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# Cash for Kidneys? Utilizing Incentives to End America's Organ Shortage

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## CASH FOR KIDNEYS? UTILIZING INCENTIVES TO END AMERICA'S ORGAN SHORTAGE

*Steve P. Calandrillo\**

### ABSTRACT

Over eighty-five thousand Americans are currently on the national waitlist to receive kidneys, livers, hearts or other human organs due to the failure of their own. Sadly, over half of these people will die while waiting for the miracle of life to arrive. Some will travel to other countries to purchase organs on the black market in a last ditch effort to save their lives. All of those involved wish that finding an organ would be far easier than it is today.

Since the passage of Al Gore's National Organ Transplant Act, it has been illegal in the United States to sell human organs, although the same cannot be said for human tissues, blood plasma, ova, and sperm. Morality and distributive justice concerns form the backbone of traditional arguments opposing organ sales, as many Americans find it unacceptable to "purchase life." The poor would be exploited and pressured into selling organs to escape debt, often with little knowledge of the risks they incurred and the costs that they might later impose on society's health care system.

While these are legitimate fears, we must also be cognizant of the ramifications of our public policy choices. Since thousands die each year while waiting for organs that never arrive, we must explore incentives that can change this terrible outcome. Regulated markets in organ sales could go far to safeguard against abuses while preserving their benefits. Distributive justice concerns could be partially remedied by subsidizing the purchase of human organs for the poor, and by insisting that potential sellers be fully educated about the increased risks they incur. To compensate for the externalities imposed on America's health care system, a portion of organ sale receipts could be placed into an insurance pool that guarantees that those

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whose health later deteriorates will be cared for without burdening society's limited resources.

Moreover, if conscience dictates that living-donor organ sales must never occur, it is incumbent upon society to focus on other methods of incentivizing organ availability. By giving priority to Americans who are willing to donate organs themselves, we could overcome the paradox between the widespread public support for donation and the reality that relatively few people affirmatively sign up today. "Futures markets," which allow payment now for organs harvested only at death, can overcome concerns regarding the risks and abuses posed by taking organs from living individuals. More modestly, the law could permit reimbursement of the donor's family for burial expenses if they agree to part with a deceased loved one's organs. In addition, state governments could provide tax breaks to encourage donation, or waive driver's license fees for those who opt in.

If any form of monetary inducement runs afoul of federal law, far more attention must be paid to the concept of "paired organ exchanges," an ingenious method of facilitating organ swaps that does not involve any financial consideration. In addition, basing waiting list priority on a person's own willingness to donate would inspire millions of Americans to opt in to donation who today have not yet taken the trouble to sign up. Furthermore, rather than ask Americans to opt in to donation, we could presume consent unless otherwise stated to take advantage of the public consensus in favor of donation that often goes unacted upon. Moreover, hospitals and health care professionals should be better trained to request donations from decedents' families in a manner sensitive to the grieving process, and the media must do a better job of increasing public awareness of the crisis than that which it does today.

In sum, we must act aggressively to improve America's organ donation law and procurement policy. If we do not do so, tens of thousands will pay for our failures with their lives.

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## INTRODUCTION

A small Bosnian newspaper recently carried an ad that read, “[s]trong, healthy 35-year-old man, married, 2 children, offers kidney for sale. Blood type A-positive.”<sup>1</sup> Some readers might find this shocking and offensive. The same cannot be said for the Brooklyn woman who was recently told by her physician, “get a kidney any way [you can], or expect to die.”<sup>2</sup> Situations like these are reproduced thousands of times over across the world today, as individuals in dire need are faced with terrible choices. For some, poverty drives them to sell their organs, while for others, imminent death drives them to buy.

In just the time it takes to read this paper, one American will die because she could not find a suitable organ in time.<sup>3</sup> Currently, over 85,000 people in the U.S. are on the national waitlist for an organ—approximately 60,000 in need of a kidney, 17,000 seeking a liver, 4,000 desperate for a lung, and 3,500 hoping for a heart.<sup>4</sup> In contrast to the overwhelming demand, the number of human organs actually supplied is far more muted: only 25,000 transplants occurred in 2003, with organs reaped from a mere 13,000 individuals.<sup>5</sup> Those stark numbers are made even more alarming by the sad reality that over 6,000 Americans die every year while waiting for a transplant.<sup>6</sup> Some Americans choose to travel abroad in a last-ditch effort to

<sup>1</sup> See *Kidneys on Sale in Bosnia*, THE STATESMAN, Jan. 22, 2002, available at 2002 WL 3378308 (detailing the newspaper kidney advertisement and the illegal organ trade).

<sup>2</sup> Larry Rohter, *Tracking the Sale of a Kidney on a Path of Poverty and Hope*, N.Y. TIMES, May 23, 2004, § 1, at 1 (internal quotation marks omitted). Rohter recounts the tale of Alberty Jose da Silva, the impoverished Brazilian son of a prostitute, who showed the scars where a kidney and rib were removed in exchange for \$6,000. *Id.* Da Silva viewed the sale as an escape from poverty, and the Brooklyn recipient viewed it as an escape from certain death. *See id.*

<sup>3</sup> Approximately 17 individuals die each day while waiting for an organ, translating to one person every 1.4 hours. Living Legacy Registry, *Donation Statistics, a t* <http://livinglegacyregistry.org/learn/statistics/index.html> (last visited Nov. 3, 2004) [hereinafter Living Legacy Registry].

<sup>4</sup> The Organ Procurement and Transplantation Network (“OPTN”), *Data, a t* <http://www.optn.org/data/> (last visited Nov. 3, 2004). The transplant community is joined under a nationwide umbrella called the Organ Procurement and Transplantation Network. OPTN, *About OPTN, a t* <http://www.optn.org/optn/> (last visited Nov. 3, 2004). The United Network for Organ Sharing (“UNOS”) administers the OPTN under contract with the U.S. Department of Health and Human Services. *Id.*

<sup>5</sup> See OPTN, at <http://optn.org/latestData/viewDataReports.asp> (reporting national data, including the number of transplants per state since 1988). *See also* ORGAN PROCUREMENT TRANSPLANTATION NETWORK & SCIENTIFIC REGISTRY OF TRANSPLANT RECIPIENTS, OPTN/SRTR 2003 ANNUAL REPORT I-1, available at [http://www.optn.org/AR2003/Chapter\\_I\\_AR\\_Print.pdf](http://www.optn.org/AR2003/Chapter_I_AR_Print.pdf) (last visited Nov. 3, 2004).

<sup>6</sup> See Living Legacy Registry, *supra* note 3. These numbers are actually understated because they

find a black market organ that will allow them to escape death; many more die wishing they had the option to purchase the kidney they need here in the U.S.<sup>7</sup>

Ironically, the severe shortage is not due to a lack of donation-appropriate organs, but rather, the fact that most of those organs are taken to the grave by their owners.<sup>8</sup> Each year, thousands of Americans die in ways that would allow for their organs to be harvested, but relatively few of those individuals are donors.<sup>9</sup> In fact, approximately three quarters of the American public has not opted in to organ donation, and the roughly 25% who have done so cannot come close to supporting the nation's needs.<sup>10</sup>

do not include the hundreds of Americans who die after they have become too sick to be candidates for a transplant. See Alexander Tabarrok, *Life-Saving Incentives: Consequences, Costs and Solutions to the Organ Shortage*, THE LIBR. OF ECON. & LIBERTY, ¶ 1 (Apr. 5, 2004), at <http://www.econlib.org/library/Columns/y2004/Tabarrokorgans.html> (last visited April 5, 2005).

<sup>7</sup> See Eamonn O'Neill, *The Cost of Living*, THE SCOTSMAN, Mar. 10, 2001, at 14, available at 2001 WL 14095051 (detailing the various illegal markets for kidneys abroad, and noting that 300 Americans travel to foreign countries each year in a last ditch effort to save their lives).

<sup>8</sup> See Eric Cohen, *Organs for Sale*, PUB. INT., 114, 115 (2003) (reviewing DAVID L. KASERMAN & A.H. BARNETT, THE U.S. ORGAN PROCUREMENT SYSTEM: A PRESCRIPTION FOR REFORM) (stating that "[d]eath produces more usable bodies than [the] current system is able to exploit and more usable organs than existing organ demand"); S.Rep.No. 98-382, at 2 (1984), reprinted in 1984 U.S.S.C.A.N. 3975, 3976 (noting that organs are only harvested from less than 15% of individuals who die in ways that would be suitable for donation). Further, Peter Young reports that while 10,000 to 12,000 people die in a manner that allows donation, organs are collected from only one-third. Peter S. Young, *Moving to Compensate Families in the Human-Organ Market*, N.Y. TIMES, July 8, 1994, at B7.

<sup>9</sup> The National Kidney Foundation estimates 10,000 to 14,000 people who die each year meet the criteria for organ donation, but less than half of that number become actual organ donors. National Kidney Foundation, *Twenty-Five Facts About Organ Donation and Transplantation*, at <http://www.kidney.org/general/news/factsheet.cfm?id=30> (last visited Nov. 4, 2004). Henry Hansmann adds that roughly 20,000 Americans die annually under circumstances that would make their organs suitable for harvesting, but only about 15% donate their organs. Henry Hansmann, *The Economics and Ethics of Markets for Human Organs*, 14 J. HEALTH POL., POL'Y & L. 57, 60 (1989). Furthermore, studies of organ procurement efficiency from those who died in ways that would allow donation indicated that only 37% to 59% of viable organs were actually harvested. See R.W. Evans et al., *The Potential Supply of Organ Donors: An Assessment of the Efficiency of Organ Procurement Efforts in the United States*, 267 J. AMER. MED. ASS'N. 239, 242 (1992); see also Edward Guadagnoli et al., *Potential Organ-Donor Supply and Efficiency of Organ Procurement Organizations*, 24 HEALTH CARE FINANC. REV. 101, 104 (2003) (finding that the procurement efficiency for a majority of organ procurement organizations ("OPOs") ranged between 30% to 40%, meaning that only three to four in ten suitable organs were actually donated).

<sup>10</sup> The number of Americans who support organ donation versus those who have actually signed up as donors varies somewhat from survey to survey. A 1993 poll indicated that just 28% of Americans had granted permission for organ donation on their driver's license or on a signed donor card, while 55% said they would be willing to be donors. See The Gallup Organization, Inc., *The American Public's Attitudes Toward Organ Donation and Transplantation: A Survey* (1993), available at [http://www.transweb.org/reference/articles/gallup\\_survey/gallup\\_chap3.html](http://www.transweb.org/reference/articles/gallup_survey/gallup_chap3.html) (last visited Nov. 5, 2004);

This article addresses the growing organ shortage in America, analyzes current donation and procurement law, and explores both monetary and nonmonetary incentives aimed at eliminating the worsening crisis. Part I details the law governing human organ donation. Under both the Uniform Anatomical Gift Act (“UAGA”)<sup>11</sup> and the National Organ Transplant Act (“NOTA”),<sup>12</sup> no donor of a human organ may receive “valuable consideration” for providing it.<sup>13</sup> Congress’ intention was simply that the organ recipient be given the “gift” of life—not one which she had to purchase on the market. In reality, the consequences of the Act bear little resemblance to its initial intent. Organ scarcity has been the unintended result, leading to a thriving global black market in human organ sales.

Part II explores the traditional arguments that scholars and legislators have raised against legalizing the sale of human organs. Notions of morality, distributive justice, imperfect information, and negative externalities are routinely offered to justify the current law prohibiting sales. Part III explores some of the limitations of the above rationales, offering reasons why properly regulated organ sales may not be as farfetched or offensive as some initially think. I will offer suggestions for responsible regulation of sales to guard against the abuses and exploitation rampant on the black market, and to ensure that a seller’s decision is truly voluntary, fully informed, competent, and enduring.

Part IV proposes and analyzes incentive-based solutions to cure the organ crisis in America. Monetary incentives short of outright sale by living donors would go far towards boosting organ supply while reducing the concerns raised by open markets in organs. Some scholars have suggested “futures markets,”<sup>14</sup> allowing individuals to receive remuneration today in

see also Cass R. Sunstein and Richard H. Thaler, *Libertarian Paternalism Is Not an Oxymoron*, 70 U. CHI. L. REV. 1159, 1192, n.124 (2003) (citing to results of 1993 Gallup poll). Hansmann cites to a 1985 poll that showed that that only 17% of Americans had completed organ donor cards. See Hansmann, *supra* note 9, at 60 n.9. A 1999 study found that 81% of Americans support organ donation, but only 42% reported that they had actually signed an organ donor card. See Pew Research Center for the People & the Press, *Organ Donor Topline* (May 12-16, 1999) at <http://people-press.org/reports/print.php3?PageID=298> (last visited Nov. 5, 2004).

<sup>11</sup> Unif. Anatomical Gift Act §§ 1-11 (amended 1987), 8A U.L.A. 99 (1968).

<sup>12</sup> 42 U.S.C. §§ 273-274e (2000). NOTA was proposed by then-congressman Al Gore partially in response to growing concerns that a market in human kidneys was about to be formed by Dr. H. Barry Jacobs, founder of the International Kidney Exchange. See Walter Sullivan, *Buying of Kidneys of Poor Attacked*, N.Y. TIMES, Sept. 24, 1983, § 1, at 9.

<sup>13</sup> See UNIF. ANATOMICAL GIFT ACT § 10(a), 8A U.L.A. 62 (1987); 42 U.S.C. § 274e(a) (2000).

<sup>14</sup> See Lloyd R. Cohen, *Increasing the Supply of Transplant Organs: The Virtues of a Futures Market*, 58 GEO. WASH. L. REV. 1, 1 (1989); see also LLOYD R. COHEN, *INCREASING THE SUPPLY OF TRANSPLANT ORGANS: THE VIRTUES OF AN OPTIONS MARKET* (R.G. Landes 1995); Hansmann, *supra* note 9, at 62.

exchange for agreeing to have their organs donated at death.<sup>15</sup> A few states have considered tax deductions for donors,<sup>16</sup> and some even offer nominal amounts of money to individuals who opt in to donation when renewing their driver's licenses.<sup>17</sup> By modifying and combining some of these ideas, I will propose ways that we could dramatically raise organ donor participation rates while staying within the confines of NOTA and UAGA.

Moreover, there are numerous non-monetary incentives that U.S. legislators and public policy makers need to explore in earnest. Basing waiting list priority on the patient's own willingness to donate would inspire millions of Americans to opt in to donation who today have not yet taken the trouble to sign up.<sup>18</sup> "Paired organ exchanges" are also capable of creating moneyless markets that incentivize donation by capitalizing on families' self-interest to preserve the life of a loved one even where relatives are not a good biological match.<sup>19</sup> Establishing a national donor database would be

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<sup>15</sup> See Hansmann, *supra* note 9, at 62-63. Cohen proposes payment to the seller's beneficiary at death rather than payment to the seller during her lifetime. See Lloyd Cohen, *supra* note 14, at 33. He has also argued for a broader market-based system to increase organ supply and provide for a fairer allocation of organs to patients. See Lloyd R. Cohen, *Increasing Supply, Improving Allocation, and Furthering Justice and Decency in Organ Acquisition and Allocation: The Many Virtues of Markets*, 1 GRAFT 122 (1998).

<sup>16</sup> See Jo Napolitano, *Wisconsin Senate Approves Tax Deduction for Organ Donors*, N.Y. TIMES, Jan. 23, 2004, at A12. Napolitano notes that Wisconsin is not the first state to attempt to create incentives to spur organ donation—Indiana is considering nearly identical legislation, and the Kansas legislature thought about providing tax breaks for blood and organ donation in 2000. *Id.* However, the Kansas bill stalled out when the state's attorney general authored an opinion that the proposed legislation would run afoul of NOTA. *Id.*

<sup>17</sup> See Tabarrok, *supra* note 6 (noting that Georgia offers \$9 to residents who agree to become organ donors at the time of driver license renewal, but that this incentive is in danger of being rescinded in an attempt to boost state revenue). Connecticut is among the states that have considered similar measures. See Hansmann, *supra* note 9, at 63.

<sup>18</sup> This concept has been put into practice by LifeSharers, an organization that encourages people to become member donors by offering them priority to the organs of fellow members should they ever need one—i.e., priority based on one's own willingness to donate. See LifeSharers, at <http://www.lifesharers.com/> [hereinafter LifeSharers] (last visited Nov. 5, 2004). Further, it seems intuitively fair that, all else equal, organ priority should be given to those individuals who themselves are willing to make the same sacrifice to save the lives of others in need. Unfortunately, 70% of organs transplanted today go to recipients who are not themselves signed up as donors. See *id.*

<sup>19</sup> Michael T. Morley, *Increasing the Supply of Organs for Transplantation Through Paired Organ Exchanges*, 21 YALE L. & POL'Y REV. 221, 223-24 (2003); David Wessel, *Easing the Kidney Shortage*, WALL ST. J., June 17, 2004, at B1. Paired organ exchanges involve matching families of patients on the nationwide waitlist who are willing to donate to save a loved one's life but who cannot do so because they are not good biological matches. By pairing those willing donors with strangers who are also willing donors but who face the same biological predicament with a loved one of their own, an organ swap can be arranged that saves two people's lives. Even better, the nonmonetary exchange stays well within the confines of current law prohibiting the payment of valuable consideration for human organs.



an important additional step in facilitating these organ swaps.<sup>20</sup> Furthermore, presumed consent or required request statutes have the potential to substantially boost the supply of available organs without requiring any financial remuneration to donors.<sup>21</sup> Lastly, an aggressive public education and awareness campaign regarding the crucial need for organs is also essential, as a large majority of Americans support the concept of donation but simply never take the step to sign up.<sup>22</sup>

In the final analysis, we must critically analyze the justifications for the ban on human organ sales and reconsider the dire ramifications that accompany it. If conscience dictates that we must never allow payment in exchange for life-saving human organs, we owe a duty to the thousands of Americans who are dying annually to act aggressively to explore other ways to save their lives. Utilizing affirmative incentives to accomplish this purpose should not be overlooked any longer.

## I. AN OVERVIEW OF ORGAN DONATION LAW—AND ITS UNINTENDED CONSEQUENCES

### A. *The Law: The National Organ Transplant Act and the Uniform Anatomical Gift Act*

In 1954, a team of surgeons successfully transplanted the first kidney from Ronald Herrick to his identical twin Richard who was dying from

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<sup>20</sup> Morley, *supra* note 19, at 224.

<sup>21</sup> Countries such as Austria, Denmark, France, Poland, Switzerland, Finland, Greece, Italy, Norway, Spain, and Sweden all presume that their citizens want to donate their organs at death unless the individual expressly opts out during her lifetime. Sheldon F. Kurtz & Michael J. Saks, *The Transplant Paradox: Overwhelming Public Support for Organ Donation vs. Under-Supply of Organs: The Iowa Organ Procurement Study*, 21 J. CORP. L. 767, 778-79 (1996).

<sup>22</sup> *Id.* at 768, 802; Hansmann, *supra* note 9, at 60 n.9 (citing a 1985 poll showing only 17 percent of Americans completed donor cards); Pew Research Center for the People and the Press, *supra* note 10 (noting that 81% of the public supports organ donation but only 42% indicated that they had actually backed up their beliefs by signing a donor card). At the state level, an online survey by LifeSource showed that 92% of residents in North Dakota, South Dakota and Minnesota supported the concept of organ donation, but only 58% have acted upon those intentions. Dave Kolpack, *Willing Organ Donors Not Signing Up*, BISMARCK TRIBUNE (NORTH DAKOTA), June 26, 2003, at 8A (finding that 93% of North Dakota citizens approved of organ donation, but less than two-thirds had checked the donor box on their license); see also Kathleen Longcore & Sharon Emery, *One Last Loss: A Willingness to Donate Organs Isn't Always Enough to Make it Happen*, GRAND RAPIDS PRESS, Dec. 7, 2003, at A1. (stating that "[w]hile public opinion polls [in Michigan] show broad support for organ donation, only about 600,000 Michigan residents—7 percent—are signed up.").

kidney disease.<sup>23</sup> This monumental medical achievement raised the potential to save thousands of lives, but created a need for novel legal regulation of the human body.

Historically, there were no common law property rights in human corpses or the organs that laid therein.<sup>24</sup> Once transplantation became possible, it was necessary for state and federal legislatures to regulate organ donations to provide a legal mechanism for proper transfer.<sup>25</sup> In 1968, the

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<sup>23</sup> Susan J. Landers, *Transplants: 50 Years of Saving Lives*, Feb. 16, 2004, available at <http://www.ama-assn.org/amednews/2004/02/16/hll20216.htm> (last visited April 5, 2005). The earliest human organ transplant was a 1911 testis allograft, performed by surgeons in the United States. Laurel R. Siegel, *Re-Engineering the Laws of Organ Transplantation*, 49 EMORY L.J. 917, 920 (2000). Some years later, French-born physician Alexis Carrel greatly advanced the art of transplantation by devising techniques for rejoining blood vessels, discovering rejection, improving transplantation skills and triggering further organ transplant research. *Id.* In the 1950s, U.S. doctors conducted live human kidney transplants. By 1967, a South African surgeon performed the first human heart transplant. *Id.* Xenotransplantation, or the transplantation of organs from one species to another, also got its start in the early twentieth century, with much less success. See Xenotransplantation on the Web, at <http://www.xenotransplant.ineu.org/xenotrans/index.htm> (last visited April 5, 2005). The concept is far more controversial than traditional organ transplantation in clinical and ethical circles, as many commentators worry about the unknown health risks and consequences that could be created by intermingling organs from two different species. See Margaret A. Clark, *This Little Piggy Went to Market: The Xenotransplantation and Xenozoonose Debate*, 27 J.L. MED. & ETHICS 137, 138-39 (1999); Jack M. Kress, *Xenotransplantation: Ethics and Economics*, 53 FOOD & DRUG L.J. 353, 371-79 (1998).

<sup>24</sup> English common law did not recognize property rights in human corpses. Siegel, *supra* note 23, at 927. In the last few decades in America, however, common law regarding this subject has begun to evolve. Generally, state courts have bestowed upon family members a quasi-property right in human corpses, and have found that a relative's property rights allows them to make decisions about organ donations. See, e.g., *Brotherton v. Cleveland*, 923 F.2d 477, 481 (6th Cir. 1991) (holding that widow of deceased had a legitimate claim of entitlement in her husband's body, including his corneas, which was protected by the due process clause of the Constitution). There have been some limitations placed on these quasi-property rights, however. Courts have determined that human organs contain no inherent value, and have therefore not allowed claims for conversion based upon them. See *Shults v. United States*, 995 F. Supp. 1270, 1273-1276 (D. Kan. 1998) (holding that a cause of action for conversion is inappropriate, but that a tort claim such as intentional infliction of emotional distress may be applicable if the requisite elements were met). Further, a compelling state interest or statutory right granted to the medical examiner can supercede a relative's property rights to do what she pleases with a loved one's body. *State v. Powell*, 497 So.2d 1188 (Fla. 1986) (holding that the state interest in providing sight to blind citizens is compelling enough to allow removal of corneas from a corpse without notice to the next of kin). Additionally, the Georgia Supreme Court upheld a statute allowing corneal tissue to be removed without the consent of the family, reasoning that maintaining public health was one of the fundamental duties of the state. *Georgia Lions Eye Bank, Inc. v. Lavant*, 335 S.E.2d 127, 128 (Ga. 1985). For a more thorough treatment of the evolution of thinking regarding property interests in the human body, see R. Alta Charo, *Skin and Bones: Post-Mortem Markets in Human Tissue*, 26 NOVA L. REV. 421 (2002). See also Guido Calabresi, *An Introduction to Legal Thought: Four Approaches to Law and to the Allocation of Body Parts*, 55 STAN. L. REV. 2113 (2003); Radhika Rao, *Property, Privacy and the Human Body*, 80 B.U. L. REV. 359 (2000).

