system; what, as a matter of fact, they object to is the marketisation of kidneys. There are a plenitude of arguments (and counterarguments) that have been marshalled with regard to kidney sales. In this section, I succinctly review them with the view to decipher implications for a more compelling and robust ethical enquiry.

1.3.1. Arguments for Kidney Sales

The contentions for kidney sales are multifaceted. There are five that, I think, need elucidating here—namely, (1) improving the survival rates of patients and addressing kidney shortage; (2) the analogy between the risks of kidney sales and risky labour; (3) paternalism and the primacy of autonomy; (4) kidney sales as a counterpoise to black markets; and (5) the so-called “prima facie” claim for kidney sales. These varied strands of argumentation are not mutually exclusive, for they are tailored toward promulgating the legalisation of kidney sales to mitigate shortage. In the paragraphs that follow I shall summarise these views.

First, proponents of kidney sales—and, by extension, organ sales in general—contend kidney sales would increase the number of available kidneys for transplant, decrease the number of patients with end-stage renal disease who are likely to die whilst awaiting transplant, shorten the waiting time and, finally, ameliorate the survival rates of patients (Matas, 2004; Wilkinson & Garrard, 1996; Radcliffe Richards, 1996). In their analysis of the United States

Renal Data System (USRDS)—national data system that collates information about end-stage renal disease as well as chronic kidney disease in the United States—Wolfe et al. (1999), for example, find that transplant recipients had the advantage of long-term survival over waitlisted haemodialysis recipients. And given that the kidneys from living donors conduce to the long-term survival of transplant recipients relative to those from deceased donors, proponents of kidney sales employ this tactic as a corroboration for their staunch defence of a regulated payment for organs. After all, they contend, there are already manifold legal precedents to the commercialisation of body parts and substances—eggs, sperms, blood, including payments for surrogacy (Matas, 2004). Even if it is counterargued that the shortage is artificially constructed (Scheper-Hughes, 2000), market proponents insist that this does not negate the deaths from non-availability of kidneys. Prohibitionists posit that lives could well be salvaged without necessarily permitting kidney sales: either the presumed consent system could be ameliorated or the ways in which bereaved relatives are contacted could be improved (Hinkley, 2005), or, according to Sandor (2014), the state can cultivate altruism by promoting “biosocial solidarity” amongst its citizens.

Second, market proponents posit that the perilousness of kidney sales is not a sufficient reason for prohibiting kidney sales. If we pay people for doing what, from a general point of view, are risky and even honour them for doing those—for example, fire-fighters, astronauts, miners, to name but a few—then kidney sales should not be interdicted even though it is risky (Cameron & Hoffenberg, 1999; Fabre, 2006; Wilkinson & Garrard, 1996; Brecher, 1994; Harris, 1992; Savulescu, 2003). But this analogy has been refuted by Malmqvist (2015) who contends that it is a false analogy not least in consequence of the incomparability of the risks of kidney sales and that of risky labour; and even though it is intensely dispositive that those two scenarios are comparable, it does not lend significance to the supposition that kidney sales should be allowed. Additionally, kidney sale is not an occupation like any risky labour.

Market proponents also posit that adult individuals are autonomous moral agents who should be left to pursue their own values, absent state encumbrance (Fabre, 2006; Gill & Sade, 2002). This autonomy-centred argument has been challenged by many scholars who posit that kidney sale is something no one could ever be in a position autonomously to allow or consent to; hence there is no genuine consent with regard to kidney sales (Rippon, 2014; Hughes, 2009). Since I will be positing an autonomy-based position for kidney sales, I shall not delve into this here, though it seems mistaken, I think, to presuppose that autonomy over one's body is a value that is meant only for the rich in the Western world—the epigraph I have inscribed at the top of this chapter from the anthropologist Nancy Scheper-Hughes seems to suggest this.

But even more compelling is the argument of market proponents that there are black markets for human kidneys, and the mere fact of prohibiting kidney sales has not led to a decline in the illicit trade in human kidneys (Scheper-Hughes, 2000; Friedlaender, 2002). There are over 10,000 black market operations involving the trade in human kidneys annually so much so that it is foolhardy to suppose that a legislative ban on kidney sales would halt the kidney sales (Campbell & Davison, 2012). The Global Financial Integrity (2017) estimates that illegal trade in organs—kidney, heart, liver, pancreas, and lungs—engenders approximately US\$840 million to US\$1.7 billion annually; illegal trade in kidney alone generates US\$50,000 to \$120,000 annually and there are over 7,995 illegal transplants per year (p. 29). Not only are vendors emotionally and psychologically traumatised by the sale of their kidneys, they do not receive sufficient healthcare after illegal transactions. This statistic alone lends credence to the views of market proponents such as Taylor (2005) who presses on to suggest that it is “morally imperative” to allow markets in human body parts to mitigate these precarities on the poor. But Kerstein (2016) is not of the same mind with Taylor, in part because poor people, in Kerstein's view, are liable to the exploitation by aggressive debt collectors even in regulated markets; and

if regulated markets are tolerated in the United States then it could trickle down, by way of a slippery slope, to developing states with high corruption such as India, Pakistan, and so on.

Finally, market proponents such as Gill and Sade (2002) make a “prima facie” case for kidney sales based on two different claims—the (1) “good donor claim” and (2) “sale of tissue claim.” The good donor claim is the idea that it is already morally and legally permissible for a living person to transfer or donate kidney to someone else; and if that is the case, then kidney sales should be legally sanctioned. Additionally, the sale of tissue claim posits that if it is legally and morally permissible for people to sell eggs and sperms, then we should equally allow them to sell their kidneys. In other words, the motive of financial or monetary self-interest is not a good enough reason to interdict kidney sales. Surely, opponents of markets in kidneys would oppose both claims, for they would contend that we cannot draw parallels between the sale of tissue and the sale of kidneys, nor can we infer from the fact that kidney donation is allowed to allude to the sale of human kidneys (see Satz, 2010; Sandel, 2012; Brecher, 1990).

So far I have reviewed the arguments in support of markets in human kidneys. Opponents of market-favourable viewpoints would almost invariably object—notwithstanding how intuitive and philosophically swaying the contentions of market proponents are—to the commercialisation of human kidneys. We are, so it seems to me, perennially confronted with the question as to why kidney sales is ethically wrong under all circumstances. In the next section, therefore, I shall review the ripostes against kidney sales which have been rendered by vituperative adversaries of markets in human kidneys.

1.3.2. Arguments Against Kidney Sales

The arguments against kidney sales have taken many different forms. For our purposes, I shall review five that are salient and constitute the strongest challenge to the contention for kidney sales—viz. (1) human dignity (bodily integrity); (2) exploitation of the poor; (3) lack of genuine consent; (4) harm to the kidney vendor, and (5) the crowding out of altruism. Matas (2004) has pinpointed problems that opponents of kidney sales contend might stem from regulated markets such as the objections of organised religions, the fears of the abuse of the system once it is fully legalised, the difficulty in amending or modifying the law once kidney sales are accepted, and the erosion of trust in governments and doctors, but these are not reviewed here because they seem to be triggered more by anxieties about politics—and human nature—than by rationally persuasive arguments; nor are they necessarily prompted by real-world data.

First, opponents of markets contend that kidney sales instrumentalise the person by making the person a means to another's end or—to put it more bluntly—it commodifies the human person (Radin, 1996). This notion of instrumentalising the human person derives from a Kantian deontological ethical postulation that persons or their body parts should not be sold or bought for any reasons given that the seller is intrinsically priceless and, *ex hypothesi*, should not lose his human dignity by being denigrated to the lowest level of commodities (Kerstein, 2009). However, as market proponents have contended, a person is not equivalent to his kidney or one or more of his body parts (Kerstein, 2009; Wilkinson, 2000; Gill & Sade, 2002). Implied in the charge that kidney sales instrumentalises the human person is the notion that it violates bodily integrity. But, again, that nephrectomy violates bodily integrity is not a sufficient reason to ban kidney sales since most surgical procedures and recreational activities also contravene bodily integrity, yet they are not actually legally prohibited by the state (Matas, 2004).

Another argument that market opponents posit is that kidney sales is exploitative of the poor since the impoverished are more susceptible to trading away their kidneys in order to eke out a bare existence than are the rich (Satz, 2010; Rippon, 2014; Lawlor, 2011). If this argument is applied more broadly, then it implies that citizens of poor developing countries will serve as donors for rich citizens of developed countries in the world. This argument from exploitation of the condition of poor people has, however, been refuted by Wilkinson and Garrard (1996) who contend that kidney sales are not necessarily exploitative since if vendors are educated, wealthy, informed and possess rationality, then it is difficult—and perhaps even impossible—to comprehend what it means to be in an exploitative market transaction whilst possessing all the requisite resources for a decent life. And, furthermore, Wilkinson and Garrard (1996) argue that we typically permit poorly paid labour—which are intrinsically exploitative—and yet we discard kidney sales: such inconsistency in our moral thinking is, they conclude, vacuous and empty of meaning seemingly stemming more from emotive reasons than rational reflection (p. 335).

Intimately connected to the problem of exploitation is the contention that there is no genuine consent in situations of abject poverty, for it is to impose options on the underprivileged by requiring them to sell the only thing they have, such as kidneys. Put simply, the underprivileged does not have autonomy and accordingly there is no such thing as genuine consent in situations of kidney sales, as the disadvantaged is incompetent through ignorance, coerced by deprivation and unrefusable offers (see Radcliffe Richards, 1996; Radcliffe Richards, 2009; Hughes, 2009). But, if the potential donor is not autonomous due to his relative deprivation, why is a potential donor autonomous even if he is in abject poverty? (Mates, 2004). If we interdict kidney sales because of the apparent lack of genuine consent in the process then we should, so the argument goes, be correspondingly prepared to defenestrate kidney donation altogether. Why privilege kidney donation over kidney sales?

There are additional concerns about harms to kidney vendors that may be caused by endorsing kidney sales. The contention here is that kidney sales can inevitably lead to the death of the kidney vendor (Radcliffe Richards, 2012). Again, as has rightly been contended by Wilkinson and Garrard (1996), kidney donation similarly poses harm to the donor—every so often it leads to the death of the donor. But if kidney donation is harmful as much as kidney sales then it leaves open the vacuum as to what makes the former desirable and latter repugnant. If it is argued that the kidney donor dies doing something purportedly “noble” then it could as well be the case that the kidney vendor might use the financial reward for “noble” causes (Matas, 2004). And since there is no neat demarcation between the surgical risks for vendors and donors, the view that kidney sales should be prohibited on the grounds of surgical and long-term risks does not hold much water (Matas, 2004).

Perhaps the greatest charge against kidney sales—and organ sales, in general—is that it reduces or undermines the practice of donation as people gradually do not feel any moral obligation to donate kidneys without the expectation of financial or monetary reward (Abouna, 1991; Satz, 2010; Sandel, 2012). This hypothesis was tested and confirmed by Titmuss (1997) regarding blood donation, but there is scepticism this can be generalised for other forms of donation such as kidneys (Campbell, 2009; Archard, 2002). A further concern about kidney sales in relation to altruism is that the practice drives out “giving relationships” which are intrinsically of ethical and social value independent of their pragmatic consequences (Wilkinson & Garrard, 1996, p. 335). But as Harvey (1990) re-joins, it is not really empirically dispositive that people would voluntarily donate their kidneys independent of imbursement. In addition, kidney donation and kidney sales could co-exist without any skirmish in much the same way professional social work and charitable social work typically co-exist without any complications (Wilkinson & Garrard, 1996, p. 335).

Table 1 Arguments For and Against Kidney Sales

Pro Kidney Sales	(1) shortage in human kidneys	(1) commodification	Contra Kidney Sales
	(2) illicit trade in human kidneys	(2) exploitation of the poor	
	(3) nephrectomy and risky labour	(3) harms and risks to the vendor	
	(4) the primacy of autonomy	(4) lack of genuine consent	
	(5) “prima facie” claims	(5) crowding out of altruism	

From the foregoing reviews of the rationale behind the clamour for kidney sales, it is lucid that the issue necessitates a more focused—or, more precisely, in-depth—ethical enquiry given the woolliness of the traditional arguments marshalled for and against a regulated market in kidney. I shall assess the criticisms against kidney sales in the third chapter of this research. In the next section, I will show that arguments on both sides to the conundrum miss the point and that we need a novel lens as much to comprehend as to address it, untethered by emotional sensibilities, unfettered by atavism, and put aright by the intricate frugality of rational deliberation.

1.4. Implications for Ethical Enquiry

All the urgings pro and contra kidney sales suffer from grave maladies; hence it is unsurprising that the stippled argumentations have continued ad nauseam, for far from inspiring a *consensus sapientium*, they have not really succeeded in addressing the multifarious challenges associated with the proposal for a regulated market in kidney sales. Part of the problem, I think, lies in the failure of market proponents and opponents in clarifying the pertinent terms of the debate and the faulty presuppositions and rationales upon which the issue is framed. In this section of this

chapter, I attempt an elucidation of the salient leitmotifs in order to bring the problem to a novel light within which to appositely approach it.

