

## Department of ethics

# The case for allowing kidney sales

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When the practice of buying kidneys from live vendors first came to light some years ago, it aroused such horror that all professional associations denounced it<sup>1,2</sup> and nearly all countries have now made it illegal.<sup>3</sup> Such political and professional unanimity may seem to leave no room for further debate, but we nevertheless think it important to reopen the discussion.

The well-known shortage of kidneys for transplantation causes much suffering and death. Dialysis is a wretched experience for most patients, and is anyway rationed in most places and simply unavailable to the majority of patients in most developing countries.<sup>5</sup> Since most potential kidney vendors will never become unpaid donors, either during life or posthumously, the prohibition of sales must be presumed to exclude kidneys that would otherwise be available. It is therefore essential to make sure that there is adequate justification for the resulting harm.

Most people will recognise in themselves the feelings of outrage and disgust that led to an outright ban on kidney sales, and such feelings typically have a force that seems to their possessors to need no further justification. Nevertheless, if we are to deny treatment to the suffering and dying we need better reasons than our own feelings of disgust.

In this paper we outline our reasons for thinking that the arguments commonly offered for prohibiting organ sales do not work, and therefore that the debate should be reopened.<sup>6,7</sup> Here we consider only the selling of kidneys by living vendors, but our arguments have wider implications.

The commonest objection to kidney selling is expressed on behalf of the vendors: the exploited poor, who need to be protected against the greedy rich. However, the vendors are themselves anxious to sell,<sup>8</sup> and see this practice as the best option open to them. The worse we think the selling of a kidney, therefore, the worse should seem the position of the vendors when that option is removed. Unless this appearance is

illusory, the prohibition of sales does even more harm than first seemed, in harming vendors as well as recipients. To this argument it is replied that the vendors' apparent choice is not genuine. It is said that they are likely to be too uneducated to understand the risks, and that this precludes informed consent. It is also claimed that, since they are coerced by their economic circumstances, their consent cannot count as genuine.<sup>9</sup>

Although both these arguments appeal to the importance of autonomous choice, they are quite different. The first claim is that the vendors are not competent to make a genuine choice within a given range of options. The second, by contrast, is that poverty has so restricted the range of options that organ selling has become the best, and therefore, in effect, that the range is too small. Once this distinction is drawn, it can be seen that neither argument works as a justification of prohibition.<sup>7</sup>

If our ground for concern is that the range of choices is too small, we cannot improve matters by removing the best option that poverty has left, and making the range smaller still. To do so is to make subsequent choices, by this criterion, even less autonomous. The only way to improve matters is to lessen the poverty until organ selling no longer seems the best option; and if that could be achieved, prohibition would be irrelevant because nobody would want to sell.

The other line of argument may seem more promising, since ignorance does preclude informed consent. However, the likely ignorance of the subjects is not a reason for banning altogether a procedure for which consent is required. In other contexts, the value we place on autonomy leads us to insist on information and counselling, and that is what it should suggest in the case of organ selling as well. It may be said that this approach is impracticable, because the educational level of potential vendors is too limited to make explanation feasible, or because no system could reliably counteract the misinformation of nefarious middlemen and profiteering clinics. But even if we accepted that no possible vendor could be competent to consent, that would justify only putting the decision in the hands of competent guardians. To justify total prohibition it would also be necessary to show that organ selling must always be against the interests of potential vendors, and it is most unlikely that this would be done.

The risk involved in nephrectomy is not in itself high, and most people regard it as acceptable for living related donors.<sup>10</sup> Since the procedure is, in principle, the same for vendors as for unpaid donors, any systematic difference between the worthwhileness of the risk for vendors and donors presumably lies on the other side of the calculation, in the expected benefit. Nevertheless the

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exchange of money cannot in itself turn an acceptable risk into an unacceptable one from the vendor's point of view. It depends entirely on what the money is wanted for.

