ARE BANS ON KIDNEY SALES UNJUSTIFIABLY PATERNALISTIC?

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ABSTRACT

This paper challenges the view that bans on kidney sales are unjustifiably paternalistic, that is, that they unduly deny people the freedom to make decisions about their own bodies in order to protect them from harm. I argue that not even principled anti-paternalists should reject such bans. This is because their rationale is not hard paternalism, which anti-paternalists repudiate, but soft paternalism, which they in principle accept. More precisely, I suggest that their rationale is what Franklin Miller and Alan Wertheimer call ‘group soft paternalism’. Group soft paternalistic policies restrict the freedom of autonomous individuals, not for their own good (hard paternalism), but as an unavoidable consequence of seeking to protect other, non-autonomous individuals from harms that they have not voluntarily chosen (soft paternalism). Group soft paternalism supports prohibiting kidney sales on three conditions: (1) that such sales are potentially harmful to vendors, (2) that many vendors would suffer impaired autonomy, and (3) that distinguishing between autonomous and non-autonomous vendors and interfering only with the latter is unfeasible. I provide reasons for thinking that these conditions will often hold.

INTRODUCTION

Since the first successful human kidney transplants in the 1950s the procedure has emerged as the treatment of choice for end-stage renal disease. The demand for transplants has increased steadily over the last several decades due to a range of factors, including improved transplantation techniques, better immunosuppression drugs, and an aging population. However, the number of transplantable kidneys from deceased and living donors has not seen a similar increase. Hence the often described ‘kidney shortage’. Patients wait increasingly longer for transplants, relying instead on less effective and more burdensome dialysis treatments (where these are available) and sometimes dying while waiting.

Different measures have been taken or envisaged in order to address the kidney shortage. These include using lower quality cadaver kidneys, moving from explicit to presumed consent to cadaveric donation, and permitting living donation to non-relatives and living undirected donation to strangers. A particularly debated proposal is to attract more living donors by offering payment for kidneys. However, kidney sales are illegal almost everywhere and condemned by powerful international organisations such as the EU and the UN.

The near universal ban on kidney sales is increasingly criticised in the literature. The most obvious and widely rehearsed criticism appeals to efficiency. Payment would attract more donors, it is argued, thus increasing the number of kidneys available for transplant, potentially saving or improving the lives of patients waiting for them.¹ This is a powerful

¹ See, e.g. J. Radcliffe-Richards. Nephurious Goings On: Kidney Sales and Moral Arguments. *J Med Philos* 1996; 21: 375-416; J.S. Cameron & R. Hoffenberg. The Ethics of Organ Transplantation Reconsidered: Paid Organ Donation and the Use of Executed Prisoners as Donors. *Kidney Int* 1999; 55: 724-732; C.A. Erin & J. Harris. An Ethical Market in Human Organs. *J Med Ethics* 2003; 29: 137-138; A.J. Matas. The Case for Living Kidney Sales:

argument – everyone agrees on the importance of avoiding death and reducing suffering – but it has one notable limitation. The effect of allowing payment on the availability of kidneys is ultimately a complex empirical question. While there are good armchair reasons to think that payment would increase availability (people often do things for money that they would not do for free), one can also think of reasons why it would not. Some opponents of markets in body parts even think that payment may *decrease* the amount of organs available by discouraging those who would otherwise donate for free.² And both sides of the debate can cite empirical evidence to support their case.³

Rationale, Objections and Concerns. *Am J Transplant* 2004; 4: 2007-2017; F. Omar, G. Tufveson & S. Welin. Compensated Living Kidney Donation: A Plea for Pragmatism. *Health Care Anal* 2010; 18: 85-101; S. Wilkinson. 2003. *Bodies for Sale: Ethics and Exploitation in the Human Body Trade*. London: Routledge; J.S. Taylor. 2005. *Stakes and Kidneys: Why Markets in Human Body Parts are Morally Imperative*. Aldershot: Ashgate.

² T.L. Zutlevics. Markets and The Needy: Organ Sales or Aid? *J Appl Philos* 2001; 18: 297-301.

³ Proponents of kidney sales can draw on economic studies on the efficiency of such sales, e.g. G.S. Becker & J.J. Elias. Introducing Incentives in the Market for Live and Cadaveric Organ Donations. *J Econ Perspect* 2007; 21(3): 3-24. Their critics may appeal to recent evidence of a much more ambiguous relationship between payment and the willingness to provide kidneys than has usually been assumed. See A. Rid et al. Would You Sell a Kidney in a Regulated Kidney Market? Results of an Exploratory Study. *J Med Ethics* 2009; 35: 558-564. Market critics may also extrapolate from Richard Titmuss' classic work on the altruism-eroding effects of a market in blood. See R.M. Titmuss. 1970. *The Gift Relationship: From Human Blood to Social Policy*. London: George Allen and Unwin.

THE ANTI-PATERNALIST ARGUMENT

There is another, more principled argument against banning kidney sales. In liberal societies it is generally assumed that people should be free to live their lives as they wish unless there are good reasons for restricting their freedom. Some reasons for restriction – especially the prevention of harm to third parties – enjoy wide acceptance, while others are more controversial. Champions of liberty are particularly suspicious of limiting people's choices for their own good: in many areas of life there is a presumption against *paternalism*.

