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# A Matter of Priority: Transplanting Organs Preferentially to Registered Donors

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## A MATTER OF PRIORITY: TRANSPLANTING ORGANS PREFERENTIALLY TO REGISTERED DONORS

*Adam J. Kolber\**

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I. INTRODUCTION	

In June 2002, the policymaking body of the American Medical Association (AMA) took a dramatic step toward changing the foundational principles underlying our system of organ donation. Inviting substantial controversy, the AMA's House of Delegates voted to encourage research examining whether financial incentives should be used to increase organ donation.<sup>1</sup> Such incentives would hopefully ease the nation's "alarming shortage of donor organs."<sup>2</sup> While the new

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1. See AMA POLICY H-140.897 § 1, CADAVERIC ORGAN DONATION: ENCOURAGING THE STUDY OF MOTIVATION (June 18, 2002) (stating that in addition to promoting voluntary organ donation, "physicians should support innovative approaches to encourage organ donation" by supporting "and, if appropriate, participat[ing] in the conduct of ethically designed research studies of financial incentives"). The American Society of Transplant Surgeons and the United Network for Organ Sharing have also endorsed such studies. See Andis Robeznieks, *Feds Have Final Say on Organ Donor Initiatives*, AM. MED. NEWS, July 22, 2002, available at [http://www.ama-assn.org/sci-pubs/amnews/pick\\_02/prsc0722.htm](http://www.ama-assn.org/sci-pubs/amnews/pick_02/prsc0722.htm).

2. Press Release, Am. Med. Ass'n, AMA House Supports Studies on Organ Donation Incentives (July 18, 2002), at <http://journals.iranscience.net:800/Default/www.ama-assn.org/ama/pub/article/1616-6378.html>.

AMA policy encouraged the study of all kinds of donation incentive programs, the AMA's press release focused on financial incentives,<sup>3</sup> as did the national media.<sup>4</sup>

The fact that a mainstream organization like the AMA would even consider mixing money and body parts represents a radical shift in our willingness to seek innovative solutions to the organ shortage. The AMA and organ donation researchers have failed, however, to give adequate attention to an alternative donation incentive plan. In this Article, I propose to encourage organ donation by offering registered donors preferential access to the organ supply. This policy would motivate people to register and better recognize the contribution that registered donors make toward easing the organ shortage.

The idea of offering allocation priority as a means of encouraging donor registration has received surprisingly little attention.<sup>5</sup> Yet, such an incentive would lead many more people to become organ donors and would thereby increase the organ supply and the number of lives saved by transplant surgery. Even if we offer only a small priority incentive, the stakes are high enough that we might induce many more people to register. By contrast, according to a 1993 Gallup poll, about 80% of those surveyed stated that financial

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3. See *id.* ("Concerned with the alarming shortage of donor organs, the [AMA's] House of Delegate[s] voted today to encourage organ procurement agencies and transplant centers to study the use of financial incentives to increase organ donation.").

4. See, e.g., John M. Hubbell, *New Support for Rewarding Organ Donations*, S.F. CHRON., June 20, 2002, at A4; Bruce Japsen, *AMA: Study Paying for Organ Donation*, CHI. TRIB., June 19, 2002, at 1 ("Among the incentives the AMA debated included tax credits or payments of \$500 to \$1,000 toward funeral expenses incurred by the donor family.").

