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KidneyMatch.com: The Ethics of Solicited Organ Donations

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In June 2008, nearly 80,000 people in the United States were waiting for organs to save them from kidney failure or an indefinite future on dialysis.[1] The growing demand for renal transplantation has pushed the median wait time for a donated cadaveric organ to over three years, although waits of five to seven years are not uncommon in major metropolitan areas.[2] The number of patients on the waiting list for kidney transplantation has increased by approximately 10 percent annually, yet the number of donors has increased by only 4 percent each year.[3] There simply are not enough organs to go around. Since organs from cadaveric donors are increasingly difficult to find, patients are urged to try to find a live donor who is willing to give up one of his or her kidneys for the sake of the patient. Now, in fact, more kidney transplants use live organ donors than cadaveric ones.[4] Indeed, since live donations have a higher success rate than cadaveric donations, such efforts benefit the patient in more ways than one. The most obvious source of live organs has always been the patient's family — parents, adult children, siblings, cousins — especially when exact tissue matching was necessary. But newer antirejection medications make an exact match less necessary, and so donations have been approved from spouses and from close friends who have an emotional, but not biological, connection to the patient. As time has passed, the definition of a "friend" has gradually been expanded to include co-workers and fellow church members, even if the actual connection between the patient and the donor is tenuous.

If these recruitment efforts fail, the next obvious step is for patients to seek donations from unrelated donors through whatever means are available. In a computer-savvy world, many have turned to the internet to plead their cases in the hope that some altruistic stranger will come forward and offer to donate one of her or his organs. Not surprisingly, several services, most notably *MatchingDonors.com,* have emerged to facilitate the interaction between patients and donors. For a fee of $295 (which can be waived for economic hardship), *Matching Donors.com* allows patients to tell their stories and post pictures to make their case. About 250 patients have profiles posted to the website at any given time. Potential donors can register for free, and over 5,000 people have done so. To date, *MatchingDonors.com* claims, the service has facilitated 78 renal transplants at more than 20 different hospitals, with about another 40 in the works.[5] Only seven of the hospitals have refused.[6]

Until 2006, the American Society of Transplant Surgeons publicly resisted efforts to expand donations through the internet. The society acknowledged that genuine friendships may develop over the internet and that such friendships may provide the emotional tie that is generally required for donations, but they wanted

to confine such donations to "pre-existing" relationships. The society was "strongly opposed to the solicitation of organs by recipients or their agents. . . . We believe that such solicitation and directed donation will undermine the trust and fairness on which the system of organ transplantation depends."[7]

Now, however, the society claims, "In so far as these solicited directed donors will add an additional scarce resource, there are ethical grounds to proceed with these types of transplants as long as the motivation is based in altruism and there are well defined safeguards regarding informed consent. . . ."[8]

The United Network for Organ Sharing (UNOS), which oversees organ transplants in the United States, has no official policy on such donations. Its past president, Francis Delmonico, MD, has argued, "I don't think we can legislate or regulate how people get to know each other. Once that occurs and someone decides they want to save another person, I don't think we ought to stop that as long as they are medically suitable, are not violating the law, and are fully informed."[9]

The decision to transplant is left to each hospital. But very few hospitals have an official policy on whether to accept such donations. We argue here that hospitals should be reluctant to accept such donations, but not that they should categorically refuse them. A better approach would be to try to offer a more systematic promotion of kidney donations, including altruistic donations from unrelated, living individuals to those most in need, based roughly on the current UNOS ranking criteria.

