

AN EMBODIMENT CRITIQUE OF HUMAN
TISSUE MARKETS

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A thesis submitted in partial fulfillment of the
requirements for the degree of

MASTERS OF ARTS IN PHILOSOPHY

WASHINGTON STATE UNIVERSITY
Department of Philosophy

MAY 2009

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ACKNOWLEDGEMENT

Dr. Dan Holbrook instrumentally influenced the arguments used for supporting my thesis. He graciously listened to all my ideas and gave direct constructive criticism making my time with him somewhat bitter sweet. I chose Dr. Holbrook as my chair because I felt that if I could defend my embodiment thesis to a frank utilitarian, then I would be thoroughly prepared enough to defend it against other opposing theories.

Dr. Bill Kabasenche recommended many of the authors used in this paper and the discussions we had in his graduate level course lead to the thesis of this paper.

Dr. Mary Bloodsworth-Lugo not only influenced this paper but also inspired me to come to Washington State University. Due to the discussions we had in her office, I was able to articulate where my embodiment approach originates from and its necessary parameters. Finally, I would also like to thank Kathy James and Teri Mayfield for editing many portions of this paper.

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Abstract

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March 2009

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Working within embodied theories of the self and expanding upon our view of how humans perceive the sacrifice of human tissue donation, we may begin to understand how market systems with human organs victimize people. Embodiment descriptions of human perspectives from Sally Gadow and Helen Fielding are discussed. Gadow describes the body to patients as a lived body and Fielding defines the body as a medium and mean through which we engage with the world around us. Their theories of the human perspective shed new light on previous Marxist objections to human tissue markets. The embodiment theory has to have a strong sense of autonomy and the commodification of people inherently jeopardizes the autonomy of people. This thesis uses Lawrence Cohen's collection of perspectives offered by organ vendors in order to highlight the negative impacts of human tissue markets and the commodification of people. Using a form of care ethics and reciprocal justice to frame the embodiment theories, I argue that there is a moral difference between organ donation and organ vending.

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DEDICATION

I would like to thank a number of people in my life who have helped me become the kind of person and philosopher I am today. Without all of their support and inspiration I would have never had the confidence to advance in my education or write this thesis. Growing up in poverty with my brothers Jack Rosman and Luke Rosman, under the care of my mother Lana Rosman, has established powerful and unforgettable memories for me. Despite the constant pain and defensive mode of poverty, all three of you loved me, encouraged me, and reminded me to laugh when only tears would come. Therefore, I write this thesis in honor of all three of you.

There are many second parents I had in my life whom also influenced my optimism regarding this ethically challenging subject. They include my wise sister Kimberly Lewis, wild father Jack Lewis, concerned uncle Jerry Lewis, spiritually enlightened Pastor George Abrams, feminist Grandmother Betty Conklin, loving Grandfather Ernie Wilson, and the rational and forgiving couple who took care of me during my most determining years, Tom Capaul and Jennifer Pearson. It is because of the safety net that all of you provided for me that I am now a stubborn optimist for humanitarian ideals.

Finally, I would like to thank Kevin James for his unconditional support as my best friend and life partner. Throughout this process he has listened to my ideas and worries, and without his technical skills my computer would have robbed me of this thesis months ago.

CHAPTER ONE

INTRODUCTION

When we permanently take away something that belongs to the physical body of a healthy person and connect it into the body of a sick person, something more than therapeutic healing is occurring. The physical health of a healthy body is significantly jeopardized for another person. When this act is done out of love for someone they care about, it resembles similar heroic actions of a parent sacrificing something for their child. However, when this act is done between an individual in need of money and a wealthy person in need of a vital organ, it then becomes a new form of human exploitation. This thesis will use an embodied theory of a person as the foundation for an ethical approach to deciphering the moral difference between organ donation and organ vending. Rachel Kohen's theory of care ethics and justice is used in developing the lived body theory so it can provide concrete parameters and application for biotechnology in the practice of medicine. This thesis argues that embodiment theorists using care ethics and justice need to provide a firm boundary of protection for people before they are able to justify harming a person for the benefit of another person in regard to organ donation. This boundary does not allow for the commodification of people and thus does not support organ vending.

After the introduction, this thesis is divided into four main chapters. The embodiment approach used in this thesis comes from a feminist branch of phenomenology. Sally Gadow and Helen Fielding describe embodiment as a state and

space in which a person begins to consciously recognize oneself, articulate oneself, and engage with others. Embodiment theorists argue that given the fragile state of our medium, the human body, we should be protected from exploitation and unnecessary harm. The commodification of the human body jeopardizes people and their autonomy. There are several ways in which feminists have been trying to articulate the embodiment theory and some have called it an in-between space, a lived body, or a medium. However, the foundation of all of these theories argues that the body should not be perceived mechanically. Phenomenologists work tirelessly to break down the dualist description of a human body that has previously been used in hurting people, and quieting the many human perspectives that exist. Finally, this chapter addresses the way in which an ethicists working within an embodied theory can pull from systems of care and justice. By upholding reciprocal relationships, they are able to articulate care in a system that people can relate too and work with within bioethics

The third chapter investigates biocommerce and how it had originally arrived onto the American scene. This chapter begins by discussing all the various sought after human tissue in biotechnology, the types of organs and human tissue that sick patients wait to receive, the growing lengths of waitlists, and the grim outlook for most people on the waitlists. A distinction is made between people who need an organ or some other form of human tissue, and people who painfully desire an organ or human tissue. Given the feminist approach and the goals of medicine, this chapter argues that both groups of people should be cared for but that justice is needed to balance the different types of human needs with a strong sense of autonomy. Finally, this chapter argues that the seed

of biocommerce is our human desire to care for oneself and their loved ones. When analyzing the ways some people and American medical professionals have broken international laws, there is a connection between their actions and a vigilante approach to justice.

The fourth chapter is where the embodiment approach meets directly with the topic at hand, and discusses the distinct differences between organ donation and organ vending. The first section of this chapter expresses the problem with the “second step” when deciding on what pieces of your body you would sell and how much each piece of your body is worth. This type of commodification is only necessary in organ vending but not organ donation. Organ donation encompasses the embodiment perspective because when we donate an organ, both the people’s lives are considered *immeasurable* and worth protecting from both the donor’s perspective and the receiver’s perspective. Finally, this chapter argues that human tissue markets are inherently exploitive, and that all the immeasurable reasons for a donor to donate are lost when they begin to view themselves as nothing more than a tool for a wealthier person.

The fifth chapter addresses some dominant criticisms of the embodiment conclusions regarding human tissue markets. The first criticism attacks the feminist embodiment theory of autonomy and their “agenda” of taking away “the best option” for people in poverty to sell renewable resources and certain organs to release themselves out of debt. Second, how are embodiment theorists able to value any person’s life over another? Third, people in poverty already put their lives in more risky situations to repay their debt and organ vending may in fact be the least risky of all their options. Finally,

this chapter discusses two possible programs that were introduced by a proponent of human tissue markets. These programs could certainly be used by embodiment theorists to meet the needs of a majority of the people on the organ transplant lists without creating a market system of human tissue.

Embodiment theorists are developing a theory that can address the organ shortage but not reduce people to a mere bundle of spare parts for wealthier individuals. An embodiment theory is an ethical theory and will not reduce itself to a minimalist theory of addressing issues by throwing some money at the problem. It calls upon people to search their creative powers, their hearts, and values for an answer without victimizing other people. The embodiment theory is fairly new but it has the potential to address many ethical debates in a way that patients can again feel autonomous and whole. It is a theory that encourages people to voice their perspectives and seek solutions to their needs that does not commodify people.

CHAPTER TWO

EMBODIMENT THEORY

This chapter is the most ambitious of the chapters and strives to establish two generally agreed upon premises about the embodiment approach and how the theory can be used in bioethics. First, abstract definitions about people, such as the dualist distinction between the mind and body, may be helpful to scientists working towards a desired outcome. However, these definitions are not always as helpful in ethics because they are often times too abstract and unrelatable to the actual experience of people participating in the systems, the patients. People may “imagine” a world where their mind is separated from their body, but the world in which they engage in and participate within, is necessarily from a space that is both their body and their mind. Second, in order to relate to other people within the embodiment approach, we need to appreciate their perspectives. This paper uses Susan Sherwin’s lenses approach to talk about organ donor’s experiences and organ vendor’s experiences in a way that aims at not marginalizing or excluding the perspectives of others in similar situations.

A common approach for embodiment theorists applying their theory to bioethics is to use a structure of care and justice. There are two key principles for embodiment theorists designing an ethical system of care and justice. First, to care about people we must respond to the fragile human body as well as the fragile human perspective. This fragility calls upon us to be both creative and intelligent when designing an ethical system of behaviors that should happen or ought to happen. We should not simply make a statement of needs that exist in the world and then demand that those needs be met with

ways that would jeopardize the autonomy of all the people in the system. We need to find bioethical approaches that make supererogatory options only available for people who reciprocally care for each other. Hopefully, the strategy will be able to reasonably meet the medical needs of people as well as uphold the immeasurable value of all the people involved in the relationship. Second, the commodification of people tears at the autonomy of people, and breaks down the foundation of the embodiment theory by disassembling people. For example, if selling a piece of your body became an actual legal possibility, then people in need of money to support themselves are then obligated to some degree in that system to decide upon which piece of their body they are willing to sell and for what price. Third, embodiment theorists must hold firm the distinct boundary of a person's body from the bodies of other people. As this line becomes less distinct in bioethics, it becomes even more important for embodiment theorists to establish and protect it. This line provides the beginning value from which care and justice can be applied to bioethics.

Phenomenology

Phenomenology erupted onto the philosophical scene in the early 20th century with Edmund Husserl, Martin Heidegger, Jean-Paul Sartre, and Maurice Merleau-Ponty. There is some dissent as to what the study of phenomenology is and should be. However, there are some standard methods and they are described in the Stanford Encyclopedia as,

“(1) We describe a type of experience just as we find it in our own (past) experience. ... (2) We interpret a type of experience by relating it to relevant features of context. ... (3) We analyze the form of a type of experience. In the end, all the classical phenomenologists practiced

analysis of experience, factoring out notable features for further elaboration” (3).

Phenomenologists place a strong emphasis on the awareness of a person’s conscious state and the relationship between the person and the world around him/her. Specifically within Merleau-Ponty’s book Phenomenology of Perception he is especially dissatisfied with the mechanical explanations of a person and descriptive psychology. Merleau-Ponty writes, “I am not the outcome or the meeting-point of numerous casual agencies which determine my bodily or psychological make-up. I cannot conceive myself as nothing but a bit of the world, a mere object of biological, psychological, or sociological investigation” (ix). Merleau-Ponty is criticizing the unrelatable definition of a person’s perspective offered by the incomplete dualist definitions of a human being. Proponents of phenomenology dispute definitions that dissect the complexity of a person into what appears as a collection of scientific parts rather than parts *of* the self working together in constant movement. Although scientists recognize an organic whole (the human body), they tend to be unable to say much about how an individual relates to his/her own body and his/her placement of values in regards to their health.

Phenomenologists worry that dualist theories and scientific approaches are detrimental to the human experience because they threaten the voices and perspectives of the people they are supposed to be articulating. Merleau-Ponty explains this objection and writes, “Perception is not a science of the world, it is not even an act, a deliberate taking up of a position; it is the background from which all acts stand out, and is presupposed by them” (xi). Within phenomenology a person’s experience is essential

and therefore it should be valued. A person's conscious awareness and perspective of the world around her/him is the starting point of any form of knowledge.