5. For some exceptions to the rule, see Rupert Jarvis, *Join the Club: A Modest Proposal to Increase Availability of Donor Organs*, in THE ETHICS OF ORGAN TRANSPLANTS 183 (Arthur L. Caplan & Daniel H. Coelho eds., 1998); J. Muyskens, *Should Receiving Depend Upon Willingness to Give?*, 24 TRANSPLANTATION PROC. 2181, 2181-84 (1992); David A. Peters, *A Unified Approach to Organ Donor Recruitment, Organ Procurement, and Distribution*, 3 J.L. & HEALTH 157-79 (1988-89); Richard Schwindt & Aidan Vining, *Proposal for a Mutual Insurance Pool for Transplant Organs*, 23 J. HEALTH POL., POL'Y & L. 725 (1998); JAMES F. BURDICK ET AL., *PREFERRED STATUS FOR ORGAN DONORS: A REPORT OF THE UNITED NETWORK FOR ORGAN SHARING ETHICS COMMITTEE* (June 20, 1993), available at <http://www.unos.org/resources/bioethics.asp?index=5> [hereinafter UNOS ETHICS COMMITTEE]. My proposal differs most notably from these others by describing how, at least conceptually, a priority allocation scheme can be made pareto superior to our current distribution scheme (see discussion *infra* Part IV) and by describing why we should not fear that priority incentives will reduce societal altruism or harmfully commodify the human body. See discussion *infra* Part V. I also comment on a recent private initiative to create priority incentives through the mutual agreement of a group of organ donors. See discussion *infra* Part IV.

incentives would have no effect on the likelihood that they would donate organs.<sup>6</sup> Only 12% said that financial incentives would make them more likely to donate, and as many as 5% said that financial incentives would make them less likely to donate.<sup>7</sup>

The Gallup poll did not explore respondents' views on priority incentives.<sup>8</sup> However, because priority incentives offer donors the possibility of increasing their life expectancy, they provide a strong motivation to donate. And, unlike financial incentives, priority incentives can be instituted without passing new legislation and without raising fears about turning human bodies into cash. Though these concerns are largely unfounded, they still represent a political obstacle to the implementation of financial incentives. Many also fear that financial incentives will have undesirable distributional effects based on wealth. By contrast, priority incentives would allow people at all levels of wealth to register for organ priority and provide wealthier people with neither a reduced burden to donate organs nor an increased opportunity to receive them.

While it may initially seem unsettling to give preference to some people over others in a life or death situation, current allocation policy already reflects a variety of non-medical, value-laden preferences.<sup>9</sup> Our choice is really to decide which set of preferences to give and how they should be weighed against each other. Accordingly, my fundamental goal is not to advocate a particular system of priority allocation but rather to defend the fundamental fairness of such allocations and argue that we should use some kind of non-altruistic incentive, probably priority-based but possibly financially-based, as a means to ameliorate the current organ shortage.

Traditionally, organ donation has been viewed as an act of altruism. One should register to donate, it is said, because doing so can save a life—an act which is a sufficient reward in itself.<sup>10</sup> For all its rhetorical grandeur, however, such thinking has failed to convince potential donors. From 1995 to 2000, the number of people waiting for bodily organs increased by 80%,<sup>11</sup> and there are currently over

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6. THE GALLUP ORGANIZATION, INC., *THE AMERICAN PUBLIC'S ATTITUDES TOWARD ORGAN DONATION AND TRANSPLANTATION* (Feb. 1993), at 43, *available at* [http://www.transweb.org/reference/articles/gallup\\_survey/gallup\\_index.html](http://www.transweb.org/reference/articles/gallup_survey/gallup_index.html). Given that pollsters did not mention the size of financial incentives, we should not be overly reliant on responses to this question.

7. *Id.*

8. *See id.*

9. *See infra* text accompanying notes 50-55.

10. *See infra* text accompanying notes 189-95.

11. U.S. DEP'T OF HEALTH AND HUMAN SERVICES, DIVISION OF TRANSPLANTATION, *GUIDELINES FOR DONOR REGISTRY DEVELOPMENT CONFERENCE: FINAL REPORT* (Aug.

