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PERSPECTIVES ON FINANCIAL INCENTIVES TO INDUCE LIVE DONOR KIDNEY DONATION: SCHOLARSHIPS IN EXCHANGE FOR THE GIFT OF LIFE

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I. INTRODUCTION

The need for increasing the supply of transplantable kidneys is great. There are now more than 80,000 patients on the national waiting list for kidney transplants.¹ At the end of 2005, there were approximately 341,000 patients in the United States suffering from end stage renal disease and receiving dialysis treatment, most of whom had not been listed for a transplant.² Increasing the number of kidneys available for transplantation is imperative. The authors applaud Mr. Linford's creative efforts to address this critical need.³ Nevertheless, we cannot endorse his proposal.

Proposals to offer financial incentives to help alleviate the acknowledged organ shortage are not new and have taken many forms.⁴ Outright cash payments occupy the most obvious end of the financial incentive spectrum,

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1. Organ Procurement and Transplantation Network, Current U.S. Waiting List (by Organ), at www.optn.org/latestData/step2.asp (follow "Waiting List"; then follow "Registrations"; then follow "Overall by Organ") (last visited Mar. 25, 2009).

2. NAT'L KIDNEY FOUND., FACT SHEET: END STAGE RENAL DISEASE IN THE UNITED STATES (2008), at www.kidney.org/news/newsroom/fs_new/esrdinUS.cfm (last visited Mar. 25, 2009).

3. Jake Linford, *The Kidney Donor Scholarship Act: How College Scholarships Can Provide Financial Incentives for Kidney Donations While Preserving Altruistic Meaning*, 2 ST. LOUIS U. J. HEALTH L. & POL'Y 265 (2009).

4. See, e.g., E.A. Friedman & A.L. Friedman, *Payment for Donor Kidneys: Pros and Cons*, 69 KIDNEY INT'L 960, 961 (2006) (proposing to increase the pool of transplantable kidneys by legalizing sale and establishing a fair market price); Francis L. Delmonico et al., *Ethical Incentives – Not Payment – For Organ Donation*, 346 NEW ENG. J. MED. 2002 (2002) (describing various proposals to increase the supply of transplantable kidneys including donor medals of honor, reimbursement for funeral expenses, organ exchanges, donor insurance, and ensuring access to organs for previous donors).

while consideration such as lifetime health insurance benefits, given to the living donor to address the clear risks and disincentives attendant to the organ donation, occupy the other end.⁵ Presently, the law prohibiting valuable consideration in exchange for organs allows for little flexibility.⁶ In the past the law has even frustrated innovative attempts to transplant donor organs, such as paired kidney donations. Mr. Linford's proposal to offer college scholarships as an incentive for organ donation calls to mind the current, spirited debate over the propriety of giving financial incentives to individuals who donate a kidney.⁷ The Executive Committee of United Network for Organ Sharing (UNOS) and its Board of Directors recently decided against taking a position in the debate because, inter alia, it could conflict with UNOS's role as the federal contractor operating the national Organ Procurement and Transplantation Network (OPTN), which oversees living and deceased donor transplantation in the United States.⁸ Neither UNOS nor the OPTN has taken a position regarding the issue of financial incentives. The decision as to whether such incentives should be given to potential donors is one better left to society as a whole rather than the organization that serves as the steward of donated organs and is charged with their equitable allocation among patients who are waiting for a transplant.

The goal of this essay is not to respond to the many known and unknown operational challenges of a scholarship incentive, but instead to

5. See generally Friedman & Friedman, *supra* note 4, at 962 (arguing that legalizing financial incentives for donation will eliminate black markets, create a safer organ supply, and help ease the shortage of viable organs); A.P. Monaco, *Rewards for Organ Donation: The Time Has Come*, 69 KIDNEY INT'L 955 *passim* (2006) (proposing financial compensation that is more nuanced than the traditional "buying and selling" proposals); Arthur J. Matas, *The Case for Living Kidney Sales: Rationale, Objections and Concerns*, 4 AM. J. TRANSPLANTATION 2007, 2008-09 (2004) (arguing for the legalization of payments for donations, but focusing on regulation to ensure safety and non-exploitation).