The foundational supposition of the contention for commercialisation of kidneys, to begin with, is the putative shortage of kidney supply. The argument seems to draw ethical conclusions from empirical observations—this is speciously tinged with the colourations of a naturalistic fallacy. Kidney shortage cannot, I think, be the basis of ethical verdicts as to whether it is right or wrong to commercialise human body parts. Sandor (2014) is categorically right to aver that “scarcity is a policy problem of allocation and better management of health care while the nature and methods of the consent and the status of the human body are ethical and legal issues” (p. 399). Indeed, it seems to me that the commercialisation of human kidneys would equally not address kidney shortage, neither can individual altruism or the state promotion of what Sandor (2014) calls “biosocial solidarity” do any better. Economics must be deftly disentangled from ethics, for whereas the former addresses the problematic of how to satisfy unlimited human needs with scarce resources available to us, the latter is concerned with what it means for a life to flourish. And, for lives to flourish in the eudemonic sense, we need to traverse the notion of scarcity and decipher other avenues to ground one’s right to dispense with one’s kidneys as one chooses.

If scarcity is not a ground for commercialising kidneys, the gruesome fact of the illicit trade in kidneys is not a sufficient ground for commercialising it, either. That state laws— notwithstanding how ogriish they might appear—are almost inevitably trespassed by criminals does not mean that criminality should be legalised, tout court. Indeed, crimes are committed everywhere and everywhen—corruption, rape, murder, stalking, and what have you. Apposite law enforcement agencies are needed to curb these vicious proclivities in much the same way that the illicit trade in kidneys requires robust and effective law enforcement; for the

commercialisation of kidneys would not halt the illegal markets in kidneys since some desperate kidney recipients would still want to exploit the illicit networks to obtain cheaper kidneys. In matters of demand and supply, the price of commodities is often a significant determinant of consumer behaviour. Hence, the need for other spheres to ground the commercialisation of kidneys beckons.

Furthermore, the analogies—between risky nephrectomy and risky labour, and between kidney sale and the sale of other tissues—are very much susceptible to the fallacy of false analogy, not least because there should be a distinction between regenerative and non-regenerative organs. Sandor (2014) posits that regenerative organs or tissues—blood, semen, eggs, bone marrows, for instance—involve less harm to the patient provided the surgical procedure or extraction is performed devoid of any complications whilst non-regenerative organs—kidneys, heart, liver, say—involve significant harm and thus require a composite concatenation of information and consent (p. 400). This distinction is crucial, I think, because it shows that the intensity of harm is incomparable in the cases which are generally compared with nephrectomy. Again, one could quit doing risky labours if one thinks it is incompatible with one’s autonomy, but how does one regain one’s kidney after it is sold and if the aftermaths of nephrectomy engender death? Risky labour is, I think, a faulty analogy and cannot serve as the backdoor to permitting kidney sales. And whilst donation founded on altruism is a supererogatory act, kidney sales via manipulation leads to bitterness and regrets. Moniruzzaman’s (2012) ethnographic fieldwork in Bangladesh robustly unearths the torment that accrue from “bioviolence” as Bangladeshi organ sellers wail in excruciating pain and insomnia for having been manipulated to vend their organs.

It seems to me that only the argument founded on personal autonomy can ground the right to commercialise human kidneys. But, again, the proponents of the autonomy-centred

contention have not appositely clarified what they mean by personal autonomy—the concept is frequently employed by liberals and non-liberals in ways that are, in my view, vaguely ambiguous. What does it profit a word if it gains the world and loses its own meaning? I do think that clarifying the features of autonomy in respect of rights and bodily integrity would serve to dissolve the various counterarguments from commodification, exploitation, lack of genuine consent, harm, and the putative crowding out of altruism. For, personal autonomy, appositely comprehended, is the bailiwick of the liberal community—if one is to validate commercialising kidneys, then there is no better foundation to build upon than that jugged out by liberalism. Personal autonomy is consistent with *living* rather than *cadaver* donation as my focus in this research is the former. The justification for concentrating on kidney sales by the living is that the argument for kidney sales has been furnaced in the language of reducing—or, in the extreme, eliminating—shortage by increasing living donations. And, furthermore, personal autonomy invariably applies *not* to corpses but to animate beings-in-the-world within the constraints of spatio-temporal realities.

Philosophers usually make a distinction between morality and ethics, with the one pointing to what we owe one other—actions done to others—and the other fixated on actions that concern one’s own life (see Habermas, 2003; Appiah, 2005). My contention for “moralised markets” in human kidneys draws on this crucial distinction, for it seems to me that our bodies and how we employ them belong, in the final analysis, to us, and what we owe one other is respect for their bodies and how they utilise them for their own ethical flourishing, assuming that they are autonomous. One final disclaimer: this is not policy research that delves into problem-solution nexuses. This is a work of ethics, and though it could have myriad policy implications, that is beyond the scope of this research. If one is interested in policies related to kidney trade, I would suggest looking through some policy papers elsewhere; but if one is interested in exploring this difficult subject with the conceptual tools of philosophy, then one

is obviously welcome. I may not be able to persuade you that the commercialisation of kidneys should be based on shortage or illicit trade—I do not, in fact, share these views—but I can well convince you to *think things through* within the parameters of personal autonomy. To this issue I turn in the second chapter.

CHAPTER 2: THE ETHICS OF ORGAN SALE

In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign.

—John Stuart Mill

The question of personal autonomy, of the rights over one's body—bodily autonomy—and of the relationship between the state and the body is one that has long perturbed moral, legal and political theorists. Notwithstanding the putative amorphousness of the concepts of personal autonomy, bodily autonomy, and bodily integrity, they are the terminus a quo and terminus ad quem of the prevailing liberal ethos. Because the problematic of kidney sales intersects the spheres of autonomy and bodily integrity—and, a fortiori, the domains of rights and justice—this chapter will serve as the framework with which to gauge the moral permissibility of the regulated markets in human kidneys. The first section focuses on the exposition of personal autonomy in respect of bodily autonomy and integrity. The second section is devoted to the discussion of personal autonomy from a rights-based framework. And the final section applies the garnered concepts to the issue of whether and when kidney sales may be permissible.

2.1. Personal Autonomy, Dignity, and Justice

Personal autonomy seems to have a short history and a long past. From the time of Plato and Aristotle through to Kant and John Stuart Mill, the notion of personal autonomy has been the subject of much contestation—albeit from distinct perspectives. However, the idea of personal autonomy as a signifier of bodily autonomy and integrity is one that contemporary bioethicists and legal theorists have yet to figure out. In this section, my discussion of personal autonomy will be tendentiously presentist with an eye on its implicature for bodily autonomy and bodily

integrity. Again, the emphasis in my deliberations is personal autonomy rather than moral and political autonomy. Whilst personal autonomy centres on the individual's capacity and agency to choose and decide for himself or herself independent of any specific moral principles, moral autonomy focuses on individuals' independent decisions that are consonant with some moral laws or principles. For its part, political autonomy is the characteristic feature that ensures that one's decisions are respected within a political context. These forms of autonomy are, I think, conceptually distinct and must be kept apart to evade the fallacy of equivocation.

2.1.1. The Demands of Personal Autonomy

Etymologically “autonomy” derives from the Ancient Greek word *autónomos*—αὐτόνομος—which is a conjunction of αὐτός (self) and νόμος (rule)—autonomy is by definition self-rule, that is, the capacity for self-governance (Wicks, 2016, p. 2). By fusing the word “personal” to autonomy, however, the idea of self-governance transmogrifies into a more intricate concept in need of further elucidation. What does it mean to govern one's person? And, furthermore, what does personal autonomy demand? A succinct voyage into the idea of personhood would clear, I think, the ground for a fruitful discourse on personal autonomy.

Whilst striving to define personhood some theorists have tended toward some sort of Cartesian dualism—Cartesians make a distinction between the *res cogitans* (the thinking mind) and the *res extensa* (the corporeal body) with the latter subordinate to the former. This means that the conscious subject is disembodied: it is the thinking that forms the basis of personhood rather than the mechanised body which is only there to be dominated by the mind (Shildrick, 1997). Warren (1997) contends that it is the psychological component—the mental and behavioural capacities—that makes a being a person rather than its biological and physiological features. This viewpoint is likewise endorsed by Singer (1995) who considers

consciousness and the capacity for reason as the criteria of personhood—with this, Singer conveniently excludes children as well as those in persistent vegetative state from personhood. Similarly, Harris (1985) contends that the rational capacity to value one's existence is the basis of personhood; once this capacity is lost, personhood also vanishes. Accordingly, for these authors, the human body is not useful for personhood since the person is simply his or her own consciousness.

There are a few caveats, however, with the allusion to rationality as the essence of personhood. First, it seems impossible, I think, to reconcile such a perspective with the concept of human rights which are applicable to all of humanity independent of rational capacity. The patient in a persistent vegetative state—although incapacitated to make any conscious decisions about his or her life and continued treatment—still possesses rights including the right to life and to freedom from degrading treatment (Wicks, 2016). Second, such an approach that emphasises the priority of the mind would find it hard to explain the persistence of a person over time. Do I cease being Promise once I lose my capacity for psychological experiences—that is, my self-awareness of my continued existence over time? The psychological criterion of personhood—the so-called psychological-continuity view—endorsed by Parfit (1984) posits that one's past or future person depends on the inheritance of some mental features. But some authors have rejected this and instead endorsed the brute-physical view which suggests that an individual's bodily features uniquely picks him or her out through time (Korsgaard, 1989; Olson, 1997). Merely losing one's rational capacity does not rid one of one's personhood; nor does the loss of one or more bodily characteristics preclude our participation in personhood. By this we are drawn into the metaphysics of personal identity which is the topos of contestation amongst metaphysicians. Although the temptation from my philosophical training endears me to delve into this fascinating debate, I do not address this issue as it is beyond the scope of this research.

Indeed, it seems to me that any person is a concatenation of psychological and physiological properties—an entity is a person if he or she is an embodied being conscious of its occupancy of the same body, of its continued existence over time, and has rational capacity. To govern one's person is to have control over one's body and mind, that is, to be the sole author of one's own decisions and choices in relation to one's present conditions and future activities as well as the basic capacity for retrojection into one's past activities. As persons inhabiting a spatio-temporal universe, our rational and physiological capacities to engage with the world around us make us who we really are, give us our true identity. To exercise personal autonomy is to “identify standards, preferences and values and to have your own actions and events in your life to conform to those standards, satisfy those preferences and realise those values” (Herring & Wall, 2017, p. 575). Our bodies act as the point of convergence between our subjectivities and the objective universe where our standards, values, and preferences are ultimately realised (Herring & Wall, 2017).

Personal autonomy in relation to our bodies thus refers to two dimensions: bodily autonomy and bodily integrity, with the one pointing to intentional action and the other pointing toward freedom from physical interference (Wicks, 2016; Herring & Wall, 2017). These dimensions, though closely related, are conceptually distinct. Whereas bodily integrity refers to freedom from physical interference with one's body—the “negative liberties” such as freedom from physical assault, punishment, torture, compelled eugenic sterilisation; and positive duties on the state to protect persons from interference with their bodies—bodily autonomy means that an individual is free to do whatever they want with their bodies provided they do not interfere with others' bodily integrity (Herring & Wall, 2017, p. 575). Personal autonomy demands that the decisions of the embodied self be respected; and because our subjective experiences—pleasure, pain, well-being, flourishing, identities, relationships, and the like—are mediated by our physiological capacities, it is through having regard for others'

bodies that we allow them the room to flourish. Bodily autonomy and bodily integrity posit the body as akin to a property right that excludes others from the body (I shall discuss this in section 2.2 of this chapter). But the question immediately arises: what does it take to be veritably autonomous—that is, what are the minimum criteria of personal autonomy? To this problematic I turn in the next section.

2.1.2. Minimal Conditions of Personal Autonomy

Different authors have outlined a myriad of conditions for personal autonomy. Harry Frankfurt and Gerald Dworkin are often credited with developing the hierarchical account of personal autonomy. For Frankfurt (1988), the minimum condition for ascribing personal autonomy is that an agent's first-order desire to commit an act is sanctioned by a second-order desire that endorses the first-order desire: we are autonomous, in other words, to the extent that we have the ability not only to identify with our desires but also to consider overriding them. Dworkin (1988) takes this idea further to delineate two conditions of personal autonomy: authenticity and independence. A person's desires and motives are authentic to the extent that they identify with them; and whereas those desires and motives are procedurally independent if they are sieved of manipulation, coercion and deception, they are substantively independent insofar as the person does not renege on the autochthonousness of his or her thought and action prior to acting on his or her desires and motives (Dworkin, 1988).

