U.K. Bioethics, U.K. Metabioethics: Organ Sales and the Justification of Bioethical Methods

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Two (Complementary) Approaches

Bioethicists currently working in the United Kingdom demonstrate—as indeed do the very best of their colleagues internationally—an eagerness to engage in two extremely different but complementary approaches to their subject. First, they readily become involved in discussions of concrete bioethical issues that are of great concern to the medical profession, legislators, and the wider U.K. public. Second, perhaps because they recognize the importance of the "first-order" questions that exercise the public imagination, they show themselves commendably willing to turn their critical gaze onto the very methods and frameworks they use to address those questions. The first approach we can properly call "bioethical," whereas we might term the second approach "metabioethical."

As an example of the sort of first-order issue on which U.K. bioethicists have of late had much to say, I will, in what follows, start by focusing on a cluster of concerns around commercial live-organ donation. I do so for two reasons. First, recent work on this topic (in the shape of a slew of articles and at least one important book) has been of very high quality, showcasing the rigor and incisiveness of U.K. bioethics and addressing a very real crisis in the numbers of organs available for transplant. Second, the views typically expressed on commercial donation in this work throw vividly into relief the divide between the opinions of academic bioethicists, on the one hand, and those of the man, woman, medical professional, and legislator in the street, on the other. It is quite possibly the existence of this divide that has motivated the sort of metabioethical work I survey later in this article. That is, if the methods of bioethics frequently produce what amount to highly counterintuitive results, it is appropriate that bioethicists should occasionally step back and ask whether those methods can really be justified—especially if bioethical work is to make its proper impact on public debate.

A Crisis in Organ Donation: The Ethicists' Response

It is small wonder that bioethicists in the United Kingdom have turned their attention to the question of organ donation. According to figures cited by Charles Erin and John Harris, as of late November 2002, it was the case that 667 people had donated organs, 2,055 had received transplants, and a staggering 5,615 people were still awaiting transplants.[1] The numbers of people listed on

Cambridge Quarterly of Healthcare Ethics (2004), **13**, 226–235. Printed in the USA.

the National Health Service's Organ Donor Register are pitifully small, despite the fact that surveys repeatedly show around 70% of the U.K. public declaring that they would be willing to donate organs after their deaths.[2] Clearly, many more organs need to be available for transplant if we are to avoid large numbers of people dying and the expense and inconvenience of procedures such as dialysis.

The crucial question is, clearly, what course of action will both increase the number of available organs and be ethically acceptable? The prospects for a system of presumed consent for postmortem donation have, unfortunately, been all but destroyed by an organ-retention scandal involving Alder Hey Children's Hospital in Liverpool, in which organs of dead children were retained for research without the consent of the parents. Whether those scandals ought to have had this effect on public opinion is an important and largely neglected question, though it has been addressed, and answered firmly in the negative, by at least two U.K. bioethicists.[3]

What is more, public opinion in the United Kingdom is overwhelmingly opposed, on ethical grounds, to commercial dealing in human organs and tissues, and the practice is outlawed under the Human Organ Transplants Act 1989 (HOTA).[4] A number of objections are raised to the practice, identifying various harms that would supposedly accompany it. A number of U.K. bioethicists have treated these objections with some suspicion, both because of the way in which they are raised and on the grounds of their content. Janet Radcliffe-Richards, for instance, takes the former tack. She holds that, whereas opponents of commercial donation tend to insist that it will lead to coercion, exploitation, reduced donation, and so on, it actually seems that they are opposed to the practice not on the basis of these allegedly likely outcomes but because they think it wrong "in itself."[5] Her reasons for this belief are twofold.

First, she notes that when the practice initially came to light in the United Kingdom, its condemnation followed immediately, without any weighing of pros and cons or careful analysis of the likely outcomes. Most significantly, the huge benefits that might attend its acceptance (namely, a potentially large increase in the numbers of organs available for transplant) were never even mentioned, let alone considered, by those who saw fit to condemn it. The implication seems to be that this would be odd if the opponents of the practice were genuinely utilizing a risk-benefit model of ethical reasoning, rather than merely representing themselves as doing so.