Unearthing the complexity of our human condition and human perspectives, Bloodsworth-Lugo articulates the lived body theory by examining sexuality and race. In Bloodsworth-Lugo's book, In-Between Bodies she explains the lived body as follows, "The subject is neither a passive surface nor an active, unrestrained site. In this respect, the bodies at the center of feminist analyses of sexual difference are bodies as lived; that is, bodies that reside in-between nature and culture" (19). It would be an incomplete or lacking description at best to say that a person is purely the product of their biological functional needs expressing themselves in their given societal training and pressures. Within many cultures, words of gay, homosexual, bisexual, lesbian, and even queer emerge from the notion that they are strange and don't fit into *a* biological understanding of the body or society's physical pressure to be heterosexual. Furthermore, it is still unclear whether sexuality *is* biologically enforced. Bloodsworth-Lugo even uses the example of people with a male anatomy but think they are lesbians, although they do not meet the standard definition of a lesbian, they feel a sense of something the general society does not fully understand.

The space between our minds and our bodies is where all people *live*. Even people who *try* to follow the rules and do what they are told, seem to be *trying* to not live in the place that they are coming from. The body and the mind are intertwined in such a way that it is impossible to separate one from the other and expect that to be a person you are reduced merely to a brain in a vat or a pet learning new tricks from his or her culture.

We all live in a space that is embodied and when we reach out into the world we reach from a space that encompasses our body, culture, and mind. Given the many components and influences on the lived body, the lived body is thus a constantly fragile state always adapting to new influences. Given the fragility of our lived body, some embodiment theorists argue for ethical systems that strongly protect the autonomy of people. Currently basic human rights such as safe access to nourishment, housing, employment, protection from oppression, and the topic we are discussing in this paper, health care are being advocated for by feminists coming from many traditions of ethics. However, one consistent requirement with embodiment theorists is the inability to commodify people because that action requires people to view themselves as collection of parts.

A Feminist Approach to Global Bioethics

In Susan Sherwin's article, *Feminist Reflections on the Role of Theories in a Global Bioethics*, she explains some of the ways in which feminists may encounter problems in their approach when addressing biomedical ethical debates on a global scale. This essay tries to avoid many of the problems by following her commonly applied guidelines of using metaphors and moral theories as lenses. She argues that metaphors have a tendency to dismiss partially related issues or sentiments that people may feel towards the particular issues at hand. Despite the illumination metaphors may provide, there is a concern that by using metaphors we may accidentally overlook issues reflective of all individuals in their particular culture and/or values. Sherwin writes, "I recommend that we think of the "competing" theoretical options as a set of lenses available for

helping us understand the complex moral dimensions of bioethics. Lenses are readily switched when we want a different “view” of something; they may even be layered on top of one another” (23). This essay will use metaphors and moral theories as eye lenses which we should put on to better understand the group of people we wish to help and give a voice to. There are no Meta lenses that provide the “correct” perception for viewing other people’s perspectives. The lenses approach only gives us an opportunity to try and understand another person’s perspective.

We may need within our comprehension of biomedical issues in India a set of lenses which understands the state of poverty as a norm and one that often leads to hunger and death. Another set of lenses that may also need to be added to our glasses is their vegetarian values coming from their belief of an afterlife. If someone is trying to help the women of that country a second pair of lenses that show the specific type of gender roles that they are heavily indoctrinated into by their family members and legal status may be useful. These lenses are important for a Western philosopher if they wish to give a voice and a solution that is representative of people from an entirely different culture and socio-economic situation. Specifically, within Sherwin’s article she gives an example of how the Western view tends to perceive the body as a machine whereas Japanese or aboriginal people do not hold this conception of the body.

Sherwin also asks for a radical reuse of consequentialism and deontology. Sherwin acknowledges that there is a pull in ethics to rely on these moral theories because there is a value in each theory that is useful in even cross culture moral discussions. However, she argues that, “...none provides reliable grounds for resolving

all morally difficult problems through deductive application of its central principle” (21). Sherwin asks us to decipher if a particular rule, such as truth telling, is relevant in all situations. If we try and use competing theories like glasses to help us see all the moral questions involved in a particular moral debate, we may find that some are more useful than others.

The lenses approach allows for care ethicists, including embodiment theorists, to try and help people in other countries with a system that can assist them in meeting the needs of the people they wish to help without ostracizing people. If a woman in India lives her life in a constant state of poverty, controlled by her husband, and essentially uses all of the lenses described in this essay, she can still easily add another set of lenses which feels particularly relevant to her given her experiences. The lenses approach is designed to invite participants in the discussion and give all of their concerns a place to be voiced and acknowledged. There is an added sort of flexibility to answering global biomedical ethical questions when we value moral theories and religions, but find the more difficult task at hand trying to discover whether a particular guideline is appropriate within the specific context within which we are working. Sherwin’s lenses approach will be particularly useful when this paper applies care ethics to bioethical questions concerning human tissue.

Francis Kane, Grace Clement, and Mary Kane wrote the article *Live Kidney Donations and the Ethic of Care*. In their article they argue that impartiality may be applicable to cadaver donations but live kidney donations support community rather than impartiality because live kidney donations exist in a context of meaningful human

relationships. Their approach to this subject is very similar to the thesis offered in this paper. They write,

“Our methodology is, broadly speaking, phenomenological; that is, we try to render an account of the moral transactions found embedded in the practice of live donations. Though our purpose is, in part practical...in paying close attention to what donors and recipients say, we have been lead to the conclusion that the care framework captures, in a more coherent and comprehensive way, the moral situation of live kidney donations in addition to offering guidance for practitioners that is more attentive to the actual moral transactions embedded in them” (174).

The care ethic approach understands that live donors donate because their well being is significantly determined by the health of their loved one. If a person has kidney failure and their close relatives or friends offer a kidney, their friends commonly do so because his/her life directly impacts their loved one’s well being. The example the authors use is donations from a parent to a child. Typically most parents are forever scarred if they have to bury a child and when their child was ill many will exhibit the ailments of their sick child. A parent and a child are connected so tightly that to deny a parent the opportunity to donate to their child would counter the actual preexisting relationship. However, to make a moral requirement on all people to donate a kidney or some other form of their human tissue necessarily places people in a position that does not prioritize their being or their values. “The ethics of care makes sense of those differences because it locates our primary ethical responsibilities within relationships that are already established and responsibilities already accepted” (Kane et al. 181). However, whenever a person sacrifices their health for someone they love in care ethics the act is understood as a supererogatory act and not a morally required act.

Impartiality is attacked in care ethics with what is often referred to as the “Jellyby fallacy”. This originates from Charles Dickens Bleak House, and the notorious character Jellyby. She is described as suffering a moral hyperopia,

“...whose eyes “had the curious habit of seeming to look a long way off.” The children at her feet, by contrast, are horribly neglected. Without getting into details of the contemporary debate between what we have called impartiality and partiality, it seems evident that there is a circle of care, which widens out from our most intimate relationships. As care becomes diffused, it becomes less effective, and our responsibilities become less urgent. (Kane et al, 181)”

Intimate relationships in part require responsibilities that are not typically required upon strangers. Parents have a moral responsibility to feed, cloth, and nurture their children, whereas as the children’s aunt or uncle does not have to provide the primary burden of care for them. There is also a consequentialist motive lurking in the Jellyby fallacy.

When we feel connected to other people we tend to be more motivated to act and meet their needs as opposed to the needs of strangers. There is a feeling of powerlessness when people try and meet all the needs of the world. In care ethics in order to keep people motivated in providing positive changes, moral demands are primarily made upon our closest and intimate circles.

When care ethicists begin to look at moral theories as malleable towards global biomedical ethical debates, the serious concern and question that follows is: Where can the line be drawn, if it can, when employing a care ethic that encourages impartiality? Daryl Koehn addresses this question in the introduction of her book Rethinking Feminist Ethics and explains how care ethicists may find reasons for hurting the lives and safety of innocent bystanders when they only care for a limited number of people. Koehn articulates this slippery slope with the old Greek story of Persephone and her mother’s

(Demeter) revenge on the earth to bring her daughter back from Hades. Putting aside other rich discussions of Persephone's lack of voice in this story and focusing on Demeter's decisions and actions we can find a clear correlation between her actions and the actions of those who engage in human tissue markets. Koehn writes,

“Noddings and Gilligan either forgot or gloss over the fact that Demeter is so angered by the loss of her daughter that she attempts to kill all living things on the face of the earth in retaliation. Demeter is so convinced of the rightness of her own caring that she will brook no opposition to her will. ...To the extent that an ethic of care or empathy provides no incentive to self-reflection, the caregiver may easily slip into a self-righteous anger” (3).

In a similar way people who find justifications to take the vital organs of other human beings or use the wombs of others purely as a means to their end are manipulating care ethics in a way that could justify any horrendous act.

In addressing this slope, Koehn argues that we should empathetically relate to all those who seek justice for the atrocities against them. With the inclusion of justice in care ethics, the self righteous behavior of vigilantes to harm innocent people for their own ambitions would be examined in proportion to the needs of others and not justifiable in care ethics. This is, of course, a theory that has its challenges. Although in the end, it does not sanction violent acts against people who are forced and coerced due to oppression and poverty to cut their bodies up for strangers, or put their lives at risk by carrying the life of another whom they will never know once *their* purpose was served. Restricting harm done to other people for your own ambition is a direct consequence of the embodiments aim to protect the organic whole of people and their means of engaging with the world.

The demand for human organs does not make it morally justifiable to further perpetuate the victimization of impoverished societies. A person who is in need of an organ should be perceived as a victim: however, just because our bodies take destructive paths of their own does not give people the right to harm another person's chance at a long and healthy life. An embodied theory takes into consideration a fuller notion of a person and the theory is unable to objectify people in such a way, thus allowing a person to sell an organ to meet a capitalist notion of supply and demand. A person's organs and well being are forever intertwined in their infinite relationship. However, if a person freely donates a renewable human tissue such as hair or small amounts of blood, the infinite relationship can continue. Whereas when people donate vital organs and consequently lose their life, the relationship ends and thus is no longer infinite. The infinity of a person's life is only made possible in life and not in death. Endangering this relationship contradicts the very core of autonomy, human dignity, and reciprocity. We may all very well face hard times in our lives that may lead to our death, but in those desperate times we are not morally justified in violating the rights of others.

Medium Theory

When biotechnological descriptions of human bodies reflect a machine, they are not actually describing how humans generally perceive their bodies. Helen Fielding is concerned, as with other phenomenologists, that the mind/body dualism has suppressed the very essence of what it means to live in a conscious state that is intertwined within its body and interacting with its environment. Fielding writes,

“We are not yet at the point where we generally regard human bodies as storehouses of material that can be used for biotechnological systems: but we are certainly moving in that direction. Regarding human bodies in this way flattens the significance of our everyday lives, and hence of what is really at stake; the realm of what is possible is paradoxically reduced” (Fielding, 535).

A mechanical view of a body may argue that a hand is just a tool. However, when a woman looks at her hand, she feels more than just simple reflections of hot, cold, sharp, or soft. Depending on her lenses she may see that her hand is shaped liked her grandmother’s hand and feel close to her family or she may see her childhood scars from climbing trees and be reminded of her courageous spirit. Her body means more to her than any machine part. Machines cannot create a unique human perspective without a *human* designing the program. Fielding argues that the mechanical view of a human body is not representative of our true sentiments and it should not be used as a moral justification for biomedical ethicists to manipulate other people’s body parts.