Prohibiting kidney sales seems to sit uneasily with that presumption. Stewart Cameron and Raymond Hoffenberg argue: 'The denial of the ability to donate an organ for cash is a denial of autonomy for the poor individual who is deprived of the ability to decide what is best...for himself and his family.'⁴ Instead, it is implied, the decision what is best for him is – paternalistically – made by others. In the same vein, Julian Savulescu writes:

If we should be allowed to sell our labour, why not the means to that labour? If we should be allowed to risk damaging our bodies for pleasure (by smoking or skiing), why not for money which we will use to realise other goods in life? To ban a market in organs is, paradoxically, to constrain what people can do with their own lives...It is paternalism in its worst form.⁵

What these and other authors claim is that bans on kidney sales are *unjustifiably paternalistic*, that they unduly deny people the freedom to make choices concerning their own bodies in

⁴ Cameron & Hoffenberg, *op. cit.* note 1, p. 728.

⁵ J. Savulescu. Is the Sale of Body Parts Wrong? *J Med Ethics* 29: 138-139.

order to protect them from harm.⁶ There are good reasons to take this argument seriously. Not only does it accord with a widely shared commitment to individual liberty. It is also stronger than the efficiency argument in the sense that it does not depend on empirical assumptions about the possible effects of permitting sales. Hence Savulescu's claim that '[w]hether or not a private market in organs will increase supply or improve its quality, it seems that people have a right to sell them.'⁷

Despite its initial appeal, however, I believe that the anti-paternalist argument against prohibiting kidney sales is ultimately unconvincing. My aim in this paper is to show why. I shall argue that not even principled anti-paternalists need to reject such prohibition; nor need it conflict with a broader commitment to liberty. I first explain why this is so in principle, comparing bans on kidney sales with other liberty-limiting policies. However, the extent to which this argument supports prohibition in practice depends on different empirical and ethical assumptions, which I then discuss. But I begin with some conceptual remarks that are needed to unpack the anti-paternalist argument and situate my critique of it. What is paternalism? And what does it mean to say that somebody is an anti-paternalist?

PATERNALISM

Paternalism is the interference with a person's freedom justified by reasons referring to that person's good or welfare. This is admittedly only a rough characterisation but it suffices for

⁶ In addition to the authors already cited, see Matas, *op. cit.* note 1; G. Dworkin. 1994.

Morality, Harm, and the Law. Boulder, CO: Westview. The argument is sometimes mentioned but not endorsed. See R. Audi, The Morality and Utility of Organ Transplantation. *Utilitas* 1996; 8: 141-158.

⁷ Savulescu, *op. cit.* note 5, p. 139.

the present purpose. It agrees with influential more elaborated accounts of paternalism without importing unnecessary or controversial details from them.⁸

Note the word ‘justified’ in the above characterisation. Actions and policies that limit people’s freedom may affect their welfare positively without that being the reason invoked to justify them. A law prohibiting smoking in bars limits the freedom of smoking customers and it benefits them insofar as it makes them smoke less. But the law is not paternalistic if seeks to protect non-smoking employees instead of smoking customers. It is the *justification* of an action of policy that makes it paternalistic, not its *effects*. In this and many other cases there are different reasons available to support one and the same liberty-limiting policy.⁹ This opens for disagreement about whether the policy is paternalistic or not.

Another important thing to note is the indirect or mediated nature of many paternalistic restrictions. It is often the case that, as Gerald Dworkin puts it, ‘in trying to protect the welfare of a class of persons we find that the only way to do so will involve restricting the freedom of other persons besides those who are benefited’.¹⁰ Suppose that the anti-smoking law just mentioned is indeed paternalistic: its purpose is to protect the smokers. It is not any less paternalistic if non-smoking bar owners rather than the smoking customers are punished when smoking occurs. The bar owners are immediately interfered with, but the freedom of the customers is just as restricted: they may not choose to take the risks associated with smoking when visiting bars. By contrast, many other paternalistic policies are not

⁸ G. Dworkin. Paternalism. *Monist* 1972; 56(1): 64-84; D. Archard. Paternalism defined. *Analysis* 1990; 50(1): 36-42; J. Feinberg. 1986. *Harm to Self: The Moral Limits of the Criminal Law (Volume 3)*. Oxford: Oxford University Press; T.L. Beauchamp & J.F. Childress, J.F. 2001. *Principles of Biomedical Ethics*, 5th ed. Oxford: Oxford University Press.

⁹ Dworkin, *op. cit.* note 8; Feinberg, *op. cit.* note 8.

¹⁰ Dworkin, *op. cit.* note 8, p. 68.

mediated in this way. A law mandating seat-belt use restricts the freedom only of those it seeks to protect.