THE CASE FOR SOLICITATIONS

The most compelling argument for allowing solicited organ transplants is that the kidneys obtained from altruistic donors are organs that would not otherwise be donated. If so, then some people benefit from the donation and none are harmed.[10] Consider everyone who is or might be affected by the donation: the recipient, the rest of the transplant waiting list, the donor, and everyone else. Obviously, the person receiving the organ from an altruistic donor benefits from it. Everyone below that person on the transplant list benefits because the recipient is no longer on the list and so they are all moved up the list, and so each of these people becomes somewhat more likely to receive an organ.[11] No one above the person on the transplant list is harmed because the kidney would not otherwise be available, and so it neither improves nor decreases their odds of receiving an organ. The donor is not harmed, the argument claims, as long as he or she understands and accepts the risk freely and gives meaningful informed consent to the procedure. No one else is harmed, simply because no one else is affected, one way or the other, by the donation. Thus, proponents claim, the new situation is better than the old in a straightforward way: some people benefit and none are made worse-off. Surely, the argument concludes, an act from which some people benefit and none are harmed is morally permissible.

Before we accept this argument, however, we should examine it in more detail. The argument depends crucially on three claims, which will be examined in detail: (1) the organs solicited through the internet would not otherwise be available to any of the patients on the list, (2) the donors are not harmed by giving up their kidneys, and (3) no one else is harmed by the transaction.

POTENTIAL HARM TO OTHERS

The claim (1) that those higher on the list are not harmed by the donation rests on the assumption that the solicited organ would not be available to them. This claim is true only if the sole reason that people donate is in response to the particular personal stories they find on a website and that they would refuse to donate to anyone else. However, we can imagine that the kinds of stories told on *MatchingDonors.com* might motivate some people to donate an organ altruistically to whomever needs it most. If suitably channeled, their desire to donate might lead them to give a kidney to, say, the official waiting list maintained by UNOS, a list that carefully weighs the many factors that determine who can best use a given organ at a given time. For that reason, some have argued that we should counsel potential donors about how their gift might benefit the next person on the waiting list, rather than the individual who solicited their organ.[12]

We can even imagine a public awareness campaign — much like that used for blood donations — that would extol the virtues of giving to the UNOS list and thereby increase the number of donors. Indeed, on independent grounds, such a program is certainly worthwhile.

However, even if such a campaign were effective, some people would still want to give their organs only to the specific person whose particular story moved them, and they might then be unwilling to donate to anyone else. So, whatever the independent merits of a public awareness campaign, we should accept the claim that in some cases, the donor would not allow her or his organ to be used by anyone else. In these cases, those above the patient on the UNOS list are not harmed.

THE LIMITS OF AUTONOMY

The claim (2) that donors themselves are not harmed when they freely consent to give an organ may also seem uncontroversial, but in fact, donors *are* harmed: an organ donation is a major operation that injures donors, and it requires significant recovery time and involves serious risks. To claim that donors are not harmed, we must argue that the injury and the health risks associated with donation are outweighed by the benefits that donors receive by helping recipients, by being altruistic in general, and by exercising their autonomy. Blood donations, which have virtually no risk, raise little concern. Similarly, bone-marrow donations, which have relatively little risk in themselves and carry little long-term risk, also raise few concerns. Because the risk of kidney donation is higher — both because the surgery itself carries some risk and, more importantly, because it carries long-term risks apart from the operation itself — the issues are more complex. At this point, however, as long as the donors themselves are the only one affected, autonomy usually trumps. We typically allow people to weigh these factors for themselves and then decide what is best based on their own values and judgments. After all, we allow people to bungee jump off high bridges, despite the very real risks, for nothing more than the thrill of it; generally, donors themselves can decide what risks they are willing to take for what benefits. So, for kidney donations, it would seem, we should allow potential donors to make these judgments for themselves, provided that the act of donation is not medically contraindicated.

Yet there are limits to autonomy: we obviously don't allow live heart donations, even from parents to children — although we revere people who are willing to sacrifice their lives so that others may live. Carl Elliott argues that it may be morally acceptable, or even praiseworthy, for a person to be willing to make such a sacrifice, but that doctors, who must treat their patients equally, cannot morally accept such donations.[13] We are willing to accept a certain amount of paternalism here. We think individuals should not take on too much risk, even if they understand it and are willing to accept it, and they certainly should not expect others to aid them when they do take exorbitant risks.[14]