Second, Radcliffe-Richards points out that, whenever a consequentialist objection to a market in human organs is defeated (an objection that makes mention of a harm to be expected from the existence of such a market), opponents instantly produce another to take its place. But this is not what we would expect if the vanquished objection were the *real* reason for the opponents' condemnation. Radcliffe-Richards adds to these two points the observation that

> If you regard organ selling as wrong in itself you may well embrace all suggestions of dangers and difficulties with relief, because they seem to strengthen the political case for prohibition.[6]

Radcliffe-Richards does not address the possibility that a commercial market in human organs might *actually* be "wrong in itself," though it can admittedly be hard to see how such a claim might be supported. And if it actually is the case that those who believe such a market would be intrinsically wrong only

ever deploy arguments pointing instead to its supposedly harmful outcomes, it is tempting to think that they too find it hard to formulate adequate justifications for their real beliefs. It might, on the other hand, simply be that they feel their actual reasons, although sufficient to establish the unethical nature of a commercial market, would be ineffective as a means to ensuring prohibition.

And what of the common objections to live commercial donation? Are they really so easily defeated as Radcliffe-Richards seems to think? The strength of those most commonly used is assessed in a chapter of Stephen Wilkinson's book, *Bodies for Sale: Ethics and Exploitation in the Human Body Trade*.[7] Whether or not one agrees with Wilkinson's conclusions, his book manifestly exemplifies all that is good in current U.K. bioethics: it is written with admirable clarity, precisely and skillfully argued, and, although relentlessly rational, never loses sight of the sensitive and frequently emotive nature of its subject matter.

The chief objections to organ sales that Wilkinson considers are that such sales would cause (excessive) harm to donors, that permitting them would have the socially adverse effect of reducing the amount of altruism in the world, that any consent to organ sales on the part of vendors would be invalid, that organ vendors' donations would inevitably be coerced, and that many organ vendors would be subject to exploitation. Here, I report Wilkinson's response to the first two objections. I also refer briefly to his response to the last objection (that a commercial market in human organs would be exploitative) a little later.

Wilkinson is dismissive of the claim that organ sales ought to be prohibited on the grounds that permitting them would bring harm to donors. First of all, there is the straightforwardly empirical fact that kidney removal, for instance, is, if performed in proper conditions, actually not all that dangerous, carrying a perioperative mortality rate of about 0.03%.[8] Furthermore, if we wish not to expose potential commercial donors to harm, then the very last thing we ought to do is to prohibit the practice:

> the best way of avoiding harm to organ donors is not to criminalise and drive sale underground but rather to accept and regulate it. This style of argument is familiar from other contexts, notably debates about the legalisation of abortion, drugs, and prostitution.[9]

What seems to me the strongest of Wilkinson's responses to the "harm" objection is this: if performed under proper conditions (which, as the previous point makes clear, can only be guaranteed if the practice is legal), commercial live donation would obviously be no more harmful than noncommercial live donation. The fact that organs are paid for in no way increases the already very small risk associated with live donation.

However, Wilkinson acknowledges the possibility that those who deploy the "harm" objection might do so because they adhere to the principle that it is wrong to *pay* people to endanger themselves. But can this principle be justified? What is certain is that, if it *were* justified, it would show that professions such as firefighting and motor racing (both of which carry greater risks than live organ donation) are unethical. And this is a result to which we presumably do not wish to commit ourselves.

The subject of the "harm" objections outlined by Wilkinson so far is personal harm. He goes on to consider a supposed social harm arising from permitting organ sales. The claim is that permitting such sales would reduce the amount

of altruism in the world. Because altruism is a good, the argument runs, we ought not to do anything that will reduce it.