Further, a distinction is commonly made between soft and hard paternalism.¹¹ Soft paternalism interferes with substantially non-autonomous conduct, while hard paternalism interferes with substantially autonomous conduct. The gist of the distinction is easy enough to grasp even if it is left open precisely what ‘autonomous’ and ‘substantially’ mean. Some soft paternalistic restrictions protect people assumed on the whole to lack sufficient capacity for autonomous decision-making. Children are not allowed to buy alcohol or tobacco or to decide themselves whether they want to participate in clinical research. Other soft paternalistic interventions interfere with particular non-autonomous or non-voluntary choices of otherwise competent people. Consider as an illustration Mill’s example of preventing a person from crossing a bridge that unbeknownst to her is unsafe.¹² By contrast, hard paternalistic interventions restrict the freedom of substantially autonomous persons in order to protect them from their own voluntary choices. Requiring a competent and fully informed Jehovah’s Witness to receive a lifesaving blood transfusion against her will is a classic example.

Hard paternalism is generally considered much more difficult to justify than soft paternalism. The reason is that respect for autonomy is considered of great moral importance and that only hard paternalism involves violating autonomy. This is not to say that soft

¹¹ Feinberg, *op. cit.* note 8.

¹² J.S. Mill. 1978. *On Liberty*. Indianapolis, Ind.: Hackett. Note that Mill himself does not explicitly distinguish between soft and hard paternalism; others draw such a distinction based on his work.

paternalism is always unproblematic. Interference may be unpleasant or frustrating even when it targets non-autonomous behaviour and then requires justification by weighty reasons.¹³

Some philosophers reject all forms of hard paternalism.¹⁴ That is, they think that interfering with an autonomous person's voluntary choices is not just difficult but impossible to justify by appealing to that person's own welfare. When I use the label 'anti-paternalist' I refer to those who hold this view. It is important to note that anti-paternalists accept soft paternalism. Indeed, their commitment to individual autonomy may lead them to strongly endorse it. Joel Feinberg argues that soft paternalism is ultimately motivated by a concern for autonomy rather than welfare:

[T]he law's concern should not be with the wisdom, prudence, or dangerousness of [a person's] choice, but rather with whether or not the choice is truly his. Its concern should be to help implement [his] choice, not to protect him from harm as such.¹⁵

I agree that a concern for autonomy is the main justification for soft paternalism, but I think it should be granted that considerations of welfare carry some weight as well. Returning to Mill's ignorant bridge-crosser, there is stronger reason to interfere if the bridge spans a violent glacial river than if it spans a gentle stream because the potential harm is greater in the first case. This should be granted even if one thinks (as anti-paternalists like Feinberg do) that

¹³ For more on why soft paternalism needs justification, see chapter 2 in A. Wertheimer. 2011. *Rethinking the Ethics of Clinical Research: Widening the Lens*. Oxford: Oxford University Press.

¹⁴ Feinberg, *op. cit.* note 8.

¹⁵ *Ibid*: 12.

the real concern is with the person's ignorance rather than with the harm itself, and that no valid reason for interference remains once her ignorance is removed.

CHALLENGING THE ANTI-PATERNALIST ARGUMENT

The structure of the anti-paternalist argument against banning kidney sales was not clear in the earlier quotes, but the above conceptual remarks make possible the following explication:

- (i) Bans on kidney sales restrict the liberty of would-be vendors
- (ii) The reason for that restriction is to protect the would-be vendors' welfare
- (iii) Bans on kidney sales are therefore paternalistic (from (i) and (ii))
- (iv) The choices that bans on kidney sales seek to interfere with are substantially autonomous choices
- (v) Bans on kidney sales are therefore a form of hard paternalism (from (iii) and (iv))
- (vi) Hard paternalism is never justified
- (vii) Bans on kidney sales are therefore not justified (from (v) and (vi))

As stated the argument appears valid: the conclusion follows from the premises. But are the premises true? Premise (i) is trivial; the point with prohibition is precisely to impose limits on people's liberty. Premise (vi) – the essence of the anti-paternalist position – is notoriously controversial. Many believe that hard paternalism is sometimes justified and may accept preventing informed and competent people from voluntarily selling a kidney in order to protect them from the risks involved. However, I will accept this premise for the sake of the discussion. I want to convince the anti-paternalist, not convert her. Other things equal, an

argument is stronger if it is potentially acceptable to anti-paternalists as well as to others than if it invokes hard paternalism.

One might challenge premise (ii) by pointing towards harms to others than vendors, the prevention of which provides a non-paternalistic rationale for prohibiting sales. But harms to whom? It is unlikely that recipients of transplants would be harmed, at least if permitting sales increased the availability of kidneys. On the contrary, many of them would presumably benefit from a transplant that they would not otherwise get. However, potential recipients would be harmed if permitting sales undermined altruistic donation to the extent that less rather than more kidneys became available, thus decreasing rather than increasing their chances of getting one. Recipients could also be harmed if kidneys obtained through sale were of lower quality than donated kidneys. Perhaps there are also more general harms. Some believe that altruism is a societal good, the erosion of which is bad for everyone.¹⁶ Others think that permitting certain sales may reinforce a general tendency to value things as commodities at the expense of other forms of valuation.¹⁷ Also, Debra Satz argues that when some individuals sell certain things they may harm others by changing the options available to them. For instance, if kidney sales are widespread moneylenders may view kidneys as collateral, making it more difficult to obtain loans for those unwilling to part with a kidney.¹⁸

Importantly, prohibiting kidney sales is not paternalistic, whether justifiably or unjustifiably so, if the rationale is to prevent any such third party harm. Such a response to the anti-paternalist challenge may well be viable, but I will pursue a different strategy. It is easier

¹⁶ Titmuss, *op. cit.* note 3.