Kidney transplants fall in between these kinds of cases: the risks to donors are significant, but not prohibitive. Hemorrhage; injury to adjacent organs such as the bowel, liver, or spleen; infection; and the need for additional surgery are all possible complications of undergoing a donor nephrectomy (either open or via laparoscopic technique).[15] Post-operative hospitalization is usually short (several days) and donors are able to return to their normal activities without restrictions within four to six weeks. But in the long term the donor is at risk for the development of hypertension, renal insufficiency, and even renal failure, that would require hemodialysis or renal transplantation.[16] Most institutions have determined that the risk of kidney donation is significant enough that they are reluctant to allow individuals to take the risk unless they would benefit from the donation because they have a real stake in the well-being of the recipient. So we think it an acceptable risk for family members and for close friends, both of whom have an emotional stake in the life of the recipient. Of course, even more distant friends and members of a church community may have some emotional ties to the patient. But casual acquaintances and anonymous members of large churches don't meet this criterion, and so if we take this requirement seriously, we may have to exclude some donations that have been previously allowed.

Adopting such a policy would, of course, encourage some people to game the system by inventing stories of previous relationships. Indeed, we may acquiesce to donations from casual acquaintances, not

because we think they are morally innocent, but because the harm to the donor is not too great and the costs of weeding out inappropriate donors is too high. Similarly, we could conclude that policing internet relationships would simply be too difficult, and we would rather not encourage deceit. However, the two cases differ in one morally crucial aspect: even distant friends and church members share a community with the patient, and contributing to that community has direct benefits to the donor. Moreover, the fact that we acquiesce to dubious donations because we think it too costly to police them does not imply that we should not attempt to discourage them when we can and to bar them when the evidence that there is no real relationship is obvious. Nevertheless, precisely because the risks are well known and relatively modest, the case for prohibiting internet solicitations on the grounds that it will harm the donor is weak.

INSTITUTIONAL HARMS: UNDERMINING THE SYSTEM

The claim (3) that no one outside the waiting lists is harmed by solicited donations is only obviously true if we assume harms occur only if we can identify particular persons who are harmed. But harms need not be assignable to particular people. Think, for example, of what we might call "institutional harms." An institutional harm can occur in at least one of two ways: (a) when a practice undermines an institution that benefits people in general, even if the practice directly harms no specific person; or (b) when an institution harms a group of people even if no particular person can claim that she or he was hurt by it. Either way, the existence of institutional harms undercuts the claim that the only outsiders who could be affected by the donation are those on the waiting list. Of course, this abstract point does nothing to show that internet solicitations do in fact cause institutional harms, but they might do so in at least three ways: (a) by undermining the whole transplant allocation system, (b) by unfairly promoting the interests of some groups at the expense of others, or (c) by leading to the commodification of organs that would itself be morally suspect.

The most straightforward institutional harm that we might think solicitations cause is (a) that they would sabotage the whole UNOS mechanism. The perception that the transplant rankings could be circumvented by the rich and the savvy undermines the general sense that the system is fair. A widespread belief that the system is unfair, that people "like me" are unlikely to benefit by it, and that it works against them would lead to a broad distrust of the system, which would undermine efforts to increase donations of both cadaveric and live organs.[17] Insofar as people think that internet solicitations allow some people — those who have the education and the resources to use the internet effectively — to manipulate the system, then people lose faith in the system as a whole. Such a result might not affect anyone currently on the list, one way or the other, because its full effects would only be seen several years from now. But it would obviously impose great cost on people who will need organs in the future. The question, then, is how likely is it that internet solicitations would lead to a general disillusionment with the transplant system? Any answer is speculative, but since few people understand how the organ distribution system currently works, the probability that a change in the rules would lead to a drop in donations seems low. Such a possibility does not, then, constitute a strong objection to the internet solicitations.

