Beneficence and Paternalism

Brendan's Big Book of Bioethics | Brendan Shea, PhD (Brendan.Shea@rctc.edu)

1 CONTENTS

2 HOW MUCH AID IS ENOUGH? THE PRINCIPLE OF BENEFICENCE

In this lesson, you'll learn to:

1. Distinguish the principle of beneficence from that of nonmaleficence.
2. Analyze the relationship between beneficence and the moral norm of reciprocity.
3. Explain the debate between libertarians, utilitarians, and principalists regarding the scope of beneficence.
4. Apply the principle of beneficence to issues such as continued and expanded access to experimental treatments.

The common morality requires that we both respect the decisions of competent persons (the principle of **autonomy**) and that we refrain from harming other people and animals (the principle of **nonmaleficence**). It also requires that we take positive steps to *aid* others, and that we consider what the net *outcomes* of our actions will be (for everyone affected by them). These requirements fall under the principle of **beneficence,** or the "moral obligation to act for the benefit of others."[1] This principle mandates that we do the following, at least in cases where it is relatively easy for us to do so:

1. Intervene to prevent others from being harmed, or to protect their rights. Rescue those in danger.
2. Give aid to others that need it, in the form of money, time, emotional support, and so on.
3. Help people who cannot fend for themselves (children, those with disabilities, perhaps some animals).

Figure 1 Vet with dog. (Brendan Shea x Dall-E).

Ethical theorists have widely diverging views about how much this principle demands of us:

Some **libertarian** or **rights-based** theorists have argued that while we may have duties of **specific benevolence** (toward family members, clients, patients, and so on), we have almost no obligations of **general benevolence** (toward strangers). According to these thinkers, morality requires simply that we "mind our own business" by respecting others' autonomy and not harming them. One problem: This view underestimates how much we ourselves have been benefitted by the actions of other people/animals (and thus, how much we owe them). It implausibly suggests that it is morally OK for us to stand by and allow people to drown, starve, or be killed even when we could prevent this with little effort.

Utilitarianism holds that our *only* moral obligation is that of beneficence, and that an act is moral just in the case it maximizes net well-being (or minimizes net suffering) for absolutely all persons and animals affected by it. Peter Singer (a famous bioethicist) argues that both utilitarianism and many traditional religious ethics entail the following: "if it is in our power to prevent something bad from happening, without thereby sacrificing anything of comparable moral importance, we ought, morally, to do it." One problem: Singer's

[1] For an overview of the importance of the beneficence in work on applied ethics, see: Tom Beauchamp, "The Principle of Beneficence in Applied Ethics," in *The Stanford Encyclopedia of Philosophy*, ed. Edward N. Zalta, Spring 2019, 2019, https://plato.stanford.edu/archives/spr2019/entries/principle-beneficence/.

principle would require that we give nearly ALL of our time and money to causes such as poverty relief. For many people, this is simply far too demanding[2].

Principlism (the view defended by Beauchamp and Childress's *Principles of Biomedical Ethics*) holds an intermediate view between these two "extreme views". In particular, it claims that I have *prima facie obligations of beneficence* toward person P when:

1. P is "at risk of significant loss of or damage to life, health, of some other basic interest."
2. My action (either by itself or in concert with the actions of others) is necessary to prevent this loss or damage.
3. My action will *probably* work to prevent this loss or damage.
4. My action "would not present significant risks, costs, or burdens" to me.
5. The benefits to P can be expected to outweigh any harms or costs that I expect to incur.

The differences between these three theories show up in different judgments about cases. So, for example: A libertarian holds that you are *never* morally required to help a stranger (no matter how small the cost to you!). A utilitarian, by contrast, would hold that you are *always* required to help strangers, so long as it doesn't harm you more than it helps them (so, you would have to sacrifice your own life to save two strangers' lives). Finally, a principlist would hold that you sometimes have to aid strangers (so long there is no *significant* risk, cost, or burden to you).

2.1 Expanded Access and Continued Access

On some occasions, researchers have offered patients **expanded access** to treatments or drugs that are still undergoing testing. In other cases, they have offered **continued access** to these (not-yet approved) drugs/treatments to patients who have *participated* in preliminary tests of these things, and who have shown positive results. A question: Does beneficence morally *obligate* researchers to offer patients expanded or continued access?

Is Expanded Access Required? Why? B-C argue that researchers are NOT (usually) morally obligated to offer expanded access to drugs because (1) there is no evidence these drugs will actually *help* patients and (2) in certain cases, doing so may cause problems for clinical trials (e.g., if the "wrong" type of patient is included in the data, this may lead to the failure of the clinical trial). In some special cases (e.g., when existing treatments have failed, there is good reason to think the experimental treatment might work, and it will not disrupt clinical testing), researchers should consider offering expanded access.

Is Continued Access Required? Why? By contrast, B-C argue that researchers ARE (usually) morally obligated to provide continued access, since (1) they "owe" the patients for their participation in the study, (2) there is good reason to think the patients will be helped, and (3) there is no possibility of this ruining the clinical trial (which has already been completed). In the case of continued access, the researcher's obligation of beneficence is grounded on **reciprocity**, or "the act of practice of making an appropriate and often proportional return—for example, returning benefit with proportional benefit, countering harm-causing activities with proportional criminal sentencing, and reciprocating friendly and generous actions with

[2] For an introduction to this debate see Peter Singer, "Famine, Affluence, and Morality," *Philosophy & Public Affairs*, 1972, 229–243; https://www.utilitarian.net/singer/by/1972----.htm, Richard W. Miller, "Beneficence, Duty and Distance," *Philosophy & Public Affairs* 32, no. 4 (2004): 357–383.

gratitude." Beauchamp and Childress, among others, argue that many of our obligations of general and specific beneficence are actually grounded in this way:

2.2 Reciprocity and Beneficence

As suggested by the case studies above, medical professionals owe a LOT to other members of society. This includes both formal training in tax-payer subsidized schools, clinics, and hospitals and informal learning based on experiences with previous patients. Medical professionals also rely heavily on publicly-funded facilities and medical research to do their jobs. It is incorrect to think of medical professionals as "independent" or "self-sufficient" individuals who don't "owe" anything to their patients beyond the absolute minimum.

Similarly, patients owe a lot to medical professionals and to other patients, in that their treatments would not have been possible without lots of previous research and experience. This suggests that patients have some obligation to be beneficent—for example, by agreeing to participate in research studies when they can do so with little risk to themselves. We can even have obligations of beneficence to animals used in experiments, in that they have helped us gain knowledge. This means, among other things, that research animals ought to be as well-treated as possible (even if the research will foreseeably lead to their deaths).

2.3 Review Questions

In your own words describe the difference between nonmaleficence and beneficence. Can you give an example of a case where these principles might *conflict* (for example, a case where you could help many people, but only by harming someone else)?

Suppose that a deadly influenza (or COVID) epidemic breaks out. You are a skilled medical professional and estimate that, if you *volunteer* to work at a local clinic, you could save TWO people's lives. However, you would stand a 10% chance of dying (for at-risk workers, this was probably realistic in cases such as the 1918 influenza pandemic).

1. Is this a duty of specific or general beneficence? Why?
2. What would a libertarian say about this situation? A utilitarian? A principlist? What do *you* think?
3. Would your (moral) duties change if there were very little risk to you (beyond having to work for a few days without pay)?
4. Would your (moral) duties change if the people you could save were your patients, and treating them was "part of your job" (for which you were paid, had already signed a contract, etc.)? If so, how?
5. Would your (moral) duties change if the people you could save were "important" people, such as other medical professionals, or important political/religious/scientific leaders? If so, how?
6. Would your (moral) duties change if the people affected were your family members or friends? How?

3 What is Paternalism? Is it Ever OK to Behave Paternalistically?

In this lesson, you'll learn to:

1. Define paternalism, and distinguish between soft and hard paternalism.
2. Identify current issues in bioethics that involve conflicts between respecting patient autonomy and promoting patient welfare.

3. Analyze current issues related to paternalism, and explain the benefits and drawbacks of different policy interventions.