Both hierarchical accounts have been refuted. Frankfurt's account does not make room for the possibility that the second-order, higher-order, desires can be subject to manipulation by a hypnotist, and it is quite foolhardy to regard a hypnotised—mind-controlled—agent autonomous; hence a historical account of how such second-order desires are generated is indispensable for an account of personal autonomy (Mele, 2001). Further, it seems impossible

to identify the sources of the second-order desires that Frankfurt mentions, for if they themselves depend on third-order and fourth-order desires and so on, then there is the danger of infinite regression whereby we cannot lay hold on one source to determine the agent's autonomy (Watson, 1975). Dworkin's account—though distinct from Frankfurt's owing to its addition of independence as condition of autonomy—is similarly problematic in part because it does not provide any account as to why autonomy is compromised by factors such as coercion, manipulation, and deception (Taylor, 2009). Taylor's work attempts to provide an account of autonomy that is rid of coercion and manipulation and deception, and that also meets the condition of the agent identifying with his or her autochthonous desires and motives.

In an overextended formulation of the conditions of personal autonomy, Taylor (2009) argues that the “threshold condition” must be met in order for a person to be considered autonomous in respect of kidney sales. The threshold condition posits, first, that “the information on which she based the decision has not been affected by another agent with the end of leading her to make a particular decision, or a decision from a particular class of decisions” (p. 7); second, that “if the information on which a person makes her decision has been affected by another agent with the end of leading her to make a particular decision, or a decision from a particular class of decisions, she is aware of the way in which it has been so affected” (p. 7); and third, that “if the information on which a person bases her decision has been affected by another agent with the end of leading her to make a particular decision, or a decision from a particular class of decisions, and if she is not aware of the way in which the information on which she is basing her decision has been so affected, then she did not make the decision that the agent who was affecting the information she had access to with the intent of leading her to make a particular decision intended her to make” (p. 7). Such a rather abstruse condition of personal autonomy may well explain how coercion or manipulation could be excluded from the content of an autonomous decision, but it does not descry a factor such as

poverty that might impede autonomous decisions even with the absence of those autonomy-undermining conditions.

Raz's (1988) tripartite conditions of autonomy include endowment with appropriate mental abilities to form and execute intentions, availability of options to choose from, and the absence of manipulation and coercion (p. 372). Whilst it is quite lucid that Taylor's (2009) conditions implicitly satisfy the criterion of the absence of coercion to a large extent—and minimum rationality and adequate options to a lesser extent—it seems to me that these accounts of personal autonomy preclude the autonomy-constitutive condition such as the availability of minimum resources—food, shelter, education, healthcare, and basic income—devoid of which autonomy is virtually impossible.

In my view, whilst adequate mental capacities which enable us to identify with our goals and desires—and to choose from an adequate range of options—and the absence of coercion are all conditions for autonomy, they are inadequate since the dearth of minimum resources by itself can constrain an agent's options, diminish his or her mental abilities—poor nutrition, say, can impede the functioning of the brain—and coerce an agent to do what he or she would otherwise not do had he or she been provided with those resources. An ideally just state is one that makes it possible for all citizens to have these minimum resources that are profoundly constitutive of personal autonomy. I label these minimum resources “autonomy-constituting” in part because without them the discourse on personal autonomy would be half-baked. Once everyone has these minimum resources and provided also they themselves have appropriate mental capacities and are divested of coercion, manipulation, and deception—that is, provided they meet Taylor's threshold condition—they should, I think, be allowed to do as they please with their bodies in their quest to nurture and lead ethically flourishing lives.

2.1.3. Self-Respect, Dignity, and Justice

In the previous sections, I discussed personhood and personal autonomy. The question arises as to what connects these concepts? It seems to me that self-respect is one concept that plaits them together. Self-respect has to do with the relations amongst persons and respect for the intrinsic worth of persons *as* persons. Two kinds of self-respect are frequently distinguished—namely, recognition self-respect and evaluative self-respect. Whilst the former is an intrinsic property of persons, the latter is essentially acquired through one’s efforts, character and moral conduct (see Darwall, 1977; Dillon, 2018; Fabre, 2006, pp. 28–30).

Recognition self-respect—variously dubbed “status worth”—is worth that derives from one’s essential nature as a person. To respect oneself as a person involves regarding and appreciating oneself as having dignity by virtue of being a person and this acts as a moral constraint on our action. Given that equality, agency, and individuality have been considered as the foundation of dignity in the Kantian diction, three forms of recognition self-respect can be distinguished. First, respect for oneself as a person amongst other persons within a moral community, that is, as an equal with other persons such that one understands oneself as possessing certain moral rights that other persons ought to respect (Dillon, 2018). This type of recognition self-respect precludes one from selling oneself into slavery, for example. Second, respect for oneself as an agent that can act in an autochthonous way and value appropriately (Dillon, 2018). This type of recognition precludes one from engaging in self-debasing acts since it would imply that one does not respect oneself as an agent. Third, the respect for oneself as an individual with one’s own normative self-conception about what it means to ethically flourish: a person who lives an inauthentic live and blandly follows the caprices of others would then be regarded in this sense as lacking this type of self-recognition

(Dillon, 2018). All these forms of recognition self-respect pinpoint the intrinsic worth of persons that constrains degrading treatments.

Evaluative self-respect—in stark contrast to recognition self-respect—rests on the appraisal of oneself that derives from the normative self-conception that one has *as* a person. Evaluative self-respect ensures that one lives up to the values, commitments, and standards that one sets for oneself (Dillon, 2018). Through what we do or become—through our behaviour and acts—we either merit or do not merit evaluative respect. Although it is a matter of justice that there is recognition respect for one another in a moral community, the same cannot be said for evaluative respect for one another—in other words, evaluative self-respect is beyond the scope of justice even though others’ disapproval of our pursuits that exhibit features of persons could hamper our flourishing. The reason is in large part because justice is concerned with how we should act toward one another than with how we should feel toward one another (Fabre, 2006, p. 29). Having some mental disposition toward other persons is emblematic of evaluative self-respect and this is rather impossible to gauge from the normative standpoint of justice.

The type of self-respect employed in this research is recognition self-respect. A just society is one that provides avenues for persons to respect themselves and to respect one another just by virtue of their personhood. Exactly in consequence of all persons having projects and plans and goals, failure to respect them as persons with some intrinsic moral worth and dignity would really deter them from flourishing. Thus, a well-ordered society promotes equal respect for all by virtue of their personhood and deters persons from degrading themselves and others. In the next section, I turn to rights in terms of their forms and functions.

2.2. Clarifying Rights: Form and Function

Personal autonomy in relation to our bodies is, as I have argued, akin to a property right. That bodies are similar to property rights implies that they are possessed by individual persons and could be utilised—when the minimal conditions of personal autonomy that I have outlined are satisfied—by individuals in whatever ways they themselves deem fit, including, of course, to make profit from the sale of parts of those bodies. There is no better way, I think, to explicate and to comprehend the body as a property right without an analysis of rights in terms of its form and functions and reasons. In this section, then, I analyse the possession and utilisation of the body from a rights-based perspective in order to expatiate on its implication for sale of body parts—kidneys, in particular—especially in the domain of moral enquiry. To begin with, I comprehend rights as legally or morally or customarily valid entitlements that ensure the performance of certain types of actions on the part of the individual and also the performance of certain types of actions on the part of society—government and other individuals—in the protection of the individual from legal, social, and political interference. This definition is, I think, fairly consistent with those of most scholars on rights such as Jones (1994), Campbell (2006), Hohfeld (1917), Raz (1988), Feinberg (1970), and Edmundson (2012).

2.2.1. Form: Privileges, Claims, Powers, Immunities

The eminent American legal theorist Wesley Hohfeld is prominent for promulgating a schema for understanding the nature of rights and the logical relations between rights. Hohfeld (1917) underlines four basic kinds of rights—oft-times dubbed “Hohfeldian jural relations” (Kramer, 2001)—namely, (1) liberty-rights, (2) claim-rights, (3) power-rights, and (4) immunity-rights. These Hohfeldian relations invariably delimit the relations two agents: the right-holder and the right-addressee, the two agents in the jural relationship.

Liberty-rights—or privilege-rights—ensure that the right-holder is exempted from performing a positive duty, that is, that the right-holder can act or not act. The right-addressee's position is defined by the absence of right, and the correlative of the right-holder's privilege-rights is the complete absence of rights on the part of the right-addressee (Hohfeld, 1917, p. 710). Take, by way of a caricatural example, right to one's carriage. One has a right to ride one's carriage if one so chooses and no one has a right to deter one from doing that. By the same token, to assert that A has a privilege with respect to B is simply to assert that B has a no-claim against A's ϕ -ing; and, further, that A has no duty to B to refrain from ϕ -ing. Right to speech is an instance of privilege-right.

Claim-rights are the entitlements—positive and negative—of a right-holder that create duties for right-addressees (Hohfeld, 1917, p. 710). Claim-rights create either a positive or negative duty for right-addressees. Bodily integrity and property rights are paradigmatic claim-rights, for they create negative duties on rights-addressees to refrain from interfering with one's body and property (Wenar, 2005). Similarly, a contract between two parties—say, an employer and an employee—creates a claim-right for the employee to be paid her wages and a duty for the employer to pay the employee's wages. Children as well do have claim-rights against abusive treatments from parents; and parents have a duty to ensure that their kids are well taken care of—say, by providing children with education. Entitlements and duties work as correlatives.

Power-rights pinpoint the capacity of a right-holder to alter the legal situation—the claims and privileges—of the right-addressee by imposing a novel duty on the right-addressee (Hohfeld, 1917, p. 710). If A promises B that she will do something, then she is automatically under a duty to do it; at one and the same time the promise precludes A's privilege not to do the thing in question and gives B a claim. Congruently, consider the relations between a sailor and a captain. A sailor may not have any particular duties to carry out at the moment, but the

captain of the ship has the power-right to order the sailor to perform a particular activity—for example, the captain could order the sailor to scrub the deck. By ordering the sailor to scrub the deck the captain alters the legal situation of the sailor, that is, the captain alters the situation from not-having-a-duty-to- ϕ to having-a-duty-to- ϕ ; or, from having-a-privilege-to- ϕ to not-having-a-privilege-to- ϕ . This is because the sailor had no duty to scrub the deck until the captain ordered him or her to do so. Power and liability are therefore correlatives (Hohfeld, 1917, p. 710). Wenar (2005) posits that the paradigmatic examples of situations whereby the right-holder can alter his or her right and those of the right-addressee include, but, of course are not limited to, selling, sentencing, and waiving, amongst others.

Immunity-rights are simply the inverse of power-rights, for they refer to the situation where the right-addressee lacks the legal capacity to alter the right-holder's claim or privilege. For example, no one has the right to impose their religion—say, Islam or Buddhism—on me; this means that I have immunity-right not to be compelled to accept anyone's religion. Immunity-rights are a core feature of American constitutionalism—and the constitutional practice of many established democracies today—which safeguards religious freedom (Jones, 1994, p. 24). The right of tenure of a professor is an immunity as it precludes his university from firing him. Immunity and disability are correlatives since the immunity of X disables Y from altering X's legal situation (Hohfeld, 1917, p. 710).

So far it could be realised that powers and liberties assume the form “X has a right to ϕ ” whilst claims and immunities take the form “X has a right that Y ϕ — ϕ is used as an active verb (Wenar, 2005, p. 225). Hart (2012) regards the law itself as the union between primary rules—that is, rules that require agents to act or, contrariwise, to refrain from acting—and secondary rules—that is, rules that sketch how agents can bring about and change those primary rules. Whereas primary rules founded on the Hohfeldian framework would, I think, comprise claims and liberties, the secondary rules would include powers and immunities. An