<sup>25</sup> Before federal legislation could be passed, several states adopted their own versions of organ donation laws. In 1947, California became the first state to regulate the bequeathment of organs. Lloyd

National Conference of Commissioners on Uniform State Laws ("NCCUSL") drafted the Uniform Anatomical Gift Act ("UAGA"), which provided for uniform regulation of anatomical gifts and defined persons who could gift their organs.<sup>26</sup> The UAGA limited the ability to donate organs to the individual upon her death or to her next of kin if the deceased had not expressed her wishes.<sup>27</sup> If either the decedent or next of kin refused to consent, then donation could not occur regardless of the hospital's or physician's wishes.<sup>28</sup> Further, the original UAGA did not explicitly address the potential for human organ sales, but the use of the word "gift" in the statute's title was widely interpreted to outlaw them.<sup>29</sup> By 1973, every state had adopted a version of the UAGA.<sup>30</sup>

Nearly twenty years after its passage, NCCUSL amended the UAGA in 1987 to clarify its intent, and revised certain provisions in an attempt to spur widespread organ donation—which had yet to materialize.<sup>31</sup> First, the statute was simplified to ensure that the donor's wishes were followed upon death rather than overridden by her next of kin.<sup>32</sup> Next, the amended UAGA explicitly banned the sale of organs, and imposed severe penalties for violations—including possible imprisonment.<sup>33</sup> However, there was no limitation placed on providing "valuable consideration" for the "removal,

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R. Cohen, *Organ Transplant Market Would Save Lives*, NAT'L L.J., Jan. 29, 1996, at A19. Many other states followed California's example, although the provisions varied. *Id.* Thus, prior to the UAGA, organ donation law and policy was far from uniform and in need of federal assistance.

<sup>26</sup> UNIF. ANATOMICAL GIFT ACT §§ 1-11 (amended 1987), 8A U.L.A. 94 (1968). The UAGA provides that an individual of at least eighteen years of age and of sound mind may donate her organs upon death. *See id.* at § 2(a). The desire to donate may be evidenced through a will or a signed donor card. *Id.* at § 4(a)(b).

<sup>27</sup> *Id.* at § 2(b).

<sup>28</sup> *Id.* at § 2(a)-(c).

<sup>29</sup> Cohen, *supra* note 25. The chairman of the drafting committee did not intend for the UAGA to expressly prevent organ sales, believing the matter should be "left to the decency of intelligent human beings." Hansmann, *supra* note 9, at 58.

<sup>30</sup> Hansmann, *supra* note 9, at 58.

<sup>31</sup> UNIF. ANATOMICAL GIFT ACT § 6(a)(1)-(3) and comment (1987); *see also* Siegel, *supra* note 23, at 933. For an excellent comparison of the 1968 and 1987 Acts, *see* Lisa E. Douglass, *Organ Donation, Procurement and Transplantation: The Process, The Problems, The Law*, 65 UMKC L. REV. 201 (1996).

<sup>32</sup> *See* UNIF. ANATOMICAL GIFT ACT § 2(h). Use of anatomical gifts for transplantation was also made a higher priority than research or therapy. *See id.* at § 6(a)(1)-(3) and comment (1987); *see also* Siegel, *supra* note 23, at 933.

<sup>33</sup> UNIF. ANATOMICAL GIFT ACT § 10. Violations result in a felony conviction, with the potential for imprisonment not exceeding five years and a monetary fine of \$50,000. *See id.* However, only twenty-one states adopted the amended UAGA with the specific prohibitions on organ sales; others still do not explicitly recognize by statute the prohibition of organ sales included in the 1987 amendments. *See* Siegel, *supra* note 23, at 933.

processing, disposal, preservation, quality control, storage, transportation or implantation of a [human organ].”<sup>34</sup> These provisions echoed the recently enacted National Organ Transplant Act,<sup>35</sup> discussed *infra*. The revised UAGA also added provisions requiring that hospitals discuss with adult patients the option of organ donation, and that they inform family members of their authority to consent to the harvesting of their deceased relative’s organs.<sup>36</sup> Finally, medical examiners were authorized to harvest organs if, after reasonable efforts, the decedent’s family members could not be located.

A vital companion to the UAGA, the National Organ Transplant Act (“NOTA”) was passed in 1984 in an attempt to better organize and encourage organ donations, while clarifying the bounds of acceptable organ procurement practices.<sup>37</sup> While numerous advances in medical transplant technology now allowed human organs to be viable for longer periods of time and new anti-rejection drugs like cyclosporine increased the transplantation success rate,<sup>38</sup> most usable organs were still being taken to the grave along with their owners.<sup>39</sup> In fact, at the time of NOTA’s passage, nearly 20,000 people were dying annually with organs that were suitable for transplantation—but only 15% of them were being recovered.<sup>40</sup> In response, an entrepreneurial physician, H. Barry Jacobs proposed an organ brokerage called the International Kidney Exchange that would allow sales by both domestic and international donors to overcome the shortage of organs supplied.<sup>41</sup> Talk of an express “organs-for-sale” system did not go over well with the National Kidney Foundation or American politicians.<sup>42</sup> Congress, led by

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<sup>34</sup> UNIF. ANATOMICAL GIFT ACT § 10(b).

<sup>35</sup> 42 U.S.C. §§ 273-74(g) (2000).

<sup>36</sup> UNIF. ANATOMICAL GIFT ACT § 3.

<sup>37</sup> 42 U.S.C. §§ 273-74(g) (2000); Siegel, *supra* note 23, at 934-35.

<sup>38</sup> Siegel, *supra* note 23, at 921-22. The invention of immunosuppressive drugs in the late 1970s “led to an explosion in the number of organ transplants in the 1980s and 1990s.” *Id.* Continued drug development has made rejection even less problematic. *Id.* at 922. With improved medical technology and greater success rates—but not enough organs—the situation was ripe for an illegal market to spring up.

<sup>39</sup> S. Rep. No. 98-382 at 2 (1984), reprinted in 1984 U.S.S.C.A.N. 3975, 3976.

<sup>40</sup> *Id.*

<sup>41</sup> Sullivan, *supra* note 12, at 9; Ann McIntosh, Comment, *Regulating the “Gift of Life”: The 1987 Uniform Anatomical Gift Act*, 65 WASH. L. REV. 171, 174 n.30 (1990). Dr. Jacobs proposed the kidney-for-sale system in order to help alleviate the plight of the 70,000 Americans who were dependent on dialysis machines. Sullivan, *supra* note 12, at 9. His proposed market included purchasing kidneys from people living in underdeveloped countries. *Id.*

<sup>42</sup> See Sullivan, *supra* note 12, at 9. Dr. Jacobs’ proposal drew strong opposition on ethical and medical grounds from the National Kidney Foundation. *Id.* He also was not aided by his dubious past, which included the revocation of his medical license after being convicted of mail fraud in a case related to Medicare billing. *Id.*

then-congressman Al Gore, passed NOTA easily to preserve the “gift” aspect of human organ donations,<sup>43</sup> while at the same time organizing and encouraging donations to occur in the first place.

To designate the bounds of acceptable organ procurement practice, NOTA provides: “It shall be 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.”<sup>44</sup> Organs were defined in NOTA as “kidney, liver, heart, lung, pancreas, bone marrow, cornea, eye, bone, and skin, . . . and any other human organ specified by the Secretary of Health and Human Services by regulation.”<sup>45</sup> Thus, Congress began explicitly regulating an area that had been implicitly regulated in the original UAGA—selling organs was now un-

<sup>43</sup> Neal Conan, *Talk of the Nation: Ethics and Economics of a Human Organs Trade* (NPR radio broadcast, Dec. 9, 2003). NOTA was passed with very little debate—the Senate Labor and Human Resources Committee easily concluded that “individuals or organizations should not profit by the sale of human organs for transplantation.” S. Rep. No. 98-382, at 16, *reprinted in* 1984 U.S.C.C.A.N. at 3982. The Committee noted that because the UAGA was silent regarding organ sales, new legislation was necessary to clear up any confusion that remained regarding the issue. *See id.* at 17.

<sup>44</sup> 42 U.S.C. § 274e(a) (1994). NOTA enforces this prohibition by threatening individuals who violate the law with a fine of up to \$50,000, or imprisonment of five years or less. § 274e(b). Because laws concerning treatment, consent, and definition of death fall under state law, the prohibition in NOTA relates solely to “interstate commerce.” S. Rep. No. 98-382, at 17, *reprinted in* 1984 U.S.C.C.A.N. at 3983. However, several famous constitutional law cases have defined “interstate commerce” quite broadly. *See, e.g.,* Wickard v. Filburn, 317 U.S. 111 (1942); Heart of Atlanta Motel v. United States, 379 U.S. 241 (1964). Others have argued, however, that NOTA’s outright ban on organ sales may violate an individual’s privacy right under the U.S. Constitution. *See* Karen Johnson, *The Sale of Human Organs: Implicating a Privacy Right*, 21 VAL. U. L. REV. 741, 761-62 (1987). Johnson’s argument runs as follows: there is a fundamental privacy right in decisions regarding medical treatment as well as those that affect bodily integrity, including what an individual does with her own organs. *See id.* Heightened scrutiny and narrow tailoring requirements apply to legislation that affects fundamental rights. *Id.* Organ sales also impact a personal right—under *Plyler v. Doe*, economic legislation that interferes with personal rights triggers intermediate scrutiny. *See id.; see also* *Plyler v. Doe*, 457 U.S. 202, 217-18, n.16 (1981). Intermediate scrutiny demands that there be an important governmental interest served by the law, and that the limitation imposed be substantially related to achieving that interest. *See* Johnson, *supra*. Some of the government’s interests in banning organ sales include: (1) protecting the mental and physical health of the seller, (2) preserving the quality of transplant organs, (3) safeguarding the integrity of the medical profession, and (4) minimizing the impact on society due to the potential for dehumanization. *See id.* at 757-58. Johnson concludes that during the lifetime of the donor, the government’s interests are likely to be substantial enough to outweigh the wish of the donor to sell his or her organs. However, once brain death occurs, this is no longer true. *Id.* at 759. NOTA, in failing to distinguish between *inter vivos* sales versus sales that occur after death, may not be narrowly tailored (as would be required if strict scrutiny applied) or substantially related (as would be required with intermediate scrutiny) to achieve the governmental interests at stake. *Id.*; *see also* Rao, *supra* note 24, at 387-400 (exploring the connection between privacy and property in the context of the human body); Charo, *supra* note 24, at 432; Calabresi, *supra* note 24, at 2135-37.

<sup>45</sup> 42 U.S.C. § 274e(c)(1).

questionably illegal.<sup>46</sup> However, just like the revised UAGA promulgated three years later, NOTA explains that valuable consideration “does not include the reasonable payments associated with the removal, transplantation, implantation, processing, preservation, quality control, and storage of a human organ.”<sup>47</sup> This carve-out for organ transplant support services has spawned the creation of an enormous industry with equally large price tags attached—even though human organs are not for sale, everything else associated with their transplantation most definitely is.<sup>48</sup> Furthermore, NOTA's ban on organ sales does not limit the selling of renewable human tissues, like ova, sperm and blood.<sup>49</sup>

In addition to NOTA's bedrock prohibition on human organ sales, the Act was intended to spur procurement of organs through non-financial means and designed to ensure fair national health policy regarding organ allocation.<sup>50</sup> To that end, NOTA created an elaborate system to foster organ donation, including the Organ Procurement and Transplantation Network (“OPTN”), a non-profit, privately funded organization charged with formulating standards for organ allocation and systemizing organ matching.<sup>51</sup> Congress mandated the creation of a dual computerized system to facilitate OPTN's objectives, one which lists all patients requiring transplants and the other which is designed to match these patients to donors.<sup>52</sup> Additionally,

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<sup>46</sup> See S. Rep. No. 98-382 at 2, reprinted in 1984 U.S.C.A.N. at 3978.

<sup>47</sup> 42 U.S.C. § 274e(c)(2). Further, the “expenses of travel, housing, and lost wages incurred by the donor of a human organ in connection with the donation of the organ” can also be reimbursed. *Id.*

<sup>48</sup> See Emanuel Thorne & Gilah Langer, *The Body's Value Has Gone Up; Who Should Profit from Organs?*, N.Y. TIMES, Sept. 8, 1986, at A23 (arguing that the medical team performing the transplant can reap the full value of the supposedly free organ donation by increasing their prices for other services to capture the patient's entire willingness to pay); Young, *supra* note 8 (noting that there is a “big markup” on transplant support services that accompanies NOTA's ban on human organ sales).

<sup>49</sup> The Senate Labor and Human Resources Committee distinguished between the sale of organs versus blood products because the latter are regenerative and do not pose a threat to the donor's health. See S. Rep. No. 98-382, at 16-17, reprinted in 1984 U.S.C.A.N. at 3982. For a detailed discussion of the rights and rules associated with the sale of human tissues, see Julia D. Mahoney, *The Market for Human Tissue*, 86 VA. L. REV. 163, 167-96 (2000); Judith B. Prowda, *Moore v. The Regents of the University of California: An Ethical Debate on Informed Consent and Property Rights in a Patient's Cells*, 77 J. PAT. & TRADEMARK OFF. SOC'Y. 611, 620-25 (1995).

<sup>50</sup> Gail L. Daubert, Comment, *Politics, Policies, and Problems with Organ Transplantation: Government Regulation Needed to Ration Organs Equitably*, 50 ADMIN. L. REV. 459, 463 (1998).

<sup>51</sup> The Organ Procurement and Transplant Network (“OPTN”), *About OPTN*, at <http://www.optn.org/optn/> (last visited April 5, 2005). The OPTN was also intended to have an educational component, sharing information with physicians regarding organ donation. James F. Blumstein, *Government's Role in Organ Transplantation Policy*, 14 J. HEALTH POL. POL'Y & L. 5, 13-14 (1989). The OPTN was expected to conduct studies concerning organ donation and transplants and work to increase the nation's organ supply. 42 U.S.C. § 274(b)(2)(I)-(K) (1994). The United Network for Organ Sharing (“UNOS”) became the first and only OPTN.

<sup>52</sup> 42 U.S.C. § 274(b)(A)(i)-(ii); Blumstein, *supra* note 51, at 13.

Congress increased funding for organ procurement organizations (“OPOs”), regional groups which are part of the OPTN and which are responsible for obtaining organs.<sup>53</sup> Congress believed additional OPOs could increase organ supply (and hence transplants) since OPOs are expected to “participate in systematic efforts, including professional education, to acquire all useable organs from potential donors.”<sup>54</sup> Once a successful match is made, OPOs are tasked with procuring and arranging the delivery of organs.<sup>55</sup> They are also responsible for working with hospitals to establish organ procurement and donation protocols.<sup>56</sup> Thus, OPOs are the legislature’s tool of choice today to increase voluntary organ donations and to ensure that organs are distributed properly.<sup>57</sup>

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<sup>53</sup> Siegel, *supra* note 23, at 935-36. Currently, there are 62 OPOs, covering populations ranging from one to twelve million people. See Judy Packer-Tursman, *Organ-Sharing System: How Would It Work?*, PITTSBURGH POST-GAZETTE, July 21, 1999, at A1. Siegel describes the role of OPOs as follows:

Each OPO must participate in the OPTN. The Secretary of Health and Human Services makes grants to OPOs to execute projects that increase the supply of donated organs. Each OPO locates potential organ donors and arranges for the acquisition, preservation, and transportation of the organs to transplant centers. The OPO must coordinate its activities with transplant centers within its region. An OPO is also responsible for helping hospitals establish protocols for determining the organ donor status of its patients.

Siegel, *supra* note 23, at 935-36.

<sup>54</sup> 42 USCA § 273(b)(3)(B).

<sup>55</sup> 42 USCA § 273(b)(3)(e)-(f).

<sup>56</sup> 42 USCA § 273(b)(3)(k). Generally, the organ allocation system gives top priority to patients who are close biological matches, since closer matching tends to result in better longterm survival after transplantation. When possible, in order to minimize organ preservation time, organs are offered first to patients locally, then regionally, then nationally. Waiting time is used to break ties between patients who are similar in other respects. See UNOS *Facts and Figures*, at <http://www.unos.org/Resources/factsheets.asp?fs=5> (last visited April 5, 2005). More detailed donation and distribution policies can be found at <http://www.unos.org/policiesandbylaws/policies.asp?resources=true> (last visited April 5, 2005). See also Judy Packer-Tursman, *Report: New Rule Won't Make Liver Transplant Harder to Get*, PITTSBURGH POST-GAZETTE, Aug. 25, 1999, at A3. There has been concern though that the system is inadequate to meet the needs of the sickest patients nationwide. See Daubert, *supra* note 50, at 469.

<sup>57</sup> Finally, NOTA established other mechanisms for encouraging organ donation, including a Task Force on Organ Transplantation. See National Organ Transplant Act, Title I-Task Force on Organ Transplantation, 42 U.S.C. § 273 (2000). As Siegel discusses, the Task Force was designed to examine the problems relating to organ procurement and recommend potential solutions. See Siegel, *supra* note 23, at 936. She summarizes its conclusions and impact succinctly:

The Task Force’s 1986 report determined that most families of potential donors were unaware of their option to donate, that OPOs varied in their ability to procure organs, and a lack of uniformity decreased the OPTN’s effectiveness. The Task Force recommended the establishment of a national network to regulate organ acquisition and distribution. The Task Force report suggested increasing public education and outreach, requiring hospitals to routinely ask the immediate family to consider organ donation, and allocating resources based on objective criteria. In response, Congress included in the Omnibus Budget Reconciliation Act of 1986 an amendment to the Social Security Act. This amendment mandated that all facilities engaging in organ procurement or transplant procedures become members of the OPTN or else forfeit their participation in Medicare and Medicaid. UNOS, essentially, be-

## B. *The Law's Unintended Consequence: Organ Scarcity*

The large majority of Americans support NOTA's and UAGA's legal framework providing for altruistic organ donations. A 1999 study showed that 81% of Americans support the concept of voluntary organ donation.<sup>58</sup> However, Americans have yet to match their ideals with their actions, as only about one-quarter have actually signed up as registered donors.<sup>59</sup> Compounding the problem is the fact that many health care professionals are reluctant to ask family members for consent to harvest the organs of the deceased, and many families refuse to give consent.<sup>60</sup> In the United States, when potential donors<sup>61</sup> are not registered as organ donors, only half of the deceased's relatives consent to donation.<sup>62</sup>

Thus, despite NOTA's and UAGA's noble intention of encouraging voluntary organ donation, shortages continue to worsen. Today's statistics are downright alarming. Every 13 minutes, a new name is added to the United States' National Organ Transplant Waiting List.<sup>63</sup> On average, 17

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came the regulator of the OPOs and hospitals, which conformed from fear of losing Medicare and Medicaid privileges.

*Id.* (internal citations omitted).

<sup>58</sup> Pew Research Center for the People and the Press, *supra* note 10.

<sup>59</sup> A 1993 poll indicated that just 28% of Americans have signed up as organ donors. The Gallup Organization, Inc., *supra* note 10. Hansmann cites to a 1985 poll that showed that that only 17% of Americans had completed organ donor cards. *See* Hansmann, *supra* note 9, at 60 n.9. A 1999 study found that only 42% of Americans reported that they had actually signed an organ donor card. *See* Pew Research Center for the People and the Press, *supra* note 10. The fact that Americans largely do not back up their beliefs with actions has led some to question the amount of money spent on educating the public regarding the need for voluntary organ donations, since these public awareness campaigns have not been extremely successful in producing results. *See* John Jurgensen, *Organ Donor Dilemma Plans to Spur Donations Raise Ethical Questions*, THE HARTFORD COURANT, Dec. 12, 2003, at D1 (stating that the millions of dollars spent on public awareness has done little good); Conan, *supra* note 43 (claiming that advertising regarding organ donation has not been successful).

<sup>60</sup> Orly Hazony, *Increasing the Supply of Cadaver Organs for Transplantation: Recognizing that the Real Problem is Psychological Not Legal*, 3 HEALTH MATRIX 219, 231-39 (1993). The National Kidney Foundation estimates that about 35% of potential donors never become donors because family members refuse to give consent. *See* National Kidney Foundation, *supra* note 9. Ellen Sheehy and colleagues estimated that the percentage of families who agree to donate when asked was 54%. Ellen Sheehy et al., *Estimating the Number of Potential Organ Donors in the United States*, 349 NEW ENG. J. MED. 667, 673, fig. 3 (2003).

<sup>61</sup> Here, a "potential" donor signifies a person who is legally dead (i.e., has suffered brain death) but who still has viable organs that would be suitable for transplantation if she or her family were to consent.

<sup>62</sup> Jurgensen, *supra* note 59. *But cf.* Tabarrok, *supra* note 6 (finding that when families are informed of their loved one's interest in donating, they usually assent to donation).

<sup>63</sup> Living Legacy Registry, *Register to Become an Organ or Tissue Donor*, at <http://livinglegacyregistry.org/> (last visited April 5, 2005). The Living Legacy Registry was created by



patients die every day while awaiting an organ—one person every 85 minutes.<sup>64</sup> In 2003, 6,776 Americans died while awaiting an organ transplant, according to official reports.<sup>65</sup> 7,227 died in 2002, and 7,178 died in 2001.<sup>66</sup> The actual figures are in fact considerably higher—patients who are on the waiting list but become too sick to undergo transplant surgery are taken off the list and their eventual deaths are not recorded in official figures.<sup>67</sup> In addition, many people who could benefit from an organ transplant are never put on the waiting list because the probability of obtaining an organ is too low.<sup>68</sup>

As of November 15, 2004, 87,310 Americans were candidates for an organ.<sup>69</sup> Of this number, 63,438 awaited a kidney, 3,366 a heart, 17,920 a liver, and 3,972 a lung.<sup>70</sup> Conversely, the total number of organ transplants performed in the U.S. in 2003 was just 25,468, of which 15,138 were kidneys (8,670 from cadavers, and 6,468 from living donors).<sup>71</sup> The disparity between these numbers requires that patients often wait many years for an organ to be found.<sup>72</sup> The OPTN 2003 Annual Report bluntly states: “The problem of long waiting times for transplant candidates and/or the continued growth in waiting list size underscores the simple reality: *supply of organs does not meet the need.*”<sup>73</sup>

This reality is depicted graphically below with the help of economic analysis—a useful tool in illustrating the effect of NOTA and UAGA.

legislation passed in 2003 to help enable the public to make educated choices about donation, as well as register their choice to donate. *Id.*

<sup>64</sup> *See id.*

<sup>65</sup> *See* OPTN, *National Data Reports*, at <http://www.optn.org/latestData/step2.asp> (search category “Waiting list removals, Removal reasons by year”) (last visited Nov. 15, 2004).

<sup>66</sup> *See id.*

<sup>67</sup> *See* Tabarrok, *supra* note 6.

<sup>68</sup> *Id.*

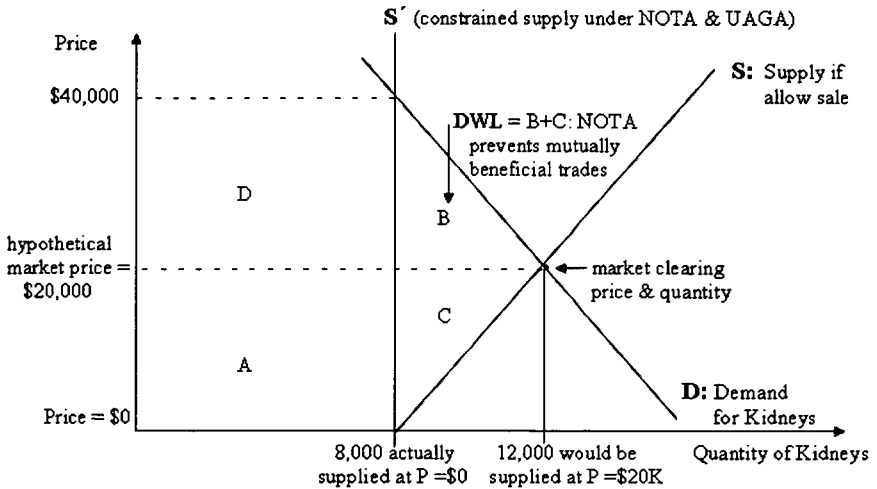
<sup>69</sup> *See* UNOS, *Data*, at <http://www.unos.org> (last visited Nov. 15, 2004).