6. National Organ Transplant Act (NOTA), 42 U.S.C. § 274e (2000) (making it "unlawful for any person to knowingly acquire, receive, or otherwise transfer any human organ for valuable consideration for use in human transplantation if the transfer affects interstate commerce.").

7. See Sally L. Satel & Benjamin E. Hippen, *When Altruism Is Not Enough: The Worsening Organ Shortage and What It Means for the Elderly*, 15 ELDER L.J. 153, 196-97 n.265 (2007) (listing the plethora of publications debating the various donation incentive proposals); Delmonico et al., *supra* note 4, at 2003-04 (discussing several ethical incentives to increase organ donation).

8. See generally Press Release, United Network for Organ Sharing, UNOS Again Receives National Transplant Network Contract (Oct. 3, 2005), at www.unos.org/news/newsDetail.asp?id=492 (last visited Mar. 25, 2009) (stating that UNOS has been awarded the federal contract to supervise the nation's OPTN).

offer the personal perspectives of the authors who have broad knowledge of the debate regarding incentives for organ donation.

II. ARGUMENTS FOR AND AGAINST FINANCIAL INCENTIVES

Mr. Linford does not suggest that living donor organ donation will supplant deceased donor organ donation, but rather that the financial incentive program will increase the volume of living donations to close the gap between the existing supply of transplantable organs and the need for those organs as quantified by the number of candidates on the waiting list. A purely economic analysis of this gap between supply and demand might suggest that an appropriate incentive could motivate potential donors who would not otherwise donate to do so.⁹

A. Arguments Favoring Financial Incentives

The criticisms of the present system based upon altruism are well-defined,¹⁰ and the unfortunate consequence of failing to adequately resolve the shortage of organs for transplantation is, and will be, the multiplication of suffering by candidates on the waiting list and the stark reality that many people will die while waiting for a suitable donor organ. Proponents of systems to provide financial incentives suggest that the current altruism-based system is inadequate to meet the current demand for donor organs, and that demographic data suggests that this disparity is growing.¹¹ It is argued that the results of an increased disparity between supply and demand engender many unsatisfactory consequences, including but not limited to the following:

- “[A]n expansion of time on the waiting list which effectively excludes the vast majority of patients on dialysis without a living donor”;
- “[R]ecipients who are older and sicker when they come up for transplantation as a consequence of their extended vintage on dialysis”;

9. See generally PAUL A. SAMUELSON & WILLIAM D. NORDHAUS, *ECONOMICS* 67 (18th ed., 2004) (describing basic supply and demand theories and applications); Richard A. Epstein, *The Human and Economic Dimensions of Altruism: The Case of Organ Transplantation*, 37 J. LEGAL STUD. 459, 465-66 (2008) (discussing how to model supply and demand for organ donation under different arrangements).

10. See Epstein, *supra* note 9, at 460-61 (noting that altruism for organ donation is not the most efficient method to govern the current regime of organ transplantation).

11. See Laura Meckler, *Kidney Shortage Inspires a Radical Idea: Organ Sales*, WALL ST. J., Nov. 13, 2007, at A1 (describing how the gap between kidney supply and demand has increased); Gabriel M. Danovitch, *Cultural Barriers to Kidney Transplantation: A New Frontier*, 84 TRANSPLANTATION 462, 462 (2007) (explaining that only a system of financial incentives will work to increase organ donation).