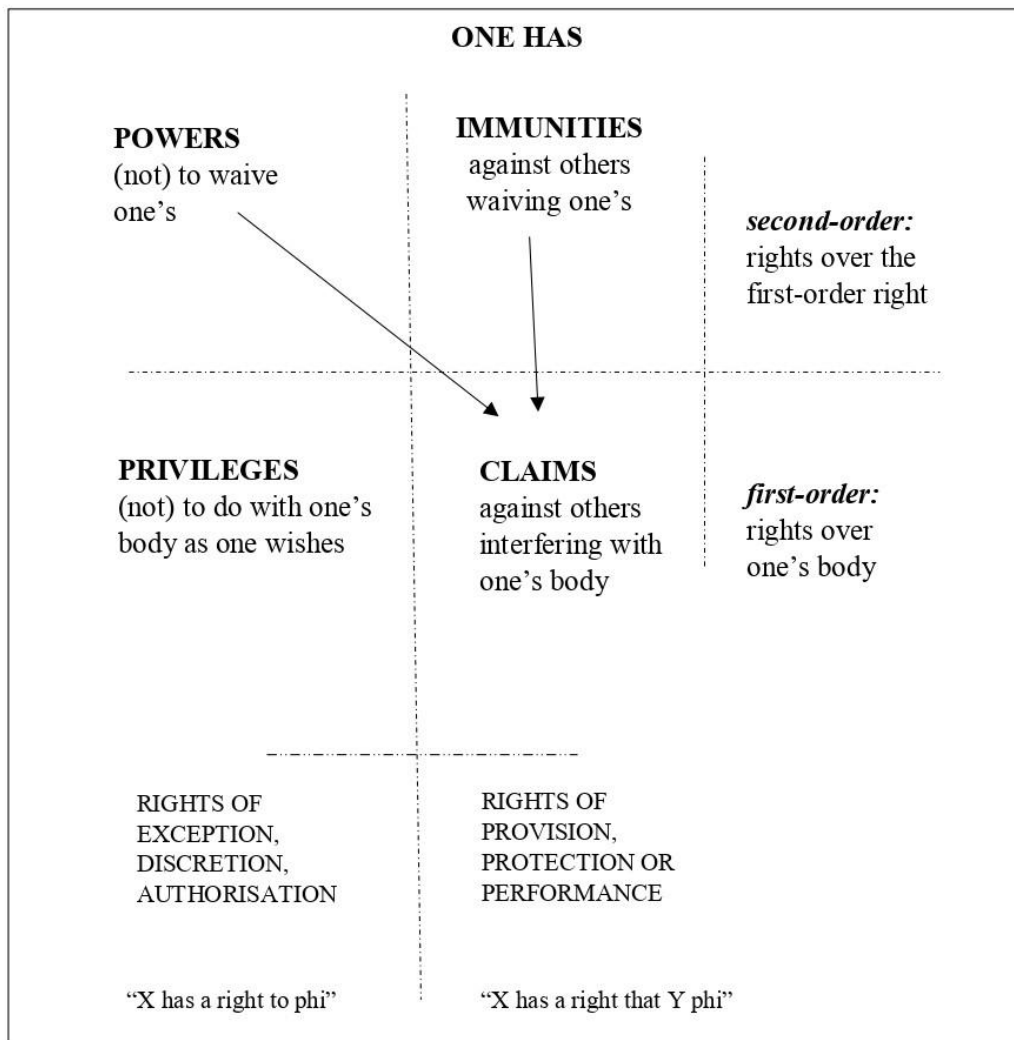
alternative way many legal—and moral—theorists have categorised this is to posit claim and privilege, on the one hand, as first-order rights, and power and immunity, on the other, as the second-order rights: the second-order rights leave one the room to change first-order rights (Kramer, 2001; Kruff, 2004). Finally, it is also worth noting that legal rights like in the Hohfeldian schema do not relate to—they are not coterminous with—attitudinal rights such as rights to feel (affective rights), rights to doubt or to believe (epistemic rights) or even rights to want (conative rights); these attitudinal rights fall short of being classified in the same way as rights of conduct since they are only privileges (see Wenar, 2003). This distinction is quite crucial in disentangling legal, moral and customary rights from the mundane usage of rights.

What does it entail to assert that one has rights over one's body—that is, that one has bodily autonomy and bodily integrity—in the Hohfeldian schematised framework? Drawing on Wenar's (2005) informative diagram, this means that one has—from the first-order perspective—the privilege to do with one's body as one wishes, and the claim against others interfering with one's body. This claim generates duty on others not to interfere with one's body—say, it creates a duty on others not to touch one's body. From the second-order rights outlook, one has the power to change the status of the first-order rights—for example, one has the sole power to waive one's claim against others interfering with one's body as well as the immunity against other persons waiving one's claims to bodily integrity. Power and privileges can be formalised as *freedoms to* whilst claims and immunities are *freedoms from* (Wenar, 2005). All categories of rights— be they moral, legal, or customary—fit into the Hohfeldian analytical scheme.

But one's right over one's body does not include the privilege to harm others: the right has its contours even though those contours do not alter its fundamental shape. Mill's (1863) harm principle—a fraction which constitutes my epigraph at the top of this chapter—precludes the harming of others, for this would encroach upon others' bodily integrity and autonomy.

Self-regarding actions—no matter how harmful they might be to one’s well-being—are not, in the Millian peroration, in the sphere of justifiable state coercion. Although this is a controversial moral principle of liberalism, its merit lies in the fact that it attempts to defend individuality and personal autonomy against the parodies of custom and coercion. But, as I shall be arguing later, sometimes the state has to intervene to enhance our autonomy in part because some who may vend their kidneys are not really autonomous.

Figure 1 Bodily Autonomy/Integrity in Hohfeldian Schema



Adapted: Wenar (2005, p. 233)

I have so far been exploring the intricate discourse on rights. But what—the inquisitive enquirer might prod further—qualifies privileges, claims, powers and immunities as rights? What, to put it more bluntly, make claims, powers, liberties, and immunities invariably rights whereas oppositions and correlatives such as duties, no-rights, and disabilities are not rights? For some theorists, on the one hand, our choices—our wills—qualify those myriad subsets as rights, and for others, on the other hand, our interests qualify those subsets as rights. In the next section, then, I oppugn this longstanding quibble amongst theorists about the qualification of rights.

2.2.2 Function: Will versus Interest

Theorists have long contested the function of rights in terms of what rights do for right-holders as well as what differentiates rights from other characteristics of the normative world such as principle, rules, and duties. The end-result of these contestations has been the polarisation into two big camps of theorists with the will theorists in one camp, and the interest theorists, in the other. In this section, I explore the bone of contention amongst the theorists—the will theorists and interest theorists—and ultimately posit my own take on the problematic.

For will theorists—who trace their intellectual genealogy back to Immanuel Kant—rights are rights *only* if it they enforceable: for one to possess a right, so the argument goes, one must be as much competent as authorised to waive or request the enforceability of the right (Kramer, 2001; Frydrych, 2018, p. 568; Ripstein, 2009). The implication of this is that the right-holder, as a “small-scale sovereign” (Hart, 1982), has a *locus standi* through which to effectuate his or her will within the boundaries of the law. Put differently, one’s having right amounts to one having control over the will of others in respect of it; and if someone acts contrary to one’s will in regard to the object of one’s right, then one’s right is violated. For will theorists, freedom is synonymous with rights; to have a right is to have freedom. But they limit

having a will to persons with capacities to exercise Hohfeldian power-rights to alter the duties of others; hence animals and incapacitated persons—including children—are excluded from the equation since they do not possess power-rights (Wenar, 2005, p. 239; MacCormick, 1982).

Despite its attractive suppositions, will theory has been confuted by interest theorists. First, in part because will theory recognises only powers as right, it neglects other Hohfeldian rights (Kramer, 2001). This is preposterous because it means that privileges like right to speech would cease being a right, and claim-rights like bodily integrity are not rights. Second, limiting rights to right-holders' cognitive capacities would preclude children and comatose adults from having rights, and this is at complete variance with our common-sensical understanding of certain rights—for example, the right to bodily integrity—as applicable to these persons notwithstanding their cognitive incapacities (Wenar, 2005, p. 240).

Interest theorists—who trace their intellectual lineage to Jeremy Bentham—contend that rights are rights only if they promote the right-holder's interest (well-being); accordingly, the function of rights is to advance the right-holder's interests (Kramer, 2001; Raz, 1984). If one has a right to something it implies that it is one's interest or to one's benefit, and someone else has the duty to provide it. But this is a problematic position, too, in large part because not all rights further the interests of the right-holder (Wenar, 2005, p. 241; Cruft, 2004, pp. 372–373). Again, specifying the specific interests necessary and sufficient for rights seem almost impossible—women's rights, animal rights, educational rights, healthcare rights, welfare rights, and so forth. Finally, interest theorists cannot satisfactorily account for third-party beneficiaries or interests (Sreenivasan, 2005, p. 262). The merit of the interest theory, however, is that it can embrace all Hohfeldian relations; thus, it intrinsically has a more comprehensive reach relative to the presuppositions of will theory (Kramer, 2013).

There have been recent attempts to move the debate between will and interest theorists forward. This has stimulated the development of alternative accounts—such as Wenar’s (2005) several functions theory, Sreenivasan’s (2005) complex hybrid theory, Cruft’s (2004) interest-theory-with-exceptions and inclusive theory, Rainbolt’s (2006) justified-normative-constraint-theory, and Wenar’s (2013) kind-desire theory, amongst others. Whether these modifications—or, as it were, “refinements”—have stamped out the polarisations between both theoretical camps is still a matter of dissensus; for, according to Frydrych (2018), these are all camouflaged versions of interest theory that purport to be something else. Alas, due to the space constraints, I do not penetrate into this debate, nor do I assess these various revisionist accounts.

It seems to me that these theorists miss the point of the role of idealisations in theory-building. When we theorise, what we do is idealise—that is, we simplify certain facts in the world so as to get at what we wish to explain. All theories are partly true and partly false; indeed, Appiah (2017) is categorically correct to contend that idealisations are “useful untruths”: they are semi-fictions with practical uses. And what we do ask from theories is that they explicate what they seek to explicate; we do not expect theories to be useful for all purposes at all times. That would be a categorical error. So, when we employ will theory in explaining the function of rights, we should, I think, pay attention to the fact that the theory is meant to explain or endorse human freedom. By the same token, when we employ interest theory, we should be cognisant of the fact that the theory is marshalled to explicate well-being. Which theory is better seems, I think, to depend upon the specific purposes of the theorist who uses the one or the other, for they are all defective from different normative and empirical standpoints. Precisely because individual persons have interests that they wish to secure—they are concerned as much about their well-being as about their flourishing—through vending their kidneys, it seems to me that the interest theory of rights is well-suited for this research. Thus, I shall employ the interest theory of rights whilst contending for kidney sales. To this I will

now turn in the final section of this chapter—the apotheosis of my research—where I plait together all the ideas I have explored so far.

2.3. In Defence of Markets in Human Organs

Deprivation, manipulation, deception, and coercion: these are all constraints on autonomous choices. Indeed, decisions deriving from such circumstances are anything but autochthonous. It is no wonder, then, that the critics of kidney sales have pounced on its defenders, for not only is the practice susceptible to one or more of such precarious conditions, the practice itself, so the argument goes, signifies that the human person is commodified, exploited, and rid of his or her dignity *as* a person. But suppose that there is an ideally just state that guarantees its citizens the provision of minimum resources and precludes features such as deception, manipulation, and coercion with regard to kidney sales. Suppose, additionally, that the state counts solely on persuasion in relation to citizens' choices. Should kidney sales still be interdicted as unethical?

Indeed, it seems to me that if the constraints on personal autonomy—deprivation, manipulation and coercion—are precluded, then it would be overwhelmingly paternalistic to deny persons the right to sell their kidneys in pursuit of their own conception of the good. In other words, provided that persons are autonomous in the senses delimited in this thesis, they have the right—moral and legal right—to sell their kidneys to anyone who intends to purchase. The right of the autonomous Person A, for example, to vend one of his kidneys to Person B (this is merely a thought experiment) can be construed in four ways following the Hohfeldian analytical scheme: first, that A has the power to alter his relation to B by making her the novel owner of his kidney once he receives some financial payment from her; second, that A has the privilege—the liberty—to vend his kidney to B, absent third-party interference; third, that A has a claim against the state—and other third-parties—to acknowledge the legal validity of his

transaction with B; and finally, that person A has immunity against the state preventing him from carrying out the transaction—or waiving his claim-rights—to do so in relation to person B. Emblematially, precisely in consequence of persons having interest in their flourishing, interests which make them right-holders, denying them the opportunity to sell their kidneys in pursuit of their flourishing even when their personal autonomy is not at stake on the grounds that it is unethical or morally repugnant would, I think, be counterproductive: it is tantamount, *sensu stricto*, to tyranny.

A person, as I have argued, is not one or more of his or her body parts: my kidney and I are not coterminous even though I need at least a functioning kidney to be alive. I have other features that make me a person: my mind and its consciousness, my brain, my heart, my lungs, my liver, my eyes, my tongue, my pancreas, and so forth. To reduce my personhood to my kidney is to undermine—and, to a large extent, disrespect—my personhood, for it means that what I am is nothing but my kidney, that is, that I am not an embodied person. I am who I am because my personhood is so multifarious, so vast that each one of my features has to be specially examined by distinct specialists: an ophthalmologist for my eyes; a cardiologist for my heart and blood vessels; a pulmonologist for my lungs and respiratory tract; an audiologist for my ears; a dentist for my oral cavity; a hepatologist for my gallbladder, pancreas and liver; and a neurologist for my brain, spinal cord, and nerves. I am somewhat a mystery not least because all these body parts together make up *me*—they give me my personhood—but each one on its own is *not* me. Thanks to this paradox for making me who I am, for with it I am a person. Indeed, it would be a fallacy of composition—that error in human thought that what is true of the part must be true of the whole, and thus that the whole is just its parts—to infer from the fact that I have kidneys to say that I am my kidney, that my kidney is my personhood.

That one vends one's kidney to another does not entail that one lacks recognition self-respect, that is, that one fails to respect one's dignity; as I said, because one is not one's kidney,

selling one's kidney is not—cannot be—an act of self-debasement. To debase oneself applies to the situation of selling oneself into slavery; but most liberals—myself included—think that this act is contrary to the liberal value of personal autonomy. Critics of organ sales invariably allude to this to remonstrate against the apparent commodification and exploitation of the person that the market in organs implies. But, as I say, these critics make grave ontological and categorical mistakes (I will address this in detail in the third chapter). If a person is autonomous and decides to sell one of his kidneys, that is not the same as saying the person sells himself: it is more apt, I think, to assert that the person sells a part of his body—his kidney—and not his autonomy or personhood. A person remains a person prior to and after kidney sales; hence recognition respect should be accorded kidney vendors as their dignity is indivisible.

