Editorial

Commerce and medical ethics

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Several of the papers in this issue of the journal address issues of commerce in relation to medical ethics.

Dr John Keown¹ argues in favour of the long-established British, and more recently also European Union, policy that blood for transfusion purposes should be donated, rather than sold. Even if – counterfactually – it were more expensive to use unpaid donors, he suggests, the promotion of altruism and social solidarity that the voluntary system promotes would justify the extra expense.

Dr Donna Dickenson,² responding to Dr Don Evans's earlier paper in the journal,³ argues (a) (like Dr Evans) that if men are to be paid for "donating" their sperm for infertility treatment then women, for whom such donation is a taxing and painful process, should also be paid; but (b) (unlike Dr Evans) that neither men nor women should be paid, but rather that people in general should altruistically donate their gametes for the benefit of others.

Professor Tom Sorell⁴ argues that the current UK government emphasis on quasi commercial internal markets, buying and selling services, and regarding patients in the National Health Service as customers and or "consumers", is mistaken, and that instead a model based on solidarity is preferable.

Some of the arguments presented by these authors are persuasive. For example, in relation to blood donation Dr Keown argues that payment is unnecessary; that unpaid donation encourages altruism and social solidarity, whereas payment tends to undermine these virtues; and that blood that has not been paid for tends to be safer for the recipients than blood that has been bought from the donors. He goes on to argue that payment for blood "involves a significant risk of exploiting the poor and socially disadvantaged". Even if this can be guarded against by, for example, existing reputable companies working under careful regulation in the first world, extension of such activity within Europe might encourage less developed countries to embark (or continue) on the path of paid donation. This would risk widespread and serious exploitation, including exploitation by rich nations of the citizens of poor nations, and the inhibition of voluntary donation programmes in developing

countries by commercial companies from rich nations attracting away potential volunteers by paying for their blood and taking it away, thus depriving those needing blood in the poor nations.

He then suggests, by a series of questions under the subheading "Commercialisation of the human body", that payment for blood may lead, by treating a part of the human body as property, to devaluation of the human body, to an instrumental view of human beings as means rather than as ends, as objects rather than subjects, and to the possibility of treating other bodily parts as chattels.

There can be little doubt that altruism and social solidarity are morally desirable, indeed admirable, phenomena and, other things being equal, to be encouraged. Nor would most people doubt that if a course of action can reliably be predicted to produce more harm than benefit then there has to be very strong moral justification for pursuing it. The altruistic unpaid blood donor system in the UK and several other European nations does appear to be working and to be more beneficial than a paid system and there seems no reason at present to move away from it to a commercial system of paying blood donors, given that sufficient donors are obtainable to provide sufficient blood for our needs. It is indeed a moral bonus that the system of unpaid donation encourages altruism and a strong sense of social solidarity among the donors and the recipients and is a fine example to everyone else.

The other arguments offered by Dr Keown are less secure. Exploitation is an emotive and ambiguous term meaning the use of someone to achieve the exploiter's own ends. The morally undesirable form of exploitation is the use of people for our own ends in ways that are detrimental to those people and/or that fail to respect their autonomy (and thus, in Kantian terminology, use them merely as means and not also as ends in themselves). While paid blood donors *might* be exploited in this sense there is no need for this to occur and provided a system of paid donation is carefully regulated there seems no reason to assume that donors are likely to be exploited in this morally undesirable sense. On the contrary,

selling their blood, if they are paid well for it, far from being to the detriment of poor people, may benefit them, and actually enhance rather than infringe their autonomy. Nor need it be the case that overseas commercial companies buying blood in poor countries will reduce its availability locally. Governments could, for example, make it a condition for licensing such commerce that half of all blood bought would be made available for provision to their own nationals.

Similarly, doubts confront the range of worries that treating body parts as property will lead to "an instrumental view of human beings, as means rather than as ends, as moral and legal objects rather than subjects". Certainly Dr Keown points to a possible "empirical slippery slope" here (a claim that as a matter of fact rather than logic things are likely to go in the way predicted) – but there is certainly no *need* for things to go that way. On the contrary, uncoerced selling of something by one person to another on the basis of a mutually agreed price is typically a clear example of two people treating each other *not* merely as means to achieving their own aims but also, since each is co-operating in pursuit of the other's aims, as ends in themselves. Of course the empirical slippery slope argument has to be taken seriously whenever it is used. But it also needs to be remembered that this argument is available (and usually used) to oppose all innovations. The evidence in particular cases needs to be thoroughly assessed and the foregone anticipated benefits of the innovation, and their probabilities, need to be set against the anticipated harms and their probabilities. Without such evidence empirical slippery slope arguments tend to involve little more than the trading of opposed opinions between proponents and opponents of proposed changes.

Like Dr Keown, Dr Dickenson and Professor Sorell also point to the fact that a commercial approach in health care tends to undermine altruism and social solidarity, whether in the provision of eggs and sperms for infertility treatment, or in the attitudes engendered by turning patients into customers and consumers, and health care organisations into quasi markets.

Clearly the promotion of altruism and social solidarity are noble aims and where they do not interfere with, let alone where they promote, optimal health care, as with our current unpaid blood donor system, all well and good. But it remains an open question – and to a large extent a political question – how much in general a commercial approach in health care discourages rather than encourages better health care. There is a danger in being too ready to offer blanket condemnation of commerce in health care in lofty favour of altruism and social solidarity that health care may suffer.

Where more harm than benefit is likely to arise from a commercial approach it is surely right to

avoid it or modify it. But suppose evidence accrues that in some particular area of health care – whether in its management or in obtaining adequate supplies of blood or gametes – health care is actually threatened by reliance on a non-commercial approach. Suppose people simply stop volunteering to donate their blood, or (perhaps more likely) suppose women refuse to undergo the inconvenience and considerable discomfort of providing eggs unless they are paid for it? As Dr Evans points out³ the voluntary unpaid approach to non-therapeutic medical research has already failed to produce enough volunteer research subjects and a controlled system of payments has been instituted. Should this be stopped in favour of promoting altruism and social solidarity or should it be continued in pursuit of better health care?

If payment is to be allowed in order to promote some areas of health care at the expense of promoting altruism and social solidarity, what would justify selection of other areas – for example fertility treatment based on the use of donated gametes – for the promotion of such social engineering at the expense of health care? Yet a blanket prohibition of "commerce" – ie payment for services – in pursuit of altruism and social solidarity would effectively destroy the bulk of health care. For commerce in health care is entailed wherever health care workers, professional or otherwise, are paid for their services. It would indeed be wonderful (in both senses) if doctors and nurses and hospital cleaners and home-helps and pharmacists and pharmaceutical companies gave their services to the sick free of charge. If done voluntarily would certainly reflect an enormous increase in altruism and would both reflect and produce an enormous increase in social solidarity. But in the absence of major changes in human nature reliance on such altruism would be associated, it can be safely predicted, with a catastrophic reduction in the provision of beneficial health care!

When benefits in altruism and social solidarity can be obtained along with the maintenance of optimal health care we can all cheer. But should the pursuit of altruism and social solidarity impair the provision of health care many would give priority to optimal health care even at the cost of more commerce and less altruism.

References

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- 3 Evans D. Guest editorial: Procuring gametes for research and therapy. *Journal of Medical Ethics* 1995; 21: 261–2.
- 4 Sorell T. Morality, consumerism and the internal market in health care. *Journal of Medical Ethics* 1997; 23: 71–6.