Wilkinson deals with this objection by casting doubt first on the notion that altruism is always a good, and second on the claim that allowing organ sales would lead to a decline in altruism. First, it is not as if there is already in place a substantial practice of altruistic donation that would be adversely affected by the existence of a commercial market. Indeed, if there were, there would be no *need* for a commercial market. Second, Wilkinson points out that the existence of a commercial market could plausibly *increase* the number of altruistic acts performed. For example, HOTA was introduced in the United Kingdom following the discovery that a British doctor had arranged, for the benefit of his private patients, the sale of kidneys by Turkish peasants. Now, as Wilkinson points out:

> One of the less well-known facts of the case is that one of the Turkish organ vendors was offering his kidney for sale in order to be able to purchase lifesaving medication for his daughter, who was suffering from tuberculosis. Since this man had "no employment and no other saleable assets", stopping him from selling his kidney prevented an act of altruism and deprived his daughter of her best chance of being saved.[10]

It is not clear that the only altruism-related concerns about commercial donation are those addressed by Wilkinson, however. That is, supposedly as an example of the sort of "decrease in altruism" objection leveled at commercial donation, he quotes the following, from an article by J. Cameron and R. Hoffenberg in *Kidney International*:

> Organs are priceless and should be donated for altruistic reasons . . . provision of an organ should be seen as a donation or gift . . . freely given in the spirit of altruism.[11]

However, this seems to me not to be an instance of the sort of "altruism maximizing" argument that Wilkinson considers and rejects. Instead, it is an argument that (a) says something about the sorts of things human organs are (things that are priceless, and so things to which it is not appropriate to assign a monetary value), and (b) says that the only sort of donation that, as it were, fits the sort of things that organs are is one motivated by altruism. So, the claim is not that we ought to bring it about that there is more altruism in the world, or that we ought not to bring it about that there is less. Rather, the claim is that, if we are to donate organs, we ought only to donate them from the motive of altruism. Now, whether this argument is sound is not my concern here: my point is simply that it is not an argument of the sort that Wilkinson apparently takes it be. (It might be pointed out, though, that it ignores the possibility that one might seek monetary gain *in order* to carry out an act of altruism, as did the Turkish kidney vendor mentioned earlier.)

Now, Wilkinson of course admits that not all possible arrangements for the sale of organs from live donors are ethically defensible. Those that genuinely involve coercion or lack of consent, for instance, are straightforwardly wrong. But he, and others who broadly agree with him, think that there is nothing *in principle* wrong with the idea of a commercial market in human organs: what is

needed is a set of proper regulations and procedures to ensure that such a market avoids ethically unacceptable practices.

Regulating Organ Sales and Avoiding Exploitation

In their paper "An Ethical Market in Human Organs,"[12] Charles A. Erin and John Harris proposed a number of such regulations. Essentially, their ethical market would have three features. First, it would be confined to a self-governing geopolitical area, and only citizens within that area could buy and sell in the market. As a result, donors would be contributing, and would know themselves to be contributing, to a system that would potentially benefit them, their families, and their friends. Second, there would be only one purchaser (an agency such as the National Health Service in the United Kingdom), and that purchaser would ensure fair distribution. The purchaser would, because of the market's first feature, not exploit low-income countries, and it would ensure the proper screening of all donated organs. Third, "reasonable compensation" would be given to donors. Interestingly, bearing in mind Wilkinson's points about altruism, Erin and Harris say that "altruism . . . would be undiminished by sale. We do not after all regard medicine as any the less a caring profession because doctors are paid."[13]

Commenting on Erin and Harris's proposal,[14] Janet Radcliffe-Richards notes that it starts from the assumption (which, she thinks, is correct) that banning organ sales is "presumptively bad." It is presumptively bad because it will lead to many deaths and much suffering. The burden of proof then falls on those who object to organ sales to show why allowing them would be worse than banning them.