- “[I]ncreasing emotional pressure on any available [living] donor to donate and the consequent strain on the altruistic features of donor motivation”;
- “[A]n upsurge in the practice of international organ trafficking [–] traveling to a developing country for the purpose of purchasing an organ in which the incentives for vendors are to avoid disclosing co-morbid conditions, brokers to suppress any information which might interfere with a successful transaction and recipients not to disclose the transaction for fear of prosecution or ostracism by health care professionals”; and
- “[A] proliferation of the . . . desperate public solicitations of organs on the internet and elsewhere.”¹²

It has been suggested that the straightforward application of the principles of supply and demand will cure the growing shortage of organs for transplantation.¹³ That is, a live donor would be willing to take on certain risks to part with a priceless and lifesaving donor organ for an appropriate price. Under the present system based upon altruism, the appropriate “price” might be the joy of prolonging the life of a family member suffering from organ failure or the sense of self-fulfillment experienced by the infrequent live donor that does not direct a specific recipient of their donated organ.¹⁴ The issue is the appropriate price that society is willing to tolerate while people are dying waiting for a life saving organ. Through the prohibition against valuable consideration contained in the National Organ Transplant Act (NOTA),¹⁵ society has expressed a preference in favor of the altruism-based organ donation system.¹⁶ This societal preference may not be absolute. Proponents of the current altruism-based system insist that it has not reached its full potential to recover donor organs. However, seventeen people die every day waiting for the organ offer that will never come and despite worthy efforts to maximize

12. *Organ Transplantation and Procurement—Policy Proposals: Hearing Before President’s Council on Bioethics* (June 22, 2006) (testimony of Benjamin E. Hippen, M.D., Transplant Nephrologist, Metrolina Nephrology Associates), at www.bioethics.gov/transcripts/june06/session4.html (last visited Mar. 25, 2009) [hereinafter Hippen Testimony].

13. COMM. ON INCREASING RATES OF ORGAN DONATION, INST. OF MED., ORGAN DONATION: OPPORTUNITIES FOR ACTION, REPORT BRIEF 1 (2006), available at www.iom.edu/Object.file/Master/34/281/organdonationforweb.pdf (last visited Mar. 25, 2009); Epstein, *supra* note 9, at 465-66.

14. See generally Gilbert Meilaender, *Gifts of the Body*, NEW ATLANTIS, Summer 2006, at 25, 32-33 (considering the personal fulfillment donors may experience from donating organs); Satel & Hippen, *supra* note 7, at 192 (noting that participants in surveys and social psychology experiments are less willing to perform a task they had already agreed to do for free if it came with an offer of money).

15. National Organ Transplant Act, 42 U.S.C. § 274e (2000).

16. See Friedman & Friedman, *supra* note 4, at 961 (discussing the various national and international movements in support of the NOTA prohibition of organ sales).

the number of organs recovered, it is generally accepted that the disparity between the supply and demand for transplantable organs continues to grow.¹⁷ Would society hold fast to this prohibition if the daily death toll continued its slow climb to fifty or hundred deaths per day? “[W]e need not rely on thought experiments or on heavily qualified examples from social science to realize the repugnant future consequences of more of the same.”¹⁸ Even though death may not be a “[p]roblem to [b]e [s]olved”,¹⁹ preventable deaths should never be tolerated.

B. Arguments Against Financial Incentives

Despite [various] proposals for pilot studies, compelling arguments against financial incentives for organ donation have been eloquently made since this concept was last considered by the UNOS Ethics Committee.²⁰ Practical questions as to the source and amount of compensation, when during the process it would be offered, and how the system would be administered are raised first.

Moreover, those against financial incentives base their objections primarily on the argument that the current altruistic system has not failed as much as it has not been fully promoted. To support this position, it has been suggested that donation rates could decrease under such a system due to a backlash and losses from the current donor pool based on pure altruistic giving. Actually, it could be argued, this altruism extends beyond the donor and the donor family to include many others (neurosurgeons, neurologists, emergency room and intensive care nurses, etc.) who participate in the donation process without added compensation. In fact, anecdotal reports from organ donor families indicate that such incentives would be interpreted as “repayment” and would have changed their response to request for donation due to a perceived or real element of coercion.