INSTITUTIONAL HARMS: FAVORING THE SAVVY

A second, related way that organ solicitations could cause an institutional harm is (b) by unfairly promoting the interests of some over others. As Douglas Hanto argues, "Directed donation ties donation to the emotional appeal, public relations skills, photogenicity and financial resources of the patient, family and others involved in the campaign. It assumes that the person soliciting for the organ is ethically special because of some characteristic that allows an exemption from criteria that apply to everyone else."[18] Kidneys are distributed to those who are the most media savvy, to those who are most telegenic, and to those who can tell the most heart-wrenching story — not to those in the greatest need.[19] Of course, much of life works this way, from job interviews to political candidacies. Too often, jobs do not go to the best qualified or to the persons who need them most, but to the persons who can present themselves the best. Still, we often think the

basics of life should not be based on such criteria. As an analogy, think of a system of assistance for the poor that is run completely on charity as opposed to one based on state welfare. Such a system may provide an unreliable source of support for the poor, and it could often be short of money at exactly the times when people need it the most. But, even more importantly, such a system might humiliate the poor by forcing them to beg to survive, and it might favor those who can grovel in the right way rather than those with the greatest claim. Indeed, the logical extreme of such a system is a feudal world in which every person is dependent on his social superiors for the basics of life.[20] In the same way, a system of organ distribution that unduly favors those who plead their case the best becomes geared to favor one type of recipient for morally and medically irrelevant factors. Such a system would harm those who cannot plead their case well and deny them organs, and it would even harm those who can make such please by forcing them to act in a way they may find humiliating.

In both the welfare and the organ cases, the *donors* prefer a system in which they have the power to judge whether the recipients are "worthy" of their donation, in which they can expect to receive direct gratitude from the recipient, and in which they can see the results of their beneficence. While these motivations are not inherently immoral, they may contain a morally dubious desire to control the process, if not the other person. Such a system gives power to the donors, a power whose use may undercut the altruism of their act. The creation of that power is perhaps unavoidable; the gift relationship that is created between the donor and the recipient in both cases is bound to be complex. In the case of organ donations, the complexities are even worse, because the need is so great and the duties of gratitude and reciprocation that are created can never be fully discharged.[21] For that reason, such gifts from relatives and friends can be overwhelming, even oppressive.[22] For just that reason, many *recipients* would prefer to receive an organ from a stranger, from whom they can escape and to whom they would feel less responsibility if complications arise.[23] But of course these motivations *are* morally suspect: recipients will feel less guilty if they lose their new organ through their own negligence than if it had come from a friend or relative. So, both the donors and the recipients may prefer a system that encourages internet solicitations of organs. But the fact that both the donors and the recipients would consent to this arrangement does not make it just. Indeed, any time one party in a transaction is desperate, he or she may agree to unjust terms. Think, for example, of labor contracts in desperately poor countries; if the alternatives are bad enough, many people would even consent to become slaves.

We solve the problems created by private charity by creating a welfare system in which people have rights to basic goods, and we then set up a social mechanism that taxes some to support others to insure that society can protect that right. Such a solution is not, of course, feasible for organ donations. We cannot "tax" anyone to provide the organs necessary to support a right to needed organs without dramatically undermining the autonomy we value so highly. The procurement of organs, then, will always require us to cultivate donors, and so donors or their surrogates will always have much power in any system we devise. But only if we were to accept the principle that what donors want is always what is most important are we forced to the conclusion that they are entitled to control the whole process. By the same logic, we should accept the conclusion that if what the donors want is money, then they should be allowed to negotiate whatever the market will bear.[24] The principle that the donor should be allowed to control the process, then, may lead to a free market in organs and the full commodification of organs. If we reject that principle, then we should set up a system that is more fair to all potential recipients.

INSTITUTIONAL HARMS: THE COMMODIFICATION OF ORGANS

A third potential source of institutional harms lies in (c) an indirect path to the commodification of organs. Think, as an example, of the institutional harms of slavery. Even if slaves were treated humanely, we think the very act of being owned by another person is degrading — even if some might choose it to save themselves from a desperate financial plight or from death. Even free Blacks in the nineteenth century were harmed by the institution, because the very existence of Black slavery legitimated the view that Blacks were inherently inferior. We do not regard a ban on slavery as unwarranted paternalism; we regard it as a way of

protecting the most vulnerable and of maintaining the basic dignity of all humans. People simply are not commodities that can be bought and sold.