¹⁷ M.J. Radin. 1996. *Contested Commodities: The Trouble With Trade in Sex, Body Parts, and Other Things*. Cambridge, Mass.: Harvard University Press; cf. Audi, *op. cit.* note 6.

¹⁸ D. Satz. 2010. *Why Some Things Should Not Be for Sale: The Moral Limits of Markets*. Oxford: Oxford University Press.

to see why kidney sales might harm vendors than why they might harm recipients or society. I will therefore accept premise (ii) and instead challenge premise (iv): the claim that the choices that bans on kidney sales seek to interfere with are substantially autonomous. If that claim is not true, such bans are not a form of hard paternalism and thus not unjustifiable on anti-paternalists grounds.

However, I should point out right away that I do not think that the choice to sell a kidney is *necessarily* non-autonomous or non-autonomous in the *large majority* of cases. On the face of it, it seems that many kidney vendors would meet standard criteria of autonomous agency: intentionality, understanding, and absence of controlling influences.¹⁹ Some potential vendors may fail to understand the consequences of the sale, but that could be remedied by supplying information.²⁰ Others may be in such desperate need of money that they have no other choice than to sell a kidney. But is the lack of acceptable alternatives incompatible with autonomy? Not always, it seems; one can autonomously consent to a life saving treatment when the sole alternative is death.²¹ Yet others may not be desperate but still find the offer of a large sum of money for their kidney difficult to refuse. However, that need not imply that they are coerced into selling: people can autonomously accept large sums of money in other contexts, for example when offered well-paid jobs or lottery prices.²² And even if it is true that some vendors would lack sufficient information, be desperate or be unable to resist large monetary offers, it does not follow that all or a large majority of them would.

More could certainly be said about these arguments, but they do make it seem implausible that everyone or nearly everyone who would sell a kidney would do so non-

¹⁹ Beauchamp & Childress, *op. cit.* note 8.

²⁰ Radcliffe-Richards, *op. cit.* note 1.

²¹ M. Wilkinson & A. Moore, A. Inducements in Research. *Bioethics* 1997; 11: 373-389.

²² Wilkinson, *op. cit.* note 1.

autonomously. However, it may still be the case that *many* vendors would suffer impaired autonomy. Indeed, this weaker claim will be crucial to my argument, and I will return to it below.

GROUP SOFT PATERNALISM

Let me first recapitulate two things. I have granted that bans on kidney sales seek to protect the welfare of those who might consider selling a kidney. I have also granted that many of the sales they block would have been autonomously chosen. Does it not follow that such bans are paternalistic in the hard sense repudiated by anti-paternalists? Not necessarily. Recall the distinction between the justification of paternalistic policies and their effects. It may be that one *effect* of prohibiting kidney sales is the restriction of autonomous choices, but that the *justification* of the prohibition is the prevention of choices that are not autonomous. It may be that the prohibition relies on a rationale that Franklin Miller and Alan Wertheimer call ‘group soft paternalism’. Consider one of their examples from another context:

Some people who are not physicians have the requisite knowledge and judgment to decide safely whether and how to administer a prescription medication. Under current policy, however, no one is free to obtain the medication without a physician’s prescription, because *most* people lack the decisional capability to self-medicate. Given that it is simply not feasible or cost-effective to adopt different standards for those who are and are not sufficiently autonomous, we adopt a policy under which the autonomous individuals must suffer restriction of their freedom, not for their own good (this is not hard paternalism), but as the

unfortunate and unavoidable byproduct of a policy designed for the sake of those who are not capable of acting autonomously.²³

Miller and Wertheimer argue that group soft paternalism is part of the justification of the system regulating human subjects research in the US.²⁴ For instance, IRBs make risk-benefit assessments of research protocols before participants are given the opportunity to enrol; participants may not decide for themselves what risks they are willing to take. Some of them are probably capable of correctly assessing risks and benefits, but everyone is denied the opportunity to do so because many others are not. The freedom of the autonomous participants is restricted as an effect of protecting the non-autonomous ones from self-imposed harm.

Many other social policies can be defended in the same way as drug prescriptions and research regulation. Consider age restrictions on self-regarding behaviour like drinking, smoking, and gambling. Such behaviour is potentially dangerous for everyone, but adults are permitted to decide for themselves whether they are willing to take the risks involved. Minors as a group are denied that opportunity even though some of them are mature enough to make an equally informed and reflected decision as are most adults. One important reason is that many other minors are not capable of making such a decision.²⁵ Here, too, restrictions are imposed on the whole group in order to protect a non-autonomous subset.