In ordinary English, a *paternalistic* government or institution means "one that makes decisions for its subjects in the way a father [or parent] would for his children" (OED). A paternalistic government treats its citizens as "children," and will overrule citizens' desires "for their own best interest." In the context of biomedical ethics, **paternalism** can be defined as "is the interference of a state or an individual with another person, against their will, and defended or motivated by a claim that the person interfered with will be better off or protected from harm."[3] Some examples of paternalistic actions include.

1. Making some drugs available *only* by prescription, and refusing to give them to some patients who want them.
2. Taxing other drugs (such as alcohol and cigarettes) in order to make people use them less, which can help their health.
3. Forcing medical treatment on children, dementia patients, or other persons with low cognitive function.
4. Refusing to carry out some medical treatment *because you think it would harm the patient* (for example, refusing to give assistance to a depressed person who wants help committing suicide).
5. Some hospital safety regulations, such as requiring certain patients to use wheelchairs, etc.
6. Making people save money when young and working (in the form Social Security taxes) for living expenses they will have when they are old.
7. Requiring that people wear motorcycle helmets, buckle their seat belts, etc., in order to prevent injuries.

Since nearly all of our actions (e.g., to abuse drugs or to not wear a seatbelt) affect other people as well (such as children, taxpayers, etc.), none of these laws is "purely" paternalistic. However, all of them seem to be at least partially paternalistic—at least part of the reason they were passed was to stop people from doing things that might harm *themselves* in the long run[4].

[3] Gerald Dworkin, "Paternalism," in *The Stanford Encyclopedia of Philosophy*, ed. Edward N. Zalta, Winter 2017 (Metaphysics Research Lab, Stanford University, 2017), https://plato.stanford.edu/archives/win2017/entries/paternalism/.

[44] For an intro to current economic/philosophical/medical debates over paternalism, and how we might "permissibly" convince people to make better decision about their health, finances, etc. see Dworkin; Adrien Barton and Till Grüne-Yanoff, "From Libertarian Paternalism to Nudging—and Beyond," *Review of Philosophy and Psychology* 6, no. 3 (September 1, 2015): 341–59, https://doi.org/10.1007/s13164-015-0268-x.

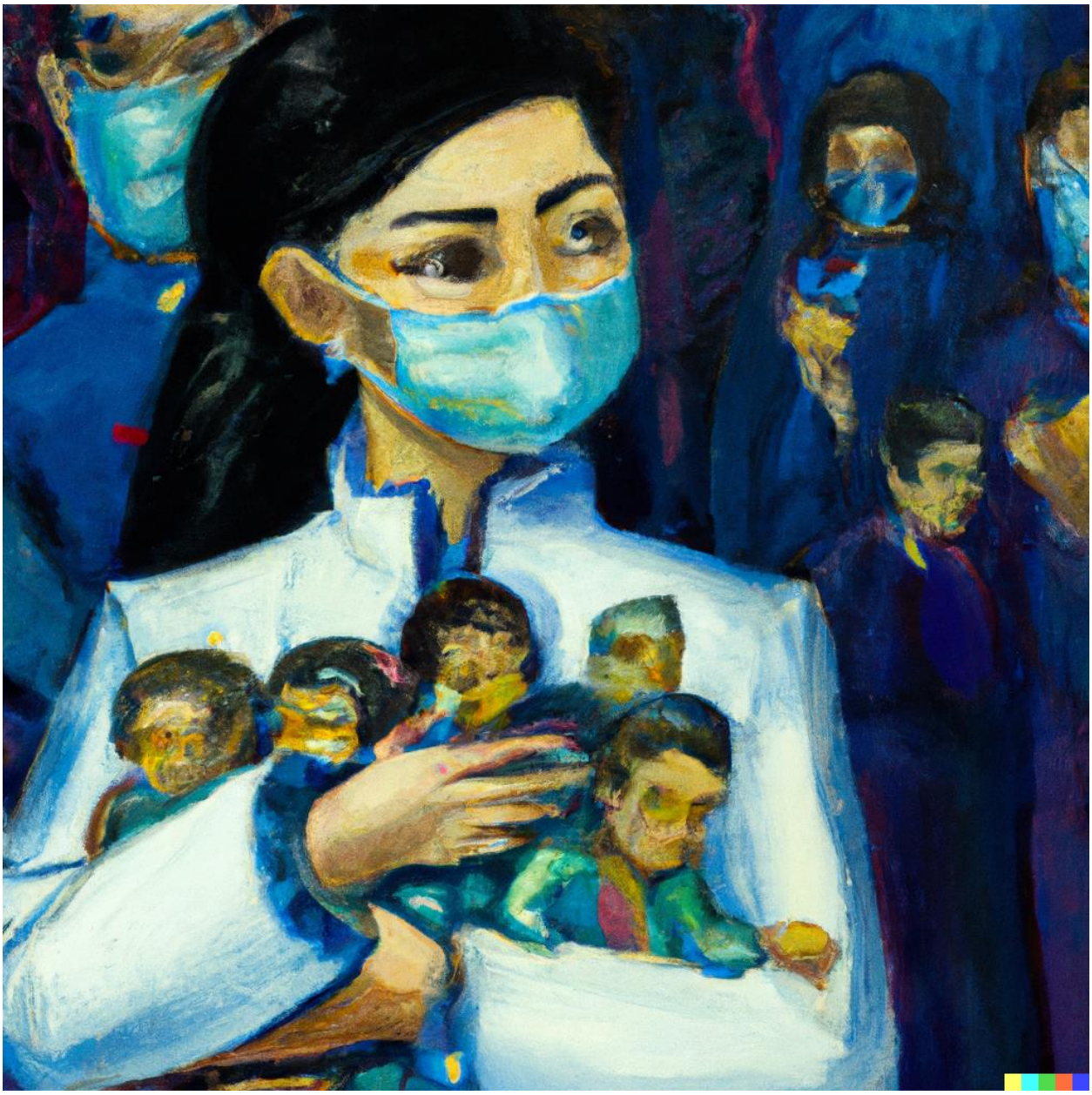

Figure 2 The paternalistic physician (Brendan Shea x Dall-E).

3.1 SOFT PATERNALISM: MAKING DECISIONS FOR THE NON-COMPETENT

Many laws governing children are blatantly paternalistic—they cannot buy alcohol or cigarettes, must go to school, cannot consent to marriage (or sex), and so on. All of these laws are "for the children's own good." This is considered **soft paternalism** (sometimes also called **weak paternalism),** since children are "incompetent" and many of their actions are "non-voluntary." Other groups affected by soft paternalism include patients with severe dementia or developmental disabilities, and people who are temporarily incompetent because of drugs, fear, and so on. Almost everyone agrees that soft paternalism can be morally justified in many cases, since the people affected are not autonomous. Medical professionals and surrogates should not feel obligated to "obey" the expressed wishes of incompetent patients. **Surrogates** sometimes

practice soft paternalism when they make decisions for incompetent patients (e.g., parents make decisions for children; spouses make decisions for each other). B-C argue that surrogates ought to

1. obey a previously competent patients' wishes if these are known (the **pure autonomy standard**);
2. when these wishes are NOT known, act in the patient's best interests (the **best interest standard**) by
3. asking themselves "What would the patient want if they were competent?" (the **substituted judgment standard**).

In practice, all three standards can be used together, with some standards working better for certain sorts of cases.

3.2 HARD PATERNALISM: STOPPING ADULTS FROM MAKING BAD DECISIONS

Not all paternalism is limited to non-competent patients, however. For example, we have laws preventing adults (even well-educated, perfectly competent ones) from selling their organs or serving as prostitutes. These are all instances of **hard paternalism,** since the people affected are perfectly autonomous and may even offer reasoned arguments that they *want* to use heroin, sell their organs, or whatever. In medicine, hard paternalism occurs when caregivers "make" competent patients do something they would not consent to (but which will benefit them) by lying, manipulation, or simply refusing to go along with their wishes. Since this conflicts with the principle of autonomy, these actions need to be considered carefully.

