Organ Transplantation: The Ethos of Human Body Parts

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Organ Transplantation

The Ethos of Human Body Parts

A Thesis

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Introduction

Maria*, a young Brazilian woman, has recently been feeling some pain in her abdomen. She goes to visit her gynecologist to determine if there is a problem and what that problem might be. A few days later, the specialist calls to inform her that they have found some benign cysts on her ovaries and they will have to be removed with an invasive surgical procedure. Maria agrees to the surgery and approximately a week later, checks herself into the hospital. The surgery goes smoothly and Maria recovers after a week or so. She returns home and goes about her normal life. After a few months, however, Maria is still having significant pain around the site of her scar from the surgery. She travels to see her internist about the problem. He takes a few X-rays of Maria’s abdomen, and to his surprise, discovers the following: one of Maria’s kidneys is missing. “What do you mean ‘missing’?, asks Maria.” “It has been removed”, is the doctor’s reply, ‘most likely during the surgery to remove your ovarian cysts.” When Maria and her internist confront the surgeon, he claims that the kidney was entangled with one of her ovaries and had to be removed. Subsequently, other doctors have stated that this anatomically impossible. Maria remains in litigation with the doctor over the unlawful removal to this day.(28)

Yes, this is a true story. So, why was Maria’s kidney harvested again her will? So it could be sold for a tidy profit on the black market. The organ trade is a booming business on the world stage. The problem is, in most countries, it is highly illegal. The purpose of this thesis is to question this extremely popular, yet prohibited, practice. However, before we can find any answers, we have to explore the world of organ transplantation. What exactly is organ transplantation? How did this medical technology come about? What exactly does organ transplantation entail? Once we have discovered what it is, we have to know how it is governed.

* name has been changed
What are the national and international laws governing the exchange of human body parts? This takes us to the crucial question: Why do organs need to be sold? More importantly, is it truly unethical to participate in the vending and purchasing of human body parts? These are only a few of the questions that this piece will attempt to address. Next, we will look at two countries, who actively, legally, pursue the human organ trade. Are they in violation of human rights? Are they benefiting their nation in any way? Lastly, we will talk about a woman who experienced something quite the opposite of Maria: a woman who donated an organ of her own free will, absent of incentive or compensation. We will explore why this woman’s gift has a greater impact on ideas that vie against the human organ trade.

As you read this piece, think about what you would do if you were Maria. How would you feel about someone taking your organ without your consent? What if you had given your consent? Would you want to be paid for your organ? Is a human body part a marketable good to be sold? Welcome, my friend, to the ethos of human body parts.
Chapter One

WHAT IS ORGAN TRANSPLANTATION?

Procedures and Principles

Naturally, the best way to begin a discussion of this topic would be to define both an organ and transplantation. In the simplest denotative terms, an organ is a grouping of tissues that form a functional, as well as structural, unit within a living organism. (1) Thus, when an organ is no longer capable of performing said function, as a consequence of disease or injury, modern medicine often seeks to replace that organ with a new, healthy version. This well-known procedure is termed a transplant, which is a surgical operation that introduces an organ or tissue from a donor to a recipient. (2) A donor can either be living or dead, depending on the organ that is to be transplanted. While living donations tend to be more successful than donations from a cadaver, there are times when a deceased donor is the only option. Obviously, one cannot receive a heart from a living donor. The organs that can be donated by the living include the kidney, part of a liver or lung and stem cells. Usually, the donation from the living donor is transplanted within minutes of retrieval. This alacrity is essential, because organs deteriorate quickly following removal or death. Consequently, when dealing with organs from a cadaver, doctors prefer to obtain consent from the donor prior to their death, to avoid dealing with potentially lengthy discussions with the donor’s proxy or family, an issue that will be explored later. Organs from a deceased donor can remain viable anywhere from a few hours to a few days, if they are kept at a low temperature. Despite the threat of breakdown, donations from cadavers hold one advantage over those from a living person: one healthy deceased donor can provide several individuals with a transplant. One donor has the opportunity to provide two corneas, two kidneys, a liver, lungs, and a heart. (27)
Donation of said organs, of course, depends upon one of the main principles of transplantation: tissue matching. Tissue matching is advantageous because the immune system is programmed to attack any tissue that is foreign – this includes the transplant. This immune assault on the tissue is called rejection. A transplantation that is a close match, that is, one from a sibling or another family member, can reduce the severity of rejection and enhance the long-term outcome for the recipient. To match tissue, one must consider specific molecules, called antigens, that are present on the surface of every cell in the body. These molecules are called human leukocyte antigens (HLA) or are sometimes referred to as the major histocompatibility complex (MHC). The HLAs of each individual are unique; however, the possibility exists that family members will possess a few of the same antigens. Hence, a donation from a sibling or another relative is desirable. While a match with a non-related donor is highly unlikely, doctors will still attempt to locate a donor whose tissue type at least resembles that of the recipient. In addition to MHC classification, the blood of the transplantation recipient is also tested. The blood is screened for antibodies against the antigens of the tissues of the specific donor. These antibodies can arise as a result of blood transfusions, a previous transplantation or pregnancy. If such antibodies were present in the blood, they would bind to the antigens on the surface of the cells of the donor tissue and the donor tissue would be subsequently destroyed, resulting in severe rejection. Accordingly, if the antibodies are discovered, the transplantation procedure is aborted. (27)

Rejection also plays a significant role in the second principle of organ transplantation: suppression of the immune system. Not only does rejection result in the destruction of the transplanted organ, but it has other serious side effects, including fever, fatigue, and abrupt changes in blood pressure, which can be dangerous. Rejection commonly occurs immediately following transplantation, although it can occur weeks, month, or even years following the surgery. In order to prohibit the immunological attack on the transplant, which the body views as foreign,
immunosuppressants are utilized. These drugs do exactly as their name suggests - they inhibit the function of the immune system. Some immunosuppressants, such as the corticosteroid Prednisone®, suppress the immune system as a whole, while others, such as the fungal metabolite cyclosporine, inhibit T lymphocytes, a particular type of white blood cell. While immune system suppression is important for preventing or halting rejection, it can, as one might have guessed, become significantly problematic. With immune suppression comes a greatly increased risk of infection, especially opportunistic infections. While a healthy individual might easily recover from a rhinovirus (the common cold), an immunosuppressed individual would very likely become seriously ill from such a pathogen. Since the immune system is primarily responsible for keeping cancer cells in check, immunosuppression also carries with it an increased risk of cancer, especially lymphoma. (Lymphoma is cancer of the lymphatic system, a primary component of the immune system). In addition to the risks associated with immunosuppression, the immunosuppressive drugs carry some serious side effects. For example, Prednisone® can cause high blood sugar, osteoporosis, stomach ulcers, fragile skin and excess facial hair. Cyclosporine can cause liver and kidney damage, high blood pressure, and an additional cancer risk. While the consequences of transplantation seem rather dire, a choice to not replace an organ usually means certain death or, if the patient is lucky, serious physical impairment.

Tissue matching is done prior to transplantation; immunosuppression is employed following the organ replacement. What exactly happens in between? As it would not be prudent to delve into the detailed procedures for every organ transplant, we will focus on one: the kidney. According to the Organ Procurement and Transplantation Network (OPTN), the national transplant network established by Congress, kidneys are the most common organ transplanted in the United States, with over 17,000 recipients last year alone. (25) While a kidney can be obtained through both living and cadaveric donations, over two-thirds of the kidneys transplanted in the
United States are obtained from cadavers; these are usually individuals who have perished in a car accident. Why are kidney transplants so “popular”? If one does not replace a failing kidney, he or she is facing a lifetime of expensive, time-consuming dialysis, requiring a four to six hour stay in the hospital, oftentimes more than once a week. Kidney transplantation offers a viable alternative to such an arduous procedure. To use the simplest description of the process, the first step in the transplantation, following the assessment of tissue compatibility, is the removal of the kidney (or kidneys) from the donor. The kidney is then cooled and transported quickly. An incision is made in the pelvis of the recipient, and the kidney is attached to their blood vessels, as well as their bladder. The nonfunctional kidneys are left in the body. With that, the transplantation is complete. If the patient were to experience rejection despite immunosuppressive therapy, another kidney could be utilized. Unless the rejected kidney was causing significant health problems, it would be left in the recipient’s body, similar to the original nonfunctional kidneys. Later, we will learn about the emotional effects of a kidney transplantation procedure when we learn the story of Lynn Chabot-Long, a living donor who gave one of her kidneys to her brother. (27)