²³ F.G. Miller & A. Wertheimer. Facing Up to Paternalism in Research Ethics. *Hastings Cent Rep* 2007; 37(3): 24-34: 28. A revised version of the paper is included in Wertheimer, *op. cit.* note 13.

²⁴ Their argument has wider application since many other countries have similar systems.

²⁵ Another reason for excluding minors as a group from some forms of self-harming behaviour (smoking, drinking) is that such behaviour is more dangerous for them than for

My contention is that a prohibition on kidney sales can in principle be defended on analogous, group soft paternalistic grounds. Because such a defence relies on soft rather than hard paternalism, it is potentially acceptable to anti-paternalists and easier to accept for others as well. More precisely, if (1) kidney sales are potentially harmful to vendors, (2) some vendors are expected not to act autonomously, and (3) it is not feasible to adopt different standards for autonomous and non-autonomous would-be vendors, then there is good reason to deny everybody the opportunity to sell a kidney in order to protect the non-autonomous. These are three big ‘ifs’, however, and each needs to be examined separately before it can be determined how convincing the argument is.

GROUP SOFT PATERNALISM AND KIDNEY SALES

Harm to vendors

Paternalistic policies seek to promote or protect the welfare of at least some of those whose freedom they restrict. Prohibiting kidney sales would thus not be paternalistic – whether justifiably or unjustifiably so – if vendors faced no risks of harm. Like any other surgery, a nephrectomy does involve risks. However, these risks appear to be rather low in favourable

adults. While important, I do not think that is the only reason for distinguishing between the two groups. The risks involved in such behaviour differ considerably also between different groups of adults (men and women, different ethnic and social groups, etc.). Yet society tends to impose the same restrictions on all competent adults with respect to self-harming behaviour, presumably because they are all considered capable of choosing whether the risks are worth taking.

circumstances; a comprehensive and much cited US study indicates a 0.03% mortality rate among living kidney donors.²⁶

Advocates of kidney sales claim that such risks are not sufficiently high to ban sales for paternalistic reasons. They offer two analogies in support of that view. First, people are permitted to take jobs and engage in pastimes with mortality rates similar to or higher than that of a nephrectomy.²⁷ It seems inconsistent to allow them to pursue these activities for money or pleasure, but not to make the supposedly no more risky choice of parting with a kidney for money. Second, kidney sales would presumably be no riskier than living unpaid kidney donation because payment as such would not add any risk to the procedure.²⁸ If society permits people to take a certain risk in order to give away a kidney for free, it seems that it cannot consistently deny them to take an equal risk in order to sell it.

The risk of a nephrectomy may not in fact be comparable to the risks involved in dangerous jobs and pastimes: it may be higher than usually assumed in the long term or calculated over a different time span.²⁹ If so, the first of the analogies is weakened. However, there is a different reason why *both* analogies fail to undermine the sort of paternalistic argument for prohibiting kidney sales that I propose. Even if the risk of a nephrectomy is in fact equal to the risks encountered in dangerous jobs, it does not follow that kidney sales must

²⁶ A.J. Matas et al. Morbidity and Mortality After Living Kidney Donation, 1999-2001: Survey of United States Transplant Centers. *Am J Transplant* 2003; 3: 830-834.

²⁷ Radcliffe-Richards, *op. cit.* note 1; Wilkinson, *op. cit.* note 1; Cameron & Hoffenberg, *op. cit.* note 1; Taylor, *op. cit.* note 1; Savulescu, *op. cit.* note 5.

²⁸ Radcliffe-Richards, *op. cit.* note 1; Wilkinson, *op. cit.* note 1; Taylor, *op. cit.* note 1.

²⁹ For the first claim, see W. Glannon. Underestimating the Risk in Living Kidney Donation. *J Med Ethics* 2008; 34: 127-128. For the second claim, see S. Horrobin. Stakes and Ladders. *Rejuvenation Res* 2005; 8: 258-263.

be permitted if such jobs are permitted. Nor must people be allowed to sell a kidney because they are allowed to give one away for free, even if the risk is no greater. This is because the case for soft paternalistic intervention with harmful behaviour does not primarily hinge on the magnitude of harm avoided, but on whether the harm is autonomously chosen. The aim is to protect individuals from harmful choices that are not *truly theirs*. So it is not inconsistent to permit people to take hazardous jobs or donate a kidney but deny them the equally risky choice of selling a kidney if the latter choice is more likely to be non-autonomous.

Focus is thus shifted from risks to kidney vendors to the quality of their decision, a question to which I return below. Note first, however, that while less important than often assumed, the magnitude of these risks is not simply irrelevant to my argument. Other things equal, the argument is stronger the higher the risks are. I pointed out earlier that while soft paternalism aims to protect people from harmful choices that are not truly theirs, its justification turns at least to some extent on how harmful these choices are. Moreover, the group soft paternalist argument needs to justify not only denying non-autonomous would-be vendors the opportunity to sell, but also restricting the freedom of other, autonomous people for their sake. And higher rather than lower risks to non-autonomous vendors are more likely to carry that justificatory burden.

