

Organ Markets and the Ends of Medicine

F. DANIEL DAVIS

Center for Clinical Bioethics, Georgetown University, Washington, DC, USA

SAMUEL J. CROWE

Office of Science Policy, Office of the Director, National Institutes of Health, Washington, DC, USA

As the gap between the need for and supply of human organs continues to widen, the aim of securing additional sources of these “gifts of the body” has become a seemingly overriding moral imperative, one that could—and some argue, should—override the widespread ban on organ markets. As a medical practice, organ transplantation entails the inherent risk that one human being, a donor, will become little more than a means to the end of healing for another human being and that he or she will come to have a purely instrumental value. With the establishment of organ markets, not only will the harms of instrumentalization be a reality—the ends of medicine will be further compromised and confused.

Keywords: *bodily integrity, dignity, ends of medicine, organ markets, organ transplantation*

I. INTRODUCTION

The buying and selling of human organs are practices at the forefront of debates about organ procurement throughout the world. Revelations about “black markets” and “underground” trading in human organs are not the only reason for the surge of interest in organ markets: although banned in the United States and throughout most of the world (with the exception of Iran¹), markets are promoted by their advocates as a solution to the chronic,

Address correspondence to: F. Daniel Davis, PhD, 5513 Nebraska Avenue, NW, Washington, DC, USA. E-mail: fdanieldavis@gmail.com

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increasingly acute global shortage of human organs and, thus, as a means to the goal of relieving considerable human suffering and improving human health. Taking the *critical* need for human organs as an unquestionable premise, market proponents argue that legalized organ sales would provide an effective incentive for people who are otherwise reluctant to give up parts of themselves (as living or deceased organ sources) or of their “newly dead” loved ones. This argument, which joins economic self-interest to a utilitarian logic, is not the only one advanced on behalf of the cause of organ markets: other proponents maintain that the freedom to sell one’s organs would constitute a legitimate extension of individual liberty, an ideal central to the American political tradition.²

Critics of organ markets, among whom we number ourselves, marshal several ethical arguments against the buying and selling of human organs. Citing data on the “graying” of the ranks of those waiting for and receiving organs, some raise concerns about the potential harm to intergenerational relations that could result from the creation of a market in organs.³ They argue that organ markets could pit young against old for the simple reason that the former tend to have the healthiest and most desirable organs, whereas the latter tend both to need organs and to have the resources to pay for them. Thus, a market in organs might mean that the young, in effect, become—ever more so than they are today—the source of organs for their parents’ or their grandparents’ generations.⁴ Others cite the exploitation of the poor and vulnerable, which has been all too evident in the proliferation of black markets for human organs in Southeast Asia and other areas of the developing world.⁵ Some focus on the implications of a market in organs from the dead, in which family members sell the organs of their deceased loved ones. They worry that harm could be caused by the intrusions of organ commerce at a time and in a setting usually devoted to mourning by the living of the loss of the dead.⁶ These arguments echo our own concerns about the social effects of organ markets, but they are not crucial to our critique of selling and buying human organs. Rather, our critique turns on a concept of the proper ends of medicine, ends that are conditioned by our vulnerability, our integrity, and our dignity as embodied beings. Our critique culminates in the conclusion that markets in human organs would be inconsistent with the ends of medicine, rightly understood, and would be harmful to our nature as embodied beings.

In developing our critique, it is important, first, to describe two contexts: one is the global dynamics of organ need and organ supply; the other is contemporary medicine and the state of the question—*what are the ends of medicine?*

II. ORGAN MARKETS AND THE GLOBAL NEED FOR HUMAN ORGANS

In the United States and throughout much of the developed world, wherever transplantation is possible and organ procurement is geographically

coordinated and organized, one problem dominates all others: the chronic and increasingly acute shortage of organs. As of November 2008, the waiting list for organs in the United States numbered more than 100,000. A rough estimate of the gap between organ need and organ supply can be obtained by comparing this six-figure number with the five-figure number of transplant recipients in 2007—28,358.⁷ Although the gap varies from country to country, concerted efforts to boost the supply of human organs are underway on a global scale. Some involve the use or consideration of different approaches to organ donation and procurement—for example, the presumed consent laws of Belgium, France, and Spain.⁸ Others depend upon a more disciplined approach to identifying potential donors and to persuading them or their loved ones to consent to donation; this is exemplified, for example, in the Transplant Growth and Management Collaborative, spearheaded by the U.S. Department of Health and Human Services' Division of Transplantation in the Health Resources and Services Administration.

It is in this context of burgeoning need and constrained supply that organ market advocacy has gained ground. In the United States, in the deliberations that led to Congressional passage of the National Organ Transplantation Act of 1984, concerns about the injurious effects of organ selling were reflected in the Act's prohibitions against "valuable consideration."⁹ At that time, the future dynamics of need and supply were unavoidably speculative, in part, because the therapeutic efficacy and range of transplantation were not yet completely established. Today, the benefits of transplantation are well established for most solid organs, and the dynamics of supply and need have become alarmingly concrete—the tolls and hazards of unmet need all too distressingly quantified. And, with respect to the transplantation of kidneys, the organs for which the demand is greatest, the advantages of preemptive transplant, before the onset of renal failure, have been documented.¹⁰ Given the ever-growing waiting list, the burden of morbidity and mortality that people on the list often suffer, and the clinical and economic logic of preemptive transplant, one is hard-pressed to question the apparently unassailable need for human organs. Indeed, that need has assumed the gravity of an overriding moral imperative—overriding, some would argue, our ethical concerns about markets in human organs.