Opponents of financial incentives point out that there would be potentially decreased emotional gain for the donor family, decreased respect for life and the sanctity of the human body, and a loss of the personal link that currently exists in the donation process. Great concern

17. *Id.* at 960.

18. B.E. Hippen & R.S. Gaston, *The Conspicuous Costs of More of the Same*, 6 AM. J. TRANSPLANTATION 1503, 1504 (2006).

19. Meilaender, *supra* note 14, at 26-28.

20. The following five paragraphs are reproduced from EDWARD W. NELSON ET AL., PAYMENT SUBCOMM., UNITED NETWORK FOR ORGAN SHARING (UNOS), FINANCIAL INCENTIVES FOR ORGAN DONATION (1993), at www.unos.org/resources/bioethics.asp?index=4 (last visited Mar. 25, 2009). UNOS provides this information to the public to stimulate discussion about the issue of financial incentives for organ donation.

has also been expressed regarding a potential rich versus poor phenomena and the fact that financial need should not be linked in a coercive way to giving consent for organ procurement. Ironically, such incentives directed primarily at [minority] communit[ies] would undoubtedly recall for many the past experience of "commerce in bodies" that is unfortunately a part of our country's history.

Beyond theoretical concerns, those opposed to financial incentives for organ donation predict the potential loss of control of this process to government bureaucracies and "organ brokers" with tremendous increase in administrative requirements and therefore cost. Such money would be better spent on more education for the public and the medical communities regarding the need for organ donation via the current system and the benefit to society as a whole through this process.

Beyond the fact that proposed incentives may actually prove to be disincentives to potential donors, it has been argued that financial gain by the donor family does not address the problem that many potential donor families are never asked [about their desire to donate]. This failure by the medical community to participate in the donation process would not be addressed by incentives directed at the potential donor alone. Finally, not unlike the criticisms directed at the results of recent public opinion polls, those against financial incentives point out that field tests of such proposals would not measure all the possible effects and yet risk losing the best parts of the current system.

Opponents of financial incentives in general and Mr. Linford's proposed scholarship incentive system would argue that such a system is unjust because the natural and expected typical donor under that system would be among the most disadvantaged members of our society.²¹ That is, any type of financial incentive is going to appeal to the least affluent families that likely have the least knowledge about other options to fund higher education. While higher education is an admirable goal, any financial incentive system will not be able to overcome this fundamental shortcoming. A strong case can be made for helping the poor through the *removal of disincentives to donation*²² as described *infra* without such a coercive effect.

While the number of organs donated, lives extended, and the amount of money saved by organ transplantation can be quantified, many facets of organ transplantation defy economic analysis. "The fundamental truths of our society, of life and liberty, are values that should not have a monetary price. These values are degraded when a poor person feels compelled to risk death for the sole purpose of obtaining monetary payment for a body

21. Benjamin Hippen, *The Case for Kidney Markets*, NEW ATLANTIS, Fall 2006, at 47, 60; Satel & Hippen, *supra* note 7, at 198.

22. See *infra* Section IV, Subsection A (Removal of Disincentives to Donation).

part.”²³ An educational benefit can be seen as simply an alternative to a direct monetary payment—a benefit that will appeal to the poor person who might otherwise have used the direct monetary payment to further their education but a poor person nonetheless.

Ethicists also argue that a system of financial incentives would commodify the body.²⁴ Arguments can be made that the right of individual autonomy should permit the sale of human organs and tissues, much the same way as markets exist for blood products and reproductive cells voluntarily provided from living vendors. This right of autonomy is limited. Consider the following examples: a parent should not be permitted to donate their heart to their sick child; prostitution is illegal in most states; and persons should not be allowed to sell themselves into indentured servitude.

