

## Reading SAL Week 10

*We've been talking about donation of organs. This article and its companion by Veatch talk about the recipients of organs: what constitutes justice—distributive justice-- fair distribution of a scarce resource?*

**Childress:** Fairness in the Allocation and Delivery of Health Care: Organ Transplantation

Childress takes on the task of morally evaluating a test case of distribution of a scarce medical resource—in this case, organs available for the huge waiting list of possible recipients. How can it be fairly decided who will be the person to receive an available organ?

- (1) There should be publicly available criteria—that are seen to be fair by potential donees.
- (2) Justice requires substantive standards for justice, considered as rendering to each person their due: both formal and material.
  - a. Formal criterion for justice: similar treatment for similar cases—cases that are similar in terms of equality of material criteria: that is, for cases that are justly prioritized, the sum of material criteria  $a+b+c+d+e$  should be greater than the sum of those criteria for cases lower on the list.
  - b. Morally relevant material criteria: Need. Merit. Social value (= 'contribution'). Status. Ability to pay. Morally irrelevant criteria: Race. Gender. (What about disability status? Different since the ADA; cf. Sandra Jensen case)

There are two stages of the organ allocation process: Getting listed; and getting an organ once you are on the list.

- (1) Getting listed: The waiting list should be assembled on the basis of primarily medical criteria (= medical utility): the degree of need, and the probability of benefiting from the organ.

“Medical utility” is basically utility from the standpoint of the organ: if it is going to be used, it should be used as effectively and efficiently as possible. So although lots of people want and need it, it will do the *most* (utilitarian) good if it goes to the person who needs it most and whom it will benefit the most. If the transplant will not cure all the patient's problems, it will from the standpoint of the organ, be more effective if it goes to someone whose problems will thereby be completely remediated...
- (2) Getting an organ once you are on the list: UNOS and the point system.

Childress discusses two iterations of the point system: Starzl's and the revision. In both cases points are allocated on time on the waiting list, antibodies, and tissue match (=HLA, in the jargon of the trade). In the second iteration the weights were shifted; Veatch preferred Starzl's version (see the next article).

Lots of blah blah blah here about technical details of the various trade-offs, not all of which I understand...

Childress points out that in terms of who gets the organ, the major factors at stake are the degree of need, and the likelihood of successful outcome for the transplant, and that these can often be at odds; the sicker you are when you are on the list, the less likely the probability of long-term benefit. Also, (p. 729-30), those factors weigh differently depending upon the organ in question (ie, kidneys v. livers...). Thus a purely 'objective' determination of choice seems very unlikely. He also suggests on p. 730 something like the god-committee: “a broadly representative group that includes patient, community and ethical perspectives, as well as those of the medical professionals involved.”

He discusses the allocation of organs to non-citizens (ie foreign nationals)—a tricky issue since historically speaking, when transplant was being developed lots of foreign nationals were among the first recipients, at a stage when the procedure was much closer to human experimentation than standard (=successful) medical practice.

The other really interesting section is on the effect on selection of ability to pay (pp. 732-4). Transplantation is very expensive—for all organs. For kidneys, the cost of transplantation as well as dialysis is covered by federal funding. All other organs, you are more or less on your own. Immunosuppression drugs can cost anywhere from \$5-7K a year, and that is initially covered by Medicare for only the first year, although when Childress was writing (199x) the time was being extended to 3 years (which is NOT lifetime coverage). The government wished to reduce the impression that transplantation

was going to be available only to the wealthy, but inevitably financial considerations still enter, especially for organs other than kidneys.

Conclusion: Fairness is important. Utility (medical utility) and respect for persons are also important; and the various principles need to be balanced in organ distribution. It's hard to figure out what to do with transplantation of organs other than kidneys (and he speaks of this in terms of "what would be the fairest policy in an unfair system?" referring to the absence in the US of a universal national health system). Fourth, any solution we attain now is likely to change over time as the situation changes. Fifth, although he has concentrated primarily on ethical issues in organ allocation, ethics is not the only relevant consideration; "those questions arise in a complex mix of social, political, scientific, medical and other factors."

### **Veatch: Equality, Justice and Rightness in Allocating Health Care: A Response to Childress**

Veatch takes Childress to task on various points of the allocation calculations, and makes clear his position that 'medical utility'—calculations from the standpoint of the organ—are too utilitarian for his taste. The criteria which compensate for social discrimination against various underrepresented populations should be prioritized, in his view.