She then argues that, if a *total* ban on sales is presumptively bad, so too must be any *restriction* of sales. That is, the burden of proof will again fall on those who want to introduce restrictions, to show why those restrictions are justified. And because Erin and Harris patently do introduce restrictions, Radcliffe-Richards takes it upon herself to raise questions about the justification for doing so.

First, she asks why Erin and Harris insist that there should be only one purchaser of organs per market. She acknowledges that the aim of this restriction is equity of distribution, which is of course desirable. However, she writes:

> in countries where there is no such service, or where it is generally accepted . . . [as in the United Kingdom] . . . that people who find the public service inadequate to their needs should be allowed to go outside it, is there any justification for providing special restrictions on the freedom to make private arrangements to find a kidney?

Second, Radcliffe-Richards questions why the proposed market should be restricted to one self-governing geopolitical area. She concedes that a one-way traffic of organs from the poor to the rich would be undesirable but maintains that its undesirability is not sufficient to establish whether on balance (that is, when all the costs and benefits have been weighed) it ought to be allowed. Additionally, she points out that lots of existing trade between poor and rich countries is similarly undesirable, but that it would presumably be still more undesirable for poorer countries if it were to stop altogether. Radcliffe-

Richards's point mirrors one made by Wilkinson about the claim that an unrestricted commercial market in organs would inevitably prove exploitative of the world's poor:

> it seems at best ironic and, more likely, patently unfair to exclude from an organ trading system the very people who most need the money it could provide. . . . How will a poor person who is willing to sell a kidney for $2,000 to buy medical treatment for her daughter feel when she's told that (to protect her from exploitation) *she* isn't allowed to sell—while, at the same time, a relatively rich neighbor is allowed to sell her kidney for $100,000 to fund home improvements?[15]

Radcliffe-Richards's commentary ends by admitting that there may be answers to the questions she raises and that Erin and Harris's proposal might include restrictions solely "to give it greater chance of political success."[16] In a reply, Erin and Harris confirm that this is precisely the reason that their proposal takes the form it does. That is, they insist that, by meeting the most common objections, even when those objections are unsound, a proposal stands a greater chance of being accepted and consequently can start to deliver the benefits that will result from an increased number of organs available for transplant. Erin and Harris's proposal is, therefore, thoroughly pragmatic: it recognizes that greater benefits can sometimes accrue from pandering to fallacious objections than from sticking to one's philosophical guns.

In fairness to Radcliffe-Richards, it is understandable that she should have failed to notice this feature of Erin and Harris's proposal. After all, their pragmatic intent is not stated in the original paper: a paper that, furthermore, bears the title "An *Ethical* Market in Human Organs" rather than "A Market in Human Organs that Is Likely to Be Thought Ethical by Legislators" or something of the sort. What is more, Erin and Harris state the following constraint on organ sales:

> To meet *legitimate* ethical and regulatory concerns, any commercial scheme must have built into it safeguards against *wrongful* exploitation. . . . [emphasis added][17]

They then seem to present their proposal as adhering to this constraint. It is understandable, then, that the reader should take the proposal to be meeting *legitimate* (rather than unsound) ethical concerns and to be safeguarding against genuinely *wrongful* exploitation.

Metabioethics in the United Kingdom: Is Bioethics Just *Too* Rational?

Despite small disagreements, however, we can see that the U.K. bioethicists considered here are overwhelmingly of the opinion that an ethical market in human organs is possible. Even so, as Radcliffe-Richards notes, "most professional and political opinion is still against [organ sales]."[18] She might have added, quite correctly, that most *public* opinion is against organ sales too. This gives rise to some important questions. Why do the methods of bioethics tend so frequently to deliver results that are at variance with public opinion? Does this mean there is something wrong with those methods? Or does it mean there

is something wrong with the way that medical professionals, politicians, and the general public typically arrive at ethical conclusions?