Alternatively, Fielding offers the *medium* theory. Fielding partially draws her description of the medium from Merleau-Ponty’s cognitive perception and writes,

“What we learn from Merleau-Ponty is that the embodied subject does not merely make sense of the world through means of cognitive rational capacities; the subject gathers the world into a meaningful situation projected as an intentional arc which “brings about the unity of the senses, of intelligence, of sensibility, of motility” ... The bodily schema structures the body’s inherent openness to the world allowing the subject to grant creatively meaning to what is new from within the structures of what the subject has already incorporated.” (Fielding, 538)

A person’s perception of the world around her has meaning because she gives it meaning and she is unable to ever fully pull herself out and create a purely objective perception. Her medium or conscious state is always in motion but when the world only views *her* as a means she may actually believe that her desires, including protecting her own medium, is not a worthy ambition. However, Fielding as well as Merleau-Ponty, go on to explain

that although the world may try and have her embody a second class perspective, she will never fully be able to stop perceiving the world in her own way.

Conversely, if we then begin to see some groups of people as more important than other groups, and list some people as mere tools, we will adapt our perspective to that prejudicial status quo. Fielding writes, “Those of us who are privileged in the West have become used to seeing poverty in our own streets; it has become too easy to walk by outstretched hands, experiencing self-reproach, perhaps perceivable in our quickened pace. In the same way, we too adapt to the idea and to the practice of the sale of organs” (543). Instead of seeing outstretched hands of impoverished people asking for food, shelter, human rights, and honorable work, we see *lesser* people as undeserving of their basic needs or our attention, unless of course we want something from them. We begin to adapt to seeing them as already being less than human and argue that they should be happy with any sort of *assistance* the wealthier provide.

This sad state of affairs seems to find some support with the old saying that, “Beggars can’t be choosy”. A beggar can’t be choosy because he has no other choice. The choice of their future is put into the hands of those of who are in a *higher* position. This narrow view takes away the perception of those in need and easily describes them as machines. A machine cannot object because it is not physically able to and in a similar way, neither can impoverished people object when they are targeted for their organs or their wombs. The biotechnological way of defining the body creates a real threat towards a person’s autonomy, especially if we apply this sort of definition of a person as

the foundation for addressing biomedical ethical questions. Fielding specifically voices a concern with using this type of definition of the self to justify the sale of one's organs.

The medium has a delicate nature and because of this it is important to respect all the parts of the medium and not alienate any piece or deny any importance it may have within a person. A simple but reflective example of this delicate nature is the experience people have with donating their hair for charity organizations. An individual must first grow their hair out several inches. While their hair grows, many people form a bond with their own hair and it is not until they donate their hair that they feel a sense of loss with their hair being cut. People form bonds that become a part of their medium and those relationships may at first only be recognized within the subconscious level. However once the hair is gone, there is a sense that part of oneself is gone and the individual now has a series of emotions they are forced to choose from and reconcile. Hair may only be a human extremity of protein but it means something to people who have it and to people who don't have it. Human body parts and a woman's womb are significant components to being human and the description of them is equivocal to any market system of human goods that are designed by humans and produced from the "labor" of machines. Without our medium, we are nothing and eventually our measurements will reflect this bankrupt notion of the self.

Application of the Biomedical Embodiment Theory

In traditional bioethics literature, the anthologies designed for undergraduate biomedical ethical courses often refer to feminist ethics as an *alternative* ethical approach

for bioethicists and sometimes explain the foundation of feminist bioethics belonging to the early discussions of Carol Gilligan's care ethics work. The best-selling bioethics anthology with case studies is Biomedical Ethics, edited by Thomas Mappes and David Degrazia. Mappes and DeGrazia list feminist ethics in a subdominant category compiled of virtue ethics, reflective reasoning, and appeals to coherence and casuistry, which focuses on case-based reasoning. These alternative theories and methods have many overlapping approaches for the best way to serve the overall health and well being of patients.

Generally care ethicists argue that good medicine is different for different people and too contextualized for any one moral code to be the choice of all medical professionals with all of their patients. Simply explained, patients differ based on their environmental background, medical background, mental functions, life ambitions, and tolerance of pain. Medicine as well, varies greatly depending on the resources available for patients, patient's wealth, and current and/or approved medical procedures and medication. Therefore, there is no moral code or theory that can address all patients in the same way, without being too vague as to not be able to lay forth a medical plan, or too particular as to deny patients a plan that is *adaptable* to their needs.

Care ethical systems have been traditionally associated with the medical position of nurses. Mappes and DeGrazia reiterate this stereotype and write, "Thus, in bioethics, feminist ethics urges careful examination of the interests of women in matters of reproduction and as the almost exclusive participants in the profession of nursing" (32). In regards to their first claim, generally feminist do focus on issues of reproduction

because these matters can and do jeopardize the overall health of women. However, it is a mistake to narrowly presume that feminists are only worried about women in any ethical theory and even more negatively presumptuous to be of this opinion in regards to biomedical ethics. Feminists write on a variety of issues in biomedical ethics, including but not limited to end of life issues, health care access for people in poverty, traditional medical procedures that affect both mothers and the birth of their children, and the encouragement of patient's autonomy in medical regulations. Feminist are particularly attracted to the issue of autonomy because it is essential in the support of a patient's wishes to understand where their wishes are coming from and why they hold significance to their patients. Feminist biomedical ethicists try to rethink these issues and find solutions that uphold many different kinds of people given their unique situations.

The way that these unique situations are recognized and brought to light is with the nursing profession. Traditionally it has been nurses who gather information from their patients about their medical history, family medical history, and their desired outcome of visiting a doctor. Many times the nurses try to explain medical procedures or different medication options in terms that their patients can fully comprehend. In the medical field there tends to be several nurses who work with a primary physician or lead attendant. This plan is designed to save patients as well as the medical institutions time and money due to the limited number of physicians and the higher costs of hiring physicians as opposed to nurses. Given this situation, it is the nurses who are the most likely to remember their patient's names and stories. Conventionally the nurse is seen as a middle position serving both the patients and the doctor. However, as time changes, we

now have nurse practitioners who fulfill both the doctor's role and the nurse's role. Also, depending on your income level you might be able to afford one on one attention from a doctor and speak very little to nurses. Finally, there are now nursing programs that allow nurses to receive a doctorate in nursing. However, most nurses find their ethical obligation to their patients somewhat different than doctors because they are asked to get to know their patients and tend to their patients more attentively and advocate for their patient's desires to their attending physician.

The current condition of our medical institutions has intertwined nursing ethics and feminist ethics in a way as to have many nurses adopt the notion of embodiment. Sally Gadow, who was once a nurse practicing medicine, now writes on the way bioethicists should define the body. She argues that the body should be described as a *lived body*. Critiquing current scientific definitions of the body she writes,

“In effect, scientific language is inadequate for describing the subject's body because it is designed to express only a finite reality and finite meanings. As *self*, however – that which develops its own reality and meanings – the body is infinite. It is not of course, infinite *as object*, able to transcend space and time. Its infinity is the infinity of self, that which transcends fixed determinations.” (Gadow 96)

The body is not only an object which others can describe, but persons themselves also define their own bodies in their uniquely subjective way, a way that may or may not stay the same throughout their life time, and a way that others may not agree with. Therefore the self has an infinite set of relational possibilities at all moments in its lifetime. The definition of the self is not easily categorized into pieces and placed in a particular place or time.

The infinity of pure subjectivity is intertwined with an objectified self. Gadow writes, “The aesthetic relation can thus be characterized as a complex balance of form and freedom, in which both subject and object reciprocally affect and develop one another, the subject responding freely to the values expressed by the object.” (Gadow, 97)

The body, if life is extended long enough, will begin to take a different shape, as it once did before at youth. This change is not just significant at youth or older ages, but rather occurs throughout the lifetime of an individual, with a person’s self-determination stretching their genetic material to limits that another’s did not. An example of this is with identical twins. Within my own family we have several sets of identical twins and each set always has one twin that is more outspoken, has an abundant wealth of creative master plans, and that particular twin is always taller than his brother. Within the lived body theory, the body is determined by the internal dialogue it possesses, personal choices, society, and of course its biological makeup plays a role in this infinite relationship.

Gadow’s theory is differentiated from dualist arguments by urging this relationship not to be articulated negatively. However, unlike a traditional dualist, she does not believe that this relationship should be viewed as being at odds with each other, but rather as an object of aesthetic relation. Gadow eloquently writes,

“The subsequent level, which I term “cultural immediacy,” is the reuniting of self and body by the transcending of that struggle. ...They are mutually determining now in the positive sense of mutually enabling. The otherness which the self experiences as the (object) body is affirmed as necessary for the full development and articulation of the self and thus for the *reality* of the self.” (Gadow 91)

The reality of an individual is only realized when individuals begin to relate to themselves as a physical being transcended through an infinite conscious state of being. This is how people interact with the world and how a person relates to herself.

Sally Gadow's theory is not devoid of similar complications of Fielding's description of a medium. In fact, Gadow addresses these concerns in her early papers as well as within her present day papers. A lived body theory is not a simplified, dissected, and true by definition description of the human body. Despite dualist arguments being simple, they do not truly reflect the way people are and how they interact with the world. In Gadow's 2000 article, *Philosophy as Falling: Aiming for Grace*, she argues that post-dualists' writing within philosophy needs to be both, "rational and clear but sensuous and ambiguous" (Gadow, 89). Gadow recapturing Scarry's work writes, "Philosophical texts need to express not only the weightlessness of concepts but the solidarity of bodies, if it is to invite an understanding of embodiment without invoking dualism." (Gadow, 90) Gadow does not believe that the explanation of a human body should be simplified or even completely objectified into parts, especially within philosophical works. If philosophy begins only to define things scientifically, embodiment is lost and patients affected by policies influenced by bioethicists will no longer be represented and physicians will have no way to carry out the medical wishes of all their patients. Gadow uses examples from feminist philosophy to express how the patronizing voice of a woman's body does or should work, does not truly represent the way every woman feels about her body or wants to feel about her body. When bioethicists and doctors divorce the description of a woman's body from her actual experience with it, this only alienates

the woman from the system that is supposed to define and help her in *her* own goals. This alienation objectifies the woman's body into such an abstraction that the functionality of her ovaries or reproductive system seem to belong more to a gynecologist than to the patient herself. While acknowledging the presence of something more belonging only to the patient and the patient's perspective of herself, Gadow urges philosophical literature to account for both the objective criteria of biological systems and the patient's goals. Since it is the responsibility of both health care professionals and bioethicists to work *for* the patient, their definitions need to relate to the patient and represent the possibility, spectrum, and true sentiments of people.

In some ways the embodiment theory is limited within medicine, particularly with mental illnesses that can *control* a patient's reasoning functions. For example, if perhaps there is a patient who is anorexic and on the verge of killing herself by not eating, she may wish that the people around her and her doctor would *help* her lose weight. However, a rational doctor and caring loved one would not want to help her in her particular ambition of losing more weight. The embodiment theory *seems* to be at risk of being manipulated by these vulnerable patients and puts their lives more at risk when there are no exact moral codes to follow in medicine. However, given that the embodiment theory does not support patronizing medical professionals, in a similar way it would not support the life threatening ambitions of mental and medical diseases. Admittedly these types of situations present a grey area when applying embodiment theories to medical procedures. Unlike unquestionable medical codes, the patients are

asked to be a part of the discussion and a medical plan that is partially designed by the patient is put into action.