III. LIVING DONATION

Organs for transplantation are recovered either from deceased donors or from living donors.²⁵ Living donation involves the voluntary and informed consent to injure the living donor’s body “in order to relieve the suffering or preserve the life of another (usually, though not always, another to whom one is closely bound by ties of kinship or affection).”²⁶ Mr. Linford’s proposal is limited to providing a financial incentive for kidney donation from living donors.²⁷ It is important to note that kidney donation is not without risk for the donor. Between 1999 and 2007, there were thirteen living donors who died in the United States within thirty days following surgery.²⁸ The death of a kidney donor immediately following surgery occurred in 2008.²⁹ Data collected by UNOS between 2005 and 2007 indicate there were 768 adverse medical events within six weeks following surgery, including hospital readmissions and reoperations.³⁰ The decision to remove a kidney from a healthy patient is not one to be made lightly or under coercive circumstances. Due to the risks described above, it is imperative that treating physicians and surgeons have access to absolutely truthful and complete information from the donor during the pre-surgical workup in order to minimize those risks.

23. Delmonico et al., *supra* note 4, at 2004.

24. John H. Evans, *Commodifying Life? A Pilot Study of Opinions Regarding Financial Incentives for Organ Donation*, 28 J. HEALTH POL. POL’Y & L. 1003, 1003-04 (2003).

25. Meilaender, *supra* note 14 at 29, 32-33.

26. *Id.* at 33.

27. Linford, *supra* note 3, at 272.

28. Data on file with authors.

29. Susan Edelman, *Kidney OP Gave Her Life, But Took Her Love – Husband Made Ultimate Sacrifice for Wife*, N.Y. POST, Dec. 21, 2008, at 19.

30. Data on file with authors.

In addition, although rare, living kidney donors have developed end stage renal disease in their remaining kidney requiring that they receive a kidney transplant.³¹ “The need for a transplant in a previous kidney donor should constitute the highest priority in the allocation of organs.”³²

There are many benefits to the individual recipient of the living donor kidney transplant, as well as benefits to the pool of candidates waiting for an appropriate donor kidney. Living kidney donation comprises an increasing percentage of the total kidneys donated per year.³³

Proponents of the current altruism-based system of living donation will note several advantages that would be compromised by a shift to an incentive-based system including the following:

- The total number of available organs may decrease as a result of providing financial incentives through a reduction in the current rates of deceased and living donation;³⁴
- The United States system could become flooded by foreign nationals wishing to enter the country, which could overwhelm the current system.³⁵ One result could be that restrictions would be placed on the number of transplants³⁶ for people with end stage renal disease because of their country of origin, or in the absence of such quotas, that waiting times for Americans could increase;
- Financial incentives might expand the pool of potential organ transplant candidates to include the old and infirm that might not otherwise seek an organ transplant in the current system;³⁷ and
- Financial incentives increase pressure and the likelihood that a prospective donor might be less than candid when disclosing their medical history to avoid being disqualified; this increases the risk to recipients of donor-transmitted diseases;³⁸

31. Delmonico et al., *supra* note 4, at 2004.

32. *Id.*

33. See California Pacific Med. Ctr., Living Kidney Donation, at www.cpmc.org/advanced/kidney/patients/topics/living_donation.html (last visited Mar. 25, 2009) (noting that living kidney donation has increased to more than forty percent of all kidney donations).

34. See Evans, *supra* note 24, at 1022-23 (discussing that direct or indirect policies of commodification will cause a decrease in the number of organs that are donated due to people finding such policies repulsive); NELSON ET AL., *supra* note 20 (explaining that organ donation rates could decrease under a financial incentive based system).

35. See, e.g., Danovitch, *supra* note 11, at 463 (discussing kidney “transplant tourism,” where people travel abroad to buy kidneys and receive transplants in China).

36. See *id.* (“[T]he number of living donor transplants in Hong-Kong has decreased and is now only 15% to 20% of all kidney transplants performed there.”).

37. See Satel & Hippen, *supra* note 7, at 156-57 & fig.1 (detailing that more elderly individuals are being considered for organ transplantation).

