Ethics, commerce, and kidneys

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As the number of patients waiting for cadaver renal transplants continues to rise the arguments against paying for live donated organs bear re-examination.

One ethical argument is that such payment would lead to exploitation of vulnerable people.^{1,2} The sort of people who would sell organs are the poor, who have few other options available for gaining money (such as employment), and so are at risk of being exploited. Exploitation could mean either that individuals are pressured into donating a kidney when they do not really want to, or that they are not paid a fair price. If exploitation means not paying a fair price this is no argument against payment for organs but is an argument for a fair price.

If, however, exploitation means the pressure to donate this brings into question donors' free will and motivation.³ The assumption behind this questioning is that introducing money into an act of donating a kidney necessarily removes the truly voluntary element from that act. Those who argue this must explain why it is that I can make a truly voluntary decision to sell my labour or my house but not when I decide to undergo surgery and sell a kidney. There is no sense in which being paid impairs free will, but if the concern is for freedom of action then the solution is to increase the options available, and hence freedom of action, by (for example) allowing the sale of organs.⁴

It is also said that commerce would lead to third parties profiting from trafficking in organs.⁵ It would be possible, however, to regulate the market in such a way that this did not occur—for example, by restricting the purchase of organs to one authority under the control of the NHS, which would be obliged to use the organs for NHS patients and would be prohibited from selling them.¹ Furthermore, it is incumbent on those who argue against payment for organs on these grounds to say why it is wrong for third parties to benefit from commerce in organs but not wrong for them to profit from other commercial transactions in medicine.

Morris has said that commerce demeans the relationship between donor and recipient.¹ There are two possible readings of this statement. If it refers specifically to the relationship between the individuals involved then it needs to be explained why this particular example of commerce is demeaning while (for example) a patient paying a surgeon is not. Moreover, we need to know why the demeaning of this relationship is worse than depriving the potential recipient of the needed kidney and the donor of the payment. We also need to know what right we have to prevent those individuals entering the relationship, whether demeaning or not.

Alternatively, Morris's statement may mean that commerce demeans altruistic donation—but the fact that some people sell kidneys clearly enhances, rather than debases, the altruistic nature of a donated kidney, as not only is the donor giving a kidney, but forgoing possible payment as well.⁵

The notion that commerce demeans the relationship between donor and recipient derives from another idea: that human organs are not items that can be bought and sold. In one sense this is factually untrue. What must be meant is that an individual has no right to sell an organ. It is clear that no person other than myself could be said to own my organs, so this argument must depend on the belief that some higher

authority prohibits their sale. In that case some reason must be given for believing that the higher authority would prohibit their sale, even though this sale may well relieve the suffering of another person. The relevance of this argument to a secular society is not clear because anyone with religious objection to the sale of organs need not be involved.

Finally, there are two practical arguments against commerce in organs. Firstly, there is a danger that potential vendors might obscure personal details that make them likely to be carriers of infections, in particular HIV infection, so that they will be accepted as donors. Safeguards could, however, be instituted, such as not paying for the organ until six months after the transplantation, and paying only if the recipient remains HIV negative. Also, the overall risk of transmitted infection could be assessed and explained to the potential recipient, who would then decide if it were a risk he or she were prepared to take, in the same way that he or she would take a risk of transmission of HIV infection with a cadaver graft.

The second practical argument is that paying for kidneys might reduce the supply of donated organs. This is impossible to prove without trying out payment for donation. A reduced supply of "free" kidneys might not matter if the overall number of transplants increased, unless the number of non-renal organs available for transplantation also fell.

If doctors and the law are to deny patients access to a potentially limitless source of organs, courtesy at least requires that we know why they do so. The reasons seem to be more practical than ethical. The objections to commerce in kidneys may not be unsurmountable.

1 Morris PJ. Problems facing the society today. Presidential address: the Transplantation Society, 1986. *Transplant Proc* 1987;19:16-9.

2 Sells RA. Ethics and priorities of organ procurement and allocation. *Transplant Proc* 1989;21:1391-4.

3 Evans M. Organ donations should not be restricted to relatives. *J Med Ethics* 1989;15:17-20.

4 Harvey J. Paying organ donors. *J Med Ethics* 1990;16:117-9.

5 Perry C. Human organs and the open market. *Ethics* 1980;91:63-71.

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If multiple sclerosis affects the bladder is a woman's ability to have an orgasm likely to be destroyed?

The answer must be yes for the vast majority, but it is not inevitably so. In women with multiple sclerosis the commonest sexual dysfunctions are failure of arousal and failure of orgasm.¹ As with bladder dysfunction, impairment can arise from lesions at many levels of the central nervous system, and the incidence of problems increases with the degree of disability and the duration of the disease. There is a strong correlation of sexual dysfunction with sphincter dysfunction, although this is not invariable.² Furthermore, remissions may occur, with restoration of sexual function.² Even with multiple sclerosis the basis of impairment is not necessarily organic, and psychological factors, which can be surmounted, may underlie failure to achieve an orgasm.—E M R CRITCHLEY, consultant neurologist, Preston, Lancashire

1 Minderhoud JM, Leemhuis JG, Kremer J, et al. Sexual disturbances arising from multiple sclerosis. *Acta Neurol Scand* 1984;70:299-311.

2 Gautier-Smith PC. Sexual dysfunction and the nervous system. In: Aminoff MJ, ed. *Neurology and general medicine*. London: Churchill Livingstone, 1989:471-86.