Revamping the United States Organ Donation System: An Ethical Justification for Compensated Live Organ Donation

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REVAMPING THE UNITED STATES ORGAN DONATION SYSTEM: AN ETHICAL
JUSTIFICATION FOR COMPENSATED LIVE ORGAN DONATION

A Dissertation
Submitted to the McAnulty College and Graduate School of Liberal Arts

Duquesne University

In partial fulfillment of the requirements for
the degree of Doctor of Philosophy

By
Jordan G. Potter, M.A.

May 2017
REVAMPING THE UNITED STATES ORGAN DONATION SYSTEM: AN ETHICAL JUSTIFICATION FOR COMPENSATED LIVE ORGAN DONATION

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ABSTRACT

REVAMPING THE UNITED STATES ORGAN DONATION SYSTEM: AN ETHICAL
JUSTIFICATION FOR COMPENSATED LIVE ORGAN DONATION

By

Jordan G. Potter, M.A.

May 2017

Dissertation supervised by Professor Gerard Magill

With over 100,000 Americans currently on organ waiting lists in the United States, the mass shortage of viable organs for transplantation is one of the most pressing healthcare issues that we face as a country today. Thousands of these individuals on organ waiting lists will ultimately die waiting on an organ transplant that will never come. Many differing proposals have been discussed with the aim of increasing organ donation rates and the raw number of organs available for transplant, including changing our default consent status for cadaveric organ donation and the option of incentivizing organ donation by compensating live donors with financial incentives. Iran is the only nation in the world that currently has a legally regulated system of compensated live organ donation (CLOD), specifically for kidneys, and it has been successful since its implementation, even eradicating its kidney waiting list, which no other nation in the world can claim. However, even with this practical success, CLOD has been a very
controversial concept in the professional bioethics literature, and it has been labeled as unethical and illegal in many Western countries, including the United States.

This dissertation utilizes arguments and principles from applied ethics, political philosophy, and behavioral economics to ethically and practically analyze the need for revamping the entire United States organ donation system, including both live and cadaveric organ donation. The primary focus of this dissertation will be on justifying the ethical basis of CLOD in the United States, and a practical model of CLOD will be proposed that also includes significant changes to the cadaveric organ donation system.

The dissertation proceeds as follows. Chapter one gives a brief overview of the issues and debate surrounding CLOD. Chapter two provides the necessary background context for establishing the practical need and feasibility of a system of CLOD in the United States, including examining past, present, and future systems of organ donation and situating the medical, moral, and political bases of a potential system of CLOD in the United States. Chapters three and four examine the major ethical components and arguments for and against CLOD, including but not limited to the ethical principles of principlism and the objections from exploitation and commodification. Chapter five ethically analyzes the differing types of cadaveric organ donation and examines several other potential proposals for procuring organs. And finally, chapter six amalgamates the previous arguments and develops them into a complete proposal for a practical model to revamp the current United States organ donation system to create a more efficient and ethical system of organ donation, procurement, and transplantation.
DEDICATION

To my wife, Kim, and our children, Jackson and Addison: thank you for enduring me during this trying time.
“I hold it to be the inalienable right of anybody to go to hell in his own way.” – Robert Frost

Though I have undoubtedly been aided by numerous individuals during this journey, several individuals deserve special acknowledgement and thanks:

- My wife, Kim, who has been a lasting source of support during this stressful time – from picking up and moving across the country for this doctoral program to taking care of our children during the many long hours I put into research and writing;
- My children, Jackson and Addison, who have loved me unconditionally, even though work and research has at times not allowed me to spend as much time with them as I would prefer;
- My parents, Dean and Karol, who have always pushed me to achieve more than I thought was possible;
- Glory Smith, who has always been an advocate in my corner and a source of timely advice;
- Dr. Gerard Magill, who has always been an ardent advocate of my work and a personal supporter of me as a person and a professional;
- Dr. Joris Gielen, who has always given me excellent advice and helped bring out my inner libertarian, even if that was never his aim;
- And finally, Dr. Henk ten Have, who has always challenged me and forced me to think in new ways outside of my own perspective.
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Chapter 1 – Introduction

In a December 2007 bulletin, the World Health Organization (WHO) reported that 66,000 kidney transplants, 21,000 liver transplants, and 6,000 heart transplants occurred globally in 2005.1 In the United States less than a decade later, the United States transplant organization, the Organ Procurement and Transplantation Network (OPTN), which is ran by the private, non-profit United Network for Organ Sharing (UNOS), reports that over 121,000 Americans are currently on the United States’ organ transplant waiting list alone, and approximately 100,000 of those individuals comprise the kidney waiting list.2 In addition, nearly 15,000 Americans are waiting on a liver transplant, and thousands upon thousands more are waiting for heart, pancreas, lung, and intestine transplants.3 It’s estimated that the US organ waiting list is growing by upwards of several thousand patients per year.4

These statistics highlight the growing crisis that is the global organ shortage. In virtually every nation around the world, the demand for viable organs for transplantation greatly exceeds the available supply. Many differing proposals have been discussed with the aim of increasing organ donation rates and the raw number of organs available for transplant, including changing our default consent status for cadaveric organ donation and the option of incentivizing organ donation by compensating live donors with financial incentives. Iran is the only nation in the world that currently has a legally regulated system of compensated live organ donation (CLOD), specifically for kidneys, and it has been successful since its implementation, even eradicating its kidney waiting list, which no other nation in the world can claim. However, even with this practical success, CLOD has been a very controversial concept in the professional literature, and it has been labeled an unethical and illegal practice in many Western countries, including the United States.
Utilizing arguments and principles from applied ethics, political philosophy, and behavioral economics, this dissertation aims to completely revamp the United States organ transplant system, including both live and cadaveric organ donation, with the main focus on providing a political and ethical justification for adopting a legally regulated system of CLOD throughout the United States, along with positing a new proposal for cadaveric organ donation that connects a mandated choice philosophy with a presumed consent default status. Chapter one begins the dissertation by laying the foundation for the thesis. This is accomplished by giving a brief introduction and discussion into each step that is required to develop and argue this thesis, including an introduction to the practical need and context for CLOD, the ethical principles and arguments for and against CLOD, the various differing proposals surrounding cadaveric and imminent death organ donation, and the practical model of CLOD that this dissertation proposes.

1.1) Practical Need for Compensated Live Organ Donation

With organs being a scarce valuable resource, various different attempts have been made by nations to garner the most viable organs as possible for transplantation. Generally, these organizational attempts have centered on systems of cadaveric organ donation, but certain other systems have existed that revolved around creating incentives, especially financial incentives, to promote live organ donation. Though several of these systems of incentives have definitively shown their ability to increase raw organ donation and transplantation numbers, and even eliminate waiting lists in one example, they have largely, and in some cases of unregulated markets, justifiably, been met by skepticism and disgust due to alleged ethical concerns dealing with the use of financial incentives for promoting organ donation. However, due to the fact that these incentives are highly effective at increasing the raw numbers of viable organs for transplantation and the inherent time limit that would be set on these methods due to the ongoing
developments in the realm of regenerative medicine that are relevant to organ transplantation, perhaps it is time that we give compensated organ donation another look.  

The differing systems of organ donation and transplantation of the past and present can primarily be divided into two groups: non-compensated systems of organ donation and compensated systems of organ donation. These groups are then further broken down into various different formats and types, such as opt-in legislation versus opt-out legislation and unregulated, open markets versus regulated, closed markets. The most common type of organ donation system involves cadaveric donation, and the two main types of cadaveric donation systems are opt-in and opt-out systems. Opt-in systems, otherwise known as explicit or informed consent systems, require potential donors to “opt in” to a donor registry in order to be considered a donor candidate upon death. On the other hand, opt-out or presumed consent systems require individuals to “opt out” of the presumed donor status if they do not wish to donate their organs upon their death. Both systems come in hard and soft formats. Soft formats allow the deceased’s family to veto donation, whereas hard formats do not allow the family this option. A lesser known and used intermediary between these two systems is a system known as mandated choice or required response, and this system opts to mandate individuals to explicitly define their preference for donation. This system will be discussed in more detail later on in the dissertation.  

Intuitively, it would seem that opt-out systems are more efficient than opt-in systems at increasing the viable organ supply. In 2002, thirteen out of the top fifteen nations in number of people donating organs per million were nations with opt-out systems, including Spain, Austria, and Belgium making up three of the top four nations. Today the disparity between the two systems is even greater with the opt-out systems of Spain (35 people per million), Croatia (34 people per million), and Belgium (30 people per million) producing many more viable organs.
than the opt-in systems of the US (25 people per million), UK (18 people per million), and Germany (12 people per million). However, others have recently challenged this claim on two main fronts. First, some argue that the apparent necessity to receive the deceased’s family’s permission for donation, even in opt-out countries, is just as much of an obstacle for opt-out systems as opt-in systems. Second, others argue that other contextual factors are at play beyond the differences in consent. For example, some studies have shown that the difference between donation rates in opt-in countries versus opt-out countries is negligible after controlling for the differences in each country’s relevant mortality. Other contextual factors might be the environment of organ donation, including the attention paid towards organ donation and its priority within the nation. Many point to the very active and energetic approach that Spain took towards organ donation to show that other contextual factors are in play. Whatever the case may be, though, it is undeniable that neither system can effectively eliminate or greatly reduce organ waiting lists on their own, and both systems ultimately require live donors to meet their quota.

But simply allowing live organ donation itself is not sufficient to meet the demand for viable organs. This is evidenced by the failures of many new policies to effectively increase the raw numbers, i.e. expanding brain death criteria, raising donor age limit, allowing altruistic donations from strangers, etc., in addition to the many national waiting lists today in countries with live organ donation. Rather, live organ donation must be incentivized in order to attract enough donors to even come close to meeting the demand for viable organs available for transplantation. The effectiveness of incentivizing donation has been well documented in the countries of Iran, India, and the Philippines, among others, even if some of these examples have largely been considered unethical. Before 1994, India had an open market on kidney sales, i.e. no legislation governing it, and the use of monetary compensation for kidney donation made
India one of the largest transplant centers in the world with low organ prices and almost immediate availability. The Philippines was also in a similar situation up until 2008, and it became one of the world’s hotspots for organ transplants due to an abundance of available organs to purchase for transplantation at a low price. Unfortunately, human rights abuses and other ethical issues stemming from a lack of regulation and the presence of organ brokers began to occur in these countries, leading to a ban on unrelated living organ donation in India in 1994. A similar ban on foreign unrelated living organ donation occurred in the Philippines in 2008. Similar situations were also true of Pakistan and Bangladesh until 2010 (the ratification of the Transplantation of Human Organs and Tissues Ordinance) and 1999 (the passing of the Organ Transplant Act), respectively, though there are reports of a large, illegal, underground black market in Bangladesh still today.

Iran is another example of a system of CLOD, specifically in kidneys, that has notably increased the amount of viable organs available for transplantation. Similar to India, Iran began as an unregulated international market, but sweeping changes in the early 1990’s led to strict regulations being imposed on the kidney buying process. These changes and incentives have been effective, even eliminating Iran’s kidney waiting list since 1999. By allotting two separate monetary payments to donors in a highly regulated process, with the help of charities, Iran has effectively incentivized live kidney donation without falling into the perilous terrain of organ brokers and organ trafficking that was seen in India and the Philippines. This avoidance of brokers and the black market is primarily due to the role played by Non-Governmental Organizations (NGOs) that regulate and manage the administrative process of matching donors and recipients. These NGOs, such as the Iranian Patients’ Kidney Foundation and the Dialysis and Transplant Patients Association, are known as the Anjomans in Iran, and they’re primarily
made up of Iranian volunteers who are organ transplant recipients themselves. Of course, this doesn’t mean that the Iranian model is perfect, because it suffers from two significant ethical flaws that must be addressed in any American model – extreme bodily commodification and a lack of consistent interpretation of laws, oversight, and regulations across the provinces of Iran.

A final example of incentivized and compensated donation is the case of Israel. Unlike India, Iran, Pakistan, Bangladesh, and the Philippines, though, Israel does not use monetary compensation to incentivize organ donation. Rather, Israel uses several non-financial incentives to promote both live and cadaveric organ donation, including prioritization in matters of organ allocation. This is akin to a strategy known as a “nudge” or libertarian paternalism, though it’s technically not a “nudge” itself, which I’ll discuss in more detail later with mandated choice cadaveric organ donation. If an individual either donates an organ to another or signs up to be a cadaveric donor, they are granted priority over non-donors in cases of organ allocation and organ waiting lists. In addition to this incentive, other financial reimbursements are granted, including reimbursements for lost wages, travel and medical expenses, and five years’ worth of life and health insurance. The introduction of these incentives greatly increased both the number of deceased organ donors and the number of newly signed donor cards, highlighting yet another example of the practical need and effectiveness of compensated donation. Thus, it’s clear that incentivized live organ donation, including both financial and non-financial incentives, is an effective way to increase organ donation rates and the total raw numbers of viable organs.

Beyond changes in consent policies and providing incentives for live organ donation, there is also substantial hope that in the near future scientific advancements can also help alleviate the current mass shortage of organs, specifically by harnessing the power of stem cells and regenerative medicine, which is defined as:
...an emerging interdisciplinary field of research and clinical applications focused on the repair, replacement or regeneration of cells, tissues or organs to restore impaired function resulting from any cause, including congenital defects, disease, trauma and aging. It uses a combination of several technological approaches that moves it beyond traditional transplantation and replacement therapies. These approaches may include, but are not limited to, the use of soluble molecules, gene therapy, stem cell transplantation, tissue engineering and the reprogramming of cell and tissue types.29

This significant promise is due to the powerful nature of stem cells. Stem cells have the ability to differentiate into many differing specialized cell types in the body, which is a characteristic known as pluripotency.30 Cell-based therapies utilize this ability by inducing differentiation into certain types of cells needed to repair or regenerate damaged tissues or organs.31 In this regard, stem cell therapy might work on two different mechanisms. First, this therapy might work as a “vehicle that delivers complex signals to a target tissue without actually integrating into the tissue itself.” Via this mechanism, stem cells actually function as drug-like entities to deliver drug-like effects, such as anti-inflammation, to the damaged tissues. There is even evidence of the efficacy of this mechanism in certain recent studies, though this is controversial because it is not well understood how this mechanism operates. Second, stem cells could also “restore tissue function…as integrated participants in the target tissue,” i.e. by ultimately becoming regenerated tissue of the targeted organ.32

Though there is still much to learn and many practical hurdles that keep this method from being a widespread clinical tool today, this second mechanism is the more desired and useful method that is hoped to become a practical reality in the near future, though the transplantation of hematopoietic stem cells, i.e. ultimately bone marrow transplants, is an actual practical example of this mechanism that is in use today. Rather than merely relying on some poorly understood beneficial side effects of stem cell-based therapies, actual diseased tissue, such as cardiac tissue, could be regenerated and replaced in the heart itself. Further, thanks to the promises of induced pluripotent stem cells, which are essentially reprogrammed adult stem cells
that are extremely similar to embryonic human stem cells, autologous cell replacements could ultimately make these therapies much more effective by eliminating the issues of immunosuppression and host rejection. Similar types of genetic therapies also have the potential to cure genetic diseases by taking advantage of certain viruses’ ability to attach to a host’s DNA and supplant certain genes and utilizing these genetically-engineered viruses that are equipped with the healthy gene in order to replace the damaged or dysfunctional gene. This can be completed by direct gene transfer or through living stem cells as vehicles for gene transfer, which is even more useful with the versatility of induced pluripotent stem cells. These therapies ultimately avoid the need for burdensome transplantation procedures, which also come with a life-sentence of medication to prevent organ rejection. Thus, both cell-based and genetic therapies are extremely valuable methods for regenerative medicine to deal with issues of organ and tissue ailments both now and in the future.

Another method of regenerative medicine that is also showing promise for future application to organ waiting lists is the concept of tissue engineering. Essentially, tissue engineering “is an interdisciplinary field that applies the principles of engineering and the life sciences toward the development of biological substitutes that restore, maintain, or improve tissue function.” In fact, tissue engineering can be seen as a middle ground option between the more fundamental aspects of regenerative medicine in stem cell-based and genetic therapies, where tissues and organs are regenerated, for the most part, in vivo from the application of stem cells, and the more practical and current aspects of allogenic transplants of whole tissues and organs. By utilizing “natural, synthetic, or semisynthetic tissue and organ mimics that are fully functional from the start, or that grow into the required functionality,” tissue engineering
provides a middle ground option to grow tissues and organs *ex vivo*, most likely from autologous cells, which can then be transplanted into the individual.38

The process of tissue engineering is rather complex, and it necessarily involves three different components, named the tissue engineering triad – stem cells, scaffolds, and growth-stimulating signals for the cells to grow. Scaffolds are similar to the extracellular matrix found surrounding most cells. In fact, they’re produced to mimic the functions of the extracellular matrix itself, because the extracellular matrix is essentially just a complex framework, or a skeleton in a sense, that gives tissues shape and acts as a mediator and in-between amongst the various cells that reside in its vicinity.39 Scaffolds then work as a complex skeleton from which stem cells and the growth stimulating agents and materials are embedded. Ideally, after being embedded an optimal microenvironment for cellular growth appears, and the stem cells grow, proliferate, and fill out the structure that is given by the scaffold. After a certain amount of growth, the newly formed tissue is implanted into the individual, and as the cells begin and continue to proliferate, differentiate, and integrate into the surrounding tissue, the degradable scaffold itself ultimately dissolves and the tissue starts functioning as it should.40

These scaffolds can be made from natural or synthetic biomaterials, though one of the easiest ways is to use extracellular matrix itself after it has been decellularized, i.e. stripped of its cells.41 But 3D printing has opened new doors for tissue engineering, which is why research is now moving towards 3D organ printing. Organ printing is defined as a “rapid prototyping computer-aided 3D printing technology, based on using layer by layer deposition of cell and/or cell aggregates into a 3D gel with sequential maturation of the printed construct into perfused and vascularized living tissue or organ.”42 Essentially, 3D bioprinting involves a 3D printer that harnesses a modified inkjet technology to develop a 3D tissue or organ from a 2D CT scan
blueprint. Upon a biocompatible and degradable scaffold, the 3D bioprinter applies this “ink,” which is essentially a medium made up of growth factors and living stem cells that have been differentiated to the appropriate type for the tissue, in a layered format to ultimately achieve the 3D object. The success of these methods of 3D bioprinting is substantial. In 2014, approximately $537 million was spent on printed body parts throughout the United States, and researchers regularly used printed tissues and simple organs to test experimental drugs. Though issues with vascularity limit the potential applications of 3D bioprinting to smaller tissues at the moment, new research is progressing on advancing life-sustaining vascular networks for the possibility of printing larger and more complex tissues and organs. Thus, though this technology is currently limited to simpler types of tissues, tissue engineering as a whole has immense value to regenerative medicine’s application to organ and tissue ailments, and eventually we’ll have the knowledge, technology, and resources to make modern day transplants between individuals a thing of the past.

A final method of regenerative medicine is the concept of xenotransplantation, which is the transplantation of tissue from one species into another. This concept actually dates back to the 1960’s, with one patient transplanted with a kidney from a chimpanzee actually surviving for nine months, though the patient and others ultimately died from the effects of xenorejection from the transplant. The “Baby Fae” case in 1984 of a newborn infant who died after rejection of a xenograft heart transplant is also another infamous case of xenotransplantation gone wrong. These cases highlight the biggest hurdle in xenotransplantation - the issue of xenorejection, i.e. the natural incompatibility and ultimate rejection of xenografts transplanted into differing species. This is mainly due to the cell surface antigen alpha-Gal that all nonprimates possess, because humans have antibodies that cause immediate rejection when they come into contact
with alpha-Gal in these animal cells. Two main methods are currently being researched to overcome this hurdle. The first involves utilizing genetic engineering to change the genetic makeup of tissues in order to avoid xenorejection.48

The second method would be to make human/nonhuman chimeras to try and avoid xenorejection. Human/nonhuman chimeras are organisms that are composed from two different sets of cells from differing species – one human and one not. Generally, chimeras are created by integrating two different embryos, and this results in cells from differing origins in many different tissues throughout the body. If the process of localizing the chimera’s human cells in certain tissues and organs in high enough proportions is perfected, then human/nonhuman chimeras could conceivably be viable organ donors for human recipients. Though this is far from being a clinical reality, the recent advances in knowledge of induced pluripotent stem cells and “the ad hoc creation of solid organs within…chimeras” might make the use of human/nonhuman (specifically pig) chimeras a real possibility for organ transplantation in the near future.49

However, the most promising chimeric and xenotransplantation research involves the new CRISPR technology. By utilizing the gene editing capabilities of CRISPR, it may be possible to delete a pig embryo’s ability to grow a pancreas (or other organ), implant human induced pluripotent cells to replace that ability in the pig embryo’s DNA, and grow a human pancreas within the pig fetus. There is actually already a current team at the University of California, Davis experimenting with this type of procedure, though they are only allowing the embryo to grow for 28 days before ultimately destroying it for analysis.50

Thus, there are numerous different potential future applications of regenerative medicine that hold the promise to make long organ and tissue scarcities a thing of the past. Though there are some ethical issues inherent within some of these potential methods, including issues of
justice, allocation, and animal rights, most of these methods, outside of certain elements of xenotransplantation, seem to be ethically palatable options that only contain practical ethical issues rather than conceptual ethical issues. Further, though the majority of these methods are not yet feasible, it is generally believed that our scientific knowledge and capabilities in regenerative medicine will ultimately combine with transplant medicine to create viable, efficacious methods that ultimately eradicate, or at the very least greatly lessen, the two major current issues in transplant medicine – immunosuppression-free transplantation and a renewable, potentially inexhaustible source of organs and tissues.51

Therefore, since we know both (1) that incentives do improve organ donation and transplantation rates and (2) that it is essentially just a matter of time until progress in regenerative medicine ultimately lessens or eradicates the need for incentivized donation, we have a moral responsibility to do everything that we can to save the lives of those suffering from organ failure and tissue ailments today. By not allowing these individuals to help themselves, we’re essentially damning them to a life of misery and ill health, or even worse, death, due to living in a time without the luxury of regenerative medicine, which is discrimination based upon a non-moral property that these individuals had no choice in bringing about. Furthermore, there’s an argument to be made that the moral distinction between purchasing an organ from another individual and ultimately purchasing an organ that was engineered in the lab or created in a farm animal is blurry at best. So there seems to be sufficient justification to at least attempt to find an ethically palatable system of CLOD that minimizes any harms while maximizing potential benefits, both practically and ethically, and we have the moral responsibility and obligation to enact and allow any such system in a pluralistic, moral society.
Now that it has been shown how we have a moral obligation to not prohibit an ethically palatable system of CLOD (should there be one), it is prudent to situate CLOD in its proper medical, political, and moral context. For example, it is widely accepted that the benefits of live kidney donation greatly outweigh the harms associated with it, as evidenced by the widespread acceptance of altruistic live kidney donation. Studies suggest that there is minimal short-term and long-term medical risk involved in kidney donation, with one study even finding an 85 percent survival rate 20 years after kidney donation. There is also fairly conclusive evidence that the rate of renal failure is no higher after donating a kidney compared to the normal population, with short-term risks only constituting a .03 percent chance of mortality and a 20 percent chance of morbidity shortly after the donation procedure. These results of the safety of live kidney donation have also been corroborated in a more recent 2010 study of over 80,000 live donors, and the results once again provide evidence that “live kidney donation is safe and free from significant long-term excess mortality.” And even those very few studies that do find increased rates of these issues, albeit very minimal increases, argue that their “findings will not change our opinion in promoting live-kidney donation.” And though rarer and a slightly more serious operation, recent studies suggest that living liver donation is comparable to living kidney donation, and mortality for donors does not significantly differ from healthy non-donors.

Regarding the political and moral context, being one of the Enlightenment’s most successful achievements, the political philosophy of classical liberalism emphasizes the equality and freedom of all peoples and the primacy of the individual. Compared to other political philosophies, liberalism is then mainly focused on individual freedoms and rights and the protection of these freedoms and rights from government intrusion. Namely, this political philosophy perceives these freedoms and rights to be personal autonomy, i.e. the capacity for
rational self-governance, self-determination, and personal freedom, which specifically includes the ability to develop one’s own conception of the good, or view of how to live one’s life based on one’s values, desires, and beliefs. Thus, two things must necessarily be absent in this political philosophy in order for individuals to consistently exercise their autonomy: State perfectionism and paternalism. First, State perfectionism is the view that there are some conceptions of the good that are better than others, and it is the prerogative of the State to promote these particular conceptions. Second, paternalism can be defined as “when those in positions of authority refuse to act according to people’s wishes, or they restrict people’s freedom, or in other ways attempt to influence their behavior, allegedly in the recipients’ own best interests [as judged by those in authority].”

For liberalism, both State perfectionism and paternalism unjustifiably violate individuals’ rights to autonomy and the freedom to develop and practice one’s own conception of the good. However, these are the exact types of actions, i.e. paternalism and limiting behaviors that are considered bad or evil for society, that characterize government interventions and laws, because, otherwise, we would ultimately live in an anarchic state. Clearly, then, liberalism’s focus on the individual runs counter to the utilitarian outlook of many governmental interventions into the lives of the population, even if that comes at the expense of certain individual liberties. Therein lies the liberal answer to the vast majority of governmental interventions – the liberal objection, which states that governmental interventions are objectionable, unjustifiable, and illegitimate due to them ultimately amounting to State interference into individual autonomy, rights, and freedoms. However, personal autonomy within liberalism, and ultimately ethics, is not absolute, which is where the harm principle comes into the picture.
Though being known primarily for his advancement and fuller development of the normative ethical theory of utilitarianism, John Stuart Mill was also substantially interested in political philosophy, specifically the relationship between individuals and the State. Since certain limits must necessarily be placed on individual autonomy, or risk slipping into anarchy, he developed the harm principle to determine when and how it was appropriate for the State to legitimately interfere with individual liberties and freedoms. It states:

…the sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number, is self-protection. That the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant.\textsuperscript{63}

Whether explicitly or implicitly, this principle has long been a guiding measure to determine the justifiability of State intervention upon individual liberties within liberal societies, even in the United States. Per the harm principle, State intervention is only justifiable to prevent harm to others, and though the promotion of benefitting oneself and others and the prevention of harm to oneself are noble pursuits, they are not legitimate State interventions into individual freedoms.

Regarding the moral and political context of CLOD in the United States, this sets the limit for what the State can and cannot justifiably prohibit for its citizens. Since our liberal society is dedicated to a pluralistic understanding of conceptions of the good, i.e. a denial of State perfectionism, and avoiding paternalism is necessary to implement this dedication to pluralism, the State cannot justifiably, either morally or politically, prohibit any action or behavior that does not protect others and prevent them from harm \textit{from others}, and this is a necessary requirement since protection from self-regarding harm is not justified by the harm principle, which is discussed in more detail later. Thus, as long as an ethically palatable system of CLOD can be developed that does not explicitly harm others, then the State has no moral or political justification for its prohibition by law. The rest of this dissertation will now focus on
justifying the ethically palatable nature of CLOD and developing a practical national system for implementation that revamps our system of both live and cadaveric organ donation.

1.2) Autonomy, Justice, and Exploitation

The strongest arguments in the debate surrounding CLOD revolve around the concept of principlism, which contains the four main ethical principles guiding modern bioethics: autonomy, justice, beneficence, and non-maleficence. In particular, the principles of autonomy and justice are especially useful in this debate, and they are used in both the positive arguments of autonomous freedom and social justice and the negative argument from exploitation. And not only do the principles of autonomy and justice figure prominently in the debate regarding CLOD, they also are two of the most discussed and debated ethical principles within applied ethics, which is primarily due to their importance and relevance in applied ethical issues. An examination of these ethical principles highlights how these principles are consistent with a regulated form of CLOD and how a prohibition ultimately violates each principle.

Though not a universally shared sentiment, many feel that the principle of autonomy is the *primus inter pares*, or first among equals, of the four principles approach, because it is the reason for the existence of morality and plays a major role in the other three principles. Autonomy is defined as a concept of self-governance that is free from controlling interferences from others and impediments on meaningful choice. The autonomous person acts according to a self-chosen plan without unduly interference or limitations upon that plan from other individuals. When one does not act autonomously, it is due to the incapability of realizing the plans and desires of the individual, and this incapability arises from some sort of excessive hindrance upon the freedom of the agent. Three conditions are necessary for autonomous action: intentionality, understanding, and noncontrol. For the act to be autonomous, the action must be intentionally
willed, and the agent must adequately understand the action and its consequences. The agent must also not be under the controlling influence of another, because an agent can only act autonomously when the act is not directly affected by an impressionable factor or influence that affects the agent’s plans.69

The principle of autonomy does have its limits, though, and restrictions upon autonomy are usually justified in protection of the autonomy of others.70 This is in accordance with the negative obligation imposed by autonomy, which states that autonomous agents should not interfere in the autonomous actions of other agents. There is also a positive obligation imposed by autonomy, and it states that agents should foster autonomous agency for fellow agents, which includes the dissemination of information that is potentially relevant to an action they are deliberating on.71

In support of CLOD, Gerald Dworkin labels this type of autonomy as bodily autonomy, and he defines it as the “capacity to make choices about how [one’s] body is to be treated by others… [and] the primary good achieved by such a right is the recognition of the individual as sovereign over his own body.”72 Thus, the principle of autonomy takes a very libertarian stance and argues that agents have the right to exercise their autonomy, and as long as it passes the obligations imposed by autonomy, then this right to autonomous decision-making over one’s body should not be infringed.73 CLOD passes the negative obligation of autonomy, because no other agent’s autonomy is restricted in individual organ sale. Furthermore, a strictly regulated system of CLOD would have safeguards to foster autonomous decision-making and informed consent, which reflects the positive obligation of autonomy.74 This argument then posits that the prohibition on CLOD is paternalistic and in violation of the moral obligation to respect
individual autonomy, and unless other moral obligations are overriding, respecting the principle of individual autonomy can partially justify regulated systems of CLOD.75

Another concept of principilism is the principle of justice, and it is also used by some to support CLOD. As a concept, justice cannot be restricted to a singular definition, but in the context of organ donation, it usually refers to matters of distribution of scarce resources.76 Traditionally, the principle of justice is regarded as an other-regarding virtue that can be bound to a character or an act.77 It also provides a guide to areas of concern for specific normative theories to address.78 Though there are three main differing conceptions of justice, i.e. utilitarian, libertarian, and egalitarian, I will primarily focus on egalitarian conceptions of justice, because it seems fairly uncontroversial that both utilitarian and libertarian conceptions of justice would be heavily opposed to any sort of prohibition that both (1) limited overall utility and (2) limited individual freedoms by an act of the State.79

One of the most influential egalitarian theories of justice is Martha Nussbaum’s capabilities theory, and it provides the principle with normative content tailored to a global and international context.80 In the context of CLOD, it has been argued by proponents that prohibiting CLOD has denied many in need of organ transplants the essential capabilities of life, good bodily health, and the right not to die prematurely, which are all essential conditions of her capabilities theory of justice.81 Furthermore, it can also be argued that the prohibition of CLOD also violates the normative egalitarian principle of the fair-opportunity rule, which claims that individuals “should not be denied social benefits on the basis of undeserved disadvantageous properties, because they are not responsible for these properties.”82 This is because individuals with this particular disadvantageous property, i.e. a faulty organ, are being unduly penalized for this property that they had no responsibility in creating.
Where these theories of justice are oriented towards the recipient, other arguments from justice are oriented towards the donors. For example, Robert Veatch argues that since the goods of life have been systematically denied to the poorest and most vulnerable of our society, it is unethical and unjust to prohibit one of the last financial benefits these families might have, namely compensated organ donation. After the Eliot Spitzer prostitution scandal, Martha Nussbaum came out with a very similar argument to Veatch’s in favor of prostitution, arguing that “the idea that we ought to penalize women with few choices by removing one of the ones they do have is grotesque...” In an earlier article, she argues that it is short-sighted to “rule off-limits an option that may be the only livelihood for many poor women...”, and though this is aimed at prostitution rather than compensated organ donation, it is similarly short-sighted and unjust to remove the option of donating one’s organs for a profit and reducing one’s ability to better oneself even further. Thus, the principle of justice is consistent with a regulated system of CLOD that treats every person, whether poor or rich or healthy or unhealthy, as equals, and a prohibition of CLOD would ultimately violate the obligations of this moral principle by treating equals unequally and punishing individuals for conditions that they may not necessarily be morally responsible for. These arguments are related to the paradox problem of the exploitation objection and the Non-Worseness Claim (NWC) of the exploitation debate, which will both be detailed shortly.

But though these two principles are regularly used by proponents to argue for the justification of CLOD, they’re also relevant to one of the primary objections to CLOD known as the exploitation objection. And while being a fairly common notion in applied ethics, many misunderstand the definition and implications of exploitation, which has led to many differing claims and concepts of exploitation in the literature. However, though there are numerous
differing conceptions of exploitation ranging from Marxist interpretations to conceptions based on Kantian notions of treating others instrumentally, there are certain necessary components that are required for the act of exploitation to take place, which makes establishing a basic working definition that encompasses the vast majority of these conceptions of exploitation possible.\textsuperscript{87} Essentially, three things must be present in every case of exploitation – the exploiter extracting some benefit from the use/involvement of the exploitee, the exploiter benefitting \textit{at the expense} of the exploitee, and unfairness.\textsuperscript{88} Thus, one basic working definition for the concept of exploitation that both fits the majority of the various differing conceptions of exploitation and takes into account these three necessary components is “taking unfair advantage of another,” or more precisely - “A exploits B when A takes unfair advantage of B.”\textsuperscript{89}

To highlight the function of these three necessary components and how exploitation necessarily takes unfair advantage of another, it is necessary to view them in action in a paradigmatic case of immoral exploitation. Coincidentally, these three components can best be examined in the examples of \textit{open, unregulated markets} for organs in developing nations of the past, which is an entirely different concept than this dissertation’s proposal for CLOD. For example when India was a burgeoning open kidney market before it was illegalized and pushed the trade underground, organ brokers would regularly bring the poorest individuals together with wealthier individuals needing a transplant, and they would generally pay around $2,500 to $4,000 for a kidney. However, the donors usually received less than $1,000 of that sum due to the organ broker’s fees and price of administration, and many times donors even received less, or nothing at all, due to corrupt organ brokers, which highlights one of the main problems in open, unregulated markets as the presence of exploitative organ brokers.\textsuperscript{90}
Thus, it’s easy to see how the donor is being unfairly taken advantage of due to the three required components of exploitation being met in this example - both the organ broker and buyer derived benefit from the donor (profit and an organ for transplantation), this benefit came at the expense of the donor (unfair price for an organ, not receiving the entire payment for the organ due to the broker, and/or being cheated out of the agreed upon price), which ultimately makes this situation seriously unfair due to the presence of fraud and an unfair price. Of course, it could be argued that this benefit does not come at the expense of the donor, because the donor was paid and is now better off due to the situation. However, exploitation deals with the normative rather than the descriptive, so coming at the expense of the donor is in relation to a fair transaction rather than whatever transaction actually obtained. This is termed the difference between the no-transaction baseline and the fairness baseline, where the former corresponds to the descriptive and the latter corresponds to the normative. Relative to no transaction whatsoever, exploitation often betters the exploitee. But the requirement of the benefit coming at the expense of the donor isn’t necessarily related to what did happen in this transaction versus no transaction whatsoever, i.e. the no-transaction baseline, but rather what should have happened under a fair transaction, i.e. the fairness baseline. So while the donor might actually be better off in this situation due to the sale of an organ, the donor would have been even better-off after the sale of an organ in a fair transaction, which realistically would be more than approximately the $1,000 that is usually received, meaning this truly does come at the expense of the donor.91

This brings up another important fact about exploitation – as shown above, and in other cases such as clandestine sweat shops, immoral exploitation can still occur when the exploitee benefits from the exploitation itself.92 Thus, a distinction should be made between two differing sets of types of exploitation, specifically between nonconsensual exploitation and consensual
exploitation and between harmful exploitation and mutually advantageous exploitation. The
difference between nonconsensual and consensual exploitation is the presence of valid, informed
consent to the exploitative transaction. The other distinction is between harmful exploitation,
where only the exploiter benefits from the transaction purely at the expense of the exploitee, and
mutually advantageous exploitation, where both the exploiter and exploitee benefit in some way
from the transaction. In cases involving nonconsensual transactions or one-sided harmful
exploitation, it’s pretty clear that exploitation has taken place. On the other hand, certainly there
are cases of consensual, mutually advantageous exploitation (CMAE) transactions where it’s not
always clear that immoral exploitation has occurred, because both sides seem to agree upon a
transaction that benefits both of them without seemingly, at least on the surface, coming at the
expense of the exploited. For the purposes of the exploitation objection to CLOD, then, this is
of utmost importance, because any argument against the immorality, and potential prohibition, of
CLOD will necessarily rely on both proper consent and mutual advantages to both parties.

This is actually an area of the professional literature on exploitation that there is not a
consensus view on. In virtually every major conception of exploitation in the literature, there are
moral undertones to the presence and act of exploitation, as seen with “unfairness” being a
necessary component of exploitation. Thus, the accusation of exploitation is almost always
considered a moral judgement, i.e. acts of exploitation are considered immoral and wrong.
However, the moral component of “unfairness” isn’t necessarily the most clear and direct
concept, and it’s certainly not an inherently and/or absolutely immoral concept, i.e. every single
unfair scenario is not necessarily immoral. There are varying levels of unfairness, and there are
quite a few things in the world that aren’t really fair, yet we fail to consider them immoral. This
falls right in line with the intuition that certain CMAE transactions aren’t necessarily immoral,
even if there is a level of unfairness to them. So in cases of CMAE transactions, there actually might be arrangements that aren’t technically immoral due to not being “unfair” enough.94

This sentiment is best justified by what is referred to as the Non-Worseness Claim (NWC). The NWC claims that, “in cases where $A$ has a right not to transact with $B$, and where transacting with $B$ is not worse for $B$ than not transacting with $B$ at all, then it cannot be seriously wrong for $A$ to engage in this transaction, even if its terms are judged to be unfair by some external standard.”95 So even if there is some inherent unfairness in a certain CMAE transaction, the NWC argues that if there’s no moral obligation to get involved and involvement is no worse than non-involvement, then there is nothing seriously wrong or immoral with an exploitative transaction that is consensual and mutually advantageous. In the language used earlier, as long as the unfairness ultimately is in relation to the fairness baseline and not the no-transaction baseline, i.e. involvement doesn’t make the exploited’s situation worse, and there is sufficient benefit for both sides, then the levels of unfairness in CMAE transactions are not sufficient enough to qualify this act as unethical. Of course, some might question the moral character and motivations of the exploiter in this type of exploitation, but moral character and motivations aren’t necessarily relevant or defeating for the NWC. Discussing the issue of price gouging, another example of a CMAE transaction, Zwolinski offers the following regarding character and the NWC:

But NWC is not a thesis about moral character, it is a thesis about the wrongness of moral acts. And this is importantly different. Vicious people can perform morally permissible [emphasis added] actions. Think, for instance, of Kant's shopkeeper who returns the correct change to a naive customer only out of a selfish concern for his own reputation and long-term profit. If he could be sure he could steal a penny from a child's change and get away with it, he would, but prudence dictates restraint. Such a person has a bad moral character. But the act he is performing—giving the child back her correct change—is perfectly innocent… Thus, Snyder's concerns about NWC do not give us reason to prohibit price gouging, or even condemn it. For all his arguments show (correctly, I think) that price gouging can sometimes be done by morally vicious people. They do not show that the act of price gouging itself is morally impermissible [emphasis added].96

Thus, we can now distinguish among three different types of mutually advantageous transactions: nonconsensual, mutually advantageous exploitation (NCMAE), consensual,
mutually advantageous exploitation (CMAE), and non-exploitative mutually advantageous transactions (NEMA), which we have no reason to suspect are unethical in the first place. As stated above, since CLOD is necessarily a mutually advantageous transaction and the latter two mentioned types of mutually advantageous transactions are ethically permissible types of transactions, for the exploitation objection to CLOD to be sufficient in its aims for prohibition, it must be determined that CLOD is (1) an example of a NCMAE transaction, (2) ethically distinguishable from other similar types of NCMAE transactions that are currently not prohibited by law, and (3) “harmful” enough, both qualitatively and quantitatively, to justify prohibition by law. Unsurprisingly, the majority of the claims made by the exploitation objection are aimed directly at the process of consent in CLOD, so the objection is still capable of meeting these demands and constituting a legitimate objection to CLOD.

To ethically analyze the issue of CLOD to determine its status as an exploitative practice, it must be compared with the necessary components of exploitation that were discussed above, namely - the exploiter extracting some benefit from the use/involvement of the exploitee, the exploiter benefiting at the expense of the exploitee, and unfairness. The first component is obviously present, because it’s clear that both sides are significantly advantaged and benefitted by the transaction. Unfairness is also obviously present, because it’s the lack of complete equity between individuals that allows the transaction to take place in the first place, albeit in differing areas, i.e. the donor lacking in money and the recipient lacking in organ health. This unfairness is empirically verified, too. For example, though there are significant other motivations to donate a kidney in Iran, such as the moral value of charity, financial reasons were also a major donor motivation, as evidenced by the pool of commercial donors consisting primarily of the poor.
Thus, unfairness is present in the unequal starting positions of each party rather than within the transaction itself.

But can one really make the argument that the recipient (exploiter) benefits *at the expense of* the donor (exploitee)? In a regulated system of CLOD, no, because the donor is receiving a *fair* price for the organ, or at least what we can reasonably conclude as a fair price given the economic studies on the matter (over $15,000 for kidney/$37,600 for liver according to a recent study). Remember, for the benefit to come *at the expense of* the donor, the transaction must make the donor worse off relative to the *fairness baseline*, even if it makes the donor better off relative to the *no-transaction baseline*. But in this case, the donor is actually better off relative to both baselines, because (1) the transaction is better than no transaction for the donor and (2) the transaction is based on a fair price for the organ. Of course, it could be argued that there is no proper standard to convert the worth of an organ to monetary value, meaning organs are incommensurable with monetary value. However, this is a problematic claim for two reasons: (1) it’s not clear at all that goods can ultimately be incommensurable and (2) incommensurability doesn’t necessarily make a transaction of goods unfair, meaning it isn’t sufficient as an objection. Thus, it seems clear that a regulated system of CLOD ultimately does not meet the required components to label it as an example of immoral exploitation. Alan Wertheimer, a world-renowned expert on the concept of exploitation, seems to agree with this overall analysis:

A mutually advantageous transaction is arguably (wrongly) exploitative only if the outcome is (in some way) unfair to B. This is not merely definitional. After all, it may be thought that a transaction is exploitative whenever it takes advantage of B's vulnerabilities or desperate situation to strike a deal. That is false. For if A makes a reasonable proposal that B has no alternative but to accept given B's desperate situation, A does not exploit B. If a doctor proposes to perform life-saving surgery for a reasonable fee, the patient is hardly exploited, even though the patient would not have agreed but for the fact that her life was in danger [emphasis added].

To understand why this practice ultimately represents a NEMA transaction rather than an exploitative transaction, a distinction must be made between *taking unfair advantage* of an
individual (exploitation) and taking advantage of an unfair situation (not exploitation), which are two vastly different concepts with differing moral motivations. This distinction is very important to make, because as shown above, it would otherwise label professionals such as physicians and auto-mechanics as professional exploiters, since they rely upon a certain disadvantaged situation of an individual, e.g. health problems, car trouble, etc., to make a living.  

Mark Cherry labels this distinction as “the line between the unfortunate and the unfair,” and he further states:

That someone is poor or otherwise disadvantaged due to unfortunate circumstances does not imply either that he is unable to make rational choices given his limited choice set or that one acts improperly when one seeks to trade with or otherwise engage such a person in a market transaction [emphasis added] — for example, by offering the disadvantaged person a job or the real possibility of securing valuable rewards. More must be said to demonstrate that one acts in a morally blameworthy fashion when one extends an offer to a poor individual, which seeks to improve his prospects and to which he had no prior entitlement, such as when one offers valuable compensation for organ donation [emphasis added].

To justify this distinction, one needs only to look at Kant’s second formulation of the Categorical Imperative, which isn’t surprising since many individual conceptions of exploitation rely on this Kantian notion. This formulation claims that we should always treat individuals as ends in themselves and never merely as a means to an end, which essentially means that we should never treat others instrumentally. Taking unfair advantage would then equate to treating individuals as an instrument and merely as a means to an end. Specifically, this would take the form of recipients not respecting donors as ends in themselves and offering them an unfair price for donation, which would ultimately just treat the donor as a means to an end, i.e. a host of an organ for transplantation. On the other hand, taking advantage of an unfair situation does not necessarily equate to treating individuals instrumentally, and at least in the case of CLOD, both sides are ultimately taking advantage of an unfair situation that the other party is in, i.e. vulnerability with the donor’s finances and recipient’s health, to benefit from a mutually advantageous transaction, while still treating the other party as an end in themselves.
Since neither party benefits at the expense of the other party, the regulated systems of CLOD clearly do not meet the required conditions for exploitation, and CLOD is simply a system of NEMA transactions. But even if we did allow the Iranian model of CLOD to be considered a system of CMAE transactions, the NWC argument above highlighted why we should think that there’s *nothing seriously wrong or immoral* with CMAE transactions, ultimately making them ethically permissible. But going even further down the rabbit hole, even if we granted the contentious claim that exploitation is always harmful and morally wrong, it still would not justify its prohibition by law. This is because in classically liberal societies like the United States, which this dissertation is ultimately focusing on, the harm principle, i.e. the guiding normative principle regarding State interference into individuals’ lives, ultimately allows for self-regarding harm. As long as the harm that someone *consensually* brings on oneself is self-regarding, doesn’t violate any specific duty, such as becoming intoxicated while on police duty, and doesn’t cause perceptible harm to any particular person, then individuals have the freedom to partake in it, according to the harm principle. Therefore, it seems painfully obvious that (1) regulated systems of CLOD are not examples of exploitation and (2) even at its worst, there is no justification for prohibiting consensual cases of CLOD, which brings us to the two other main claims utilized within the exploitation objection.

These claims generally deal with the issues of consent and autonomy regarding exploitation. For example, Paul Hughes argues that rather than being an autonomy-enhancing option, allowing poorer populations to donate their organs for compensation might just be autonomy-undermining and constraining their liberty even more, because the option of CLOD is coercive and autonomy-limiting. Thus, this claim of the argument from exploitation argues both that the opportunity to be compensated for donation is autonomy-limiting and that the
decision to actually donate for compensation is a forced response due to coercive financial influences, making it an unethical practice.107

If this sounds fairly paternalistic, then it shouldn’t be surprising that this argument is ultimately based on a neo-Marxian conception of exploitation, especially the autonomy-limiting component. Marx’s original conception of the exploitation of the worker revolves around the criticism that the “capitalist” unfairly takes advantage of the worker by converting the “surplus value” of the workers’ labor into profit, which he argues belongs to the workers’ themselves, but given the constraint of options for the workers, i.e. they must work and produce this labor for the wages that support their families, they must necessarily continue to labor for their exploiter.108 In CLOD, an autonomy-constraining option, rather than an autonomy-enhancing option, is defined as one that “presupposes and/or reinforces” a system of constrained options in the first place. For example, these opponents argue that CLOD only works in a society that presupposes large populations of poor people with limited, constrained options, which unduly influences them to donate their organ for compensation.109 Additionally, these opponents also claim that CLOD reinforces these constrained choice-sets by keeping these poor donors’ options constrained.110

However, this isn’t necessarily empirically true in regulated markets. And this is a fallacy that many objections to CLOD, such as Jha and Chugh, ultimately make – they compare data from unregulated markets and extrapolate that information to argue that regulated markets would fare the same.111 But, again, this isn’t necessarily true. For example, in a study of Iranian donors and recipients it was found that though most donors were poor, 16% were from the middle class. Further, over 86% of the Iranian recipients were either poor (50%) or from the middle-class (36%), meaning only a little over 13% of kidneys went to the rich.112 This also contradicts other objections to CLOD that ultimately assume that regulated systems of CLOD would ultimately
only serve the rich at the expense of the poor. Further, this also shows that a system of CLOD does not then necessarily presuppose large poor populations with limited, constrained options, though they certainly would make for a more robust market.

Similarly, there’s no evidence that CLOD in regulated markets reinforces constrained choice-sets like has been observed in the open, unregulated markets and black markets in organs. Like many other articles and opponents, Hughes makes this argument by using evidence and articles from unregulated open and black markets, like India, which was a wildly unregulated market full of organ trafficking, coercion, and outright exploitation. He even openly admits that it could be different in regulated markets, but he essentially states that this is an empirical claim that we cannot know about before actually studying the consequences of an actual regulated market, conveniently ignoring the example of Iran.