III. ORGAN TRANSPLANTATION AND CONTEMPORARY MEDICINE: PROMISE AND PARADOX

Organ transplantation offers a revealing window into the promise and the paradoxes of contemporary medicine. In its evolution from failure-ridden experiment to routine therapy, in the drive to push its frontiers further and further, and in its juxtaposition of potential good with possible harm: in all these ways and more, organ transplantation mirrors contemporary medicine at its most intensive, hope inspiring, and disquieting. And just as the ethical

precepts that guide transplant practice seem increasingly vulnerable to controversy, confusion, and corrosion, medicine—as practice and profession—seems plagued by a malaise that is, at once, teleological and moral. Indeed, in the face of medicine’s gathering powers, we seem all the more conflicted and uncertain about the ends to which these powers should be put: To the diagnosis, treatment, and, if possible, cure of disease? To the enhancement of human cognitive, reproductive, or physical function? To the extension of the natural lifespan? To the fulfillment of the patient’s desires, insofar as fulfillment is possible? Moreover, these disputes about the proper ends of medicine are, at the same time, disputes about the morality of medicine—about the role of the market and of physician self-interest, about physician and patient autonomy, about concepts of obligation and virtue, and about individual goods and social benefits in determining the scope and limits of physician practice as well as the very nature of the medical profession as such.¹¹

These broader currents of controversy in contemporary medicine are reflected in many of the debates that have marked transplant history since the mid-1950s—and that persist until the present day. At the vortex of these debates are questions about the procurement of organs from the dead as well as the living. The era of successful organ transplantation was inaugurated with the removal of a kidney from a living donor and its implantation in his twin brother—that is, with what transplant pioneer Joseph Murray described as a “compromise” of traditional medical ethics insofar as this first effective transplant entailed not only helping a patient but also transforming a healthy human being into a patient.¹² Under what conditions, then, are such ethical compromises legitimate? In the early 1960s, transplantation using organs from deceased donors began to achieve success, raising persistent questions and concerns about the boundaries between caring for the dying until death and using the dead as health-restoring, life-extending resources for the living. The allocation of human organs also has been hotly contested terrain in recent years, with many disputes surrounding the relative significance of two principles, equity and utility. More recently, the question of how best to increase the supply of human organs has been paramount, as well as pervasive in its effect on the entire ethical framework for transplant practice. With the goal of either generating more organs or more efficiently using the constrained supply, proposals have been advanced to abandon the “dead donor rule,”¹³ to redefine the neurological standard (such that individuals suffering the loss of higher brain functions only can be declared dead),¹⁴ to emphasize utility in kidney allocation,¹⁵ to offer various incentives for deceased donation,¹⁶ and, of course, to establish markets in human organs, especially in kidneys from living vendors.¹⁷

It is unlikely that we will resolve these debates and controversies about transplantation in particular—or contemporary medicine in general—once and for all. At best, we can only hope to clarify and to hone our own reasoning and respectfully challenge the reasoning of those who argue in different

ways and, perhaps, to different conclusions. With this hope in mind, in what follows, we first identify what we take to be the principal contending positions in the debate about the ends of medicine; second, we articulate and defend a particular conception of the ends of medicine; and third, we apply this conception to a critique of organ markets.

IV. THE ENDS AND THE MORALITY OF CONTEMPORARY MEDICINE: CONTENDING POSITIONS

We begin in earnest here by first acknowledging two premises for our reflections on medicine, transplantation, and organ markets. In Part II, we alluded to the first, that is, that concepts of the ends of medicine are intimately bound up with concepts of medical morality: teleology is inseparable from morality. Understandings of medical morality, at the very least, imply particular understandings of the ends of medicine; the obverse is also true. One of our tasks here will be to substantiate this claim with illustrative examples. The second premise is this: the relationship between physician and patient is the epicenter of medical morality; moreover, it is in and through this relationship that the ends of medicine are realized—whether, as we shall see, those ends are construed as the products of negotiation, as established through the achievements of biomedical science and human desire, or as somehow inherent in certain abiding realities.

Surveying current debates about the ends of medicine and about the morality of the physician-patient relationship, we believe three contending “clusters” of ideas can be delineated. We say “clusters” to indicate that these ideas tend to be bundled together but not by any rigorous logic, as one might expect in a fully articulated and developed theory. With one such cluster of ideas, the ethically ideal relationship between physician and patient is fundamentally contractual in nature: physician and patient encounter each other as autonomous equals and their joint task is to negotiate the goals or the outcomes to which both will agree to aspire.¹⁸ Neither possesses moral and, thus, decisional authority. There are no fixed goals—no ends that exist independently of the negotiated outcomes for the relationship.

In a second cluster of ideas, the ideal relationship between physician and patient is morally anchored in the principle of respect for autonomy¹⁹: within certain limits (e.g., of the law), the physician reasons and acts in the service of goals decided solely and chosen by the patient as instrumental to his or her health-related preferences and, ultimately, aims in life. The only significant constraint on patient choice is the boundary between what is and is not yet practically possible for medicine.