In general, furthermore, the poorer a potential vendor, the more likely it is that the sale of a kidney will be worth whatever risk there is. 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,<sup>11</sup> or extricating themselves from poverty and debt—should be thought so misguided as to need saving from themselves.

It will be said that this does not take account of the reality of the vendors' circumstances: that risks are likely to be greater than for unpaid donors because poverty is detrimental to health, and vendors are often not given proper care. They may also be underpaid or cheated, or may waste their money through inexperience. However, once again, these arguments apply far more strongly to many other activities by which the poor try to earn money, and which we do not forbid. The best way to address such problems would be by regulation and perhaps a central purchasing system, to provide screening, counselling, reliable payment, insurance, and financial advice.<sup>12</sup>

To this it will be replied that no system of screening and control could be complete, and that both vendors and recipients would always be at risk of exploitation and poor treatment. But all the evidence we have shows that there is much more scope for exploitation and abuse when a supply of desperately wanted goods is made illegal. It is, furthermore, not clear why it should be thought harder to police a legal trade than the present complete ban.

Furthermore, even if vendors and recipients would always be at risk of exploitation, that does not alter the fact that if they choose this option, all alternatives must seem worse to them. Trying to end exploitation by prohibition is rather like ending slum dwelling by bulldozing slums: it ends the evil in that form, but only by making things worse for the victims. If we want to protect the exploited, we can do it only by removing the poverty that makes them vulnerable, or, failing that, by controlling the trade.

Another familiar objection is that it is unfair for the rich to have privileges not available to the poor. This argument, however, is irrelevant to the issue of organ selling as such. If organ selling is wrong for this reason, so are all benefits available to the rich, including all private medicine, and, for that matter, all public provision of medicine in rich countries (including transplantation of donated organs) that is unavailable in poor ones. Furthermore, all purchasing could be done by a central organisation responsible for fair distribution.<sup>12</sup>

It is frequently asserted that organ donation must be altruistic to be acceptable,<sup>13</sup> and that this rules out payment. However, there are two problems with this claim. First, altruism does not distinguish donors from vendors. If a father who saves his daughter's life by giving her a kidney is altruistic, it is difficult to see why his selling a kidney to pay for some other operation to save her life should be thought less so. Second, nobody believes in general that unless some useful action is altruistic it is better to forbid it altogether.

It is said that the practice would undermine

confidence in the medical profession, because of the association of doctors with money-making practices. That, however, would be a reason for objecting to all private practice; and in this case the objection could easily be met by the separation of purchasing and treatment. There could, for instance, be independent trusts<sup>12</sup> to fix charges and handle accounts, as well as to ensure fair play and high standards. It is alleged that allowing the trade would lessen the supply of donated cadaveric kidneys.<sup>14</sup> But although some possible donors might decide to sell instead, their organs would be available, so there would be no loss in the total. And in the meantime, many people will agree to sell who would not otherwise donate.

It is said that in parts of the world where women and children are essentially chattels there would be a danger of their being coerced into becoming vendors. This argument, however, would work as strongly against unpaid living kidney donation, and even more strongly against many far more harmful practices which do not attract calls for their prohibition. Again, regulation would provide the most reliable means of protection.

It is said that selling kidneys would set us on a slippery slope to selling vital organs such as hearts. But that argument would apply equally to the case of the unpaid kidney donation, and nobody is afraid that that will result in the donation of hearts. It is entirely feasible to have laws and professional practices that allow the giving or selling only of non-vital organs. Another objection is that allowing organ sales is impossible because it would outrage public opinion. But this claim is about western public opinion: in many potential vendor communities, organ selling is more acceptable than cadaveric donation, and this argument amounts to a claim that other people should follow western cultural preferences rather than their own. There is, anyway, evidence that the western public is far less opposed to the idea, than are medical and political professionals.<sup>15</sup>

It must be stressed that we are not arguing for the positive conclusion that organ sales must always be acceptable, let alone that there should be an unfettered market. Our claim is only that none of the familiar arguments against organ selling works, and this allows for the possibility that better arguments may yet be found.