<sup>70</sup> *See* OPTN, *National Data*, at <http://www.optn.org/latestData/rptData.asp> (search category “Waiting List, Overall by Organ”) (last visited Nov. 15, 2004).

<sup>71</sup> *See id.* (search category “Transplant, Transplants by Donor Type”) (last visited Nov. 15, 2004).

<sup>72</sup> *See id.* (search category “Median Waiting Time”); *see generally* Susan Hankin Denise, *Note, Regulating the Sale of Human Organs*, 71 VA. L. REV. 1015, 1019 (1985) (stating that waitlist times are “often measured in years rather than months.”); Phyllis Coleman, “*Brother, Can You Spare a Liver?*” *Five Ways to Increase Organ Donation*, 31 VAL. U. L. REV. 1, 1-2 (1996) (discussing the issues involved in average organ waiting times).

<sup>73</sup> *See* U.S. DEP’T OF HEALTH & HUMAN SERVICES, 2003 ANNUAL REPORT OF THE U.S. ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK AND THE SCIENTIFIC REGISTRY OF TRANSPLANT RECIPIENTS: TRANSPLANT DATA 1993-2003, available at [http://www.ustransplant.org/p/ar?y=2003&p=chapter\\_i\\_ar\\_cd.htm,i](http://www.ustransplant.org/p/ar?y=2003&p=chapter_i_ar_cd.htm,i) (last visited April 5, 2005) (emphasis added).



When society bans organ sales, it is analogous to imposing a price ceiling of \$0 on human organs.<sup>74</sup> Even at this artificially suppressed price, economists Pindyck and Rubinfeld note that 8,000 organs will still be supplied, solely on the basis of the donor's altruism.<sup>75</sup> However, supply is constrained at that point, as no more organs can be induced into the marketplace through the incentive of payment. While 8,000 kidneys are supplied, 12,000 are actually demanded.<sup>76</sup> If sales were legal, Pindyck and Rubinfeld estimate that the market clearing price would be \$20,000<sup>77</sup>—i.e., at a price of \$20,000, 4,000 more kidneys would be supplied, and 4,000 people currently on dialysis would be willing to purchase them. Because federal law prohibits sales, however, these mutually beneficial trades never occur.<sup>78</sup> Potential suppliers are forced to keep both of their kidneys even though some would rather sell them, and those in need are forced to wait (and possibly perish while doing so) even though they would be more than willing to buy a kidney if they could. Economists refer to the absence of these mutually beneficial trades as “deadweight loss”—both buyers and sellers would be better off without the law banning human organ sales, but for other reasons we prevent the trade from occurring.<sup>79</sup> The areas marked A + C represent the loss to suppliers because they are not allowed to sell kid-

<sup>74</sup> Price ceilings are the inverse of more commonly imposed price floors, the most widely used example of which is the federal minimum wage.

<sup>75</sup> See ROBERT S. PINDYCK & DANIEL L. RUBINFELD, *MICROECONOMICS* 292-94 (2d ed. 1992).

<sup>76</sup> *Id.* at 292-93.

<sup>77</sup> *Id.* The \$20,000 figure was an estimate made in 1992; the market price for kidneys today would likely be significantly higher.

<sup>78</sup> *Id.* at 292.

<sup>79</sup> *Id.* at 294.

neys, while A - B equals the “gain” to recipients if kidneys are free. (Triangle A represents the boon of free kidneys to those who actually receive them, while B represents the people who need kidneys, could have and would have purchased them under a market system, but are prohibited from doing so under federal law.)<sup>80</sup> The idea behind NOTA and UAGA is that kidney recipients are given the “gift” of life, not one which they must pay for.<sup>81</sup> Of course, that idea holds true only for the 8,000 individuals who were fortunate enough to actually find one; surely the other 4,000 who find themselves in the deadweight loss triangle do not perceive current law to be a “gift.”

Thus, the law banning human organ sales has the unintended and unfortunate consequence of restricting supply below market clearing levels and preventing mutually beneficial trades from occurring. As a result, over 6,000 people die each year, but still, this tragic outcome may be justified on the basis of morality, distributive justice, or externality concerns if we were to allow organ sales instead.<sup>82</sup> Many individuals believe that it would be immoral to commodify the human body, that any “informed consent” to sale would be based solely on the temptation of a cash reward, that negative externalities would fall on society to care for sellers whose health later deteriorated, and that the distributive consequences of allowing sales would be perverse (i.e., the poor would be exploited into selling their organs, and only the wealthy would have access to those organs supplied). All of these concerns will be addressed in Parts II and III.

### C. *The Thriving Global Black Market: A Recipe for Abuse and Exploitation*

As a result of the legal and public policy decision to ban organ sales in the U.S., not only is there a serious disparity between organ demand and supply, but a thriving global black marketplace ripe for abuse and exploitation as well.

It is illegal in nearly all developed nations to sell or buy a human organ—only in Iran and Pakistan is there a legal market.<sup>83</sup> Nevertheless,

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<sup>80</sup> Regions A + D represent the total value of kidneys when supply is constrained. One should note that the total value under artificial supply constraints due to NOTA and UAGA is less than the total value were a free marketplace permitted (which would encompass A + D + B + C).

<sup>81</sup> See PINDYCK & RUBINFELD, *supra* note 75, at 294.

<sup>82</sup> See *infra* Part II.

<sup>83</sup> See Vidya Ram, *International Traffic in Human Organs*, 19 FRONTLINE, Issue 7, Mar. 30 - Apr. 12, 2002, at 61, available at <http://www.flonnet.com/fl1907/19070730.htm> (last visited April 5, 2005); Eddie Fitzmaurice, *Rich Developer Pays Poor Pakistani \$8000 for One of Her Kidneys*, SUN HERALD (SYDNEY), Mar. 30, 2003, at 76, available at 2003 WL 7332302.

many other countries, including Israel, India, South Africa, Turkey, China, Russia, Iraq, Argentina, and Brazil do not stringently enforce laws prohibiting the sale and purchase of human organs.<sup>84</sup> Moreover, given the literally life-or-death consequences, many patients, doctors and organ brokers are not deterred in the least by the illegality of cash transactions in human organs.

As a result, a global black market in human organs and a booming transplant tourism industry has emerged.<sup>85</sup> The severe organ shortage in the United States has led many dialysis patients to become reluctant participants, as they purchase organs abroad, usually from downtrodden sellers seeking to escape the poverty of their homeland.<sup>86</sup> In fact, three hundred Americans travel abroad each year to buy a human organ, usually kidneys.<sup>87</sup> The trade is not limited to Americans with means, as thousands of persons from developed nations who await transplants have decided to travel to countries where purchase of human organs is legal or where bans are not strictly enforced. A wealthy Englishman, Thor Andersen, sparked debate over the ethics of this practice when he became the first major figure to publicly admit to being a transplant tourist.<sup>88</sup> He traveled to Pakistan to legally purchase a kidney from a poor 22-year-old Pakistani villager.<sup>89</sup> Andersen was not deterred by the perceived immorality of the transaction, and reportedly expected his private health insurance provider to reimburse him for the costs of his trip and surgery.<sup>90</sup> He argued that he did nothing illegal and that his health care costs were less than what they would have been had he continued dialysis treatments. In other words, he claims that it is cost-effective and welfare-maximizing to buy organs for transplant.<sup>91</sup>

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<sup>84</sup> See Marina Jimenez, *Europe's Poorest Sell Their Kidneys*, NATIONAL POST, Mar. 29, 2002, at A1, available at 2002 WL 17680080; Michael Finkel, *Complications*, N.Y. TIMES, May 27, 2001, at F26; O'Neill, *supra* note 7; Jeremy Laurance, *Surgeons Call for Legislated Trade in Body Parts*, THE INDEPENDENT-LONDON, Apr. 9, 2002, at 10.

<sup>85</sup> See Robyn S. Shapiro, *Legal Issues in Payment of Living Donors for Solid Organs*, HUMAN RIGHTS MAGAZINE, Spring 2003, at 19; Joanna Geary, *Illegal Live Organ Surgery Reopens Donor Debate*, BIRMINGHAM POST, Sept. 24, 2003, at 2; Ram, *supra* note 83.

<sup>86</sup> See Mann Aiyappa, *Kidney Racket—Many Questions Unanswered*, THE TIMES OF INDIA, Jan. 19, 2002 (discussing the fact that poor sellers are themselves often from different countries and are lured by organ brokers into the transaction.) See Marina Jimenez, *'Doctor Vulture': At the Center of Istanbul's Illicit Kidney Trade is a Shadowy 44-Year-Old Surgeon Whose Transplant 'Donors' Are Not Always Willing Ones*, NATIONAL POST, Mar. 30, 2002, at B02, available at 2002 WL 17680437.

<sup>87</sup> See O'Neill, *supra* note 7.

<sup>88</sup> See Fitzmaurice, *supra* note 83; Tessa Mayes, *Tycoon Buys Pakistan Girl's Kidney*, SUNDAY TIMES (LONDON), Mar. 23, 2003, at 13.

<sup>89</sup> See Fitzmaurice, *supra* note 83.

<sup>90</sup> See *id.*

<sup>91</sup> See *id.* Dialysis costs approximately \$50,000 per year, making it far more expensive than a one-time transplant. TransWeb.org, *What Are the Real Costs of Transplants?*, a t

In nations where sales are nominally illegal, the black market has not been much deterred. Kidney sales were banned in India in 1994, but patients continue to capitalize on kidney brokers (often working on behalf of Indian hospitals) to locate seller-donors.<sup>92</sup> To circumvent the law, donors simply sign an affidavit swearing they are not being paid.<sup>93</sup> In 2001, it was estimated that nearly \$10 million dollars had exchanged hands for 4,000 transplants in Bombay alone.<sup>94</sup> Lax medical standards have made prosecution extremely difficult, leading India to become known as the world's "warehouse for kidneys."<sup>95</sup> In addition, despite a ban on sales, Iraq possessed one of world's best black marketplaces for human organs prior to America's invasion in 2003.<sup>96</sup> One Palestinian family boasted three children who had received successful illegal kidney transplants in Baghdad.<sup>97</sup>

The inability to effectively prosecute these transactions is not unique to Asian and Middle Eastern nations. In Estonia, a group of Israeli doctors were caught illegally transplanting organs, but the case was not pursued by authorities.<sup>98</sup> One Austrian, who offered his kidney for sale, was recently convicted in a German court and handed a 2000 euro fine and four-month suspended sentence—a sanction that would hardly seem to deter desperate patients who willingly pay tens of thousands of dollars for life-saving organs.<sup>99</sup>

Illegal organ transplants take place even in America. There is no national transplant screening board in the United States; each hospital sets its own rules for who can be a live organ donor.<sup>100</sup> Foreign patients often arrive with a willing, unrelated "donor" and money in hand.<sup>101</sup> Some U.S. hospitals have a "don't ask, don't tell" policy with respect to foreigner organ transplants,<sup>102</sup> and organ brokers know how to find these hospitals. To

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<http://www.transweb.org/qa/asktw/answers/answers9505/TherealcostsofTransplants.html> (last visited Oct. 25, 2004) (posting of Phillip J. Held, M.D.).

<sup>92</sup> See John Ungeod-Thomas and David Orr, *GPs Offer Kidneys from Living Third World Donors*, SUNDAY TIMES (LONDON), Apr. 1, 2001, available at LEXIS, News Library, Times.file.

<sup>93</sup> *Id.*

<sup>94</sup> O'Neill, *supra* note 7.

<sup>95</sup> *Id.*

<sup>96</sup> See Finkel, *supra* note 84. Iraq's black market is likely no longer thriving after the U.S. led invasion of the country in 2003.

<sup>97</sup> *Id.*

<sup>98</sup> O'Neill, *supra* note 7.

<sup>99</sup> *Austrian Who Offered Kidney for Sale On Internet Is Convicted*, AUSTRIA TODAY, July 14, 2003, available at 2003 WL 59216100.

<sup>100</sup> See Finkel, *supra* note 84.

<sup>101</sup> See *id.*

<sup>102</sup> See *id.*; *Your Money or Your Life: The Kidney Trade*, CBSNEWS.COM July 31, 2002, at <http://www.cbsnews.com/stories/2002/02/11/48hours/main328962.shtml> (last visited April 5, 2005)

avoid strict federal regulations banning sales, the foreign donors and recipients merely pretend to be related.<sup>103</sup> As recently as 2001, dozens of Moldavians were suspected of seeking to enter the U.S. to illegally sell their kidneys.<sup>104</sup> Clearly, the black market is not merely a problem outside of American borders.

Worse, the lack of a legally regulated organ marketplace or effective organ donation policy in the U.S. has resulted in gross exploitation of the poor elsewhere in the world.<sup>105</sup> Sellers in illegal markets are usually facing desperate situations, and are often unemployed and dealing with serious health problems of their own.<sup>106</sup> This combination of factors makes them easy targets for unscrupulous organ brokers and doctors who answer to no legal authority. Human rights abuses are commonplace, as even prisoners and homeless people are exploited for the benefit of unscrupulous actors.<sup>107</sup>

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(citing to Dr. Michael Friedlander).

<sup>103</sup> See *id.*

<sup>104</sup> See Jimenez, *supra* note 84.

<sup>105</sup> See Christian Williams, *Combating the Problems of Human Rights Abuses and Inadequate Organ Supply Through Presumed Donative Consent*, 26 CASE W. RES. J. INT'L L. 315, 315-16, 344-46 (1994).

<sup>106</sup> *Your Money or Your Life*, *supra* note 102 (quoting Nancy Scheper-Hughes, director of Organs Watch, an international group that monitors the sale of human organs and the people who sell them).

<sup>107</sup> O'Neill, *supra* note 7. For example, reports have surfaced that homeless persons in Argentina and South Africa have been murdered for their organs. *Id.* Doctors in those countries loosely define brain death in order to meet their quota of organs for the military hospitals who, in turn, transplant them to patients in the ruling class. *Id.* There have even been accusations that homeless persons are given drugs to induce symptoms of brain death and that their organs are then removed. *Id.*; Williams, *supra* note 105, at 316.

Even when organs are harvested from cadavers instead of living human beings, the potential for abuse of the deceased and their families remains. The Chinese lead the world in selling organs from criminals' cadavers to patients from countries including Taiwan, France, Indonesia, the United States, and Great Britain. See O'Neill, *supra* note 7. Not coincidentally, China also leads the world in executions, as the death penalty is employed for crimes that the rest of the world would consider relatively minor, including petty theft and tax evasion. *Cf.* John Schauble, *Crime Clamp Puts China at the Top of the Execution List*, THE AGE, Apr. 11, 2002, at 11. This indiscriminate use of capital punishment has led Amnesty International officials to speculate that the ability to illegally sell human organs is an incentive for Chinese authorities to kill prisoners. See Steven Dennis, *My 7,000 Kidney From Convict On Death Row: Mike Pays For Organ From China*, MIRROR, Jan. 11, 2001, at 17. In fact, one doctor claimed he witnessed a prisoner's organs being harvested while he was still breathing. See Miriam Donohoe, *Organ Harvesting Claims Denied: Beijing Says Claims of Taking Organs From the Executed are Lies*, THE IRISH TIMES, July 5, 2001, at 12. Additionally, the rights of the family of the deceased are commonly violated, as prisoners' organs are often sold regardless of their family's consent. *Id.* Since remains are cremated, families often do not know what happened to the organs of their loved ones. *Id.*

Finally, despite this potential for abuse, some have suggested prisoner organ donation as a partial solution to America's organ shortage. In fact, Missouri legislators proposed a bill that would commute the sentences of death row inmates to life in prison if they agreed to donate an organ to some-

In fact, a landmark 2002 study of illegal kidney sales in India revealed that of the 305 sellers surveyed, 96% sold a kidney in an effort to escape debt.<sup>108</sup> Unfortunately, given the absence of legal oversight, those individuals were paid on average one-third less than that which they were promised.<sup>109</sup> Further, after selling a kidney, family income declined, the donors' debt burden did not ease, and 86% reported that their health worsened significantly.<sup>110</sup> Some argue that the illegality of the transaction itself may cause some of the problems experienced by these donors—they are typically afraid to seek post-operative care and are given no psychological counseling to deal with the ramifications of their choice.<sup>111</sup>

Thus, despite the developed world's noble intention to ensure that organ donations truly represent the gift of life for recipients, severe organ shortages have ensued, leading to thousands of needless deaths as well as a thriving global black marketplace that exploits its participants. In response,

one in need. See Kim Bell, *Bill Would Let Inmates Barter Their Organs*, ST. LOUIS POST-DISPATCH, Feb. 6, 1998, at C3. The topic is quite controversial, as one must reasonably query whether a death row prisoner can exercise his informed consent in the same way as an individual whose freedom has not been deprived by his prior actions. See Mark F. Anderson, *The Prisoner as Organ Donor*, 50 SYRACUSE L. REV. 951, 956 (2000) (finding the existing prisoner donation proposals wanting, and offering an alternative that would allow prisoners not on death row to donate their organs to prisoners in need); Whitney Hinkle, *Giving Until It Hurts: Prisoners are Not the Answer to the National Organ Shortage*, 35 IND. L. REV. 593, 610-12 (2002); Laura-Hill M. Patton, *A Call for Common Sense: Organ Donation and the Executed Prisoner*, 3 VA. J. SOC. POL'Y & L. 387, 415-16 (1996). Thus, given the rampant human rights abuses that plague prisoner populations across the world, we should think twice before opening up inmates to another potential avenue of exploitation. As a practical note, organ donation by prisoners in the U.S. is rarely permitted. See Anderson, *supra* at 957 n.20.

<sup>108</sup> Madhav Goyal et al., *Economic and Health Consequences of Selling a Kidney in India*, 288 J. AMER. MED. ASSOC. 1589, 1591 (2002). Debt included food and household expenses, rent, marriage, and medical costs. *Id.*

<sup>109</sup> See *id.*

<sup>110</sup> See *id.*

<sup>111</sup> Lyndsay S. Baines and Rahul M. Jindal, *Letters, Consequences of Selling a Kidney in India*, 289 J. AMER. MED. ASSOC. 697 (2003). Baines and Jindal argue that the hostility and anger of Indian sellers may be a product of the caste system and may result from lack of psychological support. *Id.* While Goyal's study emphasized that the health of donors deteriorated, Baines and Jindal posit that this may have also occurred in the absence of any organ sale due to underlying poverty. *Id.* Further, the illegality of organ sales themselves may cause post-operative care to be of low quality. Amitabh Chandra, *Letters, Consequences of Selling a Kidney in India*, 289 J. AMER. MED. ASSOC. 697, 697 (2003). In addition, some survey respondents may have downplayed financial outcomes (including remuneration received) to avoid incriminating themselves. Prem K.G. Chandran, *Letters, Consequences of Selling a Kidney in India*, 289 J. AMER. MED. ASSOC. 697, 698 (2003). Finally, educated sellers might experience more positive outcomes because they are better able to capitalize on immediate economic gain, and studies have shown that the health of Western donors does not substantially worsen after kidney donation. S.S.M. Razvi, *Letters, Consequences of Selling a Kidney in India*, 289 J. AMER. MED. ASSOC. 697, 698 (2003).

several commentators have recommended that some form of legalized human organ sales be permitted. To date, none of these proposals have been acted upon in any substantial manner by public policy decisionmakers. Furthermore, critics have assailed legalized organ sales on multiple grounds, decrying the immorality of commodifying the human body, questioning the distributive impact on the poor, and lamenting the potential negative consequences for society.

## II. TRADITIONAL ARGUMENTS AGAINST LEGALIZING HUMAN ORGAN SALES

The government has a number of legitimate interests in banning human organ sales. Concerns regarding morality, distributive justice, imperfect information and negative externalities have persuaded public policy decisionmakers that the risks of legalized markets are too great to justify their benefits.

### A. *Morality: It Is Inappropriate to Commodify the Human Body*

At the heart of NOTA's ban on human organ sales is a fundamental concern that the dignity of man would be debased if life, health or body parts were exchanged across a market.<sup>112</sup> One will often hear people say, "Only God determines when to give or take life"—it should not be determined by dollars.<sup>113</sup> Courts and legislatures have long argued that the sanctity of the body is essential to human dignity and autonomy.<sup>114</sup> Drawing

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<sup>112</sup> Daubert, *supra* note 50, at 466. As Gail Daubert describes, "Congress decided that proposals for buying and selling organs ran counter to society's ethical and moral values and thus refused to allow human organs to be commodified. *Id.* Congress rejected what it deemed "supply-side cannibalism" as a means of increasing the number of organs available for transplant, claiming it did not want to make the 'poor a source of spare parts for the rich.'" *Id.*; see also *id.* at 466 n.43 (citing to *Procurement & Allocation of Human Organs for Transplantation, 1983: Before the Subcommittee on Investigation & Oversight of the House Committee on Science & Technology, 98th Cong. (1983), reprinted in National Organ Transplant Act of 1984, Legislative History of Pub. L. No. 98-507, Vol. 2 (1990), at 307-18, 218, 248*) (quoting then-Congressman Albert Gore, Jr., chairman of subcommittee, who stated that the sale of organs "blurs the distinction between people and things, as human organs become simply another commodity to be bought and sold in the marketplace").

<sup>113</sup> Telephone interview with Alyse Merritt, marketing representative for MorningstarInteractive.com (July 1, 2004). Relatedly, some physicians believe it would undermine the integrity of the medical profession to become involved in legalized human organ markets—i.e., doctors should be healers, not facilitators of a trade in human body parts. See, e.g., Johnson, *supra* note 44, at 749 (framing this concern as more of a legislative one than that of a physician's).

<sup>114</sup> Melissa M. Perry, *Fragmented Bodies, Legal Privilege, and Commodification in Science and Medicine*, 51 ME. L. REV. 169, 174, 183-97 (1999) (discussing courts' and legislatures' use of the



heavily on the wisdom of renowned philosopher Emanuel Kant, Stephen Munzer similarly urges that it would offend human dignity to allow unrestricted market transactions in organs.<sup>115</sup> The overarching fear is that the human body should not be treated as a commodity to be bought and sold<sup>116</sup>—doing so would have a dangerous and dehumanizing impact on society.<sup>117</sup> When organs are donated to prevent another human being's death, this represents the ultimate altruistic "gift" of life, one which has no monetary strings attached.<sup>118</sup>

Furthermore, a strong belief in inalienable rights justifies the prohibition on sales of body parts.<sup>119</sup> While libertarians argue that a person should

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argument that the sanctity of the body is essential to human dignity and autonomy, but noting that it comes at the expense of science's "entrepreneurial interest" in its subjects).

<sup>115</sup> Stephen R. Munzer, *An Uneasy Case Against Property Rights in Body Parts*, 11 SOC. PHIL. & POL'Y 259 (1994); Stephen R. Munzer, *Kant and Property Rights in Body Parts*, 6 CAN. J.L. & JURIS. 319, 320 (1993); cf. Mark F. Grady, *Politiization of Commodities: The Case of Cadaveric Organs*, 20 J. CORP. L. 51, 56-58 (1995) (exploring Munzer's argument and arguing for a limited form of human organ sales to be permitted).

<sup>116</sup> The legislative history states succinctly: "It is the sense of the [Senate Labor and Human Resources] committee that individuals or organizations should not profit by the sale of human organs for transplantation . . . . The committee believes that human body parts should not be viewed as commodities." See S. Rep. No. 98-382 (1984), at 16-17, reprinted in 1984 U.S.C.C.A.N. 3975, 3982-83.