These are the sorts of "metabioethical" questions that U.K. bioethicists frequently ask themselves. Recently, a good deal of such metabioethical work has been showcased in a volume entitled *Scratching the Surface of Bioethics*.[19] The book contains examinations of the American principlist approach to bioethics,[20] of the roles best played by both philosophy and sociology in bioethics,[21] and of the relationship between empirical and nonempirical approaches to the discipline.[22] Here, I focus on those papers that most readily address the question of how bioethics results in what seem to many to be counterintuitive results, and whether, because of this, its methods can be justified. Specifically, the papers in question address the issue of the proper role of reason in bioethics, given that critics frequently hold that the strange conclusions reached by bioethicists result from an inappropriate reliance on reason as a guide in ethical matters. This opinion is succinctly stated in the contribution from Tuija Takala, a Finnish philosopher living and working in the United Kingdom:

> The willingness and ability to analyze rationally the core of ethical issues is regarded as proof of one's inhumane and insensitive nature—and of one's inability to understand ethical matters.[23]

According to those who level such criticisms at bioethicists, what is needed in bioethics is a nonrational, emotional approach. However, Takala contends that this is as untenable as the claim that bioethics should be *purely* rational: both reason (sense) and emotion (sensibility) have their roles to play, and a bioethics that rejects either will be all the poorer for that rejection.

The main problem with a purely feeling-based approach to bioethical problems, according to Takala, is that it inevitably ends up giving weight to some feelings at the expense of others and that this is unjustifiable by the approach's own lights. To illustrate this point, let us consider the case of organ sales again. The thought of people selling organs evokes feelings of disgust in many. Then again, the thought of thousands of people dying for want of transplant organs equally evokes disgust in others. Inevitably more weight will be given to one of these feelings of disgust over the other. But where is the justification for this? It certainly cannot come from within the emotion-based approach itself. As Takala says:

> Emotions and convictions are not truly considered in models that include some feelings and reject others, or argue for some convictions at the expense of others. . . . Therefore, the only way to take all emotions and convictions equally seriously is to take none of them too seriously.[24]

This last point is similar to one made in a paper by Harry Lesser in the same volume. Lesser argues that the chief problem with purely emotion-based approaches, such as that put forward by Anne Maclean in her book *The Elimination of Morality*,[25] is that they tend to look at our actual ethical practices, and at the responses that are *as a matter of fact* elicited by various bioethical problems. The difficulty with this, of course, is that "there appears to be no way of saying that 'this is what we do' settles the matter when what we do is nice and not when it is nasty."[26]

Takala, however, is just as dismissive of purely reason-based approaches, with which she sees two problems. First, ethics is patently concerned with issues of human well-being and happiness, and reason alone cannot account for these. Second, there is, she maintains, "no one universal reason to be consulted to begin with."[27] What she means by the first of these claims is fairly self-evident. But what does she mean by the second? The claim seems to be that reason can, as experience shows us, frequently operate in contrary directions. The thought here appears to be that there is seldom any one "rational thing to do."[28]

Takala's conclusion, as mentioned previously, is that both reason and emotion ought to be exercised in our approach to bioethical questions. And when, as will frequently happen, we cannot decide *whose* reason and *whose* feelings ought to guide us, we will simply have to find workable compromises. Given the nature of reason and emotion, a true consensus will never be achievable. Therefore, "the philosophical bioethicist's main task is to try to formulate minimal regulations that would take everyone's senses and sensibilities into account,"[29] at least as far as possible. It is just this sort of pragmatic and realistic approach that, we can assume, underlies Erin and Harris's suggested regulations for a market in human organs.