The History of Organ Transplantation

Organ transplantation seems to be a fairly commonplace medical procedure today. In fact, it was only during the second half of the twentieth century that surgeons had access to the techniques and technology required to perform transplantations. At present, approximately twenty-five human organs are available for removal from cadavers. These organs include blood vessels and tendons, bone marrow, corneas, heart, glands, kidneys, liver, nerves and skin. Conversely, in 1954, only one organ was being transplanted. That year, the first successful organ transplant took place at the Peter Bent Brigham Hospital in Boston, Massachusetts. (26) Dr. Joseph E. Murray, who received the Nobel Prize for medicine in 1990, pioneered the procedure. (4) The kidney was obtained from a living donor – the identical twin of the recipient; this type of transplantation is
called an isograft. (This was obviously important in regards to tissue compatibility and prevention of organ rejection). The transplanted kidney functioned for nine years subsequent to the transplant. (26) In 1967, the first successful liver transplant was performed by Dr. Thomas Starzl, at the University of Colorado. On December 3 of that same year, Dr. Christian Barnard of South Africa performed the first successful heart transplant, at the Groote Schur Hospital in Capetown. In the following year, the first successful heart transplant took place in the United States, led by Dr. Norman Shumway at Stanford University. (3, 4, 26)

While celebrating these milestones, a grim future lay ahead for the medical community. The surgeons found that the success rate for transplantations continued to be extremely low. While some of the first procedures used organs obtained from family members, not every patient in need of an organ had such an option. Efforts to transplant organs from cadavers, a transplantation known as an allograft, were not nearly as successful as those initial transplants had been. Doctors had yet to discover a way in which to stop the immune system’s rejection of the foreign tissue. This inability made donations from cadavers unattractive, and given the shortage of living donors, made organs scarce as well. Organ transplantation was a gamble at best. (26) This was the case until 1978, when Jean Borel discovered cyclosporine. (3) Cyclosporine, which was approved for commercial use in 1983, proved to be an incredible breakthrough for the science of organ transplantation. Derived from fungus, cyclosporine suppresses the function of T-lymphocytes, a type of white blood cell, effectively disabling the immune system. This prevents rejection of the foreign tissue and allows for successful cadaveric and living organ transplantation. Cyclosporine was the anti-rejection medication of choice for nearly two decades, when FK-506, or tacrolimus was introduced. Tacrolimus, like cyclosporine, attacks T-lymphocytes. This new drug was reported to be 50 to 100 times more effective than cyclosporine. (26) Both of these drugs, as well as numerous other immunosuppressants that have arrived on the market, have markedly
brightened the outlook for those receiving new organs. Today, one year survival rates for organ recipients range between seventy and ninety percent. (4)

At the start of this chapter, we had classified organs using their simplest definition. To many, however, the organ is more than a structural and functional unit within a living organism. Connotatively, some might say that the organ defines who we are – besides being a source of life, they can also serve as an expression of self. For example, the lung gives us breath so that we can speak; the heart has long been used as a symbol for the core of our humanity, as a representation for our soul. In addition, to some individuals, the power to remove an organ indicates the power to give and take away life. When we can say that a life has ended? As a consequence of all of these connotations, the science of organ transplantation as found itself in the midst of both a legal and ethical battlefield. Questions of consent to donation and how donation should be regulated have been raised in our nation’s courtrooms and on the international stage; committees to determine the definition of brain death and theethicality of removing organs from a brain dead individual have been formed. In the following two chapters, we will explore both the legal and ethical aspects of organ transplantation and explore the impact of this science beyond the operating table.
Chapter Two

ORGAN TRANSPLANTATION & THE LAW

As Sir Francis Bacon once said, “Laws and institutions must go hand in hand with the progress of the human mind”. Thus, it comes as no surprise that, as medicine saw great advancement in the form of organ transplantation, the law followed immediately in its footsteps. Both domestically and in the world forum, legislation was passed and guidelines were established in an attempt to control the direction of this new technology. This legislation continues to be reevaluated and reformed as new developments arise and humanitarian considerations emerge.

The United States

In 1968, approximately one year after the performance of the first successful liver transplant, the National Conference of Commissioners on Uniform State Laws (NCCUSL) enacted the Uniform Anatomical Gift Act, heretofore referred to as UAGA. UAGA was the initial call to action for both the nation and its composite states and perhaps the first step toward public donation awareness as well. UAGA “regulates the procurement of organs from cadaveric donors and establishes ethical and legal guidelines for organ transplantation”. (18) The act, the range of which was confined to cadaveric organ donors, sought to furnish a standardized procedure for the donation of organs and other body parts, with body parts delineated as “blood, organs, tissues, arteries, eyes, fluids, and ‘any other portions of the human body’”.(18) This procedure was divided into two parts: those individuals who were permitted to donate organs and body parts and those individuals who were authorized to receive such donations. The former was further broken down into two separate means of donation. The first means provided that a donor could, prior to his or her death, designate his or her body parts for transplantation; a desire which would be implemented via a will or witness document. Today, endowment of body parts is frequently
effectuated with an “organ donor” designation on a driver’s license. (18) The second means of
donation placed the decision-making power with the donor’s family members. “Each family
member was ranked according to a greater ‘rite’ to donate: (1) spouse; (2) an adult son or daughter;
(3) either parent; (4) adult siblings (sister or brother); (5) guardian; (6) any others authorized or
obligated to dispose of the body.” (18). Of course, the family members are only permitted to make
such a donation in the absence of any objection previously made by the deceased individual.
Accordingly, a particular family member is also not sanctioned to prevent organ donation by the
deceded individual if he or she had formerly chosen to be designated as an organ donor.

As was previously noted, the law does not provide solely for those who are able to donate,
but also for those who are eligible to receive such donations. UAGA specifies that donations of a
cadaver or a specific human body part may be made to four separate entities: “(1) any hospital,
surgeon, or physician, for medical or dental education, research, advancement of medical or dental
science, therapy, or transplantation; (2) any accredited medical or dental school, college or
university for education, research, advancement of medical or dental science, or therapy; (3) any
bank or storage facility, for medical or dental education, research, advancement of medical or
dental science, therapy, or transplantation; (4) any specified individual for therapy or
transplantation needed by him.” (18) In short, donations were meant to serve scientific and medical
innovation. Their classification as donations meant that they were given altruistically, hopefully in
pursuit of the latter. Such an understanding might aid in explaining why there was one key issue
that the 1968 UAGA did not address.

The law did not exclude financial compensation for organs or other body parts, which
might be quite surprising to some. Michelle Goodwin, author of *Black Markets: The Supply and
Demand of Body Parts*, speculates that the lack of such a provision in UAGA was due to the fact
that body parts were not commonly utilized for organ transplantation at the time. They possessed
In 1968, organ transplantation was in its infancy – rates of rejection were extremely high and immunosuppressants, such as cyclosporine, had not yet been discovered. Not to mention, cadavers and their parts were an integral part of science and medicine long before the advent of transplantation. “Medical schools and early biotech industries were also in need of body parts”(18) and they were, presumably, willing to pay for them. Such a payment would not necessarily be unethical. Consequently, UAGA intentionally left the question of compensation for organ donation open-ended. Despite this omission, by 1973, all 50 states had adopted the UAGA. As organ transplantation techniques improved and the procedures became more commonplace, the act began to serve as a paradigm for organ procurement, not solely organ donation regulation, as its creators originally intended. Along with this evolution arose a myriad of problems.

The provisions of the original act were ineffective for the purposes of procuring organs. With the introduction of cyclosporine in 1978, organ transplantation procedures became more feasible and popular, and the UAGA was completely unsuccessful in increasing the national organ supply in order to fulfill the rising demand. At the time, the desire to donate organs subsequent to death was primarily communicated through an advanced directive, such as a will. “Wills delayed the harvesting process due to their very nature, requiring that the document be found, read and possibly probated.” (18) If the UAGA was to serve as a model for organ obtainment, major revisions were required. The call for reform was heightened due to the act’s failure to address financial incentives for organ donation. A serious threat existed (a serious threat still exists) of organs developing into free market commodities in the absence of governmental parameters or supervision. Soon, “fears associated with slavery, child abductions, and body snatching for organ removal heightened tensions across the nation”,(18) and by the 1980s, reports of a developing
organ trade overseas had reached the United States, and posed a serious problem for the 1968 UAGA.

The solution was the 1987 UAGA, which attempted to address the aforementioned concerns. The critical areas addressed by the new act included: whether or not the coroner or medical examiner possessed authority to harvest organs, and under what authority such an action could occur, a requirement that both physicians and hospitals request organ donation, and that the physician was permitted to enforce a donor’s desire to bequeath his or her organs, thereby reinforcing that relatives were not permitted to cancel their loved one’s gift. (18) Most importantly, the 1987 UAGA definitively banned the intrastate sale and purchase of human body parts. This established the human body part market in the United States as a “donation-based organ supply system (D-BOSS)” (26), a classification that will be important to our subsequent discussion of the current world organ trade. A D-BOSS is unique in that it is based entirely upon the compassion of the donor, a system that can seriously hinder the procurement of organs. Despite the important development of nullifying a United States organ market, only 26 states have adopted the 1987 version of the UAGA. This produces “untenable gaps in the law” (18), a problem that is further exacerbated by the fact that neither version of the UAGA is in sync with the federal statutes regarding organ transplantation.

