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You Get What You Pay For?: Rethinking U.S. Organ Procurement Policy in Light of Foreign Models

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You Get What You Pay For?: Rethinking U.S. Organ Procurement Policy in Light of Foreign Models

ABSTRACT

The U.S. organ transplant system is in crisis due to the paucity of transplantable organs. Such a shortage exists because otherwise viable organs are too often buried along with the bodies in which they reside. Organs are wasted because the existing U.S. organ transplant system sets up barriers to organ donation—chiefly the legal presumption of unwillingness to donate (“voluntary donation”) and the National Organ Transplant Act’s ban on the transfer of organs for valuable consideration. This Note surveys the qualified successes of Austria, Belgium, Brazil, and France with their various “presumed consent” models of organ procurement. It also considers other proposals, including monetary and non-monetary incentives for organ donation. In light of the limitations of these proposals, this Note concludes with two recommendations: (1) the creation of a trial program of regulated open markets for cadaveric organs in one or several states; and (2) the implementation of a national donor registry with a system of priority based on willingness to donate. These measures would best address the organ shortage within the existing U.S. legal and ethical framework.

TABLE OF CONTENTS

I.	INTRODUCTION.....	353
II.	BACKGROUND: U.S. ORGAN DONATION LAW AND ITS CONSEQUENCES.....	354
	A. <i>The UAGA</i>	355
	B. <i>NOTA</i>	355
	C. <i>Voluntary Donation</i>	357
	D. <i>Presumed Consent in the U.S.</i>	359
	E. <i>Obstacles to Reform</i>	359
	F. <i>Consequences</i>	362
III.	ALTERNATE APPROACHES TO ORGAN PROCUREMENT OUTSIDE THE UNITED STATES.....	363
	A. <i>Presumed Consent</i>	363
	1. France	363
	2. Belgium.....	364
	3. Austria	364
	4. Summation of European Presumed Consent	365
	5. Brazil	365
	B. <i>Presumed Consent with No Opt-out</i>	366
	C. <i>Other Non-Monetary Incentives</i>	367
	1. Priority Based on Willingness to Donate ...	367
	2. Paired Organ Exchanges	369
	3. National Donor Registry.....	370
	D. <i>Monetary Incentives</i>	371
	1. Tax Breaks	371
	2. Futures Markets	372
	3. Discounted Driver's License Fees	373
	4. Reimbursement of Donors' Medical and Burial Expenses	375
	E. Proposals.....	376
	1. A Regulated Open Market.....	376
	2. A National Donor Registry & Priority Based on Willingness to Donate.....	379
IV.	CONCLUSION.....	379

I. INTRODUCTION

*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

In the United States, more than 100,000 people wait on the national organ transplant waiting list.² Of those, approximately 74,000 are waiting for a kidney, 17,000 for a liver, 2,700 for a heart, and 2,300 for a lung.³ The gap between the transplants needed and the transplants actually performed is daunting. Between January and August 2007, fewer than 20,000 organ transplants were performed in the U.S., from just 9,800 donors.⁴ Because of the difference between the numbers of transplants needed and performed, the waiting list is growing—by more than 10,000 in the last three years⁵ and roughly 5,000 per year on average.⁶ The waiting list continues to grow despite the fact that 18 United States citizens die each day while waiting for an organ.⁷

That the shortage exists not for a lack suitable organs, but for the fact that most suitable organs are buried with their original owners, renders the situation all the more regrettable—and

1. Shelby E. Robinson, *Organs for Sale? An Analysis of Proposed Systems for Compensating Organ Providers*, 70 U. COLO. L. REV. 1019, 1019 (1999) (citing Theodore Silver, *The Case for a Post-Mortem Organ Draft and a Proposed Model Organ Draft*, 68 B.U. L. REV. 681, 681 (1988)).

2. Organ Procurement and Transplantation Network, Data, <http://www.optn.org/data/> (last visited Dec. 24, 2008) [hereinafter OPTN Data]. The OPTN is the United States' national network linking the professionals involved in the donation and transplantation system. Organ Procurement and Transplantation Network, About OPTN, <http://www.optn.org/optn> (last visited Dec. 24, 2008). Congress established the OPTN under the National Organ Transplant Act (NOTA) of 1984. *Id.* The United Network for Organ Sharing (UNOS) administers the OPTN under the authority of the U.S. Department of Health and Human Services. *Id.*

3. OPTN Data, *supra* note 2.

4. *Id.*

5. Steve P. Calandrillo, *Cash for Kidneys? Utilizing Incentives to End America's Organ Shortage*, 13 GEO. MASON L. REV. 69, 72 (2004); *United Network for Organ Sharing, Report Identifies Transplant Trends for 2004*, Mar. 17, 2005, <http://www.unos.org/news/newsDetail.asp?id=411> ("The organ transplant waiting list saw an increase of 130 percent in the past decade from 35,751 patients at the end of 1994 to 82,885 at the end of 2003.").

6. REVISED UNIF. ANATOMICAL GIFT ACT Prefatory Note (2007), available at <http://www.anatomicalgiftact.org/DesktopDefault.aspx?tabindex=1&tabid=63>.

7. Donate Life Today—Understanding Donation, Statistics, <http://www.donatelifetoday.com/content/understanding-donation/statistics> (last visited Dec. 24, 2008).

correctable.⁸ Thousands of U.S. citizens die each year in ways that leave their organs intact and suitable for harvesting.⁹ The minority—twenty-five percent—who have volunteered for organ donation cannot nearly support the nation's transplant needs.¹⁰

This Note addresses the U.S. organ shortage by analyzing other nations' successes and failures with alternative organ procurement systems. Part II describes the current state of U.S. organ transplant law and the consequences of its failure to provide a sufficient supply of organs for transplant. Part III considers the experiences of other nations with alternative organ procurement systems, particularly "presumed consent" laws. It weighs the advantages and disadvantages of these systems and other proposals that would create incentives for organ donation and streamline the organ procurement process. Finally, Part III also proposes that the United States use a combination of these systems, establishing a regulated open market incorporating elements of organ futures markets and implementing a mandatory national donor registry with priority for recipients who are also registered as donors. Part IV offers a conclusion.

II. BACKGROUND: U.S. ORGAN DONATION LAW AND ITS CONSEQUENCES

Organ transplantation became a genuine medical option in the 1950s and 1960s. In 1954, surgeons performed the first successful kidney transplant, from Ronald Herrick to his twin brother Richard.¹¹ In the late 1960s, three more events led to modern transplant practice: the development of a set of neurological criteria for determining the occurrence of brain death, the first successful human heart transplant by Dr. Christian Barnard in 1967, and the development of immunosuppressive drugs to prevent organ recipients from rejecting transplanted organs.¹² The wide availability of organ transplants required the development of regulations governing organ donations in order both to provide legal mechanisms for organ transfer and to protect potential donors of cadaveric organs from exploitation.¹³ In 1968, shortly after the first successful heart transplant, the National Conference of Commissioners on Uniform State Laws (NCCUSL) drafted the Uniform Anatomical Gift Act

8. Calandrillo, *supra* note 5, at 73.

9. *Id.*

10. *Id.*

11. *See id.* at 76–77 (describing the first successful kidney transplant).

12. REVISED UNIF. ANATOMICAL GIFT ACT, *supra* note 6, Prefatory Note (describing the first successful heart transplant and the events giving rise to the UAGA).

13. *See Calandrillo, supra* note 5, at 77 (describing the lack of common law protection that corpses and organs suffered from).