In medicine it is not *simply* the patient's physical body that should be supported but also the aspirations and desires the patient intertwines within their body and expresses with the world around them. Anne Reichold explains how moral descriptions of people are incomplete and their considerations of the ethical dilemmas are lacking, at best, when people are not encouraged to respond towards their vulnerability and fragility. Reichold stresses this point and writes,

“The phenomenological approach to embodiment avoids the dualist gap between mind and body, and thus reflects embodiment as an integrated concept of mental and physical ascriptions. ...in ethics the embodied nature of persons opens up the conceptual frame of suffering, acting and responsibility that makes ethical questions and answers possible.”
(Reichold, 170)

The embodiment theory is not an obstacle for patients but rather a tool or way for them to genuinely express themselves. It can be used by medical professionals when they are trying to understand their patients perspectives, ambitions, and how medical technology can best serve all of the needs of their patient's. The embodiment theory has significantly impacted nursing ethics and the way nurses help patients in their job duties.

CHAPTER THREE

HUMAN TISSUE

This chapter has two main objectives for setting up the embodiment critique of human tissue markets. First, in a historical context it will explain how medicine evolved to depend on human tissue in new ways that erupted into biocommerce. Second, it will show how the need and desire for human tissue drove many of the preexisting policies regarding organ vending and the negative and inconsistent consequences in policies that followed.

The Rise of Biocommerce

In America during the 1960's many things happened on a nationally recognized scale regarding human rights. Included among the many historical events was the Presidential Commission on the Status of Women. This commission found that women were discriminated against in both the workplace and in government. Also at this time the Civil Rights movement was in full force and Martin Luther King delivered our country's course changing speech, "I Have a Dream". Human rights were being expanded to include oppressed people in our society and how to implement the rights was being discussed from coast to coast. However, as human rights expanded to include all Americans regardless of their gender or ethnic heritage, a new set of human concerns was beginning that would eventually affect people on a global scale. When biomedical ethicists discuss the significance of the 1960's, they tend to focus heavily on birth control pills being accessible to women and the sexual revolution that followed. However,

biotechnology was advancing at a rapid pace in many areas of medicine and in 1963 a sibling kidney donation took place because Ruth Phillips had made the initiative to contact her brother's doctor and offer her kidney to her brother Robert Phillips, who was dying of kidney failure (Altman 1). Initially the surgery was considered highly experimental and Mr. Phillips was only hoping for "two good years" but he became the longest surviving kidney recipient in the world.

There are many significant things that occurred due to this successful transfer. First, organ donation began to transition from being considered an experimental procedure to a therapeutic procedure. Soon, the drug cyclosporine would finalize this transition, making it possible to suppress a recipient's immune system. Second, given the successful transfer between siblings, doctor's medically speculated on the other types of donations and donor pools that would be possible. Initially, the only successful organ transplantation that had prolonged the life of the recipient for a significant amount of time (2 years) happened in 1954 when a man received a kidney from his twin brother. However, now the donor pool was expanded to include family members and medical debates began to include the realization that a donor could potentially be a genetic stranger.¹ The donor pool was expanded to included chimpanzees when a "dying man" was given a chimpanzee's heart at the University of Mississippi's Medical Center. The individual's name was never released but he is known by the medical community and the

¹ Organ transplant surgeries have been documented from as early as the 18th century. However, during many of the early surgeries there was little knowledge of what particular organ's functions were or even where they belong in the human anatomy. Examples of this are transplants that occurred in France in the year of 1906 when, "...doctors performed about 40 kidney transplants, but all the patients died. In some early transplants, the donor kidney was placed not in the pelvis, as is now standard practice, but in areas like the arm or thigh" (Altman, 1). Out of respect for the knowledge that thorough doctors gained before operating on a person I will refrain from discussing transplants that resemble morbid human curiosity more than a life saving feasible option for a sick patient.

media as a ‘dying man’ who received a chimpanzee’s heart that beat for 90 minutes (UMMC, 1).

The medical community realized that any organ could be a potential donation and the donor pool could include family members, strangers, and other species. Much needed debate needed to follow and guidelines on how to receive full consent should have come before putting medical theories into practice. Unfortunately, this was not the case and human bodies were beginning to be thought of as ‘gold mines’ from a market perception. Because of this many medical doctors violated the rights of their patients and even many United States government officials used a dualistic theory of the human body to resolve the legal battles that followed.

One of the scandalous situations that followed was when Dr. David Golde decided to ‘secretly’ extract his patient, John Moore’s blood, and other cell tissue to patent the tissue and make drugs from the tissue. John Moore had survived Hairy Sickle Cell Leukemia and it was hoped that his antibodies created from surviving the disease could be used in research and/or created to make new kinds of medicine for people battling the disease. Dr. David Golde never gave John Moore the opportunity to donate them on his own because Dr. David Golde wanted to be the “owner” of the antibody. Consequently, Dr. David Golde lied to his patient and asked John Moore to fly from his home in Seattle Washington to Los Angeles California to “take some more tests”. John Moore became suspicious and after his lawyer did some research he found that his client’s body tissue had become patent 4,438,042. Moore felt betrayed that his own doctor would sell his body parts without his consent. Lori Andrews and Dorothy Nelkin

describe Moore's feelings and thoughts and write, "Moore at first reacted with disbelief. Then as he thought more about what had happened, he felt "violated for dollars," "invaded," "raped". His body had been appropriated without his knowledge or his consent"(28). Moore also felt outraged that his doctor would lie to him about prescribed "medical procedures" without fully disclosing their purposes.

When Moore decided to sue his former doctor Mr. Golde, the courts themselves were not prepared to handle that kind of case. The first trial judge for the case threw it out because it was so unusual. However, eventually the case made its way to the California Supreme Court where in many ways their ruling revictimized John Moore. The court denied Mr. Moore property rights over his body but argued that his patient's rights were infringed upon. From a logical analysis it is unclear how you could justify patient's rights only in the presence of a doctor but argue that in any other part of their treatment their body is not protected. Despite their flawed reasoning this was the court's ruling. Andrews and Nelkin explain the judges ruling and write,

"There the justices were deeply divided. Each wrote eloquently about the meaning of the body; some described it as a sacred temple, others as a biomedical factory. ...A majority of the justices, for differing reasons, finally rejected Moore's claim to have a property interest in his body. Even though the law in many ways was on his side, the justices seemed swayed by the heady promise of biotechnology. They didn't want to slow down research by universities or biotechnology companies. They described researchers in general as "innocent parties" engaged in socially useful activities, who have no reason to believe that their use of a particular cell sample might be against a donor's wishes. (29)"

In the justices ruling there are many things that do not represent the ambitions of patients or our society's culture in general. First, where is their definition of innocent coming from? Innocent parties are not driven to control majority shares in companies or patents,

and if they were driven for selfish ambitions they should have lost the title “innocent” when they used their work title as a means to make other people contribute to *their* profits without their consent. Second, how did the doctor know the donor’s wishes if he never asked the donor what their wishes are? There was more than negligence at play given that the physician was having his patient fly to other cities for “treatments”. Third, anytime someone lies to someone else and does not receive consent for taking away something that belongs to another person, it is considered stealing. Just because the substance stolen is renewable, such as an antibody, does not mean that it is no longer stealing. When a gardener plants pumpkins in her front yard because they get the best sunlight there and when she has produces such a large crop that she loses count, it is still considered stealing for the neighbors to take some pumpkins without her consent. She can produce more pumpkins with the seeds from her other pumpkins on the vine: however, that does not mean that some pumpkins have not been stolen from her. People who extract tissue cells from other people are stealing and just because they may be doctors with supposed good intentions it does not change the act of stealing into some other verb.

Some may argue that John Moore had no intellectual property claims of his antibody and aside from deception he was not really violated. At least not violated or exploited to the extreme of rape. However, if a woman was sleeping in her bedroom and a rapist came in her bedroom, drugged her so that she would never know that she was raped, the rapist used many forms of “protection” to avoid the transmission of diseases, and the victim was placed back in a position where she would never know that she was

raped, can we still define this person as a victim? Not being considered extremist, most people would say yes, the person should still be considered a victim. The victim did not give consent to their body being used in that way for the means of another person. Also, the theory that we have to have intellectual property claims to reject the advances of other people's ambitions is not generally agreed upon in bioethics. When consent becomes questionable we no longer consider their participation in the study ethical. For example, bioethicists no longer support using psychiatric hospitals as an "ethical pool" of test subjects. In a similar way John Moore has moral rights to his body and to protect his body from the uses of others, even if he does not consciously know all the possibilities of his body.

There are three ways that the court's ruling qualifies as exploitation from an embodiment perspective. First, John Moore's body is not a tool for other people's bodies. John Moore's body *is* John Moore's medium through which he interacts with the world. Second, when Moore learned that others are willing to steal pieces of his body for a profit, he learned that his body had been exploited by a person sworn to protect him. In the structure of care ethics harm to a person can potentially be morally justifiable, only if it is openly consented for, understood as a supererogatory act, and exists in a mutually agreed upon relationship of trust and responsibilities. Dr. Golde violated John Moore's trust, neglected his well being, and never received full consent. The judges argued that researchers in biotechnology are "innocent" because they are only behaving like Good Samaritans and to simply "waste" human tissue that could benefit humanity was unfair to humanity. However, the criteria for being a Good Samaritan depends on all the

consequences produced. Moore's loss of security is not a good consequence and the increased vulnerable state of patients is also not a good consequence. The Good Samaritan clause is intended to protect general citizens in their right to deliver some perceived life saving treatments such as CPR without being sued from unforeseeable damage or unintended damage. However, when a doctor lies to a patient they are inevitably creating a negative outcome of distrust between the patient and the doctor. Lying doctors are intentionally creating harm to their patients wellbeing and trust with the medical profession.

Third, consent and choices were never made available to John Moore when they could have been and thus Dr. Golde's actions are not morally justifiable from an embodiment perspective. Dr. Golde never explained to John Moore the ways his body could help save the lives of others who suffer from Hairy Sickle Cell Leukemia. Perhaps John Moore would not have wanted to "sell" his antibodies but instead "donate" them to people. Dr. Golde did not know how his patient would respond and disregarded his patient's voice for his own financial gain.

Unfortunately, this was not a rare ruling to take place in America. As promised, precedent law can recreate bad rulings just as it can recreate good rulings, and several similar cases and rulings followed. "John Moore is now a growing number of individuals whose cell lines you can order up by perusing the American Type Culture Collection or one of its foreign counterparts. ...Thousands of individuals are listed, but it is doubtful that more than a handful of them or their families realize that they are part of this elite market" (Andrews and Nelkin 31). One family that does realize what happened is the

family of Henrietta Lacks. She was an African American woman who died of ovarian cancer in 1951. Currently you can still buy her cells, but it comes with a bearing on your conscience. “In a recent interview, her husband said, “As far as them selling my wife’s cells without my knowledge and making a profit-I don’t like it at all. They are exploiting both of us”(Andrews and Nelkin 33). In my opinion, this is how the general public perceives taking body parts from sick patients, lying to the victim and their families, and selling stolen body parts to make a large profit.

In the end, whether or not you believe that the embodiment approach is the theory we should take in ethical debates regarding human tissue, we should all agree that the *medical community as a whole* needs to be a place where patients feel safe and respected. Medical professionals and researchers should not have a right to steal pieces of a person’s body and use it as a means for an outcome they desire. Even the strictest of consequentialists can see the outcome of such a system to be counterproductive. If patients do not feel safe in the presence of a doctor or don’t feel that a medical community will look out for their interests, they will simply not seek medical attention or be open with sharing the details of their situation given their legitimate fear of going to a medical building. Society tends to argue that it is morally unacceptable to exploit people, and it should be consistent to determine that we should not find it morally acceptable to exploit sick patients. Society’s perspective of doctors has already suffered due to these cases, and it is important to not repeat the same mistakes of our past.