Three years prior to the revision of the UAGA, “as a result of the tremendous advances made in transplanting human body parts, ‘Congress felt the need to protect citizens from the potential negative implications of the market’”. (26) They attempted to provide this protection by passing the National Organ Transplant Act, heretofore referred to as NOTA. NOTA commenced the process of creating “a comprehensive framework for the development and implementation of transplantation policy that would bring together organ procurement organizations and transplant centers within one national coordinated system.” (34) The national coordinated system established
by NOTA was the National Organ Procurement and Transplantation Network, or OPTN. The House Committee designed OPTN to be a well-structured and dynamic network with the primary goal of matching donated organs. In a marked deviation from a wholly regulatory stance, Congress declared that the task of organizing the OPTN’s activities should reside within the private sector. In order to accomplish this directive, Congress sought out already established companies that participated in organ matching. One of these was UNOS, the United Network for Organ Sharing, “a private nonprofit organization, [that] already maintained a voluntary transplant registry and computer matching system.”(34) In 1984, UNOS was awarded $370,000 in government funds to begin establishing a national system for organ matching. Three years later, at the same time that the UAGA was being revamped, another $1.2 million was awarded by OPTN to UNOS, in order to combine the computer and data collection capabilities of the latter, with another existing nonrenal transplant registry. UNOS is still under contract with OPTN today and its goal continues to be “the establishment and maintenance of a single, computerized, national waiting list for the matching of organs with potential recipients.”(34) Subsequent to its penning in 1984, OPTN has undergone some significant revisions. In 1986, Congress passed the Omnibus Reconciliation Act (OBRA), which had a rather unique and precedential effect on the relationship between private institutions and the federal government. OBRA, a new §1138 of the Social Securities Act, required that all transplant centers be members of and abide by the rules and requirements of OPTN (and by default, UNOS), if they wanted to qualify for Medicare and Medicaid payments. Among these rules were mandatory physician training, stringent laboratory standards and equitable organ allocation. The intention of §1138 was to shield transplant patients from shoddy medical practice and to ensure that they had equitable access to the limited organ supply. The fact that UNOS was given such extensive control did not sit well with some, but “while it is extraordinary for a private
contractor to assert authority on behalf of government, challenges to its constitutionality have been unsuccessful.”(34)

Another key provision included in NOTA was the mandatory establishment of a Task Force. The Task Force was charged with investigating the various aspects of organ transplantation. A team of physicians, scientists, federal officials, and individuals with expertise in law, theology, ethics, health care financing and social behavior examined the medical, legal, ethical, economic and social issues involved with human organ procurement and transplantation. The results of these examinations, as well as recommendations for how to proceed in the legislative arena were provided to the House Committee by the Task Force. The Task Force concluded that “organs are donated in a spirit of altruism and volunteerism and constitute a national resource to be used for the public good.”(34) Such a conclusion goes hand-in-hand with the third major provision of NOTA: the ban of the purchase or sale of human organs.

Under NOTA, selling or purchasing human body parts in interstate commerce is a federal offense. The criminal component of NOTA, 42 U.S.C.A. § 274e, states the following: “(a) It shall be unlawful for any person to knowingly acquire, receive, or otherwise transfer any human organ for valuable consideration for use in human transplantation if the transfer affects interstate commerce; (b) Any person who violates subsection (a) of this section shall be fined not more than $50,000 or imprisoned not more than five years, or both.”(26) The term “valuable consideration” in subsection (a) does not include the reasonable payments associated with harvesting, transporting, and implanting the organ, essentially, the cost incurred for the various stages of donation. The criminalization of the sale of organs occurred due to Congress’ apprehension that a free market approach to organ procurement would arise. The ban on organ commerce, “one of the first regulatory measures concerning transplantation that was unrelated to the federal government’s role as payer”(34) has faced some significant criticism. Firstly, it hinders opportunities for testing
incentives which have the potential to increase donation and the organ supply. Financial compensation for a donor or the family, or for example, an offer of a free trip to a living donor, might entice an individual to donate an organ. However, under the NOTA Criminal Code, such actions would be highly illegal. In addition, others contend that a society that prohibits the vending of organs and then allocates them according to ability to pay is nothing short of hypocritical. How does one discriminate between purchasing an organ and purchasing an organ transplant procedure, with the organ (necessarily) provided? Some even suggest that creating a free market for organs is the only reliable way to ensure that organ banks will have a sufficient supply of body parts. To ban such commerce not only “drastically stunt[s]... the growth of the nation’s organ bank”(26), but it also allows a highly lucrative and inefficient black market organ trade to flourish. This black market, and its inherent lack of regulation, affords great opportunity for exploitation of the ill-educated and impoverished, an already common occurrence in other nations. The final, and perhaps most controversial criticism against the ban of the human organ trade, is that Congress made the incorrect assumption that granting permission for the buying and selling of human body parts would violate social norms. Is a free market for organs immoral and unethical? We will explore arguments from both ends of the spectrum. (26, 34)

Despite such censure, NOTA continues to serve as the cornerstone on which organ transplantation laws and regulations are based in the United States. World guidelines for organ transplantation appear to be following in its footsteps.

The World

In May of 1987, the Fortieth World Health Assembly convened in Geneva, Switzerland. At this Assembly, they adopted resolution WHA40.13: The Development of Guiding Principles for Human Organ Transplants. The primary impetus for creating the resolution was the concern of the World Health Organization (WHO) at what seemed to be a rapidly progressing trade for
profit in human organs. By 1991, they had created a final draft of the resolution, in the hopes of
ending human exploitation and shutting down the black market for organs. The nine Guiding
Principles are set out in the following.

Guiding Principle 1 establishes that an organ can be removed from a deceased person, if
lawful consent is acquired or if no evidence of objection on the part of the donor exists, in the
absence of said lawful consent. Guiding Principle 2 addresses the issue of bias on the part of the
doctors, instructing that a physician determining whether or not the death of a patient and possible
organ donor occurred should not be directly involved in any of the necessary processes for
transplantation: organ retrieval, transport, or implantation, nor should they be involved, in any
capacity, with the care of the organ recipient. Interestingly, Guiding Principle 3, instructs that
organs should preferably be removed from the body of a deceased person, and that a living donor
should only be utilized if genetically related to the organ recipient. Guiding Principle 4 is a blanket
prohibition of the removal of organs from a living minor. Exceptions can be made by individual
nations, but only for the purpose of retrieving regenerative tissues, i.e. bone marrow, blood.

Subsequent to the establishment of the rules that should govern legal organ donation, Guidelines 5
through 9 all address some aspect of the black market in organs. Most importantly, Guideline 5
states the following: “The human body and its parts cannot be the subject of commercial
transactions. Accordingly, giving or receiving payment (including any other compensation or
reward) for organs should be prohibited.”(37) The WHO comments on this guideline, stating that
sanctions for the selling or purchasing of human body parts will be determined independently by
each nation. In addition, similar to the criminal section of NOTA, the WHO does not recognize
the costs associated with retrieval, transportation, and the surgical procedure as commercial
transactions. Guideline 6 bans advertising one’s organs or the organs of another for sale, while
Guideline 7 prohibits physicians from receiving payments, or utilizing an organ for transplantation.
that was knowingly obtained through the black market. Guideline 8 instructs that an institution or facility involved with organ transplantation should receive only the payments associated with the services rendered and no additional compensation. Finally, Guideline 9 purports that justice demands that organs for transplantation be distributed based on medical, not financial need. This provision directly addresses the criticisms that arose against NOTA’s ban of the organ trade. The WHO Guidelines ban the sale of organs, but they also do not allocate organs based upon the ability to pay. (37)

The WHO protocols have been adopted by 192 nations, including the United States, and have not been altered in 16 years. However, there is one rather significant caveat to the issuance of these regulations. They are completely non-binding and enforceable. In essence, they are suggestions for how to codify organ transplantation in one’s country. Consequently, since the guidelines have been put in place, world organ sales have only increased. The WHO has no enforcement powers, nor can they provide funding to smaller countries to enable them to monitor illegal organ sales. The antitrafficking protocols place a burden on these nations, and the economic incentive for monitoring, regulating, and prosecuting cases of organ purchasing and vending is minimal. (18) Thus, while the WHO provides a strong, well-informed model for national organ regulation, it itself does not offer much aid in the face of the growing free market in organs.