The emotion-based approach to the sorts of questions that bioethics raises is, as one would suspect, hugely suspicious of moral theory. For this reason, it is often explicitly characterized as "antitheoretical." A spirited defense of the importance of moral theory to bioethics is, however, offered by Eve Garrard and Stephen Wilkinson in their paper "Does Bioethics Need Moral Theory?".[30]

Those in the antitheory camp frequently make two criticisms of normative moral theory: first, that theory offers no real guidance about how we ought to act, and so is practically useless; and second, that the different varieties of theory (most notably, consequentialist and deontological theories) tend to offer indistinguishable conclusions in real-life situations. Garrard and Wilkinson, with considerable analytical skill, rebut each criticism individually but also point out that they are mutually incompatible: "the claim that theory is not action-guiding is not really consistent with the claim that the different theories guide action in the same direction."[31] That done, they move on to consider whether the antitheorist is right to claim that metaethics—"theories that concern themselves with the meaning and status of moral utterances, and with the existence and nature of moral properties and facts"[32]—is of no relevance to bioethics. This antitheoretical position, Garrard and Wilkinson think, is also mistaken because, as they show, several well-known metaethical views have very real implications for action. Relativism, for instance (the view that the truth or falsity of a given moral judgment always depends on the culture of the person who makes it), in addition to being philosophically questionable,

> commits us, as bioethicists, to being deeply conservative, or at least conservative with respect to the present conventions and practices of our own society. This is because we can "read off" the answers to moral questions from public opinion and because (since, on this view, "might is right") there appears not to be a perspective from which to criticize prevailing views on moral matters.[33]

This is an especially important point, given that the sort of antitheoretical stance championed by Anne Maclean—a stance that regards our actual prac-

tices as authoritative in matters of ethics—tends, as Harry Lesser notes, to slide into just this sort of cultural relativism.[34] If Lesser is right, and if we want to avoid the impact of such relativism on our answers to bioethical questions and on the very way in which we do bioethics, then we clearly ought to give antitheory a wide berth.

In conclusion, it seems worth reemphasizing the plausibility of the claim that any healthy bioethical "scene" must not only engage in the important first-order bioethical questions of the day—the questions that exercise medical professionals, legislators, and the general public. It must also frequently turn its attention back on itself and critically examine its own methods. This being the case, and given the evidence available, it would appear that bioethics in the United Kingdom is, happily, in the best of health.

Notes

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3. English V, Sommerville A. Presumed consent for transplantation: a dead issue after Alder Hey? *Journal of Medical Ethics* 2003;29:147–52.
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6. See note 5, Radcliffe-Richards 2003:148.
7. Wilkinson S. *Bodies for Sale: Ethics and Exploitation in the Human Body Trade*. London: Routledge; 2003.
8. See note 7, Wilkinson 2003:107.
9. See note 7, Wilkinson 2003:108.
10. See note 7, Wilkinson 2003:112.
11. See note 7, Wilkinson 2003:109.
12. See note 1, Erin, Harris 2003.
13. See note 1, Erin, Harris 2003:138.
14. See note 5, Radcliffe-Richards 2003.
15. See note 7, Wilkinson 2003:131.
16. See note 5, Radcliffe-Richards 2003:140.
17. See note 1, Erin, Harris 2003:137.
18. See note 5, Radcliffe-Richards 2003:139.
19. Häyry M, Takala T, eds. *Scratching the Surface of Bioethics*. Amsterdam: Rodopi; 2003.
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24. See note 23, Takala 2003:31.
25. Maclean A. *The Elimination of Morality: Reflections on Utilitarianism and Bioethics*. London: Routledge; 1993.
26. Lesser H. Anne Maclean's criticism of bioethics. In: Häyry M, Takala T, eds. *Scratching the Surface of Bioethics*. Amsterdam: Rodopi; 2003:57–63.
27. See note 23, Takala 2003:31.
28. See note 23, Takala 2003:32.

29. See note 23, Takala 2003:33.
30. Garrard E, Wilkinson S. Does bioethics need moral theory? In: Häyry M, Takala T, eds. *Scratching the Surface of Bioethics*. Amsterdam: Rodopi; 2003:35–45.
31. See note 30, Garrard, Wilkinson 2003:36.
32. See note 30, Garrard, Wilkinson 2003:39.
33. See note 30, Garrard, Wilkinson 2003:40.
34. See note 26, Lesser 2003:60.