In the third and final cluster of ideas, respect for the patient’s own conception of what is or is not good for him or her is acknowledged, but not in isolation from—or as a decisive trump to—the physician’s principal duty to

seek the good of the patient as a vulnerable, ultimately mortal human organism. Although it is legitimate to speak of differing, possible goals of care, these are decided in relationship to the ends of medicine, which are inherent in the realities of the physician-patient relationship, an encounter between a person seeking healing and a professional, equipped with specialized knowledge and skill and bound by the promise to utilize that knowledge and skill in the service of healing.²⁰ The ends are, moreover, two-fold. One is ultimate: it is the normative end of health—the well working and well-being of the whole human organism. The other is proximate: it is healing for a particular patient, achieved through an action by the physician that is both right, insofar as it is informed by sound scientific and clinical evidence, and good, insofar as it accords with the patient's sense of his or her own good and with the integrity of the physician's clinical judgment. Thus, any proper course of clinical judgment on behalf of a patient can be mapped against three coordinates:

- One, the judgment must be grounded in objective knowledge of the human organism, especially of the mechanisms, signs, and symptoms of health and disease, as well as in established knowledge of the effectiveness of diagnostic and therapeutic interventions; the possession of expert knowledge and experience is a hallmark of medicine as a profession—and of the physician as a member of that profession,
- two, the judgment must accord with the patient's understanding of what is good for him or her because physicians treat and care for human beings, not just bodies, and human beings possess the capacity for reason and for choice—a capacity that deserves and demands respect, and
- three, the judgment must exemplify integrity, that is, it must accord with certain goods internal to the practice and profession of medicine—first and foremost, that judgment must be formed and made in the interests of the good of the patient and not in the interests of the good of the physician or of some other individual.

Neither this ultimate end nor this proximate end is negotiated or constructed; rather, conceptually and practically, each *defines* the nature of medicine as such—such that to assert otherwise is to render the discipline and the profession fundamentally incoherent.

Thus, between the first and second clusters of ideas, on the one hand, and the third cluster, on the other, there is a marked contrast in their respective concepts of the ends of medicine. Both the first and the second lend themselves to a fairly expansive vision of medicine's possibilities—possibilities that encompass not only the traditional ends of health and healing but also aims that might appropriately be described as transcendent. We have alluded to these in our descriptive overview of medicine's current malaise: they include the aims of enhancing normal human biological functioning, of progressively extending the span of human life, or of simply fulfilling whatever

wish the patient desires. Although it is only in recent years that these aims have begun to come within medicine's practical reach, we find a first glimpse of them in one of the founding texts of modern philosophy, Descartes' *Discourse on Method*, published in 1637. There, in speaking of the beneficial products of his method, specifically of the "notions" regarding physics that he has formed through his method, he says

. . . we might be able . . . to use them for all the purposes for which they are appropriate, and thus render ourselves, as it were, masters and possessors of our nature. This is desirable . . . principally for the maintenance of health, which unquestionably is the first good and the foundation of all the other goods of this life, for even the mind depends so greatly on the temperament and on the disposition of the organs of the body that, if it is possible to find some means to render men generally more wise and more adroit than they have been up until now, I believe that one should look for it in medicine.

After suggesting that medicine may eventually provide the means to greater wisdom, Descartes goes on to envision other achievements that steady progress in the sciences of medicine might make possible:

. . . one could rid oneself of an infinity of maladies, as much of the body as of the mind, and even perhaps also the frailty of old age, if one had a sufficient knowledge of their causes and of all the remedies that nature has provided us.²¹

Thus, the medicine of Descartes' dreams is as much a tool for enhancing and improving—that is, for mastering—human nature as it is for healing the sick. The medicine of old had no choice but to work within the constraints of human nature. It had to accept the decline of our physical and mental powers that comes with aging, along with the possibility that, in some cases, disease is resistant to medicine at its best. And the medicine of old had to accept, as well, that many human traits—from hair and eye color to sex and vulnerability to disease—remain beyond the reach of medicine's interventions. Today's Cartesian medicine seeks to free itself—and, indeed, has begun to free itself—from these limits and now seems almost unbound by any concept of human nature as a "given."

The drive that seems to animate much of contemporary medicine, in research as well as practice—the drive to push beyond the givens, especially the biological givens of the human organism—is evident in organ transplantation. In opposition to the body's natural immune response against foreign tissue, transplantation seeks to suppress the body's defenses of "self" against "non-self." Against the idea of the human body as a whole of integrated parts, transplantation posits a reductionist concept of the body as a composite of separable, "spare" parts. We hasten to add that in citing these examples, we do not mean to imply that they offer evidence of something that should be eschewed or rejected outright. Like every other medical intervention, immunosuppression has the potential to yield well-documented benefits (graft and patient survival) as well as significant harms (risk of infection,

cancer, renal failure). Moreover, the Cartesian idea that the human body is an extended, composite thing—resolvable into smaller and smaller parts, from organs and systems to tissues and cells to molecules and atoms—has been integral to the progress of the sciences of medicine, broadly speaking, and to basic investigations in organ transplantation.

As many observers have noted, however, especially in clinical practice, the reductionist (Cartesian or otherwise) as patient caregiver all too often neglects the whole, the patient as the unique organism that every human being is, worthily compelling respect for his or her dignity and integrity as such. But the same reductionist thrust is at work in a more generalized phenomenon, in the ongoing process of commodifying the human body—of reducing the body to a collection of marketable parts—with aims and results that are at odds with the ends of medicine, properly understood. To make the case for this critique of organ markets in relation to the ends of medicine, we must now more clearly specify these ends.