The Current Need for Human Tissue

In the United States there are currently 101,221 people on the waiting list to receive an organ and of those on the waitlist 78,881 are waiting to receive a kidney (OPTN). In the year of 2008 only 27,958 people received a transplant.² Their new organ may have come from a live donor or a cadaver. The odds of an individual receiving an organ are less than 1 out of 5 people and of those who do receive an organ their body may reject the organ. The waitlist in America grows each year for various controversial reasons that are beyond the traditional health factors such as kidney failure, pancreatic cancer, or heart disease. The list itself is argued to be growing because doctors are able to increase the life span of a sick patient and increase the amount of years average people live. Citing the grim outlook, Renee Fox and Judith Swazey write,

“As organ grafts and their success rates have increased, so too has “competition” for patients at the growing number of transplant centers, “with older and older and sicker and sicker patients ...now considered ‘suitable’ candidates (Annas 1988, p.621) Concomitantly, as the volume of patients on waiting lists steadily expands, the number of cadaveric organ donors in the United States has plateaued at about 4,000 persons a year for the past 3 years (Peters 1991, p. 1302)” (8).

Some have even argued that as the safety of vehicles increases, helmet laws enacted, and other safety measures put into law, the life expectancy for younger more optimal donors is increased. However, the important piece of information for this paper is that there are many people who need a vital organ and that the largest need for a particular organ is the kidney. The kidney is the organ that is usually advocated to be something people could sell because in the United States it is generally safe to remove a kidney from a live donor.

² This number was pulled from OPTN on March 16, 2009 at 2:40 and it is updated everyday.

One of the activities designed to offset the need for human tissue in America is the United States Department of Health and Human Services public information web sites. On one site they categorize four types of human tissue that can be donated by live or deceased human donor. Organs are listed as the first category. The organs that can be retrieved from a live donor in the United States include a kidney, part of the pancreas, part of a lung, part of the liver and part of the intestine. However, within hours of dying an individual is able to donate the entirety of their organs previously listed as well as their heart and liver. Tissue is listed as the second category and this category includes, “Corneas, the middle ear, skin, heart valves, bone, veins, cartilage, tendons, and ligaments ... (Organ Donor). The third category is Stem Cells and they include bone marrow, peripheral blood stem cells, and cord blood stem cells. Healthy adults between the ages of 18 to 20 can donate stem cells. The final category is Blood and Platelets. Live donors can donate blood every 56 days and platelets 24 times a year.

An interesting thing to note from the government online help tools for human tissue donation, is that the page does not list some of the more controversial legalized human tissue that can be donated in America such as eggs or sperm. Nor does the site mention the availability to “donate” your womb to a prospective parent or parents and share your body with “their” offspring. There is a sort of inconsistency specifically within America regarding the “compensation” offered for these more controversial types

of human tissue that can be donated. Depending on your education level, height, and other sort of skills your ova or sperm may be worth more than your sisters or friend.³

The necessity of human tissue seems to be categorized by two different kinds of needs. In this paper the first category will be referred to as the Need (N) Category and the second category will be referred to as the Painfully Desire (PD) Category. The N Category includes people who need a specific kind of human tissue to preserve their life in order to live a “normal” lifespan. The PD Category includes people who painfully desire a particular kind of human tissue to enhance their life. For example, a person may have the desire to have a child of their own genetic articulation and require an egg or a sperm to complete the process, or some potential parents may need to have a woman carry an embryo to term to have a child.⁴ The desire to reproduce may be rooted in a person’s biological clock or family and social expectations. The desire may bring them a significant amount of emotional and physical pain not to have a child of *their own*. The painful and real desire to have a child of their own can be endured for the rest of their life because their physical life is not at risk. Given this, we generally would classify desperate parents to be as belonging to the PD Category. Whereas someone who needs a heart transplant will have their life shortened if they do not receive a transplant and will be unable to endure anything once they have died. People waiting to receive a heart transplant are considered to be a part of the N Category.

³ Some may argue that eggs and sperm are not considered “transplant” material in the same sense as bone marrow or organs. However, reproductive cells are donated with the intention to be implanted in a person in order to produce a child or as regenerative cells as with the case of stem cells.

⁴ There are many different possible scenarios where parts of another person’s reproductive system are required for an individual or individuals to create a child.

Arguably it would be inconsiderate and inconsistent for the medical community to deny the needs of people who painfully desire something but treat all other forms of physical pain. Anytime people are in pain they seek relief from their doctors and the biological pain to have a child could be argued as similar to other physical kinds of pain physicians typically treat. There tends to be two different kinds of remedies for the PD Category. First, the person in pain has to work through their emotional grief with prescriptions and/or counseling from professionals or trusted loved ones. The person has to play a psychological role in alleviating their own pain. This may be done in a number of ways including closure or choosing to focus on other ambitions in their life. Second, sometimes human tissue from *other* human beings is sometimes *used* to remedy their pain. From an embodiment perspective of care ethics the PD Category of people should not be neglected.

The care ethics approach only allows for an intimate use of your body to be used with intimate people in your life because in these times we make ourselves extremely vulnerable emotionally and physically. Given the foundation of embodiment and the frame work of care ethics, actions similar to donating your womb or reproductive tissue, should only be done within already established close relationships of reciprocal care. In all situations the action has to be perceived as supererogatory. Some supererogatory acts could also be morally possible with a care ethics approach. One morally possible example is when a person freely chooses to be a surrogate mother for a relative or close friend. The birth mother as well as the future parent of the child can both benefit and be harmed by the good and bad consequences of the pregnancy. When the birth mom feels

pain the future parent will also report an empathetic feeling of pain not just because they influenced the person's pain but because their wellbeing is already closely tied.

However, if/or when a child is born they both tend to enjoy the gift of life they created and enjoy getting to know and develop the new family member together. This starkly contrasts the market relationship potential parents have with surrogate mothers for hire. Potential parents can seek cheaper surrogate mothers by viewing them as exploitable and potential parents are not directly concerned with the care of the surrogate mother beyond the birth of "their" child. When surrogacy is marketed and purchased it is necessarily considered exploitable by the participants. Embodiment theorists argue that the needs of people in any category should be addressed but in a way that *fully* respects a donor's autonomy and does not treat anybody's body as a marketable good. Perhaps surrogacy could be considered morally possible as a supererogatory act between already existing intimate relationships. However, it should not be considered a marketable "good" by care ethicists working within an embodiment approach.

Setting aside the discussion of reproductive donation, the final consideration that needs to be addressed is that given a person's financial and living situation, their request may be placed in a different category than someone else. Using Sherwin's lenses approach, we can see that depending on where a person lives may dictate whether or not they need a kidney to live. If the person is an American the federal government pays eighty percent of their kidney dialysis treatment and most health care insurances will pick up a majority of their treatment after the government. The life expectancy is unknown for people on kidney dialysis, but the National Kidney Foundation states that, "We do not yet

know how long patients on dialysis will live. We think that some dialysis patients may live as long as people without kidney failure”. Currently there are some Americans who have lived on kidney dialysis for more than thirty years and share their story on the kidney dialysis web site. So the prognosis of surviving kidney failure and living a long life is expected, but the life they live has a strict diet, planning before they take trips, co pay expenses, and sometimes the kidney dialysis treatment itself can be painful for a patient. Arguably an American who is in this situation could be considered to be a member of the PD Category rather than the N Category.⁵ However, if you are a poor citizen of India and have a kidney disease, your government will not pay for any portion of a kidney dialysis treatment and most poor Indian citizens will not receive any kidney dialysis treatment because they cannot afford it. Consequently, a healthy kidney is very important to your survival. There is no medical safety net for impoverished Indian citizens and worst of all they are the kinds of people being targeted to sell their only natural safety net, their spare kidney.

The Seed of Biocommerce and the Vendors That Grew From It

The seed of any commercial industry begins with a human desire. The early desire in biocommerce came from people who wanted to find a new way to stay alive or help their loved one stay alive. Steve Calandrillo who is an associate professor of the University of Washington Law School is a strong advocate for what he calls “cash incentives” to increase the donor pool for human organs. Calandrillo’s general argument

⁵ This depends also on the functioning level of your kidney. If you are an American with kidney failure and your kidney is only functioning at or below 10% then you do belong in the N Category. However, this is not the situation of the majority of Americans on the kidney transplant list.

pulls upon the conscience of society with staggering numbers of people without a good outcome. Calandrillo writes,

“A 1999 study showed that 81% of Americans support the concept of voluntary organ donation. However, Americans have yet to match their ideals with their actions, as only about one-quarter have actually signed up as register donors...Every 13 minutes, a new name is added to the United States’ National Transplant list. On average, 17 patients die every day while awaiting an organ – one person every 85 minutes”(83).

With such a grim diagnosis for sick patients many feel that they are compelled to be the cause of some new forms of harm to other people in order to stay alive. If it was not for their dire situation they would never make such a demand on society. It is not the optimal situation to receive an organ from a non-related donor simply because the success rate of a body keeping the organ is lower, the recovery for the sick patient’s body is slower, and the person usually has a longer amount of time they must use the expensive drug Cyclosporine.

Despite breaking international laws and the non optimal medical outcome of a non related donor, some sick patients have continued in their desperate plan to save their lives and *bought* pieces of organs or whole organs in black markets and foreign legalized markets. Calandrillo refers to people who search for organs in the black market as a “last ditch effort” and because so many are resorting to their last option their now exist several thriving black markets and only a few legalized markets. Calandrillo again pulls from accredited statistical research and writes,

“It is illegal in nearly all developed nations to sell or buy a human organ-only in Iran and Pakistan is there a legal market. Nevertheless, many other countries, including Israel, India, South Africa, Turkey, China, Russia, Iraq, Argentina, and Brazil do not stringently enforce laws prohibiting the sale and purchase of organs. ...In fact, three hundred Americans travel abroad each year to buy a human organ, usually kidneys” (86).

He goes on further to discuss that not all hospitals in America are innocent in upholding the United States Laws as some organ brokers know of hospitals that have a “don’t ask, don’t tell” policy when foreign organ donors are involved. These hospitals allow for Americans to bring their foreign donor to America and have the surgery done here. Also in America boarder patrols are finding illegal aliens coming specifically to America to make some quick cash by selling one of their kidneys to an American citizen. A black market does exist in America and they are partially being facilitated by our medical professionals and policy makers.

The United States government has so far only legalized some human tissue that is regenerated in a person’s body to be “compensated” for and received by the “donor”. However, third parties are allowed to sell the human tissue they accumulate. A donor who is compensated is sometimes referred to as a vendor, because the market laws of supply and demand heavily influences the compensation the vendor receives, as opposed to the “time” and “trouble” the donor experiences. The compensation price has to be high enough to entice vendors and low enough for sick people and researchers to afford. Given this flexibility, the price varies in America for human tissue depending on what human tissue is being compensated for and where the center that is providing this service is located. Given this state of affairs, there is a trend in the United States to not refer to people who utilize compensation enticement programs as donators but rather to refer to them as vendors. Much of the current literature in support of and opposed to legalizing human tissue markets, refer to compensated donors as vendors.

The United States government has allowed for third parties to set the prices and market the goods received. Similar rulings exist in the United States specifically within the context of pornography. In most states of America, prostitution is not legalized. However, if a third party records you having sex you can be legally paid for prostituting your body. In a similar way, the United States introduced a middle man policy in regards to human tissue markets. For example, you can only be “compensated” for plasma if it is retrieved by a certified third party who then turns around and sells the plasma to medical professionals. Although no one is tapping the violent act against their body, the third party does set the price for bodily fluids, markets the fluids, and sets the atmosphere where the transaction takes place. It is unclear why the government allows morally questionable actions when a third party, who profits from the transaction is introduced but the marketed person is not allowed to directly sell their plasma to the sources that need it. Either way, the embodiment approach again does not morally condone the commodification of people and by taking a person’s voice out of the “negotiation” of the process by introducing a third party, further harm seems to follow.