I anticipate two objections to my position: (1) the elitist objection, and (2) the idealist objection. The first objection might look like this: “If kidney sales are restricted only to those who already have the minimum resources, does it not suggest that only the well-off are eligible for kidney sales, thereby excluding the poor who could make some money to pursue their own conception of the good?” To this important question my answer is simple: Leave the poor out of this. If a society wants its citizens to make autonomous decisions—which I think should be the norm in all modern states—and to vend their kidneys, then it must start out by providing the minimum resources for the poor. Persuading the poor to vend their kidneys due to the fact that it could provide them some temporary relief—a relief of \$2,000—for a lifetime of pain, torment is just barbaric. Indeed, it is because the market is inherently exploitative—exploitative, that is, of the poor—that most modern economists endorse regulation to mitigate its negative externalities. It could, again, be retorted that “once persons have the minimum resources they would not be really interested in vending their kidneys.” Again, this seems like an argument against the poor, that the market exists specifically for them to utilise their body parts as sources of income. My contention is not geared toward mitigating the supposed

shortage in kidneys, but to decipher whether, under some circumstances, we have the right to sell our kidneys. No just state would, I think, allow its citizens' susceptibility to coercion from deprivation.

The second—idealist—objection would go like this: “The argument is far removed from the real world, for in reality it is *typically* the poor who are coerced by deprivation and subject to deception and manipulation to vend their kidneys.” To this objection, my response is that the aim of ethical ideals is to point toward where we *should* be heading; it is not meant to highlight only what happens, even though we theorise with one eye on the empirical realities. Again, this is a work of ethics rather than anthropology or sociology. My stance is more in sync with those who are uneasy about the current state of affairs *and* what to change it. And one of the ways of changing our perilous human condition is by idealising, by employing “as ifs” (Appiah, 2017). Once we can comprehend what a just state would look like, then it would become briskly lucid as to why persons—that is, autonomous persons—have rights to sell their kidneys for their own flourishing.

The market that we should seek for kidneys should be one with some modicum of ethics—rid of an unlevel playing field for market participants; rid of coercion, manipulation, poverty, and deception. It is, I am inclined to think, a “moralised market” that places emphasis on personal autonomy as the ground for participating in such market. The state, as the most important actor in enhancing citizens' autonomy, must seek ways to ensure that its citizens have the minimum resources and are truly autonomous. That should be the condition for persuading them to vend their kidneys. If this is so facile to comprehend, why is it thus hard for critics of organ sales to accept? In the next chapter, then, I address the critics of organ sales employing the framework developed in this chapter.

CHAPTER 3: ORGAN SALE AND ITS CRITICS

A commodity appears, at first sight, a very trivial thing, and easily understood. Its analysis shows that it is, in reality, a very queer thing, abounding in metaphysical subtleties and theological niceties.

— Karl Marx

Enfilades of objection have been rendered against kidney sales from multifarious perspectives. In this chapter I explore and assess the most potent contentions against my autonomy-centred defence of kidney sales. The chapter is oriented around three sections. In the first, I explore the commodification arguments against kidney sales. In the second section, I assess the contentions from exploitation, that is, that kidney sales are exploitative of the poor. And in the final section, I address two additional critiques against kidney sales from the perspective that the practice is against the ends of medicine and, furthermore, that it is morally repugnant. I conclude by stating that none of these criticisms of kidney sales succeeds in nullifying the individual person's right to sell his kidney—none, in other words, successfully counters the personal autonomy approach I defend in this research—in order to pursue his own conception of the good and to flourish.

3.1. *Demystifying Commodification*

Opponents of organ sales contend that the fact that one has a right to sell one's kidney does not logically mean that kidneys are—or, more bluntly, should be treated as—commodities that can be traded in regulated markets. Strands of argumentation that endorse this view thus object to the sale of organs on the grounds that it commodifies what should not be commodified, namely, kidneys. But what does commodification mean? As my epigraph of Marx shows, commodity

is difficult to define. In this section, I begin by clarifying what is entailed by commodification prior to critiquing the cluster of commodification arguments marshalled against kidney sales.

To commodify something is to transmogrify that thing into an object for exchange (Radzik & Schmitz, 1997, p. 603). Commodification can either be literal or metaphorical (or both). The literal commodification is the actual social practice of treating entities as properties that can be exchanged whilst the metaphorical commodification has to do with the attitude of talking, seeing, or thinking of all interactions as basically market transactions, that is, as geared toward exchange (Radin, 1996; Wilkinson, 2000, p. 191). Commodification as social practice and as attitude may occur concurrently but they are not necessarily intricately intertwined (Wilkinson, 2000, p. 191). Drawing on Brecher (1990), Wilkinson shows that those who argue against the sale of kidneys suppose that allowing commodification as a social practice in society would cause persons to harbour commodifying attitudes toward human bodies: commodifying attitude includes the denial of subjectivity, instrumental valuation, and fungibility (2000, pp. 192–193). Commodifying the kidney involves these three sub-attitudes that rid the person of recognition respect—namely, human dignity (Teo, 1992).

But is it plausible to argue that commodifying the kidney is contrary to dignity? I do not think it necessarily is. Commodification by itself is ethically neutral as it could as much enrich human lives as debase the person. Persons could have commodifying attitudes toward freely gifted or purchased kidneys and this makes commodifying attitudes to kidneys not intrinsically unethical (Wilkinson, 2000, pp. 194–195). What does matter, so it seems to me, is not the commodifying attitude toward kidneys—there is no neat demarcation line between what should and should not be commodified, nor is it inherently unethical to regard the kidney and other body parts as resources for exchange—but whether the commodification of kidney leads to, or is the result of, the exploitation of the person who vends his kidney. Perhaps a voyage

into the reasons for extricating kidneys from the domain of personhood commodification would clarify whether or not kidney sale is ethically wrong.

3.1.1. The Erosion of Altruistic Ethos

Titmuss (1997) is credited with contending against the commodification of blood—and, by implication, organs—on the grounds that it erodes altruism that is indispensable for community living. Archard (2002) decomposes two fundamental tenets of Titmuss' contention: first, that commodification contaminates the meaning of certain goods that should not be considered as commodifiable, that is, it makes certain goods—say, kidneys—to be seen purely in commercial terms and this inevitably engenders the domination of markets in kidneys that crowd-out the possibility of the practice of kidney donation; and second, that once the practice of kidney sale is accepted, it erodes motivation to donate kidneys (pp. 93–94). The first assumption backs the second, for it suggests that once people perceive goods only in monetary—or commodifiable—terms, then their motivation to engage in donation would radically diminish as they would rather prefer to charge a price for their goods whenever it is possible for them to do so. These two assumptions have been dubbed the “domino argument” against the social practice of organ sale (see Radin, 1989; Mack, 1989; Archard, 2002). Commodifying body parts such as kidneys would, so the argument goes, undermine the sense of community that is vital to the flourishing of society; this is precisely why the state should not allow the practice of kidney sale.

Is Titmuss' objection plausible? Of course, there is no denying that altruism is essential for the strengthening of the bonds of community, for no society could survive without some altruistic individuals. Ethicists such as Sandel (2012) and Arrow (1972) have similarly towed Titmuss' line by stressing that financial or monetary incentives have the potency of crowding out or displacing altruism. However, although historical experience might lend credence to

Titmuss' view, a systematic replication and meta-analysis of Titmuss' conjectures by Niza, Tung and Marteau (2013) shows that there is no statistically significant difference between financial and non-financial incentives in the quantity of blood donated. And even if it is true that marketising everything could drive down the social ethos of altruism, it does not mean that all goods in the society should be distributed from altruistic motives. Definitely, some goods and services must be liable to sale regardless of whether it crowds in or crowds out altruism. It would run counter, I think, to personal autonomy to force persons to donate every good and service. In other words, why should we be permitted to vend our foods, houses, clothes, and other personal belongings and then interdicted from selling our kidneys? The argument that altruism crowds out donation does not lead to the conclusion that we have no right to sell our personal belongings, including our kidneys and to make profit from them in pursuit of diverse conceptions of the good life.

Fabre (2006) contends that the appeal to altruism is implausible because the monetary and non-monetary meanings of a good—kidney—can coexist: if the meaning of kidney, for instance, is to sustain life, I could demand money for one of my kidneys whilst at the same time doing it with the idea of saving the life of a dying patient (p. 138). Moreover, for Fabre (2006, p. 138), even though it is dispositive that the meaning of kidney is to sustain life, it still does not lead to the logical conclusion that kidney has to be distributed according to that meaning. Although I concur with Fabre's position about the possible coexistence of monetary and non-monetary meanings of a good—indeed, this specific argument makes Titmuss' claim null and void—I do not think, however, it makes sense to distribute goods outside their meaning. For, if we know what the meaning of a good is, utilising it in another way rather than for the purposes for which it exists would be utterly vicious. Imagine drug abuse—the cause of a great many deaths in the world today—that is the consequence of persons employing specific substance in inappropriate ways. If drugs are not employed according to their meaning,

they engender defects rather than healing; and it would be rash, it seems to me, to endorse drug abuse. The problem, however, is that we do not really know all the meanings of goods—the same drug for curing malaria could be tailored to eradicating migraines. Just where does one draw the line regarding meaning?

If Fabre were to argue that meaning is not inherent in any good, then her stance would make more sense especially as it would lead to the logical conclusion that there is no one yardstick of meaning according to which all goods should be distributed. Marijuana might be distributed for medicinal purposes; but it could as well be distributed for spiritual purposes. Meaning itself is not a given but the consequence of the dialogical engagement amongst rationalities. Titmuss' claim is profoundly erroneous because it presupposes that there is a single meaning to every good, especially to bodily goods such as blood and kidneys. Notwithstanding Fabre's error, it is still the case that the argument against the commodification of kidneys from the altruistic viewpoint is unsustainable and likely to encroach upon personal autonomy given its potency to accentuate that the individual should concentrate on the non-monetary meaning of goods such as kidneys rather than its monetary meaning. That, I think, is ethically imperious: If kidney has monetary and non-monetary meanings, then autonomous individual persons have the right to distribute it according as they deem fit in pursuit of their conception of human flourishing.

Even more problematic for Titmuss is the idea of society founded on altruism. That seems too utopic. Societies flourish in consequence of exchange: social exchange theory suggests that all human interactions are based on exchange as parties often engage in cost-benefit analyses to maximise benefits and minimise risks and cost. To suppose that altruism explains the bonds of community is *sociologically implausible* because there is no known human society—ancient or modern—that is not founded on exchange, that is, on commodification. Kidney sale cannot contaminate whatever the meanings of kidney are, and

even if it crowds out altruistic donation, it does not logically follow that persons do not have rights over their own bodies in regard to sale. It would be too paternalistic to draw from the argument that altruism is a moral virtue that no person has the right to vend his personal belongings, including one's kidney. Because persons have interests in their own flourishing, allowing them the decorum to vend their kidneys is respectful of their personal autonomy. The argument from altruism is, I think, grossly misguided.

3.1.2. Objectification and instrumentalisation

Another meaning of commodification is that it objectifies and instrumentalises the person, that is, that it turns the person into a thing or an object that can be used as a means to another's end (see Wilkinson, 2000; Nussbaum, 1995). Objectification and instrumentalisation are closely related to the Kantian idea of dignity whereby persons should be considered ends in themselves rather than mere means to another's end: once persons and their inherent attributes are considered objects of exchange, they become dehumanised and depersonalised since they ultimately are treated as objects or things (Radin, 1991, p. 345).

The turn to objectification and instrumentalisation seems implausible. Fabre (2006) argues that although treating something as a commodity entails treating it as an object, it is possible to vend a part of oneself without treating oneself as an object, for transferring one's rights over one's kidney to another does not entail that one rejects one's rights over oneself (p. 140). This is not the same thing as selling oneself, for example, into slavery: if one sells oneself then one rejects one's right over oneself and completely treats oneself as an object without rights (Fabre, 2006, p. 140). Opponents of kidney sale seem to conflate body commodification with person commodification, for they assume that merely selling a part of oneself—kidney—amounts to selling oneself (Wilkinson, 2000, p. 197; Fried, 1978, p. 142). Indeed, kidneys may

be treated as commodities without commodifying—objectifying, instrumentalising—the kidney vendor. I could see the vendor’s kidney as instrumental to my well-being whilst respecting his intrinsic worth as a homo sapiens. Part of the reason for emphasising personal autonomy, therefore, is to avoid persons being treated as a commodity, for if autonomous persons make decisions over their own bodies it is difficult to see how their personhood would be commodified by others.