<sup>117</sup> See Finkel, *supra* note 84 (stating that treating humans as commodities is a throwback to the days of slavery). See also Johnson, *supra* note 44, at 750-51 (discussing the fear of the dehumanizing impact on society if organ sales were permitted); MARGARET JANE RADIN, *Contested Commodities, in HUMAN FLOURISHING AND LIMITS ON MARKETS* 125-26 (Harv. Univ. Press 1996).

<sup>118</sup> Consistent with the notion that donation should be seen as the ultimate act of generosity, there is concern that some individuals who today donate out of purely altruistic motivation would be deterred from doing so by an explicit marketplace in organs. In fact, according to a 1993 Gallup Poll, over 80% of Americans said they would not be spurred by monetary incentives to donate organs, and 5% indicated they would be even less likely to donate than they are today if money were offered. See The Gallup Organization, Inc., *The American Public's Attitudes Toward Organ Donation and Transplantation* 43 (Feb. 1993), available at [http://www.transweb.org/reference/articles/gallup\\_survey/gallup\\_chap7.html](http://www.transweb.org/reference/articles/gallup_survey/gallup_chap7.html) (last visited Nov. 5, 2004). Adam Kolber notes that since pollsters did not mention the size of the financial incentives at stake, we should not be overly reliant on responses to this question. Adam J. Kolber, *A Matter of Priority: Transplanting Organs Preferentially to Registered Donors*, 55 RUTGERS L. REV. 671 (2003); see also Mark F. Anderson, *The Future of Organ Transplantation: From Where Will New Donors Come, to Whom Will Their Organs Go?*, 5 HEALTH MATRIX 249, 299-301 (1995) (allowing payment of any kind cheapens the act and threatens the integrity of the entire system); Frank Morgan, *Babe the Magnificent Organ Donor? The Perils and Promises Surrounding Xenotransplantation*, 14 J. CONTEMP. HEALTH L. & POL'Y 127, 134 (1997) (altruistic donations may be curtailed by legalized market system).

<sup>119</sup> See, e.g., Conan, *supra* note 43 (noting that no one possesses total ownership over their own bodies; for instance, one cannot legally opt to become a slave or a prostitute even if she is willing). See also Susan Rose Ackerman, *Inalienability and the Theory of Property Rights*, 85 COLUM. L. REV. 931 (1985); Margaret Jane Radin, *Market Inalienability*, 100 HARV. L. REV. 1849 (1987). However, many commentators have argued vociferously for an alienable property right to one's organs. See, e.g., Wil-

be free to do as she wishes with her own body, this view has been widely rejected under prevailing law and morality. Drug use, prostitution, bigamy and incest are all legally banned—in large part due to the moral objections of nonparticipants. Less controversially, mandatory seatbelt or helmet laws restrict a person's ability to do what she wishes or to take certain risks with her own body, even if she values this freedom more than society values the need to provide for public safety. Indeed, there are myriad examples in law where individual autonomy gives way to the state's morality interest.<sup>120</sup> The ban on human organ sales is one such case.

### B. *Distributive Justice*

Related to Americans' moral aversion to human organ sales is the fear that such transactions, if legal, would have a perverse distributive impact.<sup>121</sup> If organs were allowed to be sold, it is reasonable to expect that disproportionately poor people, often minorities, would be persuaded or exploited into selling their kidneys simply to escape debt.<sup>122</sup> Conversely, it would primarily be the wealthy who could afford to purchase them.<sup>123</sup> Thus, banning human organ sales could be justified on distributive justice grounds: the law would prevent poor people from becoming the only "sellers," and it would provide both poor and wealthy individuals equal access to those organs being supplied—regardless of their ability to pay.<sup>124</sup>

liam Boulter, *Sperm, Spleens, and Other Valuables: The Need to Recognize Property Rights in Human Body Parts*, 23 HOFSTRA L. REV. 693, 715-30 (1995); Brian Hannemann, *Body Parts and Property Rights: A New Commodity for the 1990s*, 22 SW. U. L. REV. 399, 426-28 (1993); Roger D. Blair and David L. Kaserman, *The Economics and Ethics of Alternative Cadaveric Organ Procurement Policies*, 8 YALE J. ON REG. 403, 435-39 (1991).

<sup>120</sup> See, e.g., Guido Calabresi and A. Douglas Melamed, *Property Rules, Liability Rules, and Inalienability: One View of the Cathedral*, 85 HARV. L. REV. 1089, 1102-05 (1972); Calabresi, *supra* note 24, at 2132-51 (discussing the issue of whether we own our own bodies, or whether they belong at least in some instances to those who need them). See also Jacqueline Laing, *In Debt? Want to Flog One of Your Kidneys? No, This Isn't a Joke. With Staggering Amoralty Our Medical Elite Now Think It's OK for Us to Sell Our Body Organs*, DAILY MAIL, Dec. 4, 2003, at 12.

<sup>121</sup> Williams, *supra* note 105, at 316 (stating that "[o]ften, it is the poorer citizens of developing countries who are supplying organs for the members of the upper class who can afford them").

<sup>122</sup> *Id.*

<sup>123</sup> See *Kidneys Sold Here!*, THE HINDU, Feb. 24, 2002. *But cf.* Thomas Sowell, *The High Cost of Busybodies*, TOWNHALL.COM, Dec. 2, 2003, <http://www.townhall.com/columnists/thomassowell/ts20031202.shtml> (last visited April 5, 2005) (stating that society's ban on organ sales does not alleviate the problem of poverty, and that purchasers of organs in a market system would not necessarily have to be rich).

<sup>124</sup> In fact, the U.S. Department of Health and Human Services Advisory Committee on Organ Transplantation justified the ban on selling organs in this manner, stating that Congress was concerned

The potential for exploitation is not merely a theoretical or academic concern.<sup>125</sup> Newspaper and medical journal accounts of black markets in organs document the fact that poverty is the driving force behind sales.<sup>126</sup> A recent study in the *Journal of the American Medical Association* confirmed that 96% of black market kidney sellers in India agreed to the sale in an effort to escape financial hardship.<sup>127</sup> Worse, the great majority of sellers found themselves in continued debt six years later, accompanied now by deteriorated health.<sup>128</sup> On the opposite side of the spectrum, it is predominantly the wealthy of society who can afford to make organ purchases—after all, one can only pay a large sum of money to save her own life if she has the financial means to do so.<sup>129</sup>

Thus, where the poorer classes of society are exploited by markets in human organs, and where primarily the upper classes have access to the product, critics are justified in highlighting the distributive inequity of such an outcome.

### C. *Lack of Information About Risk*

Another legitimate concern posed by allowing a market for human organs is that sellers would lack sufficient information to properly weigh the consequences on themselves and society when they make the choice to trade their organs for cash.<sup>130</sup> Sellers might simply not know of the added

that “buying and selling of organs might lead to inequitable access to donor organs with the wealthy having an unfair advantage.” U.S. DEP’T OF HEALTH & HUMAN SERVICES, ADVISORY COMMITTEE ON ORGAN TRANSPLANTATION, FREQUENTLY ASKED QUESTIONS, *at* <http://www.organdonor.gov/faq.html#11> (last visited April 5, 2005).

<sup>125</sup> See John Lawrence Hill, *Exploitation*, 79 CORNELL L. REV. 631, 644-47 (1994) (proposing a theory of exploitation in three areas of legal controversy, including the voluntary sale of organs by living donors).

<sup>126</sup> See *Kidneys Sold Here!*, *supra* note 123 (detailing the illegal organ trade in India, and its ramifications for the poor); *They Made a Small Fortune, But Were Poorer by a Kidney*, THE HINDU, Jan. 19, 2002 (finding that most sellers in an Indian village were of the labor class and in financial crisis); Rohter, *supra* note 2 (recounting the tale of a poor Brazilian son of a prostitute who sold his kidney in an effort to improve the conditions in which he was living).

<sup>127</sup> Goyal et al., *supra* note 108, at 1591. The average amount received was \$1,070, although the average amount promised was \$1,410. *Id.*

<sup>128</sup> *Id.* at 1589, 1591 (71% of sellers continued to find themselves below the poverty line); *see also They Made a Small Fortune, But Were Poorer by a Kidney*, *supra* note 126 (finding that donor health deteriorated after organ sales).

<sup>129</sup> *Kidneys Sold Here*, *supra* note 123. *But cf.* Sowell, *supra* note 123.

<sup>130</sup> See PINDYCK & RUBINFELD, *supra* note 75, at 294 (citing imperfect information as a possible justification for banning organ sales).

health risks that they are taking when they agree to sell a kidney,<sup>131</sup> thinking that one kidney is just as good as two. Further, the temptation of a one-time lump sum payment to escape debt might lead some poverty stricken individuals to think that selling a kidney is worth any health risk entailed.<sup>132</sup> Compounding this problem is that potential sellers often suffer from "optimism bias"—i.e., even if they understand the precise risks involved, they often believe that those risks simply "won't happen to me."<sup>133</sup> Furthermore, sellers might impose unknown risk on buyers by concealing adverse health information in their own past so as not to be ruled out as a potential candidate for sale.<sup>134</sup> Thus, if sellers are pressured by poverty and simultaneously underestimate the risks that organ sales involve or overestimate their ability to escape them, society's confidence in their informed consent to the sale is seriously undermined.<sup>135</sup> The state therefore has a legitimate interest in stepping in to protect the mental and physical health of potential sellers against risks that they do not fully appreciate.<sup>136</sup>

In fact, data from today's black market reinforces this conclusion. Of the sellers in India's black market kidney trade, 86% reported that their health had deteriorated substantially from its pre-sale condition.<sup>137</sup> Not surprisingly, given the wisdom of hindsight, four out of five sellers would not

<sup>131</sup> For instance, potential risks include perioperative mortality and renal dysfunction in the kidney donor. G. Splendiani, *Living Donor Transplant: Wider Selection Criteria*, 36 *TRANSPLANT PROC.* 470 (2004). There are at least sixteen documented cases of individuals who have died from donating a kidney. *Procurement and Allocation of Human Organs for Transplantation: Hearings on H.R. 5580 Before the Subcomm. on Investigations and Oversight of the House Comm. on Science and Technology*, 98th Cong. 269 (1984) (testimony of Oscar Salvatierra, President of the American Society of Transplant Surgeons).

<sup>132</sup> See Sullivan, *supra* note 12 (noting that the temptation of a cash reward for selling one's kidney makes a mockery of traditional notions of informed consent).

<sup>133</sup> See generally Neil D. Weinstein, *Why it Won't Happen to Me: Perceptions of Risk Factors and Illness Susceptibility*, 3 *HEALTH PSYCHOL.* 431 (1984); Neil D. Weinstein, *Unrealistic Optimism About Susceptibility to Health Problems: Conclusions From a Community-Wide Sample*, 10 *J. BEHAV. MED.* 481 (1987); Neil D. Weinstein, *Unrealistic Optimism About Susceptibility To Health Problems*, 5 *J. BEHAV. MED.* 441 (1982).

<sup>134</sup> See PINDYCK & RUBINFELD, *supra* note 75, at 294. Thus, one could hypothesize that the quality of transplant organs could potentially decline in a for-sale regime. *But cf.* Stephen J. Spurr, *The Proposed Market for Human Organs*, 18 *J. HEALTH POL., POL'Y & L.* 189, 198 (1993) (arguing that allowing organ sales will promote quality of sold organs due to competition in the marketplace).

<sup>135</sup> See Sullivan, *supra* note 12.

<sup>136</sup> See Johnson, *supra* note 44 (detailing the various governmental interests in banning human organ sales).

<sup>137</sup> Goyal et al., *supra* note 108, at 1591, Table 3; see also Finkel, *supra* note 84. Finkel notes that organ donation may not be as safe as some argue because the studies showing a low risk of adverse events have been conducted only in wealthy nations. *Id.* By comparison, donors with poor diet and bad drinking water have a higher risk of infection that could compromise their remaining kidney, leading to short-term complications in approximately 20% of extractions. *Id.*

recommend that others follow their lead in selling organs.<sup>138</sup> Sadly, once a sale occurs, the risk to the health of the individual is irreversible. Future medical care expenditures are often required, and dialysis may be necessary in the event that the remaining kidney fails.<sup>139</sup> These costs will fall first on organ sellers and their families, but will also pose a burden to society should the seller be unable to recover or unable to pay.

#### D. *Negative Externalities Borne by Society*

While health deterioration borne by a human organ seller may fall on her own shoulders, the medical costs she cannot bear—plus her lost productivity to society—present the classic “negative externality” imposed on society. Economists define negative externalities as costs or harms that an individual person or entity creates but which are borne by someone else (in this case, the state).<sup>140</sup> Thus, the private calculus in agreeing to a sale (i.e., the amount of money received versus the predicted risks to the seller’s health) may be substantially different than the overall considerations facing society. Because sellers may lack information or overestimate their resiliency, the state can be expected to bear significant medical costs to care for some of those individuals in the future—costs that sellers will ignore in making their own decision because they do not bear them.<sup>141</sup>

In response, the state might reasonably ban organ sales entirely to prevent negative externalities from materializing in the first place. By doing so, the state overrides an individual’s preference so that it can protect the overall public interest.

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<sup>138</sup> Goyal et al., *supra* note 108, at 1591. While Goyal’s results paint a gloomy picture of organ sales, commentators have argued in response that other reasons explain the largely negative results in India. See Baines and Jindal, *supra* note 111.

<sup>139</sup> While many studies have concluded that organ donation by living donors entails a low risk of adverse events, those studies are generally of wealthy populations where sanitation and access to follow-up health care are quite good. By contrast, in countries in which individuals maintain poor diets and have access to lower quality drinking water, the risk of infection to the remaining kidney may be substantially higher. See Finkel, *supra* note 84.

<sup>140</sup> EDWARD M. GRAMLICH, A GUIDE TO BENEFIT-COST ANALYSIS 18-20 (2d ed. 1990) (discussing externalities as a basis for government intervention in the private marketplace).

<sup>141</sup> One should note, however, that the negative externality argument applies equally to those who *donate* organs as well as to those who *sell* them.

### III. ARE THE TRADITIONAL ARGUMENTS AGAINST SALES COMPELLING?

While the arguments raised above highlight legitimate concerns surrounding organ sales and their potential for abuse, a closer inspection limits their force and offers opportunities for a thoughtful regulated response.

#### A. *The Law Against Commodification of the Human Body Is Self-Contradictory*

To the extent that society subscribes to the belief that commerce in human body parts is immoral and diminishes human dignity, we must question how this justification conforms to other practices that we feel no such qualms about allowing. For instance, how can one reconcile the notion that human organs cannot and should not be sold with the reality that there is a thriving market in the sale of human tissues and products?<sup>142</sup> Most notably, sperm and ova banks prosper as Americans seek to remedy infertility problems, and often charge customers thousands of dollars for their services.<sup>143</sup> One potential response may be that unlike human organs, human tissues and body products are regenerative; thus, selling them is a less dire decision than parting with an organ.<sup>144</sup> However, the commodification argument has nothing to do with the relative sacrifice of the donor, only that the product being sold is part of a human being, and that the dignity of man

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<sup>142</sup> The Senate Labor and Human Resources Committee distinguished between banning the sale of organs versus allowing blood products because the latter are regenerative and do not pose a threat to the donor's health. See S. Rep. No. 98-382, at 16 (1984), reprinted in 1984 U.S.C.A.N. at 3982; cf. Donald Joralemon & Phil Cox, *Body Values: The Case Against Compensating for Transplant Organs*, HASTINGS CENTER REP. 27 (2003) (arguing against financial remuneration to organ sellers, but also noting that the argument in favor of compensation for organs is no different from other permissible forms of body commodification). For a detailed discussion of the law regarding the sale of human body products and parts, see William Boulier, *Sperm, Spleens, and Other Valuables: The Need to Recognize Property Rights in Human Body Parts*, 23 HOFSTRA L. REV. 693 (1995).

<sup>143</sup> See, e.g., UCSF Center for Reproductive Health, at <http://www.ucsfvfv.org/> (last visited April 5, 2005) (detailing various infertility programs); California Cryobank Sperm Bank, at <http://www.cryobank.com/> (last visited April 5, 2005). A recent law article even tackled the idea that lactating women might be given financial compensation for selling their breast milk. See Sarah E. Waldeck, *Encouraging a Market in Human Milk*, 11 COLUM. J. GENDER & L. 361 (2002).

<sup>144</sup> U.S. CONGRESS, OFFICE OF TECH. ASSESSMENT, NEW DEVELOPMENTS IN BIOTECHNOLOGY: OWNERSHIP OF HUMAN TISSUES AND CELLS—SPECIAL REPORT 3 (1987), available at <http://www.wvs.princeton.edu/cgi-bin/byteserv.prl/~ota/disk2/1987/8719/871903.PDF> (last visited April 5, 2005) (stating that “[h]ealthy people continually produce a variety of replenishable substances, including blood, skin, bone marrow, hair, urine, perspiration, saliva, milk, semen, and tears.”) For example, the ovaries contain nearly 400,000 ova, a number far in excess of what women actually need, since during an average lifespan a woman goes through about 500 menstrual cycles. The Sex Project, at <http://www.sex-project.com/female-anatomy.shtml> (last visited Oct. 25, 2004).

is debased by allowing contact with the market. Thus, the objection to allowing commerce for life-sustaining organs would apply equally to banning the sale of human tissues or products that allow for life in the first instance.<sup>145</sup>

Further, the notion that it is immoral to pay money to preserve one's health or life directly conflicts with the reality of medical practice and policy in our country. If we believed as a moral matter that money should never be exchanged for the preservation of life, why do we so readily accept the practice of charging fees for the provision of medical services at all? Politicians often speak of health care as a "fundamental right" to be provided to all regardless of their means,<sup>146</sup> but the reality indicates otherwise. When a patient visits her physician in need of an antibiotic to cure her life-threatening pneumonia, she is no less relieved of her obligation to pay than if she were visiting a grocery store and trying to purchase milk.<sup>147</sup> The truth is that individuals are forced to pay for health care if they want to receive it, and access to the system is far from guaranteed.

So, there are two stark choices that our country faces: (1) either commodifying the human body is morally inappropriate, in which case the

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<sup>145</sup> A related issue to the moral argument opposing organ sales is the question of how one would go about measuring the extent of negative moral externalities that would be created by legalizing sales. We could use a form of contingent valuation (heavily debated in the context of measuring damage from environmental harms) under which people were simply asked how much they would be willing to pay in order to live in a society that refused to allow organ sales. A problem with using such contingent valuation surveys is that they often produce results that stretch the reasonable bounds of imagination. See Note, "Ask a Silly Question . . .": *Contingent Valuation of Natural Resource Damages*, 105 HARV. L. REV. 1981, 1984-87 (1992). Further, a person's willingness to pay to receive the benefit of a certain legal rule is often far lower than the amount that they would be willing to accept to give up the same right if they were entitled to it from the outset (as a psychological matter, losing something you already have is worse than gaining something new). Thus, the moral aversion to allowing organ sales would be very difficult to measure in economic terms, but it represents a real cost. Even so, using an economic mindset to attempt to include and measure the tradeoff is a more systematic way of considering the issue than simply saying, "no dollar value can be placed on preserving or saving human life."

<sup>146</sup> For example, Congresswoman Verla Insko introduced a proposal for the amendment of North Carolina's state constitution to make health care a fundamental right for all residents. John Hood, *You Can't Create a Fundamental Right*, CAROLINA JOURNAL ONLINE, May 25, 2004 at [http://216.27.16.14/articles/display\\_story.html?id=1566](http://216.27.16.14/articles/display_story.html?id=1566) (last visited April 5, 2005). The Charter of Fundamental Rights of the European Union also considers health care to be a fundamental right, though such a position is not without opposition. See Charter of Fundamental Rights of the European Union, *Article 35: Health Care*, at [http://www.europarl.eu.int/charter/pdf/text\\_en.pdf](http://www.europarl.eu.int/charter/pdf/text_en.pdf) (last visited Oct. 25, 2004). John Kerry made expanded access to health care for all Americans one of the platforms of his presidential campaign, promising both greater coverage and cheaper cost at the same time. See Kerry Edwards, *Quality Health Care for All*, at [http://www.johnkerry.com/issues/health\\_care/fairness.html](http://www.johnkerry.com/issues/health_care/fairness.html) (last visited Oct. 25, 2004).

<sup>147</sup> One should note that emergency health care is an exception to this general reality, as The Emergency Medical Treatment and Active Labor Act (EMTALA) guarantees access to all Americans regardless of their ability to pay. See 42 U.S.C. § 1395dd (2000).

natural extension is that we have a social responsibility and obligation to provide health care for all Americans regardless of their ability to pay; or (2) if not, we should consider the possibility of various forms of market exchange for human organs much like we do for any other health care treatment. Even if the reader comes down on the side of option number one, there is no reason why the provision of life-saving organs could not be funded by a universal state health care system to ensure access for all. If health care is indeed a fundamental right, requiring that people pay for life-saving medicines or operations is not morally any different than making them pay for life-saving human organs.<sup>148</sup>

Thus, the concept of open markets for health care services and products is accepted practice in the U.S., as Americans believe in exchange systems to varying degrees in all aspects of life. With respect to organ sales, a compelling case can be made that government regulation is necessary to prevent abuse and exploitation,<sup>149</sup> but it is much more difficult to make the case that a market system involving the human body is altogether immoral from the outset.

### B. *The Distributive Justice Argument Backfired*

When Al Gore spearheaded the National Organ Transplant Act through Congress in 1984, the noble intent was that life-saving organs should never have to be purchased; rather, they should be a "gift" to the recipient.<sup>150</sup> By promulgating such a policy, we would prevent the poor from being exploited, and ensure that the wealthy were not the only segment of society who had access to life-saving organs.

While this goal is laudable, the reality has turned out quite differently. Instead of organs becoming gifts to recipients who were not required to pay for them, health care middlemen have dramatically marked up the cost of transplant related services to capture much if not all of the surplus that was intended to go to the recipient.<sup>151</sup> Economists Pindyck and Rubinfeld detail the flaws in the distributive justice rationale, noting that physicians, hospitals, and other transplant service providers are able to adjust prices upwards to take advantage of potential recipients' willingness to pay for life-saving

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<sup>148</sup> See Denise, *supra* note 72, at 1033 (stating that "the wealth discrimination argument logically applies to all medical care allocated by market forces and would thus prohibit any life-saving health care from being bought or sold").

<sup>149</sup> See *infra* Part III.E.

<sup>150</sup> See Thorne & Langer, *supra* note 48 (noting that while Congress' intent was that donated organs should be a gift, economic realities have dictated the opposite).

<sup>151</sup> See *id.*; PINDYCK & RUBINFELD, *supra* note 75, at 293-94.



transplants.<sup>152</sup> They conclude that organs are still being allocated on the basis of ability to pay today, directly contrary to Congress' noble intent.<sup>153</sup>

Furthermore, to the extent that we worry about distributive injustice, we must be cognizant of the reality that individuals' wealth levels influence all kinds of health care decisions and outcomes that occur in the U.S. already. It is no secret that wealthy people tend to live longer and healthier lives than their poorer counterparts.<sup>154</sup> In addition, despite egalitarian concerns in the U.S., roughly 43 million Americans at this very moment possess no health care insurance coverage at all.<sup>155</sup> If society were to put its money where its mouth is, this deplorable lack of coverage would certainly be remedied. Yet every attempt to pay for universal health care coverage in recent memory has died a painful political death,<sup>156</sup> leaving the "haves" and the "have nots" in continued unequal positions. As a result, there is no question that one's wealth level directly impacts their health level.