### **Radcliffe-Richards et al: The Case for Allowing Kidney Sales**

The basic arguments AGAINST allowing kidney sales:

- (1) protect the poor against exploitation by the rich, for they are ignorant and economically coerced.
  - a. BUT: if they can't sell organs, they are even more economically coerced;
  - b. And if they are ignorant, education and counseling are advised to remediate that condition.
- (2) allowing the sale of life-saving organs gives an advantage to the rich that is not available to the poor.
  - a. BUT: what does not?
  - b. And anyway—we could separate purchase from distribution. For instance, some kind of central agency could purchase any that were for sale, and then distribute them equitably, instead of re-selling them to the wealthy.
- (3) Organ giving should be altruistic.
  - a. Why?
- (4) Allowing the sale of organs would undermine community trust in medicine
  - a. Why should it? Medicine is rife with other commercialisms, and trust doesn't suffer (or if it does, this wouldn't make it suffer more)
  - b. —and if the organ supply were increased, people would regain confidence in the capacity of medicine to help them in some respects
- (5) The sale of organs would exacerbate already-great social inequality
  - a. BUT: decent regulation could prevent that; see my arguments about separating purchasing from distribution; and conditions of purchase could be regulated as well.

All these arguments apply as well to donation as to vending. What lies behind them all is the hope of the rich and the healthy to get things for free that are to their advantage, and they always object to anything that might help the destitute and the dying.

### **Erin and Harris: An Ethical Market in Human Organs**

In order to establish an ethical market in human organs, we need a single purchaser in a confined marketplace with built-in regulatory safeguards. Many of the moral risks we see in this area have to do with international trafficking in organs. But if you have a confined market, you can set it up so that residents of a given area can donate and thereby become eligible to receive organs should they ever need them themselves.

In 1998 an international organization of transplant specialists voted to regulate sales, rather than forbidding them. In 1999 physicians in the UK voted to move to presumed consent, instead of the present system of presumed refusal (but the government failed to act on the recommendation).

The problem with the present notion of "gift" is that there is absolutely no reciprocity of any sort; everyone is remunerated but the donor. That's patently unfair.

## **Joralemon and Cox: Body Values: the Case Against Compensating for Organs**

*This article makes a case for the persistence and importance of the cultural belief that our body is intimately implicated in our sense of self.*

Financial compensation for organs is back on the table via legislative proposals, AMA and UNOS, and the professional body of transplant surgeons, all asking for pilots to test the impact of various financial incentives. Their assumption is clearly utilitarian: whether a policy is ethical or not depends upon the balance of benefits and harms that results from it. They seek the moral high ground by arguing that they are acting in the interests of patients on waiting lists, and minimize the scope of the actions presented by asking only for pilots and offering incentives—not policy changes, or payments.

There are various schemes other than the current altruism-based system. They are mappable on axes ranging from voluntary to coercive, and presuppose a sense of self, of the sources of personal identity, ranging from body-as-self to body-as-property (see p. 302). Identity itself can be understood as radically individualistic, or as shared with some larger entity—family, community, ethnos, society.

1. Compensation and body parts: paying for organs compromises human dignity (an argument similar to that made against surrogacy, cloning and genetic experimentation). We should not encourage the belief that human beings are salable commodities.

But: say the commodifiers: so much of the body is already commodified that compensation for organs is a natural, maybe even an inevitable, extension of already-accepted practices.

Yes—there are all sorts of desperate risks, exploitation and commodification that we are free to engage upon—but that suggests we should reduce them all—not expand them.

Further problem when we consider the question of compensation for cadaveric donations. All the reasons for which we wish to keep the living donations as voluntary assume the ‘body as self’ picture of identity. But suggestions about compensation for cadaveric organs adopt a body-as-property picture. If we look around at the non-medical population, however, we don’t see an instant conversion of perspectives at the moment of death; rather, there is a more gradual disaggregation of the deceased from ties to the living. That may be why we are more willing to accept the idea of commodifying a living body than a dead one.

2. Commodifiers claim that it is hypocritical to object to something that you might well want for yourself if you were in the position of a person facing the same choices. Thus if a developed-world parent gives a kidney to a child, we think it’s noble and great; if a third-world parent sells a kidney to provide food for the family, we think it’s wicked. That’s hypocritical.

But our authors point out that there is a difference between understanding individual actions—and instituting policies that normalize or encourage them.

People who propose compensating for organs justify it in terms of ‘doing whatever we need to do to help the living.’ But there is no legal compulsion to rescue; indeed, it is gratuitous or supererogatory rescue in face of the absence of obligation that makes us value it.

Utilitarian arguments will not well serve the advocates of compensating for organs to increase transplantations; in terms of health-bang for the buck, you get a lot more good for a lot more people by spending the annual amount that goes to transplantation on vaccinations instead—or any other public health measure.

Not that transplantation is that great, either; as a ‘rescue’ therapy, it leaves much to be desired. And the justification of ‘rescue’ is usually an egalitarian one—something that the expense of transplantation, a luxury of the wealthy, cannot justify.

3. Commodifiers call on the appeal of modern science, and call the position which calls for more respect to the person and body one based on superstition, which will eventually be overcome by the progress of rationality. But considering the short period that their alternative ‘body as property’ has been around, compared to the duration of larger and more integrated views, perhaps theirs is the aberration.