ORGANS FOR SALE? AN ANALYSIS OF PROPOSED SYSTEMS FOR COMPENSATING ORGAN PROVIDERS

SHELBY E. ROBINSON

Every year in our nation 200,000 useful organs are consigned to the maggots for ready conversion to swill. The law indulges us in this practice while thousands anguish for want of the buried parts.[1]

INTRODUCTION

Despite the existence of a well-established and relatively refined organ procurement system,[2] the United States continues to experience a chronic shortage of transplantable human organs.[3] Because tens of thousands of Americans are on organ waiting lists,[4] the burial or cremation each year of an enormous number of potentially transplantable organs[5] constitutes a serious medical crisis.

Issues of death, serious illness, and the proper use of human body parts—subjects that strike a deep emotional chord with most people—necessarily arise in any discussion of the transplantable-organ shortage. Because these matters are so sensitive and highly personal, "[i]t may not be possible to examine alternative solutions [to America's current organ procurement system] in a completely cold and analytical fashion."[6]

---

1. Theodore Silver, *The Case for a Post-Mortem Organ Draft and a Proposed Model Organ Draft Act*, 68 B.U. L. REV. 681, 681 (1988). Professor Silver rejects the idea of compensating people for their organs, *see id.* at 703, advocating instead a system of conscription for transplantable cadaveric organs. *See id.* at 681; *see also infra* Part II.B.2 for a discussion of conscription.

2. *See infra* Part II.A. For a helpful overview of America's present system of organ procurement and allocation, see Charles K. Hawley, *Antitrust Problems and Solutions to Meet the Demand for Transplantable Organs*, 1991 U. ILL. L. REV. 1101, 1103-05. *See also* Lisa E. Douglass, *Organ Donation, Procurement and Transplantation: The Process, the Problems, the Law*, 65 UMKC L. REV. 201, 203-05 (1996) (describing one woman's experience of waiting for and finally receiving a transplantable kidney).

3. *See infra* notes 31-32 and accompanying text.

4. *See infra* note 31 and accompanying text.

5. *See infra* note 32 and accompanying text.

6. Roger D. Blair & David L. Kaserman, *The Economics and Ethics of Alternative Cadaveric Organ Procurement Policies*, 8 YALE J. ON REG. 403, 451

This is particularly true of proposed organ procurement models that call for the compensation of organ providers.[7] American society abhors any activity that smacks of trafficking in human beings.[8] Thus, the American public traditionally has been unwilling to consider any form of compensating organ providers.[9] However, because closing the deficit of transplantable organs could save or extend the lives of thousands of Americans every year,[10] any solution to this problem—including compensation for organ providers—deserves serious attention.

While the compensation of organ providers presents important practical considerations, these considerations are less troublesome than corresponding ethical concerns.[11] Still, while ethical considerations undoubtedly should be a component in the development of any organ procurement system, "the desire to promote a particular ethical environment should not come at the expense of those awaiting transplantation."[12] Indeed, the needless suffering and death of thousands of Americans every year due to a lack of transplantable organs[13] is perhaps the more compelling ethical concern.

(1991).

7. This comment uses the term "organ provider" to refer to a person who would, in the systems of compensation discussed, give up her organs for some kind of remuneration. It uses the term "organ donor" to refer to someone who allows her organs to be used during life or after death for no compensation.

8. *See* Lloyd R. Cohen, *Increasing the Supply of Transplant Organs: The Virtues of a Futures Market*, 58 GEO. WASH. L. REV. 1, 24 (1989) (arguing that a "widely felt repugnance to the notion of trafficking in human flesh" underlies the legal prohibition of a much-needed organ market); Gregory S. Crespi, *Overcoming the Legal Obstacles to the Creation of a Futures Market in Bodily Organs*, 55 OHIO ST. L.J. 1, 21 (1994) (contending that America's repulsion to anything that resembles the selling of human beings is traceable to our country's "long and unhappy historical experience with slave markets").

9. *See, e.g.*, Arthur L. Caplan, *Organ Procurement: It's Not in the Cards*, HASTINGS CTR. REP., Oct. 1984, at 9, 9-10; Hawley, *supra* note 2, at 1109; Joel D. Kallich & Jon F. Mertz, *The Transplant Imperative: Protecting Living Donors from the Pressure to Donate*, 20 J. CORP. L. 139, 145 (1994). In fact, "[p]roposals for sales of organs virtually always cause moral outrage and can be a form of political suicide." Hawley, *supra* note 2, at 1126 (footnote omitted).

10. *See infra* note 31 and accompanying text.

11. The ethical and practical concerns about compensating organ providers are sometimes in tension. For instance, while some systems of compensation might overcome problems of wasted compensation for untransplantable organs or poor quality of harvested organs, they might not measure up as well under the spotlight of ethical considerations. *See infra* Part IV.

12. *Developments in the Law: Medical Technology and the Law*, 103 HARV. L. REV. 1519, 1624 (1990).

13. *See infra* note 31 and accompanying text.

This comment analyzes three models for compensating organ providers that are possible alternatives to America's current altruistic organ procurement system. Part I discusses America's transplantable-organ shortage.[14] Part II then describes America's current organ procurement system and briefly reviews other non-compensatory systems that have been proposed for use in America or implemented in other countries. It concludes that these systems are not viable alternatives to America's organ procurement system. Next, Part III examines three proposed compensation-based systems, including the *inter vivos* sales and procurement system, the futures market, and the death benefits system. Part IV explores ethical and practical criticisms of compensation systems in general, and Part V evaluates the proposed compensation systems in terms of these criticisms. This comment concludes that, from an ethical and practical perspective, the death benefits system is the most viable of these three proposed systems for implementation in the United States.

I. THE TRANSPLANTABLE-ORGAN SHORTAGE

The field of organ transplantation has progressed significantly[15] since the first successful transplant was performed at a Boston hospital in 1954.[16] The practice has "evolved in the second half of this century from a rare curiosity to a recognized treatment"[17] and has captured the public's imagination in the process.[18] Certainly, the ability of modern medicine to extend

---

14. The unmet need for transplantable organs is a world-wide problem. This comment, however, will focus on the organ shortage and alternatives to the current procurement system in America. For an international perspective on organ shortages and organ procurement systems, see Christian Williams, *Combatting the Problems of Human Rights Abuses and Inadequate Organ Supply Through Presumed Donative Consent*, 26 CASE W. RES. J. INT'L L. 315 (1994).

15. *See* Crespi, *supra* note 8, at 8. The impressive array of body parts and fluids successfully transplanted into humans includes kidneys, hearts, lungs, livers, corneas, ovaries, testicles, fallopian tubes, blood, skin, and bone marrow. *See* Cohen, *supra* note 8, at 3.

16. The first successful organ transplant was a kidney transplant between two identical twins. *See* THOMAS E. STARZL, THE PUZZLE PEOPLE: MEMOIRS OF A TRANSPLANT SURGEON 87 (1992).

17. MARK DOWIE, WE HAVE A DONOR: THE BOLD NEW WORLD OF ORGAN TRANSPLANTING ix (1988).

18. *See id.*

It is impossible to deny the allure of organ transplantation. . . . We mar-

human lives with transplanted human organs has a dramatic appeal. The public's fascination with transplantation, unfortunately, has not translated into success in meeting the growing demand for transplantable organs.[19] Despite the enormous progress in organ transplantation and its lifesaving potential, the practice has been severely limited by a chronic shortage of usable organs.[20]

Ironically, advances in medicine have contributed significantly to America's current organ shortage. Great strides in the practice of organ transplantation have resulted in its widespread use as a medical treatment.[21] The advent of "life-maintenance equipment such as respirators, ventilators, and dialysis machines" has increased the number of people who survive serious illnesses and subsequently need organ transplants.[22] Moreover, the development of powerful immunosuppressant drugs has helped control rejection of transplantable organs by recipients,[23] thus making transplantation more viable. Advances in medical technology have made transplantation routine, inhibited primarily by the dearth of available organs.[24]

At the same time that medical technology has made organ transplantation possible, the supply of human organs is small and static. Human organs can come from live donors or cadavers.[25] Thousands of transplants with organs from live donors

---

vel at heroic, twenty-two-hour operations where "the gift of life" is deftly transferred from the newly dead to the barely living. As we watch, we sense that we are witnessing the very edge of our own existence, and the thrill is not unlike the feeling that comes with the launch of a great space mission or the birth of a child.

Id. at 1.

19. *See infra* notes 31-32 and accompanying text.

20. *See, e.g.*, Fred H. Cate, *Human Organ Transplantation: The Role of Law*, 20 J. CORP. L. 69, 70 (1994).