Besides, those who employ Kantian framework to argue against kidney sales may be applying it incorrectly in part because Kant’s position on the issue is quite ambivalent. A contemporary reconstruction of Kant’s argument on markets in human body parts by Alpinar-Şencan (2016) suggests that the Kantian framework—if followed to its logical conclusion—entails the total abandonment of both organ donation and organ sale. Because Kant’s Kingdom of Ends divides up everything into whether they have a price or dignity—and the human body is inviolable as it has dignity—it follows that organ gift and sale constitute a commodification of the human person (Alpinar-Şencan, 2016, p. 23). I do not think anyone would acquiesce in the idea that organ donation is morally wrong; but Alpinar-Şencan’s point is that to contend from Kant’s framework is to dispense with the idea of detaching body parts such as kidney to save another’s life regardless of whether it is based on other-regarding or self-regarding motives.

If the Kantian view is ambiguous, so also is the conflation of body commodification and person commodification. Because every person is an embodied self, as I have argued in chapter 2, one is not one’s kidney. One does not disrespect oneself or cease to have recognition respect simply because of the loss of one of one’s kidney due to donation or sale. In my view, respecting the moral worth—the dignity—of persons entails respecting their personhood even though one or more of their organs are absent. Persons do not lose their personhood because they do not have eyes, otherwise the great musician Stevie Wonder would cease to be a person.

Nor do persons cease to be persons if they lose one arm due to amputation to prevent the deterioration of their medical condition. Of course, selling one's kidney might be risky—and perhaps even endanger one's life in the long-run—but this does not mean that one treats one's person as an object or as a means to another's end when one sells one's kidney.

3.2. Demystifying Exploitation

Another objection to kidney sale is that it is exploitative of the poor vendor (Radcliffe Richards, 1996; Greasley, 2014; Hughes, 1998; Lawlor, 2014). Because exploitation is antithetical to personal autonomy, moral theorists are of the view that since kidney sale violates autonomy it is unethical and should be banned. But it is important to note that all moral theorists differ in their understanding of exploitation, for the concept itself is amenable to different interpretations (see Wertheimer, 1996; Harris, 1992; Kuntz, 2009, p. 553).

Hughes (1998) comprehends exploitation from the Marxist perspective of surplus value in an unjust capitalist economic system which leads to few options—and choices—for the poor (pp. 92–93). The intuition here is that the bourgeoisie make profit from the labour of the proletariat, and the latter do not have viable options—because they lack sufficient autonomy—given their limited wages. Applied to organ sales, Hughes argues that the rich impoverish the poor who already lack autonomy given their absence of viable options by purchasing the latter's kidneys. Though the neo-Marxist application to kidney sales might seem appealing, I do think that it is an *argumentum ad verecundiam*—an appeal to inappropriate authority since Marx's theory of exploitation has nothing to do with organs sales and it is difficult to draw from Marxism in this context—because there is no surplus value the frail rich kidney buyer gains from the poor seller that can be used to reinvest in the unjust capitalist economy to make more profit. Lawlor (2014) underlines this lucidly with his example of someone selling his

kidney to another without any middleman—say, a for-profit firm—that takes some of the profit and gives lesser money to the kidney vendor: just where does the surplus value of exploitation apply here? (p. 195).

Perhaps a more plausible exposition of exploitation is that presented by Wilkinson (2003) as encompassing two types, namely, wrongful use and disparity of value: what distinguishes both types of exploitation is the manner “they relate to consent and taking advantage of people’s vulnerabilities” (p. 26). Whereas both types of exploitation include using a person or some of their attributes to satiate the exploiter’s end, they differ in that wrongful use does not involve taking advantage of another’s weaknesses, whilst disparity of value relates to taking advantage of a person’s vulnerabilities. Wrongful use includes commodification, instrumentalisation, and objectification (which I have already addressed) whilst disparity of value involves the situation where a consent-invalidating factor is present that makes a person make consent to bad deals under the semblance of personal autonomy (Wilkinson, 2003, p. 23). A very lucid example of disparity of value is poverty that could lead to manipulation, ignorance, and coercion in kidney sales. Given that I have hitherto addressed the wrongful use strand of exploitation, I will now focus on expatiating on the disparity of value which, I think, is the focus of most ethicists when they contend that kidney sales are exploitative of the poor and thereby harmful to the vendors. I will argue that this is also an implausible objection to kidney sale based on my approach from personal autonomy.

3.2.1. Inequality and asymmetric vulnerability

Satz (2010) is one of the staunchest opponents of regulated markets in human kidneys. For her, although kidney sale is not the cause of inequality and asymmetric vulnerability—the disparity of income between the rich and the poor—it would magnify these inequalities and subject the

poor to an excruciatingly unjust system whereby they will be coerced by poverty to vend their kidneys to the rich. In Satz's peroration, then, kidney sale should not be permissible if the just society is one that seeks to minimise—or even eradicate—inequalities and vulnerabilities.

A view analogous to Satz's is endorsed by the ethicist Simon Rippon who contends that kidney sale is morally objectionable

...because people in poverty often find themselves either indebted or in need of cash to meet their own basic needs and those of their families, they would predictably find themselves faced with social or legal pressure to pay the bills by selling their organs, if selling organs were permitted. So we would harm people in poverty by introducing a legal market that would subject them to such pressures (Rippon, 2012, p. 148).

Rippon's emphasis, I am inclined to think, is on the *social and legal pressures* that the market, albeit regulated, would have on the poor who have nothing to sell to ameliorate their situation save their kidneys. Now, although Rippon is my friend—to borrow some lines from Aristotle in reference to Plato, his magister—truth is a much better friend. Would Rippon still hold this view if poverty were non-existent and if there was a threshold whereby the condition for selling kidneys is that the vendor has resources at the minimum level required for sustenance? I do not think so. Provided persons have the minimum resources—income, housing, education and the like, broadly understood—Rippon's contention would be profoundly implausible, even though he rightly cautions that the poor are susceptible to exploitation given their vulnerable condition.

There is another reason Rippon's contention is off the mark: it does not show how exploitation comes into the picture in respect of kidney sales. If A gives a sum of money to B in return for a kidney, this seems like a mutually advantageous transaction between both parties. A gains a kidney and B gains some amount of money—whilst the kidney would conduce to A's desire to flourish and pursue A's conception of the good, the money would enable B pursue B's ends. To pinpoint exploitation in this scenario, it really has to be shown that one of the party benefits and the other does not. Although it could be counterargued that

no price is commensurate with the loss of one's kidney or any organs in one's body, this still does not make sense because it is to assume that whatever prices given for kidney would always be lower. A regulated market would, I think, set prices for kidney below which the charge of exploitation would be plausible.

It is, of course, true that the individual's choice to donate is more often than not constrained by cultural and socio-economic contexts. The risks to kidney donors in developing countries, for example, are greater than in developed countries due in part to the disparity in technologies as well as levels of hygiene and nutrition in addition to the quality of pre-operative and post-operative care. Indeed, surveys in India (Goyal et al., 2002), in Pakistan (Moazam, Zaman & Jafarey, 2009), and in Bangladesh (Moniruzzaman, 2012) suggest that many organ vendors not only suffered bad health experiences post-surgery and even became poorer economically but also that some regretted the decision. Additionally, some organ vendors in developing countries are ostracised or discriminated in their own communities for having sold their organs so much so that some of them do not disclose to their families and friends that they had had nephrectomy (Moniruzzaman, 2012). It appears that some of the dissatisfaction that accrue from organ sales are often due to manipulation of vendors by organ brokers especially as it often occurs in black markets. But these cultural and socio-economic risks—and harms—to organ vendors are not sufficient conditions for interdicting organ sales in toto. In fact, this precarious situation entails the necessity of regulation to ensure that potential vendors are appositely informed about the risks and harms prior to undergoing nephrectomy. Although the risks will still be greater in less developed countries, vendors will, I think, be able to decide for themselves whether it is worth their while to sell their kidneys with all the risks involved in the process. Besides, risks are involved are part and parcel of most transactions in life—getting married, buying a car and so on—and the presence of risks does not signify that we should not engage in the practice, for that would mean disengaging from many similarly risky transactions.

Concerning cultural constraints, I think this changes over time, too, once the state makes it legal to vend and buy kidneys. The case of organ sales in Iran—an Islamic state and currently the only state where organ sale is legally permissible—demonstrates that what is Islamically acceptable or unacceptable with regard to kidney sales is almost always in flux and consistently being renegotiated in the light of the social, political, economic and technological conditions of the country (Tober, 2007). What this suggests is, I think, that the cultural norms with regard to kidney sales are not set in stone and government regulation, reinterpretation and reevaluation of cultural mores would have long-lasting impact on the transformation of hostile attitudes toward kidney sales.

It seems to me, then, that the argument from inequality and vulnerability of the have-nots does not hold much water due to its lop-sidedness: it cannot serve as a moral guide in the debate for or against kidney sales in large part because it conditions the impermissibility or permissibility on the poor. What if I am rich and not coerced by social and legal pressures of the market? Why would I lack the right to sell my kidney to pursue my own conception of the good and to flourish even if I am immune to Rippon's condition of poverty? Notice that this is not really an argument against the right to sell our kidneys, but against the unjust market system itself. Those are distinct and need to be addressed differently. To argue from the fact that markets are usually exploitative to the notion that we do not have rights to vend our kidneys is just a mistaking of the woods for the forests—the fact that even our current economic system is exploitative of the poor does not lead to the conclusion that we should abolish the economic system but about how to make it better. The problematic, I think, should be about how to circumvent exploitation—a question of social justice—and to ensure that the market is moralised so that it is not merely an instrument of exploitation of the poor even whilst leaving those who would wish to sell their kidneys—those with the minimum resources, divested of

autonomy-constraining conditions of coercion, ignorance, and manipulation—to exercise their rights over their person and bodies.

This is the reason I agree with Radin’s (1996) notion of “incomplete commodification” though I disagree with her view that we can allow the poor and desperate to sell their organs even whilst fighting exploitation. Rather, I do think we can interdict the buying and selling of kidneys in situations where it is deciphered that this debases the impoverished vendor without necessarily abolishing the social practice of kidney sale. So I do endorse a sort of what I would or should call “conditional commodification.” We do not interdict alcohol—regardless of how intoxicating it could be to induce serious accidents—but condition drinking alcohol on the age. This is why kids and adolescents below 18 lack the right to purchase alcohol. So, here, alcohol’s consumption and commodification is conditioned on how autonomous the person—this usually determined through age—is. This conditional commodification—the middle ground between overcommodification and undercommodification under queries of poverty and exploitation—can be considered a form of “soft paternalism” (Malmqvist, 2014) and can serve to protect the poor against exploitation by the rich under the pretext of the free market. Because my autonomy approach considers the poor as non-autonomous, I do think that soft paternalism—paternalism justified on the basis that the agent is non-autonomous and acts non-voluntarily—is justified in respect of kidney sales. Under conditional commodification, it is the state that intervenes in the market to determine whether the potential kidney vendor really has autonomy to sell his kidney.

3.2.2. Volitional ambivalence: consent and inducement

Volitional ambivalence is a “state in which an agent cannot decisively and wholeheartedly identify with either of her conflicting first-order desires. This entails that a person in such a state is not autonomous and, thus, that her choices and actions are not freely chosen” (Hughes,

2009, p. 619). Another objection to kidney sales is that genuine consent is impossible when financial incentives are involved in part because the vendor's decision is unduly induced by certain circumstances such as abject poverty and unrefusable offers (Radcliffe Richards, 2009). Wilkinson (2003) posits that with enormous deprivation, the vendor's desperation in respect of money makes him liable to vend his kidney, something the vendor would otherwise not do if he was not metaphorically coerced by poverty; and with unrefusable offers, the vendor is not desperate but the amount of money involved induces him to vend his kidney. Opponents of kidney sales conclude from these that given that such consent is really absent in kidney sales—and consent requires competence and voluntariness both of which the vendor apparently lacks—it follows that it should not be permitted.

Radcliffe Richards rejects both arguments, arguing that they do not invalidate consent. For her, the reason for inducement with payment—unrefusable offers—is geared toward making people consent to an offer that they otherwise would not consent to rather than to rid them of consent, and thus there is no issue with competence or involuntariness of consent from this perspective as the vendor voluntarily chooses between having his kidney sold (thereby earning money) or remaining in abject poverty and perhaps not acquiring university degrees (Radcliffe Richards, 2009). Again, with regard to coercion by poverty, she compares kidney sale with cancer in that the cancer patient's consent—though constrained by the fact that the patient has to choose between the painful treatment of her disease and the unchecked progression of the disease—to be treated cannot be said to be invalid simply because it was made under desperation (Radcliffe Richards, 2009, p. 291). Therefore, for Radcliffe Richards, coercion by circumstances—by the metaphorical coercer such as poverty—does not justify state paternalism or nullify the person's right to sell kidneys.

Radcliffe Richards' position seems theoretically valid but it is simply unsound in part because hers is a fallacy of false analogy: there seems to be no connection between cancer and

poverty. First, whereas cancer is a disease that happens to everyone—rich and poor—poverty is a feature of a specific class of people—it is not a disease—namely, the poor. And second, whereas cancer has its root in neutral natural causes, the same cannot be said of poverty that is the direct result of, at least in most visible cases, immoral policies and acts (Wilkinson, 2016).