V. THE ULTIMATE AND PROXIMATE ENDS OF MEDICINE

The idea that health is the ultimate end of medicine, informing and guiding the physician's encounter with a patient, is not without controversy. Of course, much of the controversy surrounds the meaning of "health" and the implications of the definition for a workable understanding of the physician's functions and duties. On the one hand, there is the excessively broad definition promulgated by the World Health Organization: health is a "state of complete physical, mental, and social well-being . . . a fundamental right of every human being."²² On the other hand, there are rather narrow, "value-free" conceptions that purport to define health in a purely objective fashion.²³ Granting that these disputes will never be settled, once and for all, we think it is nonetheless fruitful to turn, as many have, to the etymology of the word, "health."

The contemporary English word, "health," originates from the Old English, *baelp*, meaning "wholeness, a being whole, sound or well." Thus, the state of being healthy is a state of being whole. In his commentary on the etymology of "health," Leon Kass points out that ancient Greek includes two words that are often translated as "health": *hygieia*—from which we derive the word "hygiene" and which means "living well"—and *euexia*—which means "well-habitedness." As Kass also notes, neither the ancient Greek nor the Old English terms for "health" bear any relationship to the terms for disease or illness and, whereas the Old English word seems to emphasize wholeness as a complete, static state, the ancient Greek terms stress a more dynamic process—the well-functioning activity of the whole.²⁴

The ancient Greek conceptions are of relevance to our contemporary understandings of health insofar as they reflect an important insight: that the well-functioning human organism seeks, maintains, and restores balance

among its constituent elements—for the ancient Greeks, the four humors—and that this ongoing work occurs in dynamic interaction with the surrounding environment. Amid threats from within and without, the human organism engages in a constant striving to preserve its integrity as a whole. Disturbances of this balance are disintegrating and as such are the root cause of illness and disease, conditions that generate the need for physicians, individuals equipped with knowledge of the nature of the human organism and with skill to aid the human organism's natural integrative tendencies. As for the healing powers of the physician, ancient Greek conceptions of health and medicine offer two additional insights that are noteworthy for our purposes. One is this: that in aiding the natural integrative tendencies of the human organism, in seeking to restore the sick to health and to maintain the health of the healthy, the physician treats not simply the body but the whole being of the patient. And the second is this: that, in the words of the unknown Hippocratic author, "everything is not possible to medicine."²⁵ Physicians may and, indeed, must understand the nature of the human organism; they may and should seek to aid the organism's natural restorative processes through interventions of one type or another. But, there are limits to their healing powers, the natural limits of human morbidity and mortality.

Although the centuries-long hegemony of the four humors theory of health and disease has been overthrown by modern medical science, there is still much of value to be mined from these ancient sources. That "health" is a dynamic state of wholeness; that health—the integrity of the whole—is the inward natural aim of the human organism; that, the human organism is, nonetheless, vulnerable to disturbance from within and without; that the physician's healing powers are directed at the whole being of the patient; and that these powers are limited, conditioned by mortal nature of the human organism: despite more than two millennia of progress in scientific and clinical medicine, these remain illuminating apperceptions of human health and disease and of medicine itself.

What this progress has done, however, is to generate an increasingly fundamental, scientific, and objective knowledge of health and disease. Today's physicians deem an individual healthy if key measures of physiologic function are within the relevant, statistically determined normal range and if there are neither signs nor symptoms of demonstrable pathology, either of psyche or soma—again defined in relation to some objective standard of normality. Such standards are dynamic rather than fixed, in part, due to the ongoing advance of biomedical science in revealing increasingly basic physiological and pathophysiological processes within the human organism. When disease is diagnosed, the ideal therapeutic intervention is one for which there is both scientific and clinical evidence of efficacy—of greater benefits than harms—in either curing or ameliorating the disease.

At the same time, more than two millennia of clinical experience and reflection have served to further illuminate the ancient Greek insight that the whole being of the patient is—or should be—the target of the physician's

therapeutic interventions. Thus, any claim that health or disease is a purely objective condition must be qualified: states of health, illness, and disease are states of individual living human organisms, each of which experiences in particular ways the inward manifestations of these states.²⁶ Galen's simple but elegant definition of health—"a state in which we neither suffer pain nor are hindered in the functions of daily life"²⁷—reflects an appreciation of the significance of individual experience, experience that the physician must reckon with on two counts. First, the particular, often idiosyncratic and subjective experiences of the patient are essential information for the physician's clinical tasks of maintaining health and treating disease. And second, reckoning with these experiences is critical to the care of the whole being of the patient.²⁸ Health and disease cannot be fully apprehended by the physician as purely physical or bodily processes: they are states of the whole patient and, as Galen understood, directly affect and shape nearly every dimension of the patient's life—from relations with others to daily pursuits to the patient's ultimate aims in living.

At this juncture, it is important to pause and to take note of the movement of the preceding reflections, which have taken us from the revealing etymology of "health" to an account of certain norms for the physician's work of healing: we have moved, that is, from the ultimate end of medicine, health, to its proximate ends. The ultimate end, the healthy human being, shapes the entire enterprise of medicine, encompassing the generation of new knowledge and skill and the application of that knowledge and skill to the care of individual patient and to the promotion of the health of the public at large. If the ultimate end is broader and more general, the proximate end is, at once, more narrow, specific, and concrete, for the proximate end is the end inherent in every encounter between a physician and a patient, whether healthy or sick: what the patient seeks and what the physician promises to provide is a healing action that is based on scientific and clinical evidence of efficacy (in sustaining health or treating disease) and that is good (in being consistent with the patient's own subjective experience of health or disease as states essential to his or her own aims in life).²⁹ That is to say, the end of medicine in the clinical encounter is a right and good healing action for the particular patient. Actions that meet the normative end of rightness but not that of goodness—or that are good but not right—cannot be properly distinguished as *healing* actions, for they fail to take the whole being of the patient as their concern and target. They would fail, that is, as actions undertaken in the service of the patient's integrity and wholeness.