21. *See* Roger W. Evans et al., *The Potential Supply of Organ Donors*, 267 JAMA 239, 239 (1992); Hawley, *supra* note 2, at 1106.

22. Crespi, *supra* note 8, at 8; *see also* LEE GUTKIND, MANY SLEEPLESS NIGHTS: THE WORLD OF ORGAN TRANSPLANTATION 27 (1988).

23. *See* Crespi, *supra* note 8, at 8. Two of these immunosuppressants, prednisone and cyclosporine, were developed in the early 1980s. *See* PHILLIP G. WILLIAMS, LIFE FROM DEATH 3 (1989).

24. *See, e.g.*, Cate, *supra* note 20, at 70.

25. Xenotransplantation—transplanting organs and tissue from one species into another—is a potential but very controversial solution to the shortage of transplantable human organs. *See* Russell Scott, *The Terrible Imbalance: Human Organs and Tissues for Therapy—A Review of Demand and Supply*, 9 J.

take place every year,[26] but live donors are a limited source of organs because they can provide only certain "non-necessary" organs or tissues: one of two healthy kidneys, for example, or "regenerative fluids such as blood and bone marrow."[27]

The principal supply of human transplant organs is cadavers.[28] However, only a few cadaver organs are suitable for transplantation.[29] Cadaver organs with the best potential for transplant success come from people who have died in a hospital, from accidental causes.[30]

America's organ procurement system has fallen far short of obtaining all of the potentially transplantable cadaver organs. In 1998, for example, 60,299 Americans were on official waiting lists for transplant organs.[31] Many more organs are theoreti-

---

CONTEMP. HEALTH L. & POL'Y 139, 151-52 (1993).

26. *See Number of U.S. Transplants: 1988 to September 30, 1998 by Organ and Donor Type* (visited Jan. 11, 1999) <http://www.UNOS.org/frame_Default.asp?Category=Newsroom> (listing the numbers of living and cadaver organ transplants performed in the United States from 1988 to September 30, 1998).

27. Crespi, *supra* note 8, at 9. Somewhat surprisingly, the liver is on this list: "Part of a living person's liver can be transplanted and will grow in the recipient's body while the remainder will generate to normal size in the donor's body." Scott, *supra* note 25, at 156.

Despite the availability of organs from live donors, some doctors oppose the use of live donors on medical, moral, and psychological grounds. *See* GUTKIND, *supra* note 22, at 28-29. Some commentators are concerned about the potential for family members and medical personnel to coerce people into *inter vivos* organ donation. *See* Kallich & Mertz, *supra* note 9. Other commentators view live donation as economically wasteful, socially undesirable, and avoidable through systems of compensated cadaver donation. *See* Blair & Kaserman, *supra* note 6, at 430. For a useful overview of issues involving living organ donors, see Kallich & Mertz, *supra* note 9; Howard S. Schwartz, *Bioethical and Legal Considerations in Increasing the Supply of Transplantable Organs: From UAGA to "Baby Fae,"* 10 AM. J.L. & MED. 397, 423-30 (1985); *see also infra* note 154.

28. *See Number of U.S. Transplants, supra* note 26.

29. *See* Crespi, *supra* note 8, at 9.

30. *See id.* This manner of death is less likely to have resulted in damage to organs and also "allows rapid medical access to those organs after death." *Id.* Other factors affect the suitability of organs for transplantation, such as the general state of health of the decedent and the body's physiological (as opposed to chronological) age. *See* GUTKIND, *supra* note 22, at 78.

31. *See Estimated Number of Patients Listed on the National Transplant Waiting List by Organ and Overall* (visited Jan. 11, 1999) <http://www.UNOS.org/frame_Default.asp?Category=Newsroom>. The number of patients on organ waiting lists has risen steadily for the past decade. *See The Critical Organ Shortage* (visited Jan. 11, 1999) <http://www.UNOS.org/frame_Default.asp?Category=About>. Note that not everyone who needs an organ is on an organ waiting list. *See* Teri Randall, *Too Few Human Organs for Transplantation, Too Many in Need . . . and the Gap Widens*, 265 JAMA 1223, 1223 (1991). Therefore,

cally available for transplantation every year than are actually harvested for transplantation.[32] This means that every year many potentially usable organs go to waste, while tens of thousands of people remain on the organ waiting lists. Even with a comprehensive organ procurement system,[33] America's sizeable shortage of available transplantable organs has not abated,[34] and the need for a new approach is clear.

II. NON-COMPENSATORY SYSTEMS OF ORGAN PROCUREMENT

As discussed above, America's system of organ procurement has failed to obtain anywhere near all of the potentially transplantable organs.[35] The current American system is built on the willingness of individuals to donate organs after death, or sometimes during life, without compensation.[36] Some commentators advocate replacing this system of altruism with other non-compensatory organ procurement arrangements that are designed to maximize the number of organs harvested for transplantation. These alternative systems include presumed consent (in which people are presumed to consent to the donation of their cadaver organs unless they affirmatively refuse to make such a donation),[37] conscription (in which citizens' organs are harvested from their cadavers, regardless of any contrary wishes),[38] and mandated choice (in which citizens must affirmatively choose either to donate or not to donate their cadaver organs).[39] This part discusses America's current organ procurement system and examines the non-compensatory systems proposed as alternatives to it.

---

the actual number of people awaiting organs is somewhat higher than the official waiting lists reflect. *See id.*

32. *See, e.g.*, Blair & Kaserman, *supra* note 6, at 410; Crespi, *supra* note 8, at 10; Raja B. Khauli, *Issues and Controversies Surrounding Organ Donation and Transplantation: The Need for Laws that Ensure Equity and Optimal Utility of a Scarce Resource*, 27 SUFFOLK U. L. REV. 1225, 1225 (1993).

33. *See infra* notes 76-79 and accompanying text.

34. *See supra* notes 31-32 and accompanying text. Some commentators began writing about organ procurement and the potential shortage of human organs decades ago. *See, e.g.*, Jesse Dukeminier, Jr., *Supplying Organs for Transplantation*, 68 MICH. L. REV. 811 (1970).

35. *See supra* notes 31-32 and accompanying text.

36. *See, e.g.*, WILLIAMS, *supra* note 23, at 7.

37. *See infra* Part II.B.1.

38. *See infra* Part II.B.2.

39. *See infra* Part II.B.3.

A. *Encouraged Donation: The American System*

America's current system of organ procurement is based on the willingness of people to donate their organs and the organs of their loved ones.[40] Two pieces of legislation, the Uniform Anatomical Gift Acts of 1968[41] and 1987[42] and the National Organ Transplant Act,[43] have helped shape and guide this altruistic system of organ procurement.

1. The Uniform Anatomical Gift Acts

By the 1960s, most states had adopted anatomical gift statutes; however, the resulting patchwork of laws was "inadequate, confusing, and lacked uniformity."[44] Moreover, state anatomical gift laws had failed to meet the growing need for transplantable organs.[45] In response to the organ shortage, the National Conference of Commissioners on Uniform State Laws ("NCCUSL") formulated the Uniform Anatomical Gift Act of 1968 ("1968 UAGA"),[46] which all fifty states and the District of Columbia adopted with minor modifications.[47]

---

40. *See supra* note 36 and accompanying text.

41. UNIF. ANATOMICAL GIFT ACT (1968) (superseded 1987), 8A U.L.A. 63 (1993) ("1968 UAGA").

42. UNIF. ANATOMICAL GIFT ACT (1987), 8A U.L.A. 19 (1993) ("1987 UAGA").

43. Pub. L. No. 98-507, 98 Stat. 2339 (1984) (codified at 42 U.S.C. §§ 273-274 (1994)) ("NOTA").

44. Monique C. Gorsline & Rachelle L. K. Johnson, *The United States System of Organ Donation, the International Solution, and the Cadaveric Organ Donor Act: "And the Winner Is . . . "*, 20 J. CORP. L. 5, 14 (1994). The Prefatory Note to the 1968 UAGA states:

> The laws now on the [state] statute books do not, in general, deal with these [issues regarding anatomical gifts] in a complete or adequate manner. The laws are a confusing mixture of old common law dating back to the seventeenth century and state statutes that have been enacted from time to time.

Prefatory Note, UNIF. ANATOMICAL GIFT ACT (1968), 8A U.L.A. at 64-65.

45. *See* Crespi, *supra* note 8, at 12. The organ shortage began to develop during the 1960s as a result of the considerable strides the medical community made in the technology of organ transplantation. *See id.*; *see also supra* notes 21-23 and accompanying text.

46. UNIF. ANATOMICAL GIFT ACT (1968); *see also* Crespi, *supra* note 8, at 12.

47. *See* Cate, *supra* note 20, at 71 n.24 (listing the statutes through which every state and the District of Columbia adopted the 1968 UAGA).