Though this doesn’t necessarily measure choice-sets, there are several recent studies that show positive impacts and a very high satisfaction rate in Iranian donors after they have donated a kidney for compensation, which could very well indicate progress in their lives and thus additional options. Other studies show similar findings of paid donors reporting the improvement of either, or both, their immediate and/or long-term financial situations. One study showed that 86.5% of donors felt complete satisfaction after donation, with 11.5% feeling relatively satisfied. Further, one study involving six different transplant regions and 44 different individuals reported that 73% of the donors reported that their financial problems were solved, with a good mix of immediate and longer-term follow-ups within that group. Unsurprisingly, it was also found that nearly 90% of the donors interviewed were glad that they had the opportunity to donate their kidney for compensation in order to improve their financial
situations, so it seems fairly uncontroversial that the option of CLOD does in fact enhance autonomy rather than constrain it even further.117

The other main claim regularly utilized with the exploitation objection states that the decision to donate one’s organ for compensation is forced due to coercive influences, i.e. poverty, and a constrained choice set, and informed consent can never be achieved in this context due to the voluntariness of the decision, i.e. the third step in the process of informed consent, never being real.118 Sandel labels this component of the argument the “fairness objection,” and he also points to the injustice of inequality being the basis of the market. He states, “…market exchanges are not always as voluntary as market enthusiasts suggest. A peasant may agree to sell his kidney or cornea to feed his starving family, but his agreement may not really be voluntary. He may be unfairly coerced, in effect, by the necessities of his situation.”119 Essentially, where Hughes’ argument posited that adding the option of CLOD actually limited autonomy and the range of choices for individuals, this claim of the exploitation objection merely states that the range of choices for these individuals is too small in the first place, which makes the choice of CLOD unfree, coerced, and not appropriate to be an option for these individuals.120 There are two main related problems with this claim of this component of the exploitation objection – the arbitrariness problem of the exploitation objection and the paradox problem of the exploitation objection.

The main problem with this argument itself is that it is only applied conditionally and pointedly against CLOD, even though it is just as relevant and applicable to other market exchanges in this population. Essentially, then, this is what I call the arbitrariness problem of the exploitation objection – if the presence of coercive, unduly influences from a small range of options makes CLOD exploitative and unethical for poor individuals, leading to prohibition, then
virtually every market or economical exchange by poor individuals should be considered exploitative, unethical, and prohibition-worthy. Singling out CLOD for this argument is then arbitrary and inconsistent. This is actually a common type of argument used by advocates for CLOD, because it’s an obvious, pervasive, and simple objection that shows a contradiction and inconsistency in the treatment of CLOD compared to various other similar actions. For example, James Stacey Taylor discusses Gerald Dworkin making the argument that:

...if the poor should be prohibited from selling their organs for this reason then they should also be prohibited from joining the army, engaging in hazardous occupations such as highsteel construction, or being paid subjects in medical experiments, since these decisions are also often made out of economic necessity, and thus should also be considered to exhibit diminished autonomy.121

Similarly, speaking about CLOD, Mark Cherry argues:

Analogously, on the labor market, those who must settle for any unpleasant or more risky occupation, such as ditch digger, oil platform construction, or assembly line worker, must make the same type of choice; this does not necessarily mean that they are being coerced.122

Radcliffe-Richards et al. offers a similar argument comparing the inconsistent treatment between the rich and the poor when it comes to dangerous undertakings for pleasure or high pay:

If the rich are free to engage in dangerous sports for pleasure, or dangerous jobs for high pay, it is difficult to see why the poor who take the lesser risk of kidney selling for greater rewards—perhaps saving relatives’ lives, or extricating themselves from poverty and debt—should be thought so misguided as to need saving from themselves.123

Thus, the arbitrariness problem suggests that this objection is inconsistently and prejudicially used only against CLOD when it actually applies to a plethora of other market transactions and decisions where poor individuals may be “disadvantaged” and “coerced” due to a limited range of options, such as health-risking jobs, like coal mining, or being paid for medical experiments. However, this is obviously immoral due to the extreme amount of paternalism it would lead to. So just like in other dangerous occupations or activities that we allow poorer individuals to partake in, it isn’t necessary to outright prohibit these activities, but rather we must simply regulate them enough to ensure a baseline threshold of safety and protection for the participants or workers. In fact, there’s sound evidence that live kidney
donation is actually much safer and less risky than many occupations. For example, the logging industry in the United States has around 110.9 fatal injuries per 100,000 people. But when it comes to live kidney donation, recent studies have found that surgical mortality from live kidney donations is 3.1 per 10,000, which essentially expands to 31 deaths per 100,000, and there is no significant higher long-term risk of death in live kidney donors than similar, non-donor individuals in the general population. Therefore, it stands to reason that it isn’t necessary or justifiable to outright prohibit CLOD, but rather we just must ensure a baseline threshold of safety and protection, via regulation, for both the donor and the recipient.

If one still thinks that there is something substantially different about allowing a person to donate their kidney for compensation compared to allowing them to substantially risk their health by working somewhere like a coal mine or logging company, then it is due to them seeing something inherent to CLOD itself that makes it fundamentally different than coal mining and inherently immoral. But by admitting this fact, one is also admitting that the exploitation objection in itself is not sufficient as an argument to prohibit CLOD, because, otherwise, it would require massive paternalistic efforts levied against poor individuals in all kinds of similar market transactions and decisions, which is obviously immoral and unjustifiable. Therefore, the exploitation objection is not sufficient in itself and must rely on further arguments, specifically from commodification, to justifiably prohibit CLOD by law and deem it necessarily immoral.

Relatedly, the paradox problem of the exploitation objection is a similar argument against the exploitation objection as the arbitrariness problem, and it also highlights why the objection of exploitation is not sufficient as an argument against CLOD due to its tendency towards inconsistency and contradiction. Remember, this claim of the exploitation objection states that the range of choices for these individuals is too small in the first place, so the choice
of CLOD is unfree, coerced, and not appropriate to be an option for these individuals. However, this is prima facie contradictory, because it is essentially exacerbating a problem that it is arguing against, i.e. a constricted or limited choice set. So it is essentially limiting an already limited choice set, which it is arguing against in the first place. Radcliffe-Richards et al. argues that “we cannot improve matters by removing the best option that poverty has left, and making the range smaller still,” because doing so would “make subsequent choices, by this criterion, even less autonomous.” In fact, just as the arbitrariness problem also shows, the exploitation objection relies on something being inherently immoral about CLOD in order for the objection to make any sense, because, otherwise, the additional choice of CLOD would be regarded as a good thing for an otherwise limited or constricted choice set. Therefore, both the arbitrariness problem and the paradox problem show that the exploitation objection is not sufficient in itself and relies on further controversial assumptions about the inherent immoral nature of CLOD to succeed.

Cherry stated this problem the best when he wrote:

In general, it is difficult to count a policy as exploitative if, as in the case of legitimizing organ sales, it increases the number of options open to individuals. In order to see such circumstances as exploitative, one must hold that there is something intrinsically wrong or debasing in selling one's organs, so that even if one does this freely, one has been brought to do something morally injurious to oneself.

1.3) Beneficence, Non-Maleficence, and Commodification

In addition to the arguments made from autonomy, justice, and exploitation, other strong arguments from beneficence, non-maleficence, and commodification are made from both sides in the compensated donation debate. These include both conceptual arguments from ethical principles, i.e. beneficence, non-maleficence, and human dignity, and practical arguments from the context of our current situation, i.e. eliminating organ trafficking, transplant tourism, etc.

The ethical principle of beneficence basically states that one must benefit and do good towards others. It imposes an obligation upon individuals to act in ways that benefit other
people, and it also includes an element of the overall welfare and utility of maximizing good for the greatest number of people.\textsuperscript{133} Depending upon the context, there are differing types of beneficence, such as general, specific, obligatory, and ideal.\textsuperscript{134} General beneficence is beneficence towards strangers and those who we do not have emotional relationships with, and specific beneficence is the act of good towards those we do have emotional relationships with.\textsuperscript{135}

The difference between obligatory beneficence and ideal beneficence is a little more practically obscure, but theoretically the difference involves the act’s obligation. In obligatory beneficence, acts of beneficence are morally imposed and required; whereas, ideal beneficence only includes non-obligatory acts of beneficence that are nonetheless virtuous, heroic, and noble.\textsuperscript{136} These acts are generally known as “supererogatory” acts or acts of exceptional beneficence.\textsuperscript{137} From the perspective of CLOD, acts of beneficence will either be ideal/general or ideal/specific, depending upon whether or not the donor had an emotional relationship with the donee, though it stands to reason that in this case it would mostly be ideal/general beneficence.

Compensated, and thus incentivized, donation is then consistent with the principle of beneficence by creating many more acts of beneficence via the avenue of organ donation and helping others in need, either financially or in the manner of health.\textsuperscript{138} Though financial incentives for donation preclude these types of organ donation from being completely altruistic, these are still considered good acts that now benefit both parties, i.e. the donor via compensation and the recipient via a life-saving organ. In addition to the empirical evidence of the observable increased rates of organ donation in past organ markets, including Iran, recent studies also give further credit to this common sense notion that providing incentives for live kidney donation would ultimately increase the number of kidneys donated from live donors. One recent study by professional economists suggests that payments of roughly $15,200 would increase kidney
transplants by 44% and payments of $37,600 would increase liver transplants by 67%. Other studies have come up with a less optimistic projection, though they still corroborate the common sense notion that incentives for live donation will ultimately increase donation rates.

Additionally, there are several practical ways that CLOD promotes and enhances beneficence via increased rates of live organ donation, including the reduction of harmful organ trafficking and abuse and the much greater long-term survival advantages that transplant recipients have over wait-listed dialysis recipients. There are even studies that suggest that CLOD would actually save the healthcare system a substantial amount of money by getting more individuals off of government-funded dialysis at a much faster rate, and these potential savings range from $90,000 per transplant patient with 3.5 gained quality-adjusted life years (QALYs) all the way up to $270,000 when the monetary value of the QALYs is added, depending upon how value one puts on the added life years to these transplant recipients. So though a prohibition on CLOD would not necessarily violate the obligations of the principle of beneficence, it would drastically decrease beneficence acts that would otherwise be frequent.

The final principle of principlism is non-maleficence, and it essentially states to “do no harm” towards others. Though related to beneficence, non-maleficence is considered a separate ethical principle due to the differences in obligation between the two: where there is not always an obligation of beneficence towards others, there is always an obligation of non-maleficence towards others, though it’s not absolute. That being said, in the field of healthcare non-maleficence and beneficence share an almost intertwined existence due to the nature of healthcare usually employing cost-benefit ratios to decide whether or not the cost or harms, i.e. non-maleficence, of an intervention are worth the benefits or good results, i.e. beneficence. This highlights the fact that some harms can be justified for good results, and this challenges the
conventional notion of non-maleficence’s priority over beneficence in healthcare. This is especially relevant for CLOD, because at its core there is a rather distinct cost-benefit analysis that weighs the benefits of the act with its likely costs or harms. Generally, in the context of organ donation the principle of non-maleficence is associated with the harms inflicted upon the donor during the process of donating the organ. However, as highlighted in the section above, it is widely accepted that the benefits of organ donation greatly outweigh the harms associated with it, and this includes cases of CLOD, too.

On the other hand, it can be argued that prohibiting the legal regulation of a system of CLOD is actually harmful in several ways, including the promotion and overall acceptance of underground black markets in organs, organ trafficking, and transplant tourism. Prohibition of CLOD ultimately creates an environment where black markets can emerge and thrive, especially due to a much higher demand for organs; thus, there are good reasons from the obligations of non-maleficence to not prohibit such an act, of course being contingent on the fact that there are no other overriding ethical obligations, which we have yet to come across. This argument is ultimately justified by the empirical proof provided by the only regulated, legal system of CLOD in the world, i.e. Iran, which ultimately eliminated their organ black market, organ trafficking, and transplant tourism through heavy regulation of a legal system of CLOD and taking away the need and motivation for these practices.

Though it’s debatable whether this obligation to prevent harm falls under obligations of beneficence or non-maleficence, it is without a doubt an ethical obligation that we are mandated to follow, no matter which principle it belongs to. Both Nussbaum’s type of argument for prostitution, and analogously CLOD, and Veatch’s argument for CLOD via justice for the poor that were mentioned earlier are also arguments from non-maleficence, because they state that
taking one more option away from poor populations is *harming* them by keeping them pinned down in poverty and unable to help themselves out of it. The same can be said about donors themselves, too – prohibition of CLOD leads to fewer viable organs for transplantation, which is a significant, if indirect, harm caused by prohibition. Thus, the obligations imposed by the principle of non-maleficence are compatible with a regulated system of CLOD, and prohibition is ultimately a violation of the obligations of non-maleficence due to harming potential poor donors and unhealthy recipients and creating the necessary conditions and environment for the presence of organ black markets, organ trafficking, and transplant tourism.

But even though these arguments from beneficence and nonmaleficence can easily be used in favor of CLOD, they are also used in the second major objection to CLOD, the commodification objection. For example, though it has been highlighted how practical and effective the Iranian model for compensated kidney donation has been and how it has dealt with the ethical issue of the exploitation of the poor via the tremendous work of charities in Iran, one ethical issue that is still readily apparent is the utilization of the commodification of the human body that ultimately underlies the entire system, which some find to be harmful and immoral.151 In fact, this system ultimately takes an extreme form of commodifying the human body, because it essentially operates off of dual *quid pro quo* agreements that directly exchange cash for organs.

The argument from commodification is essentially based on the very first principle of the *Universal Declaration on Bioethics and Human Rights*, human dignity, which states: Human dignity, human rights, and fundamental freedoms are to be fully respected.152 Though being a widely utilized concept in ethics and human rights language, it is notoriously ambiguous, and it is difficult to find any unanimous agreement on its true definition. As a concept and principle, though, human dignity generally refers to the intrinsic value every single human being contains,
and this value is an inherent dignity that must be respected unconditionally.\textsuperscript{153} The \textit{Explanatory Memorandum on the Elaboration of the Preliminary Draft Declaration on Universal Norms on Bioethics} actually defines the concept of respect for human dignity as “[flowing] from the recognition that all persons have unconditional worth, each having the capacity to determine his or her own moral destiny. Showing disrespect to human dignity could lead to the instrumentalization of the human person.”\textsuperscript{154}

This is an ideal that is very prominent in Kantian moral philosophy, because Kant posited that humans contain an inherent value that makes us intrinsically valuable. Thus, as previously discussed, the second formulation of his Categorical Imperative for ethical action is to always treat people as ends in themselves and never merely as a means.\textsuperscript{155} This means that people should always be treated as valuable individuals and never merely as a means towards some other end. As argued above in the context of exploitation, willful two-way contracts do not treat the organ donor as a mere means in CLOD, because the donor’s intrinsic worth is being respected by honoring the terms of the contract, i.e. being compensated, which is the very basis of contractual obligations. In terms of exploitation, it’s only treating the donor as a mere means if one utilizes coercion or theft in the process. However, opponents of CLOD argue that the very nature of providing monetary compensation for a person to donate their organ treats that individual merely as a means, i.e. a collection of useful parts, rather than a valuable individual that is to be respected wholly, and it ultimately changes that individual from a “person” to a “thing.” This process treats individuals merely as a means rather than an end in themselves, thus making it an unethical action.\textsuperscript{156}

This process of turning “persons” into “things” is labeled objectification, and it alters bodily parts into commodities.\textsuperscript{157} A commodity is essentially “anything intended for
exchange.”\textsuperscript{158} It can further be described as any object of economic value.\textsuperscript{159} Thus, the process of bodily commodification is to take something with intrinsic value and objectify it, and once it is objectified it must be commercialized to give it an exchange value, which allows it to be sold for a price. This completes the transition from a “person,” or thing with intrinsic value, to a “thing” that is subject to market relations.\textsuperscript{160} Michael Sandel describes this process as corruption of the human person, and he believes it promotes an objectifying and degrading view of the human person. He argues that this corruption is caused by adding market relations to a non-market product, so to place the human body in this market situation is to corrupt the very integrity of the human person.\textsuperscript{161} There are then two argument formulations for the commodification objection. Firstly, it can be argued that compensated organ donation encourages a commodification of the human body, which is an evil bad enough in itself to justify prohibition. Secondly, it can be argued that compensated organ donation encourages a commodification of the human body, and commodifying the human body can ultimately lead to and cause a commodification of the human person, which is intrinsically wrong and should be prohibited.\textsuperscript{162}

By essentially arguing that commodifying the human body and/or person is a moral harm that has no place in our society, the commodification objection provides a seemingly serious hurdle to the goal of an ethically palatable system of compensated live organ donation that should be legally available. However, there are serious inconsistencies within the objection that raise serious questions about its justification for prohibition. These areas of weakness can be dismantled by three distinct modes of argument: arguments from liberal political philosophy, descriptive arguments of arbitrariness and a lack of consistency, and normative arguments of missing distinctions and false comparisons. When these three modes of arguments are combined,
it’s readily apparent that objections based on commodifying the human body and/or person are inconsistent and not sufficient to support a total prohibition on compensated organ donation.

The first argument comes from John Stuart Mill’s political philosophy, and it basically utilizes his harm principle to argue that even if commodification is a moral harm, the State has no authority to prohibit such a trade. Remember, the harm principle states that, “the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant.”

Thus, if we take the harm principle seriously as a normative guideline for individual freedoms in a liberal society, which most liberal societies do, though they sometimes break it, e.g. helmet mandates for motorcycle riders, then the State has no moral authority to prohibit freely chosen CLOD. In fact, the last sentence of the fuller passage detailing the harm principle explicitly states that “over his own body…the individual is sovereign.”

This is due to the harm principle’s allowance of self-regarding harm. As long as the harm that someone potentially brings on oneself is self-regarding, doesn’t violate any specific duty, such as getting drunk while on police duty, and doesn’t cause perceptible harm to any particular person, then individuals ought to have the freedom to partake in it. Even potentially harmful actions that may affect other people can be justified under the harm principle, as long as the harm is “through” the individual “in the first instance.” For example, while mountain climbing, a climber could fall and become injured, which would risk others’ lives and safety in an attempt to save him; however, since this harm occurs “through” the individual himself and wasn’t directed at anybody in particular, this is a chance and cost that society is willing to pay in order to maximize individual freedoms.

Though the harm principle provides sufficient justification for denying the legitimacy of any State prohibition on CLOD, there are further arguments that are even more damning to the
commodification objection. First, descriptive arguments and analogies can both counter the first formulation of the commodification objection and demonstrate how bodily commodification in this form is already rampant in our society. For example, the first formulation of the commodification objection states that compensated organ donation encourages the commodification of human bodies, which is evil enough in itself to justify prohibition. But what exactly differentiates the human body, specifically an organ such as the kidney, from other types of commodities? There are several different accounts of the process of commodification and what distinguishes commodities from non-commodities, but they all generally agree upon certain basic components, such as a denial of subjectivity (lacks consciousness; no concern for feelings), instrumentality (primarily has instrumental value), and fungibility (replaceable/interchangeable with other things, such as money).  

Another expanded account of commodities essentially posts these same basic components in differing language: objectification (denial of subjectivity), fungibility (interchangeable), commensurability (measurable by a common standard, such as money), and money equivalence (ability to be ranked according to dollar/money value). Thus, a commodity is then something that is (1) objectified, (2) containing no intrinsic value or importance, and (3) interchangeable/exchangeable with other things, such as money. When one receives compensation for donating an organ, then, it’s fairly obvious that all three of these factors are present, meaning CLOD is most definitely an example of commodification of the human body.

Though the question still remains whether or not this type of bodily commodification is necessarily bad enough in itself to justify prohibition. One argument against this notion is that according to these three basic components of commodification, CLOD fares no worse than altruistic live organ donation in this regard. That is, altruism does nothing to change the fact that
the transplanted organ was (1) objectified, (2) containing no intrinsic value or importance, and (3) interchangeable/exchangeable with other things, i.e. the original organ, money due to healthcare costs, etc. In fact, these three components are pre-requisites for the very possibility of organ transplantation in the first place, meaning altruistic live organ donation commodifies the body in a similar way as CLOD. Of course, it can be argued that in altruistic donation money isn’t exchanged for the organ, which suggests that it’s categorically different from the commodifying act of CLOD due to the close link between commodification and money. However, something can still be treated or regarded as a commodity without the actual exchange of money, which is justified by the fact that things can be commodified whether they’ve been given, bought, or even stolen. Further, though it’s true that money wasn’t exchanged with the donor herself in altruistic live organ donation, money was still certainly exchanged in the process in the form of healthcare and transplantation costs. So essentially rather than the donor benefitting financially, wealthy physicians, nurses, hospitals, and Organ Procurement Organizations (OPOs) reap the financial benefits from the transaction. Forcing altruistic donation then doesn’t mean that money doesn’t exchange hands. Rather, it just means that money is exchanged away from the donor herself. Ultimately, then, altruistic organ donation merely compels a great self-sacrifice on the part of the donor in a situation where all other parties benefit in a commercial setting that commodifies the human body every bit as much as CLOD.

To further defeat this formulation of the commodification objection, it should be noted that this type of bodily commodification is also rampant elsewhere in our society, which bring us to the arbitrariness problem of the commodification objection. Similar to the same-named problem with the exploitation objection, this problem highlights the arbitrary and inconsistent nature with how the commodification objection is applied in this case. There are numerous other
types of bodily commodification in our society that are not prohibited, so it’s *arbitrary and inconsistent* to only apply this objection to compensated organ donation. For example, one of the more well-known cases of bodily commodification is the ability to sign up for clinical drug trials for compensation *where researchers can test the effects of certain drugs on the human body*, and they even have dedicated websites for finding these types of research studies, even a .gov site.\footnote{171} Further, women regularly sell their eggs for thousands of dollars for fertility reasons or embryonic stem cell research.\footnote{172} In fact, in New York women can sell their eggs for research for upwards of $10,000, which is even funded by public money, similar to my proposal below.\footnote{173}

Finally, the military and Veteran’s Association even take this bodily commodification a step further by assigning individual “prices” for compensation for injuries or amputations that soldiers might have suffered in service of their country. For example, in a piece by *The Washington Post* that discusses a particular soldier’s journey to receive his compensation package for his injuries sustained in war, it is stated:

He would almost certainly be judged 100 percent disabled, entitling him to a minimum monthly payment of $2,858. He’d also receive special monthly compensation. “That’s something we pay above the basic monthly rates because of your amputations,” Washburn [the benefits counselor] said. Special monthly compensation payments vary widely and can be tough to estimate. The loss of a single foot, hand or eye is worth $101.50 a month. Two missing legs can generate an additional payment of about $1,000-$1,300 a month. Missing arms are worth an extra $1,600-$1,800 [emphasis added]. Washburn passed Shockley a spreadsheet with the categories and rates.\footnote{174}

And there are many, many more examples just like these ones above, which proves that it’s completely *inconsistent and arbitrary* to single out CLOD as an unethical commodification of the human body that should be prohibited when we live in a society that has numerous other examples of this very same concept that aren’t prohibited. Thus, as with the arbitrariness problem of the exploitation objection, this problem shows that *this objection is not sufficient* to justify prohibition of CLOD, because it doesn’t differentiate this act of bodily commodification
from other non-prohibited acts of bodily commodification, which leads us to the second formulation of the commodification objection.

The second formulation of the commodification objection argues that CLOD encourages a commodification of the human body, and commodifying the human body can ultimately lead to and cause a commodification of the human person, which is intrinsically wrong and should be prohibited. In a sense, though this claim seems stronger than the first formulation, it is also much harder to prove. In fact, it necessarily goes beyond merely proving bodily commodification, because the presence of bodily commodification does not necessarily entail commodification of the human person. The human person is a concept intimately related to, but ultimately distinct from, the human body, so there is no necessary connection between the two where commodification of the body necessarily entails commodification of the person. And ultimately, this distinction is why this formulation of the objection can be so easily defeated.

Recall from earlier the definition given for the concept of respect for human dignity as “[flowing] from the recognition that all persons have unconditional worth, each having the capacity to determine his or her own moral destiny. Showing disrespect to human dignity could lead to the instrumentalization of the human person.” Essentially, this bases the concept of respect for human dignity on human personhood, which gives humans intrinsic, unconditional worth with the ability to determine our own moral destiny, meaning respecting personhood is the requirement for respecting human dignity.

Like human dignity itself, the concept of “personhood” is a controversial moral and legal concept that has been long debated. However, it has long been utilized in the Western philosophical tradition, not legal tradition, to mean any moral agent (human or non-human) that possesses both (1) a consistent consciousness and rationality throughout time and (2) the ability
to formulate ideas and plans with the ability to act out those plans. So this raises a twofold question. First, as already answered in a positive manner, does CLOD commodify the human body? Yes. Second, does that commodification of the human body lead to and cause a commodification of the human person? It’s not obvious why this would be true. As mentioned above, though they’re intimately connected in many ways, the human person/self and the human body are two distinct concepts/entities. For example, if an individual’s hand is removed, then the human body loses an important part of itself; however, the human person is still intact and not significantly impacted. On the other hand, no pun intended, if an individual’s heart or brain is removed, then both the human body and the human person lose an integral part of themselves, since both the heart and the brain are needed for the human body to function and for the consciousness requirement of human personhood. Of course, it might be objected that even if personhood as a whole is not lost, it could be that a significant “piece” of the person is lost by losing something as integral to human flourishing as a hand, limb, eye, etc. This is very true, but by that very logic the organs of discussion here, i.e. a spare kidney and a part of a liver, would not constitute such a loss since they’re not nearly as integral to human flourishing and functioning as a hand, limb, or eye, since the body can function effectively without these donated bodily parts. Analogously, it’s like comparing the loss of a parent, sibling, or significant other to the loss of a long-lost cousin that you never met – there’s simply no comparison. Thus, this shows that at least in the secular sense of human personhood, the human body is a collection of parts that are qualitatively different and have differing associations with the concept of human personhood.

These bodily parts’ differing qualitative associations with human personhood are due to the “conceptual distances” between the concept of personhood and the necessity of that
particular body part for the existence of personhood. For example, as stated above, the hand is much more “conceptually distant” from personhood than the heart or the brain, which are both necessary for personhood. When discussing the kidney in particular, it is clear that it is extremely “conceptually distant” from the notion of human personhood, because humans were granted two kidneys when we really only need one for effective survival. This has long been known and confirmed with consistent academic study findings of the relative safety of live kidney donation, which has virtually no short or long-term side effects on the functionality of the remaining kidney or “excess mortality.”

Mark Cherry puts this notion best when he writes:

Even if sales that would necessarily involve a loss of life are ruled out, if the self is different from the organs that are separable and distinguishable from the self, **though the self may not sell some organs, it may sell others** [emphasis added]. Just as one only requires sufficient food and medicine to sustain life, rather than any particular serving of food or dose of medicine, **of those body parts that are both distinguishable and separable from the self, one only requires a sufficient set of body parts, rather than any particular parts or replacements, to sustain the biological life that in turn sustains personal life and consciousness** [emphasis added].

Thus, given the facts that (1) altruistic live kidney donation has been argued to be just as commodifying of the human body as CLOD and (2) CLOD does not even significantly affect the functioning of the human body, let alone personhood, then it is clear that CLOD is not significantly different than altruistic live kidney donation with regard to the commodification of the human body and person. Of course, this doesn’t mean that we should outright follow the Iranian model of extreme bodily commodification, because perception matters in developing an ethically palatable system of CLOD in a multicultural, liberal society such as our own. As I’ll discuss shortly, using an alternative route of compensation and couching it in the language of tax benefits is much more palatable than a market with *quid pro quo* exchanges of cash for organs.

But this isn’t to say that within our liberal society with autonomy-based ownership rights over our bodies that we don’t have the fundamental individual rights to subject ourselves and our bodies to that type of commodification. It is fairly clear that even if CLOD did represent some
sort of bodily commodification that led to commodification of the human person, the harm principle grants sovereignty over individuals’ bodies to the individuals themselves, meaning combined with the plethora of other similar types of bodily commodifying actions in our society, there would be no political justification for prohibition. The same can be said with other, lesser arguments against CLOD, such as possible stigmatization of donors and suppression of altruistic donation, which will be discussed in more detail in chapter four. However, with the addition of the ethical justification that strikes down the second formulation of the commodification objection, it is more than clear that there is absolutely no justification for prohibition on CLOD within the United States, and we should strive to minimize and regulate commodification rather than prohibit it. Once again, Cherry sums this issue up the best by stating:

Commodification of human organs is not an obvious violation of the Kantian maxim to treat persons as ends in themselves absent additional arguments showing that even consensual selling of organs is morally injurious. The organ market respects vendors as persons and moral agents. Prohibition, in contrast, may demean the poor by considering them unable to make moral decisions about their own fates [emphasis added].

1.4) Cadaveric, Imminent Death, and Other Organ Donation Proposals

Now that it’s been shown how CLOD is ethically and politically justifiable in a liberal society, it’s time to look at the ethics of cadaveric organ donation before ultimately developing a complete system of organ donation for the United States. This section analyzes the ethicality of the differing types of cadaveric organ donation systems, along with ethically analyzing several other newer proposals of organ procurement and donation.

Though opt-in, explicit consent systems are rather inefficient at procuring organs and consent from potential donors, traditionally these explicit consent systems have been considered the ethical “gold standard” of consent systems. This is because these types of systems are essentially donation models that provide the most amount of respect for the principle of individual autonomy, which is extremely important in individualistic societies like the United
States. The notion of freedom and autonomous decision-making with what happens to one’s body after death is of utmost importance to many Americans, and this consent system has generally been considered the most accurate at respecting individual autonomy, even if sometimes it doesn’t “catch” individuals that would’ve been donors.\textsuperscript{183} However, though opt-in, explicit consent systems are considered the ethical “gold standard” option for national systems of cadaveric organ donation, there is a potential ethical issue that pervades both opt-in and opt-out systems, which is family consent. In both types of systems, it is unethical to limit the family’s decision-making ability when they have clear and objective evidence of what the deceased would have wanted, both to donate and not to donate. Generally, this is only seen in legislation within Austria’s hard opt-out format, even though it practically hasn’t been enforced.\textsuperscript{184} Whatever the case, if the family truly knows what the deceased’s preferences and has clear evidence to support their claims, then legislation shouldn’t be able to hinder their involvement.

But mainly, the ethical issues generally revolve around the notion of “presumed consent” within opt-out systems. It has been vehemently argued that an opt-out system, and the overall notion of “presumed consent,” violates the principles of autonomy and informed consent, because there is no express, written consent given for organ donation. Further, most systems of “presumed consent” end up being nothing more than paternalistic systems of routine organ salvaging, as argued by Veatch and Ross.\textsuperscript{185} Where opt-in systems more closely align with the ethical principles of personal autonomy and expressly informed consent, due to involving an active informed decision about whether or not one wants to donate their organs upon death, opt-out systems align more with the principles of justice and beneficence.\textsuperscript{186}

Technically, this ethical issue is only practical in nature, though, because if a nation was able to provide massive public health education campaigns and reach full awareness of its
citizens about the opt-out organ donation process, then a lack of opting out could legitimately be viewed as consent to donate one's organs upon death. Theory isn’t always practical, though, and having a nation’s total population reach full awareness on an issue would be a Herculean task and virtually practically impossible. Essentially, this was the UK’s Organ Donation Taskforce’s viewpoint on the matter. While theoretically they had no fundamental moral objection to an opt-out system, they argued that practically it would be extremely difficult to implement without ensuring violations of informed consent and a lack of awareness in at least some of the population, so they recommended that the UK exhaust all of their options at improving their opt-in system before switching to an opt-out system. It should be noted that Wales officially converted to an opt-out system in December of 2015. Thus, in opt-out, presumed consent systems a certain level of autonomy violations is ultimately accepted as a foreseen but undesirable and unavoidable consequence of increased organ donation rates.

Fortunately, there is a way to combine the efficacy of opt-out systems with the ethicality of opt-in systems: mandated choice. Essentially, this system requires individuals to register their preference for cadaveric organ donation by asking the individual directly and requiring an answer for the completion of some sort of form or document, such as a driver’s license application. This type of system is perfectly suited for organ donation, because mandated choice systems work best in bifurcated systems with simple answers, e.g. yes or no, opt-in or opt-out, etc. This system has other advantages, as well. First, mandated choice systems allow individual preferences to be more accurately recorded via active, explicit choice. This is a very important advantage over presumed consent and even explicit consent systems, because many times the family of the individual will unfortunately deny organ donation due to not knowing the exact preferences of the deceasing individual. Further, many mandated choice systems then
allow the individual’s explicit consent to trump any family objections. For example, Illinois’ mandated choice system makes explicit consent from the individual sufficient for organ donation, meaning the individual’s family’s consent is not required. More will be said later on the importance of getting consent from individuals themselves rather than their families, but it is clear that mandated choice systems offer the advantage of more accurately recording individual preferences by requiring individuals to reveal their preferences for organ donation.191

Similarly, another related advantage is the vast increase of the base number of individuals that are explicitly asked about becoming an organ donor. In both opt-in and opt-out systems, there really is no widespread mechanism to garner preferences from individuals. In mandated choice, though, by requiring individuals to answer the question, usually via driver’s license applications or state identification cards, or, even better, on federal tax documents, the number of potential organ donors can more accurately reflect the public opinion and attitude toward organ donation, which is generally very high and supportive.192 Of course, some may argue that it’s paternalistic to require an answer and force individuals to register their preferences in this way, but with something as simple and trivial as registering a preference, ultimately this argument is hardly compelling.

Recently, several states have switched to a mandated choice system, and drastic benefits were seen almost instantly. For example, in Texas in 2010 a new law came into effect that required individuals applying for a new driver’s license to answer the question of whether or not they’d like to register as an organ donor. Before that law passed in January 2010, only two percent of adult Texans were registered as organ donors, and by July 2010 approximately five percent of adult Texans were registered as organ donors.193 The Texas Department of Public Safety workers, who were responsible for asking the question about registering as an organ
donor, went through extensive training in organ donation and the donor registry in 2012 to better answer questions that potential donors might ask before signing up, and between this training and the longer usage of the mandated choice system, by January 2013 seventeen percent of eligible Texans were registered as organ donors. Similar effects have been observed in many other states that have recently switched to systems of mandated choice, too, such as Illinois and California to name a few, including a nine percent raise in registered organ donors in the first six months of Illinois’ adoption of a system of mandated choice on driver’s license applications. Thus, there are substantial ethical and practical advantages to adopting a mandated choice system of cadaveric organ donation over a system of presumed consent or explicit consent, and it ultimately is the most ethical system of cadaveric organ donation.

But beyond the traditional models of cadaveric and live organ donation, there are some intermediary types of organ donation that don’t clearly fit into either of the two aforementioned types of organ donation. For example, with brain dead donors being a rare commodity and the multiple practical problems that are associated with donation after cardiac death (DCD), e.g. longer warm ischemic times, variable death times after withdraw of life-sustaining treatment, barring the family from being with the patient at the time of passing, etc., some are looking to expand upon the opportunities to harvest organs from those near the end of life. In addition to live and cadaveric organ donation, some have argued for the utilization of an intermediate type of donation known as imminent death organ donation (IDOD). This type of live organ donation comes at the end of life from terminally ill patients that have decided to withdraw life-sustaining treatment; however, these patients are neither brain dead nor ideal candidates for DCD, which makes cadaveric organ donation virtually impossible for these patients. Thus, in this type of donation before life-sustaining treatment is withdrawn, organ donation, i.e. excising the organ
from the still living donor, occurs, and life-sustaining treatment is withdrawn soon after the operation is over. At the present time, IDOD has been limited to one kidney at a time, though it is believed that more organs could be donated from these patients in the future.

The reason that some find this method to be controversial is due to the notion of the dead-donor rule, which has seemingly been the guiding ethical norm for the practice of organ donation throughout its existence. The dead-donor rule has two main obligations. The first obligation corresponds to cadaveric organ donation - organ donors must be dead before the procurement of organs begins - and the second obligation corresponds to live organ donation - organ procurement itself may not cause the death of the donor. Since this type of organ donation is completed before life-sustaining treatment is withdrawn while the patient is alive, it is considered a live organ donation, and this means the second obligation of the dead-donor rule is applicable to IDOD, which is the exact reason why it is currently limited to a single kidney, i.e. it’s believed that it’s extremely unlikely that excising one organ would cause or even hasten the death of the patient. However, even in rare cases where complications do occur during surgery where the death of the patient is hastened, just as in palliative sedation, as long as the true motive is excising the organ rather than hastening the death of the patient, then this act can be ethically justified by the widely accepted ethical norm of the principle of double effect.

This type of organ donation actually comes in two forms, too, with each having distinct ethical components. First, it may occur in patients who are awake, alert, and have decisional capacity, and these patients can make the autonomous, informed decision to donate an organ before they start withdrawing life-sustaining treatment. For many, this seems to be a fairly straightforward and ethically justifiable scenario. Not only does it respect and promote patient autonomy, it also promotes significant acts of beneficence and engenders much good for the
dying patient, and this beneficence is even more apparent for the patient’s family, too. For example, though not specifically discussing cases of IDOD, James Childress has noted the positive effects and good for the family that usually comes from the choice for and successful completion of organ donation in a recently deceased loved one. In the family’s own words, “This was the best thing we could have ever done. Whoever the people are that got the organs, we’re just grateful to them to keep part of him alive in this way. We’re grateful they are living.”

Said another way, this method, “could provide patients and families a middle ground—a way of avoiding futile medical care, while also honoring life by preventing the deaths of other critically ill people.”

A second and more controversial option is in permanently unconscious patients - those in a permanent vegetative state or those with a devastating neurologic injury that is considered irreversible, though not considered brain dead - where surrogate decision-makers would make this decision to donate the organ after making the decision to ultimately withdraw all life-sustaining treatment. The main issue with this option of imminent death donation involves the use of surrogate decision-making. There are two main and relevant standards of surrogate decision-making when it comes to this option of organ donation: the best interests standard and the substituted judgment standard. The best interests standard essentially states that surrogates should make the decision according to the patient’s “best interests” when no prior preferences from the patient are known. Immediately, then, we can toss out the decision of IDOD for incapacitated patients using this standard, because since this type of procedure would provide no benefit whatsoever to the patient, but only additional harm and burden, there is no objective interest in performing this donation from the perspective of the incompetent patient.
However, the substituted judgment standard is the preferred standard for surrogate decision-making, and it is based upon the subjective and known preferences of the incapacitated patient. Essentially, this standard requires the surrogate to use the known preferences and values of the incapacitated patient to make the most proper medical decision according to what the patient would ultimately want if they were making the decision themselves. Of course, the substituted judgment standard has its own problems, as well. Several recent studies have found that the substituted judgment standard is not nearly as accurate and reliable as it was once thought to be. For example, there is a significant discrepancy in the actual preferences of the patient versus the judged preferences of the patient by the surrogate, meaning surrogates are sometimes judging the patient’s preferences wrong and thus making decisions that are counter to what the patient really would’ve wanted. One study even found that surrogates are only correct in their judgments about 68% of the time, which is still a majority of the time but far from the overwhelming accuracy that this standard was once thought to possess.

Complicating things even further, along with the recent research suggesting the increased fallibility of the substituted judgment standard, there is also substantial evidence that patients’ preferences evolve and significantly change over time, especially with regard to end-of-life issues, meaning surrogates’ memories regarding past preferences of the patient might not be up to date. Furthermore, research also suggests that prior preferences aren’t necessarily even of primary importance to patients in end-of-life scenarios, because they value the opinions of family and their doctors, who they also want involved in the decision. A further problem is that IDOD is an extremely specific situation that is not well-known in the general public, so the chances of patients previously and explicitly discussing their preferences for this procedure are minimal at best. Further, cadaveric organ donation is not morally equivalent to live organ donation, so since
IDOD is a form of live organ donation, showing preferences toward or being a registered (cadaveric) organ donor is not necessarily sufficient for the substituted judgment standard. Thus, there are substantial questions regarding the required threshold that surrogate decision-makers would need to meet in order for them to justifiably conclude through the substituted judgement standard that the incapacitated patient would truly want IDOD in this situation.

On top of this issue with surrogate decision-making, there is also the issue of public perception and trust in organ donation to consider, especially with minority populations. There is already a well-known, documented distrust of the white-dominated healthcare by African-Americans, and this distrust and suspicion is present in the realm of organ donation, too. In fact, there is substantial substance to some of these concerns based on racial discrimination, with several studies suggesting that black Americans are routinely much less likely to be referred to transplant services, considered good candidates for transplantation, and placed on organ waiting lists than white Americans, even with all other factors in consideration and accounted for. The combination of this distrust with actual discrimination has led to major disparities in organ donation and allocation within this population. Further, a continued reluctance towards organ donation in this population has largely maintained this disparity due to a lack of histocompatible viable organs for transplants in African-Americans. So with the effectiveness and success of organ donation programs relying so heavily on public perception and trust in organ donation, this is a serious concern that must be taken into account, especially with regard to minority populations that are already dealing with significant disparities in this area of healthcare.

So we must truly take into consideration what widespread promotion and utilization of IDOD in incapacitated patients would do to (1) surrogate decision-makers in their attempt to interpret the patient’s obscure preferences and (2) the public perception and trust in organ
donation. This is basically the position of the chairman of the UNOS ethics committee, Dr. Peter Reese, when he says that IDOD “could erode public trust in donation in general.”

This is especially true in minority populations, who are already suspicious of and distrust white-dominated healthcare, including the organ donation sector. This primary concern in the public perception of IDOD, among other issues - such as practical issues like a possible lack of support from the medical staff, better guidance for when to offer IDOD over DCD, and better models to predict how allowing IDOD would impact the number of viable organs available for transplant, led the joint OPTN/UNOS Ethics Committee to conclude in March of 2016 that IDOD in incapacitated patients was not something to pursue further at this time.

As a rule of thumb, I believe this is the correct public position to take in IDOD in incapacitated patients, though not in capacitated patients as argued above. This does not necessarily require a total prohibition, though, because certainly there can be times when surrogate decision-makers have indisputable evidence that IDOD is what the patient would prefer. However, with the potential to severely harm public perception and trust in organ donation and the very precarious position that it forces surrogate decision-makers to make life-altering decisions from, only IDOD in capacitated patients is something that should be outright promoted and encouraged by the health team.

Other proposals for the procurement of organs includes organ donation euthanasia, procurement from prisoners, and procurement after physician-assisted suicide. In the case of organ donation euthanasia, the proposal states that the organ procurement operation itself functions as the process of euthanasia for Life Support Withdrawal Donors (LSW Donors). Basically, with the patient under anesthesia, after retrieving all of the abdominal and other thoracic organs, the transplant team removes the heart, which ultimately causes the death of the patient. Though this proposal was ultimately aimed at the permanently unconscious and those in
persistent vegetative states, it also is relevant to those LSW Donors, both capacitated and incapacitated, who want to ensure that something good comes from their deaths, i.e. donation.

However, though this proposal has significant benefits over other types of organ donation, including greatly increased efficiency, quality, and number of organs procured, it is ultimately a non-starter due to its necessary violation of the normative principles governing organ donation, including principles that obligate the act of organ donation to (1) not harm the organ donor in any significant way, (2) only remove organs from brain dead individuals, and (3) not deliberately kill the patient. Further, it also inherently violates both of the ethical obligations of the dead donor rule – (1) organ donors must be dead before the procurement of organs begins, and (2) organ procurement itself may not cause the death of the donor.

But are there special cases where this might still be justified, such as in the case of a death row inmate who is about to face the death penalty? Controversial as it may seem, there actually may be sound ethical justifications for organ donation euthanasia in the case of an executed prisoner due to the differing contexts, and there are many who have proposed harvesting organs from prisoners in various different fashions. China is actually an infamous example of a nation that once, and may still, harvested organs from executed prisoners, though they were roundly criticized for the practice due to ethical issues of consent and the potential effects it had on increasing rates of the death penalty. The UNOS ethics committee has also opposed any new changes or legislation until a fuller discussion has occurred, but they also bring up issues of consent, how it would affect certain discriminatory practices already inherent within the system, and how it would affect potential jurors who might be influenced by this decision. Until further analysis has been completed, I agree that this proposal is too risky to promote.
The final proposal involves organ donation after physician-assisted suicide. This would involve DCD after physician-assisted suicide. The patient could administer to themselves large doses of a sedative and cardioplegic agents, which would ultimately stop the heart. After the necessary time had passed to either ensure brain death or render the possibility of autoresuscitation to zero, whichever justification one is using, DCD would be completed.219 Recent research in Belgium actually suggests the effectiveness of DCD in this scenario due to the controlled nature of the death and environment, and in some cases certain thoracic organs, i.e. the lungs, were also able to be obtained, though the heart was still unattainable.220 Since the act of organ donation is separate from the act of physician-assisted suicide itself, there shouldn’t be much controversy around this proposal, and it is something that physicians should encourage their patients to consider in these instances. Thus, beyond the traditional avenues of cadaveric and live organ donation, there are several other proposals that can be helpful for minimizing the organ waiting lists in the United States. Specifically, IDOD in capacitated patients and organ donation after physician-assisted suicide are two proposals that should be thoroughly promoted and encouraged in the transplant community, and in cases where surrogates have explicit knowledge of an incapacitated patient’s significant preference for organ donation, it also can be ethically justifiable to perform IDOD in these situations, too.

1.5) A New Model for the United States Organ Donation System

Now that the ethical and practical factors regarding CLOD have been thoroughly dealt with, it is now prudent to apply this knowledge and develop a US-based system of CLOD to meet the surging demand for viable organs for transplantation. Additionally, the national cadaveric organ donation system can be revamped in the process to be more efficient and up-to-date. By modifying the Iranian model to become more ethically palatable for a pluralistic, liberal,
and multicultural American society, an ethical and effective system of CLOD and mandated choice, opt-out cadaveric organ donation can be established in the United States, specifically by utilizing tax benefits as financial incentives for donation.

As mentioned above, though the Iranian model of CLOD is the most successful system of its kind in history, it still suffers from the utilization of extreme bodily commodification, i.e. quid pro quo agreements between two parties that directly exchanges cash for an organ, due to relying on two separate direct monetary payments to the donor for their donated organ, which will most likely have to be substantially changed to be politically and ethically palatable in a multicultural, liberal society such as the United States, especially with our current political and medical climate that has struck down and criticized virtually anything close to incentivized donation.221 To address this weakness of extreme commodification in this model, a revised model must pass two conditions: (1) there must be no direct payment for organs, and (2) the notion of donation must be retained. However, though using things like moral or nonfinancial incentives would be consistent with these conditions, they do not appear to provide significant incentives to notably increase donation rates.222 One idea that meets these two conditions while still providing enough incentive for many more individuals to donate is a system based on tax benefits received for charitable donations one made throughout the year.

In the United States and most other countries, individuals are allowed to deduct charitable donations that they made off of their taxable income. When one makes any sort of donation to a religious organization, non-profit organization, charity, or government agency, the amount of the donation is a tax write-off that one does not have to pay taxes on. These incentives are promoted by nations to encourage charitable giving to charities and other organizations.223 Rather than tax deductions, though, there is also the even better option of utilizing _tax credits _as incentives for
live organ donation, because rather than just lowering the amount of taxable income that one owes, tax credits actually “provide a dollar-for-dollar reduction of your income tax liability.” Further, refundable tax credits can even reduce one’s tax liability below zero and garner the individual a tax refund, meaning actual cash in pocket rather just tax savings.\(^{224}\)

So since governmental agencies are allowed to accept charitable donations that are tax deductible, UNOS and/or OPTN, mimicking the supervisory and administrative roles played by the Iranian Ministry of Health and the Anjomans in the Iranian model, could then make donations eligible to be considered tax deductible transactions, or tax credits, under the framework of the charitable donations tax deduction. Once achieving this status, donations could then be incentivized without the appearance of extreme bodily commodification that is found in the Iranian model, because this practice could pass the two aforementioned conditions. Essentially, these tax benefits are incentives for charitable giving, so the tax deduction is just a benefit for one’s charitable gift. Of course, by definition this is still a case of commodification of the body. However, as argued earlier, the State has no right to legislate prohibition on these matters anyways, and the goal is to minimize as much as possible the appearance of commodification, or at least the direct connection between cash payment and donation, but not necessarily totally eradicate bodily commodification altogether.

The best thing about this proposal is the significant legal precedent already established for such a system. For example, the first-time home buyer credit, established by the American Recovery and Reinvestment Act of 2009, allowed first-time home buyers, subject to certain criteria, to be eligible to claim a fully refundable $8,000 tax credit, so there is precedent for these types of special tax credits and assorted benefits.\(^{225}\) Even better, in 2016 19 states already have laws allowing tax deductions or tax credits, generally valued at $10,000, for living donors as
compensation, or more technically reimbursement, for travel, lodging, and lost wages related to the living organ donation process. But the only reason that these tax benefits for living organ donation are available is because there are numerous states that don’t have laws to protect or reimburse living organ donors, which forces them to pay out of pocket to make the charitable act of organ donation, including costs associated with travel, lodging, and lost wages during testing and recovery times. So not only are we not currently properly encouraging and providing incentives for live organ donation, we’re also practically discouraging it by forcing significant costs upon the donors themselves.

So if CLOD was established at the fixed price that was mentioned earlier in the dissertation, i.e. kidneys at $15,200 and livers at $37,600, or even higher due to inflation since 2007 (when the study was completed), for the charitable donation refundable tax credit, then even those without a taxable income or tax liability can take advantage of this incentive, meaning more overall donations. Of course, more legislation would ultimately be, and currently already is, needed to better protect and reimburse living organ donors for lost wages and other expenses accrued throughout the process of donation, along with increased medical and psychological support after the operation. Beyond increased donations, there are even other benefits to this proposal. For instance, a recent study in Canada suggests that CLOD can actually save the healthcare system money in the long run. And as mentioned above, other studies support this claim, with some research suggesting savings from $90,000 with 3.5 additional QALYs to $270,000 per patient when also considering the monetary value of those QALYs, and this is ultimately due to the outrageous costs associated with government-funded dialysis. Further, the fact that the incentives aren’t necessarily instantaneous after the procedure, but come during tax refund season, also fosters an environment where voluntariness is respected and ensured and
short-term financial crises aren’t primary motivators for donating organs, which also allows
more time for patient evaluations, interviews, and meetings to ensure the overall health and
properly informed consent of the patient.