Similarly, the existence of prostitution, we can argue, harms all women by making sexuality a commodity. Even if it were true that prostitutes entered their profession voluntarily and continued to practice it because they viewed it as their best option for employment, the practice itself would demean all women. Sexuality should be something that can be bought and sold, rather than an expression of mutual self-giving and intimacy.[25] Our sexuality, we could argue, is connected closely to our identities; it is deeply a part of who we are and of how we express ourselves in our most intimate relations with others. Because sexuality is such an intimate part of ourselves, selling it alienates us from ourselves in a way that selling our labor as a doctor or an accountant does not. Prostitution creates a way of viewing all women as people whose core identities can be bought, sold, and traded, and it creates an option for people the very existence of which makes their lives worse. Prostitution thereby dehumanizes women.

In both slavery and prostitution, the institution itself undermines human dignity in the way it treats people, even when the parties agree to participate. Both also affect even those who do not directly participate in them by categorizing some people as potential commodities.

For our purposes, the question is whether solicited donation would cause harm in a similar manner. The most plausible argument that solicited donation would cause harm is that allowing it would commodify organs and lead to a market in organs. If organs do become commodified, we might then come to regard our bodies as sources of revenue, and thereby think of human bodies in ways that are disrespectful to them. Our bodies might be seen as potential sources of income, rather than as, say, temples of our souls. Like the selling of bodies for sex or trafficking in persons, the option of selling organs may be one that we do not want to exist even as a possibility. Just as prostitutes' bodies might be seen as "sex toys," human bodies might come to be seen as organ storage facilities. Like prostitution, the option of sale only has attractions for people who are desperate, and, for that reason, harvesting their organs would be exploitative. The objection, then, is that the ban on selling organs is an important measure for respecting human dignity and for protecting the most vulnerable in our society.

Some could argue that we already treat organs in precisely this way. People in the U.S. sell, for example, their sperm and their eggs, and elsewhere, people routinely sell their blood — though blood sales have long been seen as a poor way to generate the necessary blood supplies.[26] Yet blood, sperm, and eggs are different from kidneys in ways that are morally significant. The first two are replaceable, and, while eggs are not replaceable, most women have many more than they could possibly use in their lifetime. So they are not giving up any part of their bodies that are vital to their well-being when they give them away or sell them. (Bone marrow is replaceable too, but there is not — yet — a market in bone marrow.) But even in these cases, many people think the practice of selling them unseemly. In the case of a kidney, the stakes are considerably higher, and so something more important is being made into a commodity. Countries like India already support a lively market for kidneys — although the results are rather unpromising.[27] Indeed, the effects of markets for organs in poorer countries have already led the poorest to regard their organs simply as another means to pay off debts and to fear — legitimately — the theft of their organs.[28]

The key question then is whether allowing organ solicitations will in fact lead us to think of organs as commodities. Consider two different analogies for kidney donations. First, kidney donations are like other charitable donations, which donors can direct as they please.[29] Donors' kidneys are their own, and they can give them to whom they see fit. This model treats kidneys as a piece of property. When I own property, I can use it in any way I want, as long as I do not directly harm others. I can give it away if I like; I can even destroy it altogether if I wish. If I own a piece of property, I can use it to buy a new Mercedes, I can give it to the symphony or to my cousin, or I can give it to people who are in desperate need of it. Some of those choices may be morally better than others, but all of them are morally permissible. Using this model for kidney donations, barring medical considerations, I can give my kidney to whomever I wish. I do not need anyone else's permission, I do not need to know the recipient ahead of time, and I can choose the object of my generosity in any way I deem appropriate. But treating kidneys as property does commodify them. If we

treat something as property, the presumption is that we can dispose of it as we like. If, then, we treat kidneys as property, we have no reason to prevent people from giving away their organs on the internet. But we also have no reason to prohibit people from selling them: like any piece of property, we can give it away or sell it, and no one can prevent us from selling what others would prefer that we give away. Of course, many now accept exactly this conclusion and argue explicitly for an open market in organs.[30] Importantly, this argument does not invoke a slippery slope: we are not sliding from one result to a closely related result. Instead, the principle we are using treats organs as property, and because we treat organs as property, that same principle implies that we can sell them as well as give them away.