The 1968 UAGA attempts to outline a uniform system of organ donation.[48] It provides, among other things, that individuals who are at least eighteen years old and of sound mind may donate their cadaver organs.[49] Under the 1968 UAGA, an individual may indicate her desire to donate her cadaver organs not only in a will[50] but also on a signed organ donor card or other document such as a driver's license.[51] It lists classes of individuals who are allowed to donate a decedent's organs, provided that the decedent did not have a preference to the contrary.[52] The 1968 UAGA also allows people to amend, or withdraw their intention to make, an anatomical gift.[53]

Despite the 1968 UAGA's success in "providing a comprehensive framework for states to follow in rethinking and redrafting their anatomical gift laws,"[54] its wholesale adoption failed to alleviate the shortage of transplantable organs.[55] Moreover, the 1968 UAGA did not address other "inadequacies in the [existing] system of encouraging voluntary donation,"[56] nor did it discuss the sale of human organs.[57]

---

48. *See id.* at 71; Prefatory Note, UNIF. ANATOMICAL GIFT ACT (1968), 8A U.L.A. at 64-65.

49. *See* UNIF. ANATOMICAL GIFT ACT § 2(a) (1968).

50. *See id.* § 4(a).

51. *See id.* § 4(b).

52. *See id.* § 2(b). This section provides:

> Any of the following persons, in order of priority stated, when persons in prior classes are not available at the time of death, and in the absence of actual notice of contrary indications by the decedent or actual notice of opposition by a member of the same or a prior class, may give all or any part of the decedent's body . . . : (1) the spouse, (2) an adult son or daughter, (3) either parent, (4) an adult brother or sister, (5) a guardian of the person of the decedent at the time of his death, (6) any other person authorized or under obligation to dispose of the body.

Id.

53. *See id.* § 6.

54. WILLIAMS, *supra* note 23, at 9.

55. *See* Prefatory Note, UNIF. ANATOMICAL GIFT ACT (1987), 8A U.L.A. 20 (1993).

56. *Id.* at 20-21.

57. The drafters of the 1968 UAGA intentionally declined to address the subject of financial incentives for organ donation. *See* E. Blythe Stason, *The Uniform Anatomical Gift Act*, 23 BUS. LAW. 919, 927 (1968). The chairman of the drafting committee stated that "[u]ntil the matter of payment becomes a problem of some dimensions, the matter should be left to the decency of intelligent human beings." *Id.* at 928.

In response to these criticisms, the NCCUSL drafted a new version of the Uniform Anatomical Gift Act ("1987 UAGA").[58] The 1987 UAGA explicitly outlaws the sale of organs.[59] It also sets forth a scheme of "routine inquiry and required request" that compels hospitals to ask patients or their families about organ donation,[60] and mandates that law enforcement officers and emergency and medical personnel make reasonable searches for documents that show a person's organ donation preference if that person is "dead or near death."[61] Additionally, the 1987 UAGA gives priority to the wishes of the decedent over her family members by providing that "[a]n anatomical gift that is not revoked by the donor before death is irrevocable and does not require the consent or concurrence of any person after the donor's death."[62]

The 1987 UAGA met with much more resistance than the 1968 UAGA. Only fifteen states have adopted the revised UAGA.[63] States' acceptance of the 1987 UAGA has been hin-

---

58. UNIF. ANATOMICAL GIFT ACT (1987), 8A U.L.A. 19 (1993).

59. *See id.* § 10. This section provides:

> Sale or Purchase of Parts Prohibited.
>
> (a) A person may not knowingly, for valuable consideration, purchase or sell a part for transplantation or therapy, if removal of the part is intended to occur after the death of the decedent.
>
> (b) Valuable consideration does not include reasonable payment for the removal, processing, disposal, preservation, quality control, storage, transportation, or implantation of a part.
>
> (c) A person who violates this section is guilty of a [felony] and upon conviction is subject to a fine not exceeding [$50,000] or imprisonment not exceeding [five] years, or both.

Id. The 1987 UAGA defines "part" as "an organ, tissue, eye, bone, artery, blood, fluid, or other portion of a human body." *Id.* § 1(7).

60. *Id.* § 5(a), (b).

61. *Id.* § 5(c). However, organ donor documents are not a panacea for the transplantable-organ shortage. Potential organ donors frequently do not have organ donor cards with them at the time of their death. *See, e.g.*, Caplan, *supra* note 9, at 10. Moreover, "[e]ven if a valid donor card is found . . . doctors and hospitals fear professional criticism and legal liability if they procure organs against the wishes of the next-of-kin." Cate, *supra* note 20, at 82.

62. UNIF. ANATOMICAL GIFT ACT § 2(h) (1987).

63. The 1987 UAGA has been adopted in Arkansas, California, Connecticut, Hawaii, Idaho, Minnesota, Montana, Nevada, North Dakota, Rhode Island, Utah, Vermont, Virginia, Washington, and Wisconsin. *See* Table of Jurisdictions Wherein Act Has Been Adopted, UNIF. ANATOMICAL GIFT ACT (1987), 8A U.L.A. 19 (1993). The 1968 UAGA, in contrast, was "swiftly embraced by state legislatures." Ann McIntosh, *Regulating the "Gift of Life"—The 1987 Uniform Anatomical Gift Act*, 65 WASH. L. REV. 171, 176 (1990); *see also supra* note 47 and accompanying text.

dered in part by the required request provision.[64] Some commentators also have questioned the 1987 UAGA's prohibition on organ sales.[65]

2. The National Organ Transplant Act

Two events in the early 1980s prompted Congress to take action at the federal level to decrease the national organ shortage: "a series of public appeals by desperate families seeking organs and financial assistance for transplants," and "the appearance of a commercial market for transplant organs."[66] In response to these pressures, Congress passed the National Organ Transplant Act ("NOTA") in 1984.[67] NOTA has proven to be a critical piece of transplant legislation for several reasons. First, Congress firmly rejected the idea of an organ market by forbidding the sale of human organs[68] in interstate commerce.[69] Lawmakers "feared that a for-profit system would prey upon

---

64. *See* McIntosh, *supra* note 63, at 176.

65. *See id.* For a discussion of organ procurement systems which are based on compensating organ providers, see *infra* Parts III and V.

66. McIntosh, *supra* note 63, at 174 (footnote omitted). A delicensed Virginia physician's plan to start an organ brokerage business was one such indicator of the appearance of a commercial market in organs. *See infra* notes 118-24 and accompanying text.

67. Pub. L. No. 98-507, 98 Stat. 2339 (1984) (codified at 42 U.S.C. §§ 273-274 (1994)).

68. *See* 42 U.S.C. § 274e (1994). This section provides:

> (a) 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.
>
> (b) Any person who violates subsection (a) shall be fined not more than $50,000 or imprisoned not more than five years, or both.

Id. § 274e(a), (b). NOTA makes exceptions for compensation that relates to "removal, transportation, implantation, processing, preservation, quality control, and storage of a human organ or the expenses of travel, housing and lost wages incurred by the donor of a human organ in connection with the donation of the organ." *Id.* § 274e(c)(2).

69. It is difficult to imagine that any organ transplant would not implicate interstate commerce, given courts' "broad construction of Congress' commerce clause power." Susan Hankin Denise, *Regulating the Sale of Human Organs*, 71 VA. L. REV. 1015, 1025 (1985). Although the Supreme Court has shown a recent willingness to apply a more narrow definition to interstate commerce, *see* United States v. Lopez, 514 U.S. 549 (1995), it seems extremely probable that the vast majority of hospitals that perform transplants engage in enough interstate commerce to come within the purview of NOTA's prohibition on organ sales.

the indigent members of our society or the Third World as a source for organs."[70]

Another significant contribution of NOTA was the establishment of the Task Force on Organ Transplantation ("Task Force"), which, among other tasks, was charged with "conduct[ing] comprehensive examinations of the medical, legal, ethical, economic, and social issues presented by human organ procurement and transplantation."[71] One of the Task Force's recommendations was that hospitals "adopt routine inquiry/required request policies and procedures for identifying potential organ and tissue donors and for providing next-of-kin with appropriate opportunities for donation,"[72] a philosophy that was mirrored at the state level in the 1987 UAGA's required request provision.[73] Congress ultimately adopted the Task Force's recommendation of required request in the Omnibus Budget Reconciliation Act of 1986.[74] As a result, hospitals now may forfeit Medicaid and Medicare funding unless they establish "written protocols for the identification of potential organ donors."[75]

In addition to forbidding the sale of human organs and commissioning the Task Force, NOTA established the system of organ procurement and distribution that currently operates

---

70. John A. Sten, *Rethinking the National Organ Transplant Program: When Push Comes to Shove*, 11 J. CONTEMP. HEALTH L. & POL'Y 197, 208-09 (1994) (footnote omitted); *see also infra* notes 151-54 and accompanying text.