(UAGA).¹⁴ Within a few years the UAGA had been adopted in every state.¹⁵

A. *The UAGA*

When organ transplants became feasible, common law or statutory property rights in human corpses or in the organs therein did not exist.¹⁶ The 1968 Uniform Anatomical Gift Act created a statutory property right to donate one's organs, eyes, and tissue.¹⁷ Under the original UAGA, donation could only occur if the decedent had expressed her wishes to donate and the next of kin gave her consent.¹⁸ The use of the word "gift" in the title of the UAGA was widely interpreted to outlaw human organ sales, which were not explicitly addressed in the Act.¹⁹ The 1987 revisions to the UAGA clarified its intent and attempted to encourage more widespread organ donation.²⁰ Among other changes, the 1987 revisions made organ sales explicitly illegal but did not prevent the payment of consideration for the performance of the transplant and its attendant services.²¹ Thus, they kept the door open for all but the organ donors to profit from the transplant process. The revised UAGA also protected the donor's intent to donate her organs upon death against an override by her next of kin.²² It required hospitals to discuss the option of organ donation with adult patients and with family members of the deceased and also authorized medical examiners to harvest organs if they could not locate the family members of the deceased.²³

B. *NOTA*

In 1984, three years before the UAGA revisions, and in response to a burgeoning movement toward increasing supply by permitting organ sales, Congress passed the National Organ Transplant Act (NOTA).²⁴ U.S. politicians were concerned about proposals like that of Dr. H. Barry Jacobs, who wanted to address the already apparent organ shortage by establishing an organ brokerage to facilitate domestic and international kidney sales.²⁵ NOTA rendered it

14. REVISED UNIF. ANATOMICAL GIFT ACT, *supra* note 6, Prefatory Note.

15. *Id.*

16. Calandrillo, *supra* note 5, at 77.

17. See REVISED UNIF. ANATOMICAL GIFT ACT, *supra* note 6, Prefatory Note (stating that the 1968 Act created a "right to donate organs, eyes and tissue").

18. Calandrillo, *supra* note 5, at 78.

19. *Id.*

20. *Id.*

21. *Id.* at 78–79.

22. *Id.* at 78.

23. *Id.* at 79.

24. *Id.* at 79–80.

25. *Id.*

“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.”²⁶ In a provision replicated in the UAGA’s 1987 revisions, NOTA permits “reasonable payments associated with the removal, transportation, implantation, processing, preservation, quality control, and storage of a human organ.”²⁷ NOTA reaches further than the 1987 UAGA in encouraging organ donation by permitting payments for “the expenses of travel, housing, and lost wages incurred by the donor of a human organ in connection with the donation of the organ.”²⁸ Allowing payment for transplant support services as an exception to the no-consideration rule has created a large and profitable industry in organ transplants.²⁹ Again, as under the UAGA, NOTA permits all persons involved in the organ transplant process to profit from it, except the donors.

Instead of permitting organ sales, NOTA sought to encourage organ procurement by creating the Organ Procurement and Transplantation Network (OPTN), a national system whose responsibilities include establishing a national organ waiting list, matching donors and recipients, allocating organs, controlling the quality of organ acquisition and transplantation, and collecting and publishing data concerning organ donation and transplants.³⁰ Regional organ procurement organizations (OPOs) work with the OPTN and directly with hospitals and transplant centers to identify and acquire usable organs, to define organ procurement and donation protocols, and to procure and arrange the delivery of organs when matches are made.³¹ OPOs are the current legislative tools for encouraging organ donations and controlling organ distribution.³²

Despite the attempts of the UAGA and NOTA to encourage organ donation, the numbers indicate that the current organ procurement system in the United States has failed to keep up with demand.³³ A large majority of U.S. citizens—as many as 81%—profess to support organ donation, but only one-quarter have actually registered as donors.³⁴ The myriad reasons for this discrepancy include a lack of immediate personal benefit to donors; fear of

26. National Organ Transplant Act (NOTA), 42 U.S.C. § 274e(a) (2006).

27. *Id.* § 274e(c)(2).

28. *Id.*

29. See Calandrillo, *supra* note 5, at 81 (“[E]ven though human organs are not for sale, everything else associated with their transplantation most definitely is.”).

30. 42 U.S.C. § 274(b)(2).

31. *Id.* § 273(b)(3).

32. Calandrillo, *supra* note 5, at 82; see also Fred H. Cate, *Human Organ Transplantation: The Role of Law*, 20 J. CORP. L. 69, 77 (1995) (“NOTA enshrined OPOs as the backbone of the organ procurement and distribution system.”).

33. Calandrillo, *supra* note 5, at 83.

34. *Id.*

confronting one's own or one's loved ones' mortality; the difficulty of persuading the bereaved to donate their loved ones' organs; a lack of public awareness of organ shortage; and the failure of doctors, hospitals, and family members to discover the deceased's intent to donate.³⁵ Some commentators have explicitly identified U.S. transplant law as the culprit of this discrepancy and of the consequent problem of organ shortage.³⁶ One legal failure is the lack of adequate incentives to donate.³⁷ Another legal failure concerns the fact that, despite U.S. citizens' professed support for organ donation, "the law presumes an unwillingness to donate," and then, even when a donor has expressed intent to donate, it de facto permits the donor's next of kin to override that intent by refusing to consent to the donation.³⁸

C. Voluntary Donation

The legal presumption of unwillingness to donate, which is the defining characteristic of an organ transplant regime often called "voluntary donation" (but perhaps more aptly described as "presumed nonconsent"), arises from the relevant portions of the UAGA, which require an affirmative act indicating intent to donate, either by the donor during her life or by the donor's agent or next of kin after her death.³⁹ UAGA Section 5 permits a donor wishing to make an anatomical gift to do so in one of five ways: by indicating that wish on a driver's license or identification card; by will; "by any form of communication addressed to at least two adults," including one disinterested witness, during the donor's terminal illness or injury; by signing a donor card or other record; or by "authorizing that a statement or symbol indicating that the donor has made an anatomical gift be included on a donor registry."⁴⁰ In fact, despite polls indicating overwhelming support for organ donation, less than a third of those who claimed they would be willing to donate reported completing donor cards, and many who complete the cards do not have them in their possession when they die.⁴¹ Intensifying the problem of the voluntary consent program is the fact that, as the

35. Phyllis Coleman, "Brother, Can You Spare a Liver?" *Five Ways to Increase Organ Donation*, 31 VAL. U. L. REV. 1, 6-9 (1996).

36. See, e.g., Cate, *supra* note 32, at 81 ("[T]he law largely impedes donation . . ."); Calandrillo, *supra* note 5, at 86 ("[T]he law banning human organ sales has the unintended and unfortunate consequence of restricting supply . . .").

37. Cate, *supra* note 32, at 81.

38. *Id.* at 81-82.

39. See generally REVISED UNIF. ANATOMICAL GIFT ACT, *supra* note 6, §§ 5, 9.

40. *Id.* § 5(a)-(b).

41. Cate, *supra* note 32, at 81-82.

program is commonly applied, signed donor cards are useless without the consent of a deceased donor's next of kin.⁴²

UAGA Section 9 permits a decedent's next of kin to make an anatomical gift of the decedent's body or a part thereof, even if the decedent did not express her donative intent while alive.⁴³ This means of obtaining consent, however, has proved ineffective, despite the fact that "required request" laws in many U.S. states mandate that hospital or organ procurement personnel ask a decedent's next of kin to consent to organ donation.⁴⁴ According to a 1990 study in New Jersey, for instance, a required request law "[did] not ha[ve] the desired effect of significantly adding to the supply of transplantable organs."⁴⁵ Despite the mandatory request, many families of potential donors are never asked for consent because hospital personnel often overlook potential donors, at a rate that has been estimated at thirty to forty-seven percent of medically suitable donors.⁴⁶ The same 1990 study found that some hospital personnel—alternately described as "[l]ack[ing] . . . a positive orientation towards organ donation" and "lacking a commitment to organ retrieval"—responsible for requesting consent to organ donation "have a lower success rate than those with a positive attitude towards donation" because they are relatively "[u]ninterested or uninformed."⁴⁷ Ultimately, regardless of how they are asked, a decedent's family often refuse to donate her transplantable organs.⁴⁸

Thus, the ability of a decedent's next of kin to consent to organ donation on behalf of the decedent, even when the law requires someone to request this consent, not only has limited benefits for the organ supply but actually itself further limits the organ supply. As one commentator has summarized the situation:

The law thus presumes that a person does not want to donate and then minimizes the likelihood that a donor's legally expressed desire to donate will be respected. Those laws that encourage transplantation, such as required request statutes, frequently receive inadequate

42. See *id.* at 82 ("[D]octors and hospitals fear professional criticism and legal liability if they procure organs against the wishes of the next-of-kin.").