On the other side of the philosophical coin, Congress should acknowledge that while distributive justice arguments may lie behind its decision to outlaw a market-based approach to organ donation, such a determination is overtly paternalistic.<sup>157</sup> Libertarian critics might contend, "who are we to say that our judgment regarding the propriety of organ sales should supersede that of a poor person's? If she values \$50,000 more than she values her kidney so that she can fund education or provide food for her family, why does society have the right to tell her she's wrong?" Thus, if the choice comes down to starving her children versus living with one kidney while being able to provide for them, isn't the poor person (and even society)

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<sup>152</sup> See PINDYCK & RUBINFELD, *supra* note 75, at 293, fig. 9.7. Thorne & Langer, *supra* note 48. Thorne and Langer argue that since individuals on the waitlist for organs are willing to pay a certain amount for a transplant (regardless of who the money goes to), the physicians and medical teams involved may be able to raise prices accordingly to reap the patient's entire value of the transplant, not just the portion attributable to their medical services. *Id.* Hence, the value of the new kidney may not be a gift to the recipient, but rather may be captured in the form of increased payment to the medical service providers. *Id.*

<sup>153</sup> See PINDYCK & RUBINFELD, *supra* note 75, at 293, fig. 9.7. See also Michele Goodwin, *Altruism's Limits: Law, Capacity, and Organ Commodification*, 56 RUTGERS L. REV. 305 (2004) (exploring the clandestine private organ negotiation process, and noting the limits to altruism); Michele Goodwin, *Commerce in Cadavers is an Open Secret*, L.A. TIMES, Mar. 11, 2004, at B15.

<sup>154</sup> See generally JOHN ARCHIBALD LAW ROBERTSON, DECIDE THE NUCLEAR ISSUES FOR YOURSELF: NUCLEAR NEED NOT BE UNCLEAR (2003), at [www.magma.ca/~jalrober/Chapter6a.htm](http://www.magma.ca/~jalrober/Chapter6a.htm) (last visited Oct. 25, 2004) (noting that life expectancy correlates with per capita GDP, and that while wealth does not necessarily cause better health, it allows for it).

<sup>155</sup> Press Release, Econ. Statistics Admin., U.S. Census Bureau, Numbers of Americans With and Without Health Insurance Rise, Census Bureau Reports (Sept. 30, 2003), at <http://www.census.gov/Press-Release/www/2003/cb03-154.html> (last visited April 5, 2005).

<sup>156</sup> See *Clinton's Failure: Health Security Reform Plan of 1993*, at <http://my.netian.com/~pynchon/doc/healthcare.htm> (last visited Oct. 25, 2004).

<sup>157</sup> See Hansmann, *supra* note 9, at 72. See also Finkel, *supra* note 84.

better off than she was previously? If society does not believe so, it is only because we think that we know better than sellers do what is best for them.<sup>158</sup>

Finally, proponents of the distributive justice rationale for the ban on organ sales are rightly concerned that a legalized market would give the wealthy an overwhelming advantage when it comes to the ability to purchase and receive life-saving organs.<sup>159</sup> However, this fear could be alleviated by government provision of funding for organ purchases based on income or wealth levels of potential buyers.<sup>160</sup> While the wealthy could fend for themselves and would not require state assistance, the poor could be granted vouchers by the government that would cover all or part of the organ purchase price depending on the individual's need. In this manner, we could remove the concern that poor individuals would not be able to afford the purchase of organs, as they would be placed on a level playing field in the open market through responsible government assistance.

However, even if society could ensure that both rich and poor would have equal access to organs, it would still face that perverse distributive consequence that poor persons would disproportionately be the organ sellers of the world.<sup>161</sup> At least one virtue of the United States' no-sale system is that it prevents the problem of poor Americans being preyed upon to become donors. The same cannot be said across the rest of the world, where black markets in organs that exploit the poor continue to thrive.<sup>162</sup> Agents

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<sup>158</sup> In a tangential field, Alan Schwartz has argued that paternalistic decisions to invalidate certain contracts as unconscionable (in the avowed interest of protecting the weak) ultimately harm the class of people that society is trying to protect. See Alan Schwartz, *A Reexamination of Nonsubstantive Unconscionability*, 63 VA. L. REV. 1053, 1053-59, 1061-64, 1071-82 (1977). As a result, Schwartz contends that the paternalism of the rich actually hurts the poor. *Id.*

<sup>159</sup> See Williams, *supra* note 105, at 316 (stating that "[o]ften, it is the poorer citizens of developing countries who are supplying organs for the members of the upper class who can afford them").

<sup>160</sup> JAMES F. BLUMSTEIN, THE USE OF FINANCIAL INCENTIVES IN MEDICAL CARE: THE CASE OF COMMERCE IN TRANSPLANTABLE ORGANS, IN JUSTICE AND HEALTH CARE: COMPARATIVE PERSPECTIVES 9, 31 (Andrew Grubb & Maxwell J. Mehlman eds., 1995) (stating that "wealth inequality . . . is unacceptable as a basis for deciding which persons are to be recipients of organ transplants" and that this problem "could be assuaged by . . . instituting public subsidy for those whose inadequate level of wealth bars access"); Gregory S. Crespi, *Overcoming the Legal Obstacles to the Creation of a Futures Market in Bodily Organs*, 55 OHIO ST. L.J. 1, 52 (1994) (noting that a market in organs would require the establishment of public or private mechanisms to subsidize organ purchase for potential recipients who otherwise would be denied access); see Denise, *supra* note 72, at 1033, n.146 (citing Note, *Tax Consequences of Transfers of Bodily Parts*, 73 COLUM. L. REV. 842, 842 (1973)).

<sup>161</sup> See Williams, *supra* note 105. *But cf.* Sowell, *supra* note 123. Sowell argues that banning sales does not alleviate the problem of poverty and challenges the accepted wisdom that purchasers of organs would have to be wealthy. *Id.* He points out that if we are really concerned about the poor, we can have the government serve as the purchaser of organs instead of individuals. *Id.*

<sup>162</sup> See *supra* Part I.C; see also Maria N. Morelli, Note, *Organ Trafficking: Legislative Proposals to Protect Minors*, 10 AM. U. J. INT'L L. & POL'Y 917 (1995) (discussing rumors of black markets in

make a lucrative living by scouring slums for the downtrodden, poverty-stricken souls in society, and promising them riches in return for the sale of a kidney.<sup>163</sup> While these poor individuals sometimes give in to the temptation of a cash reward that they believe will change their financial fortunes well into the future, it is predominantly the agents and middlemen who reap the lion's share of the profits.<sup>164</sup>

In sum, while the distributive justice rationale for banning sales was based on the best of intentions, its force has been weakened by subsequent developments. In the U.S., organs are still rationed to a significant extent based on one's ability to pay, giving the wealthy a decided advantage even under current law. A move to any market system could be accompanied by government assistance to enable the poor to purchase organs on an equal footing, but any system faces the problem that poor individuals would overwhelmingly be placed in the unenviable position of being organ sellers.

### C. *Information Problems Could Be Corrected*

Two separate responses may be offered to address the lack of information problem faced by potential organ sellers. First, we could educate sellers about all health risks that they were about to incur to ensure their decision be fully informed and to reduce the chance they would later regret it. Second, if a person still prefers to sell her kidney despite those risks because having money to buy food and avoid starvation is worth losing the kidney, we must be willing to be overtly paternalistic if we still desire to override her decision.

Risk information and education could entail putting potential organ sellers through mandatory classes on the dangers involved in live-person organ donation.<sup>165</sup> A bevy of written materials concerning health outcomes could be produced and distributed; a person could even be required to take a short exam to demonstrate that they understood the risks they were voluntarily incurring. Even so, given the predicament of poverty which moti-

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North America, Europe, Israel and Latin America).

<sup>163</sup> See Sanjoy Hazarika, *India Debates Ethics of Buying Transplant Kidneys*, N.Y. TIMES, Aug. 17, 1992, at A20.

<sup>164</sup> See *id.*

<sup>165</sup> Most reports have shown that organ donation by living individuals is not as risky as one might think. See Leora Erun Frucht, *A Life for a Life*, THE JERUSALEM POST, Feb. 14, 2003, at 12 (noting that donors very rarely suffer from medical problems even thirty years later and that the operation itself is low-risk). However, there may be substantially greater risks imposed on third-world organ sellers who face dirty drinking water and increased chances of infection compared to their counterparts in developed nations. See Finkel, *supra* note 84.

vates most sellers (and perhaps lack of education as well), one must wonder whether informing them of all the risks would do much to change their minds.

If education is not the answer, then societal paternalism rather than imperfect information becomes the justification for banning organ sales. There are indeed many members of society who believe it is unacceptable to receive money in exchange for agreeing to take on any risk to human life.<sup>166</sup> However, this argument ignores the reality that we already sanction this practice every day, and that individuals demand increased payment to reflect risks incurred.<sup>167</sup> For instance, we need look only to the variety of dangerous occupations that we allow (and need) individuals to occupy. Firemen, policemen, and members of the military all take significant risks to their health on a daily basis, and are compensated for it with enhanced wages that reflect the "risk premium" they are voluntarily bearing in the interests of saving other people's lives.<sup>168</sup> In fact, the overall risk posed by many socially acceptable dangerous professions is far greater than the risk that an individual bears when she agrees to donate or sell one of her organs to save another human being's life.<sup>169</sup> Many of these sellers are living in horrific poverty; the chance to receive a few thousand dollars to escape the slums in exchange for taking on an added risk to their health is rational and well worth it.<sup>170</sup> It is overtly paternalistic to assume that those who make the decision to sell an organ do not know what they are doing.

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<sup>166</sup> See, e.g., Sullivan, *supra* note 12 (quoting Dr. David A. Ogden, President of the National Kidney Foundation, who believes "[i]t is immoral and unethical to place a living person at risk of surgical complication and even death [in exchange] for a cash payment"). Despite this position, society has little problem permitting thousands of Americans to undergo cosmetic plastic surgery annually, even though there are certainly risks to life involved and little or no benefit to others. At the same time, we are willing to tell people who want to undergo surgery that would save another person's life—and perhaps provide for their own family as well—that they cannot do so in exchange for payment.

<sup>167</sup> See W. Kip Viscusi, *Job Safety*, in THE CONCISE ENCYCLOPEDIA OF ECONOMICS, at <http://www.econlib.org/library/Enc/JobSafety.html> (last visited April 5, 2005). Viscusi notes that workers do demand some wage premium to reflect the dangers inherent in certain jobs. *Id.* Analogously, society allows women to make the decision to become surrogate mothers in exchange for payment, even though such a choice entails nontrivial physical and psychological risks to the mother's health.

<sup>168</sup> See *id.*

<sup>169</sup> *How to Be a Living Donor*, at [http://www.shareyourlife.org/become\\_livingdonor.html](http://www.shareyourlife.org/become_livingdonor.html) (last visited April 5, 2005) (stating that "there is little danger in living with one kidney" because "[t]he remaining kidney will enlarge to do the work that two healthy kidneys share." Further, "[t]he liver has the ability to regenerate and regain full function. Lungs and pancreas do not regenerate, but donors usually have no problems with reduced function."); see also, e.g., Frucht, *supra* note 165. *But c.f.* Finkel, *supra* note 84. The author questions the notion that donation is as safe as proponents claim, pointing out that every study finding that risks are low took place in a wealthy nation. *Id.* Conversely, donors with poor diets and bad drinking water (as is the case in many black market nations) are open to a far greater risk of infection which may compromise their remaining kidney. *Id.*

<sup>170</sup> Moreover, while the amounts paid for black market kidneys seem small by American standards,

#### D. *Negative Externalities Can Be Insured Against*

Beyond correcting risk misperceptions, we still must be concerned about potential negative externalities imposed on society by virtue of an individual's decision to sell (or donate) her organs. If her own health deteriorates as a result and society must pick up the tab for some or all of those costs, we must find a way to internalize these negative externalities at the individual level so that organ sellers include those costs in their own internal decisionmaking calculus.<sup>171</sup>

One way to prevent society from having to bear unfunded costs is to mandate that organ sellers put aside a portion of their remuneration into an insurance fund, the sole purpose of which is to guard against increased future health care costs due to the underlying organ sale. For instance, it can be expected that when a seller is left with only one kidney, she faces somewhat higher expected medical bills in the future due to the risk that the remaining kidney fails.<sup>172</sup> Insurance company actuaries are quite skilled at calculating expected costs that arise from a host of individual decisions like these.<sup>173</sup> It seems likely that given the well-developed insurance markets that exist in America,<sup>174</sup> actuaries would be able to gather data based on experience that could estimate, with reasonable certainty, the expected increase in health care costs due to the decision to sell one's organs. This data could be based on the type of organ sold, other individual health risk factors (e.g., smoker versus non-smoker, pre-sale weight, and nutrition), as well as any other variable that correlates with increased future risk from the organ sale.

Mandating such an insurance fund would comport with accepted practice in the U.S. Today, liability insurance is statutorily required for a number of risky behaviors, most notably driving.<sup>175</sup> To prevent the costs from

they are often ten times the annual wages that laborers can hope to receive in third-world countries. See Rohter, *supra* note 2. Selling a kidney may be viewed, then, as a rational decision to take advantage of a once-in-a-lifetime chance to escape debt. *Id.*

<sup>171</sup> While critics of human organ markets focus on the negative health consequences created by organ *sellers*, it should be noted that these negative externality concerns regarding future health risks apply equally to those who *donate* organs. If we fear that organ sellers are imposing unacceptable externalities on society, then we must also ask if we feel the same way about organ donors.

<sup>172</sup> However, this risk is relatively small, as most kidney donors do not experience complications even decades after their operation. Frucht, *supra* note 165, at 12.

<sup>173</sup> See Be An Actuary: A Career Without Boundaries, *What Is An Actuary?*, at <http://www.beanactuary.org/about/whatis.cfm> (last visited April 5, 2005).

<sup>174</sup> See, e.g., STEVEN SHAVELL, FOUNDATIONS OF ECONOMIC ANALYSIS OF LAW 266-67 n.11 (Harvard Univ. Press 2003).

<sup>175</sup> See Insurance Information Institute, *Can I Drive Legally Without Insurance?*, at

accidents from falling onto the government, we force individual actors to internalize those costs by requiring them to pay the insurance premium up front. In this manner, when harm materializes, the state is not left holding the bag. We still allow actors to engage in risky behavior because we understand it produces benefits that outweigh its costs, but only if they (or their insurer) are willing to bear the consequences themselves.

E. *Regulated Markets Might Be America's Best Response to Black Markets*

The objections to human organ sales detailed above all contain some merit, but lose some of their force upon closer analysis and further ignore the reality that markets in human body parts and products are, for all practical purposes, unavoidable.<sup>176</sup> Morality concerns opposing commodification of the human body are somewhat hypocritical when one considers that we allow the explicit payment of cash for human tissues, blood, semen and ova.<sup>177</sup> We also have no moral qualms about requiring individuals to pay for medical care in general, without which their health and lives can be expected to suffer. The argument regarding the distributive justice impact of allowing sales (i.e., that the poor would be sellers, and only the rich could be buyers) ignores the fact that organ transplants are still rationed on the basis of ability to pay today.<sup>178</sup> Further, distributive inequity could be partially cured by providing government subsidies to enable the poor to have equal access to available organs.<sup>179</sup>

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<http://www.iii.org/individuals/auto/a/canidrive/> (last visited Nov. 3, 2004) (stating that “[a]lmost every state requires you to have auto liability insurance”). One should note, however, that there are still many uninsured motorists on the road, all of whom are choosing to violate the law and run the risk of legal consequences.

<sup>176</sup> See Mahoney, *supra* note 49, at 166 (arguing that “markets in human biological materials not only exist but are for all practical purposes unavoidable, and that the ostensible debate over whether human tissue ought to be bought and sold distracts attention from pressing questions relating to the allocation of the burdens and benefits of the dramatic scientific advances of the past several decades”).

<sup>177</sup> For example, the Senate Labor and Human Resources Committee distinguished between the sale of organs versus blood products because the latter are regenerative and selling them does not pose a threat to the donor's health. See S. Rep. No. 98-382, at 16-17, *reprinted in* 1984 U.S.C.C.A.N. 3975, 3982; see also Mahoney, *supra* note 49.

<sup>178</sup> See PINDYCK & RUBINFELD, *supra* note 75, at 293, fig. 9.7.

<sup>179</sup> BLUMSTEIN, *supra* note 160, at 31-32 (calling for public subsidy to prevent wealth inequality from determining who enjoys access to organs); Crespi, *supra* note 160, at 52; see also Denise, *supra* note 72, at 1033; Laura G. Dooley and Robert S. Gason, *Stumbling Toward Equity: The Role of Government in Kidney Transplantation*, 1998 U. ILL. L. REV. 703, 707 nn.18-19 (1998) (citing to Blumstein's concern that unregulated markets might allow wealth inequality to dictate which patients received organs).

Moreover, if we cannot prevent the black markets in human organs that continue to thrive worldwide today, a thoughtful and responsible regulatory solution in America might be the best response. Many scholars have chronicled the reality that today's black markets lead to a host of abuses, provide for no follow-up health care, and generally exploit the poor to the wealthy's advantage.<sup>180</sup> Stephen Spurr details the potential for misrepresentation and fraud against both buyers and sellers today, as prices spiral out of control for organs that are of dubious quality.<sup>181</sup> Gloria Banks decries the exploitation of society's most vulnerable individuals in the organ sale trade, and urges legal and ethical safeguards for their protection.<sup>182</sup> Susan Hankin Denise adds that a properly regulated organ market may therefore be a better solution to the problem of scarcity than the outright ban we witness today.<sup>183</sup>

Unlike black markets, responsible regulation of an American human organ market could ensure that each individual's decision was competent, voluntary, fully informed, and enduring.<sup>184</sup> Where imperfect information about health risks leads organ sellers to underestimate the consequences of their decision, we could remedy that concern by requiring and providing risk disclosure and education prior to allowing sales.<sup>185</sup> Furthermore, responsible regulation could prevent sellers from making hasty decisions by

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180 See Spurr, *supra* note 134; Denise, *supra* note 72; Gloria J. Banks, *Legal & Ethical Safeguards: Protection of Society's Most Vulnerable Participants in a Commercialized Organ Transplantation System*, 21 AM. J.L. & MED. 45, 74 (1995).

181 See Spurr, *supra* note 134, at 191-92 (noting that black markets provide no warranties on their products, and that the competitive forces enabled by open markets and legalized organ sales will help to ensure quality).

182 See Banks, *supra* note 180. Maria Morelli further fears the potential for children to be pulled into the illegal organ trade. See Morelli, *supra* note 162, at 920.

183 See Denise, *supra* note 72, at 1035-36 (arguing that regulated markets are superior to the existing ban on organ sales in the U.S.). Of course, even a well-regulated legalized market in the U.S. may not completely eliminate black markets worldwide if patients can still find organs more cheaply abroad. However, it is reasonable to suspect that an American market would significantly reduce the demand for black market organs, especially given the ability of a regulated market to better ensure the quality of its product. Furthermore, a legalized market in the U.S. (with appropriate safeguards to prevent abuse of sellers) may lead to similar structures abroad. On the other hand, one might argue that competing markets might lead to a "race to the bottom" in terms of regulatory standards, as each country tries to gain more market share.

184 An analogy can be drawn to various assisted suicide regulatory schemes, which almost invariably call for the patient to be making an informed, competent, voluntary and enduring decision. See Steve P. Calandrillo, *Corralling Kevorkian: Regulating Physician-Assisted Suicide in America*, 7 VA. J. SOC. POL'Y & L. 41, 91-98 (1998).

185 For instance, sellers could be required to attend an organ sale risk education class, during which the various health risks involved could be explained in detail to remedy concerns regarding lack of information. However, even if society could be certain that sellers were given all appropriate information, it could not ensure against the risk of optimism bias in processing it.

requiring reasonable "cooling-off periods" prior to sale (perhaps two to four weeks) to ensure that their decision is an enduring one.<sup>186</sup> Further, strict liability could be imposed on individuals or procurement agencies who sell defective or diseased organs to prevent them from concealing adverse health information that might negatively impact recipients.<sup>187</sup> Today's third party organ brokering that exploits the poor would be prohibited, and organ allocation could be made far more equitable by providing full state subsidies to the poor.<sup>188</sup> To prevent the risk that negative externalities would fall on the state when organ sellers' health later deteriorated, we could mandate that a portion of sale proceeds be set aside in an insurance fund with the single goal of providing compensation for the future health risks and medical costs created by the decision to sell one's organs.<sup>189</sup>

Thus, given the reality of black markets, as well as the legitimate fears regarding legalized organ sales, any viable market in human organs must address the arguments raised by critics and contain substantial safeguards to minimize exploitation and abuse. By regulating appropriately, we could alleviate many of the problems faced by sellers on the black market today, and we could compensate for the enhanced future risks that sellers would be taking without placing the burden on the state. At the same time, thousands of lives that are being lost today would be saved tomorrow.

#### IV. REAL REFORMS: UTILIZING INCENTIVES TO END THE NATION'S ORGAN SHORTAGE

Despite the above analysis, any form of legalized human organ market would be far from a utopian solution: it would be political suicide to propose, entail significant administrative costs to establish and monitor, and remain morally distasteful to many Americans. While such markets have been debated without much progress in the past, far less attention has been paid to dozens of other monetary and nonmonetary incentives that could be employed. Taking an incentive-based approach would avoid imposing risk

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<sup>186</sup> Spurr, *supra* note 134, at 194 (noting that sales by living donors could be safeguarded by adding statutory "cooling off periods"). Waiting periods are also employed in other medical decisionmaking contexts that have life-or-death consequences. For example, the Oregon Death With Dignity Act requires that any patient seeking assisted suicide must wait two weeks before their request will be honored, a safeguard aimed at preventing a transitory desire to die. *See Oregon Death with Dignity Act*, Or. Rev. Stat. §§ 127.800-97 (1998), *amended by* 1999 Or. Laws Ch. 423.

<sup>187</sup> Keith N. Hylton, *The Law and Economics of Organ Procurement*, 12 L. & POL'Y 197, 209 (1990).

<sup>188</sup> *See supra* Part III.B.

<sup>189</sup> *See supra* Part III.D.



on living donors, dramatically expand the pool of available organs, and shock the conscience far less than allowing living-seller markets.<sup>190</sup>

### A. *Monetary Incentives*

#### 1. Futures Markets: Allow Payment to Donor, but Organs Harvested Only at Death

One of the more provocative financial incentives postulated to spur organ supply is the creation of a “futures market.”<sup>191</sup> Scholars like Lloyd Cohen and Gregory Crespi have suggested such markets to combat organ shortages by utilizing market incentives to induce donation, while simultaneously preventing poor individuals from permanently harming their health simply to pay off their debts.<sup>192</sup> Rather than providing money to sellers in exchange for the removal of their organs today, society could allow individuals to sell the right to harvest their organs upon their death (i.e., a futures contract).<sup>193</sup> If one or more of their organs were subsequently taken, payment would be made to a beneficiary that the donor designated at the time of entering into her futures contract.<sup>194</sup> In this manner, we could alleviate the exploitation of the poor because living donor sales would be prohibited.<sup>195</sup> Additionally, wealthy individuals would not necessarily have

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<sup>190</sup> For an excellent discussion of the role of financial incentives in the human organ debate, see James F. Blumstein, *The Use of Financial Incentives in Medical Care: The Case of Commerce in Transplantable Organs*, 3 HEALTH MATRIX 1 (1993); Curtis E. Harris and Stephen P. Alcorn, *To Solve a Deadly Shortage: Economic Incentives for Human Organ Donation*, 16 ISSUES L. & MED. 213 (2001).

<sup>191</sup> See, e.g., Lloyd Cohen, *supra* note 14, at 2; Eric Cohen, *supra* note 8; Lloyd Cohen, *supra* note 25; Conan, *supra* note 43; Crespi, *supra* note 160, at 35-37; Hansmann, *supra* note 9, at 72-74; Spurr, *supra* note 134.

<sup>192</sup> See Lloyd Cohen, *supra* note 14; Crespi, *supra* note 160.