71. Section 101(b)(1)(A), Pub. L. No. 98-507, 98 Stat. 2339 (1984).

72. TASK FORCE ON ORGAN TRANSPLANTATION, U.S. DEP'T OF HEALTH & HUM. SERV., ORGAN TRANSPLANTATION: ISSUES AND RECOMMENDATIONS 3 (1986).

73. *See* UNIF. ANATOMICAL GIFT ACT § 5(a), (b) (1987); *see also supra* notes 60-61 and accompanying text.

74. Pub. L. No. 99-509, 100 Stat. 1874, 2009 (1986) (codified at 42 U.S.C. § 1320b-8 (1994)).

75. 42 U.S.C. § 1320b-8(a)(1)(A) (1994). The statute provides that these protocols should:

> (i) assure that families of potential organ donors are made aware of the option of organ or tissue donation and their option to decline,
>
> (ii) encourage discretion and sensitivity with respect to the circumstances, views, and beliefs of such families, and
>
> (iii) require that such hospital's designated organ procurement agency . . . is notified of potential organ donors.

§ 1320b-8(a)(1)(A)(i)-(iii). Although the required request provision theoretically gives the federal government substantial power to control hospitals and increase the number of harvested cadaver organs, the system is not closely monitored and has therefore not lived up to its potential to increase the organ supply. *See* Douglass, *supra* note 2, at 211.

in the United States. NOTA created the nationwide Organ Procurement and Transplantation Network ("OPTN") to oversee and coordinate the allocation of organs throughout the country.[76] Congress chose the United Network for Organ Sharing ("UNOS"), an existing central registry of potential kidney recipients, to administer the OPTN.[77]

NOTA also authorized the establishment of regional organ procurement organizations ("OPOs").[78] An OPO "actually finds and transports the donor organ . . . . The NOTA requires that each OPO engage in a systematic effort to acquire all useable organs from potential donors, preserve these organs, and arrange to transport them to transplant centers within [the OPO's] area."[79]

Although the 1968 and 1987 UAGAs, NOTA, and America's current altruistic system of organ procurement were designed to increase the supply of transplantable organs, none has cured America's organ shortage.[80] Consequently, some commentators have called for replacing America's system of encouraged voluntarism with other non-compensatory systems of organ procurement.

B. Other Non-Compensatory Systems of Organ Procurement

1. Presumed Consent

---

76. *See* 42 U.S.C. § 274 (1994).

77. *See* James F. Blumstein, *Federal Organ Transplant Policy: A Time for Reassessment*, 22 U.C. DAVIS L. REV. 451, 463 (1989). In April 1998, the Department of Health and Human Services, which serves a "ministerial role" over the OPTN, proposed new regulations to ensure that UNOS "develop an organ allocation system that functions on a 'national' rather than a 'local-regional' basis and gives preference to the most medically urgent patients, defined as those who are very ill but who, according to their physician, have a reasonable likelihood of post-transplant survival." Gail L. Daubert, Comment, *Politics, Policies, and Problems with Organ Transplantation: Government Regulation Needed to Ration Organs Equitably*, 50 ADMIN. L. REV. 459, 465, 487 (1998). Because these regulations challenge the established system of organ allocation, they have provoked controversy among doctors, patients, and politicians. *See* Dick Thompson, *Transplant Tribulation*, TIME, Oct. 5, 1998, at 56.

78. *See* 42 U.S.C. § 273 (1994).

79. Hawley, *supra* note 2, at 1104.

80. *See supra* note 31 and accompanying text.

Presumed consent—also known as "routine salvage"[81]—is essentially a system of escheatage.[82] Presumed consent operates on the premise that, unless they state otherwise, all citizens wish to donate their organs at their death.[83] A citizen must affirmatively "opt out" of a system of presumed consent.[84] This system has been implemented in many countries, primarily in Europe.[85]

An organ procurement system based on presumed consent has some support in the United States.[86] Advocates of presumed consent in America rely on statistics showing that most Americans have a favorable attitude toward organ donation.[87] Supporters also note that this approach would remove from hospital personnel the difficult task of approaching bereaved family members to ask for a decedent's organs.[88]

---

81. Silver, *supra* note 1, at 703.

82. *See* Cohen, *supra* note 8, at 15.

83. *See* Silver, *supra* note 1, at 703.

84. *See* Cate, *supra* note 20, at 83. In some systems of presumed consent, non-donors demonstrate their wish to opt out of the presumed consent system by carrying a card, much like Americans can demonstrate their wish to be an organ donor by carrying a donor card. *See id.*

85. *See* Gorsline & Johnson, *supra* note 44, at 21. Countries using a presumed consent model of organ procurement include Argentina, Austria, Belgium, Brazil, Chile, France, Finland, Germany, Greece, Italy, Norway, Poland, Spain, Sweden, Switzerland, and the former Yugoslavia. *See id.* at 21-24. Singapore's organ procurement system, designed in consideration of the country's sizeable Muslim population, is a unique combination of presumed consent and voluntary donation. *See id.* at 24-25.

Countries using presumed consent differ in their implementation of the system, and thus in their success at procuring organs. *See id.* at 21-24. Countries with a "strong" presumed consent model, such as Austria, Poland, and Switzerland, make "the clearly expressed will of the deceased the sole criterion for objection to organ removal." *Id.* at 21 (footnote omitted). As a result, these countries tend to have higher organ procurement rates than countries with a "weak" presumed consent system, such as Finland, Greece, Italy, or Norway, where next-of-kin may object to organ donation. *See id.* at 21-24.

86. *See, e.g.*, J. Dukeminier, Jr. & D. Sanders, *Organ Transplantation: A Proposal for Routine Salvaging of Cadaver Organs*, 279 NEW ENG. J. MED. 413 (1968) (advocating a strong presumed consent system); Linda C. Fentiman, *Organ Donation as National Service: A Proposed Federal Organ Donation Law*, 27 SUFFOLK U. L. REV. 1593 (1993) (suggesting a combined system of presumed consent and compensation).

87. *See* 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, 768, 802 (1996) (citing widespread support for organ donation in both a 1993 Gallup poll and in their own study).

88. See Silver, *supra* note 1, at 704-06, for a discussion of this issue.

Opponents of presumed consent, however, point out some less attractive aspects of the system.[89] The notion that "silence equals consent" to organ donation strikes some critics as questionable.[90] One writer contends that systems of presumed consent "insidiously exploit[] the citizen's regrettable reluctance to dissent."[91] Additionally, presumed consent might not be any more effective than the current American procurement system in achieving an adequate organ supply.[92] It would also, critics charge, amount to a *de facto* system of conscripting organs.[93] Finally, presumed consent is antithetical to American culture.[94] Americans are committed to the "notions of voluntarism and autonomy,"[95] and these ideas are at odds with a system that assumes citizens wish their organs to be harvested if they do not state otherwise.[96]

2. Conscription

Conscription, even more than presumed consent, seems contrary to American ideas of autonomy. In a system of con-

---

89. For a discussion of presumed consent and its practical consequences, morality, and property rights in the human body, see Cohen, *supra* note 8, at 15-21.

90. Gorsline & Johnson, *supra* note 44, at 22.

91. Silver, *supra* note 1, at 706.

92. *See id.* Professor Silver notes that some countries with presumed consent systems have not achieved an adequate organ supply. *See id.* at 706. *But see* Williams, *supra* note 14, at 340 ("Presumed consent, when strictly followed by the state, has proved to be the best practiced method of maximizing organ procurement."). For a brief overview of presumed consent systems throughout the world, see *supra* note 85.

93. *See* Silver, *supra* note 1, at 706. Professor Silver argues that an overt system of conscription, such as the organ draft he proposes, would be preferable to presumed consent, which he contends is really "conscription in disguise." *Id.* For a discussion of conscripting human organs, see *infra* Part II.B.2.

94. One commentator, in fact, argues that "the removal of bodily tissues without adequate notice and opportunity for objection by the next of kin" violates the due process clause of the United States Constitution, and "that, in the absence of just compensation, such removals run afoul of the takings clause." 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, 529 (1990).