82,000 people on waiting lists.<sup>12</sup> Each year in the United States, over six thousand of these people die waiting,<sup>13</sup> while thousands more suffer in great distress waiting for an organ to become available. Moreover, the number of deaths on waiting lists dramatically understates the severity of the shortage. Many are excluded from even entering a waiting list because they are considered too sick to receive an organ given that organs are in such short supply.<sup>14</sup> Similarly, due to the shortage, many patients on waiting lists are removed when they become too sick to receive a transplant.<sup>15</sup>

Behind the story of the organ shortage lurks the troubling fact that its severity is largely due to our own making. The shortage is traceable to policies and practices of health care personnel, to individuals and families who refuse to donate, and to our legal and regulatory regimes which fail to offer non-altruistic donation incentives. Even one unnecessary, preventable death is a tragedy. Yet, more than 6,000 people die each year on transplant waiting lists, while it is estimated that between 7,000 and 23,000 bodies that could have been used for transplantation are buried, cremated, or otherwise returned to dust.<sup>16</sup> If the life-sustaining organs from each

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2002), at iii, available at <http://www.organdonor.gov/execsum.htm>. During the same period, the number of cadaveric donors increased by less than 12%. *Id.*

12. UNITED NETWORK FOR ORGAN SHARING, ORGAN DONORS ARE HEROES, at <http://www.unos.org> (last visited Aug. 25, 2003).

13. Dave Wendler & Neal Dickert, *The Consent Process for Cadaveric Organ Procurement: How Does It Work? How Can It Be Improved?*, 285 J. AM. MED. ASS'N 329, 329 (2001) (noting that, in 1999, "6448 [people] had died while waiting for an organ"); THE ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK, ABOUT DONATION - THE CRITICAL SHORTAGE, at <http://www.optn.org/about/donation/criticalShortage.asp> (last visited Aug. 25, 2003) (indicating that 6,439 patients on organ waiting lists died in 2001).

14. It has been estimated that some 100,000 people in the United States may die each year before even being accepted to an organ waiting list. Frederick R. Parker, Jr. et al., *Organ Procurement and Tax Policy*, 2002 Hous. J. HEALTH L. & POL'Y 173, 174 (2002); see also WILLIAM J. CURRAN ET AL., *HEALTH CARE LAW AND ETHICS* 767-68 (1998) (noting that many patients are excluded from consideration for transplantation due to hepatitis B, HIV, certain cancers, and advanced heart or lung disease).

15. For example, in 2002, 1,868 people on the waiting list were removed when they became too sick to receive a transplant. UNITED NETWORK FOR ORGAN SHARING, WAITING LIST REMOVALS, REMOVAL REASONS BY YEAR, available at <http://www.optn.org/latestData/rptData.asp> (last visited Aug. 25, 2003). It is likely that many of these patients would not have become so sick had they received a transplant sooner.

16. DAVID L. KASERMAN & A.H. BARNETT, *THE U.S. ORGAN PROCUREMENT SYSTEM, A PRESCRIPTION FOR REFORM* 4 (2002). The authors note:

Of the 2 million or so deaths that occur in the United States each year, estimates indicate that somewhere between 13,000 and 29,000 occur under circumstances that would allow the organs of the deceased to be transplanted. Of those, only 5,843 (or 28 percent of the middle of the range of prior estimates) yielded organ donations in 1999.

of these eligible donors were offered to desperate people on waiting lists, we might eliminate all, or at least a substantial number, of the deaths in the U.S. which result from organ scarcity.<sup>17</sup> The good news is that the laws, policies, and practices that have exacerbated the organ shortage can be changed to increase the number of organs that are actually transplanted.

In Part II of this Article, I describe much of the law governing organ transplantation in the U.S., as well as the allocation policies which have been adopted to rank those on waiting lists. In Part III, I briefly discuss other proposals to increase organ donation and explore the nature of our moral obligations to donate and to respect the donation preferences of others.

Elements of these proposals are used in the formulation of the priority incentive plan that I advocate in Part IV. There, I give a high-level description of how priority incentives can be implemented under government oversight. I note that it is at least conceptually possible to structure such a program so that everyone's expected waiting time—whether one is a registered donor or not—is shorter than it is under the current system. If such a plan could be implemented, there would be little ground to object to the priority allocation vis-à-vis our current allocation. In addition, until we have a national priority incentive program, I argue that we can help overcome the bureaucratic inertia which perpetuates our current allocation system by implementing priority incentives through the mutual agreement of private groups of organ donors.