43. See REVISED UNIF. ANATOMICAL GIFT ACT, *supra* note 6, § 9(a) (listing classes of people who can make an anatomical gift of a deceased's organs).

44. Cate, *supra* note 32, at 82.

45. Steven E. Ross et al., *Impact of a Required Request Law on Vital Organ Procurement*, 30 J. TRAUMA 820, 822 (1990).

46. Cate, *supra* note 32, at 82 (citing Ross et al., *supra* note 45).

47. See, e.g., Ross et al., *supra* note 45, at 822 (concluding that, among other remedies, "[a]dditional efforts to educate physicians regarding the need for organ donation . . . may do far more to enhance the donation of vital organs than mandatory request efforts.").

48. See *id.* (discussing a study showing that required request laws have not increased the procurement rate of organs at a trauma center).

resources to assure their implementation and little if any enforcement.

In short, the legal framework is stacked against donation.⁴⁹

Moreover, a shortage of available organs for transplant and its effects on the health of those on the national organ waiting list are not the only ill consequences of ineffective organ procurement laws.

D. Presumed Consent in the U.S.

Several U.S. states use a modified presumed consent system—like that of France—in limited circumstances. Under this system, the decedent's consent to donate organs and tissue is presumed after a "reasonable" or "diligent" search to determine whether the decedent objected to the donation while alive.⁵⁰ Usually this search requires giving the decedent's next of kin an opportunity to rebut the presumption of consent.⁵¹ Several states use this system to allow coroners to remove body parts from cadavers for research or transplant purposes.⁵² The removal of corneas for transplantation, for example, is governed by some form of presumed consent law in many states.⁵³ These laws typically permit removal of corneas from a cadaver during a legally required autopsy if there is a demonstrated need for the tissues and neither the decedent nor the next of kin is known to object.⁵⁴ Most of these laws have survived constitutional challenges based on due process and the Takings Clause.⁵⁵

E. Obstacles to Reform

There are several ways in which people's beliefs about organ transplantation hinder the effectiveness of current U.S. organ procurement policy and could also hinder efforts to reform that policy. The popular entertainment media, including books, movies, and television, tap into fears of organ snatching and "distort both facts and the capabilities of science and physiology."⁵⁶ Urban myths promote fear of an open organ market with stories about travelers waking in tubs of ice with their kidneys missing.⁵⁷ Historical accounts of English medical schools during the nineteenth century

49. Cate, *supra* note 32, at 83.

50. *Id.*

51. *Id.* at 84.

52. *Id.*

53. *Id.* Cate cites twenty-one such state laws. *Id.* Almost as many states have similar forms of presumed consent laws permitting the removal of pituitary glands. *Id.*

54. *Id.* Many states require the coroner or medical examiner to make a reasonable search for such an objection. *Id.*

55. Calandrillo, *supra* note 5, at 126.

56. Curtis E. Harris & Stephen P. Alcorn, *To Solve a Deadly Shortage: Economic Incentives for Human Organ Donation*, 16 ISSUES L. & MED. 213, 228 (2001) (citing such shows as *Walker, Texas Ranger* and *Law and Order*, and the book and movie *Coma*).

57. *Id.* at 228–29.

purchasing cadavers at high prices from body snatchers and murderers have also fueled this fear of an open organ market.⁵⁸ Whether justified or not, this fear inhibits people's willingness to give real consideration to organ procurement methods that involve incentives for providing transplantable organs.⁵⁹

Among other common misperceptions that also prevent people from embracing organ donation is the false perception that wealthy and famous people receive priority in the allocation of organs.⁶⁰ This perception is likely based in part on the news coverage that occurs whenever a celebrity receives an organ transplant.⁶¹

Arguably the most important sets of beliefs that affect organ transplant policy are deep-seated moral and ethical beliefs about the transfer of human organs. Lawmakers have been persuaded by these moral and ethical objections that "the risks of legalized markets [for organ sales] are too great to justify their benefits."⁶²

The morality argument is based on the "fundamental concern that the dignity of man would be debased if life, health or body parts were exchanged across a market."⁶³ Courts, legislatures, philosophers, and scholars have all argued that "the sanctity of the body is essential to human dignity and autonomy" and, therefore, that treating the human body "as a commodity to be bought and sold . . . would have a dangerous and dehumanizing impact on society."⁶⁴ According to one commentator, this "concern about the debasement of humanity" that underlies prohibitions on organ sales is "[t]he same concern . . . that has led to laws against selling one's life, freedom, children, or sexual services."⁶⁵ Another commentator describes the ban on human organ sales as one of "myriad examples in law where individual autonomy gives way to the state's morality interest," such as laws against "[d]rug use, prostitution, bigamy, and incest."⁶⁶

Another widespread concern about human organ sales is the fear that legalizing such transactions would have a perverse impact on organ distribution—that "disproportionately poor people, often minorities, would be persuaded or exploited into selling their kidneys

58. *Id.* at 229.

59. *See id.* at 228–29 (describing sinister urban legends and historical episodes related to illegal organ procurement).

60. 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, 787 (1996).

61. *Id.*

62. Calandrillo, *supra* note 5, at 91.

63. *Id.*

64. *Id.* at 91–92.

65. Robinson, *supra* note 1, at 1042.

66. Calandrillo, *supra* note 5, at 93.

simply to escape debt.”⁶⁷ At the same time, “[c]onversely, it would primarily be the wealthy who could afford to purchase them.”⁶⁸ Poor people might be “priced out of access to organs in compensation systems,” and “the organs to which they would have access might be of lesser quality.”⁶⁹ Thus, by this argument, critics of legalized organ markets could be justified on distributive justice grounds, if banning organ sales is necessary to “prevent poor people from becoming the only ‘sellers’ . . . [and to] provide both poor and wealthy individuals equal access to those organs being supplied—regardless of their ability to pay.”⁷⁰

Many critics allege that legalizing organ sales would discourage purely altruistic organ donations, offsetting (if not entirely then at least to some degree) the expected increase in organ supply produced by a compensation system.⁷¹ According to this theory, a compensation system would deter voluntary donors who are ethically opposed to receiving payment for transplantable organs.⁷² Moreover, altruistic organ donation may have a value independent of the organ procurement context per se, based on the potential for selfless donation to help bind society together.⁷³ By this argument, an organ procurement system that involves compensation and discourages altruistic donation might have other harmful effects on society.

Another ethical objection to legalized organ markets that is the concern “that sellers would lack sufficient information to properly weigh the consequences on themselves and society” when they decide to sell their organs.⁷⁴ Sellers might be unaware of the added health risks of living with one kidney rather than two.⁷⁵ They might suffer from “optimism bias,” under the influence of which they understand the risks but believe the risks will not come to fruition.⁷⁶ Thus, the pressures on sellers—poverty and natural tendencies to underestimate the risks involved and overestimate their ability to escape the risks—“seriously undermine[]” society’s confidence in the validity of sellers’ informed consent to organ sales.⁷⁷

67. *Id.*

68. *Id.*

69. Robinson, *supra* note 1, at 1041.

70. Calandrillo, *supra* note 5, at 93.

71. See, e.g., Robinson, *supra* note 1, at 1039 (discussing the negative effects of presumed consent laws on altruistic giving).

72. *Id.*

73. *Id.* at 1040 (citing RICHARD TITMUS, *THE GIFT RELATIONSHIP: FROM HUMAN BLOOD TO SOCIAL POLICY* 73 (1971)).

74. Calandrillo, *supra* note 5, at 94.

75. *Id.* at 94–95.