95. Kurtz & Saks, *supra* note 87, at 779.

96. Interestingly, many American states do operate a limited system of presumed consent in which coroners may "remove corneas [from cadavers] absent objection from the decedent's family." *Id.* at 778-79. Other states allow coroners to do so "only after there has been a reasonable inquiry to determine if there is an objection." *Id.*

scription, citizens would have no choice about the disposition of their organs.[97] Transplantable organs would be harvested from cadavers regardless of the decedent's or her family's wishes.[98] Professor Theodore Silver's proposed Model Organ Draft Act[99] is an example of a conscription system. Silver proposes that states "conscript every cadaveric organ suitable for transplantation without regard to any contrary wishes expressed by the decedent while he lives, or by surviving relatives after he dies."[100] Silver would allow exemptions only for religious objections.[101]

Conscription would, arguably, solve America's organ shortage, because under such a system the vast majority of suitable organs would be harvested for transplantation.[102] However, organ conscription is so contrary to American ideas about the role of government and bodily integrity that its implementation in America is highly unlikely.[103] One writer pointed out another weakness of the conscription system: it "would deprive the families of accident victims the cathartic effect of using their tragedy to save other people's lives."[104] Thus, given these drawbacks, conscription is not a viable solution to this country's organ shortage.[105]

---

97. *See, e.g.*, A. H. Barnett & David L. Kaserman, *The Shortage of Organs for Transplantation: Exploring the Alternatives*, 9 ISSUES L. & MED. 117 (1993).

98. *See id.*

99. *See* Silver, *supra* note 1, at 681.

100. *Id.*

101. *See id.*

102. This assumes, of course, that religious objections would be minimal.

103. Americans likely would object to such a system in which they had no voice in the disposition of something as personal and fundamental as their organs.

104. Andrew C. McDonald, *Organ Donation: The Time Has Come to Refocus the Ethical Spotlight*, 8 STAN. L. & POL'Y REV. 177, 181 (1997) (footnote omitted). The same argument applies to systems of presumed consent.

105. One commentator noted that conscription "would present serious legal problems in many Western countries, as well as potential ethical and political problems in most other countries worldwide." Williams, *supra* note 14, at 344. Professor Silver, however, asserts that an organ draft would comport with "American notions of liberty, charity, and socialized life." Silver, *supra* note 1, at 722. Silver argues that an organ draft resembles less the kind of "good Samaritan" requirements that are universally frowned upon in American society than it does a military draft or compulsory assistance to the poor through welfare, both of which are generally accepted. *See id.* at 718-20, 722.

3. Mandated Choice

Mandated choice is a third non-compensatory option for organ procurement. It resembles presumed consent in that people would state their wishes for the disposal of their cadaver organs.[106] Under a system of mandated choice, however, people would be required to opt out of *or* opt into the system: that is, make an affirmative choice either for or against cadaver organ donation.[107] A citizen's organ donation preference could be recorded when, for example, she filed a tax return or obtained or renewed a driver's license.[108]

Proponents of a system of mandated choice contend it would result in "the enhancement of individual autonomy, since each person's actual wishes would be known and followed."[109] Another benefit might be increased harvesting of available organs, as fewer suitable organs would be lost to the human propensity to avoid planning for death.[110]

For mandated choice to achieve maximum effectiveness, however, the medical community would have to alter its approach to requesting organs from decedents' families. Doctors would defeat the purpose of the system if they continued to require consent to organ donation from a decedent's next-of-kin, regardless of the expressed wishes of the decedent.[111] Moreover, the costs and logistics of operating a system in which every citizen's organ donation preference was recorded and followed would likely be prohibitive.

The practice of transplantation is ultimately governed by the grim reality that the demand for human organs heavily outweighs the supply.[112] The current American system of or-

---

106. *See* McDonald, *supra* note 104, at 183.

107. *See id.*

108. *See id.* The proposed Cadaveric Organ Donor Act ("CODA"), which was developed at the University of Iowa College of Law, is predicated on a system of mandated choice. *See* Sheldon F. Kurtz, *Forward: Organ Donation Symposium*, 20 J. CORP. L. 1, 2 (1994). CODA would require "every person to express a donative preference as a condition of obtaining a social security card, driver's license, state identification card, or alien registration card." *Id.* at 3.

109. McDonald, *supra* note 104, at 183.

110. *See id.*

111. *See id.* Some doctors are reluctant to harvest organs without consent from the decedent's family, even when the decedent's organ donation preference is known. *See supra* note 61 and accompanying text.

112. *See supra* notes 31-32 and accompanying text.

gan procurement has not met the need for organs,[113] and the procurement systems discussed above are either unpalatable or impractical for use in America. Many writers thus have suggested that compensating organ providers might be a viable mechanism for closing the gap between the need for and the availability of transplantable organs.[114] The following part addresses various systems of compensation that have been proposed as solutions to America's organ shortage.

III. PROPOSED SYSTEMS FOR COMPENSATING ORGAN PROVIDERS

Some observers have argued that the solution to the shortage of transplantable organs is compensation.[115] Proposals for compensating organ donors take several forms.[116] Some models rely on a market system for human organs, in which "organs would be treated as any other commodity that changes hands in our economy."[117] Variations on the market system of organ procurement include the *inter vivos* sales and procurement system and the futures market. A third alternative, the death benefits system, is a form of compensation that is not based on market forces.

---

113. *See id.*

114. *See infra* Part III.

115. *See* Cohen, *supra* note 8; Crespi, *supra* note 8; Henry Hansmann, *The Economics and Ethics of Markets for Human Organs*, 14 J. HEALTH POL., POL'Y & L. 57 (1989); Richard Schwindt & Aidan R. Vining, *Proposal for a Future Delivery Market for Transplant Organs*, 11 J. HEALTH POL., POL'Y & L. 483 (1986) (all supporting a futures market in human organs); *see also* Denise, *supra* note 69; Hawley, *supra* note 2; Schwartz, *supra* note 27; Note, *The Sale of Human Body Parts*, 72 MICH. L. REV. 1182 (1974).

116. Some commentators have argued that compensation for organs should be allowed, but they have not set out detailed proposals. *See, e.g.*, Denise, *supra* note 69, at 1035-37. Other commentators support compensation systems combined with other types of organ procurement systems. *See, e.g.*, Marvin Brams, *Transplantable Human Organs: Should Their Sale Be Authorized by State Statutes?*, 3 AM. J.L. & MED. 183 (1977) (supporting a combined market/altruistic system); Fentiman, *supra* note 86 (advocating a combined system of presumed consent and compensation).

117. McDonald, *supra* note 104, at 182.

A. Inter Vivos *Sales and Procurement System*

The idea of an *inter vivos* organ sales and procurement system arrived at the forefront of public consciousness in 1983, when H. Barry Jacobs of Virginia formed the International Kidney Exchange Ltd. to broker human kidneys from live donors.[118] Jacobs planned to procure kidneys from indigent third-world residents.[119] Under his plan, the organ provider "would set a price for his kidney, and Jacobs would collect $2000 to $5000 [from the buyer] for his brokerage services."[120]

Jacobs's proposal engendered a tremendous amount of hostility.[121] People were appalled at what seemed to be a callous and calculated attempt to profit from the desperate poverty of third-world residents and the desperate illnesses of people with serious kidney disease.[122] Congress included in NOTA a provision forbidding compensation for human organs[123] partly in response to Jacobs's proposal.[124]

While the idea of an *inter vivos* organ market may seem somewhat shocking, it deserves consideration because of its potential to help close the deficit in transplantable organs.[125] (Of course, an *inter vivos* organ market would not necessarily rely on destitute organ providers from developing countries.) The adoption of an *inter vivos* sales and procurement system would

---

118. *See* Margaret Engel, *Va. Doctor Plans Company to Arrange Sale of Human Kidneys*, WASH. POST, Sept. 19, 1983, at A9. Jacobs was a physician whose license had been revoked for Medicare and Medicaid fraud. *See id.*

119. *See id.* Jacobs proposed to record the "informed consent" of illiterate prospective kidney providers through tape-recorded conversations. *See id.*

120. Denise, *supra* note 69, at 1021.

121. *See id.* at 1022. Many commentators, politicians, and organizations denounced Jacobs's proposal, including the American Society of Transplant Surgeons, the Association of Independent Organ Procurement Agencies, the American Society of Transplant Physicians, and the National Kidney Foundation. *See id.*

122. *See* Samuel Gorovitz, *Kidney for Sale: The Reasons Against*, 1 BIOETHICS REP. 1, 3 (1984).

123. *See* 42 U.S.C. § 274e (1994).