The last issue to address with this proposal is funding. Due to the United States’
particular political context and its heavy reliance on a private healthcare system, it’s not as
simple as just having the federal government take the hit with these losses in tax revenue, and
even the shelling out of more tax refunds, because the US federal government is not as involved
in the healthcare system as other national federal governments are in more socialized forms of
healthcare, such as single-payer systems. However, there are several ways around this. First, as
stated above, the cost-savings of instituting a system of CLOD might ultimately pay for itself,
since it would save the federal government enormous costs involved with government-funded
dialysis. Second, it’s not unprecedented to reallocate funds in the budget to fund these types of
new programs. For example, the most recent military budget has the United States spending a
whopping $596 billion in defense spending, which is nearly $30 billion more than the next seven
countries combined, so it could very well be argued that this is a non-controversial, very
beneficial potential source of reallocated funding for this new program, especially due to the
program’s modest financial needs for compensation. Third, we could even create new taxes
and/or initiatives as a funding source, as Illinois did in the 1990s utilizing the “Live and Learn”
initiative to fund a successful media campaign aimed at increasing organ and tissue donation
rates in the state. We could even have individual state markets or regional markets around the
country, which would ensure that local tax increases would go to aid local organ donation
efforts.
Finally, the federal government could also work in conjunction with private insurance companies and require them, either the recipient’s insurance company or the actual donor’s insurance company, to reimburse the federal government for lost tax revenue and/or the amount of the refund for that individual. Depending on which insurance party would ultimately be responsible for reimbursing the federal government, this might be the most logical option due to over a quarter of our population already receiving Medicaid benefits as it is. That is, this might make the most sense if most of the donors are already utilizing entitlement healthcare, which would keep the same party, i.e. the federal government, at both ends of the transaction and eliminate the need for a third-party reimbursement. This kind of involvement and cooperation of private insurance companies has also been posited elsewhere in markets for organs from cadaveric, rather than live, organ donation.

Thus, this proposal offers a unique, practical avenue of incentivizing live organ donation via a tax framework that is already largely present that does not fall into the ethical conundrum of extreme bodily commodification like the Iranian system does. But it certainly isn’t the only proposal that has been proposed regarding CLOD. Dr. Arthur Matas, an outspoken proponent of CLOD, has also posed a somewhat similar type of proposal with a centralized agency regulating the entire trade, though he posts that the incentives could be varied depending upon the donor, e.g. health insurance vouchers or scholarships rather than direct financial considerations. Another proposal by attorney Sarah Krieger Kahan also puts control of the trade in a centralized agency, but she proposes that this agency would actually purchase organs from donors and allocate them in a way similar to how we allocate cadaveric organs now. So there are several significant proposals that hold promise as efficient models for regulating CLOD, and though they differ substantially in methods, they all share the same underlying assumption that a centralized,
federal agency should solely and strictly regulate the process to avoid corruption and unethical situations that are commonplace in open, unregulated markets.

But even beyond developing a system of CLOD, the cadaveric organ donation system can also be revamped to be more efficient and up-to-date. One way to do this is to take advantage of certain non-cognitive biases and tendencies that humans have. Due to the advancements of disciplines such as psychology and behavioral economics, it is now known that humans are not nearly as rational as we once thought we were, and we are subject to irrational influences and cognitive biases that substantially affect our decision-making. For example, default settings and the way that information or options are presented to an individual, i.e. choice-framing effects, can significantly affect the decision that an individual will make depending upon how these default settings and choice-framing effects are set up and presented.238 Manipulating these irrational biases can then be considered “choice architecture,” and libertarian paternalism, or a “nudge,” can be defined as “any aspect of choice architecture that alters people’s behavior in a predictable way without forbidding any options or significantly changing their economic incentives.”239

In actual policy, libertarian paternalism is then used in a couple of differing ways. First, there are certain default settings that necessarily require one preference over another, such as when the default is bifurcated into one of two options, as it is in organ donation. As Sunstein puts it, “default rules and starting points often matter, institutions can't avoid nudging people -- and hence can't avoid a kind of paternalism, or at least a nudge.”240 Thus, the argument is that since a preference must necessarily be set in the default setting, as long as there’s an option to opt-out of the default, then it might as well be one that promotes the best outcomes. Some posit that providing incentives or disincentives for particular actions, states, or purchases constitutes a
nudge, such as “sin taxes” that are measured hikes in taxes for certain purchases considered “sins” or undesirable habits. These have recently been employed in public health strategies aimed at curbing obesity, such as the UK’s decision to return to sin taxing sugary drinks based on the amount of sugar that they contain. Similarly, disincentives might also be used by eliminating options altogether, such as Bloomberg’s New York City large soda size ban.

However, these types of disincentive policies that eliminate options or punish individuals for choosing one option over the other are not consistent with the conditions of libertarian paternalism. The reason nudges are compatible with liberalism in many default settings is because they allow the individual to easily opt-out without being unduly forced and coerced to participate in the behavior. In eliminating options or sin taxing, though, there is no ability to opt-out, and you are either forcing individuals to change their conception of the good by taking away options or forcing them to modify their behavior, or otherwise suffer the consequences, which are higher taxes paid on items. Remember, this type of action is expressly prohibited in the definition of a nudge itself when it is stated, “To count as a mere nudge, the intervention must be easy and cheap to avoid. Nudges are not mandates. Putting the fruits at eye level counts as a nudge. Banning junk food does not.”

Similarly, incentives are not technically nudges either, because utilizing these facts doesn’t conform to the concept and definition of libertarian paternalism. This is for two reasons. First, incentives work on the “Reflective System” of human thinking rather than the “Automatic System” of human thinking that nudges work on, because incentives work through rationality by giving the individual a reason to act, which is opposed to the instinctual, unconscious mode of thinking in the “Automatic System.” Financial incentives then rely upon rational processes rather than cognitive biases to change behaviors, which, by definition, makes them incompatible
to be considered nudges. Second, by definition, nudges must work without “significantly changing their economic incentives.” However, that’s exactly how incentives work to influence decisions, so utilizing incentives is by definition not consistent with libertarian paternalism. But this isn’t to say that incentives aren’t behavioral economic interventions or part of a good choice architecture either, because they clearly are. Similarly, this also isn’t to say that incentives aren’t effective either, because many empirical studies have shown the effectiveness of using cash incentives or even lottery-based incentives to further promote public health aims.

One area where nudges are extremely beneficial is the concept of organ donation, because the default donor status is extremely preference-laden. Currently, in the United States the default setting for cadaveric organ donation is negative, and attempts to change this default setting to positive, presumed consent has largely been met by skepticism, especially by the AMA. However, studies suggest that though other factors are also necessarily involved in organ donation rates, there is strong evidence that opt-out, presumed consent systems have increased organ donation rates over opt-in, explicit consent systems. Other studies corroborate these findings. And though incentives, both financial and non-financial, are not technically nudges, they are also beneficial in organ donation, and this has led some to argue for the institution of organ donation prioritization incentives, where those that sign up to be cadaveric organ donors would ultimately receive priority over non-donors in issues of organ allocation. These types of incentives or nudges are very similar to what Israel has instituted, and the introduction of these incentives in Israel has greatly increased both the number of deceased organ donors and the number of newly signed donor cards.

Nudges and other incentives are then an effective way to increase cadaveric organ donation rates; however, as argued above, with opt-out systems it’s hard to justify any argument
that automatically presumes donation without actual explicit consent. This is why both of the aforementioned nudges and incentives, i.e. the opt-out default setting and prioritization, should be combined with a mandated choice strategy on the national or federal level. By combining these three strategies, you provide two differing nudges or incentives, i.e. the default/status quo bias and prioritization, to each individual making a decision about becoming an organ donor.254

The process would go something like this. First, via completion of driver’s license applications, state identification cards, tax returns, or some combination of these options, you mandate each individual to designate their organ donation preference. During this process, you provide them with the necessary educational information to make an informed choice, either personally or with detailed instructions for where to find more information regarding organ donation, such as a website, and along with this information will be information regarding both the prioritization incentive and the positive default status for organ donation, which gives you a far-reaching response rate for explicit consent.255 (It is explained below how a positive default status is consistent with a mandated choice approach.) Since there will already be information regarding the CLOD tax deduction and credit on the income tax return and the ACA has already established precedent for conducting this type of business on income tax returns, i.e. inquiring about one’s health insurance status, it seems that the mandated choice question for cadaveric organ donation should necessarily be on income tax returns, perhaps in addition to other state-issued forms to ensure widespread coverage.256

This type of system has two main advantages. First, this system increases the percentages of explicit consent from the actual donor, rather than a presumed consent or consent from the family, because you mandate the choice to be made by individuals themselves. This is ideal, because it is uncertain how many families really understand the preferences for organ donation
of the potential donor, which could lead to wasted organs and violated preferences or, even worse, organ donation from someone opposed to donation. From 2010 to 2016, the NHSBT estimated that 1,200 people missed out on life-saving organ transplants due to English families vetoing approximately 547 potential organ donation cases. The question is this - how many of those 547 patients truly did have a preference for organ donation that was missed out upon due to the family misjudging their preferences? With this system, though, that won’t be a worry for the majority of cases, because the health team will have either explicit consent for or against donation, which will ultimately keep the family from having to make yet another tough decision. The explicit choice of the individual should also be honored in both brain death organ donation cases and DCD cases, where possible.

The second major advantage of this system is its ability to lessen the ethical concerns with default settings of presumed consent, which is ultimately how a positive default status is consistent with a mandated choice approach. As stated above, the main ethical issue with presumed consent legislation is that it seems to go against some deeply-rooted ideations about individuals’ sovereignty over their own bodies, and it is argued that it does not respect individual autonomy and individual sovereignty to presume a preference for organ donation across a population. However, in this system actual donation based on presumed consent would be at an absolute minimum, because most of the given population would be mandated to give an explicit preference to donation. Though since no system is perfect and reaching every single member of a population isn’t really feasible, we would have to rely on the family of the patient to decide upon organ donation, under a substituted judgment standard.

Still, though, there might be exceedingly rare cases where a patient meets the criteria for organ donation, a mandated preference is not on file, and no family can be located. This would
be the only time that presumed consent would be used on a patient, and it’s not like there isn’t a precedence for this type of thing either. The Anatomy Act in several Indian states allows unclaimed bodies to be given to medical and teaching institutions for anatomical examinations and teaching purposes. Many states in the US have similar policies, including West Virginia, whose Department of Social Services has a detailed policy regarding offering unclaimed bodies to the Anatomical Board of Gift Registry after a search for an advanced directive, next of kin, and authorized representative has come up empty and the individual is to be buried at the public expense. So given these realities, a fairly persuasive argument can be made that those brain dead patients whom cannot be claimed become the responsibility of the state, and consent can be presumed on the basis of the best interests of the state as a whole.

Thus, this is essentially the justification for having a positive default status combined with a mandated choice approach. Ideally, the State tries to elicit explicit preferences from patients themselves regarding donation, and if that fails, then family members become the primary decision-makers regarding donation. If no family is present, then consent is presumed based on the responsibility and interests of the State, as there is precedent for in other contexts. Utilizing this positive default status as a nudge would then entail presenting this default setting to the individual as the “status quo” when they are making their decision. For example, the question could say something like: “Though we first try to elicit and rely on (1) you or (2) your family’s preferences for organ donation, the default option when these preferences are unknown is a willingness to donate your organs upon your death. Would you like to change this donation status now, or would you like to continue your willingness to organ donation?”

This would essentially be a modified version of a soft opt-out donation format that would proactively try to elicit and mandate donation preferences from individuals. When the individual
has not given their preferences, then the default setting would also be of use to organ
procurement specialists in their attempt to get the family to agree to organ donation. By
informing the family of its default status, you take advantage of the status quo bias and greatly
increase the likelihood of an affirmative decision for donation. Therefore, by adjoining the
mandated choice philosophy with the nudges of the default/status quo bias and prioritization,
cadaveric organ donation can be effectively incentivized, and we can enhance and protect
individual autonomy by ensuring that individuals’ preferences are being met by garnering
explicit consent for or against organ donation in much larger percentages. And by connecting
this cadaveric organ donation proposal with the CLOD proposal, along with the promotion of the
types of IDOD mentioned above, the United States organ donation system becomes completely
revamped and updated, and it constitutes a significantly more ethical and efficient system to
effectively serve the needs and respect the dignity and autonomy of thousands upon thousands of
Americans across our nation.

To conclude, this first chapter has laid the groundwork for an expanded argument of the
thesis throughout the rest of this dissertation. The remaining chapters will be dedicated to
expanding upon the brief introductory analysis contained within this chapter, and each chapter
will systematically address the complex philosophical, ethical, and practical issues that are
associated with the concept of CLOD. It is my hope that the remaining chapters provide a cogent
and compelling argument against the moral justification calling for a prohibition of CLOD.
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Chapter 2 - Practical Need for Compensated Live Organ Donation

The starting point of every argument for compensated living organ donation (CLOD) begins with the practical need for a market in organs, especially kidneys due to their ability to be procured from live patients. Primarily, this practical need concerns the major disparities between organs needed and organs available and the significant waiting times for organ transplants, including: over 120,000 Americans currently on organ waiting lists; over 100,000 of those Americans on the kidney waiting list alone; and a median wait time of 3.6 years for one’s first kidney transplant. However, this significant practical need has many contributing factors, including the failure of both cadaveric and altruistic modes of organ donation to effectively meet the organ supply, and when these failures are combined with the practical effectiveness of financial incentives for live organ donation that has been well documented in many instances across the world, a practical argument for CLOD is created. Further, considering the emergence of regenerative medicine and its possibility of relieving the mass organ shortage in the near future, along with its conceptual similarities to CLOD, a moral argument is also present in favor of the possibility of a regulated market of CLOD in the United States.

This chapter focuses on the background and practical and moral contexts for the possibility of establishing a regulated system of CLOD in the classically liberal society of the United States. Specifically, the chapter first looks backwards in time at numerous differing systems and policies of organ donation throughout the world and history of organ donation, and it is highlighted how cadaveric and altruistic means of organ donation have long been insufficient to effectively manage our transplantation needs. Next, the chapter moves to the present time and analyzes several differing current models of organ transplantation to highlight the effectiveness of financial incentives, and other types of incentives, in increasing organ
donation rates in the organ donation process. It then looks forward in time to the developing field of regenerative medicine and discusses how this promising field might ultimately alleviate mass organ shortages. Finally, the chapter ends by defining the moral obligations that we have as a society to at least consider the possibility of a regulated market of CLOD, and the medical, moral, and political contexts for such a regulated market in a pluralistic, classically liberal society are spelled out and analyzed.

2.1) Present and Past Systems: Efficiency

To begin the practical argument for the necessity of a market in organs to effectively service our growing organ needs, it is necessary to examine some examples of both non-compensated and compensated systems of organ donation of the past and present. These systems range from non-compensated, altruistic cadaveric organ donation to compensated cadaveric organ donation to compensated live kidney donation. After this examination, it will be sufficiently clear that altruistic measures are not sufficient to effectively serve our organ needs.

2.1.1) Non-Compensated Systems of Cadaveric Donation

The traditional format for cadaveric organ donation consent is known as an opt-in consent system. Also referred to as an explicit consent system, this consent system requires individuals to “opt in” to become a donor, hence its name. Opt-in systems come in soft and hard formats. Soft opt-in formats generally allow the deceased’s family to have the final say regarding the organ donation, even when the deceased individual opted in to become a donor; whereas, hard opt-in formats do not allow the deceased’s family to stop organ donation from an individual who has opted in, though these formats are rare.264

Though an explicit, active choice is inherent to the opt-in philosophy, these systems have been implemented in various different ways across the globe. For example, in the UK individuals
must opt in to the Organ Donor Register or carry an organ donor card if they wish to donate their organs after death. However, since this rarely happens the deceased’s family is oftentimes the ultimate decision-maker in whether or not to donate the deceased’s organs. Of course, it should be noted that not all of the UK is like this, because Wales recently converted to an opt-out system in December of 2015. Further, though it does not have a national registry, Germany employs a similar explicit consent system. To be an organ donor, a form known as the “Organspendeausweis” must be filled out for an individual to register as an organ donor. The form can also serve as an objection to organ donation or as an avenue of selecting a surrogate to decide for you. Things are similar in the United States, because in most states Americans must actively fill out a form or registration if they desire to become an organ donor. However, in some states the organ donor decision is required on state-issued forms. In the state of Illinois, for example, to receive your driver’s license you must indicate whether or not you would like to sign up to be an organ donor. This type of consent system is known as “mandated choice” or “required consent,” and it has given Illinois a 22 percent higher donor signup rate than the national average. We’ll talk more about this type of consent system in a later chapter.

A more modern system of cadaveric organ donation, the opt-out consent system is the counterpart to the opt-in consent system. Also known as a presumed consent system, this system presumes that individuals consent to cadaveric organ donation, and only those who have “opted out” of organ donation will not have their organs donated upon death. Like opt-in systems, opt-out systems come in several different formats, including hard, soft, and hard-group formats. Hard opt-out formats allow physicians to remove the organs of every individual that has not registered to opt out of organ donation after death, even when the family objects and knows that the individual would not have wanted her organs removed. Hard group opt-out formats function the
same as hard opt-out formats, but certain preselected groups, such as religious groups opposed to organ donation after death, are excluded from donation. Soft opt-out formats take the opposite approach, because they allow the deceased’s family to override an unwanted donation, even when the individual did not opt out of organ donation after death.269

Though less varied than opt-in systems, opt-out systems still do contain a level of variance in how they’re implemented, as evidenced by the distinctions between the differing formats. For example, Austria’s hard opt-out format passed in 1982 legally gives doctors the right to remove organs from every individual who has not recorded their objection with the national registry, even if the family objects. In practice, though, it’s believed that doctors generally succumb to the family’s wishes in order to keep the public perception of cadaveric organ donation high. In Belgium, their 1986 Law on the Removal and Transplantation of Organs enacted a soft opt-out format. Though this doesn’t hold when the deceased has given explicit consent for organ donation, this format allows the deceased’s family to override an organ donation if the individual had not opted out into the national registry, giving only presumed consent.270 Spain also employs a soft opt-out format, but one major difference distinguishes Spain’s system from Belgium’s system. Where in Spain it is expected for the doctors to explicitly ask the deceased’s family about organ donation, in Belgium this is neither expected nor required, which distinguishes between these two similar types of soft opt-out cadaveric organ donation systems.271

Intuitively, it would seem that opt-out systems are more efficient than opt-in systems at increasing the organ supply. In 2002, thirteen out of the top fifteen nations in number of people donating organs per million were nations with opt-out systems, including Spain, Austria, and Belgium making up three of the top four nations.272 Ten years later in 2012 the disparity between
the two systems is even greater with the opt-out systems of Spain (35 people per million), Croatia (34 people per million), and Belgium (30 people per million) producing many more viable organs than the opt-in systems of the US (25 people per million), UK (18 people per million), and Germany (12 people per million).²⁷³ This was further verified in a recent international study on the effects of opt-in versus opt-out legislation on the actual numbers of organ donation. It was found that opt-out systems of consent lead to more cadaveric organ donations than opt-in systems of consent, and opt-out systems also provide the highest cumulative numbers of organ donations, including both cadaveric and live donations, though interestingly there was a correlation between opt-out systems and lower rates of live organ donation.²⁷⁴

However, others have recently challenged this claim on two main fronts. First, some argue that the apparent necessity to receive the deceased’s family’s permission for donation, even in opt-out countries, is just as much of an obstacle for opt-out systems as opt-in systems. Second, others argue that outside contextual factors are also at play beyond the differences in consent. For example, some studies have suggested that the difference between donation rates in opt-in countries versus opt-out countries is negligible after controlling for the differences in each country’s relevant mortality.²⁷⁵ Other contextual factors might be the environment of organ donation, including the attention paid towards organ donation and its priority within the nation. Many point to the very active and energetic approach that Spain took towards organ donation to show that other contextual factors are in play. Whatever the case may be, though, it is undeniable that neither system can effectively eliminate or greatly reduce organ waiting lists on their own, and both systems ultimately require live donors to meet their quota.²⁷⁶ In fact, Sigrid Frye-Revere reports that even under the most optimistic of predictions that consider all potential
cadaveric donors as actual donations where kidneys are procured, less than 1/3 of the United States kidney waiting list would be eliminated, which highlights how cadaveric organ donation, especially altruistic cadaveric organ donation, is simply not a viable method in itself to satisfactorily minimize organ waiting lists, even with the aid of altruistic live donations.\textsuperscript{277}

\textbf{2.1.2) Compensated Systems of Live Donation}

Outside of cadaveric organ donation, there have been numerous examples of systems of CLOD in recent history. For example, at one time India had a robust kidney bazaar, or market, and their system represented one of the most thriving true open market for kidneys in the world. Rather than putting forth regulation regarding the terms, limits, and procedures for organ sales, India merely didn’t prohibit the sale of organs through legislation, and this led to a true open market on organs without regulations in place to restrict prices or practices. This allowed the economic principles of supply and demand to really guide market prices and practices, and it led to India becoming one of the largest transplant centers in the world with low organ prices, specifically for kidneys, and almost immediate organ availability.\textsuperscript{278} India’s reliance on the sale of organs during this time was due to the lack of brain-death criteria for cadaveric organ donation and large cultural taboos that disapproved of the act of obtaining organs from cadavers.\textsuperscript{279} In fact, the general public had a supreme disapproval of cadaveric organ donation. At that time, the process of cadaveric donation was thought of as neo-cannibalism, and this significantly restricted the use of cadaver organs for transplantation until the Transplantation of Human Organ Act established brain-death criteria in 1994, even though kidney transplants from live donors had been prevalent since the 1970’s.\textsuperscript{280}

However, major ethical and human right abuses were soon observed, and they eventually caught up with this open market that relied on organ trafficking, which is defined as:
…the recruitment, transport, transfer, harboring, or receipt of living or deceased persons or their organs by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability, or of the giving to, or the receiving by, a third party of payments or benefits to achieve the transfer of control over the potential donor, for the purpose of exploitation by the removal of organs for transplantation.281

Organ trafficking is generally administered and utilized by organ brokers, and these individuals would connect, and sometimes coerce, poor Indian individuals with wealthy Indian residents, and even non-residents. These buyers would regularly pay anywhere from $2,500 to $4,000 for a kidney, and the actual donor would receive less than $1,000 with the broker pocketing the rest. Oftentimes, though, the broker would “stiff” the donor, who would then not receive any compensation at all for donating their kidney.282 In addition to ethical problems of non-payment, reneging on promises and contracts, and coercion of donors, problems of informed consent and exploitation also arose from this open market. Many donors did not give proper informed consent to donating their kidney, because they did not fully understand the information presented or, even worse, were not even informed about the procedure. Many other human rights violations also accompanied these abuses in this open market.283

After years of social pressure from the West over their allowance and tolerance of the abuses going on in their organ trade, Indian leaders finally decided to prohibit unrelated live organ transplants in their Transplantation of Human Organ Act of 1994. This Act prohibits living organ donation from anyone that isn’t a first relative of the recipient, though exceptions can be made when a first relative isn’t available or willing to donate an organ. In addition to this prohibition, the Act also established brain death criteria, which set a precedent for cadaveric organ donation from brain-dead patients that was not an option earlier.284 The problem with this Act is the significant loophole that many brokers are still using to make money off of kidney transplants. When first relatives aren’t available for organ donation, exceptions can be made by authorization committees of hospitals for a non-relative donor, as long as the intent is altruism

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and not financial gain. Kidney brokers then use this exception to their advantage, and they coach up clients to be able to fool these committees. Almost all of these committees end up approving the non-relative donation, because it brings quite a bit of money and resources to their hospitals. This is all in addition to India’s underground organ trafficking and black market in kidneys that are transplanted in “back-alley clinics” and clandestine transplant centers that don’t even bother to go this route. Thus, though officially prohibited in India, many of India’s poorest are still selling their organs through black markets or the fooling of authorization committees.285

In a similar sort of situation, the Philippines also employed a system of compensated donation that received worldwide attention. Ferdinand Marcos, the notorious leader and dictator of the Philippines from the 1960’s through the 1980’s, suffered from kidney disease, and this prompted him to establish impressive medical institutes dedicated to kidney health and transplants. In fact, he even had two kidney transplants himself and eventually died from kidney ailments. This created an atmosphere in the Philippines that supported kidney transplants and the selling of organs. Though also occurring during this time, the Philippines’ organ trade did not really take off and receive worldwide attention until 1999 when a Manila television reporter filmed a television program based on the local organ trade.286

This television program spiked a huge increase in organ sales and trafficking activities, and the Philippines’ poor became a main target of organ brokers. These brokers would go to poor villages and slums to perform blood tests on potential donors and get their medical and contact information, and when a tissue match came in needing a kidney the potential donor was notified.287 This type of organ sale become so rampant and out of control that the Philippines government issued an administrative order to form a program to govern sales that aimed to curb these cases of organ sale that didn’t meet professional and ethical standards of transplantation.
This program was called the Philippine Organ Donation Program (PODP), and the program and administrative order actually explicitly stated that the sale and purchase of kidneys was prohibited. However, this was in theory only, because the program also established a “gratuity package” for donors as an incentive. This package included lost wages compensation, a stipend for livelihood assistance, and life insurance. Between the lost wages compensation and the stipend for livelihood assistance, the amount came out to roughly PhP 175,000. During this time, the annual family income average of the Philippines was about PhP 172,000. Thus, this package provided a large financial incentive for donors, and it ultimately amounted to a government-approved system of kidney sale, of course without the necessary safeguards, oversight, and regulations that have been effectively utilized elsewhere.288

Though the PODP’s establishment in 2002 was aimed towards the goal of curbing organ trafficking and transplantation outside of federally regulated standards, hospitals, and transplant centers, it performed this aim poorly and had virtually no effect. In fact, the Philippines government had to issue an Anti-Trafficking in Persons law just a year later in 2003 to try and further curb this illegal and abusive trafficking activity that did not adhere to federally regulated standards. Rather than stopping the organ trade that the government felt was good for their nation altogether, the law illegalized the act of using force, coercion, violence, or deceit in the procuring of organs from individuals.289 Predictably, though, this law also failed as a deterrent for organ trafficking, and though several cases have been filed in court, to date no convictions have been brought against organ traffickers from this law. While trying to force more transplants through the PODP, the laws actually had an opposite effect creating a much larger trade outside of the PODP. For example, from 2004-2006 1,182 unrelated kidney donations were registered through
the Philippine Renal Disease Registry (PRDR), but only 97 of those were completed through the PODP.²⁹⁰

Part of the issue surrounding the prevalence of organ trafficking outside of the PODP can be attributed to a certain regulation of the PODP that limited the number of transplants to foreign recipients to ten percent of each transplant facility’s total number of annual kidney transplants. The problem with this regulation was that most Filipinos were poor and could not afford to buy a kidney without charitable relief, so a vast majority of the kidney buyers came from foreign countries to buy kidneys from the Philippines. This is highlighted in the statistics that show a 1,200 percent increase in foreign transplants from 2002-2007 with over half of the transplants going to foreign recipients during this time. This led the World Health Organization (WHO) in 2007 to include the Philippines on the list of five nations of “organ trafficking hotspots.”²⁹¹

This practice of transplantation to foreign recipients from local donors is known as transplant tourism, and it is one of the most significant bioethical issues within global ethics and transplant ethics. This practice usually involves individuals who need a kidney transplant coming over from a country that doesn’t allow organ sale to the Philippines where they can legally buy themselves a kidney for transplantation. These individuals are usually motivated by long organ waiting lists in their home country and the lack of an opportunity to buy an organ from another due to their country’s prohibition. This is an extensive process that usually involves organ brokers and other health care professionals to manage the procurement of the organ, the exchanging of money, and the scheduling and location of the transplant.²⁹² This practice continued and thrived in the Philippines from 2002-2008. In 2007, the Philippines Department of Health tried revising the PODP to cut back on commercial organ transactions for foreign recipients, but pressure from groups such as the WHO eventually forced the President of the
Philippines to enact a direct ban on all kidney transplants from unrelated living donors from the Philippines to foreign recipients. Though this ban still stands, a high poverty level and high corruption index suggests that transplant tourism still exists outside of the law in the Philippines, and illegal organ trafficking is still present in the black market sale of organs there today.293

Another recent example of an open, unregulated market in human kidneys is Pakistan. In many ways, Pakistan’s situation largely mirrored the Indian situation, because Pakistan was a true open market in kidneys without any national laws regulating the process, just like in India prior to their Transplantation of Human Organ Act of 1994. Further, Pakistan’s reliance on live organ donation was a result of the lack of a national system of cadaveric organ donation, largely due to cultural and religious objections to the practice, just like India.294 At first, these live kidney donations were primarily between Pakistani family members; however, these statistics changed from 75% between Pakistani family members in 1991 to 80% between unrelated donors in 2003, and 50% of these recipients were foreign nationals, meaning transplant tourism was a major issue. This change from altruistic donation to commercial donation largely coincided with an increasing number of private hospitals offering “transplant packages” that would charge kidney recipients between $13,000 and $27,000 for a kidney transplantation, which obviously attracted many wealthy foreign nationals to Pakistan.295

Noting these drastic changes from altruistic to commercial donations and the large incidences of transplant tourism, the Pakistani government was subject to extreme pressure and scrutiny from both national and international sources of the press, in addition to influential international organizations, like the WHO. This finally led to a presidential ordinance known as the Transplantation of Organs and Tissues Ordinance, 2007, though it was vigorously fought by many in the transplant community, even to the point of one petition being filed claiming the
Ordinance violated Sharia law and was therefore unconstitutional. But this petition was struck down, and the Ordinance was unanimously ratified into law in 2010 by the National Assembly and Senate of Pakistan in 2010. This Ordinance ultimately:

…supported living related donation, recommended deceased donor programs, criminalized transplantation of organs from Pakistanis into foreigners with stiff fines and imprisonment for those convicted of these offences, and ordered the setting up of a national registry and oversight body (HOTA—Human Organ Transplantation Authority) at the federal level.296

Soon after the ratification of the Ordinance, there was a marked drop in transplant tourism operations, but in recent years there have been increasing reports of transplant tourism making a comeback in Pakistan, albeit in a much smaller scale. In addition to the Human Organ Transplantation Authority being inefficient and subject to corruption, this is primarily due to the continued cultural and societal resistance to cadaveric organ donation in Pakistan, which thwarts any attempt to firmly establish a national, robust system of cadaveric organ donation. Further, misconceptions regarding the harms of live, related kidney donations are widespread. Thus, with the lack of a cadaveric organ donation system and a lack of trust and knowledge regarding living, related kidney donations, the black market, organ trafficking, and transplant tourism are still alive and present in Pakistan today.297

Another national example that suffers from transplant tourism, organ brokering, organ trafficking, and a black market in organs is Bangladesh. Organ sale has been illegal in Bangladesh since 1999 with the passing of the Organ Transplant Act by the Bangladeshi Parliament. Violations of this law are punishable by imprisonment of up to seven years and a minimum fine of 300,000 Taka, which is around $3,800 today. However, Bangladesh’s underground organ trade is still robust and growing, and like the examples of India and Pakistan above, this is largely due to a significant poor population in Bangladesh and the virtual absence of a cadaveric organ donation program. This underground organ trade takes many different forms, too, including foreign nationals coming to Bangladesh for transplant tourism, domestic
organ trafficking with both the recipient and donor being Bangladeshi and having the transplant procedure in Bangladesh, and international organ trafficking where the recipient and donor travel to another country, usually India, for the transplant procedure. Moniruzzaman’s ethnography studied the plight of these Bangladeshi compensated kidney donors, and as seen in the organ trafficking in India’s open market prior to legislation, many accounts of exploitation, broken contracts, and coercion were reported from these donors about both organ brokers and the organ recipients. Clearly, open, unregulated markets and black markets are not effective, safe, or ethical methods of CLOD, especially for the donors themselves.

Unlike these previous four national examples of open organ sales, transplant tourism, and/or black markets in organs that are generally considered failures and required legislation to prohibit and/or substantially limit their usage, the remaining two national examples actually demonstrate more effective means of CLOD. For example, the Iranian kidney donation and transplantation system has evolved drastically for the better in the last fifty years. Originally, Iran was part of the Eurotransplant Network, and Iranian patients would either go abroad for a transplant or, in rarer cases, have a cadaver organ sent to Iran for transplantation. However, the Iranian Revolution in the late 1970’s collapsed this relationship, and due to certain cultural taboos and a lack of infrastructure and resources, a living rather than cadaveric organ donation system was implemented to serve their organ, specifically kidney, needs. Similar to India’s previous system, the Iranian system originally functioned as an unregulated international market that was welcome to anyone willing to pay the price and do the work of finding a suitable kidney match. Medical professionals initially “looked the other way” regarding this blatant form of organ sales, but over time they began condoning and ultimately accepting the practice. Beginning in the late 1980’s and early 1990’s, however, many noticed numerous problems with this open,
unregulated practice, including reneged promises from both donors and recipients, coercion, and other administrative issues that overly complicated the process, and Iranians began to contemplate regulating this compensated donation system in order to address these problems.299

Thus, the Iranian parliament and Ministry of Health ultimately started to get involved with the practice. By the late 1980’s, the Ministry of Health was compensating donors out of its own budget, and by 1995 this practice was formalized by law with its own budget and organization responsible for compensating donors, known as the Charity Foundation for Special Diseases. Further, in the early 1990’s the most profound development occurred in the licensing of Non-Governmental Organizations (NGOs) to ultimately administer and regulate the everyday processes of kidney donation, procurement, and transplantation, along with the compensation that came with the donation. These NGOs, known colloquially and collectively as the Anjomans, function primarily in the same way that an Organ Procurement Organization (OPO) does in the United States in the administration of cadaveric organ donation, though they also have the responsibility of writing contracts, holding money in escrow, and providing social services to both the recipient and donor, since live donation contains two separate living parties.300

Today, the Iranian system is a tightly regulated system that is seen by many as a good, though not perfect, model of a functioning system of CLOD, and it has effectively eliminated the Iranian kidney waiting list since 1999.301 The Anjomans register the statistics and information of both candidates for kidney transplants and willing donors into a database to find a match for each party. After obtaining the proper consents, the matched pair is introduced to each other, and the pair comes to an agreement on an acceptable price to be paid from the recipient of the kidney to the donor of the kidney, which is separate from the payment given from the government.302 The role of the Anjomans and other NGO and charity organizations that also help with the matching
and financial components of the practice cannot be overstated, because their involvement cuts out the “middle-man” of organ brokering and trafficking. This greatly lessens the chances of corruption, favoritism, and exploitation, because no conflicts of interest will occur if these organizations and the transplant teams have no financial ties to the matching of the pair.303

After the matching of the two parties and they’ve agreed on an acceptable payout from the recipient to the donor, the kidney transplant takes place, which is paid by health insurance agencies and the Iranian Ministry of Health and Medical Education.304 Once completed, the NGO Charity Foundation for Special Diseases rewards the kidney donor for their gift with further monetary compensation, known as the “gift for altruism,” in addition to a one-year free medical insurance voucher and an exemption from Iran’s mandatory two-year military service for men.305 To ensure proper protocols, fair payment, and ethical application, all transplantation centers and compensated kidney donations are located and performed in university hospitals under close supervision of the Ministry of Health and Medical Education. Iranian compensated kidney donation is further exclusively limited to Iranian citizens, and foreigners must provide a donor from their own nationality in Iran, which disallows the highly controversial practice of transplant tourism within Iran.306

Though this model has been successful in eliminating kidney waiting lists and keeping organ brokers and the black market at bay, it does have several weaknesses that should be amended in any updated model. First, the model relies on an extreme form of bodily commodification that comes from the dual direct quid pro quo agreements of cash for kidneys – the “gift for altruism” and the negotiated amount paid from the recipient to the donor. Ideally, any updated model would find a way to financially incentivize donation in a more ethically palatable and less controversial way. Second, there is significant leeway given to interpretation
and implementation of the process of CLOD among the various differing Anjomans, provinces, and even healthcare institutions in Iran, which leads to various differing implementations and formulations of the larger “Iranian model” across the nation. For example, the most extreme example of these variations is in Shiraz where there is no outside payments from recipients to donors allowed, and the governmental “gift for altruism” is considered more as a reimbursement for donation-related expenses than a payment, which is a significantly different conception of the practice than described above. And this is where much of the conflicting literature on the Iranian model stems from, because differing formulations and implementations of the laws ultimately leads into differing observations and effects. Further, these differing interpretations and implementations of the practice ultimately open up the possibility for corruption, abuse, and trafficking between provinces and different areas of Iran, so an ideal model would create a more static and strict implementation of the practice across a nation.

Finally, the last system to examine is that of Israel. Of all the developed nations of the world, perhaps none is as notorious in their hesitancy towards organ donation as Israel. This traditional aversion to organ donation has several causes. First and foremost, many traditional, orthodox Jewish groups reject brain death criteria as a valid determination of death, which virtually destroys any chances of cadaveric organ donation. Similarly, a second reason involves a seemingly hypocritical, “free riding” type of philosophy that many Israelis hold to. For example, many Israelis refuse to be organ donors themselves, via rejecting brain death criteria; however, they still allow themselves to be active candidates to receive organ transplants. Last, due to these first two reasons, Israeli medical insurance agencies have traditionally generously reimbursed those Israelis who travel abroad to receive organ transplants, because usually organs aren’t available within Israel itself.
Unlike Iran, though, Israel does not actively compensate organ donors with cash incentives. Rather, they compensate donors through financial reimbursement of lost wages and expenses and other non-financial incentives. In fact, one of the main incentives for registering as an organ donor is the non-financial incentive of gaining prioritization during situations of organ allocation. Basically, differing levels of prioritization for organ allocation will be given based upon one’s willingness to be an organ donor. For example, those Israelis who have signed an organ donor card or have given permission to donate the organs of a recently deceased first-degree relative will be given priority in organ allocation over those who have neither signed an organ donor card nor gave permission to donate the organs of a deceased first-degree relative. Furthermore, even first-degree relatives (children, spouse, siblings, etc.) of those who have signed an organ donor card are given priority in organ allocation, though it is less priority than actually signing the organ donor card oneself. This prioritization has also recently been extended to past live organ donors who are now in need of an organ themselves. This whole notion of helping those who are willing to help others is derived from the ethical rule of reciprocal altruism, and it has provided an attractive incentive for those willing to sign organ donor cards.

In addition to granting prioritization in matters of organ allocation to those who agree to sign an organ donor card, financial reimbursements are also granted to altruistic living donations that are approved by the national ethics committee. Salary reimbursement is granted on an individual basis for up to forty days of lost wages, and it is based on the average amount made during the three months immediately prior to the donation. Transportation and transplant medical costs are also reimbursed, including recovery medical costs and up to five psychological consultations. Last, reimbursements are made for five years’ worth of work capability loss and
life/medical insurances. Essentially, live organ donors are compensated for their altruistic organ donation by being granted five years of free life insurance and medical insurance, which are refunded and reimbursed unto the individual upon submission of receipt of payment. These non-financial incentives and financial reimbursements are meant to incentivize both cadaveric organ donation and live organ donation, while also discouraging the behavior of “free-riding” that is so prevalent within Israel.  

It is then clear to see that financial, and even certain non-financial, incentives for organ donation are effective ways to increase organ donation rates. In both Iran and Israel, the rate of organ donation was dramatically increased by the implementation of compensated donation. In Israel, both the number of deceased organ donors and the number of new organ donor cards signed monthly rose sharply after the implementation of the new law. In Iran, their single greatest achievement is the elimination and lack of a renal waiting list since late 1999. Further, it is also clear that regulated systems of CLOD, such as Iran’s current system, are far superior to the open, unregulated systems of CLOD, such as those that were present in India, the Philippines, Pakistan, Bangladesh, and even early Iran, where coercion, trafficking, exploitation, and black markets ultimately thrive. Thus, there is a significant practical argument for the adoption of a regulated system of CLOD in the United States. But before moving on, further practical and ethical considerations must be discussed regarding regenerative medicine and the future of organ donation and transplantation, because these considerations ultimately bolster the practical argument and initiate the ethical narrative that describes our obligations and limits regarding a regulated system of CLOD in the United States.
2.2) Potential Future Options

Though the Human Genome Project has brought much public interest to the study of genetics in the past 25 years, many people are unaware of the tremendous practical value that fruitful research in genetics can bring to the human race. This is especially true in the newer and younger realms of regenerative medicine, tissue engineering, and xenotransplantation, because the advancement of fruitful research in genetics, specifically regarding embryonic stem cells and other pluripotent stem cells, can have life-changing results for millions of people who suffer from organ and tissue ailments that must be repaired.314

2.2.1) Stem Cells and Regenerative Medicine

Being a very young field of study, there is yet to be one widely accepted definition of regenerative medicine, but one definition that broadly encompasses the far-reaching aims of the new study of regenerative medicine defines the concept thusly:

Regenerative Medicine is an emerging interdisciplinary field of research and clinical applications focused on the repair, replacement or regeneration of cells, tissues or organs to restore impaired function resulting from any cause, including congenital defects, disease, trauma and aging. It uses a combination of several technological approaches that moves it beyond traditional transplantation and replacement therapies. These approaches may include, but are not limited to, the use of soluble molecules, gene therapy, stem cell transplantation, tissue engineering and the reprogramming of cell and tissue types.315

In addition to being a comprehensive definition of regenerative medicine, this definition also makes distinctions among three different approaches of regenerative medicine: rejuvenation and repair, replacement, and regeneration. The first approach of rejuvenation and repair relates to the body’s ability to heal itself. It has recently been found that certain specialized cells in the body that were once thought to be terminally differentiated can be remodeled in a way to promote self-healing, and these even include highly specialized cells in the lungs, nerves, and heart. Thus, by remodeling these cells and enhancing the self-healing process, organ and tissue ailments can be, at least somewhat, alleviated by natural processes of the body. The second
approach of replacement is well-known in our society, because it focuses on organ and tissue transplantation. This approach aims to find methods that overcome issues of immunosuppression, host organ rejection, and organ and tissue donor shortages.\textsuperscript{316}

The third approach of regenerative medicine is regeneration, which is the most promising approach. Regeneration can come in a couple of forms. The first form is tissue engineering, and this function essentially combines scaffolds, i.e. a natural or artificial framework to grow tissue on to mimic biological processes, cells, and biologically active molecules into tissues that may be used to repair or improve damaged organs and tissues within the human body.\textsuperscript{317} The second form is simply referred to as regeneration, and it focuses on the utilization of stem cells to restore and regenerate organ and tissue function, usually via cell-based or genetic therapies. Thus, stem cells play an extremely important role in the realm of regenerative medicine, especially in therapies that repair, regenerate, and improve organ and tissue maladies.\textsuperscript{318}

Since the discovery of the technique to isolate and grow human embryonic stem cells in 1998, the nature of stem cells has been one of the main focuses of genetic research due to the tremendous potential that stem cells have for human health.\textsuperscript{319} Two main characteristics distinguish stem cells from the other cells that make up our body, and it is due to these characteristics that stem cells contain so much potential for medicine:

1. they can divide to produce copies of themselves (self-renewal) under appropriate conditions and
2. they are pluripotent, or able to differentiate into any of the three germ layers: the endoderm (which forms the lungs, gastrointestinal tract, and interior lining of the stomach), mesoderm (which forms the bones, muscles, blood, and urogenital tract), and ectoderm (which forms the epidermal tissues and nervous system).\textsuperscript{320}

The most well-known and discussed source of stem cells in the human body is embryonic stem cells. Embryonic stem cells are harvested from the inner cell mass of the blastocyst before these cells have had a chance to differentiate and specialize. These embryos that the embryonic stem cells are harvested from come from the process of \textit{in vitro} fertilization (IVF), either from
left-over fertility treatments or egg and sperm donations, which are grown in extremely intricate cultures that allow the zygote to develop into the blastocyst that provides the inner cell mass of stem cells. There are several other ways of harvesting stem cells, or stem cell-like cells, from embryos, too, including harvesting stem cells from “dead,” i.e. non-dividing, or genetically abnormal embryos, i.e. IVF embryos that have a genetic disorder, isolating primordial germ cells from older (five to seven weeks) embryos to create embryonic germ cell lines, utilizing single cells from embryos to create embryonic stem cell lines, and using parthenogenesis to create stem cell lines from unfertilized ovum.

Though being potentially extremely valuable for medicine, embryonic stem cells are not without their fair share of controversy. Though several methods of harvesting stem cells without destroying the embryo have been proposed, including utilizing single cells from embryos to create embryonic stem cell lines and using parthenogenesis to create stem cell lines from unfertilized ovum, certain ethical and practical reasons have kept these methods from being clinically tested and proven, which means that harvesting embryonic stem cells still necessarily means the destroying of a human embryo. Obviously, this is very ethically concerning to many people. Another practical issue that hinders a widespread utilization of embryonic stem cells is the relative lack of efficiency in the survival rate of the cells, because the “process of generating an embryonic stem cell line is somewhat inefficient, so [embryonic stem cell] lines are not produced each time cells from the preimplantation-stage embryo are placed into a culture dish.”

These ethical and practical issues inherent to embryonic stem cells have led researchers to look for an additional source of stem cells. This search includes both identifying new, existing sources of pluripotent stem cells and possibly “reprogramming” non-pluripotent cells to become...
Amniotic fluid stem cells have proven to be a better, more practical, and more ethical option than embryonic stem cells, and they provide several notable advantages over embryonic stem cells: easily obtained, rich-sample resource, non-controversial ethically, and better histological matches with low immunogenicity, especially with skin grafts and transplants. Other reprogramming methods of turning non-pluripotent cells to pluripotent cells include reprogramming through altered nuclear transfer, cell fusion, and somatic cell nuclear transfer, though this latter option also includes destroying an embryo-like entity. However, the most exciting and promising new source of reprogrammed stem cells is the creation and discovery of induced pluripotent stem cells.

Induced pluripotent stem cells are created through nuclear reprogramming in vitro from mature somatic cells of an adult. This process involves introducing differing genes into the mature somatic cell “that encode critical transcription factor proteins.” By forcing these cells to express these new genes that are involved in the creation and maintenance of pluripotency, these cells can be reprogrammed into an embryonic stem cell-like state that is extremely similar to the actual functioning of embryonic stem cells. How similar these cells are to embryonic stem cells was once up for debate with many experiments showing subtle differences between the two, though it wasn’t known if these were actual variations or merely due to the handling and reprogramming of the induced pluripotent cells. However, a recent study has concluded that induced pluripotent stem cells are ultimately practically equivalent to embryonic stem cells, though there is still some work to do before induced pluripotent stem cells can totally erase the need for embryonic stem cells.

One difference that is thought to be known concretely is that induced pluripotent stem cells “appear to be truly pluripotent, although they are less efficient than ESCs with respect to
differentiating into all cell types.” But they do have other advantages over embryonic stem cells. For example, they expand the possibility of generating autologous cells for cell-replacement therapy, regeneration, and transplantation, which lessens the rejection concerns that are still apparent with therapies from embryonic stem cells. This advantage is discussed in more detail below. Induced pluripotent cells have also recently been shown to be able to be reprogrammed at much more efficient rates, with some experiments even reaching one hundred percent conversion rate at reprogramming these non-pluripotent cells into induced pluripotent stem cells. This is much more efficient than the relative inefficient nature of establishing and maintaining embryonic stem cell lines in even sophisticated cultures.

Thus, it is clear that stem cells are then very important in regenerative medicine as it pertains to organ failure, transplantation, and regeneration. This is due to several differing characteristics that make stem cells an ideal medium to use in regenerative medicine. Firstly, and most importantly, stem cells’ characteristic of pluripotency, i.e. their ability to differentiate into any cell type of the three germ layers of the endoderm, mesoderm, and ectoderm of the body, makes them immensely valuable in the pursuit of regenerating damaged tissues and organs. This process is known as cell-based therapy, and it is a treatment where stem cells are induced to differentiate into the specific cell type required to repair damaged or destroyed cells or tissues. The next section discusses cell-based and genetic therapies with stem cells in more detail.

Secondly, the fact that stem cells are able to proliferate, or replicate, themselves virtually indefinitely means that they are abundant, accessible, and practical to use, once it is figured out how to more efficiently proliferate stem cell lines. In an area where scarce resources are the norm, specifically in viable organs for transplantation, this virtue of stem cells cannot be stressed enough. And both of these characteristics, i.e. pluripotency and proliferation, are observed in
both embryonic stem cells and induced pluripotent cells, which makes both types of stem cells extremely valuable and useful in the realm of regenerative medicine. Finally, a third reason that induced pluripotent cells in particular are so valuable and important in regenerative medicine is the potential to generate autologous cells, i.e. cells obtained from the same individual that they are to be used in, for cell-based therapies, tissue engineering, and even xenotransplantation. Graft-versus-host disease and organ and tissue graft rejection are serious concerns in organ and stem cell transplantation, and these immunological concerns really hinder the efficacy and practicality of many types of transplantations and stem cell therapies. However, the promise of induced pluripotent cells is that transplants and therapies will be able to be “individualized,” i.e. the reprogramming of cells from individual patients themselves to use in their own therapies, which should create induced pluripotent cells that are immunological matches that avoids possible rejection by the immune system. Thus, stem cells can and will play a major role in the further development of regenerative medicine as a therapeutic tool for clinical application.