But there is a serious reason for why Radcliffe Richards' position is basically implausible, and this is the fact that it may work in theory but not in practice. Radcliffe Richards is a philosopher, and I am inclined to suppose, with little or no knowledge of empirics in relation to kidney sales. And what happens with armchair researchers that go without empirical observations is that the reality on the ground is distorted. The reality of kidney sale is that the poor kidney vendors are coerced by the metaphorical coercer (poverty) and they are more often than not manipulated by purchasers. Consider, by way of example, the ethnography of kidney bazaar in Bangladesh by Moniruzzaman (2012) whose in-depth research makes clear that poverty coerced the thirty-three Bangladeshi kidney vendors he interviewed to sell their kidneys to mostly wealthy and middle-class people. Moniruzzaman's ethnographic research divides the odyssey of the poor vendors into three: hope (preoperative), sacrifice (operative), and suffering (postoperative), and all these stages are accompanied as much by manipulation through newspaper advertisements as by the overall ignorance of the poor vendors (2012, p. 72). Indeed, one striking observation is Moniruzzaman's averment that "Poverty forced my research participants to sell one of their body parts" (2012, p. 72) in part because the vendors were made unrefusable offers which they saw as hope—albeit false hope—that they would be financially better off post the surgery.

My point is that poverty is as coercive as a criminal that threatens to kill one if one does not do the criminal's bidding. With poverty—as Moniruzzaman's research shows—the possibility of fairness for the kidney vendors is nearly impossible as their ignorance is taken advantage of by the organ brokers who manipulate the potential vendors through advertising

unrefusable offers and making false promises. My personal autonomy approach endorses kidney sales only in the absence of these vices—that is, in the absence of poverty, of manipulation, of false promises, of ignorance of the particulars, and the like—for with them the kidney vendor is not actually autonomous. The kidney vendors in Moniruzzaman’s study did not even know what a kidney was, where it is located, and whether they can sell theirs to make some money. That is the real world of kidney bazaar which, I think, Radcliffe Richards grand theorisation does not do any justice to. So I do think that poverty is coercive from all ramifications in consequence of its myriad disabling features. The soft paternalistic state I defend has the prerogative of ensuring that the poor are precluded from such immoral transactions in order to circumvent exploitation.

3.3. Additional Critiques

The critique from commodification and exploitation standpoints are the strongest objections to kidney sales in the literature and almost all criticisms of regulated markets in human organs seem to oscillate between both of them. That is why I have dealt extensively with them in this thesis. In this section I would like to further examine two critiques that, although seemingly plausible, ultimately do not succeed in discarding kidney sale, under the conditions of personal autonomy, as ethically wrong. These are the (1) ends of medicine, and (2) moral repugnance critiques. I address them below.

3.3.1. The Ends of Medicine

Davis and Crowe (2009) advance a critique of kidney sales from the perspective of the ends—that is, the teleology or purpose—of medicine. According to the authors, medicine has ultimate and proximate ends. The ultimate end of medicine is the health—health construed as wholeness

—of the human being whilst the proximate end is the healing for a particular patient which is achieved through the intervention of the physician which is not only right—rightness herein construed as intervention informed by sound scientific and clinical practices—but also good—goodness understood as intervention consistent with the patient’s subjective conception of the good and sense of well-being (Davis & Crowe, 2009, p. 591).

Building on their sense of the ends of medicine, Davis and Crowe proceed to contend that organ sale is contrary to the ends of medicine because surgery on the kidney vendor transforms the healthy human being into a patient. As they remarkably put it,

By performing the surgery on a healthy person—one who does not medically need the surgery—the transplant surgeon, in effect, turns a healthy human being into a patient. If we have construed the physician’s central, defining duty correctly, if we have grasped the essential correlation between the physician, as healer, and the patient, as one who seeks healing, then living donation seems, at the very least, to be at odds with this duty—that is, with the ends of medicine, properly understood (Davis & Crowe, 2009, p. 596, emphasis added).

Notice that their argument seems to suggest that organ donation is as much contrary to medical morality as is organ sale. But, then, the authors decipher a way to show that their position is not contrary to kidney donation but kidney sale. They achieve this by invoking arguments from commodification and altruism (which I have already addressed in this chapter): they argue that kidney sales commodifies the human being—makes the person a means to another’s end—and also drives out the ethic of generosity and gift; if the physician acquiesces in organ sale, he or she automatically goes contrary to the telos of medicine by equally commodifying the person and ensuring that the ethic of generosity is eroded from society (Davis & Crowe, pp. 598–601). The physician’s task is to circumvent kidney sales so as not to participate in the debasement of humanity and erosion of the ethic of altruism.

Of course, I sympathise with these authors in the ways they digress, however unsuccessfully, from one post to another in their quest to breathe fresh air on the debate. The

problem, however, is that they are just wrong. Nephrectomy—whether it happens due to organ donation or organ sales—pose significant risks to the donor or vendor. It does not seem to me correct to suppose that once one becomes a kidney vendor, then the risks increase and, conversely, that once one becomes a kidney donor, the risks from nephrectomy decrease. That cannot be right. As I have shown already, both donation and vending involve some commodification, and if the end of medicine is healing of the patient by the physician—and nephrectomy contravenes the ends of medicine as it turns a healthy patient into a sick one for another’s end—then it surely follows that kidney sale and donation are both ethically wrong. That would be a preposterous view to defend. Davis and Crowe cannot sustain their view with the ends of medicine contention.

It seems to me that kidney sale and donation both involve healing as it is possible for the kidney donor or vendor to at least live a normal life under some constraints with one kidney, and the physician’s task is to ensure the success of the surgical operation, that is, that both the kidney vendor or donor and the kidney recipient remain whole—healthy—after the operation. This is consistent, I think, with the ends of medicine—namely, that all parties involved remain healthy to follow their own conception of the good unimpeded by whatever happened in the surgical room. The emphasis should therefore be on essential postoperative care for kidney vendors and recipients, and for this adequate and advanced healthcare provisions are crucial.

The problem, however, is that the postoperative care in poorer, less developed countries pose significant challenges to organ vendors in consequence of the underdeveloped medical infrastructures. With such poor healthcare provisions, it is difficult to see why organ sales should be permitted in less developed countries. This is partly why the regulated market should, I think, be restricted to advanced countries with more advanced healthcare provisions so that vendors’ health do not significantly deteriorate after nephrectomy. Be that as it may, kidney sale is, I think, consistent with the ends of medicine once the vendor and recipient receive

adequate postoperative care. Also, the ends of medicine is consistent with personal autonomy and the individual's desire to make profit from selling one of his kidneys in pursuit of his conception of the good.

3.3.2. Moral Repugnance

For some authors, a plausible objection to kidney sale is that the practice is morally repugnant or disgusting; and since the idea of such practice intuitively evokes such emotional sensibility, it should be prohibited (Kass, 2002). The problem with this view as Taylor (2015) rightly argues is that it does not highlight which particular emotions make kidney sale repugnant; nor does it allow for the rationalisation of the feelings of moral repugnance. Indeed, we must know why a particular practice is morally repugnant in order to endorse or prohibit it. Merely relying on some ambiguous intuitions and sensibilities does not say much because it reduces ethics to emotions, which should not be the case.

It is noteworthy to remember that emotions can be very misleading—they cannot be a guide to or ground ethical principles because they mutate every time according to different epochs and times. At some point there were feelings of disgust toward homosexuals and homosexual acts, but now the tide has changed in many countries. At some point in the history of China, foot-binding was a common practice—and there were feelings of disgust at women whose feet were unbound as they found it difficult to get spouses—but fierce oppositions to the practice ensured that it ended. Kwame Anthony Appiah (2010) has rightly argued that honour has historically being tailored to virtuous and vicious ends so much so that honour is not the same as morality even though honour could be made consistent with moral principles.

I could say the same about the issue of moral repugnance. For it to show why kidney sale is morally wrong, we first need to understand what emblematic features of the trade make

it so. Kass' (2002) invocation of Kantian means-end dichotomy and the indivisibility of the human body to back his point about moral repugnance is terribly disingenuous and does not really warrant any further treatment since it does not provide cogent reasons for such repugnance. Whatsoever is morally repugnant is the end-product of social constructions and constrictions; and for a specific repugnance to serve as a guide for humanity it has to withstand, I think, the test of rationality.

As we have seen, all the arguments contra kidney sales do not show why—if the individual is truly autonomous—the person has no right to vend his kidney in pursuit of his conception of the good. The critiques of kidney sales seem to be slippery slope arguments that only project fear into everyone by accentuating that permitting markets in human organs—even under the conditions I have pinpointed—would always be wrong because it would lead to exploitation, commodification of persons, erosion of altruism, distort the ends of medicine, and engender moral repugnance. But, as I have contended, those positions vividly miss the point. Indeed, autonomous persons have the right to vend their kidneys and the soft paternalist state's role is to ensure that the background of body commodification is ethically just through regulating the market and precluding non-autonomous potential vendors. In the next chapter, therefore, I will sketch some ways the market in human organs can be regulated so that it is consistent with the ideal of personal autonomy that I have developed in this research.

CHAPTER 4: TOWARD A REGULATED SYSTEM

Let's make it simple: Government control means uniformity, regulation, fees, inspection, and yes, compliance.

— Tom Graves

The three chapters in this research have delved into the ethics of organ sales to decipher why—under conditions of personal autonomy—we do have the right to vend our kidneys and to make profit from doing so. In the previous chapter I reviewed some criticisms against kidney sales and disclosed that none of them run counter to the individual's right to vend his organs. In this chapter, I chart a different course by traversing the ethical speculations to practical policy considerations regarding the regulation of kidney sales. However, I would like to emphasise—as I have done at the onset of this interesting research—that this research is not policy-oriented. What I do herein, then, is a rough sketch of how the market should be regulated to circumvent the fears detractors of kidney sale harbour toward the practice. This chapter is organised around three sections. In the first, I briefly underline why a regulated system of kidney sale is necessary. In the second, I provide some recommendations concerning the regulation of kidney sales. And in the last section, I present one final defence of kidney sale from the vantage point of autonomy.

4.1. Why do we need a regulated system of organ sales?

Due to the persistent anxiety over what legalising or permitting kidney sales might mean for humanity and the social fabric, scholars who endorse organ sales do not automatically mean by this that it should be a free (and competitive market), that is, unregulated market (see Radcliffe Richards et al., 1998; Wilkinson, 2003; Erin & Harris, 2003). Rather, the argument for necessity

of the regulated market for kidney sales draws from the fact that an unfettered market may be exploitative of the poor who lack autonomy and are typically coerced by their desperation. That this contention is plausible needs no further elaboration as we have deciphered this through the ethnographies of kidney vending in developing countries (India, Pakistan, and Bangladesh, for example).

But there is, besides exploitation, an additional reason why a regulated system of kidney sales is desirable, and that is in consequence of the potential “economic class war” that may arise due to competition over the purchase of kidneys. This sort of competition typically occurs in the free markets of the economist’s imagination that operate on the interactions between the forces of demand and supply in determining prices. This point about an “economic class war” that might be engendered through permitting markets in kidney sales is captured by Katrina A. Bramstedt in the following way:

Payments for organs equates to price tags for them, and who gets to put a price on life? Sellers (can we call them “donors”?) put a price on life when they set the “sell” price for their kidney. Patients put a price on life when they set the “buy” price for the kidney they purchase. When two patients compete for the same “donor” kidney, the bidding wars begin. Does the price matter? Why not let the wealthiest patient win? Is it morally better to allow them both to suffer on dialysis and eventually die? (Bramstedt, 2014).

This is an argument against regulation, for according to Bramstedt (2014), the backdoor organ auction is inevitable, for once we allow kidney sales, it entails that the wealthiest would get the better of it due to their personal wealth that would enable them price out the others—the poor and the middle-income patients. Although I am partially of the same mind with Bramstedt, I do think that that this is a slippery slope contention that does not automatically negate regulated markets in human kidneys. For, wherever laws are made, there will almost always be detractors; but the mere presence of some detractors does not lead us to conclude that we should have no laws altogether—that would symptomise some sort of social anarchy as almost everyone would act as if they were in a Hobbesian brutish state of nature.

Take, for instance, the case of kidney sales in Iran. Despite its promise in addressing the dearth in kidney supply in Iran and ensuring that kidney vendors receive free health insurance and government compensation in addition to postoperative care, the kidney trade in Iran still suffers many setbacks. Bengali and Mostaghim (2017) underline that though Iranian regulation exists that sets a fixed price of \$4,600 per organ, it has not fully halted the desire of sellers to cut side deals so as to make more money from well-off buyers, nor does the regulation mean that there is no existent black market. The pitfalls of the Iranian regulated system show, I think, that more needs to be done to protect the poor—who constitute the majority of kidney vendors in Iran—and to completely eradicate the illegal markets.