The seed of biocommerce begins with a person trying anything to save their life. That person reaches into their pockets and puts a price on their life by offering money to another individual in hopes that they will find their ambitions and life *only* worth the amount of money he or she has was offered. However, in any market goods tend to be moved faster when the supplier needs money. They lower the prices of their goods and make themselves available. Organ vendors in the black market resembled other goods in the black market in this respect. Organ vendors tend to be very eager to earn money in

any way they can, but not optimistic about breaking the laws, putting their life in danger, or altering their bodies. In chapter four this discussion of organ vendors will continue and the actual perspectives of organ vendors in third world countries will be expressed and examined in light of the embodiment theory. Nevertheless, it is widely agreed that vendors exist in all countries whether or not their actions are sanctioned by the governments' laws. Vendors exist because there is a need and sometimes people are willing to break the laws of their country when they feel it is worthwhile or a last resort to save their lives.

CHAPTER FOUR

AN EMBODIMENT APPROACH TO THIS MORAL DILEMMA

This chapter focuses on the reasons why embodiment theorists and care ethicists argue against the commodification of people. In correspondence with the embodiment argument that people do not perceive their body as abstract as dualists claim, this chapter draws upon people's experiences and perspectives of organ vending to legitimize the emotional harm done in human tissue markets.

The Second Step in Organ Vending

In the case of Ruth Phillips she read a story that inspired her with an idea to save some part of her brother's life. She loved her brother, she loved the time that she spent with him, and she loved her brother's source of all of these gifts, his life. Up until the point of reading the newspaper article she perhaps thought that the only way to love her brother was to care for him until he passed away. Yet, the human spirit does not always fall victim to the painful consequences of a frail body. Ruth Phillips love for her brother persevered even after her brother's doctor recommended that she not donate her kidney. She kept trying to find a doctor who would assist her in her idea. Ruth and Robert's story has a very happy ending because Ruth was able to save her brother's life. However, what would have happened if she was not a good match to donate her kidney to her brother and neither were the rest of their family members? Would she have sought help from her friends and if they didn't receive her request with the same enthusiasm would she go up

to strangers and flash some cash to find a matching donor? Why would it be that when Ruth Phillips went to strangers and tried to buy human flesh for something she was willing to do herself, that all of a sudden she was doing a morally offensive act? After all, we ask our military to put their lives at risk to enjoy more freedom in our own lives.

The answer to this question for most ethicists is found in the additional step required for an organ vendor, the commodification of people. Organ donors are considered to be acting from an altruistic motive. It is a sort of instantaneous feeling inside most people to help save the lives of their loved ones. Renee Fox and Judith Swazey elaborate on the sort of altruistic feelings a person feels and writes,

“The integrity, intimacy, and generosity of the family and each of its members are involved in their individual and collective willingness to give of themselves to a terminally ill relative in this supreme, life-sustaining way. So compelling is this act, in which so much is at stake, that “the majority” of live donors make an “immediate decision” to offer their kidney “upon hearing of the need, without rumination or further investigation. ... (33)”

From an embodiment perspective some might argue that the person has embodied their loved one in such a way that when their loved one feels pain they also feel pain, a pain that is not fully described by the words sympathy or even empathy. They literally feel pain simply because their loved one is in pain and any suggestion to alleviate their loved one’s pain would also relieve the pain they share with their loved one. However, if you are to accept the embodiment explanation it again becomes unclear that altruism can be an accurate description of a donor’s motive if the donor’s pain will also be eased. From an embodiment perspective it is not necessarily an altruistic desire that motivates a person to donate their organ but a form of self care.

For this reason it is best from an embodiment perspective to describe the donor's act as a supererogatory act. David Heyd explains a supererogatory act and writes,

“Supererogation is the technical term for the class of actions that go “beyond the call of duty.” Roughly speaking, supererogatory acts are morally good although not (strictly) required. ...The Latin etymology of “supererogation” is paying out more than is due (*super-erogare*), and the term first appears in the Latin version of the New Testament in the parable of the Good Samaritan. Although we often believe that Good Samaritanism is praiseworthy and non-obligatory at the same time, philosophical reflection raises the question whether there can be any morally good actions that are not morally required, and even if there are such actions, how come they are optional or supererogatory?”(Heyd).

The potential donor embodies the pain of their loved one and knows that she can choose from a variety of morally acceptable actions that would alleviate some of her loved one's suffering and hers. She can choose to care for her loved one by helping that person get to their doctors appointments, making sure all their medication is taken on time, or just making sure the last days of their life is comfortable. However, a potential donor *chooses* to put their own life at risk with surgery, potential death, and life changing consequences.⁶ Typically we do not advocate procedures that may cause serious harm to moral agents. Yet, in the case of a supererogatory act we make an exception because the act is redeemed by the donor's respect for their life and the life of their loved one.

What distinguishes a vendor from these situations is that vendors do not embody the needs of the recipient and they do not offer an organ because it is the best choice for the sick person who would be benefiting from their organ. They do it because the sick person is offering them money for a piece of their body. At this point the donor *has* to decide how much a piece of her body is worth and what pieces she is willing to sell.⁷ She

⁶ One kind of potential life altering consequence is that depending on the human tissue you donate it may be highly recommended to not get pregnant afterwards.

⁷ Some have even compared organ vending to similar acts such as prostitution.

has to do something so foreign as to literally put a price on her body, be naked for strangers to cut apart and take what they like, and be left with permanent scars to remind herself that she can be bought. This second step is something the organ donor never has to do. The organ donor never puts a price on herself and she does not perceive her life force as something others can pick at and buy when she is having a hard time in her life.

Personally, growing up in a childhood where I saw my mother treated very different by “good people” when we were having a hard time paying our bills compared to when we were financially independent, is an emotional wound that does not heal with money. This powerful emotional scar is not something people of poverty forget easily or at all. When people have money, education, and a form of power we see jobs only befitting to them that a “respectable” person would do. However, when the person loses their job, has a hard time finding housing, and her judgments become questionable it is quite common for people to see her as someone “willing” to service *their* degrading desires and/or needs. Not only do the caregivers bear the emotional and/or permanent scars but the children are taught from experience that if you are poor and down on your luck, the rest of the world sees you as less than them and “willing” to be abused for their benefit.

The Lack of Consent

It then becomes unclear whether or not it is possible for any form of consent when people have a lack of legal rights or security in their lives. Even a consequentialist such as John Stuart Mill recognized that when consent is coerced it is not really a full consent

that is given, merely a preference over one bad option compared to another bad option.

In The Subjection of Women Mill writes,

“The Church, indeed, was so far faithful to a better morality as to require a formal “yes” from the woman at the marriage ceremony; but there was nothing to shew that the consent was other than compulsory; and it was practically impossible for the girl to refuse compliance if the father persevered, except perhaps when she might obtain the protection of religion by a determined resolution to take monastic vows” (Mill 31).

In either “choice” the woman’s life and body would be drastically determined by the ambitions of those more powerful around her and she was unable to consent to “her choice” at all. In a similar way people who are coerced to donate due to a lack of options are unable to give anything more than a preference of a bad situation over another.

An eye opening and heart pulling look into how organ vending does affect poverty, communities, and individual attitudes about their bodily sale is provided by Lawrence Cohen in his article, *Where It Hurts: Indian Material For An Ethics Of Organ Donation*. Cohen is both a medical doctor and a Professor of Social and Cultural Anthropology at Berkeley. He has extensively researched India and their kidney markets. Cohen brings to light the many covered up stories of people who have sold their kidneys. He argues that there has not been enough information or research done on the long term effects of impoverished people who have donated a kidney. Given the lack of clean drinking water, the dirty living and working conditions of the poor, the overwhelming majority of female donors over men in a patriarchal society, organ brokers fighting over territories, the lack of the government’s desire to prosecute medical doctors who stole kidneys from people, and the growing number of people coming forth with reports that they have become too ill to work after donating a kidney, and women who are abused if

they do not donate, and women who are punched in their scars to remind them of their “inadequate status” compared to men, it is not a simple or good alternative to donate a kidney. Cohen points to the lack of research and proof that people in poverty are safe to return to work and their family after the surgery. His research also found that an overwhelming majority of people he interviewed did not gain any long term benefits from the financial incentives for selling a kidney because within 4 years of the operation they were back to the same level of debt.

The people who donated feel that they had no choice and within their own community there now exist slang words equating kidney sellers to prostitutes. In his section of what he found to be the most common perspective he wrote,

“I sold my kidney for 32,500 rupees. I had to; we had run out of credit and could not live. My friend had the operation and told me what to do. I did not know what a kidney was; the doctors showed me a video. It passes water; it cleans the blood. You have two. You can live with one, but you may get sick or die from the operation or from something later. You have to do the family-planning operation because without a kidney childbirth is very dangerous. I had already had *that* operation. What choices did I have? Yes, I was weak afterwards, sometimes I still am. But generally I am as I was before. Yes, I would do it again if I had another to give. I would have to. That money is all gone, and we are in debt. My husband needs his strength for work, and could not work if he had the operation. Yes, I also work” (Cohen 666)

In India women are the primary donors except for one region whose population is primarily traveling males looking for work. Women in India are perceived in a distinct subordinate category below their men. Not only do they work outside the home but during the day and after work they take care of their children, cook, and clean their home.

To tip the scales again in the unfair allocation of limited resources it is the women’s bodies that are compromised. Cohen explains that men that have been operated on are considered demasculated. However, when operations are performed on women

they are given opportunities. Cohen writes, “In other words, having an operation for these women has become a dominant and pervasive means of attempting to secure a certain kind of future ...Intriguingly, in these interviews the operation was said to weaken men more than it did women. ...it literally “unmanned” them” (667). Generally the women of India had undergone a hysterectomy in order to avoid future dangerous pregnancies and creating children they could not afford to care for. A hysterectomy is much more invasive to a woman’s body and drastically affects her hormone levels and energy level, whereas a vasectomy is an in out surgery with only a little effect on a male body. Now that another surgery has become popular it is again the women going under the knife to produce more money for their families. This strikes a cord in any feminist theory because these situations perceive the woman’s body as something that cannot have the same opportunities as men until they are “fixed”. It is perfectly acceptable for men to *just* go to work everyday to earn money they can for their family. However, a women needs to do *more* to fulfill her financial obligation to the family and even when the money she provides from work is not good enough to keep them out of poverty she then has to sell one of her kidneys. The newest way to treat a woman’s body as a factory for someone else is for her to become a surrogate mother. As long as the body of a person is reduced to a mere production of “goods” for other people they will never have any safety net to protect their autonomy or their body.

An embodiment theorist should not fault the men for protecting their “manhood” but we should fault the men who *rob* women of their “womanhood”. It is a woman’s body being cut a part for her family and her status in society will be reduced to a

prostitute level. It is the unfair standard that when the family is in debt a woman's body can be compromised but not a man's. Women no longer become liberated with surgeries but only become another use as a tool for their husband. Tools are not allowed to see themselves as anything more than a tool. The women who told their story along these lines felt as though they had no choice but to do every thing possible to make money. They did not consider their personal health to be as important as their husband's. Even neighborhood bullies make the correlation with selling an organ to prostitution. Cohen writes, "A young man, the son of another woman who sold her kidney, complained to us later that day that other boys call him names: "Your mother is a kidney seller!" The current order of the commodification of everything, in which the operation transforms this mother into a prostitute..." (Cohen, 667) Kidney vendors in the same way are reduced to a tool status and at the same level of a prostitute.