Now that it has been shown how important genetics and stem cells are for regenerative medicine’s application to organ failure, transplantation, and regeneration, we can look at some of the specific treatments and methods that will be available in the near future for clinical application to aid organ and tissue ailments. The main methods and treatments of regenerative medicine involve stem cell-based therapies, genetic therapies, and the use of biomaterials and scaffolds to artificially recreate tissues and organs for transplantation, and these three methods will most likely have to work together to create the most effective applications of regenerative medicine. Another related method of regenerative medicine is a concept known as xenotransplantation, which is the transplanting of organs or tissues from one species to another, usually from pigs or cows to humans.
2.2.2) Cell-Based and Genetic Therapies

Stem cell-based therapies are treatments in which stem cells are induced to differentiate into the specific cell type required to repair damaged or destroyed cells or tissues. In this regard, stem cell-therapy might work on two different mechanisms. First, they might work as “vehicles that deliver complex signals to a target tissue without actually integrating into the tissue itself.” Via this mechanism, stem cells actually function as drug-like entities to deliver drug-like effects, such as anti-inflammation, to the damaged tissues. There is even evidence of the efficacy of this mechanism in certain recent studies, though this is controversial because it is not well understood how this mechanism operates. Second, stem cells could also “restore tissue function...as integrated participants in the target tissue,” i.e. by ultimately becoming regenerated tissue of the targeted organ. Though there is still much to learn and many practical hurdles that keep this method from being a widespread clinical tool today, this second mechanism is the desired and overall better method that is hoped to become a practical reality in the near future. Rather than merely relying on some poorly understood beneficial side effects of stem cell-based therapies, actual diseased tissue, such as cardiac tissue, could be regenerated and replaced in the heart itself, and thanks to the promises of induced pluripotent stem cells, autologous cell replacements could ultimately make these therapies much more effective by eliminating the issues of immunosuppression and host rejection.

Though stem cell-therapies regenerating damaged heart or neural tissues are still a concept for the future right now, there are currently several stem-cell therapies that do effectively work under this second mechanism. The “gold standard” of this type of therapy is the transplantation of hematopoietic stem cells. Hematopoietic stem cells are multipotent cells ultimately responsible for the replenishing of the approximately one hundred billion new
hematopoietic cells that the body needs each day, because they are the only source of these cells for the blood system. These stem cells have several unique qualities: after proliferation each cell can choose between self-renewal and differentiation; they migrate in a regular and standardized fashion; and they’re regulated by apoptosis, or programmed cell death.345 In certain cancers and autoimmune diseases, the hematopoietic and immune systems can be severely damaged or dysfunctional and in need of replacement. By obtaining hematopoietic stem cells from bone marrow, peripheral blood, or “cord blood” from the placenta, these multipotent cells can be transplanted into the patient to replace their own host immune system. This transplant can either be autologous (host’s own cells) or allogenic (donor cells); however, the host’s immune system must be significantly weak enough with allogenic transplants to avoid graft rejection, which usually requires chemotherapy or radiation to attain the proper weakened status of the host immune system. Due to the danger and risks inherent to this process, the transplantation of hematopoietic stem cells are generally only used in life-threatening situations, though they still are an effective stem-cell therapy that work via this second mechanism.346

Stem cells are also useful in gene therapy. In genetic diseases where corrupted genes are responsible for an ailment, genetic therapies aim to replace the corrupted gene with its appropriate version through genetic intervention. By taking advantage of certain viruses’ ability to attach to a host’s DNA and supplant certain genes, gene therapy aims to use genetically-engineered viruses, which are modified to be not toxic or infectious, that are equipped with the healthy gene in order to replace the damaged or dysfunctional gene.347 This can be done in two ways: direct gene transfer or through living stem cells as vehicles for gene transfer. Direct gene transfer is a relatively simple process of the direct transfer of genes into the targeted tissues or organs. However, tissue or organ accessibility and the lack of control of gene integration really
limits the practical use of this method. By utilizing living stem cells as vehicles, though, such as hematopoietic stem cells, gene transfers can be manipulated in vitro, where genes are integrated much more efficiently, and then returned to the body. Additionally, the utilization of stem cells also retains “the ability to contribute to all mature blood cell types of the recipient for an extended period of time.” Embryonic stem cells and induced pluripotent stem cells are even more useful than adult stem cells as vehicles for gene therapy due to their unlimited differentiation abilities.348

In cases where hematopoietic stem cell transplants are not an option due to the severity of an immunodeficiency disease greatly increasing the risk of graft-versus-host disease, gene therapy is a life-saving alternative that doesn’t carry this risk.349 Additionally, a recent study has cured a genetic abnormality leading to cirrhotic liver disease by creating an induced pluripotent stem cell, replacing the genetic fault, and then converting or differentiating the cell into a liver cell, where the cells were working correctly six weeks later. The standard treatment for such a disease is liver transplantation, which also comes with a life-sentence of medication to prevent organ rejection. Thus, both cell-based and genetic therapies are extremely valuable methods for regenerative medicine to deal with issues of organ and tissue ailments and failures both now and in the future.350

2.2.3) Tissue Engineering

Though many tend to use the concepts of regenerative medicine and tissue engineering interchangeably, there are substantial differences between the two concepts. Primarily, the main distinction between the two concepts is that tissue engineering is actually just one of the primary and main components and fields of the overall larger discipline of regenerative medicine.351 Tissue engineering then “is an interdisciplinary field that applies the principles of engineering
and the life sciences toward the development of biological substitutes that restore, maintain, or improve tissue function.” In fact, tissue engineering can be seen as a middle ground option between the more fundamental aspects of regenerative medicine in stem cell-based and genetic therapies, where tissues and organs are regenerated, for the most part, *in vivo* from the application of stem cells, and the more practical and current aspects of allogenic transplants of whole tissues and organs. By utilizing “natural, synthetic, or semisynthetic tissue and organ mimics that are fully functional from the start, or that grow into the required functionality,” tissue engineering provides a middle ground option to grow tissues and organs *ex vivo*, most likely from autologous cells, that can then be transplanted into the individual.

The process of tissue engineering is rather complex, and it necessarily involves three different components, named the tissue engineering triad – stem cells, scaffolds, and growth-stimulating signals for the cells to grow. Scaffolds are similar to the extracellular matrix found surrounding most cells; in fact, they’re produced to mimic the functions of the extracellular matrix itself. There are several main functions of the extracellular matrix: to provide structural support for cells; to provide an environment for cells to grow, attach, migrate, and receive signals amongst each other; to give tissues their structural and mechanical properties; to provide bioactive cues to surrounding cells for regulation of cellular activities; to act as a reservoir of growth factors; and to provide a degradable environment that allows for neovascularization and remodeling in response to physiological, pathological, and challenges during dynamic tissue processes. Thus, the extracellular matrix is essentially just a complex framework, or a skeleton in a sense, that gives tissues shape and acts as a mediator and in-between amongst the various cells that reside in its vicinity. Scaffolds then work as a complex skeleton from which stem cells and the growth stimulating agents and materials are embedded. Ideally, after being embedded an
optimal microenvironment for cellular growth appears, and the stem cells grow, proliferate, and fill out the structure that is given by the scaffold. After a certain amount of growth, the newly formed tissue is implanted into the individual, and as the cells begin and continue to proliferate, differentiate, and integrate into the surrounding tissue, the degradable scaffold itself ultimately dissolves and the tissue starts functioning as it should.\textsuperscript{355}

Scaffolds can be created or prepared in several differing forms. The main approach is to use pre-made scaffolds of either natural or synthetic biomaterials, which is actually where the vast majority of research focuses on in tissue engineering. Another approach is to use the extracellular matrix itself. By stripping the matrix of its cells, a process known as decellularization, the acellular matrix can then be revamped with new cells to grow tissue to be implanted in another individual. The advantages of this type of scaffold is its naturalness, i.e. it’s as close to the real thing as you can get, and utility, because cellular matrices can be used for a plurality of tissue types and locations rather than being limited to the tissue type and function it was derived from. Further, since it has been decellularized, there is no immunity compatibility issues between donor tissues and the recipient.\textsuperscript{356}

But many tissue engineers are advancing beyond these traditional scaffold options into the realm of 3D organ printing. Organ printing is defined as a “rapid prototyping computer-aided 3D printing technology, based on using layer by layer deposition of cell and/or cell aggregates into a 3D gel with sequential maturation of the printed construct into perfused and vascularized living tissue or organ.”\textsuperscript{357} Essentially, 3D bioprinting involves a 3D printer that harnesses a modified inkjet technology to develop a 3D tissue or organ from a 2D CT scan blueprint. Upon a biocompatible and degradable scaffold, the 3D bioprinter applies this “ink,” which is essentially
a medium made up of growth factors and living stem cells that have been differentiated to the appropriate type for the tissue, in a layered format to ultimately achieve the 3D object.358

Though there are several other methods of 3D bioprinting, such as laser-based or extrusion-based, inkjet-based bioprinting, i.e. the method detailed above, is by far the most common and most promising approach. This method also has a set process and routine:

1. create a blueprint of an organ with its vascular architecture;
2. generate a bioprinting process plan;
3. isolate stem cells;
4. differentiate the stem cells into organ-specific cells;
5. prepare bioink reservoirs with organ-specific cells, blood vessel cells, and support medium and load them into the printer;
6. bioprint; and
7. place the bioprinted organ in a bioreactor prior to transplantation.359

The successes of these methods of 3D bioprinting are substantial. In 2014, approximately $537 million was spent on printed body parts throughout the United States, and researchers regularly used printed tissues and simple organs to test experimental drugs.360 Though issues with vascularity limit the potential applications of 3D bioprinting to smaller tissues at the moment, new research is progressing on advancing life-sustaining vascular networks for the possibility of printing larger and more complex tissues and organs. Thus, though this technology is currently limited to simpler types of tissues, tissue engineering as a whole has immense value to regenerative medicine’s application to organ and tissue ailments, and eventually we’ll have the knowledge, technology, and resources to make modern day transplants between individuals a thing of the past.361

2.2.4) Xenotransplantation

Finally, a third option is xenotransplantation. Xenotransplantation is the transplantation of organs or tissues from one species to another, and generally in the medical and ethical literature, the main focus is on the transplantation of tissues or organs from non-human species to humans, even though many more xenotransplants have been performed the other way around.362 In many ways, xenotransplantation is a method that has a long history and is still currently
researched and in use in some measures today. For example, tissues from other species, i.e. xenogeneic tissues, are regularly used as scaffolds in tissue engineering after being decellularized, because by stripping away the cellular content of the tissues and leaving the xenogeneic extracellular matrix, you largely remove the issues with immunocompatibility and rejection. Further, pig heart valves and intestinal submucosa (for bladder repair) have long been used in transplantation under the same type of method. This concept actually dates back to the 1960’s, too, with one patient transplanted with a kidney from a chimpanzee actually surviving for nine months, though the patient and others ultimately died from the effects of xenorejection from the transplant. The “Baby Fae” case in 1984 of a newborn infant who died after rejection of a xenograft heart transplant is also another infamous case of xenotransplantation gone wrong.

Ultimately, the issue of xenorejection, i.e. the natural incompatibility and ultimate rejection of xenografts transplanted into differing species, has limited xenotransplantation as an effective clinical tool. This is mainly due to the cell surface antigen alpha-Gal that all nonprimates possess, because humans have antibodies that cause immediate rejection when they come into contact with alpha-Gal in these animal cells. Two main methods are currently being researched to overcome this hurdle. The first involves genetic engineering. Certain research indicates that if you could genetically change the animal enough and, as John Fung of the University of Pittsburgh Medical Center puts it, make the pig “less piggish,” then you could possibly avoid xenorejection. Several companies in both the UK and US have had some success in that route by developing pigs that carry human genes that might block activation of the complement system, which should ultimately prevent rejection. A differing route of genetic engineering focuses on replacing the alpha-Gal antigen that causes rejection with a “human sugar
residue, fucosyl transferase," though it’s unknown how effective this therapy would be at preventing rejection and if these transgenic pigs would even survive the change in chemistry.367

The second method would be to make human/nonhuman chimeras to try and avoid xenorejection. Though some might argue that this method is and should be conceptually distinct from xenotransplantation, it inherently involves the core concept of xenotransplantation, so I will treat this method of creating chimeras as a part of xenotransplantation. Human/nonhuman chimeras are organisms that are composed from two different sets of cells from differing species – one human and one not. Generally, chimeras are created by integrating two different embryos, and this results in cells from differing origins in many different tissues throughout the body. If the process of localizing the chimera’s human cells in certain tissues and organs in high enough proportions is perfected, then human/nonhuman chimeras could conceivably be viable organ donors for human recipients. Though this is far from being a clinical reality, the recent advances in knowledge of induced pluripotent stem cells and “the ad hoc creation of solid organs within…chimeras” might make the use of human/nonhuman (specifically pig) chimeras a real possibility for organ transplantation in the near future.368

Other recent studies in induced pluripotent stem cells and mouse and rat chimeras also show promising results for the efficacy of induced pluripotent stem cells in disease modeling.369 Other chimeric research involves actually implanting potential organ recipients with bone marrow cells from the donors, and if these cells survive, then the potential recipient becomes a chimera of sorts, i.e. containing cells from two differing individuals. Several human-to-human heart transplants have been successful using this technique, and research shows some promise for this method in xenotransplantation, too.370 However, the most promising chimeric and xenotransplantation research involves the new CRISPR technology. By utilizing the gene editing
capabilities of CRISPR, it may be possible to delete a pig embryo’s ability to grow a particular organ, implant human induced pluripotent cells to replace that ability in the pig embryo’s DNA, and grow a human organ within the developing pig. There is actually already a current team at the University of California, Davis experimenting with this type of procedure, though they are only allowing the embryo to grow for 28 days before ultimately destroying it for analysis.371

Thus, along with cell-based and genetic therapies and tissue engineering, xenotransplantation is yet another potential tool utilizing regenerative medicine and stem cells in the treatment and therapy of tissue and organ ailments. Though there are some ethical issues attached to some of these potential methods, including issues of justice, allocation, and animal rights, most of these methods, outside of certain elements of xenotransplantation, seem to be largely ethically acceptable options that only contain practical ethical issues rather than conceptual ethical issues. Further, though the majority of these methods are not yet feasible, it is generally believed that our scientific knowledge and capabilities in regenerative medicine will ultimately combine with transplant medicine to create viable, efficacious methods that ultimately eradicate, or at the very least greatly lessen, the two major current issues in transplant medicine – immunosuppression-free transplantation and a renewable, potentially inexhaustible source of organs and tissues.372 Unfortunately, most of these procedures are still quite a few years away from human testing, which means that thousands of Americans will still suffer on dialysis for long periods of time and ultimately die from the lack of access to a transplantable organ or cure for their organ ailments.

Therefore, since we know that (1) incentives, both financial and non-financial, do improve organ donation rates, (2) it is essentially just a matter of time until progress in regenerative medicine ultimately lessens or eradicates the need for incentivized donation, and (3)
until that time, thousands will live in misery on dialysis and ultimately die without access to an organ, we have a strong moral responsibility to do everything that we can to save the lives of those suffering from organ failure and tissue ailments today. By not allowing these individuals with organ ailments to help themselves, we’re essentially damning them to a life of misery on dialysis and ill health, or even worse, death, due to living in a time a couple of decades before the luxury of regenerative medicine, which is discrimination based upon a non-moral property that these individuals had no choice in bringing about, i.e. their time of existence. And many opponents of CLOD will even admit as much, because the vast majority of opponents openly admit that there isn’t another way to effectively minimize the waiting list in such a way to prevent these types of deaths. They simply claim that CLOD is a “moral price” that is too high to pay, even for all of its practical and ethical benefits, which is an extremely paternalistic argument given our society’s extreme preference for individualism and acceptance and promotion of individual rights and autonomy.

Furthermore, there’s another argument to be made that the moral distinction between purchasing an organ from another individual and ultimately purchasing an organ that was engineered in the lab or harvested from an animal is skeptical at best, though we’ll discuss this issue in more detail in chapter four when we discuss the issue of commodification of the human body. So there is assuredly a sufficient practical justification to at least attempt to investigate the possibility of the establishment of a system of CLOD here in the United States. And if we do find that there is such a system of CLOD that minimizes harms while maximizing potential benefits, both practically and ethically, and can actually be implemented in an ethically palatable way, then we have the moral obligation and responsibility to enact and allow such a system in a
pluralistic moral society, where each individual can decide on their own whether or not they want to participate in such a practice.

2.3) The Medical, Political, and Moral Context of Living Organ Donation

Now that it has been established that there are sufficient practical justifications and moral obligations to seriously consider the possibility of instituting an ethically palatable system of CLOD in the United States, before moving on to the actual moral arguments for and against CLOD, it is prudent to situate the concept of CLOD in its proper context. Specifically, the medical, political, and moral background and context for CLOD should be fleshed out and stated to fully set up the following arguments against the prohibition of CLOD in the United States.

2.3.1) The Medical Context

It is widely accepted that the benefits of live kidney donation greatly outweigh the harms associated with the practice, as evidenced by the widespread acceptance of altruistic live kidney donation. For example, many studies suggest that there are minimal short-term and long-term medical risks involved in kidney donation, with one study even finding an 85 percent survival rate 20 years after kidney donation. Other studies have found the same minimal risks, with short-term risks only constituting a .03 percent chance of mortality and a 20 percent chance of morbidity shortly after the donation procedure. These results of the safety of live kidney donation have also been corroborated in a more recent 2010 study of over 80,000 live donors, and the results once again provide evidence that “live kidney donation is safe and free from significant long-term excess mortality.”

Another recent study in 2009 had similar findings regarding the mortality rates of live kidney donation, along with finding no increased risk of end-stage renal disease compared to non-donor controls. The study states:

Our results indicate that the life span of kidney donors is similar to that of persons who have not donated a kidney. The risk of [end-stage renal disease] ESRD does not appear to be increased
among donors, and their current health seems to be similar to that of the general population. In addition, their quality of life appears to be excellent.377

And though there are a few studies that have found very minimal increases in the rates of end-stage renal disease and other complications, even these studies conclude that their “findings will not change [their] opinion in promoting live kidney donation.”378 Further, though less common and a slightly more serious operation, recent studies suggest that living liver donation is comparably as safe as living kidney donation, and mortality for donors does not significantly differ from healthy non-donors.379 Thus, it’s clear that living kidney, and even liver, donations are safe, effective methods of treating organ ailments, specifically end-stage renal disease and acute and/or chronic liver failure. And other than being far from compelling, any argument about the safety or possible harms to donors is just as relevant and applicable to altruistic donation as it is to CLOD, which renders any such objection ineffective at qualitatively distinguishing between the two practices by this measure.

2.3.2) The Political and Moral Context

Beyond the medical context, it is also necessary to discuss the political and moral context for which any system of CLOD will be situated in, specifically the threshold and requirements that any such system would need to meet for justifiable prohibition or allowance by the State. Being one of the Enlightenment’s most successful achievements, the political philosophy of classical liberalism emphasizes the equality and freedom of all peoples and the primacy of the individual.380 Compared to other political philosophies, classical liberalism is then mainly focused on individual freedoms and rights and the protection of these freedoms and rights from government intrusion.381 Namely, this political philosophy perceives these freedoms and rights to be personal autonomy, i.e. the capacity for rational self-governance, self-determination, and personal freedom, which specifically includes the ability to develop one’s own conception of the
good, or view of how to live one’s life based on one’s values, desires, and beliefs. Thus, two
tings must necessarily be absent in this political philosophy in order for individuals to
consistently exercise their autonomy: State perfectionism and paternalism. First, State
perfectionism is the view that there are some conceptions of the good that are better than others,
and it is the prerogative of the State to promote these particular conceptions.382 Second,
paternalism can be defined as “when those in positions of authority refuse to act according to
people’s wishes, or they restrict people’s freedom, or in other ways attempt to influence their
behavior, allegedly in the recipients’ own best interests [as judged by those in authority].”383

For liberalism, both State perfectionism and paternalism unjustifiably violate individuals’
rights to autonomy and the freedom to develop and practice one’s own conception of the good.
However, these are the exact types of actions, i.e. paternalism and limiting behaviors that are
thought to be bad, immoral, or evil for society to allow, that characterize government
interventions and laws, because, otherwise, we would ultimately live in an anarchic state.
Clearly, then, liberalism’s focus on the individual runs counter to the utilitarian outlook of many
governmental interventions into the lives of the population, even if that comes at the expense of
certain individual liberties. Therein lies the liberal answer to the vast majority of governmental
interventions – the liberal objection, which states that governmental interventions are
objectionable, unjustifiable, and illegitimate due to them ultimately amounting to State
interference into individual autonomy, rights, and freedoms. However, personal autonomy within
liberalism, and ultimately ethics, is not absolute, which is where the harm principle comes into
the picture.384

Though being known primarily for his advancement and fuller development of the
normative ethical theory of utilitarianism, John Stuart Mill was also substantially interested in
political philosophy, specifically the relationship between individuals and the State. Since certain limits must necessarily be placed on individual autonomy, or risk anarchy, he developed the *harm principle* to determine when and how it was appropriate for the State to legitimately interfere with individual liberties and freedoms in a classically liberal State. This principle states:

The object of this Essay is to assert one very simple principle, as entitled to govern absolutely the dealings of society with the individual in the way of compulsion and control, whether the means used be physical force in the form of legal penalties, or the moral coercion of public opinion. That principle is, that the sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number, is self-protection. That the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinion of others, to do so would be wise, or even right. These are good reasons for remonstrating with him, or reasoning with him, or persuading him, or entreating him, but not for compelling him, or visiting him with any evil in case he do otherwise. To justify that, the conduct from which it is desired to deter him must be calculated to produce evil to someone else. The only part of the conduct of anyone, for which he is amenable to society, is that which concerns others. In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign.

Whether explicitly or implicitly, this principle has long been a guiding measure to determine the justifiability of State intervention upon individual liberties within liberal societies, even in the United States. According to the harm principle, State intervention is only justifiable to prevent harm to others, and though the promotion of benefitting oneself and others and the prevention of harm to oneself are noble pursuits, they are not legitimate State interventions into individual freedoms. In fact, the last sentence of the above passage explicitly states that “over his own body…the individual is sovereign.” This is due to the harm principle’s allowance of self-regarding harm. As long as the harm that someone potentially brings on oneself is self-regarding, doesn’t violate any specific duty, such as becoming intoxicated while on police duty, and doesn’t cause perceptible harm to any particular person, then individuals should have the freedom to partake in it. Even potentially harmful actions that may affect other people can be justified under the harm principle, as long as the harm is “through” the individual “in the first instance.” For example, while mountain climbing, a climber could fall and become injured, which would risk
others’ lives and safety in an attempt to save him; however, since this harm occurs “through” the individual himself and wasn’t directed at anybody in particular, this is a chance and cost that society should be willing to pay in order to maximize individual freedoms.386

Regarding the moral and political context of CLOD in the United States, this sets the limit for what the State can and cannot justifiably prohibit for its citizens. Since our liberal society is dedicated to a pluralistic understanding of conceptions of the good, i.e. a denial of State perfectionism, and avoiding paternalism is necessary to implement this dedication to pluralism, the State cannot justifiably, either morally or politically, prohibit any action or behavior that does not protect others and prevent them from harm from others, and this is a necessary requirement since protection from self-regarding harm is not justified by the harm principle, as mentioned above. Thus, as long as an ethically palatable system of CLOD can be developed that does not explicitly or implicitly harm others, then the State has no moral or political justification for its prohibition by law. The remaining chapters of this dissertation will now focus on justifying the ethically palatable nature of regulated systems of CLOD and developing a practical national system for implementation. The following chapter starts this process of ethical justification, and it examines the ethical concepts of autonomy, justice, and exploitation and how they relate to the issue of CLOD.
Endnotes


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285 Rothman and Rothman, Trust is not Enough: Bringing Human Rights to Medicine, 11-12.

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287 Rothman and Rothman, Trust is not Enough: Bringing Human Rights to Medicine, 23-24.


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41 Larijani, Zahedi, and Taheri, “Ethical and Legal Aspects of Organ Transplantation in Iran,” 1242.
48 Lavee et al., “Preliminary Marked Increase in the National Organ Donation Rate in Israel,” 784.
49 Lavee et al., “Preliminary Marked Increase in the National Organ Donation Rate in Israel,” 780-781.
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Chapter 3 – Autonomy, Justice, and Exploitation

With the practical need and moral obligation to consider a market in organs fleshed out and defended, the moral arguments for and against a regulated system of CLOD can now be addressed. There are certain standard moral arguments for and against CLOD that have been discussed at length throughout the professional literature. For example, arguments revolving around the concept of donor, and recipient, autonomy are some of the strongest arguments in favor of a regulated system of CLOD. Other pro-CLOD arguments center on the ethical principle of justice, and these arguments are aimed at both the donor and recipient. On the other hand, many suggest that the practice of CLOD is unethical for several reasons, including an immoral commodification of the human body and the overall suppression of altruistic organ donation, which is discussed in the next chapter. But the most common, and perhaps strongest, type of argument against CLOD revolves around the concept of exploitation, which is inherently related to the moral principles of autonomy and justice, and opponents argue that CLOD unethically exploits poor populations to exchange organs for financial considerations, which unjustly takes advantage of their socioeconomic vulnerabilities.387

This chapter analyzes these ethical arguments for and against CLOD, specifically those arguments dealing with the concepts of autonomy, justice, and exploitation. The chapter begins by analyzing the pro-CLOD ethical arguments dealing with the principles of autonomy and justice, and each argument will be fleshed out and defended. The rest of the chapter is dedicated to analyzing the exploitation objection to CLOD, and it is argued that (1) CLOD is not an example of immoral exploitation when properly regulated and (2) even if it was, the exploitation objection is insufficient to ethically distinguish CLOD from other market transactions and justify its complete prohibition by law. This argument starts with an examination of the rather vague
conception of exploitation to provide a more workable and explicit concept. The next section of the argument highlights how regulated forms of CLOD do not meet the specific conditions and definition of the concept of immoral exploitation that was fleshed out in the previous section. Finally, the argument concludes by examining the most common claims of the exploitation objection, and these claims are challenged to illuminate their inaccuracy and/or insufficiency as a moral justification to prohibit a regulated system of CLOD in the United States.

3.1) **Autonomy and Justice**

The strongest and most significant moral arguments in the debate surrounding CLOD revolve around the applied ethics concept of principlism, which contains the four main ethical principles guiding modern bioethics: autonomy, justice, beneficence, and non-maleficence. In particular, the principles of autonomy and justice are particularly relevant in this debate, especially in our very individualistic society that pays special attention to social justice. From self-ownership of one’s body to fair treatment and opportunity, these ethical principles provide compelling arguments for the moral justification of CLOD.

3.1.1) **The Principle of Respect for Autonomy**

Though not a universally shared sentiment, many feel that the principle of autonomy is the *primum inter pares*, or first among equals, of the four principles approach, because it is one of the main reasons for the existence of morality and plays a major role in the other three principles. Autonomy is defined as a concept of self-governance that is free from controlling interferences from others and impediments on meaningful choice. The autonomous person acts according to a self-chosen plan without unduly interference or limitations upon that plan from other individuals. When one does not act autonomously, it is due to the incapability of realizing the plans and desires of the individual, and this incapability arises from some sort of inability to
express one’s will or the excessive hindrance upon the freedom of the agent. Three conditions are necessary for autonomous action: intentionality, understanding, and noncontrol. For the act to be autonomous, the action must be intentionally willed, and the agent must adequately understand the action and its consequences. The agent must also not be under the controlling influence of another, because an agent can only act autonomously when the act is not directly affected by an impressionable factor or influence that affects the agent’s plans.

The principle of autonomy does have its limits, though, and restrictions upon autonomy are usually justified in protection of the autonomy of others. This is in accordance with the negative obligation imposed by autonomy, which states that autonomous agents should not interfere in the autonomous actions of other agents. There is also a positive obligation imposed by autonomy, and it states that autonomous agents should foster autonomous agency for fellow agents, which includes the dissemination of information that is potentially relevant to an action they are deliberating on.

In medicine and healthcare, the main practical avenue of respecting autonomy is the practice of informed consent. By garnering informed consent from patients before any medical intervention, physicians respect the integrity of the patient by honoring their autonomy and right to make decisions regarding their own body. Similar to the concept of autonomy itself, there are several conditions or steps to the process of informed consent, including disclosure of all relevant information, understanding of that information, voluntariness of the decision, and the actual process of attaining formal consent. In bioethics, both of these ethical principles are of the utmost importance, so it’s not surprising that they’re two of the very first mentioned global ethical principles in the UNESCO Universal Declaration on Bioethics and Human Rights.
In support of CLOD, Gerald Dworkin labels this type of autonomy as the right to bodily autonomy, and he defines it as the “capacity to make choices about how [one’s] body is to be treated by others… [and] the primary good achieved by such a right is the recognition of the individual as sovereign over his own body.” This is not a trivial right either, because outside of certain religious sects where there’s a belief that our bodies are not our own but the property of God, most of our secular, liberal society holds this right in high esteem, which is highlighted by legislation protecting abortion rights. This right is even explicitly mentioned in Mill’s harm principle that was discussed in the previous chapter: “In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign.” Thus, pro-CLOD arguments from the principle of respect for autonomy take a rather libertarian stance to this issue. These arguments claim that agents have the moral right to exercise their autonomy, specifically bodily autonomy, and as long as transactions of CLOD pass the obligations and conditions imposed by the principles of respect for autonomy and informed consent, they are morally justifiable. Further, any prohibition of CLOD by the State would then be unjustifiably paternalistic, because respecting individual autonomy both justifies the practice and obligates the State to allow such a practice without a prohibition.

But this is where much of the controversy arises regarding the principle of respect for autonomy and the concept of exploitation in CLOD. Proponents argue that in regulated systems of CLOD, these types of transactions pass the negative obligation of autonomy, because no other agent’s autonomy is restricted in individual organ sale, as opposed to the coercion and deceit associated with organ trafficking. Furthermore, a strictly regulated system of CLOD would have safeguards to foster autonomous decision making and informed consent, which reflects the positive obligation of autonomy. Opponents come to the opposite conclusion by not
qualitatively distinguishing between a regulated system of CLOD and an unregulated, open system of CLOD, which almost always involves organ trafficking, so they argue that the conditions and obligations of these principles are not met in these transactions, which leads to the exploitation objection that will be discussed below. But even most opponents of CLOD admit that if the obligations and conditions of autonomy and informed consent are met in CLOD transactions, then these moral principles would support and justify the concept of CLOD, though of course they deny that it ever, or rarely, happens in reality. Thus, the principle of respect for autonomy provides a strong, compelling argument of justification for CLOD, so long as the necessary conditions and obligations are met, and if a regulated system of CLOD can ensure that these transactions meet these conditions and obligations to respect individual autonomy and informed consent, then this principle provides a significant moral obligation to allow and support the use of CLOD in our pluralistic, liberal society that greatly values the individual conscience.

3.1.2) The Principle of Justice

Another concept of principlism is the principle of justice, and it is also used by some to support CLOD. As a concept, justice cannot be restricted to a singular definition, but in the context of organ donation and transplantation, it usually refers to matters of fair treatment and fair distribution of scarce resources. Traditionally, the principle of justice is regarded as an other-regarding virtue that can be bound to a character or an act. It also provides a guide to areas of concern for specific normative theories to address. There are three main differing conceptions of justice – utilitarian conceptions of justice, libertarian conceptions of justice, and egalitarian conceptions of justice. Utilitarian conceptions or principles of justice are grounded in the principle of utility, and they seek to maximize utility and positive value over disvalue. Libertarian conceptions of justice focus more on individual liberties and ensuring that State
actions do not inhibit or interfere with these liberties or fair free market processes that grant individuals the same freedom and opportunities to improve themselves, which is consistent with the spirit of the harm principle. This conception of justice then aims more toward just procedures rather than just outcomes, and the United States healthcare system generally follows this libertarian ideal with privatized healthcare that allows and protects each individual’s right to decide upon their own healthcare needs. Generally, it seems fairly uncontroversial that both utilitarian and libertarian conceptions of justice are heavily opposed to any sort of prohibition of CLOD that would limit both (1) overall utility and (2) individual freedoms by an act of the State, both of which would necessarily occur under such a prohibition.

On the other hand, egalitarian conceptions of justice focus more on the inherent equality of all humans, and this equality can be manifested in differing ways where every individual “should get the same, or be treated the same, or be treated as equals, in some respect.” In more detail, people “should be treated as equals, should treat one another as equals, should relate as equals, or enjoy an equality of social status of some sort.” These conceptions of justice are the most likely to oppose CLOD transactions compared to libertarian and utilitarian conceptions of justice. However, certain egalitarian theories and principles are consistent with CLOD transactions, such as Martha Nussbaum’s capabilities theory of justice. One of the most influential egalitarian theories of justice, the capabilities theory provides the principle of justice with normative content tailored to a global and international context. This theory of justice focuses on certain basic capabilities that any just system of government must provide to its citizens in order to respect human dignity and allow human flourishing. This focus on capabilities rather than actual human functioning is primarily to allow many differing “conceptions of the good” to be enacted under such a just system, which is due to a respect of
individual rights and conscience, and this allows individuals to partake or refrain in differing capabilities in proportions that they please.

In the context of CLOD, it can be argued that prohibiting CLOD transactions has denied many in need of organ transplants the essential capabilities of life, good bodily health, and the right not to die prematurely, which are all essential conditions of her capabilities theory of justice. Since we know that (1) live kidney transplantation is a safe and effective method to treat several differing otherwise fatal kidney ailments; (2) those on the transplant list (and even those thousands more on dialysis) who do not receive a kidney transplant will perish without a transplant; (3) financial incentives are effective at increasing organ donation rates; and (4) the State has prohibited CLOD primarily for paternalistic “moral” reasons rather than practical reasons, a compelling argument can be made that the State is denying certain individuals the basic and essential capabilities of life, good bodily health, and the right not to die prematurely for paternalistic “moral” reasons that should be left up to individuals to decide for themselves. In fact, this also could constitute another denial of the essential capability of practical reason, which is the capability to be able to form a conception of the good and engage in critical reflection about the planning of one’s own life. This argument from justice becomes even more compelling when combined with another normative egalitarian principle, specifically the fair-opportunity rule. Beauchamp and Childress describe the fair-opportunity rule as asserting that:

…individuals should not receive social benefits on the basis of undeserved advantageous properties and should not be denied social benefits on the basis of undeserved disadvantageous properties, because they are not responsible for these properties. Properties distributed by the lotteries of social and biological life do not provide grounds for morally acceptable discrimination between persons in social allocations if people do not have a fair chance to acquire or overcome these properties [emphasis added]…When persons are not responsible for their disabilities, the fair-opportunity rule demands that they receive help to reduce or overcome the unfortunate effects of life’s lottery of health.
Thus, the fair-opportunity rule states that since those needing transplants aren’t necessarily morally responsible for this disadvantageous property, at least in the majority of cases, it is immoral and unjust to deny them benefits and opportunities based off of this biological contingency and unfortunate effect of “life’s lottery.” Since many patients ultimately die waiting for a kidney due to a kidney supply shortage, paternalistically prohibiting CLOD transactions for “moral” reasons is immorally and unjustly discriminating against those individuals with the biological contingency of poor kidney health. So even certain theories and principles within egalitarian conceptions of justice morally obligate the allowance of a regulated system of CLOD under considerations of fairness and equality.

Now where these pro-CLOD arguments from justice are oriented towards the recipient, other arguments from justice are oriented towards the donors. For example, Robert Veatch argues that since the goods of life have been systematically denied to the poorest and most vulnerable of our society, it is unethical and unjust to prohibit one of the last financial benefits these families might have to better themselves, namely CLOD transactions. Further, after the Eliot Spitzer prostitution scandal, Martha Nussbaum came out with a very similar argument to Veatch’s in favor of prostitution, arguing that “the idea that we ought to penalize women with few choices by removing one of the ones they do have is grotesque...” In an earlier article, she argues that it is short-sighted to “rule off-limits an option that may be the only livelihood for many poor women...” Though this is aimed at prostitution rather than CLOD transactions, it is similarly short-sighted and unjust to remove the option of donating one’s organs for a profit and reducing one’s ability to better oneself even further, because this treats these individuals different than wealthier individuals and disallows them the opportunity to reach that level, which is unfair and unjust to these individuals. These arguments are related to both the Non-Worseness Claim
(NWC) and the paradox problem of the exploitation objection, which will be detailed in the following section. Thus, clearly there are significant arguments and conceptions of justice that are consistent with CLOD transactions, and this provides another compelling moral obligation against the unjustifiable nature of State prohibition of CLOD transactions. This chapter now switches its focus to a prominent objection to CLOD that inherently involves the ethical principles of autonomy and justice, specifically the exploitation objection to CLOD.

3.2) The Exploitation Objection

Though being a common concept of discussion in applied ethics, the concept of exploitation is not very well defined due to the numerous differing “conceptions of exploitation” within the professional literature and the differing claims and arguments made from these conceptions. Beyond this apparent opaqueness, though, at its base the concept of exploitation centrally concerns the presence and relationship among three key ethical principles, i.e. autonomy, human vulnerability, and justice. When the presence and/or proper relationship among these three ethical principles is corrupted, this ultimately results in one party taking unfair advantage of another party, which is the core premise of exploitation. Objections to CLOD from exploitation then generally revolve around three main themes or claims: unfairness to the donor, the undermining of donor autonomy, and the existence of constrained choice sets.

3.2.1) The Background and Context of Exploitation

Before the exploitation objection to CLOD can effectively be fleshed out, the concept of exploitation must be defined, because without a solid grounding or clarity in the concept of exploitation itself, the legitimacy of the exploitation objection as a sufficient reason to prohibit CLOD is in question from the very start. However, as previously stated, the problem is that there are many differing “conceptions of exploitation” in the literature. For example, while some
conceptions of exploitation inherently rely on Marxist interpretations, others rely on the Kantian notion of treating parties instrumentally. Further, where some conceptions require consensual issues to be present, others hold that exploitation can still occur in fully voluntary situations, and similar discrepancies among the various differing conceptions of exploitation are present with factors such as harm to the exploitee, the use of force or coercion, etc.\textsuperscript{418}

But establishing a basic working definition that encompasses the vast majority of these conceptions of exploitation isn’t impossible, because there are certain necessary components that are required for the act of exploitation to take place. Essentially, three things must be present in every case of exploitation – the exploiter extracting some benefit from the use/involvement of the exploitee, the exploiter benefitting \textit{at the expense of} the exploitee, and unfairness.\textsuperscript{419} Thus, one basic working definition for the concept of exploitation that both fits the majority of the various differing conceptions of exploitation and takes into account these three necessary components is “taking unfair advantage of another,” or more precisely - “\textit{A} exploits \textit{B} when \textit{A} takes unfair advantage of \textit{B}.”\textsuperscript{420}

To highlight the function of these three necessary components and how exploitation necessarily takes unfair advantage of another, it is necessary to view them in action in a paradigmatic case of immoral exploitation. Coincidentally, these three components can best be examined in the examples of \textit{open, unregulated markets for organs} in developing nations of the past, which is an entirely different concept than this dissertation’s proposal for CLOD. For example, when India was a burgeoning open kidney market before it was illegalized and pushed the trade underground, organ brokers would regularly bring the poorest individuals together with wealthier individuals needing a transplant, and they would generally pay around $2,500 to $4,000 for a kidney. However, the donors usually received less than $1,000 of that sum due to
the organ broker’s fees and price of administration, and many times donors even received much less, or nothing at all, due to corrupt organ brokers, which highlights one of the main problems in open, unregulated markets as the presence of exploitative organ brokers.421

Thus, it’s easy to see how the donor is being unfairly taken advantage of due to the three required components of exploitation being met in this example - both the organ broker and buyer derived benefit from the donor (profit and an organ for transplantation), this benefit came at the expense of the donor (unfair price for an organ, not receiving the entire payment for the organ due to the broker, and/or being cheated out of the agreed upon price), which ultimately makes this situation seriously unfair due to the presence of fraud and an unfair price. Of course, it could be argued that this benefit does not come at the expense of the donor, because the donor actually was paid and is now better off due to the situation. However, exploitation deals with the normative rather than the descriptive, so coming at the expense of the donor is in relation to a fair transaction rather than whatever transaction actually obtained. This is termed the difference between the no-transaction baseline and the fairness baseline, where the former corresponds to the descriptive and the latter corresponds to the normative. Relative to no transaction whatsoever, exploitation often betters the exploitee. But the requirement of the benefit coming at the expense of the donor isn’t necessarily related to what did happen in this transaction versus no transaction whatsoever, i.e. the no-transaction baseline, but rather what should have happened under a fair transaction, i.e. the fairness baseline. So while the donor might actually be better off in this situation due to the sale of an organ, the donor would have been even better-off after the sale of an organ in a fair transaction, which realistically would be more than approximately the $1,000 that is usually received, meaning this truly does come at the expense of the donor.422
This brings up another important fact about exploitation – as shown above, and in other cases such as clandestine sweat shops, immoral exploitation can still occur when the exploitee benefits from the exploitation itself.423 Thus, a distinction should be made between two differing sets of types of exploitation, specifically between nonconsensual exploitation and consensual exploitation and between harmful exploitation and mutually advantageous exploitation. The difference between nonconsensual and consensual exploitation is the presence of valid, informed consent to the exploitative transaction. The other distinction is between harmful exploitation, where only the exploiter benefits from the transaction purely at the expense of the exploitee, and mutually advantageous exploitation, where both the exploiter and exploitee benefit in some way from the transaction. In cases involving nonconsensual transactions or one-sided harmful exploitation, it’s clear when exploitation has taken place. On the other hand, certainly there are cases of consensual, mutually advantageous exploitation (CMAE) transactions where it’s not always clear that immoral exploitation has occurred, because both sides seem to agree upon a transaction that benefits both of them without seemingly, at least on the surface, coming at the expense of the exploited.424 For the purposes of the exploitation objection to CLOD, then, this is of utmost importance, because any argument against the immorality, and potential prohibition, of CLOD will necessarily rely on both proper consent and mutual advantages to both parties.

This is actually an area of the professional literature on exploitation that there is not a consensus view on. In virtually every major conception of exploitation in the literature, there are moral undertones to the presence and act of exploitation, as seen with “unfairness” being a necessary component of exploitation. Thus, the accusation of exploitation is almost always considered a moral judgement, i.e. acts of exploitation are considered immoral and wrong. However, the moral component of “unfairness” isn’t necessarily the clearest and most direct
concept, and it’s certainly not an inherently and/or *absolutely* immoral concept, i.e. every single unfair scenario is not necessarily immoral. There are varying levels of unfairness, and there are quite a few things in the world that aren’t really fair, yet we fail to consider them immoral. This falls right in line with the intuition that certain CMAE transactions aren’t necessarily immoral, even if there is a level of unfairness to them. So in cases of CMAE transactions, there actually might be arrangements that aren’t necessarily immoral due to not being “unfair” enough.\(^425\)

This sentiment is best justified by what is referred to as the Non-Worseness Claim (NWC). The NWC argues that, “in cases where A has a right not to transact with B, and where transacting with B is not worse for B than not transacting with B at all, then it cannot be seriously wrong for A to engage in this transaction, even if its terms are judged to be unfair by some external standard.”\(^426\) So even if there is some inherent unfairness in a certain CMAE transaction, the NWC argues that if there’s no moral obligation to get involved and involvement is no worse than non-involvement, then there is nothing *seriously wrong* with an exploitative transaction that is consensual and mutually advantageous. Of course, certain critics argue against the NWC due to some of these counterintuitive implications that suggest that there’s nothing seriously wrong about these types of exploitation, e.g. price gouging.

But this interpretation is based on an overly simplified and *static* bifurcated notion of ethics that just isn’t really practical or representative of real life, everyday moral decisions. Generally, people tend to distinguish solely between right actions and wrong actions, and in this view actions must be either completely right or completely wrong, or otherwise non-moral. But this is a very limited and illogical fashion to think about ethical judgments, because there is without a doubt a sliding scale on both sides. For example, stealing and mass murder are both considered ethically wrong, but certainly mass murder is much more seriously wrong than
stealing. On the other end of the spectrum, we run into the issue of obligation and duty. Certainly there are good actions that we are obligated to perform, but then there are other good actions that are outside the realm of obligation that are *good* to do, though not necessarily *required* to do. This is known as supererogation, or supererogatory moral acts. These are non-obligatory moral actions that go "beyond duty, fulfil *more* than is required, *over and above* what the agent is supposed or expected to do.”

In fact, Islamic ethics/religious law actually explicitly breaks down moral actions to be placed into one of five differing ethical categories that tend to represent this notion of a sliding scale: recommended (supererogatory), necessary (obligatory), indifferent (morally neutral or permissible), blameworthy (disfavored - conditionally evil), and forbidden (prohibited - inherently evil). Though not necessarily representative of Islamic moral theology, it could be that even individual categories have a sliding scale, e.g. one act more blameworthy or recommended than another. Unfortunately, at least in the West, when we talk about ethical actions we mostly talk about obligatory or supererogatory moral acts, and we clearly associate ethical actions with the more noble/higher categories of supererogatory moral acts and obligatory moral acts. However, as shown above, these do not constitute the whole range of ethical actions, and there are at least some moral actions that are *permissible* that are neither necessary (obligatory) or recommended beyond duty (supererogatory).

Now most Western conceptions of ethics do not make such *explicit* distinctions among categories, but with notions such as duty, obligation, and an action being inherently evil, at least some major Western conceptions of ethics actually function implicitly in this mold. And when it comes to the NWC, this is the best way to view these types of actions, because while technically still a bifurcated system where ethical judgments are broken down into one of two areas, i.e. the
ethical actions of the categories of recommended, necessary, and indifferent and the unethical actions of the categories of blameworthy and forbidden, this type of perspective on ethical judgments is dynamic in nature and able to qualitatively distinguish among ethical or unethical actions according to their nature, severity, or obligation. In the case of CLOD, then, rather than thinking in terms of the ethical versus the unethical, we should deliberate upon whether or not this particular act is morally permissible, which is the least restrictive form of ethical actions that are still ethical and permissible. When we use this sort of moral language that qualitatively distinguishes among differing ethical and unethical actions, the notion of CLOD becomes much more ethically palatable due to being put in its proper moral context.

Thus, if we view the NWC, and morality in general, in these terms, then the implications become much more ethically palatable and understandable than under the perspective of a static bifurcated system of merely right and wrong/ethical and unethical. If ethicality constitutes more of a sliding scale of judgments rather than a static bifurcated system of “the ethical and the unethical,” then this type of CMAE transaction seems ethically palatable as an action that is ethically permissible, or perhaps at least not unethical, though not necessarily obligatory or recommended as an ethical judgment that is beyond duty. Assuming premises one and four, which are the fundamental parts of the NWC, the logical argument then goes like this:

1. A is not morally obligated to get involved with the affairs of B;
2. If an action is not morally obligated, then it is ethical (or at least not ethically impermissible) to not perform that action;
3. Therefore, non-involvement is ethical (or at least not ethically impermissible);
4. For B, the involvement by A is no worse, and is usually more beneficial, than non-involvement by A;
5. Therefore, in this situation, involvement is greater than or equal to non-involvement ethically;
6. Consensual, mutually advantageous exploitative transactions constitute this type of involvement;
Therefore, consensual, mutually advantageous exploitative transactions between \(A\) and \(B\) are not ethically impermissible when there is no moral obligation to get involved and involvement of \(A\) with \(B\) leaves \(B\) no worse off than \(A\)'s non-involvement with \(B\).

And even if one does reject this notion of ethics as a sliding scale or the NWC in whole, then the burden of proof is still on the individual, because outside of disagreeing with the fundamental assumptions of the NWC, i.e. premises one and four above, it seems sufficiently counterintuitive to argue that involvement in such a situation is in any way ethically worse than non-involvement.

So as long as the unfairness ultimately is in relation to the *fairness baseline* and not the *no-transaction baseline*, i.e. involvement doesn’t make the exploited’s situation worse, and there is sufficient benefit for both sides, then the levels of unfairness in CMAE transactions are not necessarily sufficient enough to qualify this act as unethical. Of course, some might question the moral character and motivations of the exploiter in this type of exploitation, but moral character and motivations aren’t necessarily relevant or defeating for the NWC. Discussing the issue of price gouging, which is also an example of a CMAE transaction, Zwolinski offers the following regarding character and the NWC:

But NWC is not a thesis about moral character, it is a thesis about the wrongness of moral acts. And this is importantly different. Vicious people can perform morally permissible [emphasis added] actions. Think, for instance, of Kant's shopkeeper who returns the correct change to a naive customer only out of a selfish concern for his own reputation and long-term profit. If he could be sure he could steal a penny from a child's change and get away with it, he would, but prudence dictates restraint. Such a person has a bad moral character. But the act he is performing—giving the child back her correct change—is perfectly innocent… Thus, Snyder's concerns about NWC do not give us reason to prohibit price gouging, or even condemn it. For all his arguments show (correctly, I think) is that price gouging can sometimes be done by morally vicious people. They do not show that the act of price gouging itself is morally impermissible [emphasis added].