VI. THE ENDS OF MEDICINE, ORGAN TRANSPLANTATION, AND GENEROSITY

The ends of health and healing, as we have argued, define medicine. The proximate end of healing is realized through right and good healing actions,

undertaken by the physician on behalf of a sick patient with the aim of restoring some measure of wholeness, some measure of health, to that individual. Thus, the arc of this or any such healing act, situated as it is within the concrete realities of a given patient-physician relationship, is always toward the health, the wholeness, the bodily integrity of an individual human being—even if, in particular circumstances, such aims are more distant or unreachable, for example, in relationships with patients suffering from serious, life-threatening illness or with the dying.

As a bridge to our discussion of organ markets, we turn now to a brief examination of the ends of medicine—of these governing norms for the practice and the profession—in relation to organ transplantation and, in particular, living donation. Earlier we alluded to transplant pioneer Joseph Murray's observation that the very first successful living donation, which involved identical twins as giver and recipient, entailed a qualitative shift in medical ethics, a compromise, as Murray put it, of the duty to seek the good of sick patients. Why? Because living donation, then and now, entails the removal of an organ (or organ segment) from a healthy, living donor—from a human being who *becomes* a patient in order to contribute to the healing of another patient. Although the procedures for removing various types of organs or organ segments from living donors differ, they all entail a few basic steps: a surgical incision must be made, the organ or segment of the organ must be removed, and the incisions must be closed. Such procedures are distinct from other surgical interventions, even those that result in the removal of an organ. With the latter, the surgeries are deemed necessary in order to improve the health of a sick person, but with the former, a person who is healthy—healthy enough to donate a part of him or herself to another—is intentionally placed at risk, his or her bodily integrity at stake, by a procedure that has as its proximate end the restoration of some measure of healing for another human. By performing the surgery on a healthy person—one who does not medically need the surgery—the transplant surgeon, in effect, turns a healthy human being into a patient. If we have construed the physician's central, defining duty correctly, if we have grasped the essential correlation between the physician, as healer, and the patient, as one who seeks healing, then living donation seems, at the very least, to be at odds with this duty—that is, with the ends of medicine, properly understood.

With this compromise of the physician's defining duty, a risk inherent in the nature of organ transplantation is amplified. Whether the donor is deceased or living, organ transplantation involves the use of one human being—of his body and the parts of his body—as a means to the end of healing for another human being. The risk intrinsic to transplantation is that the donor will become little or nothing more than a means—that he or she will come to have a purely instrumental value for achieving the end of healing for the recipient. How can this risk be minimized in the case of living donation? Over the past fifty-plus years, three main barriers to the harm of instrumentalization—three

ethical precepts—have been put into place. The first of these barriers is comprised of criteria for the living donor's decision to donate. The donor must be provided with sufficient information about the benefits, risks, and burdens of living donation and must not be coerced when making the decision. The living donor must be informed and express understanding of the potential consequences and must freely choose to give up a part of him or herself. This precept connotes a respect for the potential donor's autonomy.

The second barrier encompasses criteria—of safety and risk—for the transplant procedure. The risk of harm to the donor—harm resulting from the surgical removal of his or her organs or organ segments—must be low if the surgery itself is to be ethically warranted. Every type of surgical intervention carries some degree of risk associated with the effects of anesthesia, of the cutting and suturing of the body, and of such postoperative complications as infection. Also, there are longer term risks to consider—for example, the increased risk of hypertension that some studies of living kidney donation have uncovered.³⁰ As Murray noted and we have emphasized, surgical intervention to retrieve organs from living donors offers no specifically medical benefit to such donors. This barrier is necessary to ensure that the patient is, at least, not seriously or permanently harmed by the procurement surgery—a consequence that would be utterly inconsistent with medicine's inherent end, the maintenance and restoration of human health.³¹

The third precept is the ethic of gifting. Enshrined in the ban on valuable consideration in the National Organ Transplantation Act of 1984, this ethic provides a barrier against two interrelated risks. One is a risk that we have already explored, that is, the risk that the donor (whether living or dead) will become nothing more than a means to the end of restored health for another—that he or she will be instrumentalized. The other risk to which this precept is obviously directed is this: that the donor and, particularly, his or her body parts will be commodified—reduced to their instrumental value, that is, to a price to be determined through the market forces of supply and demand. Both instrumentalization and commodification are, to our minds, offensive to the integrity and dignity of the embodied human being. In deference to their inherent dignity, human beings should never be treated as mere means to an end, for each is an end in himself or herself. Nor should they or their bodies—or their body parts, their organs—be treated as possessing an instrumental value, fixable in the terms of some price: neither their bodies nor their organs should be commodified.

In *Spare Parts*, Renee Fox and Judith Swazey, two of transplantation's most incisive observers, record a series of observations that help to illuminate the logic of this argument. There, they write that when an organ is given from one person to another “the psychological and moral burden is especially onerous because the gift the recipient has received from the donor is so extraordinary that it is inherently unreciprocal. They call the weight of this burden the “tyranny of the gift.”³² The tyranny of the gift has been the target

of criticism by some market proponents who contend that the selling and buying of human organs will dispense with this tyranny by introducing the reciprocities of price into the exchange of human organs. Such a contention, however, misses the point: tyranny of the gift reflects an important truth about human embodiment and bodily integrity that cannot be simply set aside in the interests of generating more organs by going further down the road to commodifying the body. Whether living or dead, a human body is always somebody—a person of dignity and invaluable worth. And any given body part, be it kidney, liver, or heart, at one time was an integral—not just a spare—part of somebody.