In Part V, I reveal what I take to be the stunning hypocrisy of our entrenched system of organ donation which, in the name of altruism, leads to unnecessary, preventable pain and death. To do so,

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*Id.* (citations omitted). The numbers in the text are generated by subtracting the approximately 6,000 bodies actually used in transplantation from these estimates of total bodies eligible for transplantation. Cf. U.S. DEP'T OF HEALTH AND HUMAN SERVS., OFFICE OF INSPECTOR GENERAL, VARIATION IN ORGAN DONATION AMONG TRANSPLANT CENTERS (May 2003), at 1, available at <http://oig.hhs.gov/oei/reports/oei-01-02-00210.pdf> (estimating "that 12,000 to 15,000 deaths annually could yield organs eligible for transplantation").

17. See KASERMAN & BARNETT, *supra* note 16 ("[T]he organ shortage is the product of a failed public policy, not of nature."); Leonard H. Bucklin, *Woe Unto Those Who Request Consent: Ethical and Legal Considerations in Rejecting a Deceased's Anatomical Gift Because There is No Consent By the Survivors*, 78 N. DAK. L. REV. 323, 324 (2002); Jarvis, *supra* note 5, at 183 ("The problem is not that there are insufficient numbers of organs potentially suitable for transplantation, but that these organs, far from being made available for transplant, are destroyed. . . ."). But cf. Arthur L. Caplan, *Is Xenografting Morally Wrong?*, in THE ETHICS OF ORGAN TRANSPLANTS 121, 123 (Arthur L. Caplan & Daniel H. Coelho eds., 1998) ("Even if drastic changes were made in existing public policies, other factors are working against the prospects for large increases in the human cadaver organ supply.").

I respond to two critiques of donation incentives.<sup>18</sup> The first critique says that one should donate organs principally for altruistic reasons and that the existence of non-altruistic incentives debases the altruistic nature of our current system. I argue that the current system is not nearly as altruistic as it is purported to be and that we cannot use altruism as a ground to defend the status quo when we know that the status quo leads to so much unnecessary suffering.

A second, related critique asserts that donation incentives inappropriately introduce market-style transactions into the transfer of human organs. Defenders of this position argue that human body parts are invested with special elements of personal identity that are debased when organs are traded like market commodities. Perhaps surprisingly, this criticism has been leveled at both financial and priority incentives. I argue that these concerns are weak as applied to either; however, they are particularly inapplicable to priority incentives because such incentives do not involve the kind of monetary exchange usually associated with market commodities.

The scope of my discussion is limited to cadaveric organ donation where organs are donated from the recently deceased to those still living.<sup>19</sup> By contrast, live organ donors provide an organ or part of an organ to another living person.<sup>20</sup> For example, one can donate a single kidney or part of a lung or liver to a friend, relative, or even a stranger. Such transplantations put donors at risk of complications from surgery and from living with reduced function in the organ systems from which they donate.<sup>21</sup> Given these risks, we cannot do much to encourage live donation simply by offering live donors priority in someday receiving an organ.<sup>22</sup> Under limited

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18. I follow the standard convention of referring to all organ transfers as "donations," even when organs are transferred for financial or in-kind compensation.

19. Virtually all cadaveric donors have been declared brain dead, although some physicians have developed protocols for declaring death in "non-heart-beating cadavers." Alexander M. Capron, *Reexamining Organ Transplantation*, 285 J. AM. MED. ASS'N 334, 335 (2001).

20. A third kind of transplantation, known as "xenotransplantation," transfers organs from animals, like apes and pigs, into humans. See Caplan, *supra* note 17, at 123; Traci J. Hoffman, *Organ Donor Laws in the U.S. and U.K.: The Need for Reform and the Promise of Xenotransplantation*, 10 IND. INT'L & COMP. L. REV. 339 (2000); Adam Kolber, Note, *Standing Upright: The Moral and Legal Standing of Humans and Other Apes*, 54 STAN. L. REV. 163, 193-95 (2001).