Whilst regulation cannot resolve every conundrum associated with kidney sale, it is, I think, an indispensable starting point if it is aptly implemented. One problem with the Iranian system is the fact that it does not exclude the poor from vending their kidneys. My framework necessarily relies on this exclusion for the endorsement of kidney sale. Though black markets in human kidneys might meet grave opposition—in part because there are invariably persons who would want to benefit from illegal activities—a well-designed regulatory framework should work well to circumvent the economic class war and to protect the poor from exploitation. Exactly because of human frailties, I do not expect the framework I will present in this chapter to be the endpoint of the discourse on regulation but, in fact, a stimulant for more discourse on regulation. To the recommendations for regulation of kidney sales I turn next.

4.2. Recommendations for regulating organ sales

There are multifarious proposals for regulating organ sales. In this section I propose some four ways for regulating markets in human kidneys that are consistent with the individual's personal autonomy—the framework that I defend in this thesis. These are not, as I have already insisted,

exhaustive proposals for regulation, but it seems to me that regulation would be more effective when the condition and ideal of personal autonomy are the backbone of kidney sale. In my view no state in current time—not even Iran, the only state with legal organ markets—has prioritised personal autonomy in regulating the sale of human kidneys.

4.2.1. State-controlled price-fixing

To evade the economic class war whereby the rich patients would price out the poor and the middle-income patients, it seems to me that there should be a fixed price for kidneys and the government should ideally be the main agent in price-fixing for kidney sales. The price-fixing and transactions between kidney purchasers and vendors should be mediated by the government as this prevents organ brokers from exploiting the poor vendors—this usually happens in black markets—and ensures that payments go directly to the kidney vendors.

The above view is in consonance with those of Erin and Harris (2003) as well as Matas (2004) who propose that kidneys should be bought by one public agency—say, the National Health Service (NHS)—and distributed according to the fair principles of medical priority. Fabre (2006) holds a different view, though: she argues that government-regulation—and price-fixing—would peg the price quite low that it might well be detrimental to the potential kidney vendors (p. 152). She thus posits that not-for-profit firms would mitigate this problem as they would ensure that the sellers come to consensus with buyers at a price reasonable for the former.

I humbly disagree with Fabre’s point, for it seems to suppose that not-for-profit firms are “market angels” that have nothing to do with the exploitative proclivities of the market. But can not-for-profit firms ensure that black markets are curtailed? I do not think so. The state has the utmost coercive and legal powers to accomplish this. The state is, I am inclined to think, typically in the best position to ensure that these externalities of kidney sales are evaded in part

because they have the means to regulate the kidney sales, and to ensure compliance with the regulation that not-for-profit firms cannot possibly do. Hence, even if it were granted that such firms are market angels, they would still need to collaborate with the state to accomplish that purpose. Governments are, moreover, in a better position to verify the health conditions of the kidney vendor prior to, and after, kidney transplantation, and to provide health insurance—at least for one year post-surgery—for vendors.

4.2.2. Geographical location

With regard to the geographical location, I think that kidney sales should occur *within* countries rather *between* countries as is currently the case in the Iranian state. Erin and Harris (2003) also propose this. The reason is that if kidney sale is permitted between countries, then poor people from the Global South will become organ harvesting sites for denizens of rich and developed countries in the Global North. The essence of regulated markets in human kidneys is to prevent this from devastating consequence of trade in human organs. Despite the fact that I endorse this view, I do think that getting rid of the black markets in organs requires regional and international cooperation as they more often than not traverse states.

Again, because of the disparity in healthcare provisions in less developed and developed states, I do think that kidney sales should be permitted only in states with advanced medical technologies since this enables the process to be less risky and harmful to both the vendor and the recipient. States without adequate healthcare provisions pose a serious challenge to kidney sales in consequence of the difficulties involved in guaranteeing that the vendor and recipient receive adequate care after nephrectomy and kidney transplantation. The regulated market in kidneys would be efficient solely in advanced countries with developed healthcare system, for most poor, undeveloped, states have yet to meet the minimum standards in healthcare provision.

4.2.3. Long-term postoperative care

My explorations of kidney sales—especially in developing countries like India, Pakistan, and Bangladesh, amongst others—in the previous chapters reveal that kidney vendors generally do not receive adequate long-term postoperative care either due to negligence of the physicians or the dearth of medical infrastructure in the country where nephrectomy took place. The regulated market in kidneys would ensure that vendors receive long-term postoperative so that the fact of their losing their kidney would not be a serious impairment of, or impediment upon, their work capacities and abilities.

Unfortunately, long-term postoperative care may not be possible at the moment in less developed countries—or, even if they were available, the dearth of medical technologies in less developed countries means that promulgating kidney sales would be counterproductive as there is the possibility of engendering societies with unfunctional persons who have lost their kidneys without any post-operative care or support from the medical sector and who would be afraid of engaging in some important tasks—including tasks that are necessary for them to survive and eke out a bare existence—for fear that they could easily lose their second kidney.

4.2.4. Informed autonomy

In the previous chapters I dealt with the issue of informed consent in kidney sale. Without such consent I do not think kidney sale is ethical. The regulated market in kidney sales would ensure that those coerced—or pressurised—by circumstances such as poverty are excluded from the equation with regard to kidney sales. Moreover, for those eligible for the practice, the regulated market should ensure that the would-be vendor is aware of the risks and harms that are tied to kidney sale and consequently given sufficient time to think through his or her choices. As we

have seen in the previous chapters, informed consent—what I dub here “informed autonomy”—is almost always a conundrum for organ sales in black markets since the vendors are mostly unaware of the risks involved and are manipulated or coerced into vending their kidneys to potential buyers. The regulated market would serve to protect those with “weak agency” (Satz, 2010)—that is, those who are pressured by their circumstances and are invariably manipulated by exploitative organ brokers.

Although one could argue that there is no such thing as perfect information—even the economists think that perfect information does not really exist in the real world—I do think that perfect information could be provided to organ vendors that would aid them make life-changing decisions about their bodies in respect of kidney sale. The ideal of personal autonomy in relation to our bodies that I have defended in these pages requires that full information be provided to vendors who already have the minimum resources to live flourishing lives. Now, it is the duty of the state to ensure the provision of these minimum resources and information to would-be sellers without which the market should not be implemented. For this, I think there should be cooperation of physicians with the state, if regulation is under the auspices of the state.

4.3. Organ Sales Reconsidered

Depending upon how you look at it, kidney sale—if appropriately regulated according to the principles of personal autonomy I have delineated—would actually make lives go well: to the kidney recipient, there is a second chance at life; to the kidney vendor, there is some additional income to pursue one’s own projects. To criticise kidney sales that it is intrinsically unethical beats my imagination and sounds more like emotive, fear-mongering ramblings founded on slippery slope contentions rather than real facts in the world. One of the problems, I think, that makes kidney sales seem so ogish is the fact that most of it happens in the black markets where

the poor are exploited and do not receive proper long-term postoperative care. But I do not think that we can depend upon black markets as a conduit for regulated markets in organs: Both are mutually exclusive, and it seems to me that regulated markets would ultimately effectively crowd out black markets if it is appositely done. Iran is a good case in point of how regulation has been able to curtail black markets in human organs (Ghods & Savaj, 2006), though this by no means imply that there are no illegal trade in kidneys in Iran.

If Iran can achieve this with its law enforcement, advanced medical technologies, and well-trained physicians, then it behoves on states around the world to commence the necessary negotiations regarding the ways they can legalise kidney sales—within the constraints of their diverse capacities—so that patients on the waiting list can have a second shot at life and donors can earn more income to make their own lives flourish.

It would be too paternalistic—dub this “hard paternalism” if you so wish—to outrightly discard kidney sale on the ground that it crowds out altruism—or commodifies—the non-commodifiable. As I have already contended, persons have interests and their interests make them right-holders. Once persons are truly autonomous in the strictest sense of the term, it would be foolhardy, I think, to impose one particular conception of the good on them. They should be left to their devices to do with their bodies whatever they so wish. Because the liberal state is founded on the principle of neutrality, it seems to me that this principle would be more respected if choices in respect of organ sales—and kidney sales in particular—are left to the autonomous person whose kidney, in the final analysis, it is.

CONCLUSION

My body is my home, my transport, my clothing, my identity. It is my greatest asset and my worst enemy. It is my constant companion, my means of financial support, a source of pain, a receptacle of pleasure, and one day it will kill me.

— Elizabeth Wicks

I orientated this thesis around the conundrum as to the moral appositeness of regulated markets in human kidneys. This problematic—which served as the conduit for my painstaking voyage into the ethics of organ sale—has perturbed persons and professionals from all walks of life. Critics of kidney sale contend that permitting the practice by way of legalisation engenders pernicious consequences in multifarious ways: the commodification of the non-commodifiable in terms of the dehumanising instrumentalisation and objectification of the human person; the crowding out of sense of community and societal altruistic ethos; the disruption of the teleology of medicine especially with regard to the physician’s moral responsibility; the exploitation of the vulnerabilities of the economically least well-off; and the obstinate inattention to the moral repugnance of the practice.

I contended throughout this research that none of these ferocious disparagements of kidney sale vitiates the moral right to vend one’s kidney. Without doubt, autochthonous persons have right over their bodies to dispense with their kidneys howsoever they wish in pursuit of their own conception of the good and the state or other third parties are obliged to acknowledge this moral right by considering them legally valid under conditions of no duress, necessity or manipulation of the would-be vendor. That autonomous persons can vend their kidneys means that the charge that kidney sale commodifies the human person is unsustainable in part because what makes one a person—that is, one’s personhood—is not synonymous with one’s kidney. Again, meaning is invariably various: there is, as I have argued, no such thing as *the* meaning

of a good; thus kidney could have monetary and non-monetary meanings with both coexisting without any quandaries. And, further, if everyone has the minimum resources at their beck and call, it is hard to conceive why the prohibition of kidney sale would make sense on the grounds of exploitation. The teleology of medicine is to restore patient's health with the best scientific knowledge available; and since kidney transplantation either through sale or donation restores health to patients with kidney failure, it is in consonance with the physician's ethics. Finally, moral repugnance is quite empty of content as we are all incognisant of the particular feelings or emotions associated with it. These counter-critical remonstrations suggest that kidney sale—and regulated markets in human kidneys—can undeniably be morally right.

Indeed, the criticisms against kidney sale is the more reason there should be a regulated market in human kidneys. Regulating the market entails that most of the vices that stem from kidney sale—as is currently the case in illegal kidney (and organ) trafficking—can be curtailed to their barest minimum. It is noteworthy that this is not a statement that regulated markets necessarily drive out black markets in kidneys, but that a state-controlled system of kidney sale with the necessary prerequisites of personal autonomy and of full information divested of manipulation and deception as its watchword would ensure that the recognition respect of persons are intact and that the economically least well-off members of society do not become mere commodities for satiating the desperations of the bourgeois kidney purchasers. The regulated market is thus geared toward precluding—or reducing—the almost omnipresent ills of economic class wars, commodification of persons, and exploitation of poor vendors: ills that unregulated markets are more often than not susceptible to.

What I defend in this research, therefore, is “conditional commodification”—a soft paternalistic approach towards the moral permissibility of kidney sale that endorses the practice only if the minimum resources are made available for all, and if the market is divested of manipulation, deception, and coercion. This conditional commodification is deeply grounded

in the respect for persons as they truly are—that is, as entities with dignity—such that, absent both conditions, allowing the practice would run counter to the foundation of liberalism and, by extension, of the liberal community. For to respect persons is to respect their autonomy in terms of what they do with their bodies provided that they do not perform actions under coercion or manipulation.

If my contention so far is plausible, then prohibiting kidney sale with the prejudiced mindset that it is immoral under all circumstances may be *reasonable* but not *rational*. Appiah (1992) makes a very crucial distinction between reasonability and rationality with the former pointing toward what one truly believes regardless of evidence—say, the beliefs in religious doctrines and teachings—and the latter fully depending upon evidence for the endorsement of beliefs as science does. It seems that there is some duck-rabbit oscillation between reasonability and rationality in the discourse of the—moral and legal—permissibility of kidney sale. Critics of kidney sale seemingly tend more toward reasonability than rationality, for their argument portend that in all possible worlds, kidney sale will always be wrong. That is reasonable, and I do comprehend their anxieties—such anxieties stem from the peculiar distrust of human nature that typically distorts the good.

But that this is reasonable does not necessarily lead us to conclude it is rational. There is no evidence that if we tried out my version of regulation that kidney sale will be equally irrational. In some possible worlds—such as the ideally regulated market in human kidneys I have now constructed—kidney sale would be reasonable and even tend toward rationality. The evidence of the fact that a regulated market in kidneys is rational is Iran which—despite its shortcomings—has striven to minimise the attendant issues of black markets, exploitation, and kidney shortage. Although it is nowhere near perfection—experience shows that it is somewhat difficult but certainly not impossible to attain perfection—it is a clear signifier of the possibility of regulated markets in kidneys coming into existence. We must work toward that.

We are bodies. Our personal autonomy is projected through our bodies—what we do with our bodies and what others do to our bodies. To reject one one’s moral right to vend one’s kidney even under the condition and ideal of personal autonomy is to disrespect their personhood. This thesis is a tender reassertion of the primacy of personal autonomy for a liberal community of equals: We cease to respect each person’s personhood once we repudiate their claims over their own bodies and organs.

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