

Joralemon & Cox, “Body Values: The Case Against Compensating for Transplant Organs”

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I. Background: Organ Shortages, Policy Pressure, and Bioethical Debate

By the early 2000s, the United States faced a widening gap between **organ demand** and **organ supply**. This crisis intensified policy interest in financial incentives for organ donation.

Key contextual developments:

- **Legislative proposals** in Congress attempted to introduce **tax credits** for organ donors and to authorize **pilot studies** that could waive the restriction on financial compensation in the *National Organ Transplantation Act (NOTA) of 1984*.
- **Medical organizations**—including the AMA, UNOS, and the American Society of Transplant Surgeons—showed increasing openness to **pilot programs** testing compensation for cadaveric organs.
- The AMA explicitly grounded its support in a **utilitarian framework**, arguing that the ethics of incentives should be judged by balancing harms and benefits. Critics within the AMA warned against allowing consequences alone to justify commodifying human organs.

Within this landscape, Joralemon and Cox intervene to argue *against* the shift toward using financial incentives in organ procurement.

II. Key Analytical Framework: Conceptualizing the Body

Joralemon & Cox emphasize that proposals for organ incentives hinge on underlying assumptions about the **relationship between the body and the self**.

They distinguish two major conceptions:

1. Body-as-Self:

- The physical body is integral to personal identity.
- Violations of bodily integrity—even postmortem—are ethically significant.

2. Body-as-Property:

- The body is detachable from the self and may be controlled, transferred, or sold.
- Supports both individualistic (“I own my own body”) and collectivist (“the state owns bodies at death”) arguments.

Most incentive-based policies presuppose **body-as-property**, while altruistic systems presuppose **body-as-self**. Figure 1 in the article maps common proposals along axes of voluntariness and bodily conception.

III. Summary of the Authors' Central Arguments

1. Commodification Concerns

Pro-incentive advocates often argue that selling organs is not different in kind from other permissible commodifications (e.g., surrogacy, sex work, risky labor). Joralemon & Cox respond:

- Similarities in exploitation between prostitution and organ selling **do not justify expanding** the range of ethically troubling markets.
- Many dangerous jobs or bodily exchanges occur due to **economic desperation**, and society should work to **reduce** such exploitative conditions, not broaden them.

For cadaveric organs, commodification raises additional concerns:

- Anthropological evidence shows that societies rarely treat death as an instantaneous separation of self and body. The dead remain socially significant for some time, which makes commodification deeply counterintuitive.
- Families' reluctance to donate is often tied to this continued sense of embodied identity.

2. The “Reasoned Ideal” Objection (Hypocrisy Argument)

Some proponents insist that critics would “change their mind” if their child needed an organ and selling a kidney could save them. The authors respond:

- Actions taken under **desperation** do not justify **institutionalizing** a practice.
- Analogous reasoning: A parent selling themselves into slavery to save a child does not justify legalizing slavery.
- Philosophical analyses must distinguish between **morally understandable actions under duress** and **policies that create markets in desperation**.

3. The “Rescue Obligation” Argument

Advocates often claim that society has a moral duty to “do everything possible” to reduce deaths on organ waiting lists. The authors critique this claim from several angles:

- **Legal tradition** in the U.S. rejects a duty to rescue; organ donation remains **voluntary**, which is precisely why altruistic donation has moral value.
- **Utilitarian considerations** weaken rescue arguments: vast sums spent on organ transplantation could save many more lives if redirected to cheaper public health interventions (e.g., vaccination).
- **Transplantation is not an unambiguous medical miracle**: survival rates vary, quality of life is often lower than portrayed, and anti-rejection drugs impose significant burdens.
- **Equity concerns**: Access to transplantation is profoundly unequal globally and domestically. If society must rescue, why only the already privileged?

4. Misplaced Faith in Scientific Rationalization

Some clinicians believe that as “scientific” views of the body advance, cultural resistance to organ commodification will fade. Joralemon & Cox argue instead:

- Clinicians’ detachment from the body is partly a product of **professional socialization**, not a universal or inevitable cultural development.
 - Even physicians show reluctance to register as organ donors, and common cultural practices (e.g., efforts to recover body remains after tragedies, concerns about “living on” through transplantation) underscore the persistence of **body-as-self** intuitions.
 - Incentive systems are therefore culturally discordant and unlikely to work without significant moral cost.
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IV. The Authors’ Conclusion

Joralemon & Cox argue that financial incentives for organ procurement are not ethically neutral experiments. They presuppose a **shift in cultural values**—from body-as-self to body-as-property—that is neither inevitable nor desirable. Ethical analysis should proceed by recognizing:

- The enduring social and cultural meaning of bodily integrity.
- The risks of exploitation and coercion inherent in organ markets.
- The moral importance of voluntariness and gift-giving in transplantation practices.

They ultimately defend retaining **altruism-based systems** and preserving the **non-commodified** moral landscape of organ donation.