21. "Doctors estimate the risk of death to liver donors to be 10 to 20 in 10,000 compared with 3 in 10,000 for kidney donors." Denise Grady, *Healthy Give Organs to Dying, Raising Issue of Risk and Ethics*, N.Y. TIMES, June 24, 2001, at A1. Some estimates are even more severe. See, e.g., Mary Carmichael, *Risking Life to Give Life*, NEWSWEEK, Apr. 22, 2002, at 53 (stating that adult live liver transplantation "defies the doctor's cardinal rule to do no harm—new statistics show that 10 percent of donors will have complications, and 1 percent will die").

22. Interestingly, live kidney donors already receive some priority should they



circumstances, however, there are analogous forms of in-kind compensation that can be provided to live donors.<sup>23</sup> As a place to start, I focus on cadaveric donation incentives because most organs are transplanted from cadavers,<sup>24</sup> and some organs can *only* be transplanted from cadavers. In addition, cadaveric donation is less expensive than live donation,<sup>25</sup> poses no risk to donors (who are deceased at the time of donation), and raises fewer ethical concerns than does live donation.<sup>26</sup>

## II. THE CURRENT ORGAN PROCUREMENT AND ALLOCATION SYSTEM

This section outlines the laws and regulations that govern organ donation and allocation in the United States. Given that our formulas for organ allocation already include a variety of value-laden judgments about who should have priority access to organs, it takes no great leap in moral thinking to provide some priority to those who register to donate and, thereby, help to reduce the scarcity which leads to the need for allocation in the first place.

### A. *The Uniform Anatomical Gift Act*

By the mid-1960s, organ transplantation technology had made substantial strides,<sup>27</sup> and the National Conference of Commissioners

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someday need a cadaveric kidney. See UNITED NETWORK FOR ORGAN SHARING, POLICY 3.5.11.6: DONATION STATUS, available at [http://www.unos.org/PoliciesandBylaws/policies/pdfs/policy\\_7.pdf](http://www.unos.org/PoliciesandBylaws/policies/pdfs/policy_7.pdf) (last modified July 27, 2003). Live kidney donors, having undergone transplant surgery and having only one kidney left, are more likely to need a kidney transplant than the average person. Thus, even with priority, live kidney donors are worse off than they were before they donated. Priority for live kidney donors, at best, reduces the disincentive to donate but does not serve independently to encourage live donation.

23. For a discussion of paired organ exchanges, see *infra* text accompanying notes 139-41; ROBERT M. VEATCH, TRANSPLANTATION ETHICS 186-202 (2000); Michael T. Morley, Note, *Increasing the Supply of Organs for Transplantation Through Paired Organ Exchanges*, 21 YALE L. & POL'Y. REV. 221 (2003).

24. In terms of bodies, there are slightly more live donors than cadaveric donors. See Sarah Lueck, *The Gift of Life Is Mainly Coming from Life Itself*, WALL ST. J., Apr. 23, 2002, at D4. However, more transplanted organs come from cadaveric donors because each cadaver can provide lifesaving organs to several people.

25. See Andrew C. MacDonald, *Organ Donation: The Time Has Come to Refocus the Ethical Spotlight*, 8 STAN. L. & POL'Y REV. 177, 179 (1997) ("When a living donor is used, the costs of the transplant increase dramatically. Living donors spend up to a week in the hospital and require pain medication for up to a month after the surgery, in addition to follow-up visits to the physician's office.").

26. See Grady, *supra* note 21 ("Increasingly, surgeons are telling people who need transplants that their relatives, spouses and friends are potential organ donors," creating "pressures on families that did not exist before. In some cases people as young as 19 are being asked to act as liver donors for their parents.").