As clear boundaries between what is and is not morally legitimate in transplantation practice, these ethical precepts³³ offer bulwarks against the inherent risk and the potential harm of transplantation, that is, that one human being will be diminished—will come to be nothing or little more than a means to the end of improved health for another. These boundaries or barriers—these ethical precepts—not only protect organ donors and recipients but also serve to align the practices of organ transplantation with the ultimate and proximate ends of medicine. In the next and final section, we develop this argument.

VII. ORGAN MARKETS, THE BODY AS PROPERTY, AND THE ENDS OF MEDICINE

The previous discussion of living donation has served to highlight what we take to be at stake in the practice of organ transplantation. We were especially concerned to describe the risk inherent in transplantation—the risk that one individual will come to have a purely instrumental value for achieving the end of healing for another human being. With the establishment of an organ market, a chief protectant from this risk, the ethic of generosity, would either be abandoned or supplanted by an ethic of selling and buying organs. We contend that the *risk* of harm would become the *reality* of harm, no matter what form an organ market might take. There are, of course, many possible kinds of markets. Some market proponents call for markets in organs from the dead: where a living would-be seller could enter into a contract to sell his or her organs after death; or, after the death of a loved one, that individual's family could contract to sell the organs of the deceased.³⁴ Others call for markets in organs from the living—especially kidneys because of the great need for them and because the physical harm to the donor caused by their removal is relatively low. Some advocate relatively free markets wherein human organs from living sources would be procured and allocated through the dynamics of supply and demand.³⁵ Others promote markets that are regulated to one degree or another: for example, by constraints that would ensure that living organ vendors are healthy, that their

decisions to sell are informed and voluntary, and that there are adequate safeguards for surgical safety and postoperative care and follow-up.³⁶ In some proposals for regulated markets, the government or a consortium of organ procurement organizations would purchase kidneys from living vendors, but allocation would occur through the established mechanisms of the Organ Procurement and Transplantation Network and would not, therefore, be subject to supply and demand.

Each of these kinds of markets, by its very nature, would entail the dissolution of the ethic of gifting. To be sure, other key ethical precepts might be maintained in a market regime: the requirement that the decision to sell be informed and voluntary could be maintained, as could the dead donor rule, or, as we have noted, the ideal of fairness in organ allocation. But the ethic of gifting and the virtue of generosity upon which it turns would be supplanted by an altogether different ethic.³⁷ As all proponents of organ markets acknowledge, the aim of establishing a market in human organs is to boost the supply of these precious resources and markets would, at least theoretically, accomplish this aim by providing potential vendors with an *incentive*, not to give but to sell parts of themselves or of their loved ones. Such incentives, by definition, undercut and dispense with the virtue of generosity in the exchange of human organs and replace it with an economic-financial calculus focused on gain. Although every such calculus is not necessarily morally bankrupt, in the exchange of human organs, the economic-financial incentives triumph over generosity and, thus, remove the most important barrier to the risk inherent in transplantation—the risk that an individual and his or her parts will come to have little or nothing more than an instrumental value. And with the removal of this barrier to transplantation's inherent risk, not only are donors instrumentalized but also commodified.

In the sale and purchase of organs, human beings are effectively reduced to things of instrumental value—a value that can be quantified as a specific price, depending upon the dynamics of supply and demand. Against this concern, some argue that the sale of organs is but another expression of human freedom—that conceiving of oneself as a collection of alienable and economically valuable parts is a legitimate exercise of liberty. But the question is at least worth posing: would such a conception, of oneself or of others, be an authentic expression of liberty or would it constitute a real or potential danger to the freedom of the self? There is danger, we contend, in thinking of our own bodies or the bodies of others as forms of personal property that are part of one's net worth and that may be sold or, when nothing else is available, *must* be sold in order to satisfy a debt or obligation or meet a need. Even with the constraints of a highly regulated market in, say, kidneys from living vendors, there are no constraints against the logic of thinking of oneself or of others as forms of property with a specific, quantifiable value.

The problem of commodification is, with organ markets, inextricable from certain dangers to the practice and profession of medicine. We have argued that the ultimate end of medicine is human health—the wholeness and bodily integrity of human individuals, each possessing a dignity that is inherent but nonetheless vulnerable to neglect or disrespect. We have also shown that there is an inherent risk in organ transplantation, the risk that the donor might be reduced to his or her purely instrumental value. The risk of harm may be mitigated by the ethical guidelines that some have proposed as constraints on, in particular, living kidney vendor markets. Nonetheless, with any form of organ market, the most important barrier to the risk of instrumentalization is removed. Embedded within the ethic of generosity is the idea and the hope that individuals may freely, without any form of coercion, choose to give of themselves for the good—in this case, the health—of another. Gestures of generosity are acts of human beings who are treated and understand themselves as ends—and not as mere means to the ends of another. In deference to the generosity of donors and the health of transplant recipients, physicians may, in good conscience, undertake the necessary surgical and medical interventions, confident that these interventions are consistent with the ends of medicine. If this ethic of generosity, however, gives way to an ethic of buying and selling, then physicians would be willing accomplices to both instrumentalization and commodification—consequences that would harm the profession of medicine in three ways.