Given the real injustice and grim outlook for people whose body parts are thought of as a commodity *no ethical* system should be quick to jump on the bandwagon of treating people as mere things that can be bought, hurt, and killed for a financial price. Even if the person themselves speaks the words "yes go ahead". As Mill explained in coerced situations where no other good and desirable outcomes exist it becomes unclear that their response is anything more than a compulsory response from a person "barely" alive responding to their environment. The life they live was not designed or accepted by them but was something they merely had to try and survive in. A life such as this is not one that any ethical theory should desire or condone.

Paul Hughes explains from a Marxian perspective that it is not just that exploitation occurs when an individual profits from the work of another without paying for the full value of the goods produced, but the system that allows this to occur should be held morally responsible. Hughes explains,

“In other words, exploitation involves the background set of options which impel worker’s to “choose” to labor for capitalist. ...The general point about Marxian exploitation is that if people’s options are so constrained by unjust economic arrangements... then the victims of such a system are plausibly regarded as less autonomous than those to begin with than those who benefit from the injustice.” (Hughes 92)

The society is unjust when a class of individual’s *have* to choose from degrading activities in order to still have *hope* that someday their lives will be better. When impoverished people have to choose to sell their organs in order to live a little longer, the system is condoning these ultimatums and in many ways encouraging it. A system that *overlooks* the individuals, who have to choose from poor working conditions that jeopardize their autonomy and perspective of how they relate around themselves, should be held morally responsible for revictimizing individuals. An open market for organs would only further the exploitation of our most vulnerable economic classes.

As an embodiment theorist I take the Marxian critique of alienation to be the worst of all that has happened. Instead of learning a valuable skill from start to finish that they can choose to work at and have a vacation from, their own body is viewed as a “factory” for others. When proponents of human tissue markets describe the situation as an “organ shortage” they are implying that the factories that produce organs are at fault (the sick patients). Then, to make things even stranger they start to look at healthy bodies as factories that are morally required to jeopardize the whole system and produce at a

lower functioning level for other factories. Given this Marxian theory of autonomy, individuals are exploited by degrading themselves or rather pieces of their body to mere *things* that can be bought for a price and they are revictimized by a system that keeps them in such impoverished situations that they have to choose between varying degrading activities to stay alive a little longer. Moral theories that condone human tissue markets have to argue that humans “should” perceive their body as a mere factory.

Phenomenologists disagree with their approach and are concerned with the severe alienation required to condone human tissue markets a person’s autonomy can never be protected.

The most vulnerable in our world are the most likely to have their medium threatened with an open market for human organs. Exploitation is not a possibility but a realization of this open market. People are exploited because they are forced into a perception of alienation from their body. The systems and people, who encourage open human tissue markets, only further victimize impoverished people by adding to the list of degrading activities they have to choose from in order to live a little longer. Although, some may argue that these people *chose* to sell their kidney it is unclear that anything is freely chosen, not coerced, and not forced by their husbands. In any human tissue market humans are degraded to mere tools or factories for others. The organ vendor’s perspective of their body becomes irrelevant to the buyer given the fact that they only view the vendor’s body as a mere tool or factory. It is disposable and can be bargained for in some other country.

Distinctions between Organ Vending and Organ Donation

There are four main ways that organ donation differs from organ vending. First, organ donations exist between individuals who live a shared life together. The people involved feel more than just sympathy but actually feel the pain that each other is in. Given this connection it is not uncommon for people on kidney transplant lists to refuse to have their family members tested to be a donor. A donor truly feels not only bad that they could be potentially hurting their loved one but they also feel the pain that the once healthy body of their loved one is enduring for them. Within human tissue markets this is significantly different because the receiver's involved first and possible only interaction with their donor consists of material amounts, contracts, and physical compatibility. The seller is valued as only a means to the buyer's ends and not someone who is need of financial help without exploitation. The buyer of an organ does not have to feel the full ramification of their actions to harm and/or potentially kill another person to save their life because they "paid" a "consenting" person for their life. People on transplant lists do not try and find the relative who will offer their organ for the cheapest price. Rather, people express that they want to preserve their relationship with their loved one and donor. They are equally concerned with the health of their loved one after the surgery. Organ donation represents a shared a bond that emulates traditional care ethics of preserving relationships. Human tissue markets are one of the worst forms of exploitation in phenomenology.

Second, if an individual donates to a loved one then both the donor and the receiver tend to work towards healing their bodies together and supporting each other

through the different trials of recovery. Donating your organ within your own community of loved ones resembles other familiar efforts that evoke positive human interactions. Presumably if the situation was reversed, either the donor or the receiver would get the medical attention needed or an organ. Organ donation and embodiment encompasses a reciprocal meaningful human relationship in which two people who were previously intertwined will work towards protecting the bonds of their relationship. Throughout this relationship they care about each other, respect each other, and value each other more than money. Segue is just as important for the donor as it is for the receiver from both of their perspectives. However, if a person is willing to buy an organ from a desperate vendor they will inherently not be as concerned with the vendor's recovery given the lack of concern the person had regarding the vendor's living situations prior to selling their kidney. If an organ is donated it will resemble the feelings and sentiments of a caring relationship and not that of a buyer demoralizing the poor by only valuing them based on pieces of their body. This touches on the immeasurable good that is exchanged when an organ donor views another person's life as something worth risking their own life for. The supererogatory act is not done for monetary gain but is done out of care and love for a precious human being.

Third, there is always the possibility that someday you will have a loved one that could use your organ. If you have already donated your organ to a different loved one, then minimal regret may be felt. However, if you sold your organ to a stranger, you might feel more remorse than the previous person because you have in a way limited the chances of your loved one receiving a match within the family.

Finally, gifts are freely given and outwardly articulate the giver's values. It would be the optimal situation to give a gift not because you have to or were coerced but because you *want* to give a gift. Organ vendors are never able to say that they "gave a gift of life". However, an organ donor can honestly say that they gave a gift from their body to save the life of their loved one, in the hopes that they both could be happy.

Organ donation in the true meaning of *donation* is morally possible with an embodiment theory. A situation where there exists a mutual bond between two people and the two people have already embodied each other's needs and feelings may bring upon a healthy desire to help ease each other's pain. When this sort of bond exists, it is no longer the case that by donating a piece of yourself, you view yourself as equitable to money. Rather, you view both yourself and the friend in need as priceless human beings in need of help. As with other similar relationships, you try and meet their needs in the best way you know how. If you are comfortable and a good match with donating your human tissue, you may do so but not be morally required.

CHAPTER FIVE

OBJECTIONS AND RESPONSES

This section responds to libertarian and consequentialist objections by breaking down the arguments themselves. By examining the actual contexts of their arguments, an embodiment theorist is able to argue that the libertarian sense of autonomy also needs to be protected from market systems that commodify people. The consequentialist argument fails from its own standard of duty by not providing a system of people that want to donate and has to create a disingenuous structure of payments to coax people into selling their organs. Finally, this chapter closes with two possible plans of actions that an embodiment theorist working in care ethics could endorse. The two plans would respond to a majority of the people on the American transplant lists.

Libertarian Objection

The libertarian agenda in medicine and ethics is important and one that should not be taken lightly. In many ways an embodiment theorists pull from the libertarian goals in validating people's wishes and perspective over their own body. However, the libertarian theory also has a spectrum of theorists that define autonomy in different ways. Some strict libertarians working in bioethics such as Nicholas Agar argue for a liberal eugenics supportive of most types of procedures that biomedical researchers can imagine including cloning or human gene manipulation. Others are not so quick and relate to Thomas Hobbes's concerns and argue that we must forfeit some rights in order to secure other rights. Most libertarians try and find a balance between the two and often times use

consequentialist theories and arguments to help find the balance between *allowing* and *securing* individual rights. Given this sort of balance many times nursing care ethicists and libertarians will come to the same sort of conclusion on how to deal with certain kinds of patients. However, we begin to see a stark difference on the spectrum of care ethics when we begin to discuss human tissue markets and a strong pull in one direction by libertarians.

Generally most libertarians argue that organ vending (with frame works of their own to avoid some forms of exploitation) should be morally permitted. The infamous article used by many organ brokers and proponents of human tissue markets articulates this argument and writes,

“It is said that in parts of the world where women and children are essentially chattels there would be a danger of their being coerced into organ vending. This argument, however, would work as strongly against unpaid living kidney donation, and even more strongly against many far more harmful practices which do not attract calls for their prohibition” (Radcliffe-Richards Et al 489).

Most libertarian theories argue that if the situation is not coerced and mutually benefiting in some way, then it should be an option for society. Given their conclusion of autonomy in these situations, libertarians believe that by limiting a person’s choices we are patronizing them. We are placing our own values on them that may not exist for them.

The argument continues and they write, “If our ground for concern is that the range of choices is too small, we cannot improve matters by removing the best option that poverty has left, and making the range smaller still. To do so is to make subsequent choices, by this criterion, even less autonomous” (Radcliff-Richards Et al 488). They argue that by opening an organ market we would be enabling individuals with more

economic opportunities that are potentially life saving for the receiver and life altering for the sellers. Libertarian proponents of human tissue markets feel that a person's choice is an essential factor in any life, especially for people who live in poverty. When we decide to be paternalistic and decide for them what is best we are taking away a person's already limited chance to be an autonomous agent.

The libertarian definition of autonomy sounds good for a rally at a political convention but is this how people perceive medicine and justice? When a person is in a hospital and they can't pay their bill do they *want* vultures to come to their bed side with violent proposals to pay their bill? No, that person came to the hospital to heal. When that person could not afford to pay their bill they wanted a *safe* and *reasonable* opportunity to repay the loan or some optimist hoped that the debt might even be forgiven. Either way, when people are hurting they do not want their only means of changing the situation to be a *new* form of pain.

One group may argue that *most* people will face a bad situation and they will have to weigh their options and values to minimize the damage. The embodiment theorists agree that on some level all of our interactions are contextualized in situations but they disagree on two points. First, two wrong situations do not necessarily make any action in response a "good" action. There are many available options to address the needs of sick patients and there are many actions available to help people pay for their hospital bill. They could pay their bill with regular payments they can afford or volunteer some of their time to help pay for the bill. We do not need to justify an option that is physically violent against other people. Second, if justice and prevention from coercion is allowed

in a libertarian theory of autonomy, then how if at all is a libertarian able to *protect* a person's autonomy, when people are able to be reduced to bundles of parts for others? This is a slippery slope for any libertarian theory trying to balancing a person's autonomy and with the autonomy of others. When libertarians turn to consequentialist frameworks to legitimize some acts but not others, then no act is inconsiderable, including acts that are harmful to people's autonomy. It is unclear that a libertarian can address this moral dilemma in their theory in a way that is distinctly different from the feminist approach with balancing care ethics and universal justice.