The WHO is not the only international organization to issue regulations regarding organ transplantation. In October 2006, the World Medical Association (WMA) General Assembly met in Pilanesburg, South Africa to discuss human organ donation and transplantation. In accordance with both NOTA and the WHO, the WMA also prohibited payments for organ donation and transplantation. The WMA explicated their reason for the prohibition by contending that monetary incentives compromise organ donation’s basis in altruism and violate the principles of justice, by awarding medical treatment based upon one’s ability to provide compensation. Doctors
are not to accept organs obtained through commercial transaction, nor, as in Guideline 6, is one permitted to advertise organs. The WMA also permits money to change hands if it involves the reasonable expenses associated with the procedure. Being a medical association, the WMA goes a step beyond the WHO in instructing doctors. Not only are they not to accept black market organs, but they are instructed to thoroughly explain to the patient why receiving and utilizing such an organ is wrong, according to the initial reasons set out by the WMA for banning the organ trade. (35)

Looking at both national and world organ transplantation regulations, one is able to recognize two distinct trends in thought. NOTA, the WHO, and the WMA, all agree that financial compensation for organs is unethical and ought to be prohibited. On the other hand, they do not believe that financial compensation provided to the numerous parties involved in an organ transplantation procedure is a violation of such a stance. The question is, are we able to separate the two? What is the distinction between buying an organ and buying an organ transplantation procedure? Some would say that it is the difference between accepting and using a gift and buying that same item from someone. Others would say there is absolutely no distinction, and the principles set forth by NOTA, the WHO, and the WMA are contradictory.

NOTA, the WHO, and the WMA have still not been able to provide definitive answers. In the United States, on rages the debate as to what constitutes compensation for organ donation. On March 12, 2007, the House passed legislation, HR 710, which will allow “paired” kidney donations, specifying that this type of donation does not violate the NOTA law prohibiting organ sales. In a paired donation, a patient that needs an organ and possesses a willing, but medically incompatible donor in the form of a family member or friend, is paired with another “couple” who have found themselves in the same situation. Essentially, the two patients exchange donors, assuring that each will receive a transplant. Current law was concerned with this particular
procedure, because trading organs could be construed as organ compensation. In fact, some hospitals have refused to perform paired organ donations, and UNOS does not currently have a database to match donor-recipient parties. HR 710 has now attempted to erase any ambiguity as to the legality of the paired donations, and the Congressional Budget Office estimates that Medicare could save $500 million in dialysis costs over the next ten years with paired donations. (30)

Trading one organ for another does not violate organ compensation laws. However, what if I trade my kidney for a diamond ring? I am not receiving any money for my organ, only goods. If trading an organ for an organ is not commerce, is trading an organ for a good not commerce as well? Paired kidney donations are important because they help to remedy the kidney shortage. However, there will surely be shortages of other organs as well. Can we keep creating exceptions to the organ compensation laws? Does the existence of an organ shortage morally legitimze trading and selling organs? Does the fact that we could potentially save lives by buying organs outweigh the potential immorality of purchasing a body part? These are all questions that need to be answered as well delve into the ethics of organ transplantation and human body parts.
Chapter Three

THE ETHICS OF ORGAN TRANSPLANTATION

According to Albert Schweitzer, “Ethics ... are nothing but reverence for life”. This is the primary predicament that the practice of organ transplantation finds itself facing. How do we save the lives of some, while at the same time, respecting and protecting the lives of others? In the realm of transplantation, there are three primary ethical concerns which require consideration. The first of these involves the definition of death. How are we able to determine when someone is dead? What is the distinction between death and brain death? How do we clinically define brain death? The second question is concerned with living donation. Who should be allowed to donate their organs? Finally, one must consider the growing international organ trade. While illegal in some nations, and legal in others, is it an ethical practice? Should it be prohibited or allowed? If it is allowed, how do we implement it? In the end, does attempting to save lives with organ transplantation mean abandoning a reverence for life?

Brain Death

Only recently in the course of human history have scientists and philosophers become interested in brain death. Looking back a bit further, one discovers that death was thought to occur sometime before the complete cessation of vital functions and before decomposition of the body.(10) Modern tradition has understood death to occur when the heart ceases to beat and breathing stops. This manifestation of death is now termed “cardiac death”.(5) Both of these definitions involve the idea that once the body is no longer functioning as whole, it is no longer alive. Residual biological activity is not sufficient for declaring an individual to still be living.(10) In the same vein, the body is unable to function as a whole without the brain as well. This leads us to the idea of “brain death”.


Although brain death is, in the grand scheme of things, a rather new concept to arrive on the medical scene, a brief look at the past suggests that the destruction of the brain has long been associated with death. “Throughout history humans have executed their unfortunate fellows by means of hanging or decapitating, thus recognizing death as the severance of the brain from the body. Even large carnivores recognize brain... death, since they seize upon and shake their prey, inflicting atlanto-axial dislocation and brain... death in their victims.” (22) What exactly is brain death? Is it the death of the entire brain, the loss of brainstem function, or the shutting down of the entire central nervous system? Since 1968, when the Ad Hoc Committee of the Harvard Medical School formally defined brain death, a significant number of clinicians have affirmed that the primary physiological element of brain death is a diagnosis of the death of the brain stem. (20) There a multitude of symptoms that trigger such a diagnosis: both the heart and the lungs require support from a ventilator, i.e. they are not able to function on their own; the pupils remain dilated and do not react to light; the eyes do not rotate in the socket when the head is moved from side to side or up and down. Other ways of testing for brain death include an electroencephalogram (EEG), which can confirm the absence of nerve function, or a flow study that would show an absence of cerebral blood flow. (5). Brain death and brainstem death are often used interchangeably in both medicine and the literature. In 1981, it was recommended, by a report to the U.S. President’s Commission, that brain death should be considered synonymous with the death of an organism as a whole.

According to Robert J. White, in his essay “The Concept of Human Death in Reference to Organ Transplantation”, the Western world has become incredibly comfortable with the idea of brain death, or what he calls the “single organ definition” of death. “Without question, the Western World, both professionally and publicly, appears to be quite comfortable with this new single organ definition of human death. In the process, it accords a unique status to the human
brain, arguing that it is what determines and characterizes the uniqueness of the human person.”(33) White goes on to argue that the single organ definition “has much to commend itself”, being that any advancement mankind has made, both presently and in the past, was a result of the human mind alone, and that all of the other organs in the body are, in fact, “subservient” to the brain. In their essay, “Death, dying and donation: organ transplantation and the diagnosis of death”, I. H. Kerridge, et. al., argue against such an idea, saying that it is in fact difficult for both the lay person and medical personnel to accept brainstem death. The “dead” patient is usually still pink and warm, and although supported by machines, the heart continues to beat and he or she is usually breathing. In fact, “a 1995 study showed that about 20% of families of brain-dead patients continued to have doubts about whether their relative was actually dead, even after brain death was explained to them, and a further 66% accepted that the patient was dead but felt emotionally that they were still alive.”(20) Even some doctors and nurses have difficulty agreeing that brain death is actually the same as death. “A study showed that many believe that brain-dead patients are ‘irreversibly dying’ or have unacceptable quality of life ... . Nurses and physicians ... talk to families as if patients were still alive, using statements such as: ‘If kept on the respirator, the patient will die of sepsis’ or: ‘At this point in time it doesn't look as if the patient is going to survive.’”(20) Such sentiments do not at all coalesce with White’s overly positive idea that the Western world is comfortable with brainstem death. As opposed to being content, I would suggest that modern medicine and the Western community has accepted brainstem death, because it serves a purpose.

The Ad Hoc Committee for Harvard Medical School established the definition of brain death only one year after the first successful liver transplant occurred in the United States, and the during the same year as the first successful heart transplant. This is hardly a coincidence. The primary motive for the medical, legal and public approval of brain death is organ transplantation. A donation from a “beating heart” donor is preferred, because this ensures the best preservation of
the viable organs. The brain dead individual is such a donor. Professor Lovell, a renal transplant pioneer, commented with the following: “The law did enter in a specific way ... as the transplantation programme developed, because of the desire for a legal definition of death that was relevant to obtaining kidneys from cadavers.” (20) After the 1968 murder charges filed against a surgeon in Japan, for the death of both the donor and the recipient following a heart transplant, doctors are not eager to harvest the organs from a person whose death may be under dispute. Consequently, the medical profession and public policy insist that vital organ donors must be declared dead before their body parts can be removed. This is known as the “dead donor rule”, a rule that is responsible for the necessity of brain death.

Born from controversy, the “dead donor rule” has succeeded in creating some if its own. The heart-beating cadaver requirement, in combination with the organ demand greatly exceeding the supply, has prompted many to attempt to widen the definition of brain death. David Lamb describes the brainstem as “the critical system of the critical system.” (22) Without the brainstem function, the brain is unable to function as a whole, and in turn, the organism is unable to function as a whole. Hence, a diagnosis of irreversible loss of brainstem function is the epitome of whole brain death. Lamb’s assertion that the brain is in fact dependent on the brainstem is an important one. In the pursuit of organs, many are eager to say that death of any part of the brain qualifies as brain death. Lamb is eager to point out that such a diagnosis would be entirely incorrect. An individual, who sustains massive damage to the cerebral hemisphere, leaving the brainstem largely intact, is not brain dead. Rather, this person is in a persistent vegetative state. Lamb is quick to show that is scientifically, philosophically and ethically unconscionable to classify someone in a non-cognitive state as dead. Those, like White, who argue the “single organ definition” of brain death, might not necessarily agree. If the brain is the supreme organ, and all other organs are “subservient” to it, then any encephalic damage might be considered sufficient to constitute brain
death. While Lamb is authoritative in the separation of the two conditions, according to Carrasco De Paula, there “has been a lack of terminological homogeneity”(10), among clinicians in regard to diagnosing brain death. “Some ... have asserted that the irreparable lesion of only one part or segment of the brain is sufficient. Of these, some indicate the cerebral cortex and speak of ‘cortical death’”(10), what Lamb would call the persistent vegetative state. Rather than contend that a non-cognitive individual is brain dead, others have attempted to use another definition of death to gain access to organs.