Thus, we can now distinguish among three different types of mutually advantageous transactions: nonconsensual, mutually advantageous exploitation (NCMAE), consensual, mutually advantageous exploitation (CMAE), and non-exploitative mutually advantageous (NEMA) transactions, which we have no reason to suspect are unethical. As stated above, since CLOD is necessarily a mutually advantageous transaction and the latter two mentioned types of
mutually advantageous transactions are ethically permissible types of transactions, for the exploitation objection to CLOD to be sufficient in its aims for prohibition, it must be determined that CLOD is (1) an example of a NCMAE transaction, (2) ethically distinguishable from other similar types of NCMAE transactions that are currently not prohibited by law, and (3) “harmful” enough, both qualitatively and quantitatively, to justify prohibition by law. Unsurprisingly, the majority of the claims made by the exploitation objection are aimed directly at the process of consent in CLOD, so the objection is still capable of meeting these demands. However, before getting into the differing claims and other arguments made by the exploitation objection, we should first briefly look at CLOD transactions themselves to see whether or not they meet the definition of exploitation.

3.2.2) CLOD and Exploitation

To ethically analyze the issue of CLOD to determine its status as an exploitative practice, it must be compared with the necessary components of exploitation that were discussed above, namely - the exploiter extracting some benefit from the use/involvement of the exploitee, the exploiter benefitting at the expense of the exploitee, and unfairness. The first component is obviously present, because it’s clear that both sides are significantly advantaged and benefitted by the transaction. Unfairness is also obviously present, because it’s the lack of complete equity between individuals that allows the transaction to take place in the first place, albeit in differing areas, i.e. the donor lacking in money and the recipient lacking in organ health. This unfairness is empirically verified, too, because using Iran as an example, though there are significant other motivations to donate a kidney in Iran, such as the moral and religious value of charity, financial reasons were also a major donor motivation, as evidenced by the pool of commercial donors.
consisting primarily of the poor. Thus, unfairness is present in the unequal starting positions of each party rather than within the transaction itself.

But can one really make the argument that the recipient (exploiter) benefits at the expense of the donor (exploitee)? Actually, no, at least in regulated markets, that is. This is because the donor is receiving a fair price for the organ, or at least what we can reasonably conclude as a fair price according to certain economic studies that have been completed on this issue. For example, in an attempt to find a minimum threshold amount that would constitute a fair payment to significantly incentivize live organ donation in the United States, noted economists Gary S. Becker and Julio Jorge Elias completed a study that came to a price of a little over $15,000 for a kidney and $37,600 for a liver that would be needed to effectively incentivize CLOD in the United States. In Iran the price is even greater, though difficult to quantify by American standards due to changing monetary values and exchange rates not being suitable methods of comparison. After making a research trip in 2008 to Iran to study their model of CLOD, Sigrid Fry-Revere had this to say regarding the payments made to donors in Iran:

Perhaps the best way to understand how much kidney sellers are paid in Iran is to use the type of comparison Dr. Ghods used when I spoke with him in New Haven, Connecticut in April 2008. He told me the going rate for a kidney at the time we spoke was equivalent to six months' salary for a registered nurse. In the United States the median salary for six months for a registered nurse in 2008 was $32,565. See the Bureau of Labor Statistics website at www.bls.gov. To expand on this type of analysis, the going rate for a kidney when I was in Iran at the end of 2008 was almost twice what the average Iranian made that year or enough to feed a rural family of four for several years. (It takes more than twice as much to stay above the poverty line in Tehran than in outlying areas.) Yet, even this type of analysis is incomplete because almost all kidney sellers received more than just monetary payment: They also received goods and services, such as health insurance vouchers, dental care, job placement services, and donations of household goods, clothing, and food. I estimate that a more realistic U.S. equivalent in purchasing power for the overall fees and services received on average by kidney sellers in Iran is closer to $45,000.

Remember, for the benefit to come at the expense of the donor, the transaction must make the donor worse off relative to the fairness baseline, even if it makes the donor better off relative to the no-transaction baseline. But in this case, the donor is actually better off relative to both baselines, because (1) the transaction is better than no transaction for the donor and (2) the
transaction is based on, what we can reasonably conclude as, a fair price for the organ, which I don’t think can be argued against, especially in the Iranian model. Of course, it could be argued that there is no proper standard to convert the worth of an organ to monetary value, meaning organs are incommensurable with monetary value. However, this is a problematic claim for two reasons: (1) it’s not clear that goods can ultimately be incommensurable in the first place and (2) incommensurability doesn’t necessarily make a transaction of goods unfair, meaning it isn’t sufficient as an objection. Further, as will be discussed next chapter, there are many other practices in our society where we actually do assign values or prices to body parts or products, so we certainly don’t behave as if all body parts or products are incommensurable with monetary value. Mark Cherry makes this remark regarding the incommensurability claim:

By itself, though, incommensurability will not establish that organ sales are illicit. The permissibility of market transactions does not require that the goods exchanged be precisely commensurable, but rather that the parties transact voluntarily, that deception or other forms of coercion are not employed, and that each is satisfied with the value to be received. This means that what is received in return is worth as least as much to the party as the which was given [emphasis added]. As others have noted, one can buy or sell “priceless” Monet paintings without claiming that the aesthetic or historic value of the artwork is “commensurate” with the money that is paid.

Thus, it seems clear that a regulated system of CLOD ultimately does not meet the required components to label it as an example of immoral exploitation. Alan Wertheimer, a world-renowned expert on the concept of exploitation and one of the authors who theorized the three required components of exploitative transactions, seems to agree with this overall analysis:

A mutually advantageous transaction is arguably (wrongly) exploitative only if the outcome is (in some way) unfair to B. This is not merely definitional. After all, it may be thought that a transaction is exploitative whenever [it] takes advantage of B's vulnerabilities or desperate situation to strike a deal. That is false. For if A makes a reasonable proposal [i.e. fair price] that B has no alternative but to accept given B's desperate situation, A does not exploit B. If a doctor proposes to perform life-saving surgery for a reasonable fee, the patient is hardly exploited, even though the patient would not have agreed but for the fact that her life was in danger [emphasis added].

To understand why this practice ultimately represents a NEMA transaction rather than a NCMAE transaction, a distinction must be made between taking unfair advantage of an
individual (exploitation) and *taking advantage of an unfair situation* (not exploitation), which are two vastly different concepts with differing moral motivations. This distinction is very important to make, because it would otherwise label professionals such as physicians and auto-mechanics as professional exploiters, since they rely upon a certain disadvantaged situation of an individual, e.g. health problems, car trouble, etc., to make a living. Mark Cherry labels this distinction as “the line between the unfortunate and the unfair,” and he further states:

That someone is poor or otherwise disadvantaged due to unfortunate circumstances does not imply either that he is unable to make rational choices given his limited choice set or that one acts improperly when one seeks to trade with or otherwise engage such a person in a market transaction — for example, by offering the disadvantaged person a job or the real possibility of securing valuable rewards. More must be said to demonstrate that one acts in a morally blameworthy fashion when one extends an offer to a poor individual, which seeks to improve his prospects and to which he had no prior entitlement — for example, when one offers valuable compensation for organ donation.

To justify this distinction, one needs only to look at Kant’s second formulation of the Categorical Imperative, which isn’t surprising due to the fact that many individual conceptions of exploitation rely on this Kantian notion. This formulation claims that we should always treat individuals as ends in themselves and never merely as a means to an end, which essentially means that we should never treat others instrumentally. *Taking unfair advantage* would then equate to treating individuals as an instrument and merely as a means to an end. Specifically, this would take the form of recipients not respecting donors as ends in themselves and offering them an unfair price for donation, which would ultimately just treat the donor as a means to an end, i.e. a host of an organ for transplantation. On the other hand, *taking advantage of an unfair situation* does not necessarily equate to treating individuals instrumentally, and at least in the case of regulated systems of CLOD, both sides are ultimately taking advantage of an unfair situation that the other party is in, i.e. vulnerability with the donor’s finances on the one hand and the recipient’s health on the other hand, to benefit off of a mutually advantageous transaction, while still treating the other party as an end in themselves.
Since neither party benefits at the expense of the other party, regulated systems of CLOD clearly do not meet the required conditions for exploitation, and it is simply a system of NEMA transactions rather than CMAE transactions. But even if we did consider regulated systems of CLOD to be systems of CMAE transactions, the NWC argument above highlighted why we should think that there’s *nothing seriously wrong or immoral* with CMAE transactions, ultimately making them *ethically permissible*. But going even further down the rabbit hole, even if we granted the contentious claim that exploitation is always harmful and morally wrong, it still would not justify its prohibition by law. This is because in classically liberal societies like the United States, which this essay is ultimately focusing on, the harm principle, i.e. the guiding normative principle regarding State interference into individuals’ lives, ultimately allows for self-regarding harm. As long as the harm that someone potentially brings on oneself is self-regarding, freely consented to, doesn’t violate any specific duty, such as becoming intoxicated while on police duty, and doesn’t cause perceptible harm to any other particular person, then individuals have the freedom to partake in it, according to the harm principle. Therefore, it seems painfully obvious that (1) regulated systems of CLOD are *not* examples of exploitation; which (2) makes arguments from exploitation that focus on the potential unfairness to the donor invalid and unsound, and proves that (3) even at its worst, there is no justification for prohibiting consensual cases of CLOD, which brings us to the two other main claims utilized within the exploitation objection that specifically focus on nonconsensual transactions.

3.2.3) *Claim One - Exploitation from Autonomy-Undermining Choices*

Though I’ve successfully shown how regulated systems of CLOD do not technically meet the conditions to be considered examples of exploitation, there are still several other differing claims from the exploitation objection that must be answered. Where the focus of the main
exploitation objection itself is interested in fair treatment of all parties involved, specifically fair prices or fair treatment that doesn’t take unfair advantage of the donor, these other claims argue that CLOD constitutes exploitation through faulty consent processes, which Tom Beauchamp labels as exploitation deriving from constraining situations. The first claim suggests that the choice of CLOD actually undermines donor autonomy rather than enhancing donor autonomy, and the second claim suggests that the poor donor’s limited choice set actually constrains autonomy enough itself, which leads to an unfree and involuntary consent to CLOD. In the literature, these claims have been discussed using terms such as false autonomy, coercion, undue inducement, etc. Further, these two claims are not necessarily represented and intended in every formation or use of the exploitation objection, but they are two of the main claims and arguments, along with the unfairness argument above, utilized by opponents with the exploitation objection in the literature.

However, this brings up an issue of presumption that should be addressed prior to the two main claims of the exploitation objection. Virtually every single manifestation of the exploitation objection implicitly makes an assumption regarding the demographics of the parties of CLOD, namely that the poor will always be the donors and the rich will always be the recipients in CLOD transactions. Now, some might consider this its own separate claim of the exploitation objection, such as Beauchamp when he describes this type of argument as exploitation deriving from systemic injustice. But this presumption is so widely presumed in these arguments that it’s present in virtually every manifestation of this objection to CLOD in the literature, so it should be addressed as an integral part of the exploitation objection itself rather than merely a claim made by differing iterations of this objection.
This component of the exploitation objection presumes that CLOD unjustifiably exploits the poor in favor of the rich, due to poor populations being the most likely to be donors and rich populations being the most likely to be recipients in CLOD transactions.444 Further, it is argued that the relationship between donor and recipient ultimately pits the poor against the rich, and it is unethical that rich recipients are able to exploit the vulnerable nature of poor populations, who might desire the financial gains of organ donation over the internal organ that they never see. Thus, the globally rich would be pitted against the globally poor, and according to proponents of this claim, the market would necessarily operate under these conditions. These proponents of this claim further argue that inequality in wealth and socioeconomic status would necessarily be a defining piece of the organ market, and a market based on this concept cannot possibly be ethically justifiable and non-exploitative.445

In fact, several of the more prominent objections to CLOD make this very presumption, and this presumption ultimately constitutes an integral part of many arguments against CLOD. For example, in his article entitled “The Case Against Kidney Sales,” Thomas George bases his claim of exploitation on an inherent relationship of the rich taking advantage of the poor:

All arguments in favour of the trade are attempts to clothe, in the garb of reason, the concept that it is all right to remove a body part from a poor person and put it into a rich one [emphasis added] …What matters here is motive: the implicit coercion in the case of the poor who sell out of financial compulsion [emphasis added] …A profile of the sellers would be revealing. It will come as no surprise that they all belong to the Third World. And it will also come as no surprise that besides the wealthy in the Third World, the potential buyers will be from the rich, white, First World and from the petroleum driven nouveau – riche [emphasis added]!446

Monir Moniruzzum’s ethnography on kidney sellers entitled “‘Living Cadavers’ in Bangladesh: Bioviolence in the Human Organ Bazaar” also makes this seemingly inherent connection between poor donors giving up their organs to rich recipients in his argument from exploitation:

The bioviolence is both exploitative and unethical, as organs are deliberately removed from the economic underclass to prolong the lives of the affluent few. In this visceral violence, the wealthy recipients are beneficiaries, while the poor sellers are mere suppliers of body parts [emphasis added], but at the severe cost of their suffering… some liberal bioethicists have proposed that a regulated organ market would be an efficient way to save the lives of dying
patients (Cherry 2005; Friedman and Friedman 2006; Hippen 2005; Matas 2008; Radcliffe-Richards 1996; Taylor 2005; Veatch 2000). In my opinion, these bioethicists generate a symbolic violence (if unconsciously) by emphasizing “saving lives” of the affluent few, while allowing bioviolence against impoverished kidney sellers [emphasis added].

And finally, in his article “The Case Against a Regulated System of Living Kidney Sales” where he, illogically, argues against the idea of a regulated system of CLOD by utilizing evidence from unregulated, open kidney markets of the past, Vivekanand Jha makes a similar connection between this rich/poor dichotomy and exploitation and states, “Allowing such an activity in any corner of the world would open the doors for rampant exploitation of the underprivileged in areas that are already plagued by vast economic inequalities.”

The problem with this presumption is that it doesn’t necessarily bear out in reality in regulated, closed kidney markets like it does in unregulated, open kidney markets, which highlights another, more substantial and pressing issue regarding these objections: they use faulty logic to extrapolate the effects and harms of unregulated, open kidney markets to regulated, closed kidney markets, which is highly illogical. For example, George’s critique of CLOD is based off of his experiences with the open organ trade in India, specifically transplant tourism and organ trafficking between the “First World” and the “Third World,” which as I showed last chapter was subject to much exploitation and human rights abuses due to organ brokers and a lack of regulation and oversight. Similarly, Jha also uses evidence from the unregulated, open kidney markets of India and Pakistan to argue against the establishment of a regulated, closed kidney market in Western countries, which are two diametrically opposed systems and contexts with no accurate analogous comparison available.

In fact, the only time Jha does try to use a relevant comparison in the regulated Iranian market, he uses the work of Zargooshi, but as Sigrid Fry-Revere has recently pointed out, this research was conducted before Iran started regulating their kidney market, which once again tries to unfairly equate unregulated and regulated markets. Fry-Revere says as much here:
Zargooshi collected his data before Iran became a regulated market. The kidney sellers Zargooshi interviewed were people who had donated before the Iranian government began to regulate kidney sales. As a result, Koplin is comparing a black market to a legal, but unregulated market. If that is the comparison (an illegal market vs. an unregulated market) then, I, for one, agree – there really isn’t much difference between the two as far as compensated donors are concerned. It would be far more meaningful to compare black market kidney sales in Pakistan, India, or the Philippines to the way in which compensated donation is currently done in the Iranian provinces of Isfahan and Razavi Khorasan (the province where Mashhad is located). Those provinces not only have the legal protections Iranian law provides all compensated donors, but also take their obligations to donors so seriously that they provide donors with all the same types of services available to recipients.451

Not coincidentally, Zargooshi’s work is the primary source for many opponents’ arguments against the justification of CLOD, specifically those critiquing Iran’s system, such as Julian Koplin’s work.452 She also stated that his research was significantly old, and she compared using this data to describe and characterize the current Iranian system as akin to “generalizing about the state of healthcare in the United States today based on data collected twenty years ago in rural Alabama.”453 Similarly, this faulty logic that attempts to equate and describe the workings and effectiveness of regulated, closed markets by using evidence from unregulated, open markets is akin to describing and discussing the practice of abortion in the United States today by using evidence and statistics from a time before Roe v. Wade, which was a time when coat-hanger abortions and clandestine, back-alley abortion clinics ran out of homes were the norm.454

Getting back to this rich versus poor presumption that is inherent in most objections from exploitation, the problem with this presumption is that it really only applies to unregulated, open organ markets, not a strictly regulated system of CLOD like this dissertation is proposing. In fact, there’s evidence from Iran’s system, from which this proposed American system is modeled after, that this type of exploitation is not a major issue within their system. In a study analyzing over 500 paid renal transplants in Iran, it was found that there was no marked difference in education levels between the donor of the kidney and its recipient. Furthermore, though 84 percent and 16 percent of the donors were from the poor or middle class, respectively, over 50 percent and 36 percent of the recipients were from these same socioeconomic classes,
respectively, with upper class recipients only constituting roughly 13 percent of the recipients. Diane Tober’s work also supports this analysis when she states, “…though the Iranian system is based on a commercial market, it is not only the wealthy who have access to donor organs. Organ recipients come from all socio-economic classes, although unrelated commercial donors come from primarily lower socio-economic backgrounds.” This evidence then supports Dr. Ghods’ study’s findings, and it suggests that this presumption is not necessarily as relevant to regulated, closed markets for organs as it is for unregulated, open markets for organs.

In fact, in more developed countries with more socialized forms of healthcare, e.g. single-payer systems, this argument doesn’t even apply conceptually with regulated markets, because there is universal coverage by the federal government that would be responsible for compensating donors for recipients of all social classes. This is even true in the United States with the social program Medicaid, which has some 97 million low-income Americans that it supports. If the federal government was the main financer and administrator of the market, which is true of this dissertation’s proposal, then most low-income individuals and families would be covered under these social programs, meaning they would be covered both as donors and recipients under such a system. Thus, rich individuals exploiting and taking advantage of poor individuals for their organs isn’t a real concern for this type of regulated system of CLOD.

Along the same lines of this presumption, some also presume that there are informational and educational hurdles that might arise with poorer populations being donors, which could lead to them being exploited due to a lack of understanding. Poorer individuals will generally have less education and knowledge regarding the transplant process, and this can lead to possible misunderstandings of the consequences of organ donation, at least of the severity, which is a violation of the principle of consent. Remember, ensuring understanding of the relevant
medical information of a procedure is one of the four key steps to attaining informed consent.\textsuperscript{459} However, once again, in regulated systems this shouldn’t be a problem, because any tightly regulated system of organ donation and transplantation will have mechanisms to ensure informed consent of donors, similar to the safeguards we currently have for live donors at transplant centers across the United States.

Now that those faulty presumptions have been dispelled, the first major claim of exploitation due to constraining situations can be analyzed. This claim of the exploitation objection actually goes beyond claims of coercion and argues that the very option and possibility of CLOD is both coercive and autonomy-limiting. One of the strongest arguments in favor of CLOD comes from the concept of bodily autonomy, which we discussed above. Because we’re a liberal, pluralistic, and individually-oriented society that believes that individuals both (1) have the right to autonomous decision-making and (2) own their own bodies, there are strong cultural and moral values supporting bodily autonomy in our society, and this concept of bodily autonomy is diametrically opposed to paternalistic prohibitions on rights and freedoms that determine what happens to one’s own body, such as a prohibition on CLOD transactions.

But certain opponents of CLOD, specifically Paul Hughes, argue that rather than being an autonomy-enhancing option, allowing poorer populations to donate their organs for compensation might actually be autonomy-undermining and constraining their liberty even more. Hughes argues that when individual choice sets become increasingly restricted and constrained, certain beneficial, but not necessarily desirable, decisions become unduly attractive and irresistible. He further posits that certain choices can actually undermine autonomy by keeping individuals in their compromised autonomous states with severely constrained choice sets. So when these two issues are combined, certain irresistible options might serve to keep
disenfranchised individuals in their situations of constrained choice sets and limited autonomy. Essentially, Hughes claims that it’s a paradox: the addition of an extra choice increases the choice set and overall autonomy, but that choice itself, which is supposedly irresistible and too good to refuse, leads back to a constrained choice set and limited overall autonomy. Hughes has this to say regarding autonomy-undermining choices:

But the rest of the story is that the reasonable alternatives available to them are so limited that the addition of certain kinds of options may have a debilitating impact on a person's autonomy and well-being. Consider, for example, the legal option of refraining from pressing charges against one's assailant. This is usually regarded as part of the arsenal of choices persons need in order to be genuinely in control of their lives. But it has been amply demonstrated that some persons, most notably adult victims of domestic assault and battery, routinely exercise this option in self-defeating ways, sometimes irrevocably so. Thus, the presence of some choices in contexts of injustice actually compromises autonomy and well-being. Moreover, if we think of a person's viable options as his real autonomy, then the presentation of additional choices which are constraining will leave a person worse off in terms of autonomy and wellbeing than he would have been without those choices.460

Thus, this claim of the argument from exploitation argues both that the opportunity to be compensated for organ donation is autonomy-limiting and that the decision to actually donate for compensation is a forced response due to coercive financial influences and a constrained choice set, making it an unethical and unjustifiable practice and worthy of prohibition.461

If this sounds fairly paternalistic, then it shouldn’t be surprising that this argument is ultimately based on a neo-Marxian conception of exploitation. Marx’s original conception of the exploitation of the worker revolves around the criticism that the “capitalist” unfairly takes advantage of workers by converting the “surplus value” of the workers’ labor into profit, which he argues belongs to the workers themselves. However, given the constraint of options for the workers, i.e. they must work and produce this labor for the wages that support their families, they must necessarily continue to labor for their exploiter.462

When discussing the issue of CLOD specifically, then, Hughes claims that the legislation of CLOD and legal option to donate one’s organ for compensation would be a forced, required choice of those individuals with severely constrained choice sets that couldn’t resist such a
tempting offer, and that choice would ultimately lead them back to a situation with limited autonomy and a severely constrained choice set. An autonomy-constraining option, rather than an autonomy-enhancing option, then would be one that “presupposes and/or reinforces” a system of individuals with constrained options in the original position. For example, Hughes argues that CLOD is only able to function in a society that presupposes large populations of poor people with limited, constrained options, which unduly influences them to donate their organ for compensation. Further, Hughes argues, CLOD reinforces these constrained choice-sets and limited autonomy by keeping these poor donors’ options constrained. So the addition of the option of CLOD would ultimately undermine these individuals’ autonomy and keep them in a situation of constrained choice sets rather than enhance their autonomy.

However, once again this issue doesn’t seem to necessarily be empirically true in regulated markets. Remember back to the study of the Iranian donors and recipients. Though the majority of the donors were poor, sixteen percent were from the middle class, which is a significant minority. So a system of CLOD does not then necessarily presuppose large poor populations with limited, constrained options, though they certainly would make for a more robust market, as James Stacy Taylor notes:

…it is not necessary for the introduction of such a market that [there] are “poor people and that we allow them to participate” in it. This is because all the proponents of such a market need presuppose is that some persons will be willing to purchase organs for transplantation, that others (of any economic standing) will be willing to sell them, and that the vendor and the purchaser will be able to agree on a price. Of course, no doubt almost all the vendors in such a market will be drawn from the ranks of the desperate poor, and so more organs would be sold if the poor did exist and were allowed to participate in such a market. But this point concerns the differential volume of trade that would take place in a current market for human organs with the participation of the poor, rather than the feasibility of such a market itself.

Similarly, there’s no evidence that in regulated markets CLOD necessarily reinforces constrained choice-sets like has been observed in the open, unregulated markets and black markets in organs. Like the many other articles and opponents that were discussed above, Paul
Hughes makes this argument by using evidence from unregulated, open markets and black markets in organs, such as India, which was a wildly unregulated market full of organ trafficking, coercion, and outright exploitation. He even openly admits that it could be different in regulated markets, but he essentially states that this is an empirical claim that we cannot know about before actually studying the consequences of an actual regulated market, conveniently ignoring the example of Iran.467

In fact, recent studies from Iran’s regulated system of CLOD don’t appear to support this notion. For example, certain recent studies found that paid donors reported the improvement of either, or both, their immediate and/or long-term financial situations. In a study involving 25 Iranian transplant centers and 600 paid living unrelated donors, 86.5% of donors felt complete satisfaction after donation, with 11.5% feeling relatively satisfied. A similar short-term study involving 30 transplant centers and 478 paid living unrelated donors had similar findings with a 91% satisfaction rate. Further, another study involving six different transplant regions and 44 different paid living unrelated donors reported that 73% of the donors reported that their financial problems were solved. Of these donors whose financial problems were solved, a little over half of the donors were interviewed within a year of donation, while the other half was interviewed in between one and seven years from their donation date, which suggests that CLOD is a viable solution for certain financial issues. Unsurprisingly, it was also found that nearly 90% of the donors interviewed were glad that they had the opportunity to donate their kidney for compensation in order to improve their financial situations.468 Thus, it seems fairly uncontroversial and clear that at least in regulated markets of CLOD, there is no necessary mechanism that “presupposes and/or reinforces” a constrained choice-set and limited autonomy,
meaning that the option of CLOD truly is an autonomy-enhancing option, rather than an autonomy-constraining option like this claim argues.

3.2.4) Claim Two - Exploitation from Constrained Choice Sets

But even if the choice of CLOD is actually autonomy-enhancing rather than autonomy-undermining, certain opponents of CLOD still argue that the choice sets are so constrained and limited that the voluntariness of the decision to donate an organ for compensation is negligible and makes consent to the transaction invalid, which is exploitation, either through coercion or an undue inducement. This claim of the exploitation objection argues that CLOD would force upon poor individuals an almost impossible dilemma: keep a part of one’s body or sell it to pay the bills. Basically, this argument states that the decision to donate one’s organ for compensation is forced due to coercive influences, i.e. poverty, and a constrained choice set, and informed consent can never be achieved in this context due to the voluntariness of the decision, i.e. the third step in the process of informed consent, never being real. Sandel labels this component of the argument the “fairness objection,” and he also points to the injustice of inequality being the basis of the market. He states, “…market exchanges are not always as voluntary as market enthusiasts suggest. A peasant may agree to sell his kidney or cornea to feed his starving family, but his agreement may not really be voluntary. He may be unfairly coerced, in effect, by the necessities of his situation.”

Essentially, where Hughes’ argument was that adding the option of CLOD actually limited autonomy and the range of choices for individuals, this claim of the exploitation objection merely states that the range of choices for these individuals is too small in the first place, which makes the choice of CLOD unfree, coerced, and not appropriate to be an option for these individuals. Of course, it’s not absolutely clear that limited choice sets necessarily lead
to exploitation, since every individual’s choice set is at least partially constrained due to factors outside their control; however, this argument focuses on choice sets that are excessively restricted, so it is a substantial and plausible enough objection that it must be fully addressed.472

There are two main related problems with this claim of the exploitation objection – the **arbitrariness problem of the exploitation objection** and the **paradox problem of the exploitation objection**. Let’s look at the arbitrariness problem first.

As shown in the statistics of Iranian donors above, a substantial minority of donors are from the middle class and not poor, which makes this claim of coercion only a *conditional objection* rather than absolute. And this is where one of the major problems of the exploitation objection arises, because it’s a *conditional argument*, both in substance and application, that seeks to “protect” poor individuals from making supposed coerced choices. The primary condition for this argument is obvious – the individual must be “poor enough” with a small enough range of options that he cannot freely make the decision to donate an organ for compensation without unduly, coercive influences affecting his decision. Alternatively, this condition could also manifest as the compensation for the act of donation being so large and attractive that it coercively convinces the individual to donate, i.e. undue inducement.473

However, in addition to this substance condition for the argument, the argument itself is also only *applied conditionally and pointedly* against CLOD, even though it is actually just as relevant and applicable to other market exchanges in this population. Essentially, then, this is what I call the **arbitrariness problem of the exploitation objection** – if the presence of coercive, unduly influences from a small range of options makes CLOD exploitative and unethical for poor individuals, leading to prohibition, then virtually every market or economical exchange by poor individuals should be considered exploitative, unethical, and prohibition-
worthy. Singling out CLOD for this argument is then *arbitrary and inconsistent*. This is actually a common type of argument used by advocates for CLOD, because it’s an obvious, pervasive, and simple objection that shows a contradiction and inconsistency in treatment of CLOD versus various other similar actions. For example, James Stacey Taylor discusses Gerald Dworkin making the argument that:

> …if the poor should be prohibited from selling their organs for this reason then they should also be prohibited from joining the army, engaging in hazardous occupations such as high-steel construction, or being paid subjects in medical experiments, since these decisions are also often made out of economic necessity, and thus should also be considered to exhibit diminished autonomy.474

Similarly, speaking about CLOD, Mark Cherry argues:

> Analogously, on the labor market, those who must settle for any unpleasant or more risky occupation, such as ditch digger, oil platform construction, or assembly line worker, must make the same type of choice; this does not necessarily mean that they are being coerced.475

Radcliffe-Richards et al. offers a similar argument comparing the inconsistent treatment between the rich and the poor when it comes to dangerous undertakings for pleasure or high pay:

> If the rich are free to engage in dangerous sports for pleasure, or dangerous jobs for high pay, it is difficult to see why the poor who take the lesser risk of kidney selling for greater rewards—perhaps saving relatives’ lives, or extricating themselves from poverty and debt—should be thought so misguided as to need saving from themselves.476

Thus, the arbitrariness problem suggests that this claim of the exploitation objection is inconsistently and prejudicially used only against CLOD when it actually applies to a plethora of other market transactions and decisions where poor individuals may be “disadvantaged” and “coerced” due to a limited range of options, such as health-risking jobs, like coal mining, or being paid for medical experiments. However, this is obviously immoral due to the extreme amount of paternalism it would lead to. So just like in other dangerous occupations or activities that we allow poorer individuals to partake in, it isn’t necessary to *outright prohibit* these activities, but rather we must simply *regulate* them enough to ensure a baseline threshold of safety and protection for the participants or workers. In fact, there’s sound evidence that live kidney donation is actually safer and less risky than many occupations. For example, on the one
hand, the logging industry in the United States has around 110.9 fatal injuries per 100,000 people. On the other hand, recent studies have found that surgical mortality from live kidney donations is 3.1 per 10,000, which essentially expands to 31 deaths per 100,000, and there is no significant higher long-term risk of death in live kidney donors than similar, non-donor individuals in the general population. Therefore, it stands to reason that it isn’t necessary or justifiable to outright prohibit CLOD, but rather we just must ensure a baseline threshold of safety and protection for both the donor and the recipient, which can be ensured via regulation.

If one still thinks that there is something substantially different about allowing a person to donate their kidney for compensation versus allowing them to substantially risk their health by working somewhere like a coal mine or logging company, then it is due to them seeing something inherent to CLOD itself that makes it fundamentally different than coal mining and inherently immoral. But by admitting this fact, one is also admitting that this claim of the exploitation objection in itself is not sufficient as an argument to prohibit CLOD, because, otherwise, it would require massive paternalistic efforts levied against poor individuals in all kinds of similar market transactions and decisions, which is obviously immoral and unjustifiable. Therefore, the exploitation objection is not sufficient in itself and must rely on further arguments, specifically the commodification objection, to justifiably prohibit CLOD by law and deem it necessarily immoral.

Relatedly, the paradox problem of the exploitation objection is a similar argument against this claim of the exploitation objection as the arbitrariness problem, and it also highlights why the objection of exploitation is not sufficient as an argument against CLOD due to its tendency towards inconsistency and contradiction. Remember, this claim of the exploitation objection states that the range of choices for these individuals is too small in the first place, so
the choice of CLOD is unfree, coerced, and *not appropriate to be an option for these individuals.* However, this is *prima facie* contradictory, because it is essentially exacerbating a problem that it is arguing against in the first place, i.e. a constricted or limited choice set. So, paradoxically, it is essentially limiting an already limited choice set, which it is arguing against in the first place.

Radcliffe-Richards et al. argues that “we cannot improve matters by removing the best option that poverty has left, and making the range smaller still,” because doing so would “make subsequent choices, by this criterion, even less autonomous.”481 Alan Wertheimer seems to agree. When discussing transactions that occur alongside or in cooperation with unjust background conditions, i.e. taking advantage of an unfair situation from earlier, he states:

> For society to say, in effect, “Because we have treated you unjustly [the poor] by failing to repair your background conditions, we will not let you improve your situation on terms that are fair, given these background conditions,” is to add insult to injury – in spades…We can lament that the transaction should have been unnecessary and work to render such transactions unnecessary in the future. But for here and now, and when the hand-waving is all done, we must ask what we should do about such transactions and relationships. And minor variations aside, we have just two choices: we can prevent them, or we can permit (and enforce) [read: regulate] them. Given those choices, it seems callous not to allow [one] to improve on his or her condition, simply because the transaction arises out of unjust background conditions.482

In fact, just as the arbitrariness problem also shows, the exploitation objection relies on something being *inherently immoral* about compensated organ donation in order for the objection to make any sense, because, otherwise, the additional choice of CLOD would be regarded as a good thing for an otherwise limited or constricted choice set. Therefore, both the arbitrariness problem and the paradox problem show that the exploitation objection is not sufficient in itself and relies on further controversial assumptions about the inherent immoral nature of CLOD to succeed. Cherry stated this problem the best when he wrote:

> In general, it is difficult to count a policy as exploitative if, as in the case of legitimizing organ sales, it increases the number of options open to individuals. In order to see such circumstances as exploitative, one must hold that there is something intrinsically wrong or debasing in selling one's organs, so that even if one does this freely, one has been brought to do something morally injurious to oneself.483
Thus, the exploitation objection ultimately doesn’t stand up to scrutiny as a sufficient argument to justify prohibition of CLOD in itself, at least in liberal, pluralistic societies such as the United States. But beyond these negative arguments deconstructing the claims of the exploitation objection, there are other more positive arguments regarding the notion of exploitation that can be made in favor of CLOD. First, one positive argument in favor of CLOD revolves around the existence of exploitation that is due primarily to the existing prohibition of a legally regulated system of CLOD. For example, de Castro argues that rather than worrying about exploitation in a heavily regulated, legal system of CLOD, we should focus on the rampant amount of harmful exploitation observed in organ black markets that thrive in nations worldwide that prohibit CLOD. These organ black markets are empirically verified with places like the Philippines, Bangladesh, and India having large clandestine, underground black markets in organs that are thriving, even though it is illegal in these areas. Furthermore, as previously mentioned in an earlier chapter, the only nation in the world with a heavily regulated system of CLOD, i.e. Iran, has effectively eliminated its organ black market due to strict governmental oversight and regulations over the entire system. Thus, not only should we worry more about exploitation in unregulated black markets in organs rather than regulated legal systems of CLOD, an argument can be made that we have a moral obligation from non-maleficence to regulate, rather than prohibit, CLOD, which I will expound upon in the next chapter.

Another positive argument in favor of CLOD argues that prohibiting CLOD only shifts the exploitation and coercion to the families of patients needing organs rather than eliminate it altogether. It’s already well known that cadaveric organ donation is hindered in many respects by the deceased’s family’s role in the decision to donate, which is due primarily to the emotional stress involved with the decision and its context. Hansmann even argues that it is a “misnomer
to call the current organ procurement system ‘voluntary’; it might be more accurate simply to call it ‘uncompensated,’” because families are essentially forced and coerced to make a decision in a time of extreme distress due to the passing of a loved one.488 The same can be said about living organ donation, too, and the family of a patient needing a kidney might even be put under more pressure and coercion to donate due to the chance to save a loved one’s life. Kishore argues that this family pressure and coercion is every bit as influential as poverty would be to poorer individuals.489 So it’s difficult to see why familial influences and coercion should be any more acceptable in living donation than the equal or lesser influences of poverty in a regulated system of CLOD, and it’s unclear how purchasing an organ for a loved one would be substantially different than donating an organ oneself.

So just as with the arbitrariness problem and paradox problem above, further arguments are needed to morally differentiate CLOD from other similar market transactions. The principles of autonomy and justice provide sound moral arguments in favor of CLOD, and combined with the insufficiency and failure of the differing claims of the exploitation objection, along with the other positive arguments from exploitation, it is clear that there are compelling moral arguments to be made from bodily autonomy and justice against the prohibition of CLOD in our society. Ultimately, the exploitation objection rests on the legitimacy of the commodification objection, which we turn to next, along with the ethical arguments from beneficence and non-maleficence.
Endnotes


396 ten Have and Jean, eds., *The UNESCO Universal Declaration on Bioethics and Human Rights*, 361.


406 Beauchamp and Childress, *Principles of Biomedical Ethics*, 254-256.


411 Beauchamp and Childress, *Principles of Biomedical Ethics*, 263.


Lawlor, "Organ Sales: Exploitative at Any Price?," 200.


Beauchamp, "Methods and Principles in Biomedical Ethics," 272.


Len Have and Jean, eds., The UNESCO Universal Declaration on Bioethics and Human Rights, 131.


Len Have and Jean, eds., The UNESCO Universal Declaration on Bioethics and Human Rights, 131-132.


Cherry, "Is a Market in Human Organs Necessarily Exploitative," 346.


Cherry, "Is a Market in Human Organs Necessarily Exploitative," 349.


Wertheimer, Exploitation, 299.

Cherry, "Is a Market in Human Organs Necessarily Exploitative," 349.


Chapter 4 – Beneficence, Non-Maleficence, and Commodification

Though the pro-CLOD arguments from the principles of autonomy and justice and the objection to CLOD from considerations of exploitation constitute the most popular and extensive arguments for and against CLOD, there are several other prominent arguments for and against CLOD that must be considered in any true ethical analysis of the concept. In addition to the principles of autonomy and justice, the other two principles of the concept of principlism, i.e. beneficence and non-maleficence, also provide strong arguments in favor of CLOD that revolve around the benefits of increased organ donation rates and cost savings, along with the avoidance of harmful, exploitative black markets in organs. On the other hand, the commodification objection argues that CLOD is a moral harm that violates human dignity and unethically commodifies the human body and/or human person, which cannot be justified by its practical benefits. Other, related objections claim that CLOD suppresses altruistic live organ donation and/or places a stigma on the compensated donors, which it is argued are both issues that are substantial enough to justify prohibition.490

This chapter analyzes these ethical arguments for and against CLOD, specifically those arguments dealing with the concepts of beneficence, non-maleficence, and commodification, along with the related objections from the suppression of altruistic donation and the potential stigma put on compensated donors. The chapter begins by analyzing the pro-CLOD arguments from beneficence and non-maleficence, and it is argued that CLOD is consistent with these ethical principles, along with being potentially morally obligatory in order to avoid and eliminate the harms associated with the black market in organs that naturally arises in the wake of prohibitive legislation of CLOD. The rest of the chapter is dedicated to analyzing the remaining major objections to CLOD, though the primary focus will be on the most significant of these
objections, i.e. the commodification objection. After a brief analysis of the background, context, and meaning of the differing formulations of the commodification objection, three rebuttals are given in response to the commodification objection in favor of CLOD: the first two rebuttals applying to the first formulation of the objection and the final rebuttal applying to the second formulation of the objection. After these three rebuttals highlight how the commodification objection is insufficient as a justifiable argument for the prohibition of CLOD, the final two objections from the suppression of altruistic donation and the potential stigma placed on compensated donors are analyzed, and it is argued that these are more practical than conceptual objections, which also do not provide sufficient moral justification for the prohibition of CLOD.

4.1) Beneficence and Non-Maleficence

Many view the principles of beneficence and non-maleficence as two sides of the same coin, because these two separate principles are regularly paired together in ethical dialogue due to their related natures. In fact, the very notion of a burden to benefit ratio analysis is based off of these principles, which is especially relevant regarding the concept of CLOD that inherently involves both benefits and burdens. However, given their differing specific focuses and the importance of the distinction between seeking benefits and the avoidance of harm in these pro-CLOD arguments, it is best to treat these two related ethical principles as distinct principles with distinct moral obligations, rather than considering them two sides of the same coin with similar focuses and obligations.

4.1.1) The Principle of Beneficence

The ethical principle of beneficence is derived from the virtue or character trait of benevolence, which is the disposition to act in ways that benefit others. Essentially, the principle of beneficence holds that one should benefit and perform good acts to and for others. The
concept is traditionally associated with terms like charity, kindness, and altruism, but in applied ethics it is broadly used “to include effectively all forms of action intended to benefit or promote the good of other persons.” This principle then imposes an obligation upon individuals to act in ways that benefit other people, though this obligation isn’t absolute, and it also includes an element of the overall welfare and utility of maximizing good for the greatest number of people. Depending upon the context, there are differing types of beneficence, such as general, specific, obligatory, and ideal. General beneficence is beneficence towards strangers and those who we do not have emotional relationships with, and specific beneficence is the act of good towards those we do have emotional relationships with.

The difference between obligatory beneficence and ideal beneficence is a little more practically obscure, but theoretically the difference involves the act’s obligation, since as stated above the principle does not impose an absolute moral obligation to always benefit others. In obligatory beneficence, acts of beneficence are morally imposed and required; whereas, ideal beneficence only includes non-obligatory acts of beneficence that are nonetheless virtuous, heroic, and noble. These acts are generally known as “supererogatory” acts or acts of exceptional beneficence, which we talked about in the previous chapter. The line between ideal/exceptional beneficence and obligatory beneficence is a point of contention in applied ethics, because many disagreements abound in the nature, scope, and limits of our moral obligation to benefit others. Fortunately, the realm of organ donation is, mostly, devoid of such a debate. From the perspective of CLOD and organ donation in general, acts of beneficence will either be ideal/general or ideal/specific, depending upon whether or not the donor had an emotional relationship with the recipient, though it stands to reason that in most cases of CLOD it would be transactions of ideal/general beneficence.
Thus, unlike the other arguments from principlism, the argument from beneficence in favor of CLOD does not necessarily invoke a moral obligation like the arguments for CLOD from autonomy (obligation to respect individual bodily autonomy) and justice (obligation for the fair treatment of the poor/rich and sick/healthy alike). But CLOD is ultimately consistent with the principle of beneficence by creating many more acts of beneficence via significantly increased rates and acts of organ donation and helping others in need, either financially or in the manner of health.497 Though financial incentives for live organ donation preclude this type of organ donation from being completely altruistic, these acts are still considered good, beneficent acts that now benefit both parties rather than just the recipient, i.e. the donor via financial compensation and the recipient via a life-saving organ.

In addition to the empirical evidence of the observable increased rates of organ donation in past organ markets, including the legally regulated market in Iran, recent studies also give further support to this common sense notion that providing incentives for live kidney donation would ultimately increase the number of kidneys donated from live donors. In an attempt to find a minimum threshold amount that would constitute a fair payment to significantly incentivize live organ donation in the United States, noted economists Gary S. Becker and Julio Jorge Elias concluded in a 2007 economics study that payments of roughly $15,200 would increase kidney transplants by 44% and payments of $37,600 would increase liver transplants by 67%, though larger payments could ultimately attract more donors, while also curbing the demand.498 Of course, this study was also completed a decade ago, so the minimum threshold for a fair payment might be significantly higher today. Other studies have come up with a less optimistic percentage of increase with a significantly smaller payment, though they still corroborate the common sense notion that incentives for live donation will ultimately increase donation rates.499
Additionally, there are several other practical ways that CLOD promotes and enhances beneficence via increased rates of live organ donation, including the reduction of harmful organ trafficking and abuse and the much greater long-term survival advantages that transplant recipients have over wait-listed dialysis recipients. This is because “both patient survival and graft survival are inversely [negatively] related to length of time on dialysis.” But beyond these significant benefits of adopting a system of CLOD, the most significant practical benefit of instituting a system of CLOD might be the cost savings that naturally follows its institution. This is because the federal government extends Medicare coverage to greater than 90% of Americans with kidney failure that need dialysis to survive via the End-Stage Renal Disease Program of the Medicare Act of 1972. And of the total fee-for-service spending by Medicare in 2014 of $435.6 billion, $32.8 billion of that overall total was comprised of fee-for-service spending for beneficiaries with end-stage renal disease, which accounts for over 7% of the overall Medicare spending. And these expenses have been continuously expanding, now accounting for $34 billion per year for dialysis care, which is a significant portion of Medicare’s overall spending.

Understanding this potential for cost savings, Arthur J. Matas and Mark Schnitzler decided to analyze the potential for cost savings in a system where the federal government would pay financial incentives to live donors. With the cost savings and better quality health outcomes associated with quicker transplants compared to long usages of dialysis, Matas and Schnitzler found that over a period of 20 years this type of system of CLOD could save the healthcare system over $90,000 per transplant patient, along with giving each transplant patient an additional 3.5 quality-adjusted life years (QALYs). If society would value this gain in QALYs at the same rate of value per QALY on dialysis, this would add an additional $174,740 to the cost-effectiveness of such a system, meaning the cost-effectiveness of such a system would equate to
nearly $270,000 per patient. Thus, even if the government would provide incentives in the range of $25,000 to $50,000, such as through tax credits, the overall system would still significantly benefit financially from CLOD, let alone the numerous other benefits that come from increased donation rates and better health outcomes. So though the argument for CLOD from beneficence isn’t one of moral obligation, the principle of beneficence certainly supports the institution of a regulated system of CLOD and is opposed to any prohibition that would significantly limit the overall amounts of beneficence in live organ donation.

4.1.2) The Principle of Non-Maleficence

The final principle of principlism is non-maleficence, and it essentially states to “do no harm” towards others. Though related to beneficence, non-maleficence is considered a separate ethical principle due to the differences in obligation between the two: where there is not always an obligation of beneficence towards others, there is always an obligation of non-maleficence towards others, though it’s not completely absolute. That being said, in the field of healthcare non-maleficence and beneficence share an almost intertwined existence due to the nature of healthcare usually employing cost-benefit ratios to decide whether or not the cost or harms, i.e. non-maleficence, of an intervention are worth the benefits or good results, i.e. beneficence. This highlights the fact that some harms can be justified for good results, and this challenges the conventional notion of non-maleficence’s priority over beneficence in healthcare. This is especially relevant for CLOD, because at its core there is a rather distinct cost-benefit analysis that weighs the benefits of the act with its likely costs or harms.

When it comes to the principle of non-maleficence and CLOD, this principle presents the most fascinating relationship with the concept, because it doesn’t necessarily interact directly with CLOD as the other principles do. Generally, in the context of organ donation the principle
of non-maleficence is associated with the harms inflicted upon the donor during the process of donating the organ.\textsuperscript{509} However, as highlighted in the previous chapter, it is widely accepted that the benefits of organ donation greatly outweigh the harms associated with it, and this includes cases of CLOD, too.\textsuperscript{510} So how exactly does the principle of non-maleficence come into play with CLOD, and how does it form a moral obligation to accept and not prohibit CLOD legally?

Well, two main claims have been argued. First, just as was argued from the principle of justice previously, some proponents argue that prohibiting CLOD is actually directly harming poor populations by disallowing them an opportunity to improve their situation. Robert Veatch actually makes this argument explicitly, though he connects this argument more with justice than non-maleficence.\textsuperscript{511} Further, after the Eliot Spitzer prostitution scandal, Martha Nussbaum came out with a very similar argument to Veatch’s in favor of prostitution, arguing that “the idea that we ought to penalize women with few choices by removing one of the ones they do have is grotesque…”\textsuperscript{512} In an earlier article, she argues that it is short-sighted to “rule off-limits an option that may be the only livelihood for many poor women…”\textsuperscript{513} All else being equal, this argument applies equally well to CLOD as to prostitution, because “ruling off-limits” one of the only acts that might benefit a poor person’s situation is an inherently harmful act.

In fact, this notion finds more support in one of the more specific normative rules from non-maleficence that Beauchamp and Childress address, specifically the rule of “not depriving others of the goods of life.”\textsuperscript{514} It’s certainly no stretch to assume that paternalistically prohibiting poor populations from exercising their bodily autonomy and improving their situation by compensated organ donation is a harmful act to these persons that deprives them of at least the opportunity to receive the goods of life, especially if we take it a step further, like Veatch, who argues that society has already denied these poor populations the goods of life. This argument is
bolstered by the fact that the last chapter highlighted why we shouldn’t think that CLOD transactions are any more exploitative or unfair than any other regular market transaction that these poor populations partake in, meaning avoiding this harm to these populations provides a strong moral obligation to oppose any prohibition of CLOD, especially when nothing else will be done to aid these populations’ plights anyways. Further, the same can be said about donors themselves, too – prohibition of CLOD leads to fewer viable organs for transplantation, which is a significant, if indirect, harm caused by prohibition. Not only does this mean fewer kidneys available, it means much more time spent on dialysis, which as Sigrid Fry-Revere reminds us in her recent book is no picnic. Discussing her friend Steve, Fry-Revere recalls this conversation:

“So why do you want a transplant?” [I asked] “I feel pretty damn awful, to be honest. I went from someone who worked full-time – you know, active runner, skier, etc., etc. – to somebody for whom just getting through the day has become a big deal…but I’ve done better than most people on dialysis.”…I had to leave, so I started to get up and put on my coat. “Hey, Sigrid,” Steve said firmly. When I stopped and turned to him, he stood up with difficulty. He shook my hand, tubes dangling from his abdomen. “Dialysis may be better than the alternative, but it’s not a solution.”