First, by participating in organ markets, the physician would become complicit in the conception of the human being that undergirds them. For in the service of healing, of restoring the wholeness and integrity of some, the physician would either directly or indirectly engage in the reduction of others to a mere means to this end. The physician would not be able to defend his or her actions based on the understanding of the human body that is captured in the concept of generosity—even if the physician believes such a conception finally to be true—because the moral framework of gifting, which embodies generosity, would be gone. Left with the conception of the body as alienable property, the reduction of the organ giver would be complete, and the practice and profession of medicine would be diminished.

Second, by willingly facilitating the vending process, the physician would take the medical profession one step further along the path of de-professionalization—of becoming merely a consortium of service providers with a certain kind of expertise, no different from other trades in the service industry, except in the power that the physician-provider makes available to the patient-consumer. All that is in the physician-provider's arsenal to affect the biology of human life could, in the most extreme scenario, become available to fulfill the patient-consumer's desires, regardless of the desires—for longer life, death, radical cosmetic alteration—once the end of medicine is lost. As biotechnological developments make more and more possible, without the proper focus on health and healing and without the proper understanding of

the human body, medicine would have increasing difficulty in drawing the line between what is and what is not permissible.

Third, de-professionalization would damage (some would argue, further damage) the patient-physician relationship, which crucially turns on trust, trust that the physician is a healer and will use his or her skills to heal and benefit the patient. Arnold Relman and others have already drawn attention to the ways in which financial incentives threaten to shift the weight of physician concerns from the interests and needs of patients to their own interests and needs—and thereby signal a crisis of professionalism for medicine. The introduction of organ markets and of physician participation in the same would, in our view, only accentuate this concern and lead to further erosion of the trust that is so essential to the efficacy of the physician-patient relationship. If the ends of medicine are further confused by the commercialization of healing, doubt, rather than confidence, will become the rule in a human relationship of critical importance in nearly everyone's life.

With this concern about the intrusion of self-economic interest in the moral motivations of physicians, we move to the conclusion of our argument and this essay. Over the past 10–15 years, an enormous literature has developed around the diagnosis and therapy of contemporary medicine's teleological and moral malaise—a malaise that some trace to the perverse incentives of financial self-interest and others to the ongoing expansion of medicine's technical capabilities in the absence of clear guidelines for the deployment of these capabilities. There is no panacea for this state of affairs, but it seems obvious, at least to us, that there are readily identifiable measures that would only exacerbate rather than ameliorate medicine's current state. It is our conviction that organ markets would constitute such a measure.

NOTES

1. Iran's living kidney vendor program is the subject of an essay authored by Hippen (2008) and published in *The Cato Institute's Policy Analysis*.

2. In addition to Hippen, Taylor and Cherry have mounted impressive defenses of organ markets, based on appeals both to liberty (and markets as vehicles for the realization of liberty) and to the improved health of organ recipients. See Taylor (2005) and Cherry (2005).

3. For example, in 1997, individuals 50 years of age and older made up 43 percent of the waiting list; by 2006, they constituted 58.5 percent. In 1997, individuals in this same age range made up 39.5 percent of all transplant recipients; by 2006, they accounted for 53.9 percent. See Table 1.4, "Characteristics of Waiting List Patients at the End of the Year, 1997 to 2006," and Table 1.10, "Transplant Recipient Characteristics, 1997 to 2006," 2007 Organ Procurement and Transplantation Network/Scientific Registry of Transplant Recipients Annual Report: Transplant Data, 1997–2006, Health Resources and Services Administration, Healthcare Systems Bureau, Division of Transplantation, Rockville, MD.

4. See, for example, the remarks by Leon Kass at a session of the President's Council on Bioethics (2006) devoted to a discussion of the issue of age and organ allocation, September 7, 2006.

5. Organ trafficking and the exploitation of the poor and vulnerable are subjects of intensive scrutiny and concern. Two succinct overviews of these problems are provided by Rothman (1998) and D. J. Rothman and S. Rothman (2003). More than 10 years ago, to call attention to the problems of trafficking and to explore solutions, a group of scholars issued the Bellagio Task Force Report on Transplantation,

Bodily Integrity, and the International Traffic in Organs (Rothman et al., 1997). International organizations have also sought to address the problems. In May 2004, the World Health Organization passed a resolution condemning the practice of organ trafficking. The most recent international effort to stiffen worldwide resolve to fight the practice is found in the Declaration of Istanbul, drafted by Participants at the International Summit on Transplant Tourism and Organ Trafficking Convened by the Transplantation Society and the International Society of Nephrology in Istanbul, Turkey, April 30 through May 2, 2008.

6. For example, see Murray (1996). Also, see Sharp (2007). During the public phase of the Council's inquiry into organ transplantation, the mortician and essayist Lynch (2006) underscored the practices of respect and mourning that define the human response to the death and loss of one's intimates.

7. All data on organ transplantation are from the Organ Procurement and Transplantation Network (OPTN) and are available from the OPTN Web site: <http://www.optn.org>.

8. See, for instance, Abadie and Gay (2006).

9. See Public Law 98–507.

10. See, for example, Kasiske et al. (2002) and Becker et al. (2006).

11. Our thinking here is situated within (and owes much to) certain currents of critical thought about biomedicine and biotechnology—currents charted, for example, by such authors and scholars as C. S. Lewis, Hans Jonas, Daniel Callahan, and Leon Kass. See, for example, Lewis (2001); Jonas (1974), (1984); Callahan (1995), (2003); and Kass (1985).