A comprehensive assessment of the harmfulness of selling a kidney is too large a task to be undertaken here.³⁰ However, some brief remarks are in order. When contemplating possible harms to vendors, it is obviously insufficient to rely solely on figures like the 0.03% mortality rate cited earlier. First, nephrectomies involve risks of a range of non-fatal harms.³¹ Second, available mortality and morbidity figures largely reflect the situation of donors in

³⁰ For useful, more extensive discussions on this topic, see Taylor, *op. cit.* note 1; Glannon *op. cit.* note 29.

³¹ Taylor, *op. cit.* note 1.

Western countries with high-standard medical care. Risks are presumably higher where skills and access to advanced equipment are more limited or where donors are not guaranteed post-operative care. In a study of more than 300 Indian kidney vendors a large majority reported deteriorated health after the sale.³² Third, in addition to medical harms there may also be economic and social harms that need to be considered. Many of the Indian vendors just mentioned reported a deteriorated economic status after the sale, likely due to a reduced ability to perform manual labour.³³ Another report describes deep shame and stigmatisation among kidney vendors in Moldova.³⁴

Kidney sales advocates may argue that while some of these harms occur in existing black kidney markets, they need not occur in the carefully regulated markets that they envision. It is true that regulation may reduce health risks and economic harms by guaranteeing that vendors receive adequate care and agreed-upon payment. But other harms are harder to avoid. Vendors dependent on physical labour will suffer economically during recovery and due to possible complications even in a regulated market, and stigmatisation cannot simply be regulated away.

It is obviously difficult to draw general conclusions about how harmful it is to sell a kidney. Many of the risks that vendors would face, as well as the possibilities for reducing these risks, are likely to vary from one place to another. The strength of the group soft paternalist argument for banning such sales varies accordingly: it is stronger where the risks are larger and more difficult to reduce and vice versa.

³² M. Goyal et al. Economic and Health Consequences of Selling a Kidney in India. *JAMA* 2002; 288: 1589-1592.

³³ Ibid.

³⁴ N. Scheper-Hughes. Rotten Trade: Millennial Capitalism, Human Values and Global Justice in Organs Trafficking. *Journal of Human Rights* 2003; 2: 197-226.

Kidney sales and autonomy

I have already granted that *all* or a *large majority* of kidney sales would probably not be substantially non-autonomous if such sales were to be legalised. However, the group soft paternalist argument rests on the different claim that *many* sales – a sufficiently large proportion (to be specified below) – would be substantially non-autonomous. The distinction between these two claims is crucial. Proponents of kidney sales sometimes rest content with rejecting the former and stronger claim, but it is the latter and weaker claim that underpins my argument.³⁵ Is that claim plausible?

Dworkin has observed that ‘those who are most likely to wish to sell their organs are those whose financial situation is most desperate’, and both proponents and critics of such sales have tended to agree.³⁶ Moreover, that assumption is supported by empirical evidence.³⁷ Now, I granted earlier that we should not be too quick to assume that the desperately poor cannot autonomously decide whether to sell a kidney. However, desperation hardly makes for ideal decision-making either. Many believe that some capacity and opportunity of weighing risks and benefits are necessary for making autonomous choices.³⁸ Few perform perfectly in

³⁵ For instance, James Stacey Taylor (*op. cit.* note 1) argues at length that ‘the typical kidney vendor’ would not suffer impaired autonomy. This is insufficient to establish his conclusion that respect for autonomy requires that a kidney market be permitted. For, as Taylor grants, there are likely to be ‘atypical’, non-autonomous vendors as well, and that may be enough for prohibiting kidney sales on group soft paternalist grounds.

³⁶ Dworkin, *op. cit.* note 6, p. 157. Proponents include Taylor, *op. cit.* note 1. Critics include Audi, *op. cit.* note 6; Zutlevics, *op. cit.* note 2.

³⁷ Goyal et al. *op. cit.* note 32.

³⁸ Beauchamp & Childress, *op. cit.* note 8.

this area: it is all too easy to discount large long-term risks in favour of small short-term benefits. When and why such mistakes occur is ultimately an empirical question, but it is not far-fetched to think that desperation increases the risk of making them. It seems easier overestimate the value of a sum of money desperately needed and easier to discount long-term risks when one's everyday existence is focused on meeting immediate needs. So insofar as kidney vendors would be recruited from the desperately poor, they would likely be if not *incapable* to decide for themselves so at least *vulnerable* to compromised decision-making.