27. The first successful cadaveric kidney transplant occurred in the Soviet Union in 1936. Curtis E. Harris & Stephen P. Alcorn, *To Solve a Deadly Shortage: Economic*

on Uniform State Laws saw a need to remedy the difficulty under then-current law of making a binding premortem organ donation.<sup>28</sup> In 1968, the Conference approved the Uniform Anatomical Gift Act (UAGA), now adopted in some form by all fifty states.<sup>29</sup> Importantly, the UAGA gave competent adults the right to donate their bodies or bodily organs for use upon their death<sup>30</sup> and to do so, as indicated in a comment, "without subsequent veto by others."<sup>31</sup> It specified "the manner of making the gift, the rights and duties at death, and the immunity from civil or criminal liability of persons who acted in good faith in accord with the provisions of the act."<sup>32</sup> Prior to its creation, donation laws were "a confusing mixture of old common law dating back to the seventeenth century and state statutes that have been enacted from time to time."<sup>33</sup>

With the severity of organ scarcity increasing, the Conference approved an amended UAGA in 1987,<sup>34</sup> which has been adopted in whole or in part by twenty-four states.<sup>35</sup> The UAGA of 1987 gives explicit priority to the expressed intentions of donors over their relatives.<sup>36</sup> For example, it "adds an option (implicit but unexpressed in the 1968 UAGA)"<sup>37</sup> that one can choose not to have one's organs donated at death, even if one's family later desired to do so. The UAGA of 1987 was also noticeably different from its predecessor in that it echoed federal legislation passed in 1984 that prohibited commerce in bodily organs.<sup>38</sup>

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*Incentives for Human Organ Donation*, 16 ISSUES L. & MED. 213, 214 (2001). Two decades later, doctors in the United States successfully transplanted a kidney from a live donor. *Id.* Then, in 1967, doctors in South Africa successfully transplanted the first human heart. *Id.*

28. Capron, *supra* note 19, at 334.

29. UNIF. ANATOMICAL GIFT ACT (1968), Table of Jurisdictions Wherein Act Has Been Adopted, 8A U.L.A. 63 (1993 & Supp. 2002).

30. *Id.* § 2(a) ("Any individual of sound mind and 18 years of age or more may give all or any part of his body for any purpose specified [in the Act] . . .").

31. *Id.* § 2 cmts.

32. Robert E. Sullivan, *The Uniform Anatomical Gift Act*, in *ORGAN AND TISSUE DONATION: ETHICAL, LEGAL, AND POLICY ISSUES* 19, 22 (Bethany Spielman ed. 1996).

33. UNIF. ANATOMICAL GIFT ACT (1968), Prefatory Note.

34. UNIF. ANATOMICAL GIFT ACT (1987), Historical Note.

35. UNIF. ANATOMICAL GIFT ACT (1987), Table of Jurisdictions Wherein Act Has Been Adopted.

36. *Id.* § 2(h). As later discussed, however, it is unlikely that medical professionals will act contrary to familial wishes. See *infra* notes 63-72 and accompanying text.

37. Sullivan, *supra* note 32, at 25.

38. UNIF. ANATOMICAL GIFT ACT § 10 (1987); National Organ Transplant Act § 301, Pub. L. No. 98-507, 98 Stat. 2339 (1984) (codified as amended at 42 U.S.C. § 274(e) (2000)).

*B. The National Organ Transplant Act*

In 1984, Congress passed the National Organ Transplant Act (NOTA)<sup>39</sup> in order to "strengthen the ability of the nation's health care system to provide organ transplants"<sup>40</sup> through the development of a nationwide organ network that can respond quickly to changes in organ allocation and procurement policies.<sup>41</sup> In addition to instituting a national ban on commercial transactions in organs,<sup>42</sup> NOTA authorized the Secretary of the Department of Health and Human Services to establish an Organ Procurement and Transplantation Network (OPTN) by contract with a private, nonprofit entity.<sup>43</sup> As part of its mission, the OPTN is specifically required to "work actively to increase the supply of donated organs."<sup>44</sup> Ever since the first contract was awarded in 1986, the OPTN has been operated by the United Network for Organ Sharing (UNOS).<sup>45</sup>