12. Reflecting on the first successful transplantations a quarter of a century later, and particularly on the procurement of organs from healthy living donors, Murray and his colleagues wrote: “Treatment is always a balance between intended good and potential adverse effects. For the healthy donor, however, there is no physical benefit. As physicians educated and motivated to make sick persons well, we had at that time to make a basic qualitative shift in our actions as we subjected healthy normal humans to extensive surgical procedures. To this extent, we compromised the injunction ‘to do no harm.’” See Murray, Tilney, and Wilson (1978).

13. In their own rethinking of the ethics of organ donation, Franklin G. Miller and Robert D. Truog recommend an explicit “jettisoning” of the dead donor rule. See Miller and Truog (2008).

14. Robert Veatch of Georgetown University's Kennedy Institute of Ethics has been a vocal proponent of this change in the neurological standard for the determination of death. See Veatch (2000).

15. The reference here is to a possible revision in the algorithm for kidney allocation, under consideration by a subcommittee of the Organ Procurement and Transplantation Network's Board of Directors. The revision would entail the calculation and incorporation of a variable known as “life years from transplant” among other possible changes. The revision is still under consideration. Information on the process may be obtained from <http://www.unos.org>.

16. See Delmonico et al. (2002) and Veatch (2003).

17. Proponents of such a market recognize that although there is an acute need for transplantable kidneys, livers, pancreases, intestines, lungs, and hearts, the need for kidneys is the greatest, accounting for about two-thirds of the national waiting list, or roughly 74,000 Americans. This need has grown considerably during the past few decades, and recent studies have shown that the need for kidneys in particular will increase even more quickly in the future. See Himmelfarb (2007) and Gilbertson et al. (2005). Although there is a need for every available kidney, some kidneys are more desirable than others—kidneys from the living tend to be healthier and, thus, last longer when transplanted. Also, the potential number of vendors from the living is much greater than from the deceased, because so few people die in ways that make them eligible sources of organs. As such, most proponents prefer a market in living vendor kidneys.

18. This understanding of the physician-patient relationship is systematically developed by Robert Veatch in his *A Theory of Medical Ethics*. See Veatch (1981).

19. In the bioethics literature, there are strong as well as weaker statements of this view. There are those who simply assert that respect for autonomy is the principle of biomedical ethics—with little or no attempt to articulate the relationship between this principle and such other principles as beneficence, nonmaleficence, or justice. Such an assertion is fundamental, for example, to Ruth Macklin's critique of the concept of human dignity, all the work of which, Macklin claims, can and should be done by the principle of respect for autonomy. A more extended development of this view is found in Engelhardt (1996). See also Dworkin (1994).

20. This view of the physician-patient relationship has been articulated and defended at great length in the works of Pellegrino and Thomasma (1981) and (1988)—as well as in numerous essays by Pellegrino (2001b), (2008a), and (2008b).

21. Descartes (1998).

22. World Health Organization (1946).

23. One of the better known and more frequently cited examples is the Boorse's (2004) essay.
24. Kass (1985).
25. Hippocrates (1983).
26. See Leon Kass's essay "The end of medicine and the pursuit of health," in Kass (1985). In order to draw and fix the distinction between the objective, observable and, to some extent, quantifiable, on the one hand, and the subjective, felt, and experienced, on the other, some scholars reserve the term "disease" for the former and the term "illness" for the latter. Some go even further to assert the critical significance of the subjective for the physician's acts of healing: Pellegrino, for example, speaks of the "fact" of illness and by that he means the determinative reality of the patient's experience for the physician's clinical thinking and doing. See Pellegrino (2001a).
27. Galen's definition of health is quoted in Temkin (1977).
28. Citing Plato's emphasis of this point in Phaedrus, Gadamer (1996) reflects on the significance of the body-self whole for the physician's healing work.
29. Our reference to the patient's own subjective experience of health or disease is meant to underscore the established possibility, repeatedly observed in clinical practice, that two patients with the same diagnosis will experience the disease in different—often very different—ways.
30. See, for example, Boudville et al. (2006).
31. Consider some of the gravest misuses of the medical arts (Nazi experiments, Tuskegee Syphilis experiment) and the harm caused by such misuses, not only to the "patients" but also to the medical profession and its practitioners.
32. Fox and Swazey (1992).
33. There are other precepts as well. For instance, by prohibiting the procurement of organs from the nearly dead, the dead donor rule shows respect for the integrity of living human beings. The practice of seeking both individual and familial consent to deceased organ donation shows respect both for the autonomy of the individual and the special relationship of family members to their dead loved ones. The principle of fairness in organ allocation reflects each human being's inherent equality with all other human beings.
34. See Cohen (1989).
35. See Epstein (1997). Also see Taylor (2005). Although some market proponents would confine markets to the procurement of organs, Epstein and Taylor support the use of organ markets in allocation.
36. See Matas (2004) and Hippen (2006).
37. Some market proponents argue that organ donation can continue even if an organ market was created, and thus, those who prefer to donate as opposed to vend their organs can do so. See the work of Hippen and Matas, for example. Although this might be true, it does not change the fact that if one chooses to sell an organ, the act is an exchange of one thing for another, whereas in organ donation, the act is primarily of one direction: a giving with nothing required in return. The latter is, by definition, an act of generosity, whereas the former is driven by a desire for gain.

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