76. *Id.*

77. *Id.*

F. Consequences

U.S. organ procurement policy has consequences beyond a domestic organ shortage. A thriving global black market in human organs has resulted from U.S. policy banning organ sales.⁷⁸ While nearly all developed nations have banned the sale and purchase of human organs, many countries do not strictly enforce these laws.⁷⁹ The illegality of the organ trade is insufficient to discourage many of those faced with the possibility of dying on an organ waiting list, and “transplant tourism” has become its own industry.⁸⁰ In Bombay in 2001, nearly US\$10 million were exchanged for kidney transplants.⁸¹ Patients use kidney brokers to locate sellers, who circumvent a ban on kidney sales by signing an affidavit swearing that they are not being paid.⁸² Before the U.S. invaded Iraq in 2003, that country was known as “one of [the] world’s best black marketplaces for human organs.”⁸³ The lack of effective prosecution of these transactions extends beyond Asia and the Middle East to Europe, as recent cases in Estonia and Germany suggest.⁸⁴

U.S. doctors perform illegal transplants, too, often under hospitals’ “don’t ask, don’t tell” policy regarding transplants involving foreigners who claim to be related.⁸⁵ U.S. hospitals set their own rules for who can be a live organ donor, and organ brokers can locate hospitals that do not question a purported familial relationship between “donors” and “donees.”⁸⁶

The lack of a regulated organ marketplace in the U.S. has resulted in exploitation of the poor throughout the world.⁸⁷ Organ sellers often face debt, unemployment, and serious health problems; as such, they are easy targets for abuse.⁸⁸ Prisoners and the homeless are among those exploited.⁸⁹ Sellers of organs on the black market are often paid less than what they were initially promised, while their financial situations and health often grow worse after the transplants.⁹⁰ Data from the Indian black market trade in kidneys

78. *Id.* at 86.

79. *Id.* at 86–87.

80. *Id.* at 87.

81. *Id.* at 88.

82. *Id.*

83. *Id.*

84. *Id.*

85. *Id.*

86. *Id.*

87. *Id.* at 89; see also Alireza Bagheri, *Asia in the Spotlight of the International Organ Trade: Time to Take Action*, 2 *ASIAN J. WTO & INT’L HEALTH L. & POL’Y* 11, 13 (2007) (describing the “sad reality” of the international organ trade, including kidnapping and missing children).

88. See Calandrillo, *supra* note 5, at 89 (asserting that people in desperate situations are those who most often fall victim to predatory tactics).

89. *Id.*

90. *Id.* at 90.

support the concern about sellers' lack of adequate information about the risks involved. In one study, 86% of the sellers there reported that their health had "deteriorated substantially" after their organ sales, and "[f]our out of five sellers would not recommend that others follow their lead in selling organs."⁹¹ In short, U.S. policy and its ban on organ sales have produced some of the same immoral and unethical consequences the ban was designed to avoid.⁹²

III. ALTERNATE APPROACHES TO ORGAN PROCUREMENT OUTSIDE THE UNITED STATES

Part II of this Note leads to the conclusion that a reconsideration of U.S. policy on organ procurement and transplantation is in order. The U.S. can learn from other nations' experiences to guide the development of its transplant system. This Part of the Note will explore the successes and failures of alternative approaches to organ procurement outside the U.S. before proposing reforms for U.S. organ procurement policy.

A. *Presumed Consent*

Most European countries and several South American countries employ a "presumed consent" system of organ procurement.⁹³ A presumed consent system is built upon the presumption that a decedent has agreed to donate her organs upon death unless she has left written instructions to the contrary.⁹⁴ The voluntary consent and presumed consent models have alternatively been referred to as opt-in and opt-out systems, respectively.⁹⁵ Different countries have implemented different forms of presumed consent.⁹⁶

1. France

The French system of presumed consent permits the removal of organs "from the cadavers of persons who have not, during their lifetime, indicated their refusal to permit such a procedure," with

91. *Id.* at 95–96 (citing Madhav Goyal et al., *Economic and Health Consequences of Selling a Kidney in India*, 288 J. AM. MED. ASS'N 1589, 1591 (2003)).

92. *See id.* at 90 (discussing failure of the developed world's plans to increase organ donation).

93. *See* Harris & Alcorn, *supra* note 56, at 224–25 (describing presumed consent laws in France, Belgium, and Austria); Monique C. Gorsline & Rachelle L.K. Johnson, Note, *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, 21, 24 (1995) (citing similar presumed consent models in Chile, Argentina, and Brazil).

94. *Id.*

95. Calandrillo, *supra* note 5, at 124.

96. Harris & Alcorn, *supra* note 56, at 224–25.

exceptions for the cadavers of minors and the incompetent.⁹⁷ The French system requires a physician both to check a patient's medical record for a written refusal to donate and to make a "reasonable effort" to determine if such a refusal exists in writing elsewhere, usually by consulting the patient's family.⁹⁸ The "reasonable effort" provision has had the effect of pushing the French system toward voluntary consent controlled by the family, with French doctors usually resorting to the consent of the next of kin—or deferring to the next of kin's refusal of consent.⁹⁹ As a result, the French system, described by one commentator as "modified presumed consent," has not created the desired organ supply.¹⁰⁰

2. Belgium

The presumed consent program in Belgium is similar to the French modified presumed consent model. Belgium allows physicians to harvest organs without the consent of the decedent's family, but most Belgian doctors consult family members regardless and act in accordance with the family's wishes.¹⁰¹ The Belgian presumed consent law improved organ availability by 183% within three years, although it still fell short of satisfying the demand.¹⁰²

3. Austria

Austria's presumed consent law is most like a true presumed consent system. It differs from the models of France and Belgium in one key respect: the Austrian doctor need not look beyond the patient's medical records for evidence of a written refusal to donate.¹⁰³ Thus, the Austrian model is not hindered by deference to the wishes of the next of kin. As a result, Austria has had much more success in procuring organs, supplying kidneys twice as effectively as the United States and most European countries.¹⁰⁴ The Austrian system still suffers from a shortage of organs, however, and has not been as successful at procuring other organs as it has with kidneys.¹⁰⁵ Austria harvests livers at only a slightly higher rate—and actually harvests hearts at a lower rate—than France and Belgium.¹⁰⁶

97. *Id.* at 224.

98. *Id.*

99. *Id.*

100. *Id.*

101. *Id.*

102. *Id.*

103. *Id.* at 225.

104. *Id.*

105. *Id.*

106. *Id.*

4. Summation of European Presumed Consent

All three of these countries have higher rates of organ procurement under their different versions of presumed consent than the United States has under its voluntary donation system.¹⁰⁷ The data generally indicate that presumed consent policies are effective at increasing organ procurement rates from eligible donors.¹⁰⁸ However, presumed consent is not perfect. The French and Belgian systems illustrate the limited benefits achieved when presumed consent is legally or de facto subject to the decedent's family's wishes.¹⁰⁹ Moreover, opponents to presumed consent often cite moral and ethical concerns when arguing that the presumption in favor of donation violates the donor's personal autonomy.¹¹⁰ As the argument goes, when consent is presumed, there is greater potential for abuse or exploitation of disadvantaged groups who would be less likely to be aware of, and less likely to exercise, their right to opt out.¹¹¹ Finally, some commentators have expressed concern that presumed consent might discourage altruism.¹¹²

5. Brazil

Brazil's experiment with presumed consent illustrates the tension between the perceived benefits and drawbacks of the presumed consent model. Brazil moved from a voluntary donation system to a presumed consent system in 1998.¹¹³ In order to be exempted from the presumption of consent, a Brazilian needed to carry a Civil Identity Card or a Driver's License bearing the expression "non-donor of organs and tissues' . . . engraved in an indelible and inviolable manner."¹¹⁴ A subsequent amendment

107. *Id.*

108. Calandrillo, *supra* note 5, at 125.

109. Harris & Alcorn, *supra* note 56, at 225.

110. 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, 721 (1999) ("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.") (quoting Calandrillo, *supra* note 5, at 125); Everton Nunes da Silva et al., *The Impact of Presumed Consent Law on Organ Donation: An Empirical Analysis from Quantile Regression for Longitudinal Data*, Proceedings of the 35th Brazilian Economics Meeting, 2007, at 1, available at <http://ideas.repec.org/p/anp/en2007/047.html>.

111. See generally Harris & Alcorn, *supra* note 56, at 225 (noting that presumed consent laws may disproportionately burden vulnerable groups, particularly the poor and uninformed).

112. *Id.* at 225.