Beauchamp and Childress argue that hard paternalism *can* be justified in medicine, but only in very special circumstances. To see how this works let's consider the case of a controlled substance (such as morphine):

REQUIREMENT (from BC ch. 6)	**EXAMPLE**
1. "A patient is at risk of significant, preventable harm."	Morphine carries a high risk of addiction. Allowing patients to buy it would put them at risk of harm.
2. "The paternalistic action will probably prevent the harm."	Limiting access to morphine will help prevent this. (Though there will always be a black market).
3. "The prevention of harm to the patient outweighs risks to the patient of the action taken."	People who are in severe pain can get a prescription. So, there is minimal risk.
4. "There is no morally better alternative to the limitation of autonomy that occurs."	There is no way to secure the benefit (preventing morphine addiction) that doesn't restrict autonomy (patients are not allowed to buy it).
5. "The least autonomy-restrictive alternative that will secure the benefit is adopted."	Most people have access to a physician, so it is not a *huge* loss of autonomy.

While these criteria seem simple enough, applying them in practice can often be difficult, not least of all because its often tough to judge how effective our paternalistic action will be, and/or what harmful side effects might occur (the "unknown unknowns"). For example, during **Prohibition** the US government banned alcohol (at least partially at paternalistic grounds), but eventually had to repeal this ban, because of both inefficacy (people kept drinking) and crime (gangsters, smugglers, etc.).

In practice, the cases in which hard paternalism is or might be acceptable (for example, restricting addictive drugs) tend to be fairly "close" to soft paternalism. (For example, drug addiction can easily lead people to lose "competence", which means that laws regarding such things might also be justified on soft paternalistic grounds). In fact some bioethicists argue (against Beauchamp and Childress) that hard paternalism is NEVER acceptable, and that ALL acceptable cases of paternalism are soft paternalism.

Other issues re: paternalism. In some cases (such as when a person attempts suicide), a **temporary intervention** may be justified in order to "make sure this is really what the person wants to do." **Passive paternalism** involves a caregiver refusing to go along with a patient's stated request "for the patient's own good." While this can be a form of hard paternalism, it is often easier to justify than active paternalism.

3.3 REVIEW QUESTIONS

1. Hard paternalism, unlike soft paternalism, involves overruling the decisions of a *fully competent* person: i.e., one who fully understands the consequences of their choice. Under what conditions, if any, is this acceptable?
2. Choose an example of a paternalistic law or policy that interests you, preferably one that involves health in some way. This could be one that is already "on the books," or it could be one that people have discussed. Now, consider what the best arguments FOR and AGAINST this law might be. You should definitely include a discussion of soft/hard paternalism (and of the potential conflicts between autonomy and beneficence), but you can also bring up other ethical considerations from the class material that you think are relevant, as well as from online research. Some examples include (please choose just ONE specific issue or law.)[5]:
    a. Laws requiring (or prohibiting) medical and social work professionals to overrule parents' religiously-grounded refusals of treatment, when it comes to their children. For example, do parents have a right to refuse a life-saving blood transfusion *for their child,* if this goes against their religion?
    b. Prohibiting the following activities for people's "own good": hard drugs, prostitution, marijuana, or selling one's kidneys.
    c. Laws allowing/prohibiting "commercial surrogacy" (paying a woman to become pregnant, carry children to term, and then give them to the intended parents.)
    d. Taxing the following sorts of goods in an effort to promote health: cigarettes, alcohol, soda, red meat.
    e. Vaccine requirements for schoolchildren, government workers, or people generally.

[55] You should be able to find quite a few arguments on both sides of these issues. On the general issue of drug legalization, you can start with the following articles, written from opposing points of view: Dan Baum, "Legalize It All," *Harper's Magazine*, April 2016, https://harpers.org/archive/2016/04/legalize-it-all/; German Lopez, "Should America Legalize All Drugs? This Story Should Give Supporters Pause.," Vox, August 6, 2018, https://www.vox.com/policy-and-politics/2018/8/6/17649036/fda-fentanyl-opioid-epidemic-drug-legalization. For more on the debate over pornography, prostitution and related "sex market" issues, see Laurie Shrage, "Feminist Perspectives on Sex Markets," in *The Stanford Encyclopedia of Philosophy*, ed. Edward N. Zalta, Fall 2016, 2016, https://plato.stanford.edu/archives/fall2016/entries/feminist-sex-markets/.

4 READING: ON DISTINGUISHING JUSTIFIABLE FROM UNJUSTIFIABLE PATERNALISM (BY LORETTA M. KOPELMAN)[6]

Paternalism is the interference with people's liberties or autonomy "for their own good" or to "prevent their harm" irrespective of the preferences of the person whose liberty is being curtailed [1]. A powerful way to understand the issues and controversies about paternalism in medicine is to consider the case of Dax Cowart, who was severely injured after a gas explosion caused second and third degree burns over 67 percent of his body [2]. A 1974 film, shot 10 months after the accident, shows Cowart undergoing painful but life-saving treatments. The film mostly consists of Cowart's interviews with Robert White, a psychiatrist at the University of Texas at Galveston. Burn unit doctors told White that Cowart was irrational and depressed and needed to be declared incompetent so his mother could be appointed his legal guardian and authorize surgery on his hands.

Unlike doctors in the burn unit, the surgeons refused to operate unless Cowart gave informed consent or was declared legally incompetent and a court-appointed surrogate authorized surgery. Dr. White and another psychiatrist found Cowart to have the capacity to make his own medical decisions and refused to participate in the process to have him declared legally incompetent. Yet Cowart's doctors were still unwilling to honor Cowart's refusals of treatments. Eventually Cowart agreed to the surgery because, he said, he believed that it was the fastest route out of the hospital, where he could reestablish control over his life [3].

The difficulty with paternalism for legally competent persons is that, first, someone's sincere belief about what is good for another person may be wrong. With the best intentions people may be mistaken about what harms or benefits others [4]. Doctors were wrong in assuming what values were most important to Cowart and in predicting that he would regain some vision and use of his hands, be able to dress himself, and attend to his personal needs. Second, limiting the liberty of competent persons offers insufficient respect for their autonomous actions or their ability to make decisions for themselves. People find it intrinsically valuable to plan their own lives and live as they wish [5]. Third, there is utility or instrumental value in letting people live as they wish because competent people generally are the best judges of what is best for them and because we learn from each other's successes and failures [6]. In deciding for ourselves, moreover, we develop our potential as autonomous persons, gain respect from others, and do not feel thwarted. Paternalism is generally considered an unwarranted interference with the liberties of people who can act autonomously because it undercuts what they want for themselves and their liberty to live out their lives as they wish as long as they do not interfere with others. Current laws and policies generally do not permit medical paternalism for legally competent persons.

[Brendan's Question: How does this view of hard paternalism differ from that laid out above?]

Sometimes we are not sure whether persons are competent who, in our view, are about to harm themselves. In such cases, it seems appropriate, perhaps even a moral duty, to interfere to determine if the person is competent. For example, a seemingly competent person may want to fly from a 15th story window, eat poisonous mushrooms, or walk into a minefield. *Weak paternalism* permits interference with the liberty of others to determine whether they are competent or capable of making a rational choice [7-9]. Most people would argue that it is justifiable to interfere with persons about to harm themselves to determine if they have the capacity to look after their interests, understand the consequences of what they are doing, or act

[6] Loretta M. Kopelman, "On Distinguishing Justifiable from Unjustifiable Paternalism," *AMA Journal of Ethics* 6, no. 2 (February 1, 2004): 72–74, https://doi.org/10.1001/virtualmentor.2004.6.2.medu1-0402.

voluntarily. Weak paternalism honors the autonomous decisions of competent persons while also protecting people who may be acting nonautonomously or on insufficient information. Weak paternalism is especially important in medicine since it extends more protection to people who are impaired by such things as illness, ignorance, drugs, or fear.

When Cowart was first taken to the hospital he demanded that the clinicians let him die. Since Cowart was disoriented and hallucinating, his doctors could justify treating Cowart over his objections, using this widely defended principle of *weak paternalism*. As the months went by and he became articulate, clear in his reasoning, and unwavering in his refusals of burdensome treatments, it became increasingly difficult for physicians to use the defense of weak paternalism.