An alternative classification of death employs the idea that with death, one loses the essential characteristics that comprise the individual person. Such characteristics include sentience, cognition, rationality, sociality, and self-awareness. According to Grant Gillett, a professor of biomedical ethics at the University of Otago in New Zealand, “the ‘ability to express and develop’ personality ‘is crucially dependent upon the intact functioning of [the] brain ... which enables [one] to interact with others and the world ... in a rich and complex manner.”(22) If this ability conferred by the brain is removed, then the body is no longer able to be seen as the locus of personhood. As such, “this person is no longer, in an ethically interesting sense, alive. Having made that decision we no longer have in our hands a person who is a patient we must care for but a body in which our former patient has no further interest (emphasis added).”(22) Gillett is not alone in his argument that loss of the ability “to interact with others and the world” is sufficient criteria for establishing that the continued existence of the patient is futile. In his essay, “To Save or Let Die: The Dilemma of Modern Medicine”, Richard McCormick purports that “the meaning, substance and consummation of life is found in human relationships.”(24) As such, life, as a value, is only to be preserved if it contains some potentiality for engaging in these human relationships. If one is unable to do so, which one could easily determine as true for those in a persistent vegetative state,
the one’s life “can be said to have achieved its potential.”(24) In other words, there is no reason or value that states that this person should go on living. They are, for all intents and purposes, dead.

While such a definitions might be important for determining whether treatment can be withdrawn from a person in a vegetative state, it is not sufficient criteria for declaring them dead; while identification of the non-cognitive individual as solely a body is convenient for the removal of said person’s organs, that does not automatically make it a true one. The fact of the matter remains: brain death requires death of the brain stem. Whether a person is philosophically alive does not change the fact that they are medically alive if their brain stem is functioning. We cannot simply declare people dead because they do not function at the level of cognition that is familiar to us, nor can we do so simply because we desire to harvest the organs. In accordance with Lamb, it is ethically important to separate the brain dead from those that are brain damaged. The term “death” does not apply to those in a persistent vegetative state. “Death” is “reserved for people who meet circulatory criteria: identification of irreversible cessation of circulation of the blood.”(20) In turn, “brain death” is a formal clinical diagnosis to be reserved solely for the death of the brainstem, and as “a surrogate marker for brain death.”(20) For patients who meet the criteria of brainstem death, organ donation is a valid option.

We have determined who can be considered dead, and of those, who we are permitted to use as organ donors. However, living donors have become an important source of organs as well. Who, of the living donors, do we allow to donate?

Living Donation

Because of the aforementioned organ supply’s inability to keep pace with the demand, as well as the yet unresolved issues surrounding the definition of brain death, countries are increasingly turning to the living as an organ source. Transplant programs involving the living are especially popular in developing nations, where liver segments, kidneys, and lung lobes are
commonly harvested from a willing donor. While these donations initially came from a genetically related family member, more and more organs are being donated by unrelated persons. These donations are considered problematic, as they could be motivated by financial compensation or other incentives; they could even be the victims of coercion. (36)

In an attempt to address the problems of payment and duress, The United Kingdom enacted the Human Organ Transplant Act (HOTA), which commanded the creation of the Unrelated Live Transplant Regulatory Authority (ULTRA). Under HOTA, it is an offence to remove an organ from a living donor or transplant such an organ, if the donor and the recipient are not genetically related. Genetically related individuals include biological parents, siblings, children, as well as nieces and nephews. HOTA does allow the Secretary of State to make exception to these regulations: “the prohibition against unrelated living donation [is lifted] under certain conditions. The most important are that (a) no payment has been or will be made, and (b) the donor's consent was not obtained by coercion or the offer of an inducement.”(11) ULTRA was created to ensure that these conditions are met in instances of unrelated living donation. The parties involved in the transplant are charged with proving the absence of coercion, meaning that ULTRA assumes that the latter has taken place from the start of their investigation. There are those that argue vehemently against the creation of ULTRA, citing that coercion is not likely to occur among unrelated persons. Even if an outsider were to attempt to use force, threats, or physical violence to pressure an individual into donating their organs, these would most likely be recognized by a capable transplant team. On the other hand, it is argued that there are a multitude of subtle pressures involved in familial relationships, which are much more conducive to coercion. While having a genetically related donor is preferable because of the decreased chance of rejection, HOTA’s regulations were not enacted for health reasons. Rather, ULTRA is, in effect,
severely limiting the number of organs available for transplant, in an attempt to stop the phenomenon of coercion – a phenomenon which occurs with both related and unrelated donors.

Even if one was able to confine living donation to related individuals, the practice has been questioned on a much deeper level. Should we allow living organ donation at all? Living donation requires that a surgeon perform a non-therapeutic, potentially life-threatening procedure on a healthy individual, a fact which seems contrary to the principle of *primum non nocere*, “first, do no harm”. Not to mention, if the patient in need of a transplant is not of age, organs are removed from living minors, oftentimes without their consent. Secondly, when the transplant donor and recipient are closely related to one another, the specter of coercion looms large. Is a mother expected to risk her life for her child? Of course, almost any mother would answer “yes” to this question. Yet, does not this compromise the freedom of her choice? In the case of sibling donations, should a mother have to choose to risk the life of one child for the other? Some argue that parents of a child in need of organ transplant should not be offered the living donation procedure. As is expected, the parents would have difficulty in refusing the procedure, and in that difficulty, would have to face the potential death of their healthy child, in addition to the grief over the child that is already ill. As George J. Annas, a lawyer and bioethicist for Boston University, stated to the New York Times: “The parents basically can’t say no.” (13) The recognition that parents feel this type of obligation toward their children leads some to question whether or not the parents have any real moral agency. Robert Crouch and Carl Elliot would contend this notion. “We must recognize that moral and emotional commitments ... are not constraints on freedom, but are rather a part of ordinary human life.” (13) If one defines moral agency as sovereign and unconnected to other humans, then yes, the moral agency of the parents must exclude the interests of others, including their children. If the mere suggestion of coercion is to be erased, then we must make every man an island. However, self-interest is intimately bound with the interests of the other
people in our lives, especially our families. Thus, a competent adult is free to donate an organ to their child, even if we believe their conscience is compelling them to do so. On the other hand, can we expect a minor to have moral agency and the ability to consent to such a procedure? Should a parent be allowed to offer consent on the minor’s behalf, and then, for all intents and purposes, force them into undergoing such an invasive procedure? The courts have continuously tried to solve such a conundrum, some suggesting that the surgery would be in the “best interest” for the child donor. The child would be psychologically damaged if they were to grow up realizing that they had the power and opportunity to save their sibling, and they did not do so. According to Crouch and Elliot, a “best interest” argument is still a questionable one: “In many cases it is far from clear that the donor is mature and sufficiently mentally developed to have an important other-regarding interest in a sibling.”(13)

There are still many questions to be answered in regard to living donation. We have yet to reconcile the surgeon’s role - is he or she doing harm? Is the risk of doing harm, the same as actually doing harm? Should only families be allowed to donate? If we do allow unrelated persons to donate, should they be financially compensated? This is the question that speaks directly to the organ trade.

The Organ Trade

Opinions involving the organ trade exist on a rather extensive continuum. There are those that are wholly for its inception, those wholly appalled by it and absolutely against it, and then there are those that fall somewhere in between. The arguments for all three stances are equally abundant and persuasive. Let us start with the proponents of organ sales.

In the essay, “Is it ethical for patient’s with renal disease to purchase kidneys from the world’s poor?” Dr. Tarek Bakdash, a neurologist, maintains that living in poverty is worse than having a poor person sell their organs; in essence, the organ trade is the lesser of two evils. For
Bakdash, poverty is itself a form of coercion and selling one’s organs offers a chance to rise above that way of life. “The argument that we should protect the poor from being exploited by banning them from selling their organs is a myth. The poor are always exploited from the day they are born, and in all avenues of life. The only thing of value left for some of them is their bodies.”(8) Regrettably, the system in place in many nations does not condone selling one’s organs, and people are forced to participate in the black market. This leads to the harvesting procedure being performed in sub-standard, often highly unsanitary conditions. The donor faces major complications, even potentially fatal illnesses as a result. These conditions are the reason, Bakdash argues, that the organ trade should be regulated. Poverty-stricken donors would have access to suitable care and would not be risking their lives to the extent that they are now. To ensure that the poor are not exploited and coerced into donating their organs, Bakdash and others have proposed laying groundwork for a “central purchasing system”. This system would provide counseling, screening, insurance, financial advice, and probably most importantly, ensure appropriate payment.