Another and perhaps stronger reason to think that many kidney sales would not be substantially autonomous is that the possibility of such sales creates incentives for coercion and other forms of illegitimate influence on the vendor's decision. It is difficult to see how a person's kidney can be a potential economic asset for her without also being a potential economic asset for other people. Imagine a poor person whose only way of obtaining enough money to pay off a debt or finance a needed medical treatment for a loved one is to sell her kidney.³⁹ Again, the choice may well be voluntary and indeed rational if the person lacks other means to reach her goals. But creditors and family members may be unwilling to rely on the person's own voluntary choice. They may find that pressuring or coercing her to sell her kidney is a much more effective way of getting what they want. The choice would then obviously not be voluntary, and thus not autonomous. One can imagine an almost endless

³⁹ These are realistic scenarios. 96% of the Indian kidney vendors in the study described earlier reported that they sold a kidney in order to pay off a debt. See Goyal et al., *op. cit.* note 32. And in a much-discussed case, a Turkish peasant sold his kidney to be able to afford life saving medication for his daughter. See Cameron & Hoffenberg, *op. cit.* note 1.

variety of such scenarios, and it seems naïve to disregard them when contemplating whether people would sell their kidneys autonomously.⁴⁰

So there is reason to think that many kidney sales would not be substantially autonomous if such sales were legalised. But just *how* many sales have to be substantially non-autonomous for the group soft paternalist argument to work? Obviously, the possibility that *somebody* might take a risk non-autonomously is not sufficient to deny everybody the chance to take that risk. If it were, society could all too easily introduce blanket prohibitions on most kinds of hazardous behaviour. Few would accept, say, completely banning salty foods because a small minority are unaware of the dangers of overconsumption and unreceptive to information campaigns. As Miller and Wertheimer note, the proportion of substantially non-autonomous decision-makers must be sufficiently large if group soft paternalism is to be justified.⁴¹

I think that the notion of a sufficiently large proportion can be specified – not in exact numbers, but at least in a non-arbitrary way. First, considerations of harm like those explored earlier appear relevant: the more dangerous a choice is, the smaller the proportion of non-autonomous decision-makers needed to deny everyone that choice.⁴² Also, what counts

⁴⁰ Kidney sales advocates typically do not address such scenarios, which is a bit surprising in view of the evidence that they in fact occur in the black Indian kidney market. See Goyal et al., *op. cit.* note 32. Taylor (*op. cit.* note 1) does address the issue, admitting that some vendors would probably be coerced, but arguing that this does not undermine his proposal for a kidney market because most other vendors would not be coerced. Again, this is a dubious sort of argument on the view that I defend: there may be good reason to prohibit sales in order to protect non-autonomous vendors, even if they are a minority.

⁴¹ Miller & Wertheimer, *op. cit.* note 23.

⁴² Cf. Wertheimer, *op. cit.* note 13.

as a sufficiently large proportion depends on considerations of distributive justice. Allow me here to pursue a line of reasoning that Miller and Wertheimer hint at but do not develop.⁴³

The argument draws on an important objection that Richard Arneson raises against Mill's anti-paternalism. Arneson observes:

Left unrestrained in self-regarding matters, more able agents are more likely to do better for themselves choosing among an unrestricted range of options, whereas less able agents are more likely to opt for a bad option that paternalism would have removed from the choice set.⁴⁴

Assuming (as Arneson plausibly does) that more able agents are likely to already be better off than less able agents, it follows that '[a] ban on paternalism...gives to the haves and takes from the have-nots'.⁴⁵ In other words, anti-paternalistic policies are prone to increasing inequalities of welfare. This gives anybody for whom equality matters morally a *pro tanto* reason to favour paternalism. And the stronger one's egalitarian leanings, the heavier will that reason weigh as compared to countervailing reasons of liberty.

Does Arneson's argument apply to the case of kidney sales? A slight modification is needed: Arneson distinguishes between more and less able, rather than autonomous and non-autonomous, decision-makers. But that does not alter the main point. Worse off kidney vendors are more likely to make a non-autonomous decision than are better off ones, for the reasons mentioned earlier. They are more vulnerable to distorted risk-benefit assessments due

⁴³ Miller & Wertheimer, *op. cit.* note 23.

⁴⁴ R.J. Arneson. Paternalism, Utility, and Fairness. Reprinted in *Mill's 'On Liberty': Critical Essays*. G. Dworkin, ed. Lanham, MD: Rowman & Littlefield: 86.

⁴⁵ *Ibid*: p. 86.

to economic desperation, and more likely to be coerced to sell because they lack other resources of interest to coercers. And decisions that are non-autonomous for these two reasons are also less likely to conduce to the vendor's own welfare. Desperate decision-makers are less likely to accurately factor in their own long-term welfare, and coerced decision-makers lack the opportunity to factor it in altogether. If this is right, anti-paternalism with respect to kidney sales will favour better off vendors and disfavour the worse off.

The upshot is that the proportion of non-autonomous kidney vendors required for the group soft paternalistic argument to work depends on how important one thinks equality is. People with egalitarian or prioritarian sympathies may endorse restricting the freedom of a fairly large majority of better off, autonomous vendors in order to protect a minority of worse off, non-autonomous vendors from further worsening their situation. Those who prioritise liberty over equality will require that the proportion of non-autonomous vendors be larger.