Cowart is now a lawyer defending patients' rights. He insists that, while he is happy to be alive, he was not treated with respect, and his competent refusal should have been honored. He was more accurate in predicting the severe limitations with which he lives and claims that the result was not worth his suffering. Honoring a patient's competent refusal of a burdensome treatment does not constitute participation in a suicide, as some doctors feared. One would hope that Cowart's doctors would have recommended or even implored him to consider life-saving treatments or meet persons with disabilities who were living full and happy lives. Still, they crossed a legal and moral line in treating this highly competent man against his will without even a court hearing.

First-year medical students at the Brody School of Medicine watch the film about Cowart, *Please Let Me Die,* in our medical humanities course [2]. It introduces them to issues of competency, informed consent, and paternalism. Most, if not all, students agree with the psychiatrists but struggle with the difficult choice faced by his doctors. Compassion seems to lead them in one direction and respect for liberty in another. There is no conflict between the need to protect sick people and to honor their self-determination when they authorize recommended treatments or hospitalizations. The problems arise when we cannot simultaneously do what we think is best for people and also respect their refusal of treatment or hospitalization, and solutions often depend on competency determinations.

[Brendan's Question: *Please Let Me Die* is an interesting film, and I'd encourage to look it up! What do you think about the Dax Cowart case, based on what you've read so here?]

4.1 JUSTIFIABLE PATERNALISM

Paternalism is justifiable if someone lacks the capacity to look after his or her interests. Some form of protection is justified or even obligatory when people cannot make decisions for themselves, suffer incapacitating illnesses, show involuntary self-destructive behavior, or make choices so inappropriate to their own established life goals that we doubt their autonomy. Interference seems justified in the presence of people's nonautonomous, self-destructive behavior or when they resort to acts that are irrational, unreasonable, and uncharacteristic. Thus, paternalism (some prefer the less sexist word "parentalism") is sometimes a duty in medicine, and clinicians have to decide when they should act like good parents and help people who cannot look out for themselves.

For example, temporary involuntary commitment of a patient may ultimately enlarge that person's liberty [8]. Civil commitment laws for persons considered dangerous to themselves are paternalistic in the sense that they interfere with the liberty or autonomy of such persons for their own good or to prevent harm. The justification for these laws is that people sometimes lack the capacity to act in their own interest. When people are very ill, they are "not themselves" and are not choosing autonomously. As a society, we can even adopt paternalistic laws for competent adults, such as requiring motorists to wear seatbelts, motorcyclists to wear helmets, prohibiting swimming in dangerous areas, and requiring parents to protect their children.

Doctors, however, are private citizens and cannot restrain the liberties of others simply because they do not like competent patients' decisions.

Limiting the liberty of others can be justified if they lack capacity to make the relevant decision (paternalism), if they pose harm to others (the harm principle), or if their behavior is so bizarre that we should intervene to allow time to determine if their actions are autonomous and informed (weak paternalism). Interference with the liberty of adults requires a heavy burden of proof to show they are incapacitated, incompetent, or a threat to themselves or others. It requires proving that the probability and magnitude of the possible harm merits the interference and that the means used are effective and the least restrictive means available [10-11].

[Brendan's Question: What would be an example of a case where paternalism IS acceptable, on this view?]

5 READING: KIDNEYS FOR SALE (BY CLAIRE ANDRE AND MANUEL VELASQUEZ)

From: https://www.scu.edu/ethics/focus-areas/bioethics/resources/kidneys-for-sale/

Claire Andre and Manuel Velasquez

[Brendan's Note: This article is from 1988. The next two articles show how this issue has changed over the years.]

When it comes to bodily parts, it's a seller's market. That's the opinion, anyway, of Barry Jacobs, who proposed to set up shop as an international broker for bodily parts. His service would include matching up kidney "donors" with patients needing kidney transplants. The donor would receive a healthy paycheck, the recipient a healthy kidney and Jacobs, a healthy percentage of the entire deal. American ingenuity and free enterprise at their best. Or is it?

Currently, prospects are grim for people in need of organ transplants. For every 100,000 transplant operations needed each year, only 10,000 are performed. Biomedical breakthroughs have greatly increased our capacity to perform successful transplants, increasing the demand for transplantable organs. But the supply of organs has not increased. Many people are simply reluctant to donate their bodily parts. In response to the shortage, proposals have come forth advocating the sale of non-vital human organs.

Proponents of the organs-for-sale scheme maintain that we have a moral duty to save lives and to reduce human suffering when it is in our capacity to do so. Thousands upon thousands of patients die each year simply because of an inadequate supply of organs. Patients needing kidneys wait years in hope of donors, all the while undergoing painful and costly dialysis treatments. Allowing a commercial market in organs could put an end to needless deaths and suffering by increasing the supply of organs. Clearly, cash payments will increase people's willingness to "donate" body parts, thereby increasing the supply. One need only look at the success of the commercial markets in increasing the supply of blood and sperm. Given the vast number of people who would be willing to part with their organs for a price, those needing organs will have a much greater chance of getting healthier or better matched ones, increasing the number of successful transplants. Up to 70 percent of transplanted kidneys will probably fail over the next 10 years, but this poor long-term outlook could be vastly improved if donors were better matched to recipients. Finally, by increasing the supply of organs, the market mechanism will eventually bring the price of organs down, so more people will be able to afford them.

Those who oppose the sale of human organs contend that society may have a duty to preserve life and relieve human suffering, but not by any means whatsoever. In particular, society should not adopt any practices that would create injustices or would violate the rights of individuals. Allowing organs to be bought and sold will do both.

Justice demands that every person have an equal right to life. To protect this right, society has an obligation to ensure that every person--whether rich or poor--has equal access to medical benefits. But if a market in organs were to develop, ability to pay would determine who could buy organs, while economic need would determine who would be motivated to sell their organs. The very wealthy would end up buyers of the organs being sold by the very poor. A market in organs would thus benefit the wealthy while putting pressures on the poor to endanger their own health. Such an unequal distribution of health benefits and burdens would be unjust.

Moreover, individuals have a right to live their lives with freedom and dignity. A market in organs would inevitably lead to abuses that would violate the freedom and dignity of individuals. Allowing organs to be bought and sold would lead to what one critic called the "plundering of peasants' parts for profits"--the exploitation of the poor and ignorant, especially in impoverished third-world countries. People living in extreme poverty are often desperate and ill-informed. Profit seekers would take advantage of this, obtaining "consent" from those who feel compelled by necessity to sell their organs, and who may not have a clear idea of the consequences of what they were doing. Such a scheme would encourage the most vulnerable in society to treat themselves as commodities and allow others to violate their rights for commercial gain.

The need for organs will only grow and, until the shortage of organs is alleviated, it is certain that thousands will die annually. But the moral issues surrounding the selling of organs promise to remain very much alive. We will have to choose between two sets of moral values: the value we place on preventing death and alleviating suffering, and the value we place on respect for human dignity and our commitment to meeting human needs in a fair and equitable manner.

[Brendan's Question: How would you describe the basic arguments FOR and AGAINST allowing the sales of organs? How do these relate to the "four principles"? To paternalism?]
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6 KIDNEYS FOR SALE: A RECONSIDERATION (BY MIRIAM SCHULMAN)

From: https://www.scu.edu/ethics/focus-areas/bioethics/resources/kidneys-for-sale-a-reconsideration/

[Brendan's Note: This article is from 2012.]

Miriam Schulman

In 1988, the Markkula Center for Applied Ethics published an article, "Kidneys for Sale," which was posted about ten years later on our Web site. It addressed the ethical issues raised by the potential for a market in human body parts.

That article has inspired sporadic emails from people asking for advice about how to sell their organs. In recent years, as the economy has soured, we've noticed an uptick in the number of such messages. Here's a sample:

I just read your information about how many people need a kidney. I would like more information about it and how I could sell one of my kidneys to your university because I really need money. I want to go to college, but it's really expensive.

These correspondents raise some of the hard questions that are inspiring a reevaluation of the question: Should organ donation remain a completely altruistic "gift of life," or should donors be compensated? The Center's Emerging Issues Group, which meets weekly to discuss ethical issues in the news, addressed these questions at a recent session. This article outlines some of the crucial considerations raised during this discussion.