113. Bailey, *supra* note 110, at 708 (citing Lei No. 9.434, de 4 de fevereiro de 1997, D.O.U. de 05.02.1997 (Brazil)).

114. *Id.* at 708 n.4 (citing Lei No. 9.434, Ch. II, art. 4, § 1).

allowed family members to opt out on behalf of decedents who did not themselves opt out.¹¹⁵ After three years, however, Brazil abandoned the presumed consent system.¹¹⁶ One study described the main problems with the Brazilian experiment as follows:

- i) lack of ample discussion about organ donation, especially about the concept of brain death, which had caused fear in some of the population that organs would be removed before they were clinically dead;
- ii) hesitation of surgeons to remove organs without family authorization;
- iii) as most poor Brazilians do not have personal identification (ID or driver license), it meant they had no way of objecting to donation while alive.¹¹⁷

The failure of presumed consent in Brazil illuminates the system's limits: any model of presumed consent must at least include checks on the presumption in order to protect those who might be systematically prevented from making the decision to opt out, i.e., those whose particular circumstances (e.g., poverty or mental illness) make it unreasonable to presume consent—that they recognized their opportunity to object and understood the consequences of their failure to exercise that opportunity.

B. *Presumed Consent with No Opt-out*

Only a few countries employ a presumed voluntary consent regime without the opportunity for the donor or the donor's family to opt out of the "donation."¹¹⁸ Proponents justify this nationalization of cadavers by considering harvestable organs a national resource.¹¹⁹ As an extreme form of presumed consent, the nationalization of cadavers creates some of the same problems that critics associate with presumed consent procurement systems. Nationalization particularly implicates concerns about the ethics and morality of denying people's right to control their own bodies.

Unscrupulous states extend nationalization of cadavers to take advantage of state control over executed prisoners' bodies to remove their organs.¹²⁰ China and Serbia have both been alleged to harvest executed prisoners' organs, China at a rate of two to three thousand organ removals per year.¹²¹ Under Chinese law, an executed prisoner's organs may only be removed if the prisoner's body is not claimed, if the prisoner has consented, or if the prisoner's family has consented.¹²² Evidence suggests, however, that executions may be

115. *Id.* at 726.

116. Nunes da Silva et al., *supra* note 110, at 6.

117. *Id.* at 7.

118. Harris & Alcorn, *supra* note 56, at 225.

119. *Id.*

120. *Id.*

121. *Id.* at 225–26.

122. *Id.* at 226.

scheduled around transplants and carried out in a way that keeps the donor alive until the organ is removed.¹²³

While nationalization serves as a useful example of an extreme system, this Note does not give it serious consideration as a means of addressing the organ shortage in the United States and abroad. At the very least, nationalization may be assumed to be both politically unpalatable and, in the case of prisoners, a violation of the Eighth Amendment prohibition against cruel and unusual punishment.¹²⁴

C. Other Non-Monetary Incentives

In addition to presumed consent, a number of policy changes could encourage private decisions to donate organs without money changing hands. In varying degrees these measures would increase the transplantable organ supply, thereby saving thousands of lives, and avoid implicating the anti-compensation principles of NOTA and UAGA.

1. Priority Based on Willingness to Donate

One proposal to encourage organ donation is to give priority to people on transplant waiting lists who have agreed to donate their own organs upon death. The nonprofit organization LifeSharers has created a network of willing donors based on this idea.¹²⁵ Members of LifeSharers sign and carry donor cards indicating their intent to make an anatomical gift, of any needed organ, effective upon death.¹²⁶ The card indicates the donor's preference that his organs be donated first to the LifeSharers member who is the most suitable match, unless no member is a suitable match.¹²⁷ LifeSharers members retain the right to donate organs to family members.¹²⁸ In return, of course, LifeSharers members receive the promise that they will receive the same preferential access to donor organs.¹²⁹ LifeSharers discourages people from joining only when they discover

123. *Id.*

124. *Id.*

Such a practice is both a perversion of any existing organ donor method and a probable violation of the Eighth Amendment. Further, the number of prisoners executed in the United States falls far short of the numbers necessary to make any meaningful difference in the shortage of vital organs.

Id.

125. See Calandrillo, *supra* note 5, at 119 (describing LifeSharers); see also LifeSharers, <http://www.lifesharers.com> (last visited Dec. 24, 2008).

126. LifeSharers, How LifeSharers Works, <http://www.lifesharers.com/howitworks.htm> (last visited Dec. 24, 2008).

127. *Id.*

128. *Id.*

129. *Id.*

that they need an organ by imposing a 180-day waiting period between joining the organization and receiving preferred access to members' organs.¹³⁰

Prioritization based on willingness to donate is appealing based on an intuitive sense of fairness but also because, without the use of financial compensation, it creates a strong incentive to donate based on a person's naturally self-interested desire to increase his own chances of finding a suitable organ.¹³¹ However, while the LifeSharers program is promising, its benefits are also limited. The organization has just 10,500 members, and it has not yet had a member die in circumstances that permitted recovery of his organs.¹³² The low enrollment has led to one critique that, with too few people enrolled to constitute a reliable supply of organs, LifeSharers gives its members the false hope that membership will actually benefit them.¹³³ Critics of offering priority to recipients based on their willingness to donate also cite the possibility of discrimination in organ allocation against people who cannot themselves donate for religious or cultural reasons and against those who are not organ donors but have demonstrated altruism in other ways.¹³⁴

In response to the first criticism, the false hope problem can be corrected by enrolling more participants in the donor-priority system. With respect to the second criticism, opting in to the program might be better perceived as a social contract rather than an indicator of moral worth (which is not, incidentally, a consideration in the current voluntary donation system).¹³⁵

UNOS has considered a similar program that would award donors points toward increasing their own likelihood of receiving an organ.¹³⁶ If UNOS were to implement such a program nationwide, it could presumably generate wider participation, perhaps even enough to constitute a reliable supply of organs to meet to organ demand of its participants.¹³⁷

130. LifeSharers, Frequently Asked Questions, <http://www.lifesharers.com/faq.asp> (last visited Dec. 24, 2008).

131. Calandrillo, *supra* note 5, at 119.

132. LifeSharers, Frequently Asked Questions, *supra* note 130.

133. Calandrillo, *supra* note 5, at 121.

134. *Id.* at 120-21; United Network for Organ Sharing Ethics Comm., OPTN, Preferred Status for Organ Donors (1993), available at <http://www.optn.org/resources/bioethics.asp?index=6>.

135. United Network for Organ Sharing Ethics Comm., *supra* note 134.

136. *Id.*

137. *Id.*

2. Paired Organ Exchanges

Paired organ exchanges involve linking willing donors and needy recipients in a quid pro quo. Essentially this constitutes a more immediate form of the donor-priority system described above.¹³⁸ Suppose Person *A* needs an organ that a family member would gladly donate, but the family member is not a match for *A*'s blood and tissue type.¹³⁹ Then suppose Person *B* needs the same organ, and *B* has a family member who would gladly donate but is not a match for *B*'s blood and tissue type.¹⁴⁰ Finally, suppose *A*'s family member is a match for *B* and *B*'s family member is a match for *A*.¹⁴¹ If *A* and *B* and their families have no way of connecting with each other, then *A* and *B* are stuck on the waiting list while their relatives are sitting on otherwise useful and transplantable organs.¹⁴² A paired organ exchange system would facilitate a transaction between *A* and *B* and their relatives, effectively moving *A* and *B* to the top of the waiting list in order to generate donations that would not otherwise occur. *A* and *B* benefit from such an exchange.

Like the donor-priority system, this paired exchange seems intuitively fair. It also creates incentives for people to donate when they otherwise might not, again, motivated by a form of self-interest.¹⁴³ It avoids the payment of consideration for human organs that gives rise to numerous other moral and ethical concerns.¹⁴⁴ This combination of advantages and minimal, if any, disadvantages has attracted some support for paired organ exchanges.

MatchingDonors.com, a paired organ exchange, involves adding information about willing donors associated with each patient in need of a transplant to the existing national database of patients waiting for organs.¹⁴⁵ Adding information to the national database could identify cross-matches effectively to create new donors and enable transplants that would not otherwise happen.¹⁴⁶ The website is a private version of a paired-exchange system that provides an online venue for patients and donors to meet and communicate, in exchange for a fee.¹⁴⁷

138. Calandrillo, *supra* note 5, at 121–22.

139. *Id.* at 122.