All the while, Western cultures do sympathize with libertarian objectives. We prefer to be able to make any decision we want, even if they are *bad* choices that have negative consequences. There is a foundational story in our culture leading back to Genesis that seems to emulate the freedom some libertarians ask for in our government and biomedical ethics. In the second chapter of Genesis of the Bible, God creates and sanctions bad options *and* tempters for those bad options. In the Garden of Eden, the Tree of Knowledge was made available to Adam and Eve despite the negative consequences it would bring upon them. "And out of the ground made the Lord God to grow every tree ... and the tree of knowledge of good and evil" (Genesis 2.9). Anyone who would choose to eat from the tree of knowledge would have chosen to disobey their God and be punished by their God. In the next chapter the story evolves and it is written; "NOW the serpent was more subtle than any beast of the field which the Lord God had made. And he said unto the woman, Yea, hath God said, Ye shall not eat of every tree of the garden? (Genesis 3.1)" The woman replies and explains that she was given an order

from God to not eat from or even touch the Tree of Knowledge because she will die. The serpent tells the woman that she will not die if she eats from the tree and entices her further with saying, “For God doth know that in the day ye eat thereof, then your eyes shall be open, and ye shall be as gods, knowing good and evil” (Genesis 3.4) Eventually Eve decides to eat from the tree and asks Adam to do the same. Adam agrees and given that they both disobeyed God’s order they were removed from the garden and suffered a hard life afterwards. The Christian story of how humans began is extremely rich with interesting lessons and possible metaphors. However, it is clear that God sanctioned both the bad options in life and the creatures that tempt us to make bad choices. In a Christian, sense both Adam and Eve are autonomous because they were free to choose from the moral choice of following God’s commands or the immoral choice not to follow God’s commands. This applies to a strict libertarian theory of autonomy because in order to be an autonomous agent one must be able to freely choose for himself whether or not he wants to live a moral life. Also, the agent gets to chose whether or not the consequences will be perceived as good or bad. The Tree of Knowledge was a gamble for Adam and for Eve. They choose to take the gamble as opposed to living in a childlike ignorant state.

In a similar way, biomedical ethicists such as Dan Brock argue that people are not really autonomous unless most options are made available to them. Brock argues for a strong sense of self determination in his justifications for controversial procedures such as physician assisted suicide and prenatal genetic testing. Brock thinks that there are some objectable ways we can use when determine whether or not a person is autonomous

to support his theory of autonomy. One of his cornerstone examples is with justifications used to make the practice of slavery immoral. Brock writes,

“To take an extreme case, even if there in fact were happy or contented slaves during the period when slavery existed in this country, their condition of slavery was bad for them and diminished the quality of their lives; being a slave to another is a condition unworthy of an individual capable of being an autonomous human being” (Brock 69).

Brock’s example points to a serious question for bioethicists. Unless humans are able to participate in new technology, how could we ever know whether the technology increased or decreased a person’s quality of life. In a similar way this example could be used to argue that since biomedical technology has made it possible for human organs to be transferred from one body to another and for fertilized eggs from strangers to be implanted and carried to term, then people should be given the option to participate in this technology and financial market. Furthermore, the advertisements for this market should be sanctioned as well. Perhaps there will be negative consequences such as coercion, physical pain, and even shame from their culture and religious beliefs, but to *really* be autonomous in a libertarian sense we need the ability to eat from the tree of knowledge and reap the positive benefits as well as the negative consequences. If we do not allow people to use these technologies we are essentially placing them in the same condition as a slave. If a person is born with a genetically deficient kidney or a uterus that cannot sustain the flourishing of an embryo, then they are being *punished* by our society by not allowing them to utilize technology in a way that would alleviate their pain and improve their life conditions.

The libertarian and Western view of autonomy seems to support an egoist philosophy and also a marketing principle that people should be able to coerce other

people. An embodiment theorist simply denies that this is the case in ethical theories and especially medicine. All people need to be protected and have their bodily needs *safely* met before they can exercise any sort of autonomy. A common example is with people who are brainwashed and have their autonomy taken away. In a similar way people in poverty can be brainwashed into believing that their debt to society is so high that they must repay it with their life or part of their being that gives them life. However, ethical theories including libertarian theories need to provide a strong sense of protection against physical abuses by other people including coercion. The protection of a person's body not to be harmed by other people or coerced to be harmed by other people is the very first step in any libertarian theory of autonomy. Human tissue donation threatens the very protection libertarians wish to secure, autonomy.

Consequentialists Objections

The main consequentialist argument in favor of cash incentives for human organs has been expressed in a number of ways by different ethical theorists. Calandrillo bluntly overviews their argument and writes, "Since thousands die each year while waiting for organs that never arrive, we must explore incentives that can change this terrible outcome"(69). Consequentialists address this dilemma by validating the life that is lost and argue that the loss of a large amount of human life is significant enough to mandate some violent means to alleviate this pain. However, consequentialists who argue in favor of cash incentives for human tissue markets are disingenuous. They want to alleviate pain and they know that making it a moral requirement on all healthy people's bodies

would essentially “scare” the herd away from consequentialism and thus not help the people on organ waitlists. So, they make it “optional” with cash incentives. However, many strict consequentialists including Peter Singer argue, that your life should be no better off than any other person’s life. For this section of the paper we should give consequentialists the benefit of the doubt and argue that they too have a sense of autonomy and have to balance individual autonomy with the needs of others.

Unfortunately for consequentialism it is within our human nature to be partial to our own needs and circle of intimate relationships, and people generally do not fall prey to the Jellyby fallacy offered by care ethicists.

In Paul Hughes’s article, *Exploitation, Autonomy, and the Case for Organ Sales* he points out the ambiguous use of autonomy by consequentialists in favor of organ sales. Hughes believes that their use is so ambiguous that it would not meet the criteria of John Stuart Mill’s consequentialism. An individual’s autonomy can only be increased if the overall additions of more possible choices do enhance a person’s well being. Hughes writes, “This sort of “subtraction by addition” is made clear by Mill in *On Liberty* when he rejects the option of selling oneself into slavery on the grounds that it defeats the purpose of autonomy and is thus not a genuine choice at all.” (Hughes 91) Society will have another reason to have a subdominant category of people poor enough that they would be willing cut their body up merely for some money. Consequentially, by enabling individuals with the option of selling their body parts, we will not enhance their autonomy or their well being. We may in fact create a negative number in the overall

utility of society because people will see themselves as objects available for the exploitation of others.

Meeting the Needs of Sick Patients from an Embodiment Perspective

Steve Calindrillo who was introduced earlier in this chapter as a proponent of human tissue markets offers two alternative types of programs that would not necessarily threaten the embodiment description of autonomy. The two programs are designed to increase the amount of organs available for people on the transplant list in America. Calindrillo offered these two programs in a list of three alternative programs that would follow the National Organ Transplant Act and the Uniform Anatomical Gift Act guidelines by not offering cash incentives. The first program is a concept that is encouraged and brought to life by the organization, Lifesharers. They argue that the waiting list priority should in the future be given to people who are they themselves registered as an organ donor. Although this is a controversial concept, from an embodiment perspective it would be hard to make a claim that when *others* die it is morally acceptable for you to receive a cadaver organ but that others should not see *your* deceased body as possible source of gifts for them in their time of need. There is a reciprocal relationship in the care ethicist application of justice that could support the Lifesharers program. This theory just asks that people be proactive in regards to securing their needs as well as considering the needs of other people. By making a decision early a person is being proactive and exercising their belief of how their being should be protected and their relationship to the organ donor list and the organ waitlist.

This theory certainly needs framework but it does not contradict the embodiment perspective. For example, perhaps children or dependents could be exempt from the rule. Also more discussion is needed for when or how long a person should be registered on the organ donor list in order to receive a priority status. However, the program has a great amount of potential to help increase the donor pool as well as protect the full sense of a person's autonomy through an embodiment perspective without commodifying people and their bodies. Most cadavers that could have had organs donated are buried and many had listed themselves as an organ donor on their license. However, without the newly deceased patient being officially registered with a national transplant lists or a family member's permission the deceased patient is cremated or buried. This application could also prevent family members the extra pain of having to *guess* what their loved one would want done with their organs if they died. The theory would also cater to some trial donor programs in Canada that are being looked into by American doctors where "less desirable" organs, such as ones that have undergone a stroke, are being used as temporary organs until a safer and closer match can be made.

The second theory Calindrillo explains, has been previously introduced by Michael Morley and David Wessel as "paired organ exchanges" and this program offers family members of a sick patient who is in need of an organ as second chance to help their loved one. If they were not a good match for their loved one they could then list themselves on a national database where a different family in the same situation could potentially give an organ for an organ. This program does not put a financial value on a person's body part and a person's being is only jeopardized when it could potentially

save the life of someone whom they share their life with. An embodiment theorist working within feminism may want procedures set up in this program to avoid exploiting family members in a position where there is no room for them to not be listed as a potential donor. However, the same type of protection is needed in any live organ donation program. This program could potentially help *the majority* of people on the waitlist (patients who need a kidney or part of someone else's liver) and give their family members the opportunity to do something their DNA did not at first allow. The author's *of Live Kidney Donation and the Ethic of Care* also discussed this very program and with some hesitation found this plan to not be in theory a contradiction to phenomenology or care ethics. They had two objections that need to be discussed before the plan is put into practice. The first criteria would be to protect family members who volunteer to be tested for compatibility. The volunteers should "...be told by the transplant team at the outset that swapping may be an option and they should be given a chance to decline upfront"(Kane et al. 183). Their second concern is more theoretical than applicable. They are concerned that this policy would be unfair to people who do not have family members willing to donate. Theoretically yes this would be a further kind of pain those patients may feel: however, in the real application of this plan they would have a greater chance of receiving a cadaver organ because less people would be on the wait list and they would be "bumped" up the list.

The third program, presumed consent does not meet the embodiment perspective. The presumed consent theory argues that unless otherwise explicitly stated, your organs on your death bed were intended to be used by individuals who need them. This program

has been put into action by Austria, Denmark, France, Poland, Finland, Greece, Italy, Norway, Spain, and Sweden. The embodiment theory argues that medical professionals should not *presume* anything about their patients without talking with their patient prior to the situation. Besides, if Calindrillo's first suggestion is put into practice it would be unnecessary to go forth and start presuming that people who had not participated in registering on the organ donor list now all of a sudden want to donate their organs.

The embodiment theory is open to hearing proposals that would increase awareness about sick patients who need an organ to stay alive and looking into plans that could be put into action to help sick patients and their families. However, given that the embodiment ethical perspective stems from both phenomenology and feminism, it is unable to sanction any sort of unrealistic or paternalistic description of how humans "should" perceive their body to meet the needs of others, nor *moments* where a person must put a monetary value on oneself. This theory wants to meet people's needs but in a way that does not disassemble some people's bodies for others. Given the rise of biocommerce and the seemingly unstoppable force of biotechnology, the protection of a person's body as well as their values need to be protected from both poverty and self righteous people who take the law into their own hands, by putting the lives of other people at risk with coercion, illness, and death.

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The human organ procurement system is a much debated and controversial topic. With reference to the sociological and economic. A black market has existed for tissue, where black market brokers made deals with funeral home owners and directors to harvest tissues and parts from bodies in their possession without the consent of the individual or family. These were then sold for a profit to researchers and doctors; false reports were sometimes created to cover up the true cause of death and the fact that the tissues could be diseased. A What are the various arguments and critiques against the altruistic procurement system and what is recommended to stand in its place? supply human tissue; a the need for the Government, with other member states, to seek the adoption of a protocol to the European Patent Convention relating to patents in the area of human and animal tissue. The Council will welcome views and comments on the report. It also hopes that the report will stimulate public discussion; and that its recommendations will lead to early action by the Government and authorities concerned. Human brown adipose tissue (BAT) can be activated to increase glucose uptake and energy expenditure, making it a potential target for treating obesity and metabolic disease. Data on the functional and anatomic characteristics of BAT are limited, however. In 20 healthy young men [12 lean, mean body mass index (BMI) $23.2 \pm 1.9 \text{ kg/m}^2$; 8 obese, BMI $34.8 \pm 3.3 \text{ kg/m}^2$] after 5 h of tolerable cold exposure, we measured BAT volume and activity by ^{18}F -labeled fluorodeoxyglucose positron emission tomography/computerized tomography (PET/CT).