124. *See* Denise, *supra* note 69, at 1023. Many state legislatures did the same. *See id.*

125. *See* J. B. Dossetor & V. Manickavel, *Ethics in Organ Donation: Contrast in Two Cultures*, 23 TRANSPLANTATION PROC. 2508 (1991) (discussing this kind of compensation system). For arguments in favor of a free market compensation system using only cadaver organs, see Blair & Kaserman, *supra* note 6; David E. Chapman, Comment, *Retailing Organs Under the Uniform Commercial Code*, 16 J. MARSHALL L. REV. 393 (1983).

be contingent on legislation overturning NOTA's and the 1987 UAGA's prohibitions on compensating organ providers.[126]

B. Futures Market

A more popular proposal for compensating organ providers is a futures market. This system has been suggested by several commentators as the answer to the shortage of transplantable human organs.[127] All proposals for a futures market share the same fundamental structure. In a futures market, a person could sell, during his life, the right to remove organs upon his death.[128] This act would create a contractual relationship between the organ provider and the organ buyer.[129] The organ buyer might be a governmental agency, a single private entity, or competing government and private entities.[130] For the purposes of this comment, the most important differences among the proposed futures market systems are the timing of payments to organ bearers (whether the organ buyer pays during the organ bearer's life or after his death) and the method of determining the price of organs (whether the price of organs will be determined by market forces).[131]

Advocates of a futures market in transplantable organs point out that such a system offers many virtues.[132] A futures market system would prevent the sale of cadaver organs by anyone but the decedent, thereby upholding individual bodily

---

126. *See* 42 U.S.C. § 274e; UNIF. ANATOMICAL GIFT ACT § 10 (1987), 8A U.L.A. 58 (1993).

127. *See* Cohen, *supra* note 8; Crespi, *supra* note 8, at 67; Hansmann, *supra* note 115; Schwindt & Vining, *supra* note 115. See Cohen, *supra* note 8, at 8-11, for a discussion of compensating organ providers in the context of the failure of America's present system of organ procurement. Professor Cohen asserts that the lack of organ donation "is not at bottom psychological and religious; it is economic." *Id.* at 50.

128. *See* Crespi, *supra* note 8, at 28.

129. *See id.*

130. *See id.* at 30.

131. *See id.* Other possible differences in futures markets include whether organ providers "would be allowed to freely assign their contingent rights to future payments"; if minors would be allowed to enter into futures contracts for their organs; the responsibilities of the "hospital or other facility in which the organ bearer dies for notifying the organ buyer and for preserving the organs in harvestable condition until they can be removed"; who can "legally contract to be an organ buyer"; and how organs procured in a futures market would be allocated to recipients. *Id.* at 29-30.

132. *See id.* at 6-7.

autonomy.[133] Proponents point out that the increase in procured organs that would result from a futures market would prevent the reliance on live organ bearers.[134] Of course, as with the *inter vivos* sales and procurement system, the adoption of a futures market in human organs would be contingent on legislation amending or superseding NOTA's and the 1987 UAGA's prohibition on compensation for organs.[135]

C. Death Benefits System

Another proposed system for compensating organ providers, the death benefits system, is not market-based. A death benefits system would compensate organ providers through "financial incentives primarily to the family of the decedent. These incentives can include estate tax deductions, funeral expense allowances, or college education benefits."[136]

One writer, John Sten, supports a death benefit system modeled after Dr. Thomas G. Peters's proposed pilot program.[137] Peters recommended that UNOS offer a "death benefit" of $1000 to families of organ providers.[138] Families would not be *required* to accept payment in return for their loved one's organs.[139] UNOS would not offer the incentive until the family member was brain dead, and would not actually pay the incentive until the organ was harvested.[140]

Sten asserts that this death benefits system would not contravene the spirit of altruism.[141] He also contends that a token payment of $1,000 would not be coercive to grieving families.[142] Additionally, this death benefits system would be practical because it would use the existing UNOS infrastruc-

---

133. *See id.*
134. *See id.* at 6.
135. *See* 42 U.S.C. § 274e (1994); UNIF. ANATOMICAL GIFT ACT § 10 (1987).
136. McDonald, *supra* note 104, at 182.
137. *See* Sten, *supra* note 70; *see also* Dr. Thomas G. Peters, *Life or Death: The Issue of Payment in Cadaveric Organ Donation*, 265 JAMA 1302 (1991).
138. *See* Peters, *supra* note 70, at 1304. Peters estimated that the death benefits program would cost UNOS $4 million per year, but notes that the benefits to society in reduced health care costs and saved lives would eclipse this amount. *See id.*
139. *See id.* at 1303.
140. *See id* at 1303-04.
141. *See id.* at 215; *infra* notes 146-50 and accompanying text.
142. *See* Sten, *supra* note 70, at 217.

ture without altering the existing organ procurement system.[143] He also notes that NOTA's prohibition on organ sales does not necessarily preclude a death benefits system, because such a system would not involve compensation of the kind that Congress intended NOTA to prohibit.[144]

The *inter vivos* sales and procurement system, the futures market, and the death benefits system all attempt to address the shortage of transplantable organs with financial incentives. As discussed in the next part, these systems have each met with disapproval because of widespread criticism of compensation systems in general.

IV. CRITICISMS OF SYSTEMS THAT COMPENSATE ORGAN PROVIDERS

Proposals for commercializing America's organ procurement system have tended to provoke shock and outrage or, at the very least, perfunctory dismissal because of ethical or practical concerns.[145] The most common objections to compensation systems are discussed below.

A. Ethical Objections to Compensating Organ Providers

1. Altruism

Most critics of compensated organ procurement systems suggest that such systems would discourage altruistic donations of organs, not only reducing the supply of organs but also harming society. "There is concern that a system which allows payment for transplantable organs will deter a voluntary donor who considers a payment system unethical or unsavory,"[146] thereby reducing the number of available organs.[147]

---

143. *See id.*

144. *See id.* at 216. Sten notes that Congress intended to prevent any coercive effects of a commercial organ market, and argues that this death benefits proposal, which calls for an incidental amount of remuneration to families within a highly regulated system that is not influenced by market forces, does not implicate Congress's concerns about a for-profit system. *See id.*

145. *See, e.g.*, Crespi, *supra* note 8, at 20-23.

146. Schwartz, *supra* note 27, at 408.

147. *See* Arthur L. Caplan et al., *Financial Compensation for Cadaver Organ Donation: Good Idea or Anathema*, 25 TRANSPLANTATION PROC. 2740, 2741 (1993); Gorsline & Johnson, *supra* note 44, at 36; McDonald, *supra* note 104, at

Some opponents of compensation characterize the donation of an organ as a "gift exchange"—that is, one of the "most powerful forces which bind[s] a social group together"[148]—and argue that this selfless act would be irreparably damaged by the compensation of organ providers.[149] These critics dislike compensating organ providers because "people [would] no longer have the same sense of satisfaction that comes from finding purpose in tragedies"—that is, by donating the organs of a loved one.[150]

2. Coercion of the Poor

Most writers are concerned that financial incentives would unfairly induce destitute people to sell their organs.[151] One commentator noted that the "implications regarding the targeting of the poor in [systems of compensation] and the donation of organs by a single social class are very disturbing."[152] Concerns about the exploitation of the poor would be heightened in a commercial system that allowed the sale of nonnecessary organs for *inter vivos* removal.[153] If allowing people

---

182 (footnote omitted). To support this claim, critics of compensation use the example of the commercial blood market. *See, e.g.*, Gorsline & Johnson, *supra* note 44, at 38.

148. RICHARD TITMUSS, THE GIFT RELATIONSHIP: FROM HUMAN BLOOD TO SOCIAL POLICY 73 (1971). Titmuss was concerned that compensating blood donors would have severely detrimental effects on the altruistic blood donation system. *See id.*

149. *See, e.g.*, Gorsline & Johnson, *supra* note 44, at 36; Khauli, *supra* note 32, at 1228. Professor Cohen, however, dismisses the altruism argument against compensating organ donors: "Prohibiting sale only encourages charity to the extent that it diminishes its character. It is hardly an act of great generosity to donate that which you cannot use [i.e., cadaveric organs] and may not sell." Cohen, *supra* note 8, at 28.

150. McDonald, *supra* note 104, at 182.

151. *See, e.g.*, James Childress, *Ethical Criteria for Procuring and Distributing Organs for Transplantation*, 14 J. HEALTH POL'Y & L. 87 (1989); *Forum: Sacred or for Sale?*, 281 HARPER'S 47 (1990); Gorsline & Johnson, *supra* note 44, at 37; McDonald, *supra* note 104, at 182; *The Sale of Body Parts*, *supra* note 115, at 1217; R. A. Sells, *Consent for Organ Donation: What Are the Ethical Principles?*, 25 TRANSPLANTATION PROC. 39, 40 (1993); McIntosh, *supra* note 63, at 178. Evidence shows that, in countries where the *inter vivos* sale and harvesting of organs is allowed, organs "tend [to be sold by] the poorest and weakest members of society." Scott, *supra* note 25, at 145.