<sup>193</sup> Lloyd Cohen, *supra* note 14, at 2. If desired, the futures market could be designed to apply only to certain organs, or to last only for a certain duration (preferably short term to allow the seller to revisit her decision periodically); see Hansmann, *supra* note 9, at 62. Additionally, futures markets could include safeguards to prevent against incentivizing individuals to sign up only because they planned to commit suicide in the near future. One method of doing so would be to institute waiting periods between the time a futures contract is entered into and the time at which a person (or their beneficiary) became eligible to receive the compensation.

<sup>194</sup> Lloyd Cohen, *supra* note 14, at 2.

<sup>195</sup> See Crespi, *supra* note 160, at 6-7 (stating that the “market could be designed so that no one would be put into the position where he would be tempted to sell a bodily organ to meet a pressing financial exigency”). However, while the risk of abusing living donors would be reduced, many Americans still identify a person’s corpse with the notion of personhood, making even cadaveric organ sales

greater access to harvested organs because futures markets do not deal with the allocation of organs, but only their supply.<sup>196</sup> Finally, the medical community would no longer need to worry about procuring the consent of the deceased's next of kin to procure viable organs.<sup>197</sup>

An analogous futures market has been proposed by Henry Hansmann.<sup>198</sup> Hansmann's idea modifies the timing and type of payment—allowing the seller herself (instead of a beneficiary) to receive a reduction in health insurance premiums today in exchange for her promise to allow her organs to be harvested at death.<sup>199</sup> The seller would be able to revisit her decision periodically, as she would elect annually either to opt in to being an organ donor (and receive the corresponding insurance discount), or elect not to do so if she so chose (and pay the traditional premium).<sup>200</sup> Further, by avoiding the harvesting of organs from living individuals, we would mitigate the concern that the seller's health would subsequently deteriorate and that society would be left having to pay the price for it.

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somewhat problematic. See Donald Joralemon and Phil Cox, *Body Values: The Case Against Compensating for Transplant Organs*, 33 HASTINGS CENTER REPORT 1 (Jan. 1, 2003) (arguing that the extensive money spent on extracting bodies from World Trade Center after the 9/11 attack reflects societal recognition of the view that the corpse is integral to one's self).

<sup>196</sup> Lloyd Cohen, *supra* note 14, at 30.

<sup>197</sup> See *id.* at 34-35.

<sup>198</sup> See Hansmann, *supra* note 9, at 61-71. Hansmann proposes a futures market wherein people could (while alive and well) sell the right to harvest their organs upon their death. *Id.* The value of the futures contract would be measured by the risk of the individual's death multiplied by the chance that her organs would be harvestable multiplied by the value of those organs. *Id.* The government could be the sole purchaser of the futures contracts, or health care insurers could purchase them as well if they found it in their financial self-interest. *Id.* Individuals could sell futures for a term or for life, and recipients of the organs (or their insurer) would pay the list price for the organ. With futures markets, insurance companies could resell rights to organs, which might lead to the problem of some companies aggressively soliciting organ futures from high risk individuals. *Id.* However, an advantage of allowing futures markets would be that the decision to sell would be made at the time when it is least problematic (without imposing risks on a living seller), and there would no longer be any need to seek permission from the person's next of kin after death. *Id.* If the seller's family objected to organ harvest by the futures holder, we could ignore the family's protest or allow the family to prevent harvesting if they were willing to pay the fair market value of the organ. *Id.* On the other hand, one unintended disadvantage of futures markets could be the shrinking of the altruistic donor pool because of the distaste that some would-be voluntary donors may associate with legalized markets. *Id.* Further, an individual who has entered into a futures contract might reasonably fear that she would receive subpar medical care after making her decision, so that her organs might be harvested sooner. *Id.* Hansmann concludes that in the long run it might be better to encourage voluntary donation, but that futures markets may help in the short term. *Id.*

<sup>199</sup> See *id.* at 63.

<sup>200</sup> See *id.* at 63.

One wrinkle in the futures market plan is whether or not organ transplant success is influenced by using a living versus deceased donor. If outcomes are similar regardless of whether a kidney comes from a living or dead individual, then futures markets should be just as successful as living-donor sales, but without the accompanying risks. However, to the extent that success rates are reduced when a transplanted organ is harvested from a deceased donor,<sup>201</sup> there may still remain a small black market in living-donor sales due to the greater chance of a positive outcome. In fact, some organ brokers convince dialysis patients today to buy organs abroad rather than wait for an American cadaveric donor by touting the benefits of live donation.<sup>202</sup> To the contrary, most studies have concluded that the difference in outcomes based on whether the organ was harvested from a living or non-living individual is relatively small.<sup>203</sup> If these studies are correct,

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201 The United Network for Organ Sharing states that “[t]ransplants from living donors are often more successful, because there is a better tissue match between the living donor and recipient. This higher rate of compatibility also decreases the risk of organ rejection.” UNOS, *Living Organ Donation*, at <http://www.unos.org/Resources/factsheets.asp?fs=2> (last visited April 5, 2005). Many studies have documented an increased chance of positive outcomes when using organs transplanted from living donors vis-à-vis organs transplanted from cadavers. See, e.g., J. Cecka and P. Terasaki, *The UNOS Scientific Renal Transplant Registry. United Network for Organ Sharing*, CLIN. TRANSPL. 1 (1994) (finding that survival rates for recipients of living donor kidneys were significantly higher than for those receiving kidneys from cadavers); J. Lowell and R. Taylor, *The Evaluation of the Living Renal Donor, Surgical Techniques And Results*, 12 SEMIN. UROL. 102 (1994) (concluding that living-donor renal transplants from either genetically related or unrelated donors have proven to have superior short-term and long-term results when compared to cadaveric transplants).

202 See Michael Pilgrim, *How Easy is it to Buy a Kidney from One of the World's Poorest People? It Took Me Just One Phone Call*, MAIL ON SUNDAY, May 25, 2003, at 52, available at 2003 WL 10412829. In the United States, even with living donor transplants, there is usually a three-hour wait between the removal of the organ and the transplant operation because one surgical team performs both operations. *Id.* Transplant brokers boast that their transplants are done ten minutes after removal of the organ because two teams of doctors are involved. *Id.* Additionally, many transplant brokers conduct testing for one month to ensure the match and health of the organ. *Id.* With cadaveric organs, medical professionals do not have the luxury of taking a month to do such testing. *Id.*

Interestingly, prior to the 2003 Iraqi war, Iraq had one of the world's safest and most affordable markets for living-donor kidneys. See Finkel, *supra* note 84. In fact, one Israeli doctor has expressed that, although it is technically illegal to buy organs in Iraq, Iraq would be the place to go to pay for a transplant. See *id.* He noted that the percentage of his patients whose organs were still functioning one year after receiving a living donor transplant abroad, in countries like Iraq, was higher than anywhere else in the world, including the United States (which primarily uses cadaveric organs). *Id.* Iraq uses living donors, has excellent surgeons, carefully screens sellers for health complications and organ matches, and provides excellent post-operative care. See *id.* However, Iraq's black market is likely no longer thriving after the U.S. led invasion of the country in 2003.

203 See, e.g., R. Knight et al., *The Influence of Acute Rejection on Long-Term Renal Allograft Survival: A Comparison of Living and Cadaveric Donor Transplantation*, 72 TRANSPLANTATION 69 (2001). The authors found that five-year survival was 90% for those receiving transplants from living relatives and 88% for those receiving cadaveric transplants. *Id.* Furthermore, a cadaveric graft that was free from acute rejection three months after transplantation had an equal likelihood of functioning at

futures markets could solve our nation's organ supply crisis without reduction in health outcomes. Even if the opposite is the case, futures markets are a solid step in the right direction, and certainly a substantial improvement over current organ supply incentives.

## 2. Tax Breaks

Another financial carrot with which a few state governments have experimented is a tax deduction designed to induce their citizens to become organ donors. Wisconsin, for example, passed a law in 2004 which allows for a tax deduction of up to \$10,000 to cover expenses resulting from a resident's decision to donate organs, including their travel, lodging and lost wages.<sup>204</sup> Supporters hail the bill as "the most ambitious move [yet] by a state government to increase transplants."<sup>205</sup>

Critics respond, however, that such a direct monetary incentive runs afoul of NOTA's prohibition on paying valuable consideration for human organs.<sup>206</sup> Howard M. Nathan, president and chief executive of the Gift of Life Donor Program, worries, "When you get as high as \$10,000 you start to wonder what that means to people and if there is some coercion that goes on with that."<sup>207</sup> Wisconsin legislator Steve Wieckert dismisses this concern, noting, "We want[ed] to be very careful that we are not getting into

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five years as that of a graft from a living related donor. *Id.*; see also Splendiani et al., *supra* note 131 (finding an organ survival rate of 97% for living donor transplants versus 93% for cadaveric transplants); K. Nishikawa and P. Terasaki, *Annual Trends and Triple Therapy—1991-2000*, CLIN. TRANSPL. 247 (2001) (The study reported that cadaver donor graft survival at one year improved from 84% in 1991 to 90% in 2000, while one-year graft survival of living donor transplants only improved from 93% in 1991 to 95% in 2000. Further, triple therapy virtually eliminated the effect of sensitization for cadaveric donor grafts.)

<sup>204</sup> Napolitano, *supra* note 16. "The bill was overwhelmingly approved by the Wisconsin State Assembly in November [2003]," and "passed in the Senate by a vote of 28 to 2." Governor James E. Doyle, a Democrat, was eager to sign it into law, stating "I'm very supportive . . . This is a big issue in Wisconsin." *Id.*

<sup>205</sup> *Id.* One should note that Wisconsin's tax break proposal is aimed at incentivizing donation by living individuals. Tax breaks for donation *after death* could likewise increase the pool of available organs.

<sup>206</sup> *Id.*

<sup>207</sup> *Id.* One of the only state representatives to vote against the bill, Bob Ziegelbauer, added that the deduction "would needlessly complicate the tax code . . . at a time when [Wisconsin] faces a fiscal crisis. Why should the government be in the business of handing out rewards to people when they do good things?" *Id.* One might respond that governments exist in large part to incentivize private actors to act in socially beneficial ways.

the business of selling organs but [instead] encourag[ing] organ donation.”<sup>208</sup>

Other states, including Indiana, are considering nearly identical legislation.<sup>209</sup> Nearby Kansas contemplated passing a similar tax break for blood and organ donation in 2000, but the bill never emerged from the committee process after the state attorney general authored an opinion that it violated NOTA’s ban on paying valuable consideration.<sup>210</sup> Outside of our national boundaries, countries like Great Britain have also weighed the impact of tax breaks as a partial solution to alleviate growing organ shortages.<sup>211</sup> Finally, Israel proposed a law which would provide financial reimbursement to donors for the time, discomfort, and inconvenience involved due to their decision to donate organs.<sup>212</sup>

Assuming tax deductions do not overstep the bounds outlined by federal law in the U.S.,<sup>213</sup> they represent a provocative move toward explicit consideration of pecuniary incentives to spur donation. On the downside, they only work if the state in question has an income tax,<sup>214</sup> and even if it does, tax deductions are peculiarly regressive—i.e., a wealthy individual in the highest marginal tax bracket would receive a greater financial benefit than would her poorer counterpart in a lower bracket. This inequity could be remedied by provision of a tax *credit* regardless of income instead of a

<sup>208</sup> *Id.*

<sup>209</sup> *Id.*

<sup>210</sup> Napolitano, *supra* note 16.

<sup>211</sup> See *Human Organs: Not for Sale*, THE GUARDIAN (MANCHESTER), Dec. 4, 2003, at 27.

<sup>212</sup> Frucht, *supra* note 165. However, this expenditure is not to be considered “payment for the sale of an organ,” and is only allowed as long as the Ministry of Health is convinced that there is no monetary incentive behind the donation. *Id.*

<sup>213</sup> The fundamental argument raised by opponents is that a tax break constitutes the payment of “valuable consideration” in contravention of NOTA’s mandate. See 42 U.S.C. § 274e(a) (2000). This argument will be addressed *infra* in Part IV.A.3. There, I suggest that state governments might discount driver’s license fees for those who check the organ donor box. To combat the response that such a benefit runs afoul of NOTA by compensating people for their decision to donate, the state could simultaneously offer a tax credit in the same amount to its citizens who refused to donate. Despite the fact that no additional valuable consideration would be given to encourage donation, my intuition is that many individuals will choose to opt in to donation in order to receive the discount immediately rather than wait until April 15th to receive the equal tax credit.

<sup>214</sup> Seven states currently do not impose an income tax on their residents (they are Alaska, Florida, Nevada, New Hampshire, South Dakota, Tennessee, Texas, Washington and Wyoming). *List of States Without Income Tax*, <http://encyclopedia.thefreedictionary.com/List%20of%20States%20Without%20Income%20Tax> (last visited April 5, 2005). Even in the majority of states that have some version of an income tax, the rate at which citizens are taxed from state to state varies greatly. Some might also reasonably question whether people would truly be incentivized to donate organs solely based on receiving a tax break. The same argument could be made regarding federal income tax treatment of charitable donations—do people donate to charities because of the tax advantages or do they do so independent of any financial carrots?

tax deduction. Furthermore, if tax breaks for living donors succeed, we should expand them to include tax incentives for donation after death as well. Moreover, a uniform federal tax credit (rather than inconsistent state efforts) would allow all Americans who wished to donate to benefit equally from their magnanimity.

### 3. Discounted Driver's License Fees

Rather than waiting for a tax credit to arrive come April 15th, a more immediate financial incentive to donate could be given directly to people when they receive or renew their driver's licenses. Today, Americans have the option to register as organ donors when they obtain their licenses. Most choose not to opt in, despite the fact that a large majority of these individuals actually support the idea of organ donation.<sup>215</sup> What explains this paradox? It is easier to do nothing than it is to act.

One simple solution to capitalize on the fact that indifference is causing many Americans not to opt in is to offer a discount or waiver of any driver's license renewal fees in exchange for their decision to check the organ donor box.<sup>216</sup> Every state imposes some nominal fee to cover the administrative costs of its department of motor vehicles (DMV). Georgia, for instance, offers its residents a \$9 discount for their agreement to become donors, although the new state governor has indicated his intention to rescind the program because of uncertainty over its legality and a desire to raise state revenues.<sup>217</sup>

Discounting driver's license fees raises the same kind of concerns as do tax breaks regarding the legality of providing valuable consideration in exchange for a person's decision to donate human organs. However, a unique combination of the tax break and discounted driver's license fee proposals should suffice to remove any legal concerns. First, the state DMV could offer to waive the license fee immediately to a driver who checked

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<sup>215</sup> See Kurtz & Saks, *supra* note 21, at 782-83; Hazony, *supra* note 60, at 236-39 (addressing the paradox between public opinion in favor of organ donation versus the actual rate of donation, and hypothesizing that the difference may be due to psychological and emotional issues hindering the decedent's family from consenting at the time of death, as well as health care providers' discomfort when it comes to requesting donation); Pew Research Center for the People and the Press, *supra* note 10 (finding that 81% of the public supports donation but only 42% have registered as donors).

<sup>216</sup> See Hansmann, *supra* note 9, at 63.

<sup>217</sup> See Tabarrok, *supra* note 6. There is concern that the law may not be legally valid due to NOTA's prohibition on the payment of valuable consideration for organs. See *id.* Georgia's governor may also rescind the \$9 offer simply to increase state revenue. *Id.* Such shortsighted financial decisions ignore the literally hundreds of thousands of additional dollars that Americans on organ waitlists impose on our health care system.

the organ donor box at renewal time. To combat the argument that this represented a payment to donors in violation of NOTA, a tax credit in the same amount could be provided to non-organ donors at the time they completed their federal tax form. In this manner, both organ donors and non-organ donors would be placed in identical financial positions—there would be no greater valuable consideration provided to organ donors. The only difference would be the timing—organ donors would receive the waiver of license fees at the counter or in the mail when they renewed their license, and non-donors would receive the identical waiver as a tax credit come April 15th.

Some might wonder then, “If the financial outcome to both donors and non-donors is the same, how would this system incentivize organ donation any better than the status quo?” The simple answer is that individuals (who are relatively indifferent or mildly in favor of organ donation) will often choose the option which is “easier.” It is easier to receive a waiver of fees at the time of renewing one’s driver’s license than it is to wait until April to claim one’s tax credit. This system would involve minor costs to the state, and could even be offset by raising fees or taxes in other areas, if necessary. Yet, it could reap enormous gains in the percentage of Americans who opted in to organ donation. Currently, over 80% of Americans support the concept of organ donation,<sup>218</sup> yet only approximately one-quarter go through the trouble to opt in.<sup>219</sup> By waiving driver’s license fees in the manner just described, it is reasonable to surmise that far more individuals will exercise their preference to opt in, if only to avoid having to fill out the paperwork to receive a future tax credit. Non-donors would not be able to complain about unequal financial treatment based on their decision to opt in or not, because they would receive the same amount of money as their donor counterparts.<sup>220</sup> The moral of the story: simply requiring people to go to

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218 See Pew Research Center for the People and the Press, *supra* note 10 (finding 81% of those surveyed support the donation of organs for transplant); The Gallup Organization, Inc., *supra* note 10 (85% of those polled were in favor of organ donation by a loved one and 60% said they would be willing to donate their own organs); see also Kurtz & Saks, *supra* note 21, at 768 (noting that the support for organ donation expressed in the 1993 Gallup Poll was surpassed in a 1995 Iowa study, in which 97% of residents interviewed expressed approval for organ donation); Hazony, *supra* note 60, at 220.

219 See The Gallup Organization, Inc., *supra* note 10 (28% of respondents indicated they had signed organ donor cards); Hansmann, *supra* note 9 (citing to a survey indicating that just 17% of Americans were registered donors).

220 Non-donors might still complain about the delay in payment (and the corresponding declining purchasing power of money over time) since their decision forces them to wait until tax season to receive the tax credit. If that becomes a major policy concern, the state could even offer to pay non-donors a nominal amount of interest to compensate for the delay in payment. My intuition is that the great majority of individuals who are indifferent to organ donation or who are mildly in support would still check the box opting into organ donation in order to receive the discounted driver’s license fees immediately rather than wait and receive the time-premium in the form of a tax credit later.

the trouble of filing for a tax credit to opt out will encourage the great majority of Americans to opt in to organ donation up front.<sup>221</sup>

#### 4. Reimbursement of Medical Care and Burial Expenses of Donors

Peter Young makes the point compellingly: why do we allow hospitals, medical teams and organ transplant service providers to make thousands of dollars from each organ donated, yet we do not permit the families of donors to receive a dime, even for burial costs.<sup>222</sup> He recounts the tragic tale of Susan Sutton, a 28-year-old who claimed her own life by gunshot after a fight with her boyfriend.<sup>223</sup> Her family made the difficult but conscientious decision to donate her organs so that others might receive the gift of life through her painful death.<sup>224</sup> Her heart, liver, corneas, and some of her bones and skin were used for transplantation.<sup>225</sup> The hospital and medical teams who performed the transplant made thousands, as did the nonprofit transplant coordination agency who arranged the transfers.<sup>226</sup> The family received nothing. They buried Susan Sutton in an unmarked grave, unable to even afford a gravestone to preserve her memory.<sup>227</sup>

At the very least, tragic stories like Susan Sutton's highlight the case for providing some financial remuneration to families of donors, if only limited reimbursement for end-of-life medical care and funeral expenses. Professor Fred Cate of Indiana University adds, "we sell body parts all the time; we just don't call it that . . . . What the advocates are saying is, 'Let's call a spade a spade. And let's not exclude the donor or the donor's family from a market that everyone else is participating in.'"<sup>228</sup> A. Bruce Bowden of the National Kidney Foundation agrees, asking that "the law be changed to permit payments of burial expenses for donors."<sup>229</sup> He suggests a "standardized and small amount," even just \$2,000, paid "through an agency like the Health Care Financing Administration to a third party, like a funeral

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<sup>221</sup> Of course, we could create a presumption of consent to organ donation at the time of registration or renewal of one's driver's license. See *infra*, Part IV.B.3.

<sup>222</sup> See Young, *supra* note 8.

<sup>223</sup> *Id.*

<sup>224</sup> See *id.*

<sup>225</sup> *Id.*

<sup>226</sup> *Id.*

<sup>227</sup> *Id.* Susan's mother Judy Sutton adds, "It's wrong that doctors make so much money off donors . . . [while we] had to borrow money for the funeral." *Id.*

<sup>228</sup> Young, *supra* note 8. Professor Cate has also written a provocative article detailing the role of law in the organ transplantation debate. See Fred H. Cate, *Human Organ Transplantation: The Role of Law*, 20 J. CORP. L. 69 (1995).

<sup>229</sup> Young, *supra* note 8.



director.”<sup>230</sup> Shelby Robinson has authored an article in support of this type of “death benefit,” arguing that such an incentive is the most viable of the various proposed systems for increasing organ procurement in the United States.<sup>231</sup>

Turning from theory to practice, Pennsylvania established the first death benefit program in the U.S. as part of 1994 legislation creating the Organ Donation Awareness Trust Fund.<sup>232</sup> In response to the organ shortage (and specifically its disproportionate impact on African-Americans),<sup>233</sup> the state permits its residents to make voluntary \$1 contributions aimed at offsetting medical and funeral expenses of donors.<sup>234</sup> Approximately \$300 per donor is allocated for this purpose,<sup>235</sup> a step in the right direction, but one which is still far short of actual expenditures incurred. Other money in the fund is allocated for developing organ donation awareness programs within the state.<sup>236</sup> A few other states have followed Pennsylvania’s lead in

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<sup>230</sup> *Id.* (internal citations omitted). Furthermore, the Ad Hoc Committee for Solving the Intractable Organ Shortage (AHCSIOS) has proposed a \$5,000 payment to the estate of the deceased, suggesting *inter alia* that the money can be used to help offset funeral or hospital expenses. AHCSIOS, at <http://www.pitt.edu/~htk/organgiving/proposal.htm> (last visited April 5, 2005).

<sup>231</sup> Shelby E. Robinson, *Organs for Sale? An Analysis of Proposed Systems for Compensating Organ Providers*, 70 U. COLO. L. REV. 1019, 1050 (1999).

<sup>232</sup> Siegel, *supra* note 23, at 940-41. Siegel believes that pilot programs modeled after Pennsylvania’s approach are the best way to create an incentive scheme for organ donation that bridges the gap between the status quo and a full-fledged market. *Id.* at 953. She also notes that Pennsylvania’s program brought to the forefront the ethical debate over paying monetary benefits to induce donation, and that concern was expressed that its provisions violated NOTA. *Id.* at 941. “The program was developed with awareness of these legal and moral obstacles, and provides a small token of appreciation to donors as opposed to a strong financial incentive.” *Id.* at 942.

<sup>233</sup> Peter A. Ubel et al., *Pennsylvania’s Voluntary Benefits Program: Evaluating an Innovative Proposal for Increasing Organ Donation*, 19 HEALTH AFFAIRS 206, 206-207 (Sept./Oct. 2000). African-Americans are negatively impacted because adequate antigen matches are rare. *Id.* at 206. Bill Robinson, a Pennsylvania state legislator with primarily African-American constituents, sponsored the legislation. *Id.* at 206-207. According to UNOS, African-Americans face an unbelievable median waiting period of 1,335 days to receive an organ. *Community Outreach in Donation and Transplantation Improving for African Americans in Maryland, a t* [http://www.mdtransplant.org/ln\\_community\\_outreach.html](http://www.mdtransplant.org/ln_community_outreach.html) (last visited November 15, 2004); [http://www.umm.edu/news/releases/transplant\\_wait\\_4-25-02.htm](http://www.umm.edu/news/releases/transplant_wait_4-25-02.htm) (last visited November 15, 2004).

<sup>234</sup> Ten percent of the fund may be spent each year for this purpose, although the compensation must be paid directly to the funeral home or hospital, not to the donor’s family or estate. Siegel, *supra* note 23, at 941.