Thus, significant moral justifications would be required to justify these harms, which as we’ve seen so far just are not present or compelling to justify such burdens and harms to people.

A second and more popular argument is that prohibiting the legal regulation of a system of CLOD is actually harmful via the promotion and overall acceptance of underground black markets in organs, organ trafficking, and transplant tourism. Prohibition of CLOD ultimately creates an environment with a high organ demand (and low supply) where black markets and organ trafficking can emerge and thrive, as seen in the numerous cases listed in chapter 2 where black markets emerged when legislation was enacted. But black markets in organs aren’t just affecting individuals in foreign countries. In a 2012 estimate, it was estimated that greater than 1,000 Americans purchase kidneys illegally annually, and this contributes to the much larger overall global black market in kidneys, which is estimated to generate between $600 million and $1.2 billion annually. Thus, there are good reasons from the obligations of non-maleficence to
not prohibit such transactions, of course being contingent on the fact that there are no other
overriding ethical obligations, which we have yet to come across. This argument is justified by
the empirical proof provided by the only regulated, legal system of CLOD in the world, i.e. Iran,
which ultimately eliminated their organ black market, organ trafficking, and transplant tourism
through heavy regulation of a legal system of CLOD and taking away the need and motivation
for these practices.518

Though it’s debatable whether this obligation to prevent harm falls under obligations of
beneficence or non-maleficence, it is without a doubt an ethical obligation that we are mandated
to follow, no matter which principle it belongs to. Beauchamp and Childress identify four main
obligations that are related to the principles of beneficence and non-maleficence:

1. One ought not to inflict evil or harm.
2. One ought to prevent evil or harm.
3. One ought to remove evil or harm.
4. One ought to do or promote good.519

They identify the first obligation with non-maleficence and the latter three obligations with
beneficence. Whatever the case may be, it’s clear that we have a moral obligation to both prevent
and remove evil or harm from occurring. And since we have empirical proof in the example of
Iran that the strict regulation of CLOD (rather than its prohibition) can more successfully raise
the supply to meet the demand decreasing the overall motivation and need for black markets, i.e.
removing and preventing the evils and harms of black markets in organs, all else being equal we
have a moral obligation from non-maleficence and/or beneficence to avoid the potential harms of
black markets and organ trafficking and strictly regulate a legal market to protect recipients and
donors alike. And even if regulation of a system of CLOD wouldn’t be able to completely
eradicate black markets and trafficking in organs, it would certainly significantly diminish and
minimize these markets and trafficking acts to a bare minimum, which is still in line with our moral obligations to remove and prevent potential harms.

One needs only to look at the recent example of abortion in America to find more empirical proof of this logic. Before the legalization of abortion via *Roe v. Wade* in 1973, women with unwanted pregnancies were driven into “back-alley clinics” to receive clandestine abortion services in unsafe conditions, using methods that were highly questionable and dangerous to the woman, including: turpentine, bleach, and detergents taken by mouth, toxic solutions squirted into the uterus, and foreign objects like coat hangers, knitting needles, bicycle spokes, ball-point pens, and even catheters inserted into the vagina. Dr. David A. Grimes describes the impact on abortion death numbers after legislation and *Roe v. Wade*:

In the year I was born, U.S. vital statistics reported that more than 700 women died from abortion. The true number was substantially higher, and the population of the country was less than half of that today. In 2010, the most recent year with data available, the Centers for Disease Control and Prevention reported 10 deaths from abortion nationwide. Why the profound change? The principal reason was the legalization of abortion in America [emphasis added]. Childbirth-related deaths have decreased over the decades, but not so dramatically. To me, it seems clear: Access to safe, legal abortion saved women’s lives [emphasis added].

Thus, it’s clear that all else being equal, which this dissertation has shown is true thus far with its deconstruction of the exploitation objection, the obligations imposed by the principle of non-maleficence are compatible with a regulated system of CLOD. Further, it’s also clear that prohibition is ultimately a violation of the obligations of non-maleficence due to harming potential poor donors and unhealthy recipients and creating the necessary conditions and environment for the presence of organ black markets, organ trafficking, and transplant tourism to exist and flourish. It would then take significant moral justification to forego these moral obligations from autonomy, justice, and non-maleficence, let alone the beneficence promoted and encouraged by a regulated system of CLOD, and justify prohibition, which leads us into the commodification objection.
4.2) The Commodification Objection

Outside of the exploitation objection, the commodification objection is the most substantial and popular argument generally utilized in favor of the prohibition of CLOD. Based on human dignity and the instrumentalization of the human body and/or person, this objection holds that CLOD is a moral harm that society should not tolerate. Relatedly, two other lesser objections are commonly associated with the commodification objection, specifically the argument from the suppression of altruistic organ donation and the argument from the potential stigma placed on donors. Though all of these arguments and objections make certain valid points and hold some merit, the remaining sections of this chapter show how these objections ultimately fail as a sufficient justification for prohibition when all factors are considered.

4.2.1) The Background and Context of Commodification

Though it has been highlighted how practical and effective a regulated model of CLOD can be and how even the Iranian model has dealt with the ethical issue of the exploitation of the poor via the tremendous work of charities in Iran and their assurances that fair payments and contracts are the status quo, one ethical issue that is still readily apparent is the utilization of the commodification of the human body that ultimately underlies the entire system. In fact, the Iranian system takes an extreme form of commodifying the human body, because it essentially operates off of dual *quid pro quo* agreements that directly exchange cash for organs.

The argument from commodification is essentially based on the very first principle of the *Universal Declaration on Bioethics and Human Rights*, the principle of human dignity, which states: Human dignity, human rights, and fundamental freedoms are to be fully respected. Though being a widely utilized concept in ethics and human rights language, the concept of human dignity is notoriously ambiguous, and it is difficult to find any unanimous agreement on
its true definition. As a practical concept and principle, though, human dignity generally refers to the intrinsic value every single human being contains, and this value is an inherent dignity that must be unconditionally respected. Kishore explains this value and dignity as “an expression of the human content of Homo sapiens. It is an expression of the properties or virtues due to which a human creature is known as a human being. These are the characteristic or attributes that are unique to the human race and not possessed by any other living form.” The *Explanatory Memorandum on the Elaboration of the Preliminary Draft Declaration on Universal Norms on Bioethics* actually defines the concept of respect for human dignity as “[flowing] from the recognition that all persons have unconditional worth, each having the capacity to determine his or her own moral destiny. Showing disrespect to human dignity could lead to the instrumentalization of the human person.”

This is an ideal that is very prominent in Kantian moral philosophy, because Kant posited that humans contain an inherent value that makes us intrinsically valuable. Speaking about Kant’s vision of human dignity, James Rachels has the following to say:

…humans have “an intrinsic worth, i.e., dignity,” because they are rational agents - that is, free agents capable of making their own decisions, setting their own goals, and guiding their conduct by reason [emphasis added]. Because the moral law is the law of reason, rational beings are the embodiment of the moral law itself. The only way that moral goodness can exist at all in the world is for rational creatures to apprehend what they should do and, acting from a sense of duty, do it. This, Kant thought, is the only thing that has “moral worth.” Thus-if there were no rational beings, the moral dimension of the world would simply disappear [emphasis added]. It makes no sense, therefore, to regard rational beings merely as one kind of valuable thing among others. They are the beings for whom mere “things” have value, and they are the beings whose conscientious actions have moral worth. So Kant concludes that their value must be absolute, and not comparable to the value of anything else [emphasis added]. If their value is “beyond all price,” it follows that rational beings must be treated “always as an end, and never as a ‘means only.’” [emphasis added] This means; on the most superficial level, that we have a strict duty of beneficence toward other persons: we must strive to promote their welfare; we must respect their rights, avoid harming them, and generally “endeavor, so far as we can, to further the ends of others.” But Kant’s idea also has a somewhat deeper implication. The beings we are talking about are rational beings, and “treating them as ends-in-themselves” means respecting their rationality. Thus we may never manipulate people, or use people, to achieve our purposes, no matter how good those purposes may be [emphasis added].

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Thus, as previously discussed, the second formulation of Kant’s Categorical Imperative for ethical action is to always treat people as ends in themselves and never merely as a means, which is an extension and application of respecting human dignity. This means that people should always be treated as valuable individuals and never merely as a means towards some other end. As argued above in the context of exploitation, consensual two-way contracts do not treat the compensated organ donor as a mere means in CLOD, because the donor’s intrinsic worth is being respected by honoring the terms of the contract, i.e. being compensated, which is the very basis of contractual obligations. In terms of exploitation, it’s only treating the donor as a mere means if one utilizes coercion, deception, or theft in the process and/or doesn’t offer a fair price. However, opponents of CLOD argue that the very nature of providing monetary compensation for a person to donate their organ treats that individual merely as a means, i.e. a collection of useful parts, rather than a valuable individual that is to be respected wholly, and it ultimately changes that individual from a “person” to a “thing.” This process treats individuals merely as a means rather than an end in themselves, thus making it an unethical action.

This process of turning “persons” into “things” is labeled objectification, and it alters bodily parts into commodities. A commodity is essentially “anything intended for exchange.” It can further be described as any object of economic value. Thus, the process of bodily commodification is to take something with intrinsic value and objectify it, and once it is objectified it must be commercialized to give it an exchange value, which allows it to be sold for a price. This completes the transition from a “person,” or thing with intrinsic value, to a “thing” that is subject to market relations. Michael Sandel describes this process as corruption of the human person, and he believes it promotes an objectifying and degrading view of the human person. He argues that this corruption is caused by adding market relations to a non-market
product, so to place the human body in this market situation is to corrupt the very integrity of the human person.533

There are then two argument formulations for the commodification objection. Firstly, it can be argued that CLOD encourages a commodification of the human body, which is a moral evil wrong enough in itself to justify prohibition. Secondly, and more strongly, it can be argued that CLOD encourages a commodification of the human body, and commodifying the human body can ultimately lead to and cause a commodification of the human person and violation of human dignity, which is intrinsically wrong and should be outright prohibited by the State.534 Many differing versions of this argument have been put forth, such as Bernard Teo’s formulation of the argument when he states:

...the human body is not like other things. Since human bodiliness is intrinsically tied to human personality and identity, it follows that respect for the human person would also be intrinsically tied to respect for the human body and its parts. Because human dignity is intrinsically linked to human embodiment, treating the body and its parts as commodities would be to strip the human body of its proper dignity.535

Cynthia B. Cohen also gives a version of this argument when she states:

Human beings ... are of incomparable ethical worth and admit of no equivalent. Each has value that is beyond the contingencies of supply and demand or of any other relative estimation. They are priceless. Consequently, to sell an integral human body part is to corrupt the very meaning of human dignity.536

By essentially arguing that commodifying the human body and/or person is a moral harm that has no place in our society, the commodification objection provides a seemingly serious hurdle to the goal of an ethically palatable system of CLOD that should be legally available. However, there are serious inconsistencies within both formulations of the objection that raise serious questions about its justification for prohibition. These areas of weakness can be dismantled by three distinct modes of argument: arguments from liberal political philosophy, descriptive arguments of arbitrariness and a lack of consistency, and normative arguments of missing distinctions and false comparisons. When these three modes of arguments are combined,
it’s readily apparent that objections based on commodifying the human body and/or person are inconsistent and not sufficient to support a total prohibition on CLOD.

4.2.2) Rebuttal One - Mill’s Harm Principle

The first rebuttal comes from John Stuart Mill’s political philosophy, and it basically utilizes his harm principle to argue that even if commodification is a moral harm, the State has no authority to prohibit individuals from participating in such a trade. Remember, the harm principle states that, “the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others. His own good, either physical or moral, is not a sufficient warrant [emphasis added].”537 Thus, if we take the harm principle seriously as a normative guideline for individual freedoms in a liberal society, which virtually every modern liberal society does, or at least purports to - though they sometimes break it, e.g. helmet mandates for motorcycle riders, then the State has no moral authority to prohibit freely chosen CLOD transactions that have been properly consented to. The harm principle itself even directly and explicitly rebukes these types of paternalistic prohibitions:

His own good, either physical or moral, is not a sufficient warrant. He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinion of others, to do so would be wise, or even right. These are good reasons for remonstrating with him, or reasoning with him, or persuading him, or entreating him, but not for compelling him, or visiting him with any evil in case he do otherwise [emphasis added].538

Thus, it is perfectly within people’s rights and freedoms in a liberal society to try and convince and dissuade another from acting in a certain way that they view to be a “moral harm” to themselves, but there is no justification for the State to prohibit acts that do not protect other citizens from harm, even if many consider the action to be harmful to the individual partaking in it himself. This is due to the harm principle’s allowance of self-regarding harm. As long as the harm that someone potentially brings on oneself is self-regarding, doesn’t violate any specific duty (such as becoming intoxicated while on police duty), and doesn’t cause perceptible harm to
any particular person, then individuals ought to have the liberty to partake in that action, according to the harm principle. Even potentially harmful actions that may affect other people can be justified under the harm principle, as long as the harm is “through” the individual “in the first instance.” For example, while mountain climbing, a climber could fall and become injured, which would risk others’ lives and safety in an attempt to save him; however, since this harm occurs “through” the individual himself and wasn’t directed at anybody in particular, this is a chance and cost that society is willing to pay in order to maximize individual freedoms.539

Further, Mill believed that this right and application of the harm principle to actions is absolute, and any self-regarding action should not be restricted or prohibited by the State.540 His belief in the absolute nature of this liberal principle was so fervent that he argued that if “all mankind minus one, were of one opinion, mankind would be no more justified in silencing that one person, than he, if he had the power, would be justified in silencing mankind.”541 He even explicitly stated this in the last sentence of the fuller passage of the harm principle with a special mention of bodily autonomy and freedom of thought, explicitly stating: “The only part of the conduct of anyone, for which he is amenable to society, is that which concerns others. In the part which merely concerns himself, his independence is, of right, absolute. Over himself, over his own body and mind, the individual is sovereign [emphasis added].”542 Many arguments implicitly use this line of reasoning in their pro-CLOD arguments, such as Gill and Sade in 2002 when they discuss the “noninterference model” of laws regarding prohibition of CLOD.543 Even Alan Wertheimer gives what amounts to be an argument against prohibition of blatantly exploitative transactions, which opponents would consider CLOD to be, due to the need for the State to respect individual autonomy and the potential of a slippery slope to State paternalism, which is directly related to this argument from the harm principle.544
However, certain opponents don’t buy this claim. In particular, Cynthia B. Cohen argues that the State can and does justifiably prohibit certain actions that cross “certain lines grounded in basic social convictions,” regardless of an individual’s bodily autonomy and whether or not it affects or harms anyone outside of the individual herself. Using the examples of the certain types of prohibition on prostitution, pornography, and Schedule I drugs, such as LSD, cannabis, and ecstasy, she argues that we already have laws that prohibit certain types of behaviors, and this is justified based upon supposed shared, common values that we hold as a society, which allowed these laws to arise in the first place. She states:

These authors would separate morality and law, retaining morality for the private sphere. That an action is morally objectionable, they argue, does not give the state a right to interfere with the action, unless it would harm others. But this claim is patently incorrect. …there are many laws that restrict the freedom of individuals with regard to uses of their own bodies, such as those against the prescription and use of Schedule I drugs, pornography, prostitution, and voluntary servitude [emphasis added].

Even though we respect the freedom of individuals to do what they want with their bodies, we draw certain lines grounded in basic social convictions beyond which we do not give effect to their free choices [emphasis added]. These convictions include that the dignity of all human beings is to be respected, that the bodies of human beings are a crucial aspect of who they are, that to sell human beings or their integral body parts is to violate their dignity as human beings, and that it is wrong to allow human beings seriously to damage their own bodies in certain ways. We have written such public beliefs into law, even though the contrary beliefs would neither interfere with the autonomous self-regarding decisions of individuals nor harm others [emphasis added].

Using John Rawls’ principle of “public reason,” or what she describes as the “body of generally accepted common sense beliefs and ways of reasoning, as well as uncontroversial scientific conclusions,” she further argues that the reason we still hold a basic social conviction against the legalization of CLOD as a society is due to the fact that nobody has been able to sway this “public reason” to a different stance with good arguments from publicly accepted values, beliefs, and ways of reasoning. Thus, she argues, CLOD is “contrary to values at the core of our life together and should therefore be prohibited.”

There are several problems with this line of argument, but the most egregious is the obvious logical fallacy that is being committed here, namely the naturalistic fallacy, otherwise
known as the “is-ought problem” or “Hume’s Law.” When using analogical reasoning between morality and law, there is a problematic tendency to attempt to justify normative claims in the moral sphere by appealing to claims or descriptive facts in the law sphere. However, this is problematic due to the differing qualitative natures of the two spheres: where the law sphere is descriptive in nature, the moral sphere (at least in the sense that we’re discussing) is normative in nature. One cannot claim what ought to be on the basis of what is, just as one cannot justify a normative claim by merely appealing to descriptive facts. When Cohen tries to rebuke the harm principle as a justification for CLOD by appealing to current American laws that don’t follow this principle, including the current legislative prohibition of CLOD, she is committing the naturalistic fallacy/Hume’s Law by trying to justify an “ought” merely through an “is,” which is logically fallacious. Human beings are fallible, which means that unjust and immoral laws can still occur in the real world, but their presence does not justify the underlying unjust and immoral sentiment. The example used earlier of helmet mandates for motorcycle riders is a perfect example of an unjust law according to the harm principle, just as is the use of “sin taxes” to discourage the practice of supposed “vices,” such as alcohol, tobacco, gambling, etc. More will be discussed about sin taxes in chapter six.

To further demonstrate this fallacy, one only needs to look at Mill’s views on these issues to show that these laws and Cohen’s argument are not in line with Mill’s liberal political philosophy in the first place. On both prostitution and drugs, specifically alcohol, and assumingly pornography, as well, Mill was staunchly against any sort of attempt meant to curb individuals from partaking in these acts due to “moral” reasons or “basic social convictions,” such as the use of “sin taxes” or outright prohibitions. The only time that restrictions or prohibitions could be put into place would be to protect others from harm, such as the regulation and policing of liquor.
establishments or the banning of a harmful drunk from purchasing anymore alcohol, and even proactive regulations and rules could be justified to keep harm from others.\textsuperscript{547} Not coincidentally, this same arrangement with proactive regulations is consistent with the thesis of this dissertation, and it’s why a regulated rather than open, unregulated market is being argued for. Clearly, then, Cohen’s argument is fallacious, inconsistent with the harm principle, and does not provide normative evidence against the unjustifiable nature of State prohibition of CLOD transactions.

But what’s more, Cohen’s use of “public reason” and “basic social conventions” would also not sit well with Mill, because that falls right in line with Mill’s worry about the “tyranny of the majority.” In a very Nietzschen fashion, Mill’s worries about the tyranny of the majority squandering individuality and individual freedoms were very real:

Society can and does execute its own mandates: and if it issues wrong mandates instead of right, or any mandates at all in things with which it ought not to meddle, it practices a social tyranny more formidable than many kinds of political oppression [emphasis added], since, though not usually upheld by such extreme penalties, it leaves fewer means of escape, penetrating much more deeply into the details of life, and enslaving the soul itself. Protection, therefore, against the tyranny of the magistrate is not enough; there needs protection also against the tyranny of the prevailing opinion and feeling; against the tendency of society to impose, by other means than civil penalties, its own ideas and practices as rules of conduct on those who dissent from them; to fetter the development, and, if possible, prevent the formation, of any individuality not in harmony with its ways, and compel all characters to fashion themselves upon the model of its own. There is a limit to the legitimate interference of collective opinion with individual independence; and to find that limit, and maintain it against encroachment, is as indispensable to a good condition of human affairs, as protection against political despotism [emphasis added].\textsuperscript{548}

Clearly, then, Cohen’s argument from “public reason” and “basic social conventions” runs counter to the normative framework of the harm principle and Mill’s larger political philosophy, because if the harm principle is as absolute as Mill contends, then no amount of “public reason” or societal agreement upon social conventions can override the absolute authority that the individual has over his own body and conscience. Remember, this is the same man who made the argument that if “all mankind minus one, were of one opinion, mankind would be no more
justified in silencing that one person, than he, if he had the power, would be justified in silencing mankind.” Thus, it seems fairly uncontroversial at this point to say that State prohibition of CLOD is not justified by or compatible with the harm principle, and if we take this normative guideline seriously, which virtually every modern liberal State purports to do, then we should regulate rather than prohibit CLOD transactions to ensure that the most utility and least amount of harm possible occurs.

4.2.3) **Rebuttal Two - Arbitrariness and Inconsistency**

Though the harm principle provides sufficient justification for denying the legitimacy of any State prohibition on CLOD, there are further arguments that are even more damning to the commodification objection. First, descriptive arguments and analogies can both counter the first formulation of the commodification objection and demonstrate how bodily commodification in this form is already rampant in our society. For example, the first formulation of the commodification objection states that compensated organ donation encourages the commodification of human bodies, which is evil enough in itself to justify prohibition. But what exactly differentiates the human body, specifically an organ such as the kidney, from other types of commodities? There are several different accounts of the process of commodification and what distinguishes commodities from non-commodities, but they all generally agree upon certain basic components, such as a denial of subjectivity (lacks consciousness; no concern for feelings), instrumentality (primarily has instrumental value), and fungibility (replaceable/interchangeable with other things, such as money). Another expanded account of commodities essentially posits these same basic components in differing language: objectification (denial of subjectivity), fungibility (interchangeable), commensurability (measurable by a common standard, such as money), and money equivalence (ability to be ranked according to dollar/money value). Thus,
a commodity is then something that is (1) objectified, (2) containing no intrinsic value or importance, and (3) interchangeable/exchangeable with other things, such as money. When one receives compensation for donating an organ, then, it’s fairly obvious that all three of these factors are present, meaning CLOD is most definitely an example of commodification of the human body.

Though the question still remains whether or not this type of bodily commodification is necessarily “bad” or “wrong” enough in itself to justify prohibition. One argument against this notion is that according to these three basic components of commodification, CLOD fares no worse than altruistic live organ donation in this regard. That is, altruism does nothing to change the fact that the transplanted organ was (1) objectified, (2) containing no intrinsic value or importance, and (3) interchangeable/exchangeable with other things, i.e. the original organ, money due to healthcare costs, etc. In fact, these three components are pre-requisites for the very possibility of organ transplantation in the first place, meaning altruistic live organ donation commodifies the body in a similar way as CLOD. Of course, it can be argued that in altruistic donation money isn’t exchanged for the organ, which suggests that it’s categorically different from the commodifying act of CLOD due to the close link between commodification and money.

However, something can still be treated or regarded as a commodity without the actual exchange of money, which is justified and proven by the fact that things can be commodified whether they’ve been given, bought, or even stolen. Further, though it’s true that money wasn’t exchanged with the donor herself in altruistic live organ donation, money was still certainly exchanged in the process in the form of healthcare and transplantation costs. So essentially rather than the donor benefitting financially, wealthy physicians, nurses, hospitals, and organ procurement organizations reap the financial benefits from the transaction. Forcing
altruistic donation rather than donor-compensated donation then doesn’t mean that money doesn’t exchange hands. Rather, it just means that money is exchanged away from the donor herself. Ultimately, then, altruistic organ donation merely compels a great self-sacrifice on the part of the donor in a situation where all other parties benefit in a commercial setting that commodifies the human body every bit as much as CLOD.

Similarly, it can also be argued that the advances in regenerative medicine pertaining to organ regeneration and transplantation will still require a significant commodification of the human body in order to function effectively. Specifically in xenotransplantation and tissue engineering, though ideally these organ transplants would be autologous, i.e. coming from your own cells, after being generated in the lab or a farm animal, the recipient would still essentially be purchasing a body part that was custom made for their body. Conceptually, this is akin to designing and ordering a custom part for your car online and going to pick it up when it is completed, which is certainly a case of blatant bodily commodification. What’s more, being a component of individualized medicine, this would be an extremely expensive procedure that would involve great cost and effort to create. And just like with both compensated and altruistic organ donation, the created organ in the lab and/or farm still is (1) objectified, (2) containing no intrinsic value or importance, and (3) interchangeable/exchangeable with other things, i.e. the original organ, money due to healthcare costs, etc. Thus, there are good, compelling reasons to think that both altruistic organ donation and regenerative medicine transplantation commodify the human body in similar ways as CLOD.

To further defeat this formulation of the commodification objection, it should be noted that this type of bodily commodification is also rampant and well-accepted elsewhere in our society, which bring us to the arbitrariness problem of the commodification objection.
Similar to the same-named problem with the exploitation objection, this problem highlights the *arbitrary and inconsistent* nature with how the commodification objection is applied in this case. There are numerous other types of bodily commodification in our society that are not prohibited, so it’s *arbitrary and inconsistent* to only apply this objection to CLOD.

In fact, many of the more notable objections to CLOD have committed this fallacy, including Delmonico et al. in 2015 when they argued against pilot experiments of financial incentives for organ donation:

> Proponents of financial incentives claim to be merely seeking pilot programs to test their proposals (2,4). **However, an experiment that abandons a moral principle—in this case, the principle that the human body as such should not be treated as an object of commerce—cannot preserve that principle** [emphasis added].

In another instance, in addition to completely ignoring our society’s liberal values and the harm principle and advocating for an extremely paternalistic perspective, in 2006 Jha and Chugh advocated for an even stricter arbitrary position against CLOD:

> Furthermore, it is imperative that we recognize the immorality of allowing people to do serious damage to themselves for the sole purpose of making money [emphasis added].

However, as stated above this type of bodily commodification is already rampant and well-accepted in our society. For example, one of the more well-known cases of bodily commodification is the ability to sign up for clinical drug trials for compensation *where researchers can actually test the effects of certain drugs on the human body* – which is pretty much a paragon of bodily commodification. They even have dedicated websites for finding these types of research studies, *even a .gov site*, which suggests the government is even actively involved already with this same type of bodily commodification. Generally, these well-known practices are widely accepted as a “necessary and important” practice for finding new and effective medications and treatments to help ailing individuals. In fact, not unlike compensated organ donation itself, there is also a level of “volunteerism” and “altruism” associated with this
practice, because at its core you are helping others while also helping yourself. So how exactly is the commodifying act of CLOD any morally different than the commodifying act of paid clinical drug trials, which is even much more explicitly bodily commodification than CLOD?

Another example is the selling of eggs, sperm, and hair. Women regularly sell their eggs for thousands of dollars for fertility reasons or embryonic stem cell research. In fact, in New York women can sell their eggs for research for upwards of $10,000, which is even funded by public money, similar to this dissertation’s proposal below. In other instances, eggs can be sold for up to $50,000 under the right circumstances. On the other hand, men can make up to $1,500 a month for sperm donations at certain sperm banks. And even hair can be sold for thousands of dollars when properly cared for. Are these not also blatant examples of bodily commodification that we regularly accept and partake in already as a society? Of course, it might be objected that the commodification of these body products is qualitatively different than the commodification of body parts, which we’ll discuss in more detail below.

One can also look towards dangerous or hazardous occupations and careers for further examples of this arbitrariness and inconsistency. For example, on the one hand, the logging industry in the United States has around 110.9 fatal injuries per 100,000 people. On the other hand, recent studies have found that surgical mortality from live kidney donations is 3.1 per 10,000, which essentially expands to 31 deaths per 100,000, and there is no significant higher long-term risk of death in live kidney donors than similar, non-donor individuals in the general population. If we follow Jha’s and Chugh’s argument and “recognize the immorality of allowing people to do serious damage to themselves for the sole purpose of making money,” then we should purposefully not allow anyone to be loggers, boxers/fighters, coal miners, or any other significantly hazardous occupation for that matter, just like we shouldn’t allow anyone to donate
their organ for compensation. But of course this is an absurd, overly paternalistic argument that has no basis in reality, especially in our liberalized, pluralistic society that greatly values individual consciences and conceptions of the good, because, otherwise, vital functions and services that our society relies on wouldn’t be possible, let alone the massive paternalistic efforts it would require to undertake this feat in the first place.

One final example should be noted to cement the issue with this formulation of the objection, which involves the bodily commodification inherent within the military, especially as it relates to combat. The military and Veteran’s Association take this bodily commodification a step further by actually assigning individual “prices” for compensation for bodily injuries or amputations that soldiers might have suffered in service of their country. For example, in a piece by *The Washington Post* that discusses a particular soldier’s journey to receive his compensation package for his injuries sustained in war, it is stated:

> He would almost certainly be judged 100 percent disabled, entitling him to a minimum monthly payment of $2,858. He’d also receive special monthly compensation. “That’s something we pay above the basic monthly rates because of your amputations,” Washburn [the benefits counselor] said. Special monthly compensation payments vary widely and can be tough to estimate. **The loss of a single foot, hand or eye is worth $101.50 a month. Two missing legs can generate an additional payment of about $1,000-$1,300 a month. Missing arms are worth an extra $1,600-$1,800.** Washburn passed Shockley a spreadsheet with the categories and rates.[565]

Thus, when Dworkin used the analogy of poor individuals joining the army due to economic considerations being of equivalent status to poor individuals partaking in CLOD transactions due to economic considerations, his analogy was much more accurate than he even imagined, because not only are the motivations the same in each scenario, but there is apparently even price-to-part bodily commodification in both scenarios.[566] And there are many, many more examples just like these ones above, which proves that it’s completely inconsistent and arbitrary to single out CLOD as an unethical commodification of the human body that should be prohibited when we live in a society that has numerous other examples of this very same concept.
that aren’t prohibited and are even well-accepted and participated in. So when Delmonico et al. and others claim that the reason CLOD should be prohibited is because “the body should not be treated as an object of commerce,” as with the arbitrariness problem of the exploitation objection, this problem shows that **this objection is not sufficient** to justify prohibition of CLOD, because it doesn’t differentiate this act of bodily commodification from other non-prohibited acts of bodily commodification, which leads us to the second formulation of the commodification objection.

4.2.4) **Rebuttal Three - Missing Distinctions and False Analogies**

The second formulation of the commodification objection argues that CLOD encourages a commodification of the human body, and commodifying the human body can ultimately lead to and cause a commodification of the human person, which is intrinsically wrong and should be prohibited. In a sense, though this claim seems stronger than the first formulation, it is also much harder to prove. In fact, it necessarily goes beyond merely proving bodily commodification, because the presence of bodily commodification does not necessarily entail commodification of the **human person**. The **human person** is a concept intimately related to, but ultimately distinct from, the human body, so there is no necessary connection between the two where commodification of the body necessarily entails commodification of the person.567 And ultimately, this distinction is why this formulation of the objection can be so easily defeated.

Recall from earlier the definition given for the concept of respect for human dignity as “[flowing] from the recognition that all persons have unconditional worth, each having the capacity to determine his or her own moral destiny. Showing disrespect to human dignity could lead to the instrumentalization of the human person.”568 Essentially, this bases the concept of respect for human dignity on **human personhood**, which gives humans intrinsic, unconditional
worth with the ability to determine our own moral destiny, meaning respecting personhood is the requirement for respecting human dignity.

Like human dignity itself, the concept of “personhood” is a controversial moral and legal concept that has been long debated. However, it has long been utilized in the Western philosophical tradition, not legal tradition, to mean any moral agent (human or non-human) that possesses both (1) a consistent consciousness and rationality throughout time and (2) the ability to formulate ideas and plans with the ability to act out those plans. Essentially, this is consistent with the Kantian view of human dignity as being inherently connected to the rational component of humanity. Remember, James Rachels described Kant’s notion of human dignity as being an intrinsic worth that each human contains based upon that very rational agency that sets humans apart from other non-rational animals:

…humans have “an intrinsic worth, i.e., dignity,” because they are rational agents - that is, free agents capable of making their own decisions, setting their own goals, and guiding their conduct by reason [emphasis added]. Because the moral law is the law of reason, rational beings are the embodiment of the moral law itself. The only way that moral goodness can exist at all in the world is for rational creatures to apprehend what they should do and, acting from a sense of duty, do it. This, Kant thought, is the only thing that has “moral worth.” Thus-if there were no rational beings, the moral dimension of the world would simply disappear [emphasis added]. But Kant's idea also has a somewhat deeper implication. The beings we are talking about are rational beings, and “treating them as ends-in-themselves” means respecting their rationality. Thus we may never manipulate people, or use people, to achieve our purposes, no matter how good those purposes may be [emphasis added].

In essence, then, respecting human dignity is equal to respecting the human person, which, in turn, is equal to respecting the rational nature and component of humanity, or in Kantian terms – always treating the individual as an end in themselves and never merely as a means.

So this raises a twofold question. First, as already answered in a positive manner, does CLOD commodify the human body? Yes. Second, does that commodification of the human body lead to and cause a commodification of the human person? It’s not obvious why this would be true. As mentioned above, though they’re intimately connected in many ways, the human person/self and the human body are two distinct concepts/entities. For example, if an individual’s
hand is removed, then the human body loses an *important* part of itself; however, the human person is still intact and not significantly impacted. On the other hand, no pun intended, if an individual’s heart or brain is removed, then both the human body and the human person lose an *integral* part of themselves, since both the heart and the brain are needed for the human body to function and for the *consciousness and rationality* requirement of human personhood.

These bodily parts’ differing qualitative associations with human personhood are due to the “conceptual distances” between the concept of personhood and the necessity of that particular body part for the existence of personhood. For example, the hand is much more “conceptually distant” from personhood than the heart or the brain, which are both necessary for the *consciousness and rationality* requirement of human personhood and human dignity. When discussing the kidney in particular, it is clear that it is extremely “conceptually distant” from the notion of human personhood, because humans were granted two kidneys when we really only need one for effective survival. Mark Cherry puts this notion best when he writes:

> Even if sales that would necessarily involve a loss of life are ruled out, if the self is different from the organs that are separable and distinguishable from the self, *though the self may not sell some organs, it may sell others* [emphasis added]. Just as one only requires sufficient food and medicine to sustain life, rather than any particular serving of food or dose of medicine, *of those body parts that are both distinguishable and separable from the self, one only requires a sufficient set of body parts, rather than any particular parts or replacements, to sustain the biological life that in turn sustains personal life and consciousness* [emphasis added].

> Of course, it might be objected that even if personhood as a whole is not lost, it could be that a significant “piece” of the person is lost by losing something as important to human flourishing and functioning as a hand, limb, eye, etc. And this is actually the mode of argument for many objections to CLOD, specifically those that want to draw a distinction between selling certain body products, such as hair, blood, sperm, and eggs, and selling body parts. Some arguments claim that the “uniqueness and irreplaceability” of body parts, such as kidneys, compared to the common and replaceable body products makes body parts qualitatively different
than body products, and to sell these things would be to lose something “unique and irreplaceable” to the human person. Others, like Cohen, make a different claim from the Kantian notion of human dignity. Cohen claims that our bodies are intrinsically related to our human dignity, but certain “integral” parts of the human body, such as our kidneys, are much more closely related to our dignity than others, such as our hair. She argues that:

**Human kidneys are qualitatively different sorts of human bits and pieces from human hair, for they sustain life** [emphasis added]. Hair, in contrast, serves mainly as personal adornment. The preservation of life is a greater value than that of exterior beautification. Kidneys, consequently, are ethically more significant to us than human hair. Yet the reason that we reject the sale of human kidneys cannot be that we think it wrong to sell something that can be used to keep people alive… **The reason we are reluctant to exchange money for human kidneys is that this would deny something distinctly valuable about human beings — their human dignity and worth** [emphasis added].

Although ours is a pluralistic society, a basic ethical premise that underlies and allows this pluralism is that human beings have a certain dignity and worth. **We are not disembodied beings, but complex combinations of intellect, emotion, appetite, spirit, and body. Our body has special value because it is the medium through which we express ourselves. Thus, our special value as human beings extends to our bodies. Yet it does not extend to all parts of our bodies. We do not ordinarily consider that hair, spit, or fingernail parings carry human dignity and worth, for these generally function as inessential human bits and pieces unrelated to what it is that makes human beings of special value. It is those parts of the body that are integral to the functioning of human beings, such as kidneys, livers, brains, hearts, and eyes, that we take to bear special dignity and worth because of their role. When we or our integral body parts are sold, our dignity as human beings is denied** [emphasis added].

She goes on to further state that:

**This argument against selling human organs seems to contradict the view so closely associated with Kant that we ought to respect the autonomous choices of individual human beings. If people freely and rationally choose to sell parts of their bodies, some might argue, they should be allowed to do so. How does this putatively Kantian position square with his view that it is ethically wrong for the human community to allow its members to sell body parts? Since the body is the medium through which the whole person acts, its integrity is essential to Kant’s view of autonomy. Respect for autonomy entails respect for the fullness of the person, including our bodies. To sell an integral part of ourselves is to misuse our autonomy in the same way that selling ourselves into slavery does so** [emphasis added]. Autonomy is an important ethical limit, but is itself limited in scope and weight. It meets one of its limits when the sale of human body parts is at issue. Even though we respect the freedom of individuals to do what they want with their lives, we draw certain lines based on human dignity beyond which we do not give effect to their free choices.

Though it has already been shown how Cohen’s arguments regarding State limitations upon individual autonomy and freedoms through paternalistic means are faulty arguments, which she repeats here, this analysis suffers from another flawed premise that ultimately cripples the entire argument, specifically the premise that the *single* kidney is an “integral” part of the human
body, human person, and/or human functioning. The word “integral” is defined as “necessary to make a whole complete; essential or fundamental.” Now, Cohen could mean two separate things here. First, she could mean that the kidneys are a fundamental part of the human body that would constitute normalcy and make the body complete, or at least the normal, idealized human body with all of its parts and no defects. However, this wouldn’t make sense, because hair, blood, fingernails, and the other types of body products that she qualitatively distinguishes from body parts are also fundamental parts of the normal, idealized human body that also play significant roles in our body’s functioning.

Thus, Cohen clearly means “integral” in the second sense focusing on the “essential” component of the term. She even uses this language in the quote above:

> We do not ordinarily consider that hair, spit, or fingernail parings carry human dignity and worth, for these generally function as inessential human bits and pieces unrelated to what it is that makes human beings of special value [emphasis added]. It is those parts of the body that are integral to the functioning of human beings [emphasis added], such as kidneys, livers, brains, hearts, and eyes, that we take to bear special dignity and worth because of their role.575

Cohen is then saying that kidneys play a much more essential role to the functioning of human beings than hair, spit, fingernails, and other bodily products, which makes these body parts much more connected and related to our human dignity than other bodily products, so to try and sell these parts would be to violate our human dignity because of these parts’ special role in maintaining our human dignity. This is without a doubt correct regarding the essential role of kidneys and their greater moral status. The filtration and blood pressure functions of kidneys are absolutely essential to human life, and certainly they have a greater moral status than lesser body products like hair and spit. Yet the problem with extending this argument to CLOD is twofold.

First, by focusing on the function of the kidney and its role in human functioning, and even the liver for that matter, the argument does not apply to organ donation, either altruistic or compensated, since the functioning role of the kidneys is not affected by removing one of the two
kidneys, or even a part of the liver. As has been pointed out throughout the dissertation thus far, live kidney and liver donations are safe and effective procedures with very minimal to no long-term side effects, meaning the functioning of the remaining kidney and liver is not affected by donation. In fact, “a single kidney with only 75 percent of its functional capacity can sustain life very well,” and a single kidney will actually grow and adjust to filter as much as two kidneys normally would in the absence of the second kidney.\textsuperscript{576} Thus, if one of an individual’s kidneys stopped functioning, then the other would make up for its absence in functionality, which just highlights the fact that \textit{a single kidney of a human pair} is not necessarily integral or essential to human functioning. Of course, removing both kidneys or all of the liver would be consistent with Cohen’s thesis, but that is not what is in question or in focus here. Since the functioning of the remaining kidney and liver is not affected by donation of a single kidney or lobe of a liver, then by Cohen’s own logic, these specific body parts, i.e. the single donated kidney and the lobe of the liver that is donated, are \textit{not integral or essential} to human functioning, meaning human dignity is not affected by this type of organ donation.

Cohen foresees this problem and tries to hedge this objection with a rather peculiar argument that amounts to an invalid analogical argument with a faulty premise. Using blood as a body product that she’s trying to qualitatively distinguish from an “integral” body part like the kidney, she makes this analogy (incorrectly) between the two:

\textit{...the blood taken from a donor and the kidney taken from a donor differ in their importance with respect to the donor’s bodily functioning. Although the whole stream of blood is integral to human functioning, a pint of it is not. A person can function physically even though missing one pint. Two kidneys are integral to bodily functioning when both are a part of the human body, yet a person can function with only one if need be. However, a kidney is not like an appendix. To remove one is to extract a discrete part of a person that up to the point of removal had been integral to human functioning [emphasis added]. Consequently, although blood and kidneys are “both physical necessities,” a kidney seems more significant for human bodily functioning than a pint of blood.}\textsuperscript{577}
Cohen argues that even though humans can function with only one kidney, when both are present in the body they are both “integral” parts of the human body that are essential to human functioning. But, once again, this just simply is not accurate, and it certainly is not consistent with the terms “integral” and “essential.” The word “essential” is defined as “absolutely necessary; extremely important.” But as discussed above, if one kidney would suddenly stop functioning, then the other kidney would grow to compensate for this issue and continue the overall process of kidney functioning, with a similar process occurring in minor liver damage. Clearly, then, a single kidney is not “absolutely necessary” to human functioning.

What’s more, to try and distinguish between blood and the kidneys, and even the liver, in this regard is peculiar and self-defeating, because it only seems to prove this point even further. Cohen argues that though blood as a whole is integral to human functioning, a pint of it is not, and a person can still function without that pint of blood. But can’t the exact same thing be said about a kidney? “Though kidneys as a whole are integral to human functioning, a single kidney is not, and a person can still function without that single kidney.” And the exact same argument can be made about the liver, too, due to its regenerative qualities. Thus, Cohen ultimately undermines her own argument here, because due to the compensatory and regenerative natures of the kidneys and liver, in terms of removal and transplantation these body parts are more akin to body products that are not “unique and irreplaceable,” meaning they’re also not “integral” or essential to human functioning in a way that would preclude them from being justifiably put on the market and in violation of human dignity.

Second, similar to the argument above in the second rebuttal, it can also be objected that by Cohen’s logic CLOD is no different than altruistic organ donation in this regard, because both acts involve losing an “integral” or essential body part, which is contrary to human dignity.
Though admitting Kant does not specifically address this issue and that he’s rather inconsistent in his arguments in this regard, Cohen still tries to justify this distinction by arguing that:

> Although he is not always internally consistent, and sometimes says that human beings should not sell minor parts of themselves such as fingers, **he seems to distinguish between body parts that are integral to physical functioning, such as testicles, and those that are not, such as hair.** Thus, he allows circumcision, and indicates that a limb that is not essential to bodily functioning can be amputated to save one’s life. His point is **not** that because it violates human dignity to sell the human body, we should not sell its parts. It is that parts of the human body ordinarily required for normal biological functioning just are the person and cannot be given a sale price without impugning the dignity of the person [emphasis added]. Munzer also reads Kant as declaring that it is those parts of the body that are integral to the human being that share in his or her dignity, saying that in Kant “the emphasis lies on the integration—the “togetherness”—of the various parts of the body that make up the entire organism. **To sell anything that is integral to that organism impairs humanity and dignity** [emphasis added].” Kant, contrary to Gill and Sade, probably would accept the donation of a kidney as moral, even though before and at the point of donation it contributes in essential ways to our ability to act in the world as embodied selves. **Such donation would not destroy integral human functioning, for, once removed, the other kidney would take over kidney function. The donation of a kidney can be taken to uphold human dignity just because this would allow the donor to share something of him- or herself as a gift to another member of the realm of ends and yet would not destroy human functioning. Donation is a gesture of altruism and of solidarity with other human beings. It is the **sale** of a kidney, however, to which Kant would object because, **at the time of donation, the kidney is essential to the person. It is not a mere appendage. To put a price on a human being in this way would be to deny embodied human dignity** [emphasis added].

But once again, this argument isn’t really putting forth any serious analysis by relying on this faulty premise of a single kidney being an “integral” and essential part of human functioning. Cohen further fails to effectively distinguish how altruistic organ donation is qualitatively different than CLOD in this regard, and she tries to justify this faulty distinction merely by the presence of pure altruism in the former case. But as argued previously in this chapter, at worst CLOD transactions will generally have mixed motivations, including motives of altruism and charity, and these transactions are still considered beneficent actions that significantly help other people. Even certain opponents of CLOD recognize that the vast majority of CLOD participants will have mixed motivations that include altruistic motives. And there’s even evidence from Iran that charity, altruism, and aiding others is almost always a motivating factor in the decision to donate an organ for compensation.
So it’s not in any way clear why a pure altruistic donation would justify such a blatant violation of human dignity, in Cohen’s words, any more than a partly altruistic donation would. Both altruistic and compensated organ donation would be acts of ideal beneficence that are not morally obligatory, so they both would be virtuous, beneficent supererogatory moral acts. Cohen doesn’t provide a compelling reason to justify this distinction, because, in her own words, “at the time of donation, the kidney is essential to the person” in both altruistic and compensated organ donation, which I showed is a faulty premise above. Clearly, then, there’s no compelling reason to think that the fact that one act of donation has purely altruistic motives compared to mixed motives of altruism and self-interest in the other act of donation is sufficient to justify and warrant such a blatant violation of human dignity, as Cohen would label it.

It then seems clear that this notion that the kidney and liver are so inherently associated with human functioning and dignity that compensated donation would constitute an assault on human dignity is fallacious, because the single kidney and donated part of the liver are neither integral nor essential for human functioning, as evidenced by the effectiveness and safety of live kidney and liver donations in the first place. And even if we did accept this faulty premise as true, it would still not be able to qualitatively distinguish between altruistic and compensated organ donation, making them both assaults on human dignity, which is obviously a counterintuitive claim that we should not accept. And finally, this fallacious argument also illuminates why the distinction between body products and body parts, at least regarding the single kidney and part of the liver, and the “uniqueness and irreplaceability” argument are not relevant here, because due to the compensatory and regenerative nature of these body parts, these body parts are neither “integral” nor essential for human functioning, meaning their removal and placement on the market violates neither human personhood nor human dignity.
The commodification objection then fails to give a compelling and sufficient justification for the prohibition of CLOD in our liberal society. However, there are still two other minor objections that must be addressed before moving on: the potential stigmatization of compensated donors and the potential suppression of altruistic organ donation. First, there is some scattered evidence that compensated donors have been stigmatized in their respective societies after donating a kidney for compensation, which has made it difficult to keep in touch with these donors and give them the proper follow-up care. This stigma then sticks with these individuals, and it can harm their reputation and ability to do certain things later on in life, such as be hired at a certain place of employment. Second, there is also some evidence that the presence and allowance of CLOD might have a suppression effect on altruistic organ donation, especially for family members, as they would rather purchase an organ for a loved one rather than donate one themselves.581 Relatedly, some claim that the allowance of CLOD might actually decrease the total overall number of organs donated due to fewer altruistic donations.582 Opponents of CLOD then suggest that these potential issues are significant enough to justify a continued prohibition.

Obviously, these issues are more practical in nature than conceptual, which ultimately makes them much easier to deal with. Regarding the potential stigmatization of donors, even if this stigmatization of donors was severe and significantly affected donors who participated in CLOD transactions, it seems fairly uncontroversial that this would still be insufficient justification for prohibition of CLOD. In American society, differing populations place various different stigmas on various different practices, such as abortion, selling sperm and eggs, stripping, drinking alcohol, smoking tobacco, etc., yet we don’t believe that these things should be prohibited due to these stigmas. Once again, this is due to our society’s acceptance of classical liberalism, especially the harm principle and moral/value pluralism. We believe that individual
autonomy and conscience is a precious right that should not be infringed upon, or at least as little as possible, and as long as a practice does not impede upon the rights or autonomy of others, then we should have the right and ability to partake in such an action, though that doesn’t mean others can’t criticize us for those actions, as discussed above in the first rebuttal.