152. Khauli, *supra* note 32, at 1228 (footnote omitted).

153. *See, e.g.*, McDonald, *supra* note 104, at 182.

to sell their cadaver organs seems to open the door to coercion, this is doubly true of *inter vivos* organ harvesting.[154]

3. Inequitable Allocation of Organs

Critics point to another ethical concern: that compensation systems would prevent the fair allocation of organs to recipients.[155] Many people agree that access to lifesaving organs "should not be a function of the financial ability to buy [these] organs."[156] These critics of compensation argue that poor people would be priced out of access to organs in compensation systems.[157] Alternatively, assuming the poor did have equal access to organs, the organs to which they would have access might be of lesser quality.[158]

4. Family Conflict

Some commentators are concerned that the compensation of organ providers could promote conflict in family relationships.[159] A family member might feel pressured to sell organs

---

154. Live kidney donation is considered to be fairly safe for the donor. Some commentators, however, point out the inconsistency in attitudes towards *inter vivos* organ sales and donations. *See* Lori B. Andrews, *My Body, My Property*, HASTINGS CTR. REP., Oct. 1986, at 28, 28-38. The *inter vivos* harvesting of a kidney is characterized as reasonably safe and routine when the kidney is donated, but as dangerous and undesirable when the harvesting is done for compensation. *See id.*; *see also supra* notes 26-27 and accompanying text.

155. *See, e.g.*, *The Sale of Human Body Parts*, *supra* note 115, at 1217 (noting the potential for inequitable allocation in a compensation system).

156. Gorsline & Johnson, *supra* note 44, at 37 (footnote omitted).

157. *See, e.g.*, Dukeminier, *supra* note 34, at 861 (acknowledging the potential for family strife in a compensation system); Gorsline & Johnson, *supra* note 44, at 37; McIntosh, *supra* note 63, at 178; Schwartz, *supra* note 27, at 408; Silver, *supra* note 1, at 701. Of course, organ transplants are extremely expensive. *See infra* note 180. Therefore, many people who lack health insurance are already priced out of the option of the transplantation procedure itself. *See* Blair & Kaserman, *supra* note 6, at 420.

158. *See, e.g.*, McDonald, *supra* note 104, at 182. McDonald notes that "[u]nless the market system includes a mechanism to maintain the national priority listing regardless of economic power, the poor would undoubtedly receive lower quality organs." *Id.* McDonald argues that the problems inherent in guarding against such inequitable allocation in a commercial system would mean "extensive and oppressive government regulatory involvement on both the supply and demand sides." *Id.*

159. *See, e.g.*, Dukeminier, *supra* note 34, at 865; Gorsline & Johnson, *supra* note 44, at 37; McIntosh, *supra* note 63, at 178.

because of financial considerations. Alternatively, a potential provider might be concerned that family members would "pull the plug" prematurely because of the financial interest at stake in the person's cadaver organs.[160] One can also imagine the extreme but theoretically plausible scenarios that might result from family members having a financial stake in a relative's organs. A person might, if desperate enough, commit suicide to provide for family members through compensation for her organs. Also, a family member might resort to murder to cash in on the financial interest in a relative's organs.

5. Basic Morality

Finally, many people regard compensation for human organs as simply immoral.[161] As one writer noted, "[t]he moral repugnance toward rewarding donation constitutes the major obstacle to society's consideration and acceptance of any system of financial compensation for donation."[162] Indeed, compensating organ providers strikes many people as fundamentally inhuman.[163] The same concern about the debasement of humanity that has led to laws against selling one's life, freedom, children, or sexual services also underlies prohibitions on selling one's organs.[164]

B. Practical Objections to Compensating Organ Providers

In addition to raising the ethical concerns that are presented by systems of compensating organ providers, writers have raised many practical and procedural objections.

160. *See* McIntosh, *supra* note 63, at 178.

161. For a brief discussion of "the general ethical principle of preservation of life," public policy, and organ sales, see Dukeminier, *supra* note 34, at 857-58.

162. Khauli, *supra* note 32, at 1229.

163. *See, e.g.*, BIOMEDICAL ETHICS, OPPOSING VIEWPOINTS (Terry O'Neill ed., 1994); McDonald, *supra* note 104, at 182. McDonald ties his argument that compensation for organs is "simply dehumanizing" to his position that compensation also has a deleterious effect on altruism. *Id.* at 182-83.

164. *See* Silver, *supra* note 1, at 703.

1. Wasted Compensation for Unusable Organs

Some observers worry that compensation would be wasted on organs that are not suitable for transplantation.[165] For example, *inter vivos* payments to people for their cadaver organs in a futures market would be vastly inefficient, since most cadaver organs are not suitable for transplant.[166]

2. Matching Between Provider and Recipient

Provider-recipient "matching" is also a practical issue for systems of compensation. For optimal transplantation success, an organ must be well matched to its recipient.[167] Human Leukocyte Antigen ("HLA") tissue typing, which "identifies proteins, called antigens, on the white blood cells," is an important indicator of this compatibility.[168] Some commentators have raised the issue of matching as an obstacle to compensation systems, noting that any system of compensating organ providers would require an extensive computerized system with information like HLA tissue typing in order to match organs to potential recipients.[169]

3. Poor Quality of Organs

Some writers suggest that the quality of procured organs might be lower in a compensation system.[170] In other words, "persons who do not now choose to donate their organs but who would respond to financial incentives to sell those organs would, on average, have organs of lower quality than those now donated."[171] One writer adds, for example, that "the people most likely to sell their organs often have health, alcohol or drug dependency problems."[172]

---

165. *See* McDonald, *supra* note 104, at 182.

166. *See id.*

167. *See* ST. FRANCIS REG'L MED. CTR., MANUAL FOR LIVE DONOR KIDNEY TRANSPLANTATION 11 (1992).

168. *Id.*

169. *See* Gorsline & Johnson, *supra* note 44, at 38. Gorsline and Johnson are concerned that a centralized system would necessarily be run by an agency and would lead to a cartel or monopoly. *See id.*

170. *See, e.g.*, McDonald, *supra* note 104, at 182.

171. Crespi, *supra* note 8, at 21.

172. McDonald, *supra* note 104, at 182; *see also* Laura A. Siminoff et al.,

4. Abuse of the System

Commentators are also concerned about the potential for abuse of the system by organ providers.[173] This problem is unique to compensation systems[174] and is especially relevant to the futures market. The nation would need a centralized system to ensure that organ bearers, tempted by financial incentives, could not sell their cadaver organs more than once through ruses such as using different names.[175]

V. APPLYING CRITICISMS TO THE PROPOSED COMPENSATION SYSTEMS

The above criticisms present valid worries about the compensation of organ donors. The *inter vivos* sales and procurement system, the futures market, and the death benefits system withstand these criticisms with varying degrees of success. This part contends that the death benefits system offers the best alternative to America's current system of organ procurement.

A. Ethical Considerations

1. Altruism

As indicated above, the altruism argument against compensating organ providers posits that Americans would be repulsed from donating their organs into a system that allowed compensation.[176] While the effects of the proposed compensation systems on altruistic donations are unknown, proponents of all three systems claim that any decrease in altruistic donations would be offset by increases in compensated donations.[177]

Public Policy Governing Organ and Tissue Procurement in the United States, ANNALS OF INTERNAL MED., July 1, 1995, at 10.

173. *See, e.g.*, McDonald, *supra* note 104, at 182.

174. In a purely altruistic organ procurement system, organ donors would have no incentive to promise their organs more than once.

175. *See* McDonald, *supra* note 104, at 182.

176. *See supra* notes 149-50 and accompanying text.

177. *See, e.g.*, Blair & Kaserman, *supra* note 6, at 442; Crespi, *supra* note 8, at 20-21. Sten notes that in a death benefits system, compensation to families would work hand in hand with the current system and therefore not "degrade whatever altruistic spirit the current procurement system presently possesses."

If this predicted decrease in organ donations did result, however, it probably would be much less severe in the death benefits system than either the *inter vivos* sales and procurement or futures market systems. Compensation under the death benefits system seems less like the overt buying and selling of organs than an incidental monetary reward for a good deed. The *inter vivos* system, because of its blatantly commercial approach to body parts, seems more likely to affect altruism. This is also true of the futures market. While it seems facially less offensive because it does not involve the retrieval of organs from living people, the futures market is indeed a commercial system. In short, the decrease of altruistic organ donations seems of the least concern in the death benefits system.