<sup>235</sup> *Id.* “Although the Act stipulates a maximum of \$3,000 compensation per family, Pennsylvania’s Organ Donor Advisory Committee has decided that the payments should approximate \$300 per family. According to Kevin Sparkman, legislators determined the amount based on the estimated amount in the fund and the estimated number of potential donors in Pennsylvania in a given year.” *Id.*

<sup>236</sup> *Id.* at 941-42. The Act allocates half of the funds raised for grants to certified organ procurement organizations to develop public awareness programs regarding donation. Fifteen percent goes to the Department of Health to further Project-Make-A-Choice, and “twenty-five percent is allocated to the

some manner,<sup>237</sup> but far more legislatures should consider the incentivizing effect of providing some amount of burial compensation to reward donors and their families who have made the decision to give the gift of life.

### 5. Recent Congressional Proposals

Recently, Congress has begun to show signs of interest in tinkering with the nation's dire organ shortage. The Organ Donation & Recovery Improvement Act,<sup>238</sup> sponsored by Congress's lone physician Bill Frist, authorizes the Department of Health and Human Services to carry out demonstration projects that include financial incentives to increase organ supply.<sup>239</sup> For instance, donors may now be reimbursed for travel and subsistence expenses incurred due to their decision to save someone else's life.<sup>240</sup> Further, the Act makes financing available for Organ Procurement Organizations to better coordinate donations, as well as for new organ donation programs to be instituted at hospitals nationwide.<sup>241</sup> Ideally, the Act will also improve education and training of health care professionals regarding the need to sensitively ask families to consent to organ donation. Hospitals could even hire special donation counselors under the guidelines of the law that specialize in this difficult yet vital task.<sup>242</sup>

The AMA has endorsed the Act and the trial financial incentives it includes, a move which surprised some commentators.<sup>243</sup> In fact one critic charged, "With staggering amorality, our medical elite now think it's OK for us to sell our body organs."<sup>244</sup> However, one would think that the most observers would be thrilled at the prospect of exploring incentives to induce

Department of Education for implementing programs in secondary schools." *Id.*

<sup>237</sup> See *infra* Part IV.B.6 (describing organ donation awareness programs in Delaware, Ohio and Florida).

<sup>238</sup> Organ Donation & Recovery Improvement Act, Pub. L. No. 108-216, 118 Stat. 584 (2004). Three related bills were also considered: H.R. 3926, 108th Cong. (2004); H.R. 399, 108th Cong. (2003); and S.573, 108th Cong. (2003). Newspaper accounts highlighted the explicit inclusion of financial incentives as a way to motivate increased organ donation. See Jim Warren, *Congressional Spotlight Shines on Increasing Donation by Offering Financial Incentives*, 13 TRANSPLANT NEWS, Issue 11, June 14, 2003; Carey Goldberg, *Fiscal Incentive Weighed to Boost U.S. Organ Supply*, BOSTON GLOBE, Oct. 8, 2003, at A1.

<sup>239</sup> Organ Donation & Recovery Improvement Act, § 377.

<sup>240</sup> § 377(a)(1).

<sup>241</sup> § 377(B).

<sup>242</sup> § 377(B).

<sup>243</sup> Laing, *supra* note 120.

<sup>244</sup> *Id.*

donation, as cost-benefit studies have demonstrated that each kidney transplanted saves \$200,000 to \$400,000 in insurance costs.<sup>245</sup>

Other recently proposed Congressional bills include the DONATE Act,<sup>246</sup> the Living Organ Donor Protections Act,<sup>247</sup> and H.R. 4042.<sup>248</sup> The DONATE Act sought to promote organ donation by providing twenty-four-hour-per-day access to state donor registries,<sup>249</sup> while the Living Organ Donor Protections Act aimed to ensure that health insurance companies could not discriminate on the basis of organ donation status.<sup>250</sup> H.R. 4042 would amend the Internal Revenue Code of 1986 to allow a tax deduction for expenses paid in connection with organ donation.<sup>251</sup> Unfortunately, proposals along these lines continue to prove uncertain, as critics lament the explicit inclusion of financial incentives as a way to motivate donors.<sup>252</sup> This concern brings us back to the heart of the debate over valuable consideration in exchange for human organs—we see that even limited, trial attempts to explore fiscal incentives are likely to encounter some resistance. On balance, however, there is support for using at least some financial incentives to increase organ donation and procurement, making such an approach a potentially attractive one in our quest to save Americans currently on the national organ waitlist.

## B. *Non-Monetary Incentives*

Besides the multitude of proposed fiscal incentives to spur donation, there are numerous ways that society could increase private motivation to donate organs without spending a single cent. No critic could raise an objection founded upon NOTA or UAGA, and thousands of lives would be saved in the process.

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<sup>245</sup> Warren, *supra* note 238.

<sup>246</sup> S. 376, 108th Cong. (2004).

<sup>247</sup> S. 186, 108th Cong. (2004). A related bill designed to protect donors is the Living Organ Donor Job Security Act of 2003, H.R. 1381, 108th Cong. (2003).

<sup>248</sup> H.R. 4042IH, To Amend the Internal Revenue Code of 1986 to Allow a Deduction for Expenses Paid in Connection with the Donation of an Organ, 108th Cong. (2004).

<sup>249</sup> S. 376, 108th Cong. § 371A(b)(2) (2004).

<sup>250</sup> S. 186, 108th Cong. § 3(b) (2004).

<sup>251</sup> H.R. 4042, 108th Cong. § 214 (2004).

<sup>252</sup> See Jim Warren, *Passage of Much Needed Transplant Bill May Depend on Finding Compromise on Financial Incentives Trial*, 13 TRANSPLANT NEWS (Transplant Communications, Inc., Baltimore, Md.), June 27, 2003, available at LEXIS, Newsletter Stories (discussing challenges to Bill Frist's Senate bill to hold a test trial to determine if monetary incentives actually work).

## 1. Priority Based on One's Own Willingness to Donate

Basing waiting list priority on the patient's own willingness to donate may inspire millions of Americans who have previously not taken the trouble to sign up to instead choose to opt in to donation. This concept has been put into practice by LifeSharers, a nonprofit organization formed just over two years ago that aims to utilize a person's internal motivation to save their own life to save the lives of others.<sup>253</sup> LifeSharers incentivizes people to become organ donors (and to become a LifeSharers member) by giving them the return promise that all members of the organization agree to donate their organs first to other members before they go into the nationwide waiting pool.<sup>254</sup> In this manner, people are encouraged to opt in to donation who otherwise might not, if only from a selfish desire to increase the likelihood that they will be able to find a suitable organ should their own organs fail sometime in the future. To prevent adverse selection (i.e., people joining only because they are currently in need of an organ),<sup>255</sup> LifeSharers

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<sup>253</sup> See LifeSharers, *supra* note 18; Steve P. Calandrillo et al., *LifeSharers: An Opting-In Paradigm Already in Operation*, 4 AMER. J. BIOETHICS 17 (2004). After LifeSharers' Executive Director, Dave Undis, read my views on organ donation in the *Seattle Times*, he invited me to join the organization as an advisor. In that capacity, I provide strategic guidance regarding ways to increase organ donation awareness and ways to incentivize more Americans to opt in. However, the views contained in this paper are my own, and do not necessarily represent those of LifeSharers. See also Steve Calandrillo, *A Gift for Life*, SEATTLE TIMES, Dec. 25, 2004; Robert Mak, *Group Wants to Improve Odds of Getting Transplant*, KING 5 TV News, Feb. 14, 2005 (television interview covering my involvement with LifeSharers).

<sup>254</sup> See *id.* UNOS currently gives live organ donors priority access if they ever need an organ later in life—so LifeSharers' provision of priority based on willingness to donate after death is simply an extension of this concept.

LifeSharers' homepage states:

LifeSharers members promise to donate upon their death, but they give fellow members first access to their organs. As LifeSharers members, you and your loved ones will have access to organs that otherwise may not be available to you. As the LifeSharers network grows, more and more organs may become available to you—if you are a member.

Even if you are already a registered organ donor, you should join the LifeSharers network.

By doing so, you will have access to organs that otherwise may not be available to you.

*Id.* Further, the laws of all fifty states allow for "directed organ donation"—i.e., a LifeSharers member can lawfully designate that they want another member to receive their organs first if there is a member in need. See LifeSharers, *Frequently Asked Questions*, at <http://lifesharers.com/faq.asp> (last visited Nov. 5, 2004) [hereinafter *LifeSharers, Frequently Asked Questions*] (citing to 42 C.F.R. § 121.8 (1999), which states that "[n]othing in this section shall prohibit the allocation of an organ to a recipient named by those authorized to make the donation.").

<sup>255</sup> In insurance markets, adverse selection refers to the dilemma that the sickest members of a given group will be the ones to sign up for insurance, simply because they know that they are the most likely to need it. This presents a real problem, because relatively healthy individuals will be disincentivized from buying the same insurance since they know they will be cross-subsidizing the sicker members of the group. See generally Steve P. Calandrillo, *Eminent Domain Economics: Should "Just Compensation" be Abolished, and Would "Takings Insurance" Work Instead?*, 64 OHIO ST. L.J. 451, 526

imposes a six-month moratorium between the date one joins the organization and the date that they are entitled to priority to other members' organs.<sup>256</sup>

LifeSharers' concept is an appealing one from an intuitive and distributive justice perspective: it seems only fair that people who agree to donate organs should receive priority if they ever need one.<sup>257</sup> Scholar Alexander Tabarrok agrees, proposing a "no give, no take" policy with respect to organs: if one does not agree to be a donor, one should not be allowed to receive the benefit of donated organs.<sup>258</sup> Ironically, approximately 70% of today's transplanted organs go to recipients who are *not* donors themselves, while thousands of those who *are* willing to be donors go without.<sup>259</sup> All else equal, the scarce supply of human organs should be allocated first to individuals who themselves are willing to sacrifice to save other people's lives. While LifeSharers has implemented this priority access concept on a grass roots basis, UNOS could modify its allocation rules to implement it immediately on a national scale.

Nevertheless, critics charge that the incentive scheme offered by LifeSharers discriminates against certain populations who cannot donate because of religious or cultural reasons, and who would therefore be disad-

(2003) (discussing adverse selection in insurance markets).

<sup>256</sup> See LifeSharers, Frequently Asked Questions, *supra* note 254 (noting that LifeSharers members do not qualify for preferential access to organs from other LifeSharers members until they have been a member for 180 days).

<sup>257</sup> See LifeSharers, LifeSharers People, at <http://lifesharers.com/people.htm> (last visited Nov. 5, 2004) [hereinafter LifeSharers People] (quoting Steve Calandrillo). See also Steve P. Calandrillo's Comments in Response to David Wessel's June 17, 2004 Capital Exchange Column: *Easing the Organ Shortage*. David Wessel, Capital Exchange Column, *How to Unite Patients with Organs They Need?*, WALL ST. J. ONLINE, June 22, 2004. (including Calandrillo's response) [hereinafter Calandrillo, *Response to Easing the Organ Shortage*]. Adam Kolber also has analyzed the issue of whether priority rules should be based on one's willingness to donate. See Kolber, *supra* note 118.

<sup>258</sup> See Tabarrok, *supra* note 6. Tabarrok also suggests awarding "extra points" to the priority position of those individuals in need of organs if they also agree to become donors themselves. See *id.*

<sup>259</sup> See LifeSharers, Frequently Asked Questions, *supra* note 254 (noting that people who have signed up as donors only receive approximately 30% of the organs transplanted in the United States). Individuals who are willing to accept donated organs, but not willing to donate their own organs, are classic "free-riders." They benefit from the altruistic acts of others, but are not willing to pay the same price that their more generous counterparts do. Free-rider problems must generally be cured with some kind of government intervention—otherwise, every individual's private incentive is to opt out, while benefiting from others who opt in. It does not take long to realize that when everyone has an incentive to free ride, extremely few people are motivated to opt in. For a discussion of the free rider problem in other contexts, see Steve P. Calandrillo, *Vanishing Vaccinations: Why Are So Many Americans Opting Out of Vaccinating Their Children?*, 37 U. MICH. J. L. REFORM 353, 420 (2004), lamenting free riding in the childhood immunization context) and Calandrillo, *supra* note 255, at 461, raising the need to prevent the free rider problem in the context of private supply of public goods, such as roads.

vantaged by their inability to join.<sup>260</sup> Further, some argue that it gives members false hope, primarily because there are not enough people on the organization's membership roster yet to constitute a reliable supply of organs.<sup>261</sup> However, membership has more than doubled in each of LifeSharers first two years of existence.<sup>262</sup> If LifeSharers continues to grow at this exponential rate, there would be more than one million members—all potential donors—by 2013.<sup>263</sup>

## 2. Paired Organ Exchanges

Analogous to LifeSharers' concept of giving priority to those who themselves are willing donors, "paired organ exchanges" are a form of moneyless market that provides strong incentives to individuals to donate so that they also might be able to receive an organ.<sup>264</sup> The idea is simple: many people in need of organs have siblings or other relatives who are

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<sup>260</sup> See Carol M. Ostrom, *The Search for Organ Donors: How Far is Too Far?*, SEATTLE TIMES, Mar. 21, 2004, at A1. However, despite popular belief, nearly all major religious denominations approve of organ donation. See *infra* Part IV.B.6.

<sup>261</sup> See Ostrom, *supra* note 260.

<sup>262</sup> See *LifeSharers Celebrates Second Anniversary: Grass-Roots Organ Donors Network Notes Progress and Accomplishments*, LIFESHARERS PRESS RELEASE (LifeSharers, Nashville, Tenn.), May 22, 2004, at <http://www.lifesharers.com/pressrelease20040522.htm> (last visited April 5, 2005). As of October 31, 2004, LifeSharers had 2,628 members, compared to just 1,651 members twelve months prior. See *Our Newsletter*, LIFESHARERS MEMBERS NEWSLETTER (LifeSharers, Nashville, Tenn.), November 2004, at <http://lifesharers.com/newsletter.htm> (last visited Nov. 15, 2004).

<sup>263</sup> Unfortunately, the growth rate of most organizations tends to slow down as they become larger, so it may take more than another nine years to hit the one million member mark. Executive Director Dave Undis notes, however, that the growth rate may not actually diminish because "LifeSharers is a classic case of the network effect—as our membership grows, the value of joining goes up. Sooner or later one of our members will get an organ from another member (an organ that they wouldn't have gotten if they hadn't been a member), and the publicity we'll get from this should cause our membership growth to accelerate." See Email from Dave Undis, Executive Director, LifeSharers, to Steve Calandrillo, Advisor, LifeSharers (Sept. 17, 2004 10:31 AM) (on file with author).

<sup>264</sup> See Morley, *supra* note 19, at 223-24. Morley asserts:

[F]ederal law should be amended so as to allow the already-existing registry of patients in need of organ transplants to bring together the families and friends of different patients on the waiting list in order to save lives . . . . A system of paired organ exchanges would facilitate transplantation in situations where a friend or family member of Patient A is incompatible with him, but would be compatible with some other person on the waiting list (Patient B), and a close friend or family member of Patient B is incompatible with her, but compatible with Patient A. The family member of patient A would donate a compatible nonvital organ to patient B, on the condition that the family member of patient B donates a compatible nonvital organ to patient A; hence the phrase "paired organ exchange . . . ."

This system would, of course, be limited to the exchange of nonvital or regenerable organs (kidneys and livers), where donation would not endanger the donor or adversely impact the donor's major life activities.

willing to donate organs to their loved one in an attempt to save their life. However, these relatives may not be blood-type matches, or the sick person may possess antibodies that could render her family member's organs unsuitable for transplantation.<sup>265</sup> While they writhe in agony wishing they could do something to help their relative directly, there is often another unrelated person on the nationwide waitlist who would be a good match for their organs. Few people are willing to donate a kidney to a stranger—but they would change their mind in a heartbeat if someone from the stranger's family had a kidney that matched their relative's blood and tissue type. Where two strangers (or their families) have organs that are compatible with each other, the law should facilitate a paired organ exchange immediately—in effect, boosting the priority of each individual to receive a transplant based on the fact that she (or her family member) donates an organ that saves someone else's life.<sup>266</sup> It seems only reasonable that we should move a person to the head of waitlist if she or her family donates an organ to save someone else.

Paired organ exchanges accomplish the dual purposes of incentivizing people to donate organs who otherwise might not (by using self-interest as motivation), while also avoiding the payment of valuable consideration for human organs (and its host of accompanying concerns).<sup>267</sup> Given these virtues, scholars such as Michael Morley advocate that the law should not only permit, but actively promote, paired organ exchanges by individuals (and their family members) who are currently on the nationwide organ waitlist.<sup>268</sup> Morley proposes to do this by modifying the existing national database of patients in need of organs to include information about individuals potentially willing to donate on behalf of each patient, and using this data to identify cross-matches.<sup>269</sup> In this manner, “the government could bring together compatible donors and recipients who would otherwise never meet, and in each successful case allow two transplants to occur that might otherwise be impossible.”<sup>270</sup>

The paired organ exchange concept has been largely overlooked in the organ donation debate, but its obvious benefits have begun to receive

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<sup>265</sup> See *id.* at 226-29; Wessel, *supra* note 19 (noting that a biological barrier often prevents a transplant from a relative).

<sup>266</sup> It is easy to see the parallels to LifeSharers' philosophy—where one is willing to donate, they should be given higher priority in receiving a transplant themselves.

<sup>267</sup> UNOS received a legal opinion that these types of paired organ exchanges do not involve “valuable consideration.” See Legal Opinion from William Mullen, *Intended Recipient Exchanges, Paired Exchanges and NOTA* § 301 (Mar. 7, 2003) (on file with author).

<sup>268</sup> See Morley, *supra* note 19, at 224.

<sup>269</sup> See *id.*

<sup>270</sup> *Id.*

greater attention very recently.<sup>271</sup> MatchingDonors.com has put into place an analogous idea that capitalizes on the fact that there are numerous donor-recipient matches possible nationwide that are not being taken advantage of—simply because donor and recipient do not know each other exists.<sup>272</sup> Hence, in exchange for a fee, the company provides “a venue where patients and potential donors can meet and communicate” to find those available donor-recipient connections which otherwise would never be made.<sup>273</sup> In addition, the pure paired organ exchange solution received national attention in June, 2004, when the *Wall Street Journal* profiled a group of physicians at Massachusetts General Hospital and Johns Hopkins engaging in the practice.<sup>274</sup> With help from Harvard economist Alvin Roth, these physicians designed a “moneyless market”<sup>275</sup>—by linking people in need with others in need, they create an exchange based not on dollars but on suitable organs. One example profiled is that of a New England father with blood type A who could not donate a kidney to his daughter with blood type B.<sup>276</sup> With the coordination of various transplant centers, he gave a kidney to a teenager (a stranger) with blood type A, and the teenager’s sister gave a kidney for the man’s daughter.<sup>277</sup> These transplant centers have even begun organ swaps involving three different people or families in need, but doing so necessarily entails increased complexity to work out the logistical details.<sup>278</sup> These difficulties are well worth it, however, when one considers that 2,000 or more people could receive transplants annually if there were simply a national database that included donors who were willing to engage in these kind of paired organ exchanges.<sup>279</sup>

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<sup>271</sup> See *id.* at 223.

<sup>272</sup> See MatchingDonors.com, at <http://matchingdonors.com/life/index.cfm> (last visited April 5, 2005).

<sup>273</sup> *Id.* Critics charge, however, that the service takes advantage of desperate people, opens the door to payment for organs, and manipulates the system so that wealthy individuals are more likely to receive transplants. See Ostrom, *supra* note 260.

<sup>274</sup> See Wessel, *supra* note 19.

<sup>275</sup> See *id.*

<sup>276</sup> See *id.*

<sup>277</sup> See *id.*

<sup>278</sup> See *id.* Doctors and hospitals have worked out some rules to facilitate exchanges and control complexity—the donor must travel to the hospital where the recipient is; participants may keep their identities private if they so choose; all surgeries in a swap begin simultaneously to avoid anyone backing out halfway through the exchange. See *id.*

<sup>279</sup> See *id.* The 2,000 lives saved figure is a projection made by Johns Hopkins transplant surgeon Robert Montgomery. I should also be careful to note that there are two distinct types of paired-organ exchanges possible: (1) I give a kidney to your sister and you give one to my brother, and (2) I give a kidney to someone on the waiting list and my brother receives priority access to kidneys from cadaveric donors across the country. See *id.*



Thus, even if paying money in return for human organs is never morally acceptable, moneyless markets that allow for paired organ exchanges can serve as an important, far less objectionable step in the right direction.<sup>280</sup>

### 3. Presumed Consent

Public opinion surveys consistently demonstrate overwhelming support for organ donation, on the order of 80% or more.<sup>281</sup> At the same time, less than three out of every ten people has signed up to become a donor.<sup>282</sup> This paradox is hard to swallow if you are one of the seventeen Americans who will die today because no organ was found in time.<sup>283</sup> Each death highlights the reality that America's organ shortage is not due to a lack of potentially life-saving organs, but rather, the fact that the vast majority of them are taken to the grave with their owner.

One method of correcting this tragic disparity is to presume that all individuals consent to have their organs donated upon death unless they have expressly opted out during their lifetime—an opt-out rather than an opt-in system.<sup>284</sup> Doing so would take advantage of the strong public consensus in favor of donation, while simultaneously overcoming the minimal barriers there are to having to affirmatively sign up to become an organ donor today. Despite the fact that checking the organ donor box on one's driver's

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<sup>280</sup> See Calandrillo, *Comments in Response to Easing the Organ Shortage*, *supra* note 257.

<sup>281</sup> See The Gallup Organization, Inc., *supra* note 10 (85% of those polled were in favor of organ donation by a loved one and 60% said they would be willing to donate their own organs); Pew Research Center for the People and the Press, *supra* note 10 (81% of respondents supported organ donation).

<sup>282</sup> See The Gallup Organization, Inc., *supra* note 10 (28% of Americans surveyed had registered as organ donors); Hansmann, *supra* note 9, at 60 n.9 (citing to a 1985 study indicating that only 17% of Americans had completed organ donor cards).

<sup>283</sup> See Living Legacy Registry, *supra* note 3.

<sup>284</sup> See, e.g., Linda C. Fentiman, *Organ Donation as National Service: A Proposes Federal Organ Donation Law*, 27 SUFFOLK U. L. REV. 1593, 1607-09 (1993) (exploring a presumed compensated donation system); Kelly Ann Keller, *The Bed of Life: A Discussion of Organ Donation, Its Legal and Scientific History, and a Recommended "Opt-Out" Solution to Organ Scarcity*, 32 STETSON L. REV. 855 (2003); Daphne D. Sipes, *Does it Matter Whether There is Public Policy or Presumed Consent in Organ Transplantation?*, 12 WHITTIER L. REV. 505 (1991); Williams, *supra* note 105, at 317-18 (advocating for the "worldwide harmonization of domestic legislation, which would . . . presum[e] the consent of the individual to donate organs while maintaining the option to withdraw consent . . ."). Of course, we could go beyond presumed consent all the way to a mandatory organ conscription system, but that would raise far more opposition than a system that allowed individuals to opt out. See, e.g., Eric Cohen, *supra* note 8, at 115 (criticizing various alternatives to increase organ donation, including presumed consent and conscription). Somewhere in the middle would be a system that forced individuals to either opt-in or opt-out before they were allowed to receive their driver's license. For minors, we could require that parents make the decision for their child when they applied for a social security number.

license seems easy, many academics have detailed the psychological barriers that prevent individuals or their families from consenting to donation at the time of their death.<sup>285</sup> It is reasonable to suspect that switching to an opt-out system in the U.S. would lead to far higher organ donor participation rates than those currently realized. In fact, consistent with this underlying hypothesis, data indicate that such policies are effective at increasing the rate of organ procurement from eligible individuals.<sup>286</sup>

In fact, many European nations, including Austria, Denmark, France, Poland and Switzerland, utilize a presumed consent system in which the decedent's organs can be removed regardless of her family's wishes unless the deceased had expressly opted out.<sup>287</sup> A more mild system is employed by Finland, Greece, Italy, Norway, Spain, and Sweden, where the decedent's family can prevent organ removal by exercising their right to object to it after their loved one's death.<sup>288</sup> An interesting hybrid regime exists in Singapore, where citizens are assumed to consent to donation, unless they are members of certain religious groups, including Islam.<sup>289</sup> This type of balanced system incorporates both public consensus in favor of donation, while respecting the beliefs of groups which would likely opt out if given the choice.