In his essay, “Why We Should Develop a Regulated System of Kidney Sales”, Arthur J. Matas, director of the renal transplant program at the University of Minnesota, has a more simplistic reason for wanting to legalize the organ trade. Financial compensation will increase the number of individuals willing to donate, which will reduce the number of patients on the transplant list that will die waiting for the organ. Essentially, Dr. Matas is attempting to reconcile the disparity between the supply and demand of transplantable organs, especially kidneys. Similarly to Bakdash, Matas also utilizes the argument that the black market organ trade already exists and puts those who are selling at a disadvantage. Rather than concern for the substandard conditions of surgery, however, Matas addresses the now fairly commonplace occurrence of “transplant tourism”. Many patients with end-stage renal disease travel to countries with unregulated systems for paid donation,
to take advantage of the latter and obtain an organ for transplant. If a regulated system was constructed in the United States, we could easily lessen, if not altogether eliminate, “transplant tourism”, as well as protect those who are selling organs here and abroad. As was also discussed in Chapter One, a kidney transplant is preferable to maintaining patients on dialysis indefinitely. Not only would a system for buying and selling organs, specifically kidneys, reduce the cost incurred with dialysis, but the transplant would also improve the quality of life and the prognosis of the recipient. “Increasing donation will shorten (or eliminate) the waiting list, shorten waiting time, and improve the survival rate for our patients.”(23) The types of payments suggested are a fixed monetary sum, long-term health insurance, reimbursement for travel and time out of work, or even a tax deduction. It would be important to show that the expected outcome for a paid donor would be the same as that of a traditional unpaid living donor, i.e. the unpaid donor would not receive better care simply because they were not burdening the healthcare system with a request for compensation. Finally, Dr. Matas argues that receiving compensation for a sperm or ovum donation is no different than receiving compensation for an organ.

Fortunately, Iran offers us an opportunity to look into the effect that having a regulated system for kidney sales has. In 1988, Iran adopted a “compensated and regulating living-unrelated donor renal transplant program.”(17) The initiation of this program saw a substantial increase in the number of renal transplants performed, and in 1999, the renal transplant waiting list in Iran was eliminated. More than 50% of patients living with end-stage renal disease are now living with a functional kidney transplant. The elimination of the waiting list also means that Iranian citizens are able to receive a kidney regardless of their financial status. All patients, rich or poor, have equal access to transplant facilities. The primary reason for this equitable distribution is the willingness of a variety of charitable organizations to compensate the program for the various expenses that the poor cannot afford. The fact that the poor would not have access to transplants is one of the
primary arguments against compensated donation. However, statistics from Ahad J. Ghods and Shekoufeh Savaj’s report on the Iranian model show that over 50% of those receiving organs were from the lowest socioeconomic class. The only social benefit awarded to kidney donors is health insurance.

Proponents of Iran’s program argue that the utilization of self-interest to influence human behavior is much more effective than reliance on altruism. Only under certain circumstances does an individual show a willingness to perform an activity that does not directly benefit him or herself, even when a person decides to donate an organ, Ghods and Savaj suggest that the donation is usually from a living related donor who is under some type of emotional coercion or familial pressure. On the other hand, self-interest is a motive for nearly all of our daily activities. This tendency is often an explanation for why altruistic living donation has met limited success, while the Iran program has succeeded in providing a kidney transplant for every patient that requires one.

Those opposed to the organ trade would ask us to bear in mind the following from Diderot: “There is no moral precept that does not have something inconvenient about it.” While payment for organs is, at least according to the data from Iran, successful in eliminating the waiting list for organs, that does not mean it is an ethical practice. While the prohibition of the organ trade might be, unfortunately, inconvenient for those in need, that does not mean that it is unjustified.

There are those that do not wholly depart from some type of financial incentive for transplantation. The American Society of Transplant Surgeons was unanimously against exchanging money for cadaver organs, whether through a direct payment or a tax incentive, because as such an exchange “would violate the ideal standard of altruism in organ donation and unacceptably commercialize the value of human life by commodifying donated organs.”(6) The panel instead suggested that appreciation be shown by reimbursing a family that wishes to donate
the organs of their loved one for the funeral or making a charitable donation on their behalf. F.L. Delmonico, et.al., in their article in the New England Journal of Medicine, also suggest incentives for organ donation; in this instance, they would be for the living donors themselves. Such incentives include: paired kidney donation, which was recently authorized by Congress; medical leave for organ donation; ensuring access to organs for previous donors or donor insurance. Why these incentives as opposed to money? The authors argue that “life and liberty are values that should not have a monetary price.”(15) When a poverty-stricken individual feels constrained to put his or her life in peril for the singular purpose of obtaining some cash, these values are tarnished. A market system for donation advances exploitation and infringes on civil liberties. A non-monetary incentive, rather, appeals to ideas of equanimity and preserves the social good that organ donation has become.

Nancy Scheper-Hughes, the head of Organs Watch at the University of California in Berkeley, is against incentives or regulation of any kind. While the idea of regulation might have merits in a highly developed country like the United States, it is simply “out of touch with the social and medical realities in many developing countries.”(8) Generally, the institutions created in these countries to monitor the harvesting organs are ineffective, corrupt or compromised by organ brokers and surgeons who refuse to operate within the system, in order to capitalize on their profit. Even if a system of regulation were in place, there is no way to ensure that the medical conditions in developing countries would improve because of it. As of now, those that sell their organs face a variety of medical complications, ranging from high blood pressure to the insufficiency of the one remaining kidney. Often, these paid donors are no longer able to find employment, as they are unable to engage in manual labor. They do not have the endurance or strength to sustain these jobs, which are the only ones available for their level of skill.
There are those that purport that paying for an organ transplant procedure, which inherently comes from an organ, is no different from actually paying for that organ. Other than the living donor or the next-of-kin of the cadaver donor, everyone involved in the process of organ transplantation receives compensation. Scheper-Hughes points out that compensation provided for serves rendered is ethically dissimilar to compensation provided for an organ. Professionals, such as the transplant surgeons and the organ procurement organization (OPO), are receiving a fee for a service rendered. Providing someone with a fee for executing their job-related responsibilities is an accepted, ethical practice in our society. Compensating someone for a body part is not.

Dr. Matas and Dr. Bakdash argued that the poor who donate their organs should be allowed to exercise their right to autonomy. They are capable of making decisions and deciding what should be done with their bodies. Matas argues that it is not exploitation if someone makes an autonomous choice, after being fully informed of the consequences of their choice. Firstly, especially in developing countries, there is no way to be certain that a paid organ donor has been provided with all of the information needed to make such a monumental decision. Secondly, how can one not call the pressures placed on the world’s refugees and poorest populations by organ brokers, exploitation? “Yes, even the poorest people of the world ‘make choices’, but they do not make these freely or under social or economic conditions of their own making. Further, the pressure of organ brokers upon the poor makes their decision to sell an organ anything but a full and autonomous choice.”(16) If someone offers you a choice between starving to death or doing something to obtain the funds to prevent it, you are going to choose the latter. However, you chose as a result of the need to fulfill basic, instinctual needs. That hardly makes it a free choice.

Finally, we encountered Dr. Matas’ argument that selling a kidney is no different from selling sperm or an ovum. I would like to take issue with that statement. There is a fundamental difference between a vital organ that is intrinsic to the structural and functional integrity of the
body, and materials that the body produces for the purposes of reproduction. While reproduction is important to the continued existence of the human race, it is not essential to an individual’s survival. In addition, the body is able to naturally discard both the sperm and the ovum: the former through ejaculation and the latter through menstruation. No one can simply eject their kidney whenever they choose. You will not die if you vend a reproductive cell. However, if you sell a kidney and your other kidney fails - you most certainly will.

The utilitarian ethic that promotes the greatest good for the greatest number is insufficient for endorsing the right to buy and sell human organs. As Kant’s categorical imperative argues, humans should always be treated as ends and never as means. To employ utilitarianism means to do just that. While eliminating the waiting list for organs through sales is more palatable than the ethical alternative of creating ways in which to increase altruistic donation, that does not make it the right choice.

In the next chapter, we will explore two countries that have garnered much attention in the United States media for the questionable practices in the realm of human organ transplantation. The ethics of organ procurement in China and India have been repeatedly questioned, as citizens from those countries have come forward to enlighten us as to some of their practices.
Chapter Four

CHINA AND INDIA

In the discussion of ethics, lofty ideas sometimes get in the way of seeing the reality of the situation. The organ trade is very real to those who are in need of an organ and very real to countries where selling a kidney or forcibly taking another’s kidney, is a common, even condoned, way of life. The organ trade is very real to the citizens of India and China.