Furthermore, virtually all of the evidence that supports this claim of donor stigma comes from places where CLOD is prohibited, such as India, Pakistan, Bangladesh, the Philippines, etc., meaning most of this evidence is coming from black markets in organs and organ trafficking victims, which isn’t surprising. In fact, even the evidence that supports this claim from Iran comes from Zargooshi, which as I discussed earlier is a very problematic source for the Iranian model due to his research occurring before the modernization of the current system in Iran when it was essentially an open, unregulated market in organs. More recent studies even contradict Zargooshi’s data and detail a very high satisfaction rate among donors who would recommend donating a kidney for compensation, which is a far cry from this supposed stigma that is placed on compensated donors. Most likely the reason for this divergence and change in attitude is the normalization of the practice in Iran. Since CLOD was brought out from the shadows, regulated, streamlined, and promoted as a societal good, no longer is a stigma attached to this practice, though of course certain subpopulations may still practice this stigmatization of compensated donors. Though certain conservative circles in America still hold this belief today, abortion largely followed this same path, and it has become normalized as an acceptable practice today. The potential stigmatization of donors is then clearly an insufficient justification for prohibition of CLOD, and more than likely once the practice was normalized in our society, no widespread stigma would be attached to compensated donors, though surely there will always be certain groups and ideologies that disagree with the practice.
As for the suppression of altruistic organ donation, this is also another practical issue, though some want to make it a conceptual issue unnecessarily. First, it should be noted that any concerns about the institution of a regulated system of CLOD actually reducing the number of organs donated are greatly misplaced, because there is significant empirical evidence that demonstrates the effectiveness of financial incentives for increasing organ donation rates. Second, it’s also unclear how great of a concern the potential suppression of altruistic organ donation really is. Many don’t buy this as a serious, legitimate issue against CLOD, even certain opponents of CLOD:

As regards the first worry, it seems that there's no compelling reason to believe that organ sale would undermine the practice of free donation. After all, professional social work and charitable social work co-exist. Also, if organ sale led to a significant overall increase in the supply of organs, this would more than compensate for the reduced number of free organs. But in any case, it is far from clear that there is a significant practice of free donation to be undermined. As Harvey points out, "it is doubtful that there is a great number of willing, non-related potential organ-donors who will give without payment". Given the high level of pain and risk involved, free donation (except by relatives, who might well waive the fee, if it were offered) is very unlikely to take place anyway.584

And this brings up another question – what is the ultimate purpose of organ donation? If altruistic organ donations fell off completely with the institution of a regulated system of CLOD, yet the organ donation rates were still much higher, would it still be justified to continue practicing CLOD with its suppression of altruistic organ donation? The answer is a resounding yes! The purpose of organ donation is to help people and to save lives, and concerns about the altruistic motivations of the donors only come secondary to this primary concern. Further, as stated several times in this chapter, CLOD transactions are ultimately beneficent actions that involve a significant level of altruism already, so there is still a significant amount of moral good and altruism being displayed and enacted in such a system, especially if the donation rates were significantly increased. So just as with the stigmatization argument, the potential suppression of
altruistic organ donation is not a sufficient justification for prohibition of CLOD, and ultimately it’s more than likely a worry that is more theoretically based than practically based.

To wrap up this chapter, given the facts that (1) altruistic live kidney donation and regenerative medicine transplantation has been argued to be just as commodifying of the human body as CLOD; (2) our society already allows and promotes several different practices that commodify the human body just as much as, if not more than, CLOD; (3) CLOD does not significantly affect the functioning of the human body; and (4) CLOD does not lead to the commodification of the human person or violation of human dignity, it is clear that CLOD is not significantly different than altruistic live kidney donation, regenerative medicine transplantation, or other accepted practices in our society with regard to the commodification of the human body and person. And if CLOD is not significantly different than these other practices in this regard, yet we allow these other practices without prohibition, then there is no justifiable reason that CLOD is prohibited by law while these other practices are accepted and promoted.

Thus, there are significant practical and moral reasons to support the lifting of the paternalistic prohibition on CLOD in the United States and advocate for the institution of a regulated market of CLOD to more effectively serve our organ transplantation needs. The last two chapters have been dedicated to the moral arguments for and against CLOD, so it is prudent to review the moral conclusions that we’ve come to during this time before moving on to the next chapter and cadaveric organ donation:

- Due to the promise of regenerative medicine alleviating the organ crisis in the near future, we have a significant moral obligation to investigate the possibility of and allow the practice of CLOD if an ethically palatable system of CLOD can be developed. It is unjustifiably discriminatory and prejudiced against non-moral properties in individuals to deny an ethically palatable system for morally paternalistic reasons that does not protect others from harm.
• We have significant moral obligations from the principles of autonomy, justice, and non-maleficence to oppose any prohibition of CLOD and support a regulated market.
  o We have good moral reasons from the principle of beneficence to oppose any prohibition of CLOD and support a regulated market.
• In a regulated market with a set, fair price paid to donors, exploitation of poor donors from unfair prices and being unfairly taken advantage of can be avoided.
• The allowance of CLOD is autonomy-enhancing, not autonomy-undermining.
• The exploitation objection from constrained choice-sets cannot adequately distinguish CLOD transactions from other market transactions. Thus, it is insufficient as justification for prohibition of CLOD and relies upon the commodification objection to ultimately succeed.
• Our society’s acceptance of classical liberalism and the harm principle voids the commodification objection as a valid argument for the prohibition of CLOD.
• The first formulation of the commodification objection cannot adequately distinguish CLOD transactions from the various other forms of bodily commodification that our society accepts and does not prohibit. Thus, it is insufficient as justification for prohibition of CLOD.
• The second formulation of the commodification objection is not a sound logical argument. Thus, it does not provide justification for prohibition of CLOD.
• The arguments from stigmatization of donors and suppression of altruistic organ donation are practical arguments that are not sufficient as justification for prohibition of CLOD.
• Therefore, the current prohibition on CLOD in the United States is practically ill-advised, morally inappropriate, and unjustifiably paternalistic.

Of course, this doesn’t mean that we should outright follow the Iranian model of extreme bodily commodification either, because perception matters in developing an ethically palatable system of CLOD in a multicultural, liberal society such as the United States. As I’ll discuss in chapter six, using an alternative route of compensation and couching it in the language of tax benefits is much more palatable than a market with *quid pro quo* exchanges of cash for organs.
But this isn’t to say that within our liberal society with autonomy-based ownership rights over our bodies that we don’t have the fundamental individual rights to subject ourselves and our bodies to that type of commodification should we so choose. At this point, it should be clear that even if CLOD did represent some sort of bodily commodification that led to commodification of the human person, the harm principle grants sovereignty over individuals’ bodies to the individuals themselves, meaning combined with the plethora of other similar types of bodily commodifying actions in our society, there would be no political or moral justification for prohibition of such a practice in a liberal society. However, with the addition of the ethical justification that strikes down the second formulation of the commodification objection, it is more than clear that there is absolutely no justification for prohibition on CLOD within the United States, and we should strive to minimize and regulate commodification rather than prohibit it. Once again, Cherry sums this issue up the best by stating:

Commodification of human organs is not an obvious violation of the Kantian maxim to treat persons as ends in themselves absent additional arguments showing that even consensual selling of organs is morally injurious. The organ market respects vendors as persons and moral agents. Prohibition, in contrast, may demean the poor by considering them unable to make moral decisions about their own fates.585
Endnotes

495 Beauchamp and Childress, Principles of Biomedical Ethics, 204-205.
514 Beauchamp and Childress, Principles of Biomedical Ethics, 154.
517 Fry-Revere, The Kidney Sellers: A Journey of Discovery in Iran, 6-7.
519 Beauchamp and Childress, Principles of Biomedical Ethics, 152-153.
523 ten Have and Jean, eds., The UNESCO Universal Declaration on Bioethics and Human Rights, 93-94.
532 Marway, Johnson, and Widdows, “Commodification of Human Tissue,” 582.
535 Bernard Teo and Bernard Tea, "Is the Adoption of More Efficient Strategies of Organ Procurement the Answer to Persistent Organ Shortage in Transplantation?," Bioethics 6, no. 2 (1992): 125.
538 Mill, On Liberty and Other Essays, 14.
541 Mill, On Liberty and Other Essays, 21.
542 Mill, On Liberty and Other Essays, 14.
549 Mill, On Liberty and Other Essays, 21.
Chapter 5 - Cadaveric, Imminent Death, and Other Organ Donation Proposals

Though thus far the dissertation has focused primarily on making the moral justification for CLOD, this chapter switches focuses and discusses some other potential proposals to increase organ donation rates. Specifically, this chapter will examine the ethics behind several differing cadaveric organ donation consent systems, including systems of opt-in, explicit consent, opt-out, presumed consent, and mandated choice, along with several other proposals that don’t necessarily belong to either of the categories of live organ donation or cadaveric organ donation. One such proposal focuses on harvesting organs from those patients near the end of life who have decided to withdraw life-sustaining treatment and let nature take its course, and these potential donors are designated as Life Support Withdrawal Donors (LSW Donors). In a general sense, the use of LSW Donors to increase organ donation rates can be labeled as Imminent Death Organ Donation (IDOD). Recently, the joint ethics committee for the Organ Procurement and Transplantation Network (OPTN) and United Network for Organ Sharing (UNOS) has debated the potential use of certain variations of IDOD within organ procurement organizations across the country. However, the OPTN/UNOS Ethics Committee concluded in March of 2016 that there was not sufficient justification for further pursuing IDOD at this time due to a major concern of harming the public perception of organ donation.

This chapter ethically analyzes these various different cadaveric organ donation consent systems and proposals to increase organ donation rates, and each system and proposal is deliberated upon to decide whether or not it should have a role in any revamped system of organ donation and transplantation in the United States. The chapter begins by looking at the three main differing consent systems used for cadaveric organ donation across the globe, and it is argued that a mandated choice consent system combines the practical effectiveness of opt-out,
presented consent systems with the ethicality and focus on autonomy that comes with opt-in, explicit consent systems. Next, the chapter transitions to the ethical analysis of IDOD, and it is argued that while one variation of IDOD certainly is unethical and can damage the public perception of organ donation, there is a variation that does not fit this bill and should be actively promoted and encouraged as a legitimate source for harvesting viable organs for transplantation. Finally, the chapter ends by looking at several alternative proposals related to IDOD, and each proposal is analyzed and judged for its practicality, ethicality, and status for implementation.

5.1) **Present and Past Cadaveric Systems: Ethicality**

Traditionally, two differing types of consent systems have dominated the debate surrounding consent processes in cadaveric organ donation – opt-in, explicit consent systems and opt-out, presumed consent systems. Each system has its particular strengths, particularly the focus and respect for individual autonomy in opt-in, explicit consent systems and the practicality and increased organ donation rates associated with opt-out, presumed consent systems. However, a newer type of consent system has become popularized in recent years that seemingly combines the strengths of the two standard systems without their weaknesses – mandated choice.

5.1.1) **Opt-In, Explicit Consent**

The opt-in, explicit consent system is the traditional consent model for cadaveric organ donation, and this type of consent system is generally considered the ethical “gold standard” of consent systems. This is because this type of consent system is essentially a donation model that provides the most amount of respect for the principle of individual autonomy, which is extremely important in individualistic societies like the United States and other states heavily influenced by Protestant individualism, such as Germany, most of the United Kingdom, and Canada. This deontological notion of freedom and autonomous decision-making with what happens to one’s
body after death is of utmost importance to many Americans, and this consent system has generally been considered the most efficient system of respecting individual autonomy, even if sometimes it doesn’t “catch” individuals that would’ve been donors.588

However, though opt-in, explicit consent systems are considered the ethical “gold standard” option for national systems of cadaveric organ donation, this ethical benefit must be weighed against the practical realities – this system is rather inefficient at procuring organs and consent from potential donors. As detailed in chapter two, compared to opt-out, presumed consent systems, it is evident that opt-in, explicit consent systems are at a significant disadvantage in effectively producing high organ donation consent rates.589 And not only is this a practical concern, but ethically-speaking this represents a substantial decrease in acts of beneficence and good will towards others, since organ donation is an extremely beneficent act that is in the supererogatory moral category. There is also a concern from non-maleficence here, because as detailed last chapter we have obligations from non-maleficence to prevent and remove evil or harm from occurring.590 So it might be argued that since we know that opt-in, explicit consent systems are not nearly as effective as opt-out, presumed consent systems, we are allowing many more people to suffer on dialysis and ultimately die from not receiving an organ, which is something that we have a moral obligation to prevent or remove from happening.

Finally, there is also another potential ethical issue that pervades both opt-in and opt-out systems, which is family consent. In both types of systems, it is unethical to limit the family’s decision-making ability when they have clear and objective evidence of what the deceased would have wanted, both to donate and not to donate. Generally, this is only seen in legislation within Austria’s hard opt-out format, even though it practically hasn’t been enforced.591 But whatever
the case may be, if the family truly knows the deceased’s preferences and has clear evidence to support their claims, then legislation shouldn’t be able to hinder their involvement.

5.1.2) Opt-Out, Presumed Consent

Primarily, though, the ethical issues generally revolve around the notion of “presumed consent” within opt-out systems. Even though opt-out, presumed consent systems have been much more effective at increasing organ donation rates than opt-in, explicit consent systems, it has been vehemently argued that an opt-out system, and the overall notion of “presumed consent,” violates the ethical principles of autonomy and informed consent, because there is no express, written consent given for organ donation, only “presumed” consent based on a failure of individuals to express an objection to organ donation. Further, some have argued that most systems of “presumed consent” are ultimately nothing more than paternalistic systems of routine organ salvaging, as argued by Robert Veatch and Lainie Ross recently:

> Even if one is not categorically opposed to taking organs without consent, there is good reason to object to policies labeled “presumed consent.” The term has the appearance of a desperate attempt to hold on to the model of consent and donation by using the language of consent for what is really a policy of routine salvaging, that is, taking organs without consent. It is simply dishonest to claim that we can presume that someone would consent when the empirical evidence shows that presumption would be wrong as much as half the time. It dresses the salvaging in the flimsy outer garb of the consent doctrine. Instead, if one favors salvaging, it is far better to admit it openly.592

They go on further to distinguish between true “presumed consent” laws and those laws that are simply disguised forms of paternalistic routine organ salvaging by the State:

> The problem with “presumed consent” is that, with a few exceptions, the existing laws never actually claim to presume consent, nor can they rightly be said to do so. They simply authorize the state’s taking of the organs without explicit permission. It therefore seems wrong to call them presumed consent laws. They are, in effect, routine salvaging laws.593

Thus, where opt-in systems more closely align with the ethical principles of personal autonomy and expressly informed consent, due to involving an active informed decision about whether or not one wants to donate their organs upon death, opt-out systems align more with the principles of justice and beneficence, due to the increased rates of beneficent acts and the focus
Veatch and Ross directly make this connection between the underlying political philosophies of certain States and their respective consent policies for cadaveric organ donation. For example, in most classically liberal Western societies and/or societies deeply influenced by Protestant individualism where the individual is the primary moral agent over the community, such as the United States, opt-in, explicit consent systems are the norm, because there’s a general societal agreement that the State needs individual consent to use individuals, or their bodies, in certain ways. On the other hand, in more communitarian, socialist, and/or Catholic societies where a focus on the individual is less robust in favor of the common good, such as many countries in Southern Europe, Scandinavia, and South America, opt-out, presumed consent systems are the norm, because it is accepted that the State or community might use individuals’ bodies for important community measures, even without individual consent.

Technically, though, this ethical issue is only practical in nature, because if a nation was able to provide massive public health education campaigns and reach full awareness of its citizens about the opt-out organ donation process, then a lack of opting out could legitimately be viewed as consent to donate one’s organs upon death. However, theory isn’t always practical, and having a nation’s total population reach full awareness on an issue would be a Herculean task and practically impossible. Compounding this problem is the fact that most of the individuals who would not be reached or informed about such a requirement and would have their autonomy violated would be the lesser well off individuals of society, such as the poor and poorly educated. This was the UK’s Organ Donation Taskforce’s viewpoint on the matter. While theoretically they had no fundamental moral objection to an opt-out system, they argued that practically it would be extremely difficult to implement without ensuring violations of informed consent and a lack of awareness in at least some of the population, so they
recommended that the UK exhaust all of their options at improving their opt-in system before switching to an opt-out system. Of course, it should be noted that the UK’s Organ Donation Taskforce’s opinion was in 2008, and since that time Wales actually officially converted to an opt-out system in December of 2015.

Thus, in opt-out, presumed consent systems a certain level of individual autonomy violation is ultimately accepted as a foreseen but undesirable and unavoidable consequence of increased organ donation rates for the common good. In a classically liberal Western society that values individualism in an extreme way, this is a very crucial ethical concern, because it’s unlikely that any consent legislation that takes power away from the individual in order to give it to the State could ultimately survive or thrive in the hyper-individualistic society and culture that rules the United States, even if it did come with increased organ donation rates.

5.1.3) Mandated Choice

Fortunately, there is a way to combine the efficacy of opt-out systems with the ethicality of opt-in systems: mandated choice. Essentially, this system requires individuals to register their preference for cadaveric organ donation by asking individuals about their preferences directly and requiring an answer for the completion of some sort of form or document, such as a driver’s license application. This type of system is perfectly suited for organ donation, because mandated choice systems work best in bifurcated systems with simple answers, e.g. yes or no, opt-in or opt-out, etc. This system has other advantages, as well. First, mandated choice systems allow individual preferences to be more accurately recorded via active, explicit choice. This is a very important advantage over presumed consent and even explicit consent systems, because many times the family of the individual will unfortunately deny organ donation due to not knowing the exact preferences of the deceasing individual. Further, many mandated choice systems then
allow the individual’s explicit consent to trump any family objections. For example, Illinois’ mandated choice system makes explicit consent from the individual sufficient for organ donation, meaning the individual’s family’s consent is not required. More will be said later on the importance of getting consent from individuals themselves rather than their families, but it is clear that mandated choice systems offer the advantage of more accurately recording individual preferences by requiring individuals to reveal their preferences for organ donation.

Similarly, another related advantage is the vast increase of the base number of individuals that are explicitly asked about becoming an organ donor. In both opt-in and opt-out systems, there really is no widespread mechanism to garner preferences from individuals, and this is ultimately the major driving factor behind the problems of both opt-in, explicit consent systems (inefficiency at attaining consent in high rates) and opt-out, presumed consent systems (violation of autonomy due to ignorance). In mandated choice, though, by requiring large proportions of the overall population to answer the question and register their preference for organ donation, usually via driver’s license applications or state identification cards, or, even better, on federal tax documents, which works perfectly well with the CLOD proposal that this dissertation is ultimately arguing for, the number of potential organ donors can more accurately reflect the public opinion and attitude towards organ donation, which is generally very high and supportive.

Recently, several states have switched to a mandated choice system, and drastic benefits were seen almost instantly. For example, in Texas in 2010 a new law came into effect that required individuals applying for a new driver’s license to answer the question of whether or not they’d like to register as an organ donor. Before that law passed in January 2010, only two percent of adult Texans were registered as organ donors, and by July 2010 approximately five
percent of adult Texans were registered as organ donors. The Texas Department of Public Safety workers, who were responsible for asking the question about registering as an organ donor, went through extensive training in organ donation and the donor registry in 2012 to better answer questions that potential donors might ask before signing up, and between this training and the longer usage of the mandated choice system, by January 2013 seventeen percent of eligible Texans were registered as organ donors. Similar effects have been observed in many other states that have recently switched to systems of mandated choice, too, such as Illinois and California to name a few, including a nine percent raise in registered organ donors in the first six months of Illinois’ adoption of a system of mandated choice on driver’s license applications.

Of course, some may argue that it’s paternalistic and coercive for States to require an answer and force individuals to register their preferences in this way, because this is a potentially complicated and private matter that would obstruct one’s ability to tend to their own business, such as renew their driver’s license, file their taxes, etc. However, with as little as is being required by a system of mandated choice, this argument is hardly compelling compared to the alternatives. In a recent journal article, Douglas MacKay and Alexandra Robinson made a similar argument that while there might be a minor moral wrong with the minimal coercion involved with mandated choice systems, it is still significantly morally better than the alternatives, which all utilize some form of “reason-bypassing nonargumentative influence,” or “nudges,” which we’ll cover next chapter, that hinders individual autonomy and influences free will/choice on the subject. While not necessarily totally agreeing with their appraisal of “nudges,” it does seem clear that a mandated choice system is a much more ethical and efficient overall option than systems of either presumed consent or explicit consent, which both contain significant weaknesses. Thus, there are substantial ethical and practical advantages to adopting a
mandated choice system of cadaveric organ donation over a system of presumed consent or explicit consent, and it ultimately is the most ethical system of cadaveric organ donation that should be utilized in any revamped American model.

5.2) **Imminent Death Organ Donation and Other Proposals**

Beyond the differing proposals for cadaveric organ donation consent systems, there have also been other recent proposals to increase organ donation rates. These proposals range from harvesting organs from those LSW Donors near the end of life to harvesting organs from prisoners and those individuals who have decided to undergo euthanasia or physician-assisted suicide. One proposal even suggests that organ procurement should be one potential method of euthanasia in order to ensure viable organs for transplantation are harvested from potential donors. But though all of these proposals would potentially increase the organ donor pool, not all of them are ethically justifiable, and some of them are not ultimately worth the potential to harm the practice of organ donation, procurement, and transplantation as a whole.

5.2.1) **Imminent Death Organ Donation**

Understanding the practical context of organ donation, specifically brain death versus cardiac death, is critical for discussing these newer proposals for organ donation, because these proposals ultimately rely and focus on this crucial moral and practical distinction in the definition and type of death. Ever since the controversial case of Bruce Tucker in 1968, the concepts of “death,” “brain death,” and “organ donation” have been intrinsically linked. Thanks in large part to developments from this controversial case in 1968, today the concept of death is largely associated with the cessation of brain function, either in part or in whole, though in some cases the lack of a beating heart is still integral to some conceptions of death, as we will see below. The legal definition of death, which has been accepted by every state in the US as set
forth by the “Uniform Determination of Death Act,” requires either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, to be considered legally dead.608

This conception of brain death is defined as a whole-brain concept of death. Though it is by far the most common and popular conception of death, it is rivaled by other competing concepts of death that don’t go quite as far as the requirement of whole-brain death. For example, the higher-brain death conception of death argues that only those activities associated with the higher components of the brain, such as human consciousness, are required to be lost to be considered truly dead. Further, there is also the more traditional and historical conception of death associated with the cessation of the functioning of the heart and lungs, and relatedly the loss of breathing and blood flow, and as seen above, it is still one way of determining death legally, which sometimes leads to awkward situations with two different ways to determine death. Many believe that the increased scientific knowledge regarding the brain’s functioning led to a fundamental shift in our conception of death in the late twentieth century.609 Of course, others have a more sinister explanation that claims that the addition of the concept of brain death is merely just a way to increase the cadaveric organ donor pool and ultimately solve a social problem by “gerrymandering” the lines between life and death, along with the additional benefits of providing clearer, more distinguishable conditions that were easy to diagnose, provided clearer prognoses, and allowed for smoother transitions.610

But it might be asked – why is the conception of death so important for the concept of organ donation? Well, that’s primarily due to two reasons. First, the dead donor rule, which we’ll discuss in much more detail below in the section on the ethics of organ donation, requires donors to be dead before removing vital organs.611 This deontological rule limits the utilitarian
justifications that can be justified in the process of organ donation, and it’s an important rule that keeps organ donation balanced as an ethical medical intervention. So the exact timing of death is crucial in this regard. Second, brain death organ donation is the absolute “gold standard” for organ donation, because it allows for the removal of virtually every abdominal and thoracic organ in a controlled environment before actually “unplugging” the cadaver from the mechanical life support that is continuing respiration, and thus blood flow that keeps the organs healthy and absent of ischemia, i.e. a lack of blood flow that damages the organs. Therefore, the diagnosis of brain death leads to the best possible scenario in the procurement of organs.

But brain death organ donation is not the only type of organ donation practiced today. In patients that do not meet the conditions of brain death, either as conscious, capacitated patients or incapacitated patients in comas or persistent vegetative states, there is still the possibility of donation after cardiac death (DCD) once life support has been decided to be withdrawn. There is also the possibility of DCD from heart attack and accident patients, too, though these cases aren’t really relevant to the proposals that we’re discussing. Depending upon the conception of death one is operating under, there are two limiting conditions that must be met before DCD can take place: (1) the amount of time that is required for the loss of circulation to lead to irreversible brain loss, and ultimately brain death, and (2) the amount of time before autoresuscitation of the heart is impossible. Depending upon the source of the information, the amount of time for these two conditions has ranged anywhere from 90 seconds to a full 10 minutes, which highlights the imprecise nature of this method of organ donation. Beyond this impreciseness, there’s also a whole host of other issues involved with DCD, including issues of consent and potential harm and/or moral distress for the caregivers and family. Furthermore, DCD is also practically inefficient in several ways: (1) it generally only procures abdominal organs and not thoracic
organs due to the ischemic injuries sustained by the thoracic organs in the cardiac death, (2) if the patient does not die quickly enough after the withdrawal of life support, DCD is not able to procure even abdominal organs due to the development of ischemic injuries, and (3) there’s only rudimentary, unreliable ways to determine which patients’ bodies will cooperate to successfully complete DCD, meaning there’s no real way to determine optimal DCD candidates. These issues highlight the need for new proposals, specifically IDOD, to avoid these practical and ethical issues that arise in DCD cases where patients do not meet the criteria for brain death.

Outside of the practical context of organ donation, there are also certain ethical norms, beyond the principles of principlism that we discussed in the previous two chapters, that are specific to organ donation that are relevant to the new proposals. One of these ethical norms that govern organ donation and transplantation that was previously mentioned is the notion of the dead donor rule. Though the principles of principlism are intrinsically linked to the ethical regulation of organ donation, the dead donor rule has been the guiding ethical norm for the practice of organ donation throughout its existence, because it is the normative tool most associated with the practice of organ donation. The dead-donor rule has two main, related obligations that correspond to the two differing main types of organ donation. The first obligation corresponds to cadaveric organ donation, and it requires organ donors to be dead before the procurement of organs begins. The second obligation corresponds to live organ donation, and it requires that organ procurement itself may not cause the death of the donor. As we will see below, the several new proposals are split between the first obligation to cadaveric organ donors and the second obligations to live organ donors.

Two other ethical principles that further regulate the process of organ donation and transplantation and are related to the two obligations of the dead donor rule, but are separate
principles in themselves, should also be mentioned. The first of these is the ethical principle requiring brain death prior to the removal of organs. As described above, the definition of death has been a contentious issue recently, but most people subscribe to some sort of version of brain death, meaning the onset of brain death is the earliest one should begin procuring organs from a cadaver in order to not violate the first obligation of the dead donor rule. Of note, proponents of DCD justify their support of DCD by arguing that the loss of circulation necessarily leads to the eventual brain death of the patient, though the ultimate question is the timing rather than the fact of this matter. The second ethical principle is the overall prohibition on killing, though it is specifically aimed at the killing of patients by their physicians. Obviously, this corresponds to the second obligation of the dead donor rule that prohibits the act of organ procurement from killing the patient. Thus, these two separate ethical principles act as outside justification for the ethical obligations imposed by the dead donor rule, giving the dead donor rule further validation as a useful normative tool in organ donation and transplantation.

Finally, with both the practical and ethical backgrounds and contexts of organ donation laid out, we can now jump into ethically analyzing the various different new proposals for organ donation. When we talk about LSW Donors with regard to IDOD, it is assumed that both brain dead and non-brain dead individuals are included in this population. However, practically this isn’t really the case, because as previously mentioned, brain dead LSW Donors do not really engender the controversy that non-brain dead LSW Donors do. This is because brain dead LSW Donation is ultimately the “gold standard” and preferred method of cadaveric organ donation today. On the other hand, due to the ethical obligations imposed by the dead donor rule, non-brain dead LSW Donation necessarily engenders controversy, and this is one of the main reasons why the OPTN/UNOS Ethics Committee ultimately rejected Living Donation Prior to Planned
Withdrawal (LD-PPW) of life support. LD-PPW was the official term that the OPTN/UNOS Ethics Committee referred to IDOD as in their investigation, but for the remaining dissertation I will refer to LD-PPW as IDOD.

IDOD is a type of organ donation that comes from patients who have previously, and separately, decided, either themselves or via their surrogate, to withdraw all life-sustaining treatment. Generally, this occurs in those terminally ill patients at the end of their lives, but it very well could also occur in patients who are not terminally ill but for some reason or another have still decided to withdraw all life-sustaining treatment. These patients are neither brain dead nor ideal candidates for DCD, which makes cadaveric organ donation virtually impossible. This type of organ donation then functions by excising the organ(s) from the still living donor, under anesthesia, of course, and withdrawing all life-sustaining treatment soon after the operation is over when the patient is stabilized. Since this type of organ donation is completed before life-sustaining treatment is withdrawn while the patient is alive and non-brain dead, it is considered a live organ donation, and this entails that the second obligation of the dead donor rule is applicable to this type of IDOD, i.e. the process of procurement should not kill the patient. Due to this obligation imposed by the dead donor rule, at the present time discussion of this type of organ donation has been limited to one kidney at a time, because it is believed that it is extremely unlikely that excising one organ, especially a kidney, would cause, or even hasten, the death of the patient, though it is ultimately believed that more organs could eventually be donated from these types of patients.

This type of organ donation actually comes in two forms, too, with each having distinct ethical components. First, it may occur in patients who are awake, alert, and have decisional capacity. Decisional capacity is a notoriously difficult concept to fully determine, categorize, and
define, but theoretically it ultimately represents the ability of patients to make autonomous, informed decisions regarding their healthcare. In fact, the criteria for determining capacity largely mirrors the steps of informed consent, specifically ensuring understanding of information and the voluntariness of the decision. A patient with decisional capacity can (1) appreciate and understand the information being relayed, (2) make a decision that is free from coercive influences, and (3) consistently use their values and preferences to make logical, i.e. reasonable, healthcare decisions. Further, rather than being a bifurcated system of capacity versus incapacity, a patient’s decisional capacity functions more on a sliding scale with differing levels of capacity, just as differing healthcare decisions require differing levels of decisional capacity to fully comprehend and deliberate upon. This is contrary to the legal notion of competence, which is bifurcated into an “either/or” scenario.

For many, this seems to be a fairly straightforward and ethically justifiable scenario in cases of patients with decisional capacity. Not only does it respect and promote patient autonomy, it also promotes significant acts of beneficence and engenders much good for the dying patient. This beneficence is even more apparent for the patient’s family, too. For example, though not specifically discussing cases of IDOD, James Childress has noted the benefits and positive effects that organ donation generally has for the donor’s family, who at the time of donation is still mourning the loss of a recently deceased loved one. In one family’s own words, “This was the best thing we could have ever done. Whoever the people are that got the organs, we’re just grateful to them to keep part of him alive in this way. We’re grateful they are living.” Said another way, this method, “could provide patients and families a middle ground—a way of avoiding futile medical care, while also honoring life by preventing the deaths of other critically ill people.”
Of course, there are still a couple of ethical components that some may take issue with. For example, more conservative individuals might still find issue with the notion of withdrawing life support, even though it is currently very widely accepted as an ethical action and ultimate right of autonomy for patients. But even if one holds this position, this type of IDOD isn’t necessarily affected by that stance, because the act of live organ donation is completely separate from the act of withdrawing life support. So there’s no real conflict between the two. Another issue that has been brought up is the fear that IDOD could effectively offer up even less overall viable organs for transplantation than the method of DCD. This is because while IDOD is subject to the obligations of the dead donor rule, which limits the types of organs they can procure via this method, i.e. only abdominal organs without thoracic organs, DCD is not held to that same obligation due to the donor already being deceased at the time of procurement. This was a potential fear that the OPTN/UNOS Ethics Committee received in feedback from various organ procurement agencies from across the country.

But this is a fear that is largely misguided for several reasons. First, as was shown above, DCD is an incredibly unreliable and unpredictable method of procuring organs due to poor predictive tools, so while there may be a higher range of organs to procure from DCD, there’s also the very real chance of gaining no organs at all due to the donor body not cooperating, i.e. not dying fast enough, or faster rates of ischemic injury to organs. Further, while DCD can technically procure both abdominal and thoracic organs, in practice the procurement team almost always only procures abdominal organs, just like IDOD, due to the rapid development of ischemic injury in thoracic organs after cardiac death. So while IDOD offers a lower range of organs procured from the donor, the success rate and confidence of retrieving the organs is much higher than in DCD. Second, DCD also requires life support to be withdrawn in the operating
suite, making things very difficult and awkward for the family, which isn’t a concern for IDOD. Third, while it is currently limited to one kidney, it is believed that virtually all of the abdominal organs could and should be procured in IDOD, meaning there’d be a significant number of organs procured from just from one donation. And finally, IDOD does not necessarily entail that DCD will not occur, as well. In fact, many suggest that both methods should ultimately be utilized to maximize the gains of organ procurement, so the fear of IDOD actually offering less organ procurement than DCD is not warranted or compelling.626

Others may worry that this type of operation might actually cause death in the terminally ill, which would violate the second obligation of the dead-donor rule. However, it is well supported that the excising of most non-thoracic organs, e.g. the kidneys, liver, etc., would not ultimately cause the death of the patient, since the patient is actively dying after removing the life-sustaining treatment anyways.627 Still, others worry that though death might not be an immediate result of this operation, these types of major operations might still hasten death to some degree or cause extra, unwarranted pain to the donor while they are actively dying, which very well could occur in certain contexts, and this would ultimately turn this concept into a slower version of “organ donation euthanasia.” But once again, it is well supported that this type of operation would neither cause nor hasten death, though additional pain after the surgery could ultimately arise - though it would be controllable by medication - and even in rare cases where complications do occur during or after surgery that actually do hasten the death of the patient, it could be justified by the widely accepted normative tool known as the principle of double effect. The principle of double effect is a normative tool that combines a deontological framework with utilitarian reasoning and principles to create an ethical system that determines when an action
that has both good and bad consequences can be morally justified. It determines this by passing actions through four required conditions:

1. The action, considered by itself and independently of its effects must not be morally evil…
2. The evil effect must not be the means of producing the good effect…The evil effects…are simply unavoidable by-products of [actions] designed to produce the good effects…
3. The evil effect is sincerely not intended, but merely tolerated.
4. There must be a proportionate reason for performing the action, in spite of its evil consequence…According to a sound prudential estimate, the good to be obtained is of sufficient value to compensate for the evil that must be tolerated.628

If the action successfully makes it through the four conditions, then it is considered an ethical action that merely has some bad, unintended consequences, even if they were foreseen consequences. In bioethics, intensive pain management at the end of life is the paradigmatic example of the principle of double effect in action, because there may be times when the proper use of intensive pain management unintentionally hastens the death of the patient. However, as long as the death of the patient wasn’t the true intention of the physician but rather an unfortunate and unintended side effect or consequence of the pain management remedy, then it is still a morally justifiable act, according to the principle of double effect. And just as in intensive pain management, as long as the true motive in IDOD is procuring an organ rather than hastening the patient’s death, then this act is ethically justifiable by the widely accepted ethical tool of the principle of double effect.629 Thus, IDOD in capacitated patients is most definitely an ethical action that should be promoted by organ procurement teams, and with the help of the principle of double effect, more aggressive procurement strategies should be implemented to maximize the potential viable organs garnered from each individual, though the patient’s well-being and overall comfortability should still be the first priority by the procurement team.

A second and more controversial option of IDOD is in permanently unconscious patients, i.e. those in a permanent vegetative state or those with a devastating neurologic injury that is considered irreversible, though not necessarily considered brain dead, or patients in an
incapacitated state where surrogate decision-makers would make this decision to donate the organ after making the decision to ultimately withdraw all life-sustaining treatment. The main issue with this option of IDOD involves the use of surrogate decision-making. There are two main and relevant standards of surrogate decision-making: the substituted judgment standard and the best interests standard. Sometimes a distinction is made between the prior, explicit articulation of the patient’s relevant preferences to the surrogate and actual substituted judgment based more off of analogical reasoning from differing known preferences of the patient, which creates an entirely new standard of decision-making; however, here I am funneling them both under the broader substituted judgement standard.630 Traditionally, the substituted judgment standard has been the preferred standard for surrogate decision-making, because it is, supposedly, based upon the subjective and previously known preferences of the incapacitated patient. Essentially, this standard requires the surrogate to use the known preferences and values of the incapacitated patient to make the most proper medical decision according to what the patient would ultimately want if they were making the decision themselves.631

The problem is that IDOD is an extremely specific and rare medical intervention that is not well-known to the general public, so the chances of patients previously and explicitly discussing their preferences for this procedure with surrogates are minimal at best. Of course, there is always the possibility of this happening, and prior, explicit articulation of the patient’s relevant preferences for this procedure would surely need to be followed. But realistically the chances of explicit articulation of this preference is slim, meaning surrogates will most likely have to come to a conclusion based upon the values, interests, and preferences of the patient on other, related issues. But this also brings up some other issues.
Several recent studies have found that the substituted judgement standard is not nearly as accurate and reliable as it was once thought to be. For example, there is significant discrepancy in the actual preferences of the patient versus the judged preferences of the patient by the surrogate, meaning surrogates are sometimes judging the patient’s preferences wrong and thus making decisions that are counter to what the patient really would’ve wanted. One study even found that surrogates are only correct in their judgments about 68% of the time, which is still a majority of the time but far from the overwhelming accuracy that this standard was once thought to possess. What’s even more troubling in this regard is the unclear status of IDOD. While it is without a doubt an example of live organ donation, it isn’t necessarily equivalent to just normal live organ donation in healthy individuals, let alone cadaveric organ donation, which would definitely affect the patient’s preference regarding the procedure. For example, it’s conceivable that a patient would actually be more willing to be a live donor in the case of IDOD than in the case where the patient was fully healthy, because IDOD doesn’t really contain the recovery time and burdens that would come with the post-operative process for a healthy, live patient. And similar arguments could be made in the other direction with a patient being more willing to be a live donor as a healthy person than as a person who is preparing for death.

This raises serious questions about the required threshold that surrogate decision-makers would need to meet in order for them to justifiably conclude through the substituted judgement standard that the incapacitated patient would truly want IDOD in this situation. For example, questions that would necessarily need to be answered to come to such a conclusion include: Did the patient show any sort of preference toward cadaveric and/or live organ donation? How much prior preference and interest should be shown by the patient in organ donation for the surrogate to justifiably make an affirmative decision on IDOD? Is expressing a favorable stance towards
organ donation enough justification for the surrogate, or is more needed to justify this decision? How much more? Is the patient explicitly expressing the wish to be an organ donor enough, or should the patient have shown enough interest in organ donation that they were previously signed up as an organ donor and/or evaluated for the possibility of being a live organ donor? Complicating things even further, along with the recent research suggesting the increased fallibility of the substituted judgment standard, there is also substantial evidence that patients’ preferences evolve and significantly change over time, especially with regard to end-of-life issues, meaning surrogates’ memories regarding past preferences of the patient might not be up to date. Furthermore, research also suggests that prior preferences aren’t necessarily even of primary importance to patients in end-of-life scenarios, because they value the opinions of family and their doctors, who they also want involved in the decision.633

Thus, there are serious issues with the substituted judgement standard when it comes to surrogate decision-making in IDOD. Unfortunately, the best interests standard doesn’t seem to fair much better here. This standard essentially states that surrogates should make the decision according to the patient’s “best interests” when no prior relevant preferences from the patient are known, and these interests should be separate from the surrogate’s own views and preferences.634 This standard is also supposed to be based upon what a “reasonable person” in this situation would want.635 Immediately, then, we can virtually toss out the decision of IDOD for incapacitated patients using this standard, because since this type of procedure would provide no benefit whatsoever to the patient, but only additional harm and burden, there is no objective interest in performing this donation from the perspective of the incompetent patient. Of course, this type of altruism could be argued to be some type of “moral benefit” in itself to the patient, though that seems to be a very difficult argument to justify due to the significant amount of
burden and harm the transplant surgery would engender for the patient, let alone the major violations of bodily integrity without explicit consent from the patient.

On top of this issue with surrogate decision-making, there is also the crucial issue of public perception and trust in organ donation to consider, especially with minority populations. Beyond the substantial minority disparities in access to healthcare, there are other significant minority disparities in healthcare that are related to internal bias and discrimination within the healthcare system. These minority disparities occur from conscious or unconscious prejudices and biases of healthcare providers that affect the ways they treat or make healthcare decisions for their patients of a minority group.\textsuperscript{636} It could also be due to an overreliance on epidemiological evidence of certain common minority population traits over the actual empirical health evidence from the individual case at hand.\textsuperscript{637} For example, several studies have shown an association between race and socioeconomic status and the likelihood of receiving surgery for the treatment of cancer, including the disparity of African Americans being significantly less likely to receive surgical resection for the treatment of non-small cell lung cancer compared to their white counterparts.\textsuperscript{638} Similar disparities have been found in minority populations in the management of pain. Interestingly, in one study male physicians prescribed higher doses of pain medication for white patients over black patients, with the opposite being true of the female physicians.\textsuperscript{639} Other studies have corroborated these minority disparities in pain assessment and pain management, including everything from pain originating from cancers and chest pains to chronic back pains.\textsuperscript{640}

These disparities, among other things, have led to the well-known, documented distrust of the white-dominated healthcare by African-Americans, and this distrust and suspicion is present in the realm of organ donation, too.\textsuperscript{641} In fact, there is substantial substance to some of
these concerns based on racial discrimination, with several studies suggesting that black Americans are routinely much less likely to be referred to transplant services, considered good candidates for transplantation, and placed on organ waiting lists than white Americans, even with all other factors in consideration and accounted for.\textsuperscript{642} The combination of this distrust with actual discrimination has led to major disparities in organ donation and allocation within this population.\textsuperscript{643} Further, a continued reluctance towards organ donation in this population has largely maintained this disparity due to a lack of histocompatible viable organs for transplants in African-Americans.\textsuperscript{644} So with the effectiveness and success of organ donation programs relying so heavily on public perception and trust in organ donation, this is a serious concern that must be taken into account, especially with regard to minority populations that are already dealing with significant disparities in this area of healthcare.

One final issue that must be discussed before moving on is the distinction between those patients who at one time had capacity but lost it due to some sort of ailment or accident and those patients who never had capacity at any point in their life. Specifically, I’m referring to newborns, especially profoundly disabled newborns, and the severely mentally handicapped. Since these individuals never had the opportunity to develop decision-making capacity, along with preferences, desires, and values, the substituted judgement standard is of no use for surrogate decision-making in these individuals, and the best interests standard is the primary tool for surrogate decision-making.\textsuperscript{645} As detailed above, the best interests standard firmly denotes IDOD as not in the best interests of patients, because it does not benefit the patient whatsoever, while also requiring significant burdens and bodily harms. Perhaps an argument can be made from best interests for IDOD in these types of incapacitated patients in the case of a sibling or close relative. However, certainly it’s not always in the patient’s best interests to donate an organ
before death, especially for non-acquaintances, and this would seemingly border the line of treating the patient instrumentally and merely as a means rather than an end in themselves, which would be a major violation of the moral obligations in Kant’s second formulation of the Categorical Imperative.646

So we must truly take into consideration what widespread promotion and utilization of IDOD in incapacitated patients would do to (1) surrogate decision-makers in their attempt to interpret the patient’s obscure preferences and (2) the public perception and trust in organ donation. This is basically the position of the chairman of the UNOS ethics committee, Dr. Peter Reese, when he says that IDOD “could erode public trust in donation in general.”647 This is especially true in minority populations, who are already suspicious of and distrust white-dominated healthcare, including the organ donation sector. This primary concern in the public perception of IDOD, among other issues - such as practical issues like a possible lack of support from the medical staff, better guidance for when to offer IDOD over DCD, and better models to predict how allowing IDOD would impact the number of viable organs available for transplant, led the OPTN/UNOS Ethics Committee to conclude in March of 2016 that IDOD in incapacitated patients was not something to pursue further at this time.648 As a rule of thumb, I believe this is the correct public position to take in IDOD in incapacitated patients, though not in capacitated patients as argued above. This does not necessarily require a total prohibition, though, because certainly there can be times when surrogate decision-makers have indisputable evidence that IDOD is what the patient would prefer. But with the potential to severely harm public perception and trust in organ donation and the very precarious position that it forces surrogate decision-makers to make life-altering decisions from, this isn’t a practice that should be outright promoted and encouraged by organ procurement organizations across the country.
5.2.2) Other Proposals

Outside of the two types of IDOD in capacitated and incapacitated patients, there are several more controversial proposals that deserve mention. All of the following proposals involve active euthanasia and/or physician-assisted suicide in some way, and one proposal even utilizes the process of organ donation, specifically procurement, as the method of active euthanasia itself. Though these are very controversial methods in themselves, the ever-increasing public support of active euthanasia and physician-assisted suicide, combined with long organ waiting lists, may make these topics of policy conversation in the near future.649

Where the two types of IDOD relied on withdrawing life support, these latter proposals rely on active euthanasia (and the related concept of capital punishment in one proposal) or physician-assisted suicide, which is the major moral distinction among the differing types. Where withdrawing life support is simply allowing the patient to die naturally by removing all life-support, active euthanasia is the deliberate and active termination of the life of a suffering patient, completed by a physician in response to a voluntary request from the patient.650 Similarly, physician-assisted suicide is also a deliberate and active termination of the life of the patient based on a voluntary request to the physician. However, rather than asking physicians to terminate patients’ lives themselves, physician-assisted suicide requires the physician to merely aid the patient in dying by providing them with the necessary lethal medications in order for patients to take their own lives.651 It should also be mentioned that while the principle of double effect supports the withdrawal of life support as a morally justifiable action that is an example of “allowing to die,” it condemns both active euthanasia and physician-assisted suicide as immoral, unjustifiable actions of “killing,” though many secular ethicists reject the principle of double effect and its conclusions regarding these actions.652
And that is what ultimately complicates the discussion of these types of proposals. These methods necessarily involve acts of active euthanasia and physician-assisted suicide, which are both extremely controversial applied ethical issues that there is no real consensus on, so analysis of these methods of organ donation will somewhat rely on some preconceived notions regarding these acts, which is problematic due to their controversial nature. For example, research suggests that the American public has long been generally in favor of the legalization of active euthanasia, especially since the 1970’s. Interestingly, though still generally viewed favorably for legalization and morality in the US, physician-assisted suicide consistently rates lower in approval ratings than active euthanasia, even though, at least secularly, it is ethically less problematic than active euthanasia. Yet even with these strong approval ratings, California recently became just the fifth state in the US where physician-assisted suicide is legally available, and there is no state where active euthanasia is legal. In fact, only a few nations in the world have currently legalized and regulated active euthanasia, including Belgium, Luxembourg, Colombia, and the Netherlands. Further, even with the majority support from the public, the majority of “professional groups, academics, and religious bodies have for the most part remained opposed to these efforts.”

In the case of organ donation euthanasia, then, the proposal states that the organ procurement operation itself functions as the process of euthanasia for LSW Donors. Basically, with the patient under anesthesia, after retrieving all of the abdominal and other thoracic organs, the transplant team removes the heart, which ultimately causes the death of the patient. Though this proposal was ultimately aimed at the permanently unconscious and those in persistent vegetative states, it also is relevant to those LSW Donors, both capacitated and incapacitated, who want to ensure that something good comes from their deaths, i.e. organ donation. This
proposal has two main advantages. Firstly, it dramatically increases the chances of retrieving all of a LSW Donor’s organs that can be donated after death. While DCD for LSW Donors ultimately requires the body’s cooperation in dying quickly enough after withdrawing life-support, which rarely occurs and usually destroys the viability of all of the thoracic organs, this method of organ donation euthanasia can control those factors by ultimately keeping the donor alive as long as needed, i.e. until they need to take out the heart. Secondly, it also is less likely than the withdrawal of life support, which would lead into DCD, to cause the patient suffering while in the process of dying. In organ donation euthanasia the patient would die during the procurement process while unconscious, so there wouldn’t necessarily be any suffering or pain at all. Dominic Wilkinson, one of the main proponents of organ donation euthanasia, argues that it, “would give people the best chance of ensuring that their organs do not go to waste after their death. It would also prevent the patient from suffering after life support was withdrawn. It would harm no one, and would potentially benefit a number of seriously ill patients in organ failure.”

Of course, though there are significant practical benefits to this proposal, its acceptance would ultimately require violation of several of the aforementioned guiding ethical norms of organ donation. Specifically, it would violate both of the ethical obligations of the dead donor rule – (1) organ donors must be dead before the procurement of organs begins, and (2) organ procurement itself may not cause the death of the donor. Furthermore, it would also violate the other related, more deontologically focused principles that obligate the act of organ donation to (1) not harm the organ donor in any significant way, (2) only remove organs from brain dead individuals, and (3) not deliberately kill the patient. Thus, it seems clear that this proposal is contrary to our current ethical conceptions of organ donation, and in order for it to ever be ethically acceptable, there would need to be a radical reformulation of our current conception of
organ donation ethics. These deontological principles play an important role in safeguarding potential donors in a medical practice that is heavily influenced by utilitarian goals and reasoning, so these principles are necessary to avoid tumbling down the slippery slope that is the utilitarian mindset of organ transplantation.

But are there special cases where this might still be justified, such as in the case of a death row inmate who is about to face the death penalty? Controversial as it may seem, there may be sound ethical justifications for organ donation euthanasia in the case of an executed prisoner due to the differing contexts, and there are many who have proposed harvesting organs from prisoners in various different fashions. In fact, one of the most interesting specialized systems of organ donation in the world is China’s peculiar situation, because for a vast majority of China’s transplant history over ninety percent of their viable transplant organs have come from executed prisoners.662 This particular source of organs really came out of necessity, because only in 2007 did Chinese authorities begin to implement a federal program with the purpose of overseeing and regulating organ transplants within the country. Before this time, no federal program of this nature existed, and it is believed this program will take many, many years to fully replace executed prisoner organs as the main source of transplant organs. This is due to strong cultural factors from Confucian views that are prevalent in China that believe the body should be kept intact after death. This cultural view has virtually eliminated the possibility of cadaveric organ donation throughout China’s history, which has left organ donation to come almost entirely from live donors and executed prisoners.663

China actually began harvesting organs from executed prisoners in 1984 after cyclosporine became available, and it started in a very secretive and clandestine manner through a confidential government document called “Rules Concerning the Utilization of Corpses or
Organs from the Corpses of Executed Prisoners.” Essentially, the document gave the State power to use the dead bodies, or its organs, of condemned criminals if the prisoner volunteered before execution, the family consented, or the family did not claim the body. The process of execution starts with a physician sedating the prisoner and inserting a breathing tube in the lungs and a catheter in one of the veins. The prisoner is then shot in the head, and the physician attaches a respirator to the breathing tube and administers drugs to insure the viability of the organs. The prisoner is then transported to the hospital where the donor is waiting and the transplant surgery takes place.