6.1 A SHORTAGE OF DONATED ORGANS

First, a few facts about the acute shortage of kidneys. As of March 6, the waiting list in the United States for all organs was 113,143, with 91,015 waiting for kidneys. In 2011, there were a total of 15,417 kidney transplants in the United States, 10,185 from deceased donors and 5,232 from living donors.

"Data such as these underscore just how scarce organs are," says Margaret McLean, director of bioethics at the Markkula Center for Applied Ethics. "About 17 people die every day while waiting for a suitable organ. Although numerous strategies have been tried to increase the number of donors—from pink dots on driver's licenses to PR campaigns to donor reciprocal chains to organ swapping—we continue to come up short."

That shortage has led to many violations of both US and international laws against kidney sales. For example, this month the Chinese news agency Xinhua reported that a 17-year-old sold his kidney, which is illegal in China, to get enough money for an iPhone. He is now suffering from renal insufficiency. "Only the truly naïve imagine that organs are not currently being sold on the black market," McLean says. The International Business Times estimates that illegal organ sales constitute a $75 million per year industry.

Should such transactions be legalized? What are the ethical questions we should ask about the sale of kidneys?

6.2 THE COMMODIFICATION OF HUMAN LIFE

Even if legalizing organ sales might inspire more donations, many ethicists reject this approach because they fear where it may lead: to the **commodification** of human life. Cynthia Cohen from the Kennedy Institute of Ethics at Georgetown writes, "Human beings…are of incomparable ethical worth and admit of no equivalent. Each has a value that is beyond the contingencies of supply and demand or of any other relative estimation. They are priceless. Consequently, to sell an integral human body part is to corrupt the very meaning of human dignity."

[Brendan's Question: What do you think of this "commodification" argument against legalizing kidney sales?]

Despite these concerns, the black market itself has put a value on human organs—about $5,000 according to most reports. Peter Minowitz, professor of political science at SCU, suggests, "The actuality is there's a thriving market for organs, even crossing global boundaries. So even though the sale of organs may, in itself, violate human dignity, that dignity is being violated now on a fairly large scale, especially among the most desperate. Maybe it would be better for them if we legalized the sale and imposed certain standards on it. It's a very complicated series of considerations, mixing moral judgment with what's going on in the real world."

6.3 DO NO HARM

Undoubtedly, increasing the supply of living donors would be good for organ recipients. According to the Organ Procurement and Transplantation Network, about 90 percent of people who receive a living-donor kidney and 82 percent of those who received a deceased-donor kidney were alive five years after the transplant.

But what happens to the donors? "Usually, in medical ethics, we are looking at harm and good respective to a single patient," says McLean. "Here we are looking at harm and good for two patients where good is going to accrue to one and potential harm to the other."

Generally, kidney donation from a living donor is seen as a relatively safe procedure, as the human body functions adequately with only one kidney. The mortality rate for the removal of a kidney (nephrectomy) is between 0.02 and 0.03 percent, major complications affect 1.5 percent of patients, and minor complications affect 8.5 percent. The University of Maryland Transplant Center states:

The risks of donation are similar to those involved with any major surgery, such as bleeding and infection. Death resulting from kidney donation is extremely rare. Current research indicates that kidney donation does not change life expectancy or increase a person's risks of developing kidney disease or other health problems.

While this picture may accurately reflect the experience of donors in first world countries, those in the developing world report less benign outcomes. Madhav Goyal, Ravindra Mehta, Lawrence Schneiderman, and Ashwini Sehgal studied 305 residents of Chennai, India, who had sold their organs. Participants were asked to rate their health status before and after the operation. Eighty-nine percent of the respondents reported at least some decline in their health. "Fifty percent complained of persistent pain at the nephrectomy site and 33 percent complained of long-term back pain."

McLean points out that society also incurs risks when someone donates a kidney. "Who pays if the donor is harmed or develops renal failure of unrelated etiology 15 years later and needs a transplant?" she asks.

In bioethics, where the first rule is "Do no harm," can the sale of kidneys be judged to conform to this basic principle? Are there better ways to protect donors so that no disproportional harm comes to them?

6.4 THE PROBLEM OF EXPLOITATION AND INFORMED CONSENT

The Indian experience points to another of the key objections that have been raised against the sale of organs: the danger that poor people will be exploited in the transaction. Nicky Santos, S.J., visiting scholar at the Ethics Center and an expert on marketing strategy for impoverished market segments, argues strongly that desperation "drives the poor to make choices which are not really in their best interests." Such lopsided transactions may exacerbate already existing inequities, where the rich have access to excellent health care and the poor do not.

That was the conclusion of the Bellagio Task Force Report to the International Red Cross on "Transplantation, Bodily Integrity, and the International Traffic in Organs":

Existing social and political inequities are such that commercialization would put powerless and deprived people at still graver risk. The physical well-being of disadvantaged populations, especially in developing countries, is already placed in jeopardy by a variety of causes, including the hazards of inadequate nutrition, substandard housing, unclean water, and parasitic infection. In these circumstances, adding organ sale to this roster would be to subject an already vulnerable group to yet another threat to its physical health and bodily integrity.

On the other hand, some view this attitude as paternalistic. "You could raise the question," says Michael McFarland, S.J., "Are the rich or those in power in a position to tell the poor they are not capable of making a decision? Doesn't that violate their human dignity? It seems to me that a person in desperate circumstances could be making a perfectly rational decision that the sale of a kidney is in his or her best interests."

McFarland, a Center visiting scholar and the former president of College of the Holy Cross, goes on, "You could see the sale of organs as a way for the poor to derive some benefit from donating an organ, which they wouldn't otherwise get. For example, if a poor person was willing to donate a kidney but couldn't afford to take the time off, wouldn't it be reasonable to allow him or her to be compensated for that time?"

More people might be persuaded by this argument if, in fact, kidney sales really did help the poor financially. But in India, donors often did not receive the benefit they expected from the sale of their organs. Ninety-six percent of the people in the study had agreed to the donation to pay off a debt, but six years after the operation, 74 percent of those studied still owed money.

Most of the benefit from organ sales goes to middlemen. Havocscope, which monitors black markets, found last May that the average reported amount paid to kidney donors was $5,000, while the average price paid by recipients was $150,000. "The real injustice to the poor is they are getting so little, while those who are involved in these illegal sales are getting all the money," says Rev. Brendan McGuire, vicar general of the Diocese of San Jose.

Santos believes that the poor cannot really make free decisions to sell their organs because they are so driven by their dire circumstances. McFarland agrees that the issue of consent is the real sticking point for creating a market for organs. "I think what stops us is the concern about being able to count on a genuine free consent on the part of the donor." But he does not believe any moral absolute makes the sale of kidneys unacceptable. "It comes back to the issue of truly informed consent. Do people understand the risks they are taking on? Are those acceptable risks? Are people capable of making free decisions about whether to take those risks?"

[Brendan's Question: What do you think—can people really "consent" to selling their organs?]

6.5 ALTRUISM OR JUSTICE

Informed consent is, of course, as crucial for organ donation as it would be for organ sale. But donation frames the process as a wholly altruistic act. "For a living donor," says McLean, "it may be a chance to help a family member or friend or even a stranger." For a person signing on to donate organs after death, it may be seen as a way to give back or not to die in vain. And for the family of a deceased donor, it's "a way to have a little bit of someone alive in the world," she continues.

Many people value this altruistic aspect of the current system and do not want to see organ donation reduced to a business transaction. But, McFarland asks, "Is it the wisest and most moral policy to run a social system like kidney donation entirely on altruism?" That may be the ideal, he agrees, but since it has not been very effective at meeting the need for organs, it may be better to "strive for justice and not depend totally on altruism."

The idea of justice encompasses concern about the exploitation of the poor, but it raises even broader concerns about fairness. These might be summed up in another email we received at the Ethics Center:

So what? Is the sale of one's kidney lawful? Morality or ethics has nothing to do with it when you're down and out. Why doesn't someone ask the same of doctors and hospitals when they sell the transplant operation? Why is it when John Q. Public sees a way into the open markets, that he gets hit with the morality/ethical questions?