For the Family

The process begins the same way every time. A family is in dire need of money – they have a mountain of debt and no longer have any credit. They have no way of living; without money, they cannot feed or cloth themselves or provide shelter for their families. A wife, a mother, hears from a friend about an operation. She tells her where to go and what exactly to do. The wife, the mother, does not know what a kidney is. The doctors show her a video, they tell her “You have two, you can live with one. You should know, you could get sick or even die from the operation, or from later complications.” In the end, knowing this fact does not really make a difference. Her family needs the money, they are counting on her. She has the operation. They pay her 32,500 rupees for her kidney; that is, approximately $1200 U.S.D. for her body part. In a short time, that $1200 is gone and the debt returns. Only the woman does not have any more kidneys to give.

There is no national cadaveric organ donation system in India. In addition, living-related donors for those in need of transplant are often unavailable or unwilling to participate. Consequently, a majority of organ donations come from paid, unrelated donors. In India, it is mostly women who sell their kidneys in exchange for the hope of financial security. In fact, it has become a “dominant and pervasive means of attempting to secure a certain kind of future.”(12) Only ten years ago, rural Indians would have been astonished to hear of a flourishing organ trade
in Mumbai. Today, these same Indians are selling their kidneys for their daughters’ wedding
dowries or to pay off their ever increasing debts. Like the woman in the story, only a year later,
they find themselves in debt again. Except this time, they are missing a kidney. (29) Not only have
they been deprived of a vital organ, but the donors are often weak and unable to work well. Often,
the scar from the nephrectomy remains painful, long after the surgery has been over. One woman
told the story of her alcoholic husband, who, every time the family was without resources, would
repeatedly hit her where her scar was, a painful reminder of a “recent past when it marked their
successful efforts to get out of extreme debt and support their households, and an indebted present
when it has come to mark the limits of that success.”(12)

India has become one of the leading countries for purchasing and selling organs. With an
average income of $11 a month for the Indian worker and a legal system that does little to hinder
the practice, in the past five years, more than 2,000 kidneys have “changed bodies”. In some cities,
nearly 95% of these transplants were the result of a commercial transaction. Nationally, the
number of commercial transactions falls to approximately 60%. (14) There are typically several
players in such a transaction: the doctor, that charges anywhere from $1000 to $2000 to perform
the surgery, organ brokers who demand a substantial fee for locating the body part, and the donor,
generally a poor mechanic or laborer, for whom the payment for an organ could be more money
than they could hope to save in a lifetime. The price for a cornea (yes, a cornea from a living
donor) is $4, 425 U.S.D.; a patch of skin goes for $55 U.S.D., and as stated in the Indian woman’s
story, anywhere from $1000 to $2000 U.S.D. for a kidney. (7)

In February of 2001, a cross-sectional survey was conducted among 305 citizens of
Chennai, India, all of whom had sold a kidney approximately 6 years before the time of the survey.
(19)Chennai is a large city in the south of India, with a population of 6 million. Nearly all of the
participants in this study - 96% - sold their kidneys to pay off debts. These debts included food
and household expenses, marriage and medical expense and rent. A consideration that did not factor in the decision to sell was helping an individual with end stage renal disease. 60% of the study participants spent the profits from the sale to repay debts; 25% spent the profits on food and clothing; 5% spent the profits on wedding dowries. The expected profit was an average of $1410 U.S.D., while the amount received was actually around $1000 U.S.D. A majority of the individuals who chose to donate their organs experienced a decline in both their economic and health status subsequent to the surgery. The average annual family income decreased by one-third, and the number of families living below the poverty line increased by nearly 20%. Over two-thirds of the participants reported that they still had substantial debt at the time of the survey, again, only six years after they had sold their kidney. In the realm of health, half of the participants complained of continual pain at the site of the nephrectomy, while one-third complained of chronic back pain. Interestingly, when asked if they would advise others to sell a kidney, an overwhelming 80% of the participants said that they would not.

The results of this study are important, because they strongly undermine many of the justifications put forth in support of the legalization of organ sales, not only in India, but internationally. We have heard from previous experts who contend that the poor should be allowed to sell an organ because it will lift them out of poverty. However, this study shows that selling a kidney did not aid in overcoming poverty. In fact, a majority of the study participants actually experienced a decline in their economic status following the donation. While a seller arguably has the right to do what they want with their body if they are sufficiently informed, this was obviously not the case among the participants. If 80% of those who sold a kidney would not recommend that others do the same, they were obviously not sufficiently informed as to what the possible outcomes and side effects of the nephrectomy could be. Besides not being adequately apprised as to the nature of the surgery, the participants were also exploited. They were given $400
less than originally promised before the surgery. Finally, the participants experienced an overall decline in health, a fact which could mean a decline in their ability to perform meaningful work, which could further sink them into poverty. The conductors of this survey have suggested that “physicians and policy makers should reexamine the value of using financial incentives to increase the supply of organs for transplantation.”(19)

Prior to this study, in 1994, Indian Parliament, after ignoring the issue for some time, attempted to do the latter. They enacted the Transplantation of Human Organs Bill. The bill outlawed the commercial trading of human organs and allowed removal of a body part only if it served a therapeutic purpose. Anyone convicted of participating in the sale of organs was to receive a sentence of two to seven years in prison. However, this law has had little affect. False claims that an organ was removed for the good of the patient are made; the compassionate donor clause of the bill is often exploited, with poor Indians being secretly paid for their organs. Sometimes, like the story of the Brazilian woman, an individual's organs are removed without their knowledge or consent. On January 29, 2004, a decade following the passage of the Human Organs Bill, the National Human Rights Commission (NHRC) wrote a letter to the Prime Minister of India, suggesting measures to check the continuing illegal human organ trade. Justice A.S. Anand, the director of the NHRC, commented on the fact that the human organ trade was a violation of human rights. The NHRC asked that the government screen the records of hospitals doing organ transplantation, specifically kidney transplants, and determine how many kidneys were removed under the clause of “compassionate donor”. If higher than 5%, the state medical board is ordered to investigate said hospital, donor and recipient. The remedial measures suggested have met with little success, Reports of sales of organs in India have only increased. (32)

A developing country such as India possesses a vast amount of dysfunction in their society and corruption in their government. Resources for enforcing laws against the organ trade and
maintaining vigilance in the face of such unjust practices are inadequate, if not wholly absent. Considering the lack of well-defined, well-executed policy, it will be difficult to draw a distinctive boundary between what qualifies as unadulterated compensation for an organ and what could be classified as incentives, incentives which could actually be placed in the category of exploitation, coercion and manipulation. “The slippery slope of commercialism is no ethical illusion but a recurrent reality in India.” (14)

Forget Lethal Injection

It was a typical day for Dr. Wang Guoqi, a military physician in China. For some time now, Dr. Guoqi had been charged with the duty of harvesting the organs from executed prisoners. Little did Dr. Guoqi know, that this day would be anything but typical. Today, the Chinese government was in particular need of valuable skin grafts for burn victims. A Chinese prisoner was taken from his cell and without ceremony, shot in the head. The shot did not kill the prisoner. Instead, Dr. Guoqi was asked to do the unthinkable. Dr. Guoqi skinned the shot prisoner’s body – skinned him while he was still alive.

In June 2001, this was one of the incidents that Wang Guoqi testified to before Congress. The executed prisoner was only one of more than 100 that Dr. Guoqi had harvested organs from during his career. He further testified that corneas and other body parts were taken for transplants and that his hospital had sold these body parts for profit. At the time, the doctor was seeking asylum in the United States. (9)

Following the introduction of cyclosporine in 1983, China implemented the “Rules Concerning the Utilization of Corpses and Organs from the Corpses of Executed Prisoners”, in 1984. This rule instructed that the harvesting of the organs of executed prisoners was permitted, if the prisoner had volunteered his body subsequent to execution, if no one claimed the prisoner’s body, or if familial consent had been provided.(21) What the rule does not delineate is what
exactly qualifies as a crime punishable by death. In the 1990s, China executed more prisoners than the rest of the world combined. According to Human Rights Watch Asia, since 1995, China has elevated the number of crimes that are punishable by death, in an effort to satiate the ever increasing demand for body parts. Thieves, tax dodgers, even pig stealers, were among the 6100 prisoners that were handed death sentences in 1996. More than 4500 executions occur every year. Executed by one bullet to the head to avoid tissue damage and loss of organ viability, prisoners are often selected for death based upon whether the blood type matches a wealthy individual looking for a transplant. Wealthy citizens of Taiwan, Hong Kong and China are able to obtain organs at will, that is, if they are willing to pay the substantial fee. A harvested kidney, organ, liver, or heart can fetch up to $30,000 U.S.D., all of which goes to the Chinese government. (9, 18, 21)

Of course, with executions and transplantations shrouded in secrecy, it is difficult to obtain data on these occurrences, and China is able to somewhat successfully deny the allegations. However, interviews before Congress and testimony from doctors that prisoners are actually executed in the manner described have created much disdain in the world community. Only last year did China finally acknowledge that an organ trade involving executed prisoners did, in fact, exist.(21) As reported by Richard Spencer of The London Telegraph, China’s associate health minister, Huang Jiefu, told a summit for transplant doctors that “most of the organs from cadavers are from executed prisoners”, a claim repeatedly denied by the government. China has enacted some new rules regarding transplants. Foreigners are only permitted entrance to China for transplants under regulations forbidding payment for the organs that the foreigners would be receiving. These regulations are supposedly a somewhat belated reaction to the WHO guidelines which strongly forbid the organ trade. These regulations, however, only apply to hospitals under the purview of the Ministry of Health. Most transplants are conducted at military hospitals, which are run by the People’s Liberation Army. In short, this means that China can continue with the
execution of prisoners for the organs and subsequently sell those organs, while maintaining laws on the books that prohibit such actions. (31)