38. See *id.* at 190 (noting that the American system of blood procurement, which is partly commercialized and financially based, is more likely to contain blood that is contaminated).

Proponents of a regulated incentive-based system of acquiring kidneys from living organ vendors argue that such a system may have several potential advantages over the present altruism-based combination of living and deceased donors including the following:

- “[A]n increase in the [total] number of organs available for transplantation on a scale that more plausibly approaches the current and future demand”;
- “[A] concomitant reduction perhaps even elimination of the root cause of international organ trafficking and unregulated internet solicitation”;
- “The opportunity for truly altruistic living donors to donate largely free of the incessant moral and emotional pressures of the desperation of their designated recipient[s]”;
- “[A]n increase in the frequency of preemptive transplantation which confer graphs of rival benefit that exceeds transplantation after any amount of time on dialysis”;
- “[T]he identification of a cohort of living vendors who are at the very lowest risk for long-term adverse outcomes eliminating another competing pressure on current and future living donors with comorbidities which are relative contraindications to donation”;
- “[O]rgans which on the whole are transplantable with fewer operative and immunologic complications as well as vastly improved long-term outcomes”;
- “[T]he leisure of time to carefully undertake all forms of vendor screening, organs from deceased donors are procured, screened and allocated under nontrivial time pressure”.³⁹

IV. INCREASING THE SUPPLY OF ORGANS FOR TRANSPLANTATION

The primary premise for those who wish to change the altruistic basis of organ donation to a model where living donors are provided financial incentives is the ever increasing size of the wait list and the rate of death for those who are waiting on the list.

One of the most successful efforts to increase the supply of deceased donor organs has been the Health Resources and Services Administration’s (“HRSA”) Organ Donation Breakthrough Collaborative.⁴⁰ The number of

39. Hippen Testimony, *supra* note 12.

40. *Organ Donation: Utilizing Public Policy and Technology to Strengthen Organ Donor Programs: Before the Subcomm. on Information Policy, Census, and National Archives of the H. Comm. on Oversight & Government Reform, 110th Cong. (2007)* (statement of James Burdick, M.D., Dir., Div. of Transplantation, Healthcare Sys. Bureau, Health Res. and Servs. Admin., U.S. Dep’t of Health and Human Servs.), at www.hhs.gov/asl/testify/2007/09/t20070925a.html (last visited Mar. 25, 2009) [hereinafter Burdick Statement].

organ donors per month in the United States has grown at an unprecedented rate since the inception of HRSA's Organ Donation Breakthrough Collaborative in September 2003.⁴¹ Organ donation increased nineteen percent for the combined collaborative periods from October 2003 through May 2006 compared to the same time period pre-Collaborative.⁴² Recent national data indicates that even greater increases in organ recovery and transplantation are possible under the existing system.⁴³

There are wide geographical variations in the number of organs that are transplanted.⁴⁴ Successful organ donation also strains a transplant center's ability to transplant all of the organs that are currently being recovered.⁴⁵ Nevertheless, the number of patients undergoing transplantation has increased while the number of patients on the national waiting list who died without a transplant has been steadily decreasing.⁴⁶

The rate of death on the waiting list has decreased sequentially over a three year period from 8.6% in 2003 to 7.0% in 2005.⁴⁷

2003			2004			2005		
Patients Ever Waiting During Year	Deaths	Death Rate	Patients Ever Waiting During Year	Deaths	Death Rate	Patients Ever Waiting During Year	Deaths	Death Rate
106,813	9,230	8.6	114,571	9,080	7.9	123,826	8,676	7.0

41. Teresa J. Shafer et al., *Organ Donation Breakthrough Collaborative: Increasing Organ Donation Through System Redesign*, CRITICAL CARE NURSE, Apr. 2006, at 33, 46-47 & fig.5.