UNOS maintains "a national list of individuals who need organs" and a national system that uses "established medical criteria to match organs and individuals included in the list."<sup>46</sup> UNOS is a membership organization that includes "transplant surgery centers, medical laboratories that perform tests for organ matching, volunteer and advocacy groups, donors and donor families, transplant recipients and patients awaiting a transplant."<sup>47</sup> As part of its central task, it coordinates activities and information-sharing among its member Organ Procurement Organizations (OPOs)<sup>48</sup> which are distributed regionally across the country. The motivating idea behind this somewhat tortuous system—in which the Department of Health and Human Services awards a contract (currently to UNOS) to operate a national organ network (called an OPTN)—was to keep the organ distribution system out of the hands of government bureaucracy and to give medical professionals (often working as part of regional OPOs) significant control over the nation's organ procurement and allocation systems.<sup>49</sup>

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39. 42 U.S.C. §§ 273-274.

40. H.R. REP. NO. 98-575, pt. 1, at 6 (1983).

41. *Id.* at 6-7.

42. 42 U.S.C. § 274(a).

43. *Id.* § 274(a), (b)(1).

44. *Id.* § 274(b)(2)(K).

45. CURRAN ET AL., *supra* note 14, at 767.

46. 42 U.S.C. § 274(b)(2)(A)(i), (ii).

47. CURRAN ET AL., *supra* note 14, at 767.

48. 42 U.S.C. § 274(b)(2); *see also id.* § 273 (setting criteria for organ procurement organizations to receive government funding). An OPO "has a defined service area that is of sufficient size to assure maximum effectiveness in the procurement and equitable distribution of organs." *Id.* § 273(b)(1)(F).

49. H.R. REP. NO. 98-575, at 9 (1984).

### C. The Current Allocation Scheme

In accord with its statutory authority, UNOS issues allocation guidelines for regional OPOs to follow.<sup>50</sup> The allocation policy is different for each organ, but all of these formulas trade off between a complicated set of factors. The criteria generally include organ compatibility, the likelihood that a transplant will be successful, the time a recipient has spent on a waiting list, and the urgency with which the patient needs an organ in order to survive or avoid irreparable injury.<sup>51</sup> These criteria frequently come into conflict. For example, younger and healthier people generally have the best prognosis for transplant success but their relative health means that having a transplant is less medically urgent.<sup>52</sup>

Substantial allocation preference is also given to recipients who live closer to a particular donor.<sup>53</sup> Geographic preference does reflect some medical considerations (it is speedier and safer to transfer organs locally), but it also reflects the belief that people will donate in larger numbers if they see the benefits of donation in their local community.<sup>54</sup> In practice, the medical urgency of one's need for an organ is often dwarfed by the policy decision to distribute organs according to a system of local geographic preference. Not surprisingly, these geographic preferences are controversial.<sup>55</sup>

The flexibility of our distribution system, which combines clinical indicators with policy considerations, makes it relatively easy to add a new policy consideration to the mixture without overhauling the entire system. Such a consideration might affect one's expected waiting time by, say, 10% or less. In Part IV, I argue that our organ allocation system could make willingness to donate just such a policy consideration by assigning some preference to people who both need organs and have previously registered as organ donors.

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50. CURRAN ET AL., *supra* note 14, at 767

51. *See id.*

52. *See* Arthur L. Caplan & Daniel H. Coelho, *Allocation and Rationing*, in *THE ETHICS OF ORGAN TRANSPLANTS* 247, 247 (Arthur L. Caplan & Daniel H. Coelho eds., 1998).