It took over two decades of international pressure from human rights agencies and other countries before China folded and started to implement a different system of organ procurement to serve their country’s transplant needs, which is still in implementation today.

However, even though they’ve long been criticized and in the last several years claimed to have ceased the practice, it is still widely believed and reported that China still regularly executes prisoners in high numbers to harvest their organs. And it has also been reported that many of these individuals are even “prisoners of conscience” against the Communist Party in China, which makes the crime that much more immoral and heinous. Primarily, the criticism surrounding the Chinese system revolves around the ethical issues of consent and the potential effects it has on increasing rates of the death penalty, which are already the highest in the world by a significant margin. The American UNOS ethics committee has also opposed any new changes or legislation for prisoner organ donation until a fuller discussion has occurred, but they also bring up issues of consent, how it would affect certain discriminatory practices already inherent within the system, and how it would affect potential jurors who might be influenced by
this decision. Until further analysis has been completed, I agree that this proposal is too risky to promote with its potential pitfalls.

Finally, the last remaining proposal involves organ donation after active euthanasia or physician-assisted suicide. At first glance, some may wonder why this proposal would be controversial at all, because (1) the element of euthanasia or suicide is not necessarily causally connected to the organ donation in any way, (2) there is no question about capacity, since decision-making capacity is a prerequisite for the legal approval of active euthanasia and physician-assisted suicide, and (3) the mode of death is not necessarily relevant to the procurement of organs in normal situations. However, as stated above in organ donation euthanasia, it’s extremely difficult to separate perspectives on active euthanasia and physician-assisted suicide from perspectives on organ donation due to their interaction in these proposals, so some might conflate the issues and have problems justifying it.

Thus, it needs to be addressed. There are two main types of this proposal. The first type would involve DCD after active euthanasia or physician-assisted suicide. The patient could be administered, or take themselves in the case of assisted suicide, large doses of a sedative and cardioplegic agents, which would ultimately stop the heart. After the necessary time had passed to either ensure brain-death or render the possibility of autoresuscitation to zero, whichever justification one is using, DCD would be completed. Recent research in Belgium actually suggests the effectiveness of DCD in this scenario due to the controlled nature of the death and environment, and in some cases certain thoracic organs, i.e. the lungs, were also able to be obtained, though the heart was still always unattainable.

A second and more radical type of this variation of IDOD would involve inducing brain death via the process of active euthanasia. This would require several medical interventions, with
increased potential for patient harm and burden, to continue the respiration and circulation of blood to the other organs while ultimately inducing brain death via catheter occlusion of both internal carotid arteries and vertebral arteries. While this would present a more ideal organ procurement environment that would ultimately allow for the procurement of both abdominal and thoracic organs, it blatantly violates several of the ethical principles that regulate organ donation, just as organ donation euthanasia does above. Furthermore, with the focus of the intervention shifting more toward organ donation rather than safe and effective euthanasia of the patient, the motivations of the procedure come into question, and the method seems to borderline convert the patient from an end in themselves to merely a means that is being treated instrumentally, which is a hallmark sign of unethical behavior, at least according to Kant.

Beyond violation of these principles and the instrumental treatment of the patient, this second type would seemingly require the act of active euthanasia in order to work, which is very prohibited in law throughout the United States. But the first type of this variation of IDOD can work in cases of physician-assisted suicide, and as reported above, there are five states in the US where physician-assisted suicide is now legally available to terminally ill patients. So the question is this – is this an ethical type of organ donation that should be promoted and encouraged, especially to the patients themselves in these states who are contemplating assisted suicide? It’s hard to find something ethically wrong with this method of organ donation, even if one finds physician-assisted suicide ethically wrong in itself. This is because the act of organ donation is conceptually distinguishable and separate from the method of death itself, and there’s nothing conceptually hypocritical about being an advocate for organ donation in these cases, while still finding the method of physician-assisted suicide immoral. A practical example can verify this line of reasoning. Many cases of brain death actually occur from suicide attempts that
deprive the brain of oxygen for a substantial amount of time. In fact, recent research suggests that around 3.8% of all brain death scenarios are caused by suicide attempts. What’s more, the families of these suicide brain dead patients exhibit a much higher rate of consent to donation than families of non-suicide brain dead patients. Thus, if there’s no moral hesitancy to accept organ donation in these patients, there should be no moral hesitancy to accept the ethicality of this type of IDOD in assisted suicide donors, and it should be promoted as a beneficent and charitable ethical action.

Certainly, then, there are several differing new organ donation proposals and changes to our current cadaveric organ donation consent process that are both ethically justifiable and practically effective at increasing either organ donation rates or the larger organ donor pool. Mandated choice consent systems combine the ethicality of opt-in, explicit consent systems with the practical effectiveness of opt-out, presumed consent systems, and this system is clearly the preferred consent system for any revamped model of organ donation here in the United States. As for the other new proposals, though several of them are clearly unethical or have true pragmatic reasons for not pursuing, there are several proposals that are clearly ethical and should be promoted and encouraged to increase the organ donor pool, specifically IDOD in capacitated patients and organ donation after physician-assisted suicide, where legal. Not only would pursuing these new proposals increase the raw number of viable organs for transplantation, they would also increase the quality of the organs by relying less on the inefficient method of DCD. And finally, we would also be doing these LSW Donors and their families a great service by ensuring that these donors live on not only in the memories of their loved ones, but also in the hearts and very being of the recipients’ bodies that are continuing to enjoy the fruits of life due to the beneficence, kindness, and selflessness exhibited by these organ donors. Now it’s finally time
to put all of these pieces and insights from the past four chapters together to form a new, revamped model for organ donation that is both ethically justifiable and practically effective.
Endnotes

589 Veatch and Ross, Transplantation Ethics, 143-144.
592 Veatch and Ross, Transplantation Ethics, 153-154.
593 Veatch and Ross, Transplantation Ethics, 154.
595 Veatch and Ross, Transplantation Ethics, 149-155.
597 Veatch and Ross, Transplantation Ethics, 152-153.
607 Veatch and Ross, Transplantation Ethics, 7.
609 Veatch and Ross, Transplantation Ethics, 43-67.
612 Veatch and Ross, Transplantation Ethics, 67-77.
613 Wilkinson and Savulescu, "Should We Allow Organ Donation Euthanasia?,” 35-36.
616 Wilkinson and Savulescu, "Should We Allow Organ Donation Euthanasia?,” 38.


Wilkinson and Savulescu, "Should We Allow Organ Donation Euthanasia?,” 40-42.


Wilkinson and Savulescu, "Should We Allow Organ Donation Euthanasia?,” 37-38.


Huang et al., “A Pilot Programme of Organ Donation after Cardiac Death in China,” 862-863.


Wilkinson and Savulescu, "Should We Allow Organ Donation Euthanasia?,” 42.


Wilkinson and Savulescu, "Should We Allow Organ Donation Euthanasia?,” 42.

Chapter 6 - A New Model for the United States Organ Donation System

Now that the moral argument in favor of CLOD has been made and defended and the various other organ donation proposals have been analyzed and evaluated for their ethicality, it is finally time to put all the pieces together and apply this knowledge to develop a United States-based system of CLOD and mandated choice, opt-out cadaveric organ donation to better meet the surging demand for viable organs for transplantation. While most calls and proposals for CLOD and other types of incentivized donation have been met with skepticism and opposition, there has long been a growing interest and suspicion that financial incentives for organ donation might be the only way to more effectively meet our organ needs. This is evidenced by the numerous different legislative proposals that have been proposed in the last two decades dealing with providing some type of incentives, both financial and non-financial, for organ donation.675 Furthermore, even the OPTN/UNOS Ethics Committee has recently finally started considering the possibility of financial incentives for organ donation, which is a major step forward from previous attitudes toward CLOD and the overall usage of financial incentives for CLOD. They’re currently working on a white paper that is anticipated to recommend that it is an appropriate time to conduct pilot studies on financial incentives for organ donation.676 Clearly, then, it is as good of a time as ever to develop a revamped model for the United States organ donation system.

By modifying the Iranian model to decrease the extreme bodily commodification present in their system and combining two of the previously discussed methods of garnering consent for cadaveric organ donation, this chapter develops an ethical and effective system of CLOD and mandated choice, opt-out cadaveric organ donation that can better serve the growing organ needs within the United States. The chapter starts off by analyzing some potential changes to the Iranian model’s compensation scheme to find a more ethically palatable method of live donor
compensation that would still provide significant incentives to increase organ donation rates from living donors. Next, potential funding options and other types of payment and scheme proposals are discussed, and it is highlighted how there is no shortage of viable options for such a system to succeed. Finally, the chapter ends by looking at the concept of libertarian paternalism, specifically as it relates to opt-out policies and “nudges,” and it is proposed that this concept of “nudges” should ultimately be combined with a mandated choice policy to create the most ethical and effective consent policy for cadaveric organ donation.

6.1) Compensated Live Organ Donation: Tax Benefits

Though the Iranian model of CLOD is clearly the most effective and ethical system of CLOD ever implemented, it still has several weak areas that can be updated and improved. Specifically, the compensation scheme, i.e. how the donors are compensated, is one area that can be substantially modified to make the practice of CLOD more ethically palatable and professional across a pluralistic, multicultural society. Further, the Iranian model’s issues with inconsistency in the implementation of the law regarding CLOD can ultimately be remedied via strict federal guidelines that all OPOs are required to follow under penalty of law, which should provide a much more efficient and consistent overall practice across the nation.

6.1.1) Tax Benefits

As mentioned above, though the Iranian model of compensated kidney donation is the most successful system of CLOD in history, it still suffers from the utilization of extreme bodily commodification, i.e. *quid pro quo* agreements between two parties that directly exchanges cash for an organ, due to relying on two separate direct monetary payments to the donor for their donated organ. Ultimately, to be ethically palatable enough to be considered politically viable for effective legislation, this compensation scheme must be substantially changed to ever have a
chance of being implanted in the multicultural, liberal society that is the United States. To address this weakness of extreme commodification in this model, a revised model must pass two conditions: (1) there must be no direct payment for organs, and (2) the notion of donation must be retained. However, though using things like moral or nonfinancial incentives would be consistent with these conditions, practically they do not appear to provide enough incentives to meet the need for viable organs.677

One idea that potentially meets these two conditions while still providing enough incentive for many more individuals to donate is a system based on tax benefits received for charitable donations one made throughout the year. In the United States and most other countries, individuals can deduct charitable donations that they made off their taxable income. When one makes any sort of donation to a religious organization, non-profit organization, charity, or government agency, the amount of the donation is a tax write-off that one does not have to pay taxes on. For example, if Shelly made $50,000 annually and was in the 25 percent tax bracket, a $10,000 donation to UNICEF would actually only cost her $7,500, because she’d be able to deduct that $10,000 off her taxable income of $50,000, making it $40,000 of taxable income. These incentives are promoted by nations to encourage charitable giving to charities and other non-profit, religious, or governmental organizations.678

Since governmental agencies and non-profit organizations can accept charitable donations that are tax deductible, OPTN and/or UNOS, mimicking the supervisory and administrative roles played by the Iranian Ministry of Health and the Anjomans in the Iranian model, could then make donations eligible to be considered tax deductible transactions under the framework of the charitable donations tax deduction. Once achieving this status, donations could then be incentivized without the appearance of extreme bodily commodification that is seen in
the Iranian model, because this practice could pass the two aforementioned conditions, i.e. there is no direct payment for organ donation and the notion of donation is retained. Essentially, these tax benefits are incentives for charitable giving, so the tax deduction is just a benefit for one’s charitable gift, i.e. their kidney (or part of their liver).

The deduction amount would have to be a large figure, though, because there’s a rather ungenerous exchange rate between actual tax savings and the dollar amount of the deduction, let alone the inherent variability of the total amount of savings based on one’s particular income totals. For example, let’s say this year Shelly, who is single, decided to donate her kidney instead of making her usual monetary donations to charity, and let’s posit that the tax deduction for a charitable kidney donation is $15,000. Shelly would then only be paying taxes on $35,000 of her $50,000 worth of taxable income, which would drop her from the 25 percent tax bracket to the 15 percent tax bracket, according to the 2015 tax year brackets. Thus, instead of owing approximately $8,300 in federal income taxes this year, Shelly would save around $3,500 and only owe approximately $4,800 in federal income taxes, which is a far cry from the original $15,000 set deduction rate.679

But as mentioned above, the inherent variability of the use of tax deductions with differing income totals in a progressive tax bracket system makes this method less than ideal for a practice that would inherently rely on a substantial financial incentive to be effective. Further, nearly half of American households don’t regularly pay federal income tax due to not having enough taxable income or already receiving enough tax benefits/breaks to eliminate their tax liability anyways, meaning this deduction would essentially be useless to half of American households, specifically the half most likely to utilize compensated donation, too.680 Thus, it makes much more sense to have live kidney donations qualify as a charitable donation tax credit.
rather than deduction, because rather than just lowering the amount of taxable income that one owes, tax credits actually “provide a dollar-for-dollar reduction of your income tax liability.” And refundable tax credits can even reduce one’s tax liability below zero and garner the individual a tax refund, meaning actual cash in pocket rather just tax savings at the end of the year, which is what this proposed system of CLOD ultimately needs to be effective.681

So if live kidney donation was established at a somewhat fixed price (more on this below) for a refundable tax credit, then even those without a taxable income or tax liability can take advantage of this incentive, meaning more overall donations. This is similar to the first-time home buyer credit established by the American Recovery and Reinvestment Act of 2009 where first-time home buyers, subject to certain criteria, were eligible for a fully refundable $8,000 tax credit, so there is precedent for these types of special tax credits and assorted benefits. Of course, in some cases it makes more financial sense to take the deduction route over the credit route, especially in the higher incomes around the bracket cut-offs, so having both options available provides incentives for the entire spectrum of income earners from poor to rich.

But at what price should this refundable tax credit be set at? As stated in chapter four, in an attempt to find a minimum threshold amount that would constitute a fair payment to significantly incentivize live organ donation in the United States, noted economists Gary S. Becker and Julio Jorge Elias concluded in a 2007 economics study that payments of roughly $15,200 would increase kidney transplants by 44% and payments of $37,600 would increase liver transplants by 67%, though larger payments could ultimately attract more donors, while also curbing the demand. Of course this study was also completed a decade ago, so the minimum threshold for a fair payment is going to be higher today due to inflation. According to the Bureau of Labor Statistics’ CPI Inflation Calculator, $15,200 in 2007 has the same buying power as...
power as $17,802.24 in 2017, and $37,600 in 2007 has the same buying power as $44,037.13 in 2017. So to make things even and at a set, recognizable number, rounding these price projections up to $20,000 and $45,000, respectively, would not only constitute fair payments for these particular organ donations, but it would also potentially raise the projected organ donation rate increases that Becker and Elias predicted, since these proposed prices are comparatively higher than their proposed price in 2007. Further, these prices would not only be considered fair to the donor, but also not unreasonably high enough to be considered too “irresistible to resist” and undue inducement. This is especially true when compared to the rates seen in the Iranian kidney model, which Sigrid Fry-Revere equates to roughly $45,000 in American currency (liver transplants involve more overall risk and recovery time, which justifies the price of live transplants matching that of Iran’s kidney transplants).

But as K. Gandhi notes, inflation and cost-of-living increases occur regularly, so a set, static price isn’t necessarily ideal either. It’s also not ideal because the cost-of-living is so vastly different across the nation. For example, $20,000 will go a lot farther for an individual in rural Nebraska than Southern California. So to make this system of CLOD as efficient and as attractive as possible, there should be price variances and adjustments based upon both yearly inflation and cost-of-living rates in the region. Another potential issue in pricing that will lead to price variance is the quality of the organ. As with any other commodity, a higher quality organ should mean more compensation for the donor than a lower quality organ. For example, a young, healthy individual with a perfect kidney should certainly be compensated more for her organ than an older, unhealthy obese individual with a kidney of lesser quality. Perhaps these prices could be determined by a standardized list of criteria with variable values attached to each, such as being a non-smoker, not overweight, physically fit, etc., along with a tiered system of tax
credits that would correspond to both the quality of the organ and the living region (cost-of-living). I won’t speculate on these potential price variances for inflation, cost-of-living, and quality, but the important thing is to note the existence of these price variances that will necessarily have to be analyzed and discussed. So there will certainly be a range of factors that the regional OPOs will have to analyze and evaluate to decide upon agreeable price determinations, but for the rest of the dissertation we will assume the standard, base price refundable tax credit of $20,000 for a kidney donation and $45,000 for a liver donation.

Now some might argue that this is just semantic manipulation, and tax benefits constitute an indirect organ payment. But analogously this would mean that tax deductions for monetary donations would be a payment for the actual cash or check involved in the charitable donation itself, which doesn’t necessarily make sense. Yes, by definition this is still a case of commodification of the human body. But as argued earlier, the State has no right to legislate prohibition on these matters anyways, and the goal is to minimize the appearance of commodification as much as possible, not necessarily totally eradicate bodily commodification altogether, which would be virtually impossible in CLOD. The overall goal is to make this process of bodily commodification ethically palatable and socially acceptable, just like the numerous other examples of bodily commodification that were mentioned in chapter five, not to erase the appearance of bodily commodification that the State has no right to govern anyways.

What’s more, the best thing about this proposal is the significant legal precedent already established for such a system. For example, as mentioned above the first-time home buyer credit, established by the American Recovery and Reinvestment Act of 2009, allowed first-time home buyers, subject to certain criteria, to be eligible to claim a fully refundable $8,000 tax credit, so there is already precedent for these types of special tax credits and assorted benefits for specific
aims and purposes. Even better, in 2016 19 states already had laws allowing tax deductions or tax credits, generally valued at $10,000, for living donors as compensation, or more technically reimbursement, for travel, lodging, and lost wages related to the living organ donation process. But the only reason that these tax benefits for living organ donation are available is because there are numerous states that don’t have laws to protect or reimburse living organ donors, which forces them to pay out of pocket to make the charitable act of organ donation, including costs associated with travel, lodging, and lost wages during testing and recovery times. So not only are we not currently properly encouraging and providing incentives for live organ donation, we’re also practically discouraging it by forcing significant costs upon the donors themselves.

This type of compensation system also provides further advantages beyond avoiding the extreme commodification of the Iranian system. For instance, one recent study suggests that CLOD can actually save the healthcare system money with double-digit increases in the percentages of viable kidneys available for transplantation, which would significantly cut federal dialysis costs. And as detailed in chapter four, this same logic fueled another study that found that CLOD could ultimately save the United States healthcare system over $90,000 per transplant patient over a period of 20 years, which we’ll discuss again below when it comes to funding. What’s more, this model based on tax benefits compensation can even lessen the concerns with the voluntariness of the decision to donate one’s organs, because the incentives, i.e. tax savings and cash refunds, wouldn’t be immediate, which means this wouldn’t be an impulsive decision based on short-term goals and desires. This would also allow ample time to conduct interviews with potential donors to further gauge voluntariness and the potential donor’s psyche, stability, and appropriateness for candidacy. Thus, this system based on tax benefits for CLOD would allow incentivized kidney donations that minimize commodification of the body and provide
several other practical benefits, both to the overall system and to the autonomy and welfare of potential donors and recipients.

6.1.2) Funding and Other Proposals

Of course, one issue that we have yet to discuss is the funding of this proposal. Due to the United States’ particular political context and its heavy reliance on a private healthcare system, it’s not as simple as just having the federal government take the hit with these losses in tax revenue, and even the shelling out of more tax refunds, because the US federal government is not as involved in the healthcare system as other federal governments are in more socialized forms of healthcare, such as single-payer systems. However, there are several ways around this.

First, as referenced several times throughout the dissertation already, there’s significant positive evidence that instituting a regulated system of CLOD in the United States would ultimately pay for itself, if not even further save the healthcare system money, due to the federal government already extending Medicare coverage to greater than 90% of Americans with kidney failure that need dialysis to survive via the End-Stage Renal Disease Program of the Medicare Act of 1972. These expenditures account for $34 billion per year for dialysis care, which is a significant portion of Medicare’s overall spending. And studies have estimated that over a 20 year period at least $90,000 could be saved per transplant patient in a regulated system of CLOD, and one could even consider up to an upper range of $270,000 saved per transplant patient if society would value the additional 3.5 QALYs gained by transplant patients with the same rate of value that is designated per QALY on dialysis. What’s more, this study was completed over a decade ago, so it very well could be that the savings are even more significant in 2017.

Thus, even compensating donors at the price of $25,000 per kidney, the overall healthcare system stands to gain at least $65,000 per transplant patient in such a system, which
means this system would essentially fund itself and even save money. Of course, this monetary gain won’t necessarily be true in every single transplant patient. Since the transplant recipient’s health insurance company is generally financially responsible for the donor’s testing, surgical, and post-operative care costs, at least some of those transplants will have recipients that are covered by either Medicare or Medicaid, meaning the federal government and/or the state, which would be reimbursed by the federal government, would be covering the cost of the transplant. That would significantly cut into the bottom line of the savings. But the savings accumulated from privately insured recipients should still more than cover these types of situations with recipients on Medicare and/or Medicaid, along with the much smaller number of liver transplants annually. At worst, this should make the system break even, which is still a major overall success. Clearly, then, this self-funding option is the most practical and politically expedient funding option for such a proposal of CLOD.

Second, it’s also not unprecedented to reallocate funds in the federal budget or even create new taxes and/or initiatives to fund these types of new programs. For example, the most recent military budget has the United States spending a whopping $596 billion in defense spending, which is nearly $30 billion more than the next seven countries combined, so it could very well be argued that this is a non-controversial, very beneficial potential source of reallocated funding for this new program, especially due to the program’s modest financial needs for compensation. In other examples, states have used new taxes and/or initiatives to fund new social programs like this in the past, including the state of Illinois in the 1990s utilizing the “Live and Learn” initiative to fund a successful media campaign aimed at increasing organ and tissue donation rates in the state.
Third, the federal government could also work in conjunction with private insurance companies and require them, either the recipient’s insurance company or the actual donor’s insurance company, to reimburse the federal government for lost tax revenue and/or the amount of the refund for that individual. Depending on which insurance party would ultimately be responsible for reimbursing the federal government, this might also be an ideal option due to over a quarter of the United States population already receiving Medicaid benefits as it is.698 That is, this might make quite a bit of sense if most of the donors are already utilizing entitlement healthcare, which would keep the same party, i.e. the federal government, at both ends of the transaction and eliminate the need for a third-party reimbursement. This kind of involvement and cooperation of private insurance companies has also been posited elsewhere in markets for organs from cadaveric, rather than live, organ donation.699

Finally, a fourth way this could work is to have this broken down on the state level with state taxes with each individual state regulating and administrating its own market. States could raise the money via the addition of a specific tax or by other initiatives, similar to the Illinois approach under George Ryan in the 1990’s, and that could offset the cost of lost tax revenue and refunds.700 In many ways, this method could offer several advantages over federal oversight, such as increased efficiency with a smaller pool of Americans and the prospect of helping one’s local neighbors. However, this also might not be feasible in all states with higher or unhealthier populations and lower budgets, and it could still lead to substantial waiting lists in certain states.

This also brings up another possibility – making this a private sector program instead of a purely federal or state program in the public sector. Proponents of this idea argue that making it a private enterprise would lead to more overall efficiency and less corruption. And in fact, there might already be some precedent for this due to the fact that the OPTN (the United States’ sole
organ procurement and transplantation network that coordinates the entire organ donation, procurement, and transplantation process) is administrated and ran under government contract by the private, non-profit organization UNOS. And ultimately, this is most likely how any system of CLOD would be organized anyways. Either UNOS would greatly expand to take upon the role of overseeing and regulating the process of CLOD, or another private, non-profit organization would be contracted by the federal government to oversee and regulate the process of CLOD.

And most likely the 58 regional OPOs would also be expanded with new departments aimed solely at administrating the process of CLOD, and they’d ultimately function like the Anjomans from the Iranian model. As for the allocation process, it would largely mimic the allocation philosophy utilized by UNOS now for cadaveric organ donors, only presumably with significantly more viable organs to work with, along with having a much greater chance of always finding a near-perfect histocompatible match for recipients, which makes the transplant much more likely to be a long-term success. And just as with cadaveric organ donation, all CLOD transactions will be required to go through the regional OPO, which ensures a fair and safe process for both the donor and the recipient. This would also guard against possible abuse and exploitation from organ brokers and those attempting transplant tourism. And, of course, CLOD transactions would necessarily need to be limited to American citizens, and permanent legal residents that pay taxes, which is another way to prevent potential abuse and exploitation. So while a completely private program of CLOD could probably never happen, especially given the fact that compensation involves federal income tax benefits, there’s a good mixture of public and private components to keep corruption at bay and efficiency at its peak, while also having the consistency of a single national compensated organ donation policy that is strictly enforced.
and mandated on the overseeing non-profit organization and the individual OPOs, which helps with the inconsistency problems that plague the Iranian model in its various provinces.

And finally, though this proposal relies on tax benefits compensation for live donors, there are other potential proposals that might also work in combination with this particular proposal. For example, college tuition, or even something as simple as in-state tuition rates, represents a powerful financial incentive for many individuals, and even long-term health insurance vouchers provide significant incentives for certain people. This type of variety of compensation options is something that Dr. Arthur Matas, an outspoken proponent of CLOD, has proposed elsewhere, and utilizing a similar sort of centralized regulating agency, he proposes that giving donors a variety of options for compensation is a way to diversify the donor pool and maximize organ donation rates to attract as many types of people to the pool of donors as possible.702 Another proposal by attorney Sarah Krieger Kahan also puts control of the trade in a centralized agency, but she proposes that this agency would actually purchase organs from donors individually and allocate these organs similar to how we allocate cadaveric organs now.703

So beyond this particular proposal relying on tax benefits compensation, there are several other substantial proposals that hold promise as efficient models for regulating CLOD in the United States, and though they differ substantially in their methods, they all share the same underlying assumption that a centralized, federal agency should solely and strictly regulate the process to avoid the corruption and unethical situations that are commonplace in open, unregulated markets for organs. Thus, this proposal offers a unique, practical, and ethical avenue of incentivizing live organ donation via a tax framework that is already largely present and does not fall into the ethical conundrum of extreme bodily commodification like the Iranian model.
6.2) **Mandated Choice, Opt-Out Cadaveric Organ Donation**

Beyond the establishment of a regulated system of CLOD in the United States, a revamped system of organ donation must also address cadaveric organ donation. As stated last chapter, there are clearly significant practical and moral reasons to adopt a consent system of mandated choice over the more traditional systems of opt-in, explicit consent and opt-out, presumed consent that still dominate many nations’ consent policies today. However, by adding a further “nudge” to the mix, mandated choice systems can be made even more efficient.

6.2.1) **Libertarian Paternalism and “Nudges”**

Due to the advancements of disciplines such as psychology and behavioral economics, it is now known that we humans are not nearly as rational as we once thought we were, and we are subject to irrational influences and cognitive biases that substantially affect our decision-making abilities. For example, default settings and the way that information or options are presented to an individual, i.e. choice-framing effects, can significantly affect the decision that an individual will make depending upon how these default settings and choice-framing effects are set up and presented. Manipulating these irrational influences and biases can then be considered part of a good “choice architecture,” or the deliberate design of the presentation of various differing choices aimed at favoring one choice over others, and libertarian paternalism, or a “nudge,” can be defined as “any aspect of choice architecture that alters people’s behavior in a predictable way without forbidding any options or significantly changing their economic incentives. To count as a mere nudge, the intervention must be easy and cheap to avoid. Nudges are not mandates. Putting the fruits at eye level counts as a nudge. Banning junk food does not.”

In actual policy, libertarian paternalism is then used in a couple differing ways. First, there are certain default settings that necessarily require one preference over another, such as
when the default is bifurcated into one of two options. As Sunstein puts it, “default rules and starting points often matter, institutions can't avoid nudging people -- and hence can't avoid a kind of paternalism, or at least a nudge.” 706 Thus, the argument is that since a preference must necessarily be set in the default setting, as long as there’s an option to opt-out of the default, then it might as well be one that promotes the best outcomes.

A second and more controversial use of policies that many consider to be nudges is the method of providing incentives or disincentives for particular actions, states, or purchases. For example, “sin taxes” are measured hikes in taxes for certain purchases considered “sins,” “vices,” or undesirable habits, i.e. habits or pleasures that lead to immediate gratification but also future health costs and consequences, such as potato chips, as determined by the State. 707 These taxes are “levied to both discourage and profit from an act purported to be harmful to society.” Generally, these are aimed at perceived vices, such as gambling, tobacco, and alcohol, to discourage their consumption. However, they’ve recently been employed in public health strategies aimed at curbing obesity, too, such as the UK’s decision to return to sin taxing sugary drinks based on the amount of sugar that they contain. 708 Similarly, disincentives might also be used by eliminating options altogether, such as Mayor Bloomberg’s New York City large soda size ban. 709

The problem with these types of actions and policies is that they’re not consistent with the conditions of libertarian paternalism. The use of disincentives, such as “sin taxing” or directly eliminating options, is hardly any different from direct paternalism, because they force individual change by eliminating options or creating penalties for not changing. The reason nudges are compatible with liberalism in many default settings is because they allow the individual to easily opt-out without being unduly forced and coerced to participate in the
behavior. In eliminating options or sin taxing, though, there is no ability to opt-out, and you are either forcing individuals to change their conception of the good by taking away options or forcing them to modify their behavior, or otherwise suffer the consequences, which are higher taxes paid on items. Remember, this type of action is expressly prohibited in the definition of a nudge itself when it is stated, “To count as a mere nudge, the intervention must be easy and cheap to avoid. Nudges are not mandates. Putting the fruits at eye level counts as a nudge. Banning junk food does not.” These policies then deny individuals the freedom to choose their own conception of the good freely and without penalty; thus, this use of disincentives, sin taxes, and the elimination of options is direct paternalism and not consistent with liberalism and Mill’s harm principle, i.e. the threshold standard for government intervention into individuals’ lives, thus it isn’t libertarian paternalism, even though some vehemently argue for this status.

Interestingly enough, though many assume that positive incentives, especially smaller financial incentives, are excellent practical examples of nudges in actions, by definition they’re technically not nudges either. This is due to two interrelated reasons. First, there is a theoretical dilemma between the two different thinking systems of the human brain that are responsible for nudges versus incentives. Nudges are supposed to work upon the more instinctive, unconscious components of human thinking, i.e. what Thaler and Sunstein call the “Automatic System” of human thinking. This is the system of human thinking responsible for making you duck when a ball is unexpectedly thrown at you or making you smile when you see a cute puppy. However, incentives don’t work via this “Automatic System” of human thinking but rather the “Reflective System” of human thinking. This system is more rational and self-conscious than instinctive and unconscious, and incentives work on this system by giving the agent an actual reason to change their behavior, i.e. incentives engage this system by changing the cost-benefit analysis. Thus,
financial incentives rely upon rational processes rather than cognitive biases to change behaviors, which, by definition, makes them incompatible to be considered nudges.714

The second reason involves the very definition of a nudge itself. Remember, the first part of the definition of a nudge states that it is “any aspect of choice architecture that alters people’s behavior in a predictable way without forbidding any options or significantly changing their economic incentives.”715 However, any effective incentive, especially financial, will necessarily change the economic incentives of the agent, so, again, by definition incentives cannot be considered nudges. But this isn’t to say that incentives - again, especially financial incentives - aren’t behavioral economic interventions or part of a good choice architecture either, because they clearly are.716 Similarly, this also isn’t to say that incentives aren’t effective either, because many empirical studies have shown the effectiveness of using cash incentives or even lottery-based incentives to further promote public health aims.717 However, though incentives are effective components of a good choice architecture with the aims of behavioral economic intervention, conceptually they are not nudges, because they require rational reasoning and significantly changing the agent’s economic incentives for effectiveness.

6.2.2) “Nudges,” Mandated Choice, and Organ Donation

One area where nudges have been extensively used is the area of organ donation. This is because the default donor status is extremely preference-laden. Currently, in the United States the default setting for cadaveric organ donation is negative, i.e. it is not assumed that you will donate your organs after death and individuals must explicitly consent and opt-in to become cadaveric organ donor, and attempts at changing this default status to a positive, presumed consent status have largely been met with skepticism, especially by the American Medical Association.718 However, though ultimately opting for a system of mandated-choice, Thaler and
Sunstein argue that a nudge and change in the default setting from negative, non-donor to positive, donor, i.e. an opt-out system of presumed consent, would significantly increase cadaveric organ donation rates.719 There is recent evidence to back up Thaler’s and Sunstein’s claim, too. In a recent systematic review, though it was found that other factors are also necessarily involved in organ donation rates, there was strong evidence that opt-out, presumed consent systems have increased organ donation rates over opt-in, explicit consent systems.720 Similar findings were also reported in another recent study that found that though the number of living donors was higher in opt-in countries than opt-out countries, deceased donor rates and the total number of kidneys and livers transplanted were higher in opt-out countries than opt-in countries.721

Similarly, others have argued for “faux” nudging in the sense of organ donation prioritization incentives where those that sign up to be cadaveric organ donors would ultimately receive priority over non-donors in issues of organ allocation.722 Some opponents have considered this method to be a disguised form of payment for organs, which is a highly questionable argument at best, or practically ineffective at increasing organ donation sign up rates.723 However, these types of incentives are very similar to what Israel has instituted, and the introduction of these incentives in Israel has greatly increased both the number of deceased organ donors and the number of newly signed donor cards.724 Of course, as was just argued above, incentives of this type are not technically nudges, though they still are an effective method of choice architecture.

Nudges and other incentives are then an effective way to increase cadaveric organ donation rates; however, as argued in the previous chapter, with opt-out, presumed consent systems it’s very difficult in our liberal, individualized society to justify any argument that
automatically presumes donation without actual explicit consent. This is why both of the
aforementioned nudges and incentives, i.e. the opt-out default setting and prioritization, should
be combined with a mandated choice strategy on the national or federal level. By combining
these three strategies, you provide two differing nudges or incentives, i.e. the default/status quo
bias and prioritization, to each individual making a decision about becoming an organ donor.725

The process would go something like this. First, via completion of driver’s license
applications, state identification cards, tax returns, or some combination of these options, you
mandate each individual to designate their organ donation preference. During this process, you
provide them with the necessary educational information to make an informed choice, either
personally or with detailed instructions for where to find more information regarding organ
donation, such as a website, and along with this information will be information regarding both
the prioritization incentive and the positive default status for organ donation, which gives you a
far-reaching response rate for explicit consent.726 (It is explained below how a positive default
status is consistent with a mandated choice approach.) Since there will already be information
regarding the CLOD tax deduction and credit on the income tax return and the ACA has already
established precedent for conducting this type of business on income tax returns, i.e. inquiring
about one’s health insurance status, it seems that the mandated choice question for cadaveric
organ donation should necessarily be on income tax returns, perhaps in addition to other state-
issued forms to ensure widespread coverage.727

This type of system has two main advantages. First, this system increases the percentages
of explicit consent from the actual donor, rather than a presumed consent or consent from the
family, because you mandate the choice to be made by individuals themselves. This is ideal,
because it is uncertain how many families truly understand the preferences for organ donation of

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the potential donor, which could lead to wasted organs and violated preferences or, even worse, organ donation from someone opposed to donation. From 2010 to 2016, the NHSBT estimated that 1,200 people missed out on life-saving organ transplants due to English families vetoing approximately 547 potential organ donation cases.\textsuperscript{728} The question is this - how many of those 547 patients truly did have a positive preference for organ donation that was missed out upon due to the family misjudging their preferences? With this system, though, that won’t be a worry for most cases, because the health team will have either explicit consent for or against donation, which will ultimately keep the family from having to make yet another tough decision.\textsuperscript{729} The explicit choice of the individual should also be honored in both brain-death organ donation cases and donation after cardiac death cases, where possible.

The second major advantage of this system is its ability to lessen the ethical concerns with default settings of presumed consent, which is ultimately how a positive default status is consistent with a mandated choice approach. As stated in the previous chapters, the main ethical issue with presumed consent legislation is that it seems to go against some deeply-rooted ideations about individuals’ sovereignty over their own bodies, and it is argued that it does not respect individual autonomy and individual sovereignty over one’s own body to presume a preference for organ donation across a population.\textsuperscript{730} However, in this system actual donation based on presumed consent would be at an absolute minimum, because most of the given population would be mandated to give an explicit preference to donation. Though since no system is perfect and reaching every single member of a population isn’t really feasible, we would have to rely on the family of the patient to decide upon organ donation, under a substituted judgment standard, i.e. the subjective preferences of the patient, in cases of no
mandated preference on file, which is essentially a soft opt-out format (with a mandated choice explicit consent primary component).731

Still, though, there might be exceedingly rare cases where a patient meets the criteria for organ donation, a mandated preference is not on file, and no family can be located. This would be the only time that presumed consent would be used on a patient, and there’s actually quite a bit of precedence for this type of thing, too. The Anatomy Act in several Indian states allows unclaimed bodies to be given to medical and teaching institutions for anatomical examinations and teaching purposes.732 Many states in the US even have similar policies, including West Virginia, whose Department of Social Services has a detailed policy regarding offering unclaimed bodies to the Anatomical Board of Gift Registry after a search for an advanced directive, next of kin, and authorized representative has come up empty and the individual is to be buried at the public expense.733 So given these realities, a fairly persuasive argument can be made that those brain-dead patients, and perhaps even patients in persistent vegetative states that are having life-sustaining treatment withdrawn and can have organs procured via donation after cardiac death, whom cannot be claimed by family become the responsibility of the State, and consent can be presumed on the basis of the best interests of the state as a whole, which can be justified due to public funds having to be used in the process.

Thus, this is essentially the justification for having a positive default status combined with a mandated choice approach. Ideally, the State tries to elicit explicit preferences from patients themselves regarding donation, and if that fails, then family members become the primary decision-makers regarding donation. If no family is present, then consent is presumed based on the responsibility and interests of the State, as there is precedent for in other contexts. Utilizing this positive default status as a nudge would then entail presenting this default setting to
the individual as the “status quo” when they are making their decision. For example, the question could say something like: “Though we first try to elicit and rely on (1) you or (2) your family’s preferences for organ donation, the default option when these preferences are unknown is a willingness to donate your organs upon your death. Would you like to change this donation status now, or would you like to continue your willingness to organ donation?”

This would essentially be a modified version of a soft opt-out donation format that would proactively try to elicit and mandate donation preferences from individuals. When the individual has not given their preferences, then the default setting would also be of use to organ procurement specialists in their attempt to persuade the family to agree to organ donation. By informing the family of its default status, you take advantage of the status quo bias and greatly increase the likelihood of an affirmative decision for donation. Therefore, by adjoining the mandated choice philosophy with the nudges of the default/status quo bias and prioritization, which would be a separate component that would be inherent within the UNOS allocation philosophy, though thoroughly promoted, cadaveric organ donation can be effectively incentivized, and we can enhance and protect individual autonomy by ensuring that individuals’ preferences are being met by garnering explicit consent for or against organ donation in much larger numbers and percentages.734

Though the above recommended changes in both CLOD and mandated choice, opt-out cadaveric organ donation should more than suffice to significantly reduce and minimize the organ waiting lists within the US, there’s also the possibility of using tax benefit incentives for cadaveric organ donation. Just as with CLOD, you could use a tax deduction and/or credit to further incentivize signing up to be an organ donor, though the deduction amount would need to be much, much smaller due to the much greater numbers and the ability to use it every year. A
bill in 2001 actually proposed a $2,500 tax credit to those who were registered as organ donors and had provided legal consent, though it never passed into law. But something like the ability to utilize a $500 to $1,000 tax deduction or credit for every year that you’re a registered organ donor should suffice for this goal. But rather than relying on another type of financial incentive like this, as a society we should view and promote cadaveric organ donation as a moral and patriotic duty of a good, morally sound citizen. This type of rhetoric with organ donation lines up well with many religious traditions, especially Christianity and Judaism, along with our liberal, secular morality. Though it’s not a strong enough duty that it should be codified by law, it is a strong enough duty that American society should promote it as a moral and patriotic obligation of the good American, of course unless there are other considerations that might make registering to be a donor impossible, such as certain cultural, religious, or health reasons.

Ultimately, this type of revamped system of organ donation and transplantation in the United States would look much different than the system we have today. Not only would there be a thriving regulated market for live organ donors with both financial and prioritization incentives, there would also be a significantly more engaged cadaveric organ donation system that actively aimed to elicit organ donation preferences rather than merely relying on word of mouth or a controversial notion of presumed consent to attain organs. Further, in addition to OPOs promoting organ donation as a patriotic and moral duty of good Americans, organ procurement specialists would be singing the same tune to grieving families in need of guidance on deciding about their loved one’s organs, along with seeking out and promoting IDOD in competent LSW Donors. The ultimate result of this revamp would be a much more efficient and robust process of both live and cadaveric organ donation, and not only would this system be much more practically efficient, it would also respect individual autonomy, promote beneficent
acts, prevent and remove harm, and ensure just and equitable treatment for the rich and
poor/healthy and unhealthy alike. With the OPTN/UNOS ethics committee finally taking the
consideration of financial incentives for organ donation seriously, it is now time to act to repeal
this archaic and paternalistic prohibition of CLOD that in the West does nothing but harm others
and encroach upon individual autonomy and conscience. It is time for all Americans to reclaim
the classical liberal roots of our forefathers, take a stand for the hundreds of thousands of
Americans on organ waiting lists, and proclaim to our overreaching federal government: “Do not
tread on me.”
Endnotes

734 Chouhan and Draper, “Modified Mandated Choice for Organ Procurement.” 157-161.
Chapter 7 - Conclusion

Though this revamped American model of organ donation is specifically tailored to the cultural, political, and moral contexts of the United States, this model’s same basic framework could also be a potentially good fit for numerous other nations around the world, and this is especially true in more developed nations and Western nations with similar cultural, political, and moral contexts, specifically those with commitments to liberal, democratic, and pluralistic values. The applicability of this model to other national contexts is due to several distinct reasons. First, rather than having a singular, global model of CLOD, regulated systems of CLOD are best suited for the national context, because national systems are easier to control, administrate, and regulate. It is very difficult to control, regulate, and administrate these types of activities across national borders, which is especially dangerous in organ donation due to the potential problems of donor exploitation and organ trafficking. Thus, keeping the model aimed at the national rather than global context is a way of both increasing efficiency and allowing tighter and more effective regulation and oversight over the entire compensated donation process. Second, the vast majority of more developed nations already include the type of tax framework and individual mechanisms needed to make this work. In fact, a global study covering the 6 populated continents and 43 countries found that nearly 90 percent of those countries have some sort of tax benefits available for charitable donations, which means the necessary framework for this model is currently present in many nations around the world already.737

Finally, the vast majority of other nations around the globe have more socialized forms of healthcare, meaning the government, or more accurately the taxpayer, is already financially responsible for the majority of its own citizens’ healthcare expenditures. This is beneficial for this model of CLOD for two reasons. First, as stated last chapter this type of national socialized
healthcare functions much easier with this model of CLOD, because there’s no ideological or practical issue with enabling a nation’s government to be the main purchaser/compensator of organs/organ donors. If the government is already largely responsible for the financial component of healthcare, then there’s no substantive issue with them also playing this role in this model of CLOD, especially when the health and financial benefits of implementing such a system are considered. Of course, the financial benefits for these types of healthcare systems will likely be significantly smaller than the financial benefits for the United States’ healthcare system, since other nations’ governments will almost always be paying for the entirety of the transplant operation costs, where the same isn’t necessarily true in the United States due to a large percentage of private health insurers. Second, one of the consequences of socialized healthcare is increased income taxes, which is required in order to have the government revenue needed to fund such a socialized system of healthcare. Thus, tax benefits compensation would be a very welcomed method of donor compensation in countries where citizens are already paying a significant amount of income taxes, and this would provide a very attractive financial incentive to potential donors.

What’s more, even while being a developing country with a poor corruption index and reputation, the related and similar Iranian model of CLOD has remained remarkably effective, efficient, and corruption-free throughout its existence, and it has effectively deterred organ trafficking, organ brokers, and transplant tourism within Iran ever since its establishment. Transparency International is a global organization with the purpose and aims of locating, broadcasting, and destroying corruption in governmental agencies throughout the world. This organization puts out an annual Corruption Perceptions Index (CPI) that ranks each country according to its corruption prevalence, perception, and control. Iran rates low in every factor of
corruption, scoring a mere 29 points out of a total of 100 points and ranking 131 out of the 176 nations that this organization surveyed. They also rank in the 20th percentile when it comes to controlling corruption.738

Thus, the fact that this model has avoided corruption in a very corrupt national government, while simultaneously meeting its goal of alleviating the kidney waiting list and halting organ trafficking and the black market, is a great testament to this model’s effectiveness, and the changes made to the proposed American model should only serve to bolster this resistance to corruption by eliminating the direct quid pro quo cash for organ exchange arrangement and providing a more thorough consistency in the application and enforcement of transplant laws and directives throughout the nation, states, and regional OPOs. Clearly, then, when one combines its national orientation, utilization of a common tax framework, consistency with socialized forms of healthcare, and ability to be effectively implemented and evade corruption, it becomes readily apparent that this is a promising model for nations struggling with long organ waiting lists worldwide.

To conclude, our current system of organ donation is broken, and as a society we have a strong moral obligation to do what we can to aid these ailing individuals until our medical and scientific capabilities make this a problem of the past. Offering financial incentives via compensation for live organ donation is the only current avenue capable of adequately addressing this problem, and this dissertation has given a substantial and compelling moral justification for the establishment of a regulated system of CLOD in the United States based on the ethical concept of principlism and the moral and political principles of classical liberalism that form the foundation of our American political philosophy. This argument for the moral justification of CLOD was systematically presented, discussed, and defended in a step-by-step
process throughout the differing chapters of the dissertation, which ultimately culminated in the final chapter that presented the proposed revamped model of organ donation and transplantation for the United States.

After giving an abbreviated version of this moral justification argument in chapter one, chapter two set the stage for the basis of CLOD by looking at past systems of organ donation, analyzing future potential avenues of organ transplantation, and elaborating on the medical, political, and moral contexts involved with the establishment of a regulated system of CLOD in the United States. This chapter then established a strong moral obligation to aid these individuals who are dying on organ waiting lists due to a lack of viable organs for transplantation. Since altruistic systems have consistently failed to meet organ needs and are very inefficient compared to systems utilizing financial incentives for organ donation, chapter two concluded that we have a strong moral obligation to not legally prohibit any morally justifiable regulated system of CLOD in the United States, since this would essentially be damning certain individuals with preventable organ failure to death due to a condition that they didn’t choose or bring about themselves, which is prejudiced and discriminatory.

Chapters three and four then thoroughly investigated the possibility of morally justifying a regulated system of CLOD in the United States. After analyzing the concept of principlism containing the moral principles of autonomy, justice, beneficence, and non-maleficence, it was concluded that we have strong moral obligations from the principles of autonomy, justice, and non-maleficence to not prohibit a regulated system of CLOD in the United States. And though the principle of beneficence does not necessarily morally obligate us to not prohibit CLOD, the principle of beneficence is clearly consistent with and in favor of regulation, rather than prohibition, of CLOD, because CLOD ultimately engenders many beneficent acts when utilized
appropriately. Common substantial objections to CLOD were also analyzed and evaluated, including objections from exploitation, commodification, stigmatization of donors, and the suppression of altruistic organ donation. Though some of these moral and practical objections have garnered much interest and support in the professional literature, it was argued and concluded that none of these objections ultimately represent a sufficient and compelling case for the justification of the legal prohibition of CLOD in the United States.

Chapter five then examined the ethicality of some popular cadaveric organ donation consent policies and other differing organ donation proposals to further revamp the American system of organ donation and transplantation. After analyzing the three major cadaveric organ donation consent policies, it was concluded that mandated choice policies are the most practical, effective, and ethically sound. Other recent organ donation proposals were also evaluated and analyzed, including proposals of IDOD, organ donation euthanasia, and donation after physician-assisted suicide, where allowed by law. It was concluded that IDOD in competent, capacitated patients and donation after physician-assisted suicide are the only two options that are ethically sound, and both of these options should be promoted by organ procurement specialists in their attempts to garner consent for organ donation and procurement.

Finally, chapter six put all of the aforementioned conclusions and findings together and delineated the proposed model that is the culmination of the entire dissertation. This proposed model ultimately utilizes tax benefits compensation to financially incentivize live organ donation and increase organ donation rates. As for cadaveric organ donation, this model combines a mandated choice consent system with an opt-out, presumed consent system to utilize “nudges” and effectively incentivize and increase cadaveric organ donation rates over the rates observed in regular mandated choice consent systems. Thus, this dissertation has made a strong case for the
moral justification of CLOD and the immoral and unjustifiable nature of legally prohibiting individuals from freely partaking in such transactions in the United States. By following these steps and implementing this new proposed model to revamp the current organ donation system, not only can we put an end to this archaic and paternalistic prohibition of CLOD that in the West does nothing but impede progress and encroach upon individual autonomy and conscience, but we can most importantly stop standing by and watching our loved ones suffer on dialysis and ultimately perish prematurely due to unjustified moral paternalism based on faulty assumptions and abstract philosophical objections that simply do not translate to the real world.

Endnotes

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