Is it fair that everyone involved in organ transplantation—doctors, hospital, nurses, recipient—gets something out of the process except the donor or the donor's family?

Also, donors on the black market are rarely paid anything approaching what the kidney is worth. Justice might be better served if donors were paid more. In the Indian study, the average price of an organ in 2001 was $1,410. Nobel Laureate in Economics Gary Becker and his colleague Julio Elias have calculated $45,000 as a fair price. Fairer, still say some ethicists, would be a system that pays the donor a figure closer to the actual cost of maintaining a patient on the waiting list for organs, including the cost of dialysis over many years. Arthur Matas and Mark Schnitzler have calculated that a transplant from a living unrelated donor would save at least $94,579.

Alternatively, the donor wouldn't necessarily need to be paid to be compensated. McLean reviews some other proposals to give something back to donors: "One suggestion has been to at least offer to pay funeral expenses for a deceased donor because for many people that's a stumbling block. For live donors—and this could be hugely attractive in the current environment —we might offer to cover their health care for the rest of their lives in exchange for doing this good. "

Another cut at fairness has recently been adopted by Israel and is advocated in the United States by the private organization Life Sharers. Top priority on Israel's waiting list goes to candidates who have themselves agreed to be donors. Those who don't sign up as donors get a transplant only if there is an excess of organs.

All proposals to allow the sale of organs raise ethical as well as medical risks. However, as E.A. Friedman and A.L. Friedman argue in Kidney International, Journal of the International Society of Nephrology:

At least debating the controlled initiation and study of potential regimens that may increase donor kidney supply in the future in a scientifically and ethically responsible manner, is better than doing nothing more productive than complaining about the current system's failure.

[Brendan's Question: What do you think of the proposals discussed in this section?]

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Apr 1, 2012

7 READING: IS IT OKAY TO HARVEST PIG KIDNEYS TO SAVE HUMAN LIVES? (BY DYLAN MATTHEWS)

We're starting to grow pigs to take their organs and put them in humans. Wait, what?

By Dylan Matthews Oct 28, 2021, 8:30am EDT

Finding the best ways to do good.

"David is a great transplant surgeon. Five of his patients need new parts — one needs a heart, the others need, respectively, liver, stomach, spleen, and spinal cord — but all are of the same, relatively rare, blood-type. By chance, David learns of a healthy specimen with that very blood-type. David can take the healthy specimen's parts, killing him, and install them in his patients, saving them."

So goes a story, one of the most famous in modern philosophy, told by the late Judith Jarvis Thomson in 1976.

The story raises many important ethical questions, but the core one is simple: Is it okay to sacrifice one life to save five? In this case, only the most hardened utilitarian would say yes. Treating a human being as nothing but a container for organs strikes many as intuitively repugnant, even if so doing would spare five others an early death.

Until recently, the question of trading a life for another through organ donation was largely hypothetical, grist for prize-winning sci-fi novels. But on September 25, Robert Montgomery showed that you could implant a pig kidney in a human, and the question became very concrete, very fast. No, we're not killing humans to harvest their organs, as Thomson or Kazuo Ishiguro imagined. But we're killing intelligent animals for their organs, and the moral consequences of that should weigh on us.

Montgomery, a surgeon who runs the Transplant Institute at NYU Langone Medical Center, performed the landmark operation on a dead subject. With the consent of the family, the body of the deceased was maintained using a ventilator for 54 hours, to see how an implanted pig kidney would function.

The kidney functioned about as well as a human kidney transplant, at least during that short window of time. At a press conference announcing the surgery, Montgomery noted that the implanted kidney, attached to a leg, "began functioning and making large amounts of urine within minutes," a key function of the kidneys. He also said that levels of creatinine (a waste product produced by muscles and filtered out by the kidney) in the donor's blood were normal, another sign of sound kidney functioning. He predicted that we could be seeing transplants of pig kidneys into living human donors within a year or two.

"If human organs are imagined as the fossil fuel of the organ supply, then pig kidneys are the wind and solar: sustainable and unlimited," Montgomery concluded.

The NYU Langone Health surgical team examines the porcine kidney for any signs of hyperacute rejection. The organ was implanted outside the body to allow for observation and tissue sampling during the 54-hour study period. *Joe Carrotta for NYU Langone Health*

For the 750,000 Americans with end-stage renal disease and the millions of others who care for them, this news is a massive game changer. A recent study found that some 43,000 people die every year in the US for lack of a kidney donation. That's more people than die annually due to homicide, HIV, or car accidents. Pig kidneys could drop that number to zero.

But here's the thing that should give us pause: The pig used in Montgomery's surgery was subsequently euthanized. There are some 63,000 new patients every year who might benefit from a kidney donation. Assuming each donor pig is stripped of both of its kidneys and then euthanized, that's more than 30,000 pigs killed every year to extend human lives.

Now, in fairness, that 30,000 is a blip next to the 131.6 million pigs slaughtered for their meat in the US in 2020 — a rounding error, given the scale of factory farming.

Nevertheless, Montgomery's breakthrough forces us to confront two questions: Is it morally justifiable to slaughter thousands of pigs annually to keep humans alive? And is it more morally justifiable than other methods that could also end the kidney shortage?

The ability to transplant pig kidneys into humans would undoubtedly save many human lives, which is, of course, a good thing. But it behooves us to take seriously the moral consequences of such an act, especially if we begin performing it on a wide scale.

7.1 THE PIG KIDNEY BREAKTHROUGH

Implanting other species' organs and tissues into humans — or xenotransplantation, to use the technical medical term — is a very old idea.

In the 1920s, the con man John Brinkley became a national celebrity for his surgeries implanting goat testicles into human scrotums, which he claimed could cure impotence (among other ills); he gained such support he almost got elected governor of Kansas in a revenge bid after the state revoked his medical license.

But more reputable figures have attempted xenotransplantations too. Keith Reemtsma at Tulane University performed 13 chimpanzee-to-human transplants in the 1960s, all but one of which failed within a couple of weeks of the procedure due to organ rejection or a resulting infection. One patient lived for another nine months before dying.

In 1984, Leonard Bailey at Loma Linda University implanted a baboon heart into a dying infant with the pseudonym Baby Fae. The baby rejected the organ, dying soon thereafter (and partly inspiring a pretty good Paul Simon song).

A major problem in all these efforts was rejection: the recipient's immune system interpreting the donated organ as a foreign body and attacking it as if it were a hostile organism. This is also sometimes a problem with human-to-human transplants. But rejection has become less of an issue with humans after the development of better immunosuppressant drugs, which prevent immune attacks on donated organs.

The NYU team went a few steps further than immunosuppressants: They used organs from genetically engineered pigs.

The pig whose kidney was implanted in the NYU surgery was a GalSafe pig, a genetically modified pig variety approved by the Food and Drug Administration this past December. It's produced by Revivicor, a subsidiary of the biotech firm United Therapeutics; Montgomery specifically thanked Martine Rothblatt, United Therapeutics' chief executive, in his announcement. The FDA did not evaluate GalSafe pigs for xenotransplantation per se, but Revivicor has been vocal about its ultimate intention being the use of gene-edited pigs as a source for transplants.

The gene modification prevented production of what's known as the alpha-gal biomolecule. Alpha-gal is present in all mammals besides primates (including humans), and its presence causes primate immune systems to reject organs. By preventing these pigs from producing that molecule, the gene edits enabled them to act as human donors much more effectively.

7.2 THE ETHICAL QUANDARY POSED BY PIG KIDNEYS

The benefits of pig-to-human kidney transplantation are obvious and profound. A recent study in the *American Journal of Nephrology* estimated that between 5 million and 10 million people worldwide suffer from kidney failure severe enough to require dialysis, or another kidney-replacement treatment (like transplantation).

Dying for lack of a transplant is awful, but so is being forced to live on dialysis. Dialysis is immensely physically draining, often preventing people from working or traveling; the rate of depression in people on dialysis is more than double that in the general population.

Some kidneys can be recovered from deceased donors, and indeed that serves as the source of most kidneys in the US. In 2020, 17,583 deceased donor kidney transplants were performed. But while there are actions that could be taken to improve recovery of kidneys from deceased donors, the simplest way to solve the

kidney shortage would be for living humans to step up and give more. Humans only need one kidney, and only 0.014 percent of people in the US would need to donate a kidney each year to end the waitlist.