Nevertheless, we claim that the burden of proof remains against the defenders of prohibition, and that until good arguments appear, the presumption must be that the trade should be regulated rather than banned altogether. Furthermore, even when there are good objections at particular times or in particular places, that should be regarded as a reason for trying to remove the objections, rather than as an excuse for permanent prohibition.

The weakness of the familiar arguments suggests that they are attempts to justify the deep feelings of repugnance which are the real driving force of prohibition, and feelings of repugnance among the rich and healthy, no matter how strongly felt, cannot justify removing the only hope of the destitute and dying. This is why we conclude that the issue should be considered again, and with scrupulous impartiality.

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## Viewpoint

# Mission-oriented research: a case study

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Composers such as J S Bach and G F Handel wrote some of their greatest music for religious services and state occasions. Important advances in physics and engineering stem from war effort. Medical scientists, on the other hand, tend to suppose that mission-oriented research is doomed to failure. Crucial breakthroughs have resulted from work initiated by investigators who set out with no practical goal,<sup>1</sup> whereas some highly specific research campaigns, such as the American “war against cancer”, have led to disappointment.<sup>2</sup>

So it was with trepidation that in 1985 I accepted an invitation to join an international task force to undertake research on the safety and efficacy of fertility-regulating methods. This was a new initiative taken by the Special Programme of Research, Development and Research Training in Human Reproduction, established by WHO. The Special Programme is now co-sponsored by the United Nations Development Programme, the United Nations Population Fund, the World Bank, and WHO. The first meeting of the steering committee included 13 scientists from developing and developed countries, together with representatives of other agencies that support research in human reproduction. After reviewing published information and research in progress, the committee listed more than 100 questions about the safety or effectiveness of currently used fertility-regulating methods. Priority was given to research relevant to developing countries, because most previous research had been done in western Europe or the USA. Other criteria included the feasibility and cost of suitable projects, and the likelihood that these might be undertaken by other agencies. After a week of discussion and debate, the committee identified nine priority areas.

Several different approaches were used for attacking research priorities. To answer questions about hormonal

contraceptives and the risk of cancer, particularly in developing countries, the task force assumed responsibility for a multicentre case-control study, the WHO Collaborative Study of Neoplasia and Steroid Contraceptives. In other instances, pilot projects were done before the launching of new multicentre studies. Most of these involved centres in developing and developed countries, and many used the established network of collaborating centres, which is a feature of the Special Programme.

Since 1985, this task force has been responsible for the publication of more than 200 scientific papers. In 1997 I undertook a critical review, to assess what has been achieved in terms of scientific knowledge and practical impact.

## Synopsis of key findings

The WHO Collaborative Study of Neoplasia and Steroid Contraceptives was a hospital-based case-control study carried out in eight developing and three developed countries, involving interviews with nearly 10 000 women with cancer and nearly 20 000 controls.<sup>3</sup> Combined oral contraceptives were found to have a protective effect against cancers of the ovary and endometrium. The relative risk of breast cancer in women who had at some time used oral contraceptives was close to 1·0, but there seemed to be some increase in risk among current and recent users. The risk of cervical cancer was found to increase with duration of oral contraception.<sup>4</sup> There was no evidence that oral contraceptives increased the risk of cancer of the liver or gallbladder.<sup>5</sup>

This study also provided the most extensive information available about the association between the injectable contraceptive, depot-medroxyprogesterone acetate (DMPA), and cancer risk. DMPA was found to have a protective effect against endometrial cancer.<sup>5</sup> There was no evidence that DMPA influenced the risks of invasive cervical cancer,<sup>6</sup> or cancers of the ovary<sup>7</sup> or liver.<sup>8</sup> Although there was some evidence of an increased

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