2. Coercion of the Poor

Coercion of the poor is a possible side effect of compensation that many people find especially unpalatable.[178] It is most likely to occur in an *inter vivos* organ market, because such a system would allow the purchase and removal of live organs. A system that allows people to sell their organs for retrieval while they are alive surely has the potential for exploiting people who desperately need money.[179] By contrast, the futures market and the death benefits system are structured to harvest only cadaver organs and therefore present a lesser possibility of poverty-based coercion. Thus, while the *inter vivos* sales and procurement system raises very compelling considerations about coercion, these concerns are present to a much lesser extent in the futures market and death benefits system, depending on one's view of the coercive nature of cadaver organ sales.

Sten, *supra* note 70, at 216. Moreover, a wholesale rejection of compensation systems because they might lessen the altruistic impulses of our citizens seems somewhat drastic, since lives are hanging in the balance while usable organs go to waste.

178. *See supra* notes 151-54 and accompanying text.

179. On the other hand, many commentators argue that it is unfair for a society that allows desperate poverty to exist to preclude people from selling their organs to improve their financial situation. *See, e.g.*, Andrews, *supra* note 154, at 37.

3. Inequitable Allocation of Organs

The inequitable allocation of organs to recipients based on their ability to pay is again of most concern in an *inter vivos* sales and procurement system or futures market, where principles of supply and demand would determine prices. If a market-driven arrangement existed in live organs, for example, many people could easily be priced out of obtaining a life-saving kidney. Therefore, if implemented, the *inter vivos* system and futures market approaches would require extensive regulation to ensure that people of lesser means were not priced out of the organ market. The fair allocation of organs is not as much a concern in the death benefits system, because a token payment of $1000 to a decedent's family would add only a small sum to the price of an already expensive transplant.[180] Transplants in effect would be no less obtainable than they are currently. Further, if the death benefit were paid by UNOS,[181] the organ recipient would bear none of the cost. Thus, the death benefits system does not present the same problem of unfair allocation of organs based on the organ recipient's ability to pay as the other compensation systems.

4. Family Conflict

The potential for family conflict is of lesser concern in the death benefits system than in an *inter vivos* or a futures market. In a death benefits system, the very modest financial interest in a family member's organs would be realized only when a family member's organs were harvested.[182] In a futures market, on the other hand, a theoretical incentive would exist for murder or suicide because a financial interest in a family member's organs would appear when that family member

---

180. The estimated first-year cost of a heart transplant is $253,200 (in 1996 dollars); the estimated annual follow-up charge is $21,900. *See Estimated Charges for Organ & Tissue Transplantation* (visited Jan. 11, 1999) <http://www.unos.org/Patients/financ_costs.htm>. For a liver transplant, the estimated first-year cost is $314,500, and the estimated annual follow-up charge is $21,900. *See id.* For a kidney transplant, the estimated first-year charge is $116,100, and the estimated annual follow-up charge is $15,900. *See id.* For estimates of first-year costs and annual follow-up charges for pancreas, heart-lung, lung, and kidney-pancreas transplants, see *id.*

181. *See* Sten, *supra* note 70, at 217.

182. *See* Peters, *supra* note 137, at 1304.

makes an *inter vivos* contract to sell her cadaver organs. Perhaps most problematically, in an *inter vivos* sales and procurement system a person might feel pressured to sell a kidney, for example, in order to provide for family members.

5. Basic Morality

Specific ethical considerations aside, the basic morality of compensating organ providers is difficult to address. Many people feel that the buying and selling of body parts is inherently wrong, regardless of a compensation system's structure or any increase in the availability of lifesaving organs.[183] On the other hand, allowing seriously ill people to suffer and die when transplantable organs could easily be made available is arguably abhorrent. Certainly, neither the *inter vivos* sales and procurement system, the futures market, nor the death benefits system definitively settles the overriding question of the morality of allowing people to be paid for their organs or the organs of their loved ones. In terms of the specific ethical concerns discussed above, however, the death benefits system remains the most promising.

B. Practical Considerations

While the ethical considerations discussed above present thorny and much-debated issues, the practical objections to compensating organ providers can be overcome fairly easily in all three systems discussed in this comment.

1. Wasted Compensation for Unusable Organs

In an *inter vivos* sales and procurement system, the organ broker could avoid wasting compensation on unusable organs by conducting extensive tests on an organ provider before her kidney (or other non-vital organ) was harvested, thus ensuring that the organ would be viable for transplantation. The organ buyer in a futures market could avoid compensation for organs that are not suitable for transplantation by contracting to buy cadaver organs during a person's lifetime but reserving payment until the person died and the organs were determined to

183. *See supra* note 9 and accompanying text.

be transplantable.[184] In the death benefits system, payment would not be offered to family members unless the decedent's organs were determined to be transplantable; therefore, compensation for unusable organs would not be an issue. Thus, wasting payment on untransplantable organs would not be an insurmountable problem in any of these systems.

2. Matching Between Provider and Recipient

Moreover, matching an organ to a recipient would be feasible under any of the three systems of compensation. In an *inter vivos* system, the organ broker would have an incentive only to arrange for the harvesting of organs for which a buyer—a matching recipient or an entity that knew of a matching recipient—existed. In a futures market, the entity acting as an organ buyer presumably would not pay for organs unless a matching recipient for the organ existed. Similarly, in a death benefits system, hospital personnel presumably would not offer the death benefit to the family of the decedent unless the organs were suitable for transplantation.[185] Thus, matching organs to recipients would not be a problem in any of the three systems.

3. Poor Quality of Organs

Low quality of organs could be addressed in all three compensation systems. The problem could be avoided in the *inter vivos* system and futures market with a regulatory structure that would ensure extensive testing of cadaver and live organs and prohibit the sale of low-quality organs to recipients.[186] Harvesting low-quality organs is not a concern in a death benefits system: if the offer of compensation were not made to a de-

---

184. Professor Crespi endorses such an approach. *See* Crespi, *supra* note 8, at 35.

185. The death benefits by Dr. Peters would operate in tandem with the existing organ procurement system. *See* Peters, *supra* note 137, at 1304. The problem of matching provided organs with recipients would present no greater problem in Sten's death benefits system, therefore, than it does in the present system.

186. *See* McDonald, *supra* note 104, at 182 (expressing concern that any market system for human organs would require considerable and unwanted governmental regulation to ensure that people with limited means to compete in such a market did not end up with low-quality organs).

cedent's family until a doctor determined that the decedent's organs were transplantable, no incentive would exist to sell or buy substandard organs. Therefore, ensuring high quality of harvested organs is possible in each of these systems.

4. Abuse of the System

Despite what critics of compensation contend, people could sell their organs more than once only in the futures market system. Such abuse would not occur in the *inter vivos* system because, presumably, the buyer of a "live" organ would not pay the organ bearer until immediately before or after the organ was harvested. In a futures market, where people could sell their cadaver organs more than once, the problem could be solved by establishing a centralized information bank of participants in the futures market[187] and allowing the recipient to pay an organ provider's family or estate only after the organ provider's death.[188] This approach would lessen an organ bearer's ability and incentive to cheat the system. The death benefits system also eliminates the concern of people selling their organs more than once: because payment for organs is offered only at death,[189] no risk exists of an organ bearer selling the same organ twice. Thus, the possibility of abuse could be fairly easily overcome in the *inter vivos* sales and procurement system, the futures market, and the death benefits system.

CONCLUSION

Despite an organized organ procurement system and a theoretical willingness on the part of the public to donate their organs, America continues to suffer from a deficit of transplantable human organs. In response to the shortage of organs, legal scholars, doctors, and economists have proposed various systems of compensating organ providers in order to alleviate this shortage. These proposals, however, have encountered many ethical and practical objections.

---

187. Professor Crespi's proposal for a futures market provides for such a centralized registry of futures contract information. *See* Crespi, *supra* note 8, at 36.

188. *See id.* at 35.

189. *See supra* note 142 and accompanying text.

Despite critics' objections, the *inter vivos* sales and procurement system, the futures market, and the death benefits system all can withstand the practical concerns raised by opponents of compensating organ providers. The problems of harvesting untransplantable organs, matching organs to recipients, maintaining an acceptable quality of organs, and the potential for abuse of the system are valid concerns, but they can be overcome in all three of the systems discussed in this comment.

The ethical objections to compensating organ donors, however, present more complex issues; in this arena, the *inter vivos* sales and procurement system and the futures market do not measure up as well as the death benefits system. A death benefits system is less likely than the other two compensation systems to result in decreased altruistic donations, coercion of the poor, unfair allocation of organs to recipients, or family conflict. A death benefits system administered by UNOS and offering families a nominal sum of money in exchange for the organs of a loved one could provide for greater availability of transplantable organs through a practical and efficient framework, without compromising ethical considerations. Thus, a death benefits system is a promising candidate for improving America's current system of organ procurement.