Despite the thousands of lives that would be saved, the most significant obstacle to enacting a presumed consent system in the U.S. is our strong tradition of individual freedom and autonomy.<sup>290</sup> Presuming that an individual has agreed to donate her organs runs afoul of many people's core beliefs in liberty and freedom from government interference. We would be forced to incur the risk that some individuals would have their organs harvested who otherwise would have exercised their right to refuse if they knew they could have. Even with stringent safeguards to protect these indi-

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<sup>285</sup> See Hazony, *supra* note 60, at 240-41. Hazony describes the need for both families and medical professionals to overcome the emotional obstacles inherent in donation. *Id.* However, she believes that better training and education of both groups can reduce the disparity between those who support donation and those who actually do it, without the need to resort to a system of presumed consent. *Id.* National Kidney Foundation data indicate that 35% of families do not consent to organ donation when their deceased relative would be a suitable candidate. See National Kidney Foundation, *supra* note 9.

<sup>286</sup> See L. Roels et al., *Effect of a Presumed Consent Law on Organ Retrieval in Belgium*, 22 *TRANSPLANT. PROC.* 2078, 2079 (1989).

<sup>287</sup> See Kurtz and Saks, *supra* note 21, at 778-79.

<sup>288</sup> See *id.* However, the burden of opting out is a non-trivial one because physicians are not required to advise families of their right to refuse. *Id.* Presumed consent systems exist outside of the European continent as well. See, e.g., Everton Bailey, *Should the State Have Rights to Your Organs? Dissecting Brazil's Mandatory Organ Donation Law*, 30 *U. MIAMI INTER-AM. L. REV.* 707 (1999).

<sup>289</sup> See Patricia Tsao, *Singapore's Presumed Consent/Explicit Consent Hybrid Organ Donation Law: A Potential Model for the U.S.* (manuscript on file with author).

<sup>290</sup> See Kurtz and Saks, *supra* note 21, at 779 (citing Albert R. Jonsen, *Transplantation of Fetal Tissue: An Ethicist's Viewpoint*, 36 *CLIN. RESEARCH* 215 (1988)).

viduals, it would be difficult to completely eliminate the risk that someone's autonomy would be violated.

However, a few states have enacted extremely limited forms of presumed consent legislation, including statutes that allow coroners to remove a decedent's corneas absent an objection from their family, or after fair inquiry to ascertain whether such an objection exists.<sup>291</sup> These laws have largely survived constitutional due process and takings clause challenges.<sup>292</sup> However, any effort to expand the notion of presumed consent to allow for the harvesting of all suitable organs at death would likely meet stiff political and constitutional resistance.<sup>293</sup> As a practical matter, it will be challenging to overcome our traditional emphasis on freedom and voluntary action to muster the political will to promulgate broad-ranging presumed consent legislation. But, by juxtaposing the decision regarding presumed consent legislation against the inevitable lives that will be lost without it, perhaps some reasonable minds can be influenced in its favor.

#### 4. Required Request

Even if we cannot gain consensus in America to move to a presumed consent system, we have shown the political and legal will to require hospitals, or other medical care providers, to ask the decedent's family to donate her organs at the time of her death. The 1987 revision to the UAGA called for health care professionals to ask families of individuals to consent to organ donation if their loved one had not already signed an organ donor card.<sup>294</sup> Various states have also enacted some form of "required request"

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<sup>291</sup> See Cate, *supra* note 228, at 84 n.115 (providing a collection of statutes); Unif. Anatomical Gift Act of 1987 § 4(a), 8A U.L.A. at 43.

<sup>292</sup> See Erik S. Jaffe, *She's Got Bette Davis('s) Eyes: Assessing the Nonconsensual Removal of Cadaver Organs Under the Takings and Due Process Clauses*, 90 COLUM. L. REV. 528, 538-42 (1990); Kurtz & Saks, *supra* note 21, at 779 n.40. Kurtz and Saks cite to *State v. Powell*, 497 So.2d 1188 (Fla. 1986) ("rejecting both due process and takings clause challenges") and *Georgia Lions Eye Bank v. Lavant*, 355 S.E.2d 127 (Ga. 1985) ("rejecting a due process challenge"). *Id.* However, the Sixth Circuit has held that removal of corneas is an unconstitutional taking of property without due process where medical records revealed decedent's wife refused to make a gift. See *Brotherton v. Cleveland*, 923 F.2d 477 (1991).

<sup>293</sup> Kurtz and Saks further posit that presumed consent statutes might be vulnerable to First Amendment challenge, at least where the donor is known to have a religious objection. See Kurtz and Saks, *supra* note 21, at 779, n.40 (citing to N.Y. Pub. Health Law § 4222 (McKinney 1978); Ohio Rev. Code Ann. § 2108.53 (West 1978)).

<sup>294</sup> Unif. Anatomical Gift Act § 3. All hospitals are required by law to have a "Required Referral" system in place. Under it, the hospital must notify the local Organ Procurement Organization (OPO) of all patient deaths. If the OPO determines that organ and/or tissue donation is appropriate in a particular case, they will have a representative contact the deceased patient's family to offer them the option of donating their loved one's organs and tissues. See The National Kidney Foundation, *supra* note 9; see

legislation.<sup>295</sup> There is still debate, however, over who should be doing the asking (i.e., doctor, nurse, hospital staff, or OPO representative), and whether or not it will work in practice.

Frankly, results of required request policies have not been as good as hoped for.<sup>296</sup> Orly Hazony offers a possible hypothesis to explain this outcome.<sup>297</sup> He suggests that psychological issues relating to organ procurement negatively impact the legal systems designed to encourage donation.<sup>298</sup> Emotional issues involved may deter the decedent's family from agreeing to donation, as well as prevent health care professionals from feeling comfortable enough to sensitively request donation from the family.<sup>299</sup> Therefore, Hazony posits that the solution to the organ shortage lies in addressing the psychological issues involved in procurement rather than adopting more restrictive legal regimes (e.g., presumed consent).<sup>300</sup> By educating health providers about the need to ask families for consent and by providing training that allows them to do so in a manner that respects the family's grieving,<sup>301</sup> Hazony argues that we could significantly increase organ donor participation rates.

Thus, legally mandating that health care providers ask for organs is not likely to have a dramatic impact if done alone. Required request statutes need to be accompanied by training, education and public awareness campaigns if they are to have the impact on organ procurement rates that was initially hoped for. Their role is important, however, in sending a clear signal that we cannot ignore the organ shortage in America simply because addressing it involves issues that are difficult for physicians and families to discuss.

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also Arlene Judith Klotzko, *Mankind's New Best Friend*, CHI. TRIB., Aug. 22, 1999, § 2, at 1 (describing today's organ donation system as one in which individuals either sign donor cards prior to death, or where their families are asked to give consent to organ donation afterwards).

<sup>295</sup> See Hansmann, *supra* note 9, at 61.

<sup>296</sup> See Hazony, *supra* note 60, at 231 (citing to Maxwell J. Mehlman, *Presumed Consent to Organ Donation: A Reevaluation*, 1 HEALTH MATRIX 31 (1991)).

<sup>297</sup> See *id.* at 220.

<sup>298</sup> See *id.* at 236-39.

<sup>299</sup> See *id.*

<sup>300</sup> See *id.* at 256-57.

<sup>301</sup> See *id.* at 246-51. Other commentators have urged that hospitals be held legally liable if they do not ascertain a patient's wishes regarding organ donation. See, e.g., Christine E. Edwards, *Giving Virginia's Anatomical Gift Code Life: Creating Liability for a Hospital's Failure to Determine Donative Intent*, 47 WASH. U. J. URB. & CONTEMP. L. 185 (1995).

## 5. National Donor Registry

While there is a national organ waitlist administered by UNOS that contains over 85,000 names, it might come as a surprise that no cohesive counterpart exists that tracks willing organ donors. The formation of a national donor registry would be a significant, commonsense step towards putting these two groups of individuals together to save thousands of lives that do not need to be lost.<sup>302</sup>

Phyllis Coleman has argued for such a database, stating that a national computer registry containing donor status, and other relevant information such as blood type, is one essential way to effectuate transplants that might otherwise never happen.<sup>303</sup> Further, paired organ exchanges would flourish if such a registry existed by allowing individuals on the waitlist, and their family members, to dramatically increase their chances of finding a suitable swap.<sup>304</sup> Today, organizations like MatchingDonors.com purport to provide this type of searching service,<sup>305</sup> but charge substantial fees.<sup>306</sup> Further, their efforts could undoubtedly be more successful if a federal registry was established to serve this very purpose.

Thus, a national donor registry could be instrumental in saving many lives without requiring that a single dime be paid by organ recipients to donors. However, federal funds would be necessary to create, maintain and update the registry in the first instance.<sup>307</sup> From a public policy perspective,

<sup>302</sup> See World Medical Association, *Statement on Human Organ and Tissue Donation and Transplantation*, at <http://www.wma.net/e/policy/wma.htm> (last visited April 5, 2005). The WMA believes that physicians are the actors in the best position to increase organ donation, and recommends exploring the formation of a national donor registry to accomplish this goal. *See id.* To date, there has been a proliferation of state organ donor registries, but there is no coherent link between them.

<sup>303</sup> See Coleman, *supra* note 72, at 2-3. Coleman details a national computer registry that would contain donor status and other relevant information, such as potential donors' blood type and whether the person has a living will. *Id.* She argues that states would need to "create and continuously update such a registry, and draft and implement detailed procedures for police and emergency medical personnel to follow in certain accident and trauma situations. Under these guidelines, law enforcement officers, paramedics, and hospital personnel would be required to ascertain donor status by checking with the national computer system as soon as possible." *Id.*

<sup>304</sup> See Morley, *supra* note 19, at 239.

<sup>305</sup> See MatchingDonors.com, *supra* note 272.

<sup>306</sup> See Ostrom, *supra* note 260 (noting that critics of MatchingDonors.com point out the fact that the service is available only for a fee, giving wealthy individuals better access to available organs than their poorer counterparts).

<sup>307</sup> See Coleman, *supra* note 72, at 2 (noting that the computer database proposal would be a more costly one compared to other alternatives, but advocating for it nonetheless given its potential benefits). Washington congressman Jay Inslee proposed a bill that would have allowed this expenditure (The Organ Donor Enhancement Act), but it never emerged from the House Subcommittee on Health. H.R. 955, 107th Cong. (2001). On the other hand, organizations such as LifeSharers have the potential to evolve into a national organ donor registry—but one which would not be administered by UNOS nor

it seems like this expenditure would be easily justified by the concomitant benefits attached.

## 6. Public Awareness Campaign

Finally, none of the previously mentioned incentive schemes or proposed solutions to the nation's organ crisis will be successful without an aggressive public awareness and education campaign backing them up.<sup>308</sup> Americans are generally aware that people die while on national organ waitlists, but few realize the staggering magnitude of the problem.<sup>309</sup> The media pays far more attention to individual deaths from earthquakes or tornadoes than it does to the thousands of annual deaths from kidney failure<sup>310</sup>—even though the latter are far more preventable than natural disasters.

As a first step, we must educate America about the crisis and correct the rampant myths and urban legends that continue to surround organ donation.<sup>311</sup> Many Americans are in favor of donation but still fear that if they signed up to become a donor, then doctors will not try as diligently to save their life if they were involved in an accident that presented a chance for organ harvesting.<sup>312</sup> Some are deterred because they believe that their fam-

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require the expenditure of scarce public funds.

<sup>308</sup> See Hazony, *supra* note 60, at 221. *But cf.* Conan, *supra* note 43 (claiming that advertising regarding organ donation has not been successful); Jurgensen, *supra* note 59 (stating that the millions of dollars spent on public awareness has done little good).

<sup>309</sup> For instance, far more Americans die while on the national organ waitlist each year than the number of people who die annually from tornadoes, floods, lightning, landslides and earthquakes combined. See Fred Schwab, *Geologic Assessment: Alan Greenspan or Pete Rose*, at <http://www.geotimes.org/june04/column.html> (last visited April 5, 2005).

<sup>310</sup> See generally Steve P. Calandrillo, *Responsible Regulation: A Sensible Cost-Benefit Risk versus Risk Approach to Federal Health and Safety Regulation*, 81 B.U. L. REV. 957, 1000-01, 1001 n.198 (2001) (detailing the public's overreaction to high tragedy but low probability events like earthquake, flood and fire, and the public's simultaneous underperception of far more common risks like heart disease and cancer.).

<sup>311</sup> See Alexandra K. Glazier, "The Brain Dead Patient was Kept Alive" and Other Disturbing Misconceptions: A Call for Amendments to the Uniform Anatomical Gift Act, 9 KAN. J.L. & PUB. POL'Y 640 (2000) (discussing the rampant urban myths surrounding organ donation and their potential to undermine public confidence in the donation process).

<sup>312</sup> See U.S. DEP'T OF HEALTH & HUMAN SERVICES, ORGAN DONATION, at <http://www.organdonor.gov/myth.html> (last visited April 5, 2005) [hereinafter ORGAN DONATION] (stating that "[o]rgan and tissue recovery takes place only after all efforts to save your life have been exhausted and death has been legally declared. The medical team treating you is completely separate from the transplant team. The organ procurement organization (OPO) is not notified until all lifesaving efforts have failed and death has been determined."). Despite these assurances, a rational choice theorist

ily will be charged for the medical expenses associated with donating their organs.<sup>313</sup> Others think they are too old to be useful donors or that waitlist priority is influenced by celebrity status.<sup>314</sup> In addition, we must correct misperceptions that most religions are opposed to donation.<sup>315</sup> In fact, nearly all major religious denominations—including Christianity and Judaism—affirmatively support organ donation where human lives can be saved.<sup>316</sup> Furthermore, some Americans would be willing to donate but choose not to because they think their bodies will be disfigured by organ harvesting, preventing an open casket funeral and causing emotional distress to loved ones.<sup>317</sup>

Mainstream advertising and public awareness campaigns will be necessary if we are to overcome the misunderstandings and outright myths that hamper organ donation participation rates today. Congress and President Bush have just taken a solid step in this direction by promulgating the Organ Donation and Recovery Improvement Act earlier this year.<sup>318</sup> The legislation provides \$5 million annually from 2005 through 2009 to fund public awareness efforts and to study ways to increase recovery and donation

would find it predictable that some patients may fear that physicians will not exhaust all potentially life-saving efforts if they think that failing to do so will yield a harvestable organ. Furthermore, while brain death is the standard for determining death today, one commentator has urged that we redefine death to include cardiac death in order to increase the available pool of donors. See Marla K. Clark, *Solving the Kidney Shortage Crisis Through the Use Of Non-Heart-Beating Cadaveric Donors: Legal Endorsement of Perfusion as a Standard Procedure*, 70 IND. L.J. 929 (1995). There has also been a recently reported case of an organ being harvested from a person who was possibly not yet brain dead. *Organs Harvested Prematurely?*, CBSNEWS.COM, available at <http://www.cbsnews.com/stories/2004/10/05/national/main647467.shtml> (last visited April 13, 2005).

<sup>313</sup> See ORGAN DONATION, *supra* note 312. Donation costs nothing to the donor's family or estate.

<sup>314</sup> See Coalition on Donation, *Donate Life—Get the Facts, Myths and Facts*, at <http://www.shareyourlife.org/facts.html> (last visited April 5, 2005). People of all ages and medical histories should consider themselves potential donors—it is one's medical condition at the time of death that will determine what organs and tissue can be donated. Further, priority is not influenced by celebrity, but rather the severity of one's illness, time spent on the waiting list already, blood type and other relevant medical information.

<sup>315</sup> See LifeCenter Northwest, *Religious Beliefs About Donation*, at <http://www.lcnw.org/facts/religious/index.html> (last visited April 5, 2005) (noting that most major religions in the U.S. approve of organ and tissue donation and consider it an act of charity).

<sup>316</sup> See MayoClinic.com, *Organ Donation: Don't Let Myths Stand In Your Way*, at <http://www.cnn.com/HEALTH/library/FL/00077.html> (last visited April 5, 2005) (stating that organ donation is consistent with the beliefs of all larger religious denominations in the United States, including Catholicism, Protestantism and most branches of Judaism.).

<sup>317</sup> See ORGAN DONATION, *supra* note 312 (refuting the notion that donation mutilates the body, and noting that an open casket funeral is still possible).

<sup>318</sup> Organ Donation & Recovery Improvement Act, Pub. L. No. 108-216, 118 Stat. 584 (2004).

rates.<sup>319</sup> At the state level, a few pilot programs to spur organ donation have recently been enacted. Delaware, for instance, has created an Organ and Tissue Donation Awareness Trust Fund charged with developing donor awareness programs, instituting educational programs in high schools, and creating an awareness campaign for state employees.<sup>320</sup> Florida followed suit by instituting an Organ and Tissue Donor Education and Procurement Trust Fund that accepts voluntary donations of one dollar as part of the collection process for licensing taxes.<sup>321</sup> The money is used to operate the state's organ certification program, maintain the organ and tissue donor registry, and educate the public regarding the need for organ and tissue donation.<sup>322</sup> Ohio's Second Chance Trust Fund is even broader in scope, as it accepts voluntary contributions that are used to (1) implement statewide public education programs about organ, tissue, and eye donation, (2) increase awareness in high schools, (3) recognize donor families, (4) develop hospital training programs, and (5) reimburse relevant parties for administrative costs.<sup>323</sup> Finally, New York proposed a bill which would amend its tax law, public health law, and the vehicle and traffic law to establish a "Gift of Life" trust fund.<sup>324</sup>

Moreover, the media can dramatically increase organ donation simply by paying greater attention to the issue. When Californian Nicholas Green was murdered in Italy, his family agreed to donate his organs, saving seven Italians in the process. In the following days, the donor card signatory rate increased in Italy by 400%.<sup>325</sup> Closer to home, when former NBA star Alonzo Mourning was forced to retire due to kidney failure, discussion regarding the benefits and dire need for organ donation surged in America.<sup>326</sup> Sadly, it should not take a tragedy to spur organ donation participation rates, but it seems that tragedies make for the best fodder on the evening news.

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<sup>319</sup> See Organ Donation & Recovery Improvement Act § 377(f).

<sup>320</sup> DEL. CODE ANN. tit.16, §§ 2710, 2730(a)-(b) (Supp. 1998).

<sup>321</sup> FLA. STAT. ANN. § 320.08047 (West Supp. 2000). A similar program is underway in Tennessee, where individuals are asked to donate \$1 to increase organ donation awareness when they get or renew their driver's license. See County Clerk, *You May Save a Life, at* <http://www.countyclerkanytime.com/donor/default.htm> (last visited April 5, 2005).

<sup>322</sup> See DEL. CODE ANN. tit. 16, §§ 2710, 2730(a)-(b) (Supp. 1998); FLA. STAT. ANN. § 320.08047 (West Supp. 2000); Siegel, *supra* note 23, at 943 (discussing various initiatives to increase public awareness regarding the need for organ donation).

<sup>323</sup> OHIO REV. CODE ANN. §§ 2108.15(A)-(H), 4506.081 (Anderson 1999).

<sup>324</sup> S. 7759, N.Y. 223rd Sess. (N.Y. 1999). Unfortunately, the bill ended up in committee and was never passed into law.

<sup>325</sup> See Barbara Sofer, *Change of Heart*, THE JERUSALEM POST, Aug. 3, 2001, at 10.

<sup>326</sup> See LifeSharers Blog, Nov. 30, 2003, *at* [http://lifesharers.blogspot.com/2003\\_11\\_01\\_lifesharers\\_archive.html](http://lifesharers.blogspot.com/2003_11_01_lifesharers_archive.html) (last visited April 5, 2005).



## CONCLUSION

All across the world today, physicians, hospitals, organ brokers, and the entire organ transplantation support industry make millions of dollars by saving people's lives when organs are found for those in desperate need. In the United States, the only parties who receive no compensation at all are the donor and her family. Some families bury their loved ones in unmarked graves because they cannot afford headstones, while various health care middlemen make thousands from the organs harvested.<sup>327</sup>

The ban on human organ sales in America was founded upon the noble intention that organs should provide the ultimate "gift" of life, not one that requires purchase on the open market. Sadly, that goal has yet to materialize—organ transplants are still prohibitively expensive for recipients, doctors and hospitals mark up their price tags to take advantage of desperate individuals' extreme willingness to pay to avoid death, and there is little in the way of government control over various black markets thriving worldwide. The poor are exploited into selling kidneys thinking that they will escape debt, only to find themselves in continued financial hardship down the road, accompanied now by deteriorated health status.

Is the solution legalized human organ sales? I don't know. Practically speaking, it is unlikely that human organ sales will ever achieve societal acceptance due to legitimate fears of abuse and exploitation. However, those dangers could be substantially safeguarded against by a responsible regulatory regime inside the U.S. To combat sellers' imperfect information problems, full risk-disclosure would be required. To address distributive justice inequities, purchases by the poor could be fully subsidized. To prevent negative externalities from falling on the state, health insurance for sellers would be mandated.

Given the risks associated with living-donor sales, however, society would be well advised to turn its energies towards exploring other means of incentivizing organ donation. Both monetary and nonmonetary incentives have to date been largely ignored by federal and state governments, but present the real potential to cure our nation's organ crisis. Futures markets that allow for organ sale, but harvesting only at death, are an intriguing way to take advantage of market supply and demand while avoiding the dangers of living-donor sales.<sup>328</sup> More modest proposals include burial compensation or tax breaks to donors or their families.<sup>329</sup> Combining tax credits with discounted driver's license fees could take advantage of the American pub-

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<sup>327</sup> See Young, *supra* note 8.

<sup>328</sup> See *supra* Part IV.A.1 (discussing proposals for futures markets outlined by Cohen, Crespi, and Hansmann).

<sup>329</sup> See *supra* Parts IV.A.2 and IV.A.4.

lic's strong support for donation which unfortunately has yet to translate into widespread organ donor status.<sup>330</sup>

Moreover, a plethora of nonmonetary incentives exist that could spur organ donation and procurement without running afoul of NOTA's prohibition on paying "valuable consideration" for human organs. By linking waitlist priority with an individual's own willingness to donate, organizations like LifeSharers incentivize people to sign up to become donors who otherwise might not, if only out of pure self-interest.<sup>331</sup> Paired organ exchanges that allow for swaps between individuals with family members in need hold tremendous promise in encouraging donation without requiring a single dime in return.<sup>332</sup> Presumed consent and required request statutes could capitalize on the overwhelming public consensus in favor of donation that often goes unacted upon today.<sup>333</sup> A computerized national registry of organ donors would make large strides in linking patients with willing individuals to create matches that they simply do not know are out there today.<sup>334</sup> Finally, all of the above proposed solutions depend largely on enhanced public awareness and education regarding the current organ crisis and what steps Americans can take to overcome it.<sup>335</sup>

In the final analysis, we must critically reexamine organ donation law and policy in the United States to ascertain why its life-saving potential has never been fully realized. If we cannot or will not do so because the topic strikes an uncomfortable nerve in our conscience, many more thousands of Americans will pay with their lives for our failures.

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330 See *supra* Part IV.A.3.

331 See *supra* Part IV.B.1.

332 See *supra* Part IV.B.2.

333 See *supra* Parts IV.B.3 and IV.B.4.

334 See *supra* Part IV.B.5.

335 See *supra* Part IV.B.6.