Pig kidneys, in that sense, are not strictly medically necessary. Voluntary living human donors could fill the gap.

But in practice, a much lower percentage than that donates a kidney. In 2020, there were only 5,234 living donor transplants — a far smaller number than deceased kidney transplants and a waitlist of more than 106,000.

Indeed, in only one country in the world are there enough human donors to provide kidneys to all who need one: Iran. And there's one likely reason for that: Kidney donors in Iran are paid for their service. Here in the US and in most of the world, paying a kidney donor is illegal.

Having donated a kidney myself, I can report that while totally manageable, it's also inconvenient and temporarily painful. And yet we ask people to provide this service, and save a life, for free — or worse, if they have to take unpaid leave for the surgery, we ask them to pay for the privilege of saving a life.

But some bioethicists are vocally opposed to compensating donors for saving a life, for fear that such a system would harm poor people. Such objections make compensation very politically difficult to enact. Polling suggests a strong majority of Americans would support paying for kidney donations if so doing would improve the supply of kidneys (which it would), but it's hardly a political issue driving many votes.

Until policy on compensation changes, the advancement of pig-organ transplantation could be our best bet for ending the kidney waitlist.

Which forces us to consider the moral quandary of exchanging a pig life for a human one.

Pigs are remarkably intelligent animals. They have good memories, love to play and explore, recognize each other, and have sophisticated social lives. Purdue animal scientist Candace Croney even taught pigs to play video games. (The pigs loved it.)

So imagine an animal like your dog, but perhaps smarter, being killed to save the life of a human. Would you be willing to kill your dog in that case? Does the question disturb you?

Montgomery agreed that the practice raises important animal welfare questions. When I asked him about the euthanizing of the donor pig, he raised the question, "Is it more humane to euthanize the pig and remove both kidneys for two transplants, or to remove one kidney and have the pig sustain the recovery period, where there's pain and risk of infection?" It's also not clear who would care for a donor pig that did survive, and who could pay for that care.

The question is even tougher when you get to organs like hearts, lungs, and pancreases, which cannot be given by a living donor. Currently only a few thousand people a year receive heart transplants, mostly because there is such a minimal supply, but the American Heart Association has argued as many as 100,000 people a year could benefit, which is plausible when you consider that heart disease is the single biggest cause of death in the US, killing more than 650,000 people in 2018.

Genetically engineered pig hearts that could work for humans could dramatically extend lifespans for people with heart disease, and the same goes for lungs, liver, and other organs. But in each such surgery, a pig would have to die for a human to live.

7.3 A QUESTION FOR PHILOSOPHERS

> *Peter Singer, the moral philosopher at Princeton who helped launch the modern animal rights movement and is also a vocal advocate for kidney donation, told me in an email that he is cautiously supportive of even lethal pig donations.*
>
> *"I would not insist on the pig surviving the surgery, because that's an uncertain benefit and would require twice as many pigs to be used," Singer wrote. "What I would like to see is that all pigs involved in the procedure — including at the research stage, which obviously will continue for some years, and including the pigs' parents — are reared in conditions that meet not only their physical needs but their psychological and social needs — so not in a factory farm. That seems a minimum quid pro quo for the benefit the pig is conferring on humans."*

(Revivicor declined to comment when asked about the living conditions of its pigs.)

Singer is a utilitarian. He believes that ethics is about maximizing the welfare of humans and animals, and so is willing to make trade-offs like these that still involve the deaths of sentient animals.

Christine Korsgaard, a professor of philosophy at Harvard, is very much not a utilitarian. She's perhaps the most eminent Kantian philosopher in the world today. Immanuel Kant, the 18th-century thinker who serves as Korsgaard's main inspiration, argued human beings must treat each other's common humanity as an end in itself, not a means to their own ends.

This idea can be hard to grasp, but the important thing to know is it places limits on how much harm you can inflict on someone or some animal in order to produce some greater good. You have to respect the humanity or dignity of all rational beings (including animals).

Korsgaard objects to pig-to-human organ transplants on basically those grounds. "I do not think it is justifiable to kill an animal so that we can use her organs for a person, any more than it would be justifiable to kill one person to use his organs for another person," Korsgaard wrote me in an email. "I think the pig does have a prior claim on her own life and her own organs. If you kill a pig for her organs, you are treating her as if she is ours, a mere resource for human use, as if she exists for us rather than for herself."

Genetically modifying the pig compounded this wrong, she wrote, as humans changed the pig's biology so it could better serve human ends. "Women don't exist to make homes for men; people of color don't exist to provide cheap labor for white people; animals don't exist to provide food, labor, and organs for people," Korsgaard concluded.

I am more of a consequentialist like Singer than a Kantian like Korsgaard. But Korsgaard's arguments have incredible force. Just like factory farming, using pigs for organs turns them into a kind of industrial commodity for humans, rather than living creatures who deserve to live full, wonderful lives. There is something distasteful about that, even if the good of increased organ supply outweighs the concern.

Mostly, the development makes me sad that humans have been so unwilling to step up and donate kidneys to each other — or create the policies that would encourage such an act — that they are resorting to taking them from another species. Donating a kidney is a routine, safe procedure, one that humans could and would likely be more willing to provide if compensated.

If the alternative to a world where thousands of pigs are killed for their kidneys every year were one where Medicare carefully screened kidney donors and paid them each $50,000 or however much is necessary to get a full supply of kidneys, then the latter world seems infinitely preferable. No person, and no pigs, would have to die.

But that is not the actual counterfactual at hand. The counterfactual is the current world, where politicians have banned compensation for organ donation and organs are in persistently short supply. Compared to that counterfactual, pig organs seem like a step forward.

Brendan's Questions:

1. **Peter Singer is a vegan (who doesn't eat pork), but nevertheless approves of pig transplant organs. What is his "utilitarian" argument for this?**
2. **Korsgaard disagrees with Singer. Why?**
3. **In your opinion, is it ethically OK to use transplant organs from pigs?**

8 READING: A MORAL ARGUMENT AGAINST THE WAR ON DRUGS (BY JULIAN SAVULESCU AND BENNETT FODDY)[7]

Former Brazilian President, Fernando Henrique Cardoso, has argued that the war on drugs has failed and cannabis should be decriminalised. He argued that the hardline approach has brought "disastrous" consequences for Latin America. Having just returned from Rio, one can only agree. One of us was staying with an eminent professor of philosophy. We were returning to her house with her 11 year old daughter, only to have our way blocked by police with machine guns. They were hunting a drug lord in the local favela – this road was the only escape route and they were preparing for possible altercation.

Cardoso highlights the practical failure of a zero-tolerance approach. A zero tolerance approach to a crime like taking drugs must always fail, in the same way as a zero-tolerance approach to alcohol, prostitution or drugs in sport will always fail. Paradoxically, the worst thing you could do to the drug lords in Rio is not to wage a war on them, but to decriminalise cocaine and marijuana. They would be out of business in one day. Supplies could be monitored, controlled and regulated – the harm to users and third parties significantly reduced.

The case for legalizing drugs has been made often, most recently by Cardoso and by Australia's foreign minister, Bob Carr, who this week co-signed a report declaring that 'the war on drugs has failed'. The argument is nearly always put forward in terms of the burdens that the drug war has imposed on us in terms of crime and public health. And it is true that these things give us good reason to abandon Nixon's war on drugs. But we so rarely hear a moral argument in favour of liberalizing drug laws. This is a mistake. Although experts have told us time and time again that things would be better without the drug war, politicians have ignored the expert advice because voters do not want drugs laws to be loosened. And voters feel this way not because they think they know better than the experts, but because they have moral objections to drug use. There is a hidden moral debate driving the war on drugs that we never seem to bring out in the open.

The original drug prohibitions had a moral rationale rather than a practical one. It began with the American prohibition of opium, which was primarily motivated by a moral objection to white people smoking in Chinese-run opium dens. This began a prohibition movement in the United States. In 1913, marijuana — which was used almost exclusively by Mexican and Indian immigrants — was prohibited for the first time by the state of California.