53. CURRAN ET AL., *supra* note 14, at 767.

54. More cynical observers have suggested that the policy reflects the political influence of smaller, local transplant centers which fear losing business to larger, more celebrated and sophisticated centers that would have a competitive advantage under a national distribution system. *See generally* Jeffrey Prottas, *The Politics of Transplantation*, in *ORGAN AND TISSUE DONATION: ETHICAL, LEGAL, AND POLICY ISSUES* 3 (Bethany Spielman ed. 1996).

55. *See, e.g.*, Brigid McMenamin, *Why People Die Waiting for Transplants*, *FORBES*, Mar. 11, 1996, at 140, 140.

### III. NON-PRIORITY PROPOSALS TO INCREASE DONATION

In this part, I briefly discuss a variety of non-priority proposals to increase the organ supply. These proposals provide background information and help frame the contours of the organ donation debate. Importantly, most of the proposals discussed should not be viewed as exclusive of each other, since they can be combined in various ways. For example, a hybrid priority-financial incentive program could give registered donors priority should they need a transplant and, should they die with transplant-eligible organs, the program could provide a death benefit to the decedent's estate.<sup>56</sup>

Because many of the proposals discussed can coexist with a priority incentive program, it is not my goal to argue that priority incentives are necessarily better than these other proposals. Rather, I argue that a priority incentive program should be, but so far has not been, considered at least as carefully as these others.

#### A. Public Awareness

The least controversial way to ease the organ shortage is to increase public awareness about donation.<sup>57</sup> There are many who would be willing to have their organs transplanted, but have not filled out an organ donor card, nor told their preferences to their families, nor even thought very much about the issue.<sup>58</sup> There are others who would donate if given accurate information designed to reduce their misconceptions and fears. For example, according to a survey by the Boston-based Partnership for Organ Donations, more than half of the families that refused to donate the organs of a deceased relative did not realize that their brain-dead relative was actually dead.<sup>59</sup> Believing it possible to recover from brain death, it is not surprising that families were reluctant to donate their loved ones' bodies.

Public awareness efforts encounter relatively little political

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56. For precedent on a hybrid priority-financial incentive program, see *infra* note 163. For precedent on a hybrid priority-presumed consent incentive program, see *infra* note 144.

57. In 2001, Health and Human Services Secretary Tommy Thompson launched the "Gift of Life" Donation Initiative to raise awareness of the organ scarcity problem. *HHS Program Pushes for Increase in Organ Donations*, THE NATION'S HEALTH, June 2001, at 5 (describing plans for a "national Workplace Partnership for Life campaign" and for "donation education programs . . . in drivers' education classes").

58. According to a 1993 Gallup poll, of those not likely to have their organs donated, 47% explained their response with "No reason/don't know/haven't given much thought," while only 5% gave religious reasons. THE GALLUP ORGANIZATION, INC., *supra* note 6, at 5.

59. McMenamin, *supra* note 55, at 144.

opposition.<sup>60</sup> There is some evidence, however, that they have limited effectiveness. For example, a British Department of Health television campaign used intense publicity to reduce organ donation refusal rates from 30% to 22%.<sup>61</sup> This is a significant, but hardly staggering, improvement. Worse yet, when the publicity campaign ended, refusal rates returned to their pre-campaign levels.<sup>62</sup> Public awareness, although the centerpiece of efforts to increase donation for many years, has proved startlingly ineffective at increasing cadaveric organ donation rates.

### *B. Better Enforcement of Existing Laws*

Under both the 1968 and 1987 versions of the UAGA, a signed document of a gift by a donor cannot be vetoed later by families.<sup>63</sup> Nevertheless, many medical professionals will not procure organs from a potential donor when family members refuse to give their (legally superfluous) consent,<sup>64</sup> even though medical personnel are immune from liability when they have documentation of a donor's gift. According to David Orentlicher, "[e]ven in cases in which a person has completed an organ donor card, transplant surgeons generally will not remove the person's organs without the family's permission."<sup>65</sup> A recent survey of OPOs supports this belief. When next of kin are opposed to donation, only 11.5% of OPOs are "very likely" or "pretty likely" to procure organs based on the deceased