42. Data on file with authors.

43. See Elizabeth M. Duke, Adm'r, Health Res. & Servs. Admin., Remarks to Organ Donation Breakthrough Collaborative Meeting (Dec. 9, 2004), at <http://archive.hrsa.gov/newsroom/releases/2004speeches/organ-donation-Dec9.htm> (last visited Mar. 25, 2009) (discussing the productivity and success of Organ Donation Breakthrough Collaborative).

44. OFFICE OF THE INSPECTOR GEN., DEP'T OF HEALTH & HUMAN SERVS., VARIATION IN ORGAN DONATION AMONG TRANSPLANT CENTERS 1 (2003), available at www.oig.hhs.gov/oei/reports/oei-01-02-00210.pdf (last visited Mar. 25, 2009).

45. See generally ORGAN PROCUREMENT & TRANSPLANTATION NETWORK/SCIENTIFIC REGISTRY OF TRANSPLANT RECIPIENTS, 2007 ANNUAL REPORT tbls. 2.12-3.18 (2007), available at www.optn.org/AR2007/download_instruction.htm (follow link for "Download 2007 Annual Report") (last visited Mar. 25, 2009) (showing that the percentage of transplant organs recovered and utilized has slowly decreased over the past decade).

46. See generally *id.* at tbl. 1.6 (showing that the rate of patients on the waiting list who died without a transplant has generally decreased from 1997 to 2006).

47. Data on file with authors.

These developments occurred during a period when there were no financial incentives to increase the potential number of donors in the United States. There is no data to suggest that the results that have been achieved would have been enhanced by financial incentives.

A. *Removal of Disincentives to Donation*

Mr. Linford's proposed solution raises several questions and concerns. It may be more prudent to attempt to increase the number of living kidney donors by removing *disincentives* to living donation. One such disincentive is that a donor may fear that he or she will lose health insurance coverage due to his or her status as a donor. A proposal currently being discussed among transplant surgeons would call for Medicare to provide lifetime coverage to persons who donate a kidney as a way to remove that disincentive and protect donors.⁴⁸ Another program now being piloted by the HRSA provides reimbursement for travel and subsistence costs on a needs basis.⁴⁹ An additional barrier for many is the loss of time from work and the potential of lost wages. Reimbursement of such costs can make a donor whole rather than rewarding them for the donation as a scholarship program would do.

The distinction between removing disincentives and reimbursing costs incurred as opposed to rewarding someone for kidney donation is not insignificant. The motivation of the donor becomes a crucial consideration with the provision of a financial incentive calling into question whether the donor's desire to receive the financial gain overrides his or her willingness to be truthful during the pre-donation medical and psychosocial evaluation. Some transplant physicians express concern that such incentives put pressure on the doctor-patient relationship by diminishing the ever important element of trust. Regardless, the transplant community is "duty bound to seek an acceptable remedy for those patients who, in their desperation, expose themselves to unanticipated danger, and their donors to exploitation."⁵⁰

V. CONCLUSION

Mr. Linford proposes an interesting solution to bridge the gap between the growing demand for donor organs and the available supply provided under the current altruism-based system. Any proposal for financial

48. See NATCO, THE ORGANIZATION FOR TRANSPLANT PROFESSIONALS, LIVING DONOR HEALTH CARE COVERAGE, INSURABILITY AND FOLLOW-UP: POSITION STATEMENT (2006), available at www.natco1.org/public_policy/documents/LivingDonorInsurability.pdf (last visited Mar. 25, 2009) NATCO offers counseling and medical management for transplant patients and their families. *Id.*

49. Burdick Statement, *supra* note 40, at 3.

50. Danovitch, *supra* note 11, at 463 (citation omitted).

incentives in general, and a higher education scholarship incentive in particular, will stimulate ethical and moral arguments both in favor and in opposition and will have numerous operational challenges to overcome, assuming that the present law prohibiting financial consideration for donor organs is amended to permit such a program. In addition, significant questions remain about the impact of financial incentives for living kidney donors and its effect on the existing rates of deceased donor and living donation.