Today, when new drugs are added to the long list of illegal substances, it is because they are judged to be "addictive", not because they are harmful. The United States' Controlled Substances Act calls for a drug to be

[7] Julian Savulescu and Bennett Foddy, "A Moral Argument against the War on Drugs," *Practical Ethics (Oxford)* (blog), April 4, 2012, http://blog.practicalethics.ox.ac.uk/2012/04/a-moral-argument-against-the-war-on-drugs/.

prohibited 'a high potential for abuse' and if it 'may lead to severe psychological or physical dependence'. The drug does not have to be harmful in any other sense. According to US government statistics, paracetamol (acetaminophen) is involved in nearly five times as many emergency room visits as MDMA, and it remains available in supermarkets around the world.

So the main reason that drugs like alcohol and caffeine are legal, but cocaine and MDMA are not, is that the latter are judged to be "addictive". (Suspend for a moment the true belief that alcohol and caffeine are addictive.) Addiction does harm the addict, to be sure. But self-harm cannot provide grounds for prohibiting a substance. As Mill famously put it, the sole legitimate reason for interfering with a person's liberty is when he risks harming others. And while it is sometimes argued that the 'drug problem' makes us all worse off, most of these harms flow directly from the zero-tolerance approach — drug prohibitions harm others when they are robbed, beaten or killed by those who run the black market of drugs.

It is sometimes argued by liberal-minded people that addictions warrant state interference because they render the addict incompetent, powerless to make an autonomous decision to take drugs. The addict becomes like a child in need of parental protection — or in this case the protection of the state. In this way 'addiction' becomes a moral concept, not a form of harm. It is a condition that robs us of our moral status.

We have argued in a number of articles (1, 2, 3, 4, 5) that such a view of addiction is false. People who take drugs are not suffering from a disease and they do not necessarily have some pathological failing of will power. They may be imprudent or irrational in taking drugs, but then again, we all are, nearly every day, in various ways when we eat unhealthily, engage in risky sports, smoke, drink or gamble. Addicts may place to greater value on pleasure, or on excitement, or escape from reality, but their addictions are not different in kind to desires for other pleasurable activities. People become "addicted" to gambling, videogames, internet use, exercise, sex, carrots, sugar and water. These substances or activities do not "hijack" the brain — they provide pleasure utilising the same brain pathways as drugs.

Every pleasurable activity is 'addictive'.

The public discourse on drugs includes liberty, health, and crime, but it so rarely includes the value of pleasure. We do not have to be hedonists to believe that pleasure is one of the important goods in a person's life. A **liberal society** should be neutral with regard to which pleasures people may pursue; it should not force people to conform to a particular conception of 'good' and 'bad' pleasures. But more importantly, if every pleasurable behaviour can be addictive, then there can be no reason to believe that the pleasures of drug use are less important than the pleasures of good food and wine, of rock-climbing and football, or of browsing the internet. Each of these things is pleasurable, and hence each is addictive, and each can be harmful if done to excess. But we all have a right to pursue the pleasures we find valuable, even though each of these pleasures puts us at risk of addictions or addiction-like problems: alcoholism, pathological internet use, sex addiction, binge eating disorder, and so on.

The right to pursue pleasure gives us reason to legalize drugs, while addiction and self-harm fail to give us good reason to prohibit them. That is the essence of a strong moral argument against the war on drugs.

There remains one possible ground for interfering in liberty and retaining the ban on drugs. That ground is the public interest. If society were to be severely impaired by liberalisation of drug laws, that might be an extreme case that warrants a ban on drugs. But our (admittedly limited) experience suggests the opposite — the Netherlands appears to have reduced its drug problem, without increasing its overall rate of drug use, by enacting relatively liberal drug laws for 'soft' drugs like marijuana. And as Cardoso argues, a complete ban seems to be strongly against the public interest, keeping drug lords in business and the user and others in a position of severe vulnerability.

In the future, perhaps we will give up our squeamishness about drugs which provide pleasure. We could use modern pharmacological science to select or even design drugs which give us the pleasure or experiences we seek, but cheaply and without serious acute or chronic health risks. For the present, the drug which we can most freely obtain is one of the most addictive, one which contributes to violent behaviour, one which produces terrible chronic health effects and the worst withdrawal syndrome of all drugs. Alcohol.

The time has come to take a rational approach to drugs.

[Brendan's Question: Should we legalize drugs? How does this relate to the ideas of soft/hard paternalism>]

9 CASE STUDY: SUPERVISED INJECTION SITES (ETHICS BOWL)

From: National High School Ethics Bowl, National Cases 2018-2019. Case Committee Chair: Dominique Déry. Case Authors and Editors: Chris Blake-Turner, Izzy Brassfield, Dominique Déry, Matthew Hernandez, Intercollegiate Ethics Bowl, Joanna Lawson, Pavel Nitchovski, Macy Salzberger, Steve Swartzer, Lauren Townsend, Jacky Wang, Rob Willison, Brian Wong, and Lili Zay

Supervised injection sites aim to reduce health and safety issues related to public consumption of illicit drugs by providing people a place where they can use drugs under the observation of trained staff. Supervised injection sites are rooted in principles of harm reduction, which focuses on reducing the unnecessary harmful effects of drug use for people who use them (and for others). The users cannot obtain the drugs at supervised injection sites, and the staff at these sites do not handle the drugs or assist in their administration; but these staff members can provide sterile supplies (thus preventing the spread of infectious diseases such as HIV), are trained to give emergency medical care when it is needed (such as administering doses of naloxone, in cases of overdose), and are able to provide users with connections to social services, drug treatment programs, and medical professionals. These sites are thus intended to complement existing programs and policies that focus on drug treatment and prevention.

Supervised injection sites are available in several countries around the world: Australia, Canada, Denmark, France, Germany and more.[8] While there are currently no supervised injection sites in the United States, several cities and states, including Seattle, San Francisco, Philadelphia, Denver, Vermont, and Delaware, are considering establishing them. However, the United States Department of Justice has recently asserted that it will take "swift and aggressive action" against any such efforts.[9]

Most research about the effects of supervised injection sites is based on a few specific sites, including Insite in Vancouver, B.C., Canada, which has been in operation for 15 years. A recent review of 75 studies concluded that supervised injection sites "promote safer injection conditions, reduce overdoses and increase access to health services. Supervised injection sites were [also] associated with less outdoor drug use, and they did not appear to have any negative impacts on crime or drug use."[10] In fact, many argue that these sites encourage their users to seek treatment for substance abuse. However, these findings are not universally accepted.

Given disagreement about the efficacy of supervised injection sites, some argue that money spent on them would be better directed elsewhere, such as to programs that aim to prevent drug use in the first place. In

[8] http://www.drugpolicy.org/issues/supervised-consumption-services
[9] https://www.npr.org/sections/health-shots/2018/07/12/628136694/harm-reduction-movement-hits-obstacles
[10] https://www.npr.org/sections/health-shots/2018/09/07/645609248/whats-the-evidence-that-supervised-drug-injection-sites-save-lives

addition, detractors argue that drug users with access to supervised injection sites still have to participate in the illegal drug trade, and that such sites do nothing to protect the safety of users while purchasing drugs. Further, staff are not able to verify the content or dosage of any given drug, making it difficult for them to support users when they have taken more or different drugs than they thought they were taking. Additionally, critics argue, by facilitating the use of illicit substances, these sites put people at risk, do nothing to address the causes of addiction, and normalize substance abuse. Moreover, public support for these sites is low: A 2018 survey conducted by the *Johns Hopkins Bloomberg School of Public Health* found that only 29% of Americans support legalizing safe injection sites in their communities.[11]

Study Questions:

1. Should the U.S. government allow the establishment of supervised injection sites? Why or why not?
2. How are harm reduction and prevention related when it comes to substance abuse? Which is more morally pressing?
3. What obligations do we have to help those who suffer from addiction? To what extent does the establishment of supervised injection sites promote and/or conflict with those obligations?

[11] https://www.clinicalpainadvisor.com/opioid-addiction/supervised-injection-sites-facts-information-pros-cons/article/807472/