Of course, property rights do have limits: generally, we cannot use our property to harm others, and society may impose some restrictions, such as environmental regulations or historical protections, on how we use our property. But only a great social good can override the presumption that we can do what we wish with our property. If, then, we assume that selling organs is wrong, then we must believe that we have good reason not to treat kidneys simply as pieces of property, as mere commodities. If we think that important body parts must be treated as something more than commodities, then we must feel that individuals should not decide how to dispose of their organs on their own; society must play an essential role in the process.

As a different model, think of the way we treat children. My children are "mine" in some sense, and I could give them away, but not in any way that I choose. Here society has an interest in the welfare of the child, and so I can only give a child away in a manner that suits that social interest. For that reason, society plays a more significant and more direct role in the process of giving away a child. Traditionally, we can "direct" our donations in very limited ways to very close relatives, but even then society has some role in deciding whether that adoption is appropriate. In this model of kidney donations, we could accept donations from anyone who wished to give, and we could then direct them to the place where they would do the most good. This model does not treat kidneys as mere property; instead, they are seen as a good over which society should exert significant control. Like children, kidneys belong to particular people, and the wishes of those people should have considerable weight in determining where the donation should go. Of course, kidneys are not children — most importantly because kidneys, as such, do not have independent interests that we must consider. Moreover, even for children, this model is breaking down: birth mothers often pick and choose adoptive parents and, more strikingly, women are paid to bear children and to give up their parental rights to particular people. Yet by thinking of kidneys as part of a broader social good, we take them out of the realm of commerce, and we would thereby better ensure that donors are treated with the dignity they deserve, both by themselves and by others.

If we think of organs as a community resource, then we should regard the supply of organs as a community project in much the same way we regard the blood supply. In the past, blood banks paid people for blood, and patients were often expected to find their own blood donors, but now, even with the shortages that occur, we think the community should respond.

How exactly society should respond is a problem to which we can only offer a few suggestions here. Since as a society we have already invested UNOS with the power to determine the best recipient for a donation, it makes sense to delegate this task to UNOS, but the important point is to set up some mechanism for review. Because its interests are directed to society as a whole, this agency would probably want to direct organs to the persons most in need. For that reason, some have suggested that a person should legitimately be able to direct a donation only to their close friends and relatives; all other donations would go to the official organ waiting list.[31] But even if we think of organs as a community resource, we need not, in principle, impose such a stringent requirement. Just as state agencies have a role in all adoptions, an entity like UNOS could approve on a case-by-case basis the desire of some donors to give to particular people. But, given the larger social mission involved here, we think some effort should be made to steer donors to recipients who might need their organs more than those who advertise on *MatchingDonors.com*. But we need not reject solicited donations altogether. We just need to insist on a social mechanism to monitor them and perhaps to channel them to where they can do what society deems to be the most good. By doing so, we avoid the institutional harms caused by the commodification of organs, and, by attempting to direct donations to the

UNOS list as much as possible, we ameliorate the injustices that are caused by the fact that some people's stories may seem more compelling.

With its completely hands-off attitude toward solicited donations, UNOS is in danger of allowing society to lose a vital role in maintaining the standards of donation. By deferring to hospitals to decide for themselves which donations are acceptable,[32] it leaves the system to sink to the lowest common denominator. If, instead, UNOS directed a national altruistic donor registry, it could do much to ensure that the process is as fair and as dignified as possible. By setting up its own website and public information campaign to put a face on the need for donations and by encouraging those who came forward to consider donating to those highest on the list, the program as a whole might be able to maintain the ban on the selling of organs and yet provide hope for everyone on the waiting list.

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NOTES

1. Organ Procurement and Transplantation Network, "Current US Waiting List, Overall by Organ," *www.optn.org/latestData/rptData.asp*, accessed 9 June 2008.