140. *Id.*

141. *Id.*

142. *See id.* (“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.”).

143. *Id.*

144. *Id.*

145. *Id.* at 122–23.

146. *Id.* at 122.

147. *Id.* at 123; MatchingDonors, <http://matchingdonors.com> (last visited Dec. 24, 2008).

A group of physicians at Massachusetts General Hospital and Johns Hopkins have also created a paired exchange market.¹⁴⁸ Their market is based solely on the availability of suitable organs and requires no fee from participants beyond their (or their insurers') payment for the procedures.¹⁴⁹ These physicians have successfully coordinated transplant centers in performing two- and even three-way organ exchanges.¹⁵⁰

3. National Donor Registry

Although UNOS maintains a national organ waiting list containing nearly 100,000 names, "no cohesive counterpart exists that tracks willing organ donors."¹⁵¹ Phyllis Coleman has argued for establishing a national registry of donors and developing detailed procedures for checking this registry.¹⁵² Because accident victims and other potential organ donors might not be carrying their donor cards, or their cards might not be located in time to harvest their organs, a national computerized registry could provide the information to determine whether useful organs might be saved, including the potential donor's consent to donate, the donor's blood type, and whether the donor had a living will.¹⁵³

The usefulness of such a registry depends upon the procedures in place for checking the registry.¹⁵⁴ Health care professionals, police officers, and emergency medical personnel should verify a potential donor's status immediately, whenever the circumstances are appropriate.¹⁵⁵ Further, a national donor registry would promote paired organ exchanges like those discussed above and would reach more potential donors than private organizations that provide this type of service.¹⁵⁶ The benefits of the national registry, however, would be largely limited by its dependence on existing incentives for potential donors to opt in to the registry. The national donor registry, therefore, promises to minimize the number of willing donors who slip through the procurement cracks but, for maximum effectiveness, should be employed along with other policies designed to create incentives for organ donation.

148. Calandrillo, *supra* note 5, at 123 (citing David Wessel, *Easing the Kidney Shortage*, WALL ST. J., June 17, 2004, at B1).

149. *Id.*

150. Wessel, *supra* note 148, at B1.

151. Calandrillo, *supra* note 5, at 128.

152. Coleman, *supra* note 35, at 39.

153. *Id.*

154. *Id.*

155. *Id.*

156. Calandrillo, *supra* note 5, at 128.

D. Monetary Incentives

1. Tax Breaks

State governments in the United States have experimented with tax deductions to encourage their citizens to donate their organs.¹⁵⁷ A 2004 Wisconsin law, for instance, created a tax deduction of up to \$10,000 for expenses resulting from organ donation, including travel, lodging, and lost wages.¹⁵⁸ Indiana and Kansas have considered similar legislation.¹⁵⁹ Outside the U.S., “countries like Great Britain have also weighed the impact of tax breaks as a partial solution to alleviate growing organ shortages.”¹⁶⁰ A proposed law in Israel would reimburse donors for costs resulting from their decision to donate organs, like the Wisconsin tax deduction.¹⁶¹

Critics note that tax deductions for organ donors are a “direct monetary incentive” that violates NOTA’s prohibition on exchanging valuable consideration for human organs.¹⁶² Other criticisms of tax deductions for organ donors are that they work only in states with an income tax and that they are regressive—they benefit wealthy individuals in higher tax brackets more than poorer people in lower tax brackets.¹⁶³ Steve Calandrillo suggests that “[t]his inequity could be remedied by provision of a tax credit regardless of income instead of a tax deduction.”¹⁶⁴ Another benefit, however, is that tax incentives inducing the rich to become organ donors have the benefit of not putting undue market pressure on the poor to sell their organs, a common critique of proposed organ procurement systems involving financial incentives for donation.¹⁶⁵

Assuming tax breaks for organ donors do not violate U.S. law, they could provide a valuable financial incentive to increase organ donation while arguably avoiding the dilemmas of direct compensation.¹⁶⁶ If successful, state-based efforts at creating tax breaks for organ donors could also be expanded to create incentives for donation after death.¹⁶⁷ Success at the state level should lead to a

157. *Id.* at 111.

158. *Id.*

159. *Id.* at 112.

160. *Id.*

161. *Id.*

162. *Id.* at 111; see also Coleman, *supra* note 35, at 17 (“[S]ome commentators object to any type of payment, arguing that operations should only be for therapeutic purposes, not to make money . . .”).

163. Calandrillo, *supra* note 5, at 112.

164. *Id.* at 112–13.

165. Coleman, *supra* note 35, at 17.

166. Calandrillo, *supra* note 5, at 112.

167. *Id.* at 113.

uniform federal tax credit in order to distribute the benefits of the system as widely as possible.¹⁶⁸

2. Futures Markets

A futures market in transplantable organs is a more radical financial incentive some have proposed to increase the organ supply.¹⁶⁹ Beyond increasing organ supply, the futures market has the additional advantage of discouraging the economic exploitation of the poor that occurs in an open organ market.¹⁷⁰ In a straightforward version of the futures market proposed by scholars Lloyd Cohen and Gregory Crespi, individuals could sell the right to harvest their organs upon death—a futures contract.¹⁷¹ In return, if their organs were subsequently taken, a beneficiary designated by the donor at the time he executed the contract would receive the contractual payment.¹⁷² In theory, poor organ sellers would not be exploited because living donor transactions would still be prohibited—their consent would not be motivated by economics, and they would not risk their health by entering such a contract.¹⁷³ Moreover, equal access to the organ supply for poor organ recipients, despite income differences, could be maintained using the futures market as a supply mechanism but not an allocation mechanism.¹⁷⁴ In other words, the system could be devised so that potential recipients would not be responsible for making the payments.¹⁷⁵

Prohibiting live donor transactions may not adequately protect the poor.¹⁷⁶ Even payments after death can coerce a poor person through his concern about how his family will survive after his death and lead to donation based on financial motives rather than altruism—whether the pressure of monetary incentives is internal to the poor seller or externally applied.¹⁷⁷ This may not be a tradeoff inherent in the futures market system, however. Henry Hansmann has proposed another form of futures market that alters the timing and type of payment from the more straightforward model just described.¹⁷⁸

168. *Id.*

169. *Id.* at 108.

170. *Id.*

171. *Id.*

172. *Id.*

173. *Id.*; see also Coleman, *supra* note 35, at 16.

174. Calandrillo, *supra* note 5, at 108–09.

175. See Robinson, *supra* note 1, at 1037 (“The organ buyer might be a governmental agency, a single private entity, or competing government and private entities.”).

176. Coleman, *supra* note 35, at 16–17.

177. *Id.*

178. Calandrillo, *supra* note 5, at 109.

In return for a promise by the seller to donate his organs at death, Hansmann's proposal allows the seller to receive immediate compensation in the form of reduced health insurance premiums.¹⁷⁹ The seller would have the opportunity to reconsider his decision annually, electing either to opt in to the program and receive the insurance discount or to opt out and pay the full premium.¹⁸⁰ Hansmann's plan redirects concern about coerced consent from the seller's interest in his family's welfare after he is dead to the seller's immediate financial self-interest.¹⁸¹ Otherwise, it shares the advantages of the more straightforward futures market described above, with the added benefit of flexibility for the seller to reconsider his decision regularly. In fact, the lower level of commitment required to enter the futures market as a "seller" with the option to reconsider might encourage more potential donors to participate in the program than would otherwise participate in a one-shot contractual system. The problem remains, however, that such a financial incentive would likely run afoul of NOTA and UAGA prohibitions on exchange of transplant organs for consideration.

3. Discounted Driver's License Fees

Many U.S. citizens do not register as organ donors because they are indifferent, they are unaware of the opportunity to do so, or they do not stand to benefit (even altruistically) from the donation.¹⁸² Most states allow drivers to indicate their intent to be an organ donor on their driver's licenses.¹⁸³ One solution to the widespread failure to opt in is to offer drivers who indicate their intent to donate organs an immediate discount on their driver's license fees when applying or renewing their licenses.¹⁸⁴ In addition to creating a modest financial incentive for organ donation, states could implement the discounted driver's license fee system at minimal cost.¹⁸⁵ However, a discount

179. *Id.*

180. *Id.*

181. *Id.*; Coleman, *supra* note 35, at 16–17.