In his book, *Organ Transplants from Executed Prisoners*, Louis Palmer argues for the harvesting of organs from death row inmates. Palmer claims that when an individual brutally ends the life of a fellow citizen, they are, in essence, playing God and violating the natural course of death. Because “capital murder is the unjustifiable denial of the inherent right to life”, society has a moral duty to “revoke those murderers’ membership in the human family.” (26) While Palmer’s argument might make sense, it only calls for the death of the capital felon. It does not call for the skinning of that felon while he is alive, or the removal of his heart and lungs while they are still beating and breathing. Nor does it call for the death of an individual who is not a murderer – should a pig stealer be forced to suffer the same fate as a homicidal maniac? The actions of the Chinese government are nothing short of torture, and being such, are in direct violation of human rights. As Glen Back says, “it is simply an inhumane act of greed.”(7)

We have heard from living donors who donate their organs out of desperation; we have heard about questionably cadaveric donors who have their body parts removed against their wills. International guidelines maintain that organ donation is inherently altruistic and should remain so. Are there people who donate out of the goodness of their heart? For our final chapter, we will hear about the experience of Lynn-Chabot Long, who donated a kidney to her brother to save his life.
Chapter Five

THE GIFT

Think about hair. Think about the reaction people have when someone cuts off the long flowing locks that they have been growing for quite some time. Think about them bawling at the salon, having a complete emotional breakdown. Now imagine it is not hair that they are cutting. Imagine it is an entire kidney that they are removing from your body - a kidney that will not grow back. A piece of you, one of your organs, is gone forever. It is going to be in someone else’s body. They are going to use your kidney, for better or for worse.

This is what Lynn Chabot-Long did. She did not have to do it. She chose to do it – to donate her kidney to her brother, who was dying of end stage renal disease due to nephritis. If hair is an emotional rollercoaster, parting with an organ is an earthquake. There are individuals who have trouble dealing with their loss – they truly feel the part of them that is missing. Then there is Lynn, who, after much contemplation, derived a great deal of joy from donating her kidney to her brother.

Lynn’s Story

Lynn, I have end stage renal disease due to nephritis. If I do not undergo a renal transplant procedure, I will die. I need a kidney, Lynn.

When Lynn first heard that her brother, Bill, was dying, she describes herself as sinking into a place of darkness, a darkness that would last for months to come. She felt alone in this place – unable to communicate with her husband or anyone in her family about her fear for her brother.

Lynn Chabot, we have determined that you are immunologically compatible with your brother, Bill. In other words, you are a match. Lynn, no one can force you to give away one of your kidneys. If you decide you want to do this, you have to think about what it will mean.
This fear only deepened when Lynn soon discovered that she was a match for Bill – that she would potentially be the one that would have to give him one of her organs. She began to think about the impact of having only one kidney: “Most people take it for granted that they have two kidneys and don’t have the slightest idea of the impact of only having one; or if there would even be any difference.” The doctor indicated that the one kidney would be perfectly able to compensate for the loss. However, if anything happened to the kidney that remained, Lynn would be in the same situation her brother was in right now.

*Lynn, it’s your brother – your best friend. What are you going to do? If we don’t decide soon, he’ll have to go on dialysis. We don’t want him to go on dialysis, Lynn.*

Lynn struggled immensely with her decision. One of the most influential factors in whether or not someone successfully navigates the process of donating an organ is whether or not they have support. Once Lynn had decided that, despite her profound fear, she would donate her organ to Bill if he needed it; she went to her colleagues at work with her decision. “When I told my colleagues what I wanted to do, they showed very little concern, and gave very little support. They all wished me luck and didn’t seem to want to hear anymore about it. Their apparent attitude toward me was very painful, because I had worked with these people for six years and it seemed like they didn’t even care what happened to me.” This reaction was a crucial turning point for Lynn. At this point, she realized that not everyone was going to be as involved in her life as she desired them to be. She realized that, with the help of her husband, Jerry, she was going to require inner strength to get through this period in her life.

*The scar on the abdomen will be significant. It will have to be kept away from the sun for approximately one year following the surgery or it will turn purple. It will never disappear completely – such is the nature of scars.*
Lynn was also uncomfortable with the physical aspect of the surgery. “All my life I have turned away from others’ scars and deformities – I empathized so much with their suffering I could not bear it.” What would it mean to not empathize, but sympathize? What would it mean to have a nephrectomy scar on her abdomen, reminding her every day that she was missing one of her organs? Lynn realized at this point, that there might be a reason that we each have two kidneys. She believes that one is for giving away, in case someone needs it.

*I need to do this. I want to do this. I need to do this for Bill. I want to do this for me.*

“Jerry and I had many discussions. ... . I wanted to do this. Even if it meant losing me, Jerry wouldn’t take this precious opportunity from me. We decided to look at it as an adventure.” In fact, Lynn felt so strongly that she was fated to give her kidney to her brother, that when she thought her older brother, Russ, was going to donate his kidney, she actually felt empty inside. The irony of Lynn’s feeling is striking. Can someone really be so benevolent, so altruistic, that they would feel emptier if they still had their organ, than if they gave it away? This is how Lynn describes herself. When Russ was no longer sure about his decision to donate, Lynn remembers talking to Bill’s wife, Karen, on the phone: “Karen, I’m doing it!” That is one decision that I have never regretted.” Lynn actually describes herself as feeling gratitude at the opportunity that was given to her.

*Why did Mom do this? Mom, you could have died. Why would you do this to me?*

However, organ donation does not only affect the donor. It affects their family as well. While Lynn felt fulfilled by bestowing a part of herself to her brother, her son, Rick was paralyzed with fear at seeing his mother after the surgery. “If she died, he would never forgive her.” He questioned her motives and the intentions of her siblings. He believed his uncle should have given away the kidney; anyone but his mother. The revulsion of family, especially children, is certainly a consideration. Such a reaction is another reason why Lynn had to learn to rely on her own
intuition and her own strength. While family was important, one cannot expect that they will give you all of the force you need.

*To quote Ambrose Redmoon, “Courage is not the absence of fear, but rather the judgment that something else is more important than fear.”*

Lynn has determined that she was courageous only after donating the kidney. She has now realized that she can do whatever she chooses to. “When difficult situations arise, I say to myself, ‘I donated a kidney, I can do this.’ (15, ref.cons.)

Not everyone is like Lynn Chabot-Long. Not everyone is so easily able to give her away a part of their body, and not look back at it with regret. This was seen in the study of the individuals in India, who sold their kidneys to raise themselves out of abject poverty. Yet, this is the veritable difference between the two, and Lynn is a prime example of why maintaining the integrity of altruistic donation is so important. Seemingly, the only way to feel truly comfortable, even fulfilled after donating an organ, is to do so from the basis of charity.
Conclusion

What does the future of organ transplantation hold in store? Are people like Lynn Chabot-Long going to slowly fade into the background? Will organs become a good to be traded? Will people have stock in organ brokerage companies?

After looking at the practices of countries like India and China, it is difficult to consider a human organ trade. An organ is much more than a structural and functional unit that allows the human body to function. It is a part of us. In many ways, it comprises who we are spiritually as well as physically. How do we put a value on something like that? How can we say that an Indian man or woman’s kidney is only worth a thousand dollars, but because I am from the United States, my kidney is worth $30,000? Why is this man or woman’s body part less worthy, simply because it is from a developing nation?

We do not allow people to prostitute themselves. Women are not allowed to sell their bodies to men for money. Why should they be allowed to sell their body parts? Not to mention, much discussion of the organ trade pivots on the idea that people commodify their organs as a result of their own free will. An Indian woman, whose family will starve if she does not sell her kidney, is not operating freely. Certainly, the Chinese prisoner who was skinned alive, did not ask for that to be done. Money changes the nature of a donation. For one, it is no longer a donation. Secondly, it puts a price on human life. Can we do that? What is the going rate for a human being? If we start to create a scale of worthiness, are we not falling into some warped version of eugenics? The organ trade is a violation of human rights. It is a violation of humanity.

Despite these ideas, I find myself conflicted. If I need an organ one day, and I have the means to pay for it, will I not want to use those means? Will I want to die, simply because of some idealistic, altruistic notion that body parts are not to be sold? I honestly do not know. What I do
know, is that if the organ trade is condoned, stories like Maria’s will happen a thousandfold more than they already do.

I hope you have thought about Maria as you have read this piece. I hope you have more questions than you have answers. I know I do. Welcome, my friends, to the ethos of human body parts.
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