2. R. Dinavahi and E. Akalin, "Preemptive Kidney Transplantation in Patients with Diabetes Mellitus," *Endocrinology and Metabolism Clinics of North America* 36 (2007): 1039-49.

3. G. Remuzzi et al., "Long-Term Outcome of Renal Transplantation from Older Donors," *New England Journal of Medicine* 354 (2006): 343-52.

4. See note 1 above.

5. *www.MatchingDonors.com*, accessed 9 June 2008.

6. We have been able to verify that 10 hospitals have performed these surgeries and that one has refused, and we have no reason to doubt claims by *MatchingDonors.com.*

7. American Society of Transplant Surgeons, "Statement on Solicitation of Donor Organs, January 20, 2005."

8. American Society of Transplant Surgeons, "Statement on Directed Donation and Solicitation of Organs, October 23, 2006."

9. Quoted in R. Stein, "Search for Transplant Organs Becomes a Web Free-For-All," *Washington Post*, September 23, 2005, p. A1.

10. See, for example, C. Robertson, "Who is Really Harmed Anyway? The Problem of Soliciting Designated Organ Donations," *American Journal of Bioethics* 5 no. 4 (2005): 16-7.

11. L.F. Ross notes that some forms of complicated donations can hurt people on the list — when, for example, someone donates to the next suitable person on the list to gain preference for a cadaveric organ for their intended recipient. But those complications do not affect the argument here. See "The Ethical Limitations in Living Donor Transplantations," *Kennedy Institute of Ethics Journal* 16 (2006): 151-72.

12. D. Steinberg, "The Allocation of Organ Donations by Altruistic Strangers," *Annals of Internal Medicine* 145 (2006): 197-203.

13. C. Elliott, *A Philosophical Disease: Bioethics, Culture, and Identity* (New York: Routledge, 1999), chap. 6.

14. In research contexts, we use a similar standard. The risks of certain experiments are simply too high to allow persons to bear them, even if they are willing to do so. For a discussion, see for example, B.A. Brody, *The Ethics of Biomedical Research* (New York: Oxford University Press, 1998), chaps. 2, 6.

15. R. El-Galley et al., "Donor Nephrectomy: A Comparison of Techniques and Results of Open, Hand Assisted and Full Laparoscopic Nephrectomy," *Journal of Urology* 171 (2004): 40-3 and A. Breda et al., "Complications of Laparoscopic Living Donor Nephrectomy and Their Management: The UCLA Experience," *Urology* 69 (2007): 49-52.

16. I. Fehrman-Ekholm, "Living Donor Kidney Transplantation," *Transplantation Proceedings* 38 (2006): 2637-41.

17. The 2005 statement of the ASTS had this view. See note 7 above.

18. D. Hanto in Harvard Medical School Ethics Forum, "Soliciting Organs on the Internet," *Lahey Clinic Medical Ethics* (Fall 2005): 5-8.

19. What counts as the greatest need in this context is not, of course, a simple matter. It depends not only on who is most likely to die without a kidney, but also on who can survive the best and the longest with a kidney, who has been waiting the longest, and other factors that the UNOS system tries to capture.

20. M. Ignatieff, *The Needs of Strangers* (New York: Viking Books, 1984), 7-23.

21. G. Meilaender, "Gifts of the Body," *New Atlantis* 13 (2006): 25-35.

22. See N. Scheper-Huges, "The Tyranny of the Gift: Sacrificial Violence in Living Donor Transplants," *American Journal of Transplantation* 7 (2007): 507-11.

23. So Martin Zandt reports, based on an informal survey of his patients at the University of Rochester Medical Center.

24. This principle does not even allow the more nuanced view of Michael Gill and Robert Sade, who argue that we should allow donors to accept money, but not allow recipients to buy them. If the donors are allowed to control the process, then they should be able to get whatever money they like. See M. Gill and R. Sade, "Paying for Kidneys: The Case against Prohibition," *Kennedy Institute of Ethics Journal* 12 (2002): 17-45.

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