182. *See, e.g.,* Calandrillo, *supra* note 5, at 113 ("Most choose not to opt in, despite the fact that a large majority . . . actually support the idea of organ donation . . ."); Coleman, *supra* note 35, at 36–37 ("With rare exceptions, the person who donates his own organs will not even be alive to witness the benefit that recipients enjoy.")

183. Coleman, *supra* note 35, at 36.

184. *See supra* note 182 (suggesting potential challenges to this proposal).

185. *See* Coleman, *supra* note 35, at 38. Coleman suggests that states might raise fees for all applicants by \$1.50 and then offer a \$5 discount to donors without decreasing revenue. *Id.* The cost to the state could be further reduced by allowing altruistic individuals to return their discount to the program and even to contribute to a fund supporting the program. *Id.*; *see also* Calandrillo, *supra* note 5, at 114 ("[M]inor costs to the state . . . could even be offset by raising fees or taxes in other areas, if necessary . . .").

would raise some of the same concerns as tax breaks regarding the legality of exchanging organs for valuable consideration.¹⁸⁶ These concerns are at least mitigated when the discount is nominal, as it almost certainly would be.¹⁸⁷ Moreover, Calandrillo proposes that a discounted driver's license fee proposal could eliminate legal concerns about the payment of consideration for human organs by offering non-organ donors a tax credit in the same amount as the discount.¹⁸⁸ With donors and non-donors "in identical financial positions," organ donors would receive no greater valuable consideration than non-donors.¹⁸⁹

As Calandrillo acknowledges, characterizing his plan in this way invites a challenge based on whether it really creates incentives for organ donation.¹⁹⁰ His response to this challenge gives the lie to his assertion that the payment of a tax credit to non-donors "should suffice to remove any legal concerns."¹⁹¹ According to his argument, the difference in timing creates the incentive.¹⁹² People who are "relatively indifferent or mildly in favor of organ donation" will choose the "easier" option of the immediate fee waiver when renewing their licenses rather than waiting until April to receive the tax credit.¹⁹³ Contrary to Calandrillo's argument, it is not difficult to conceive of the added value of receiving the discount upfront as a valuable consideration received by the organ donors and not by the non-donors.

Moreover, apart from the issue of exploitation of poor donors, neither Calandrillo nor Coleman addresses the implications of this system on donor consent; rather, Calandrillo cites this system's manipulation of donor consent as an advantage:

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. . . . The moral of the story: simply requiring people to go to the trouble of filing for a tax credit to opt out will

186. Calandrillo, *supra* note 5, at 113.

187. It is unlikely that any discounted driver's license fee could approach the amount necessary to coerce the poor into trading organs for cash. *See* Coleman, *supra* note 35, at 38–39 ("For example, a \$5 discount is not sufficient to create the kind of incentive to exploit the poor that direct payment for organs might.").

188. Calandrillo, *supra* note 5, at 114. Calandrillo asserts that the only difference between the positions of donors and non-donors would be one of 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." *Id.*

189. *Id.*

190. *Id.*

191. *Id.* at 113–14.

192. *Id.* at 114.

193. *Id.*

encourage the great majority of Americans to opt in to organ donation up front.¹⁹⁴

Without some significant procedural safeguards in place at the time of the license application or renewal and fee discount, it is not difficult to predict that some donors and their families, after accepting the fee waiver, might change their minds and insist that they never really intended to consent to becoming organ donors.

4. Reimbursement of Donors' Medical and Burial Expenses

While hospitals, health care professionals, and organ transplant service providers profit from each organ donated, families of donors typically receive nothing.¹⁹⁵ In order to draw attention to this problem, several commentators have cited the tragic tale of Susan Sutton.¹⁹⁶ After a self-inflicted gunshot wound to the head left Ms. Sutton brain dead, her family donated her heart, liver, corneas, and some of her bones and skin for transplantation.¹⁹⁷ The hospital, medical personnel, and nonprofit transplant coordination agency involved made thousands of dollars, while the family buried what remained of Susan Sutton's body in an unmarked grave because they could not afford so much as a gravestone.¹⁹⁸ It seems fundamentally unfair to donors like Ms. Sutton and her family, but moreover it illustrates the room for a potential incentive to increase organ supply.

Shelby Robinson has proposed a "death benefits" system that would compensate organ providers through the payment of financial incentives to the deceased donor's family.¹⁹⁹ These incentives could include "estate tax deductions, funeral expense allowances, or college education benefits."²⁰⁰ Robinson also describes a death benefit system in which UNOS would offer a "token payment" of \$1,000 to families of organ providers—purportedly a small enough amount so as not to "contravene the spirit of altruism" and not to coerce grieving families.²⁰¹

Pennsylvania has made a move toward reimbursing donors for medical and burial expenses by establishing the Organ Donation Awareness Trust Fund.²⁰² Residents may make voluntary one-dollar contributions to the fund, which allocates roughly three hundred

194. *Id.* at 114–15.

195. *Id.* at 115.

196. *Id.* at 115; *see also* Coleman, *supra* note 35, at 16; Harris & Alcorn, *supra* note 56, at 85.

197. Calandrillo, *supra* note 5, at 195.

198. *Id.*

199. Robinson, *supra* note 1, at 1038.

200. *Id.* (citing Andrew C. McDonald, *Organ Donation: The Time Has Come to Refocus the Ethical Spotlight*, 8 STAN. L. & POL'Y REV. 177, 182 (1997)).

201. *Id.*

202. Calandrillo, *supra* note 5, at 116.

dollars per donor for offsetting donors' medical and funeral expenses.²⁰³ While such a program is a positive step, it does not approximate the actual expenditures incurred by donors. More states should consider providing some form of burial compensation to create an additional incentive to reward organ donors and their families.

E. Proposals

All the measures discussed above have various disadvantages. The presumed consent model has had only limited success in Europe and South America.²⁰⁴ Non-monetary incentives could immediately increase the organ supply at the margins by connecting would-be recipients with viable donors,²⁰⁵ and so a system incorporating a national donor registry with priority based on willingness to donate should be implemented promptly. However, such measures are unlikely to address the severe extent of the organ shortage²⁰⁶ and thus also unlikely to significantly reduce organ recipients' dependence on worldwide black markets.²⁰⁷ A radical shift in thinking about organ transplants, from a fundamentally altruistic model to an incentive-based model, is required in the long term. This Note argues that lawmakers should eschew such conservative incentives (with commensurately conservative benefits) as tax breaks, discounted fees, and reimbursement of medical and burial expenses, in favor of a regulated open market incorporating elements of the futures markets discussed in Part III.C.2.

1. A Regulated Open Market

Governmental regulation of the organ market would be essential to the success of such a radical reform.²⁰⁸ An unregulated market for the trade of human organs would likely create many of the problems feared by opponents of any kind of incentive-based organ procurement system, chief among them a sort of organ imperialism involving exploitation of the poor and an inequitable allocation of transplantable organs among the wealthy.²⁰⁹ Such a market could

203. *Id.*

204. *See supra* Part III.A.

205. *See supra* Part III.B.

206. *See supra* Part I.

207. *See supra* Part II.E.

208. Harris & Alcorn, *supra* note 56, at 233. Harris and Alcorn propose their own regulated posthumous organ market that addresses the major concerns of opponents of a donor market. *Id.* at 232.

209. *See supra* Part II.D.

drastically increase the transplantable organ supply while reducing the demand for black-market organs and the problems they entail.²¹⁰

It remains an empirical question whether a market approach to organ procurement will increase organ supply.²¹¹ However, another rationale, the “libertarian argument,” supports the use of economic incentives.²¹² James Blumstein has described this rationale as follows:

This position emphasizes respect for the autonomy of the donor (and the ability of the donor to choose), deemphasizes paternalism, and strengthens the hand of the individual rather than the family. Payment to “donate” allows a person to determine his or her own organs’ fate, respects the right of the buyer to contract, and recognizes the ability of the medically needy donee beneficiary to benefit from the transaction.²¹³

This understanding of incentives as enhancing a donor’s personal autonomy makes a regulated organ market more appealing on at least one level than the presumed consent system that downplays an individual’s decision-making ability.