Distinguishing between vendors

The argument for any group soft paternalist policy rests on the assumption that, as Miller and Wertheimer put it, 'it is simply not feasible or cost-effective to adopt different standards for those who are and are not sufficiently autonomous.'⁴⁶ If the two different groups can be readily distinguished, the case for restricting everyone's freedom dissolves. The non-autonomous can then be protected by restrictions targeted at them alone, and the autonomous need not have their liberty curtailed. Janet Radcliffe-Richards puts the point nicely:

no one committed to the value of autonomy would rush to institute a prohibition that would limit the freedom of everyone, just on the grounds that some, or even most, of the people most likely to be involved were incapable of making

⁴⁶ Miller & Wertheimer, *op. cit.* note 23, p. 28.

autonomous choices. At the very least, the first impulse should be to try to discriminate between people, and to interfere only with the ones who are really incapable of doing so.⁴⁷

Is such discrimination feasible in the kidney sales case? Policies that distinguish between autonomous and non-autonomous decision-makers are in place in other areas. In the Netherlands, for instance, requests for legal euthanasia are carefully reviewed partly in order to make sure that only autonomous requests are met. And more pertinently, in many countries potential living unpaid organ donors are assessed in order to determine if they are making an autonomous choice.⁴⁸ Would a similar policy be any less practicable in the case of kidney sales?

I do not suggest that it would be strictly impossible to distinguish autonomous from non-autonomous would-be kidney vendors. However, such discrimination appears a good deal more difficult than in many other contexts, including living unpaid kidney donation. The point with permitting sales is to radically increase the number of kidneys available. So many more cases would have to be assessed than under current unpaid donation schemes. In addition, each case would be more difficult to assess because there would be a much wider range of pressures capable of making people part with their kidneys non-autonomously. It is

⁴⁷ Radcliffe-Richards, *op. cit.* note 1, p. 380.

⁴⁸ In the UK, for instance, such judgements are made by special assessors accredited by the Human Tissue Authority and independent of transplant teams. See Human Tissue Authority (HTA). 2011. *Guidance for Transplant Teams and Independent Assessors*. London: HTA. Available at:

<http://www.hta.gov.uk/bodyorganandtissuedonation/organdonations/independentassessors.cfm> [Accessed 14 November 2011].

true that unpaid related donors may be subject to heavy emotional and psychological pressure from family members.⁴⁹ However, as argued earlier, when a price tag is attached to somebody's kidney, the possible reasons for pressuring her to give it up multiply. The kidney becomes a potential resource for anybody who might have an interest in the person's financial resources more generally – family members as well as others.

The upshot is that discriminating between kidney vendors would present a difficult choice. Either one makes a very detailed assessment of each case in order to prevent all or most non-autonomous sales. But that approach is likely to be costly and to discourage many would-be vendors, thus severely undercutting the efficiency of the scheme. And importantly, it would probably not be feasible at all in many resource poor countries. Or one makes a much less stringent assessment in the interest of efficiency. But then many non-autonomous vendors would slip through, raising precisely the soft paternalist concerns that I have been discussing. Incompetent decision-makers would then be too exposed to risks that they have not voluntarily assumed.

Those who remain unconvinced should remember that comparable discriminating policies are often not implemented even where they could be. Why not entrust pharmacists with providing drugs without prescription to capable self-medicators, clinical researchers with enrolling participants with expert knowledge in high-risk trials, or shopkeepers with selling alcohol and tobacco to selected mature teenagers? The liberty of competent self-medicators, research participants, or teenagers would then significantly increase. But it would be difficult to prevent other, non-competent decision-makers from involuntarily incurring considerable harm. So there is reason to opt for more general restrictions instead. Kidney sales are in principle no different.

⁴⁹ J. Harvey. Paying Organ Donors. *J Med Ethics* 1990; 16: 117-119.

CONCLUSION

I have defended bans on kidney sales against the charge of paternalism. Such bans may not be paternalistic at all because they may seek to protect others than potential vendors. However, according to a different argument that I have developed at more length, they are indeed paternalistic, but only in the soft sense that not even principled anti-paternalists need find objectionable. They do restrict the freedom of autonomous would-be vendors, but only as an unavoidable consequence of protecting other vendors from harms that they have not autonomously chosen. This argument is in principle acceptable to anti-paternalists as well as to others. However, whether it supports prohibiting kidney sales at any particular time and place depends on certain conditions.

First, kidney sales must be potentially harmful to vendors. Second, a sufficiently large proportion of would-be vendors must be expected not to sell autonomously. Third, distinguishing between autonomous and non-autonomous potential vendors and interfering only with the latter must not be practicable. The greater the potential harm, the larger the proportion of non-autonomous vendors, and the more difficult a discriminating policy is to implement, the stronger the case for prohibition. I have offered some, admittedly inconclusive, reasons to think that each condition will often hold. Hopefully, I have also showed why a more conclusive case cannot be expected on the level of abstraction where my argument proceeds. The conditions involve empirical assumptions – about risks to vendors, their social and economic circumstances and the feasibility of different forms of regulation – that are likely satisfied to different degrees in different contexts. They also involve contestable normative and conceptual claims, particularly concerning the nature of autonomous choice and the importance of equality. Even if anti-paternalists ultimately remain unconvinced, at least I hope that I have given them reason to consider their position more carefully and indicated areas for future debate.

Finally, whether kidney sales should be legalised ultimately depends not only on what respect for autonomy requires, but also on other considerations, not least the effects of legalisation on the supply of transplantable kidneys. To say that bans on kidney sales are not unjustifiably paternalistic is not to say that they are justified all things considered.