The U.S. should permit states to experiment for a reasonable period of time with pilot programs creating regulated human organ markets. This would allow time to study the effects of these programs, with the eventual goal of implementing a nationwide program. The Harris and Alcorn plan for a posthumous organ market should serve as a starting point in designing such a pilot program.²¹⁴ Though a more ambitious system permitting transactions involving living donors might provide more value, this Note assumes that, at present, the moral and ethical objections to such a system would prevent it from being implemented, even on a trial basis.²¹⁵

In light of the UAGA and NOTA ban on exchanging valuable consideration for human organs, such a pilot program must begin with statutory authorization for an individual to dispose of his organs under a contractual agreement in return for compensation to be paid to the donor’s estate or to his designated beneficiary.²¹⁶ By cutting

210. See, e.g., Calandrillo, *supra* note 5, at 106 (proposing that “a thoughtful and responsible regulatory solution in America might be the best response” to thriving global black markets in human organs).

211. 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, 27 (Andrew Grubb & Maxwell J. Mehlman eds., 1995).

212. *Id.*

213. *Id.*

214. See *supra* note 208.

215. See Calandrillo, *supra* note 5, at 107 (conceding, despite apparent advantages, that “any form of legalized human organ market . . . would be political suicide to propose, entail significant administrative costs to establish and monitor, and remain morally distasteful to many Americans”).

216. Harris & Alcorn, *supra* note 56, at 232.

the donor out of the financial benefits, this plan would minimize the risk of a donor entering into a contract for quick cash.²¹⁷ It would also reduce the potential for exploitation of the poor, though a donor might still be motivated by an interest in providing for his family after his death.²¹⁸ The decedent should also be protected by prohibiting relatives from selling his organs without his express consent.²¹⁹ This could be achieved by including in the statutory authorization for this program an imposition of civil liability on relatives who exert pressure while the would-be seller is alive and criminal liability for relatives who attempt to sell organs without a decedent's express consent.

The plan should also address concerns about the influence of health care professionals pursuing transplantable organs against the medical interest of the donor.²²⁰ One way to protect donors from overzealous doctors would be to require that the physician who certifies a donor's death be independent of the decedent's family, of the potential recipient's family, and of any institutions with a stake in the transplant.²²¹ A regulatory authority responsible for administering the program could ensure independence along with statutorily imposing stiff civil and criminal penalties for violation of this independence.

The plan should eliminate concerns about inequitable organ allocation in an open market by limiting the experiment to the supply side of the market.²²² Waiting lists would continue to determine priority for organ recipients, with organ prices capped at a flat-per-organ donation rate or otherwise determined in advance according to a fee schedule, with an allowance for some market-driven price fluctuations.²²³ Moreover, inability to pay should not preclude a potential recipient from getting an organ. A governmental funding source, such as Medicare or Medicaid, might cover the cost of the organ. In the alternative, under the Harris and Alcorn plan, the Food and Drug Administration (FDA) would oversee the organ market.²²⁴ The FDA could support the cost of governmental oversight by charging licensing fees to private companies that would serve as organ brokerage houses.²²⁵ The FDA could also use a portion of the

217. *Id.*

218. *Id.*

219. *Id.*

220. Blumstein, *supra* note 211, at 38.

221. *Id.*

222. *Id.* at 39.

223. See Harris & Alcorn, *supra* note 56, at 233 (describing generally the governmental regulations necessary to prevent abuse of an organ market).

224. *Id.*

225. *Id.*

fees to fund transplant opportunities for the underinsured and uninsured.²²⁶

2. A National Donor Registry & Priority Based on Willingness to Donate

In addition to experimenting with a regulated open market for posthumous organ sales, the United States should immediately implement a national donor registry and a system of priority based on willingness to donate. As discussed above in Part III, Subparts B.1 and B.3, these proposals do not implicate the concerns about coercion, exploitation, and consent that most of the incentive-based proposals do. They are generally consistent with the altruism-based organ procurement system in place in the U.S. Nevertheless, they are likely to facilitate organ donations that might not otherwise take place.

IV. CONCLUSION

A staggering and unacceptable number of deaths occur each year in the U.S. alone when people on the national organ transplant waiting list run out of time. The vast majority of organs suitable for transplant are lost when their owners neglect to identify themselves as organ donors, despite the fact that most U.S. citizens profess their support for organ donation. The discrepancy stems from a lack of immediate personal benefit to donors, the difficulty of persuading the bereaved to donate their loved ones' organs, a lack of public awareness of organ shortage, and the failure of doctors, hospitals, and family members to discover the deceased's intent to donate.

Various organ procurement plans have been either proposed or implemented both in the United States and abroad in order to address the reasons for this discrepancy.

Presumed consent systems assume that a potential donor has consented to donate his organs, absent some evidence of intent to the contrary. As implemented in several counties, presumed consent systems vary based on what is necessary to show contrary intent and how far physicians are required to go in searching for evidence of contrary intent. Along with physicians' tendencies to attach too much weight to the next of kin's wishes, the opportunity to rebut the presumption renders presumed consent systems of limited effectiveness in increasing the organ supply. Presumed consent also creates doubts about donors' autonomy, the validity of their "consent," and exploitation of classes of people who might not be in a position to opt out.

226. *Id.*

Nationalization treats transplantable organs as a national resource, presuming the donor's consent to harvesting his organs without allowing him an opportunity to opt out. Nationalization raises grave concerns about donors' autonomy.

Priority based on willingness to donate gives preference to those on the national organ transplant waiting list who have volunteered to donate their own organs. While at odds with the altruism-based organ procurement system currently in place in the United States, this donor-priority system does not implicate the same moral and ethical dilemmas as do other systems.

Paired organ exchanges allow willing donors whose loved ones need transplants but who are not matches for those loved ones to connect with each other in order to arrange a swap.

A *national donor registry* would store information on all potential donors in order to facilitate identification of donors whose donor cards cannot be located and to capture transplantable organs that might otherwise slip through the cracks. Such a registry could also be used to facilitate paired organ exchanges.

Tax breaks offer direct financial incentives to organ donors to increase organ supply but might run afoul of the UAGA and NOTA prohibitions on the exchange of organs for valuable consideration.

Futures markets allow organ donors to enter into contracts to sell their cadaveric organs, either for immediate financial benefit or for the benefit of a designated beneficiary. Depending on how they are implemented, futures markets implicate concerns about coerced consent and exploitation of underprivileged donors.

Discounted driver's license fees offer a donor a waiver of some portion of his driver's license application or renewal fees in return for checking the "organ donor" box on his driver's license. The nominal amount of the incentive reduces, but does not eliminate, the concern about coercion.

Reimbursement of donors' medical and burial expenses at the very least provides donors' families with some form of posthumous compensation for their donations. Such reimbursement would create a limited incentive, probably with equally limited benefits for the organ supply.

Regulated open markets would allow the sale of organs with extensive government regulatory oversight in order to minimize the dangers of exploitation and coercion. By providing donor-sellers something closer to fair value for their organs, this option provides the best option for addressing the organ shortage. If done in the right way, taking precautions against abuse, it can also be a system consistent with many people's moral and ethical values, including most significantly the right to control one's own body.

This Note proposes that the states experiment with regulated open markets for cadaveric organs. Making payments only to a beneficiary or family member after the donor's death will limit the

exploitative and coercive effects of compensation for organs. Opening the market only on the supply side will help to ensure equitable allocation of organs regardless of ability to pay.

This Note further proposes the implementation of a national donor registry and a system of priority based on willingness to donate. These would facilitate purely altruistic donations and also self-interested transactions, but because they do not involve the payment of consideration, they do not raise the same moral and ethical concerns as the financial incentives.

With thousands dying on the organ transplant waiting list every year, it is time to reconsider U.S. organ procurement policy. Implementing this proposed mix of measures will address both supply and allocation issues while protecting the essential interests of the parties involved. In the absence of this or similar action, the continued failure to address seriously the national and global organ shortage will constitute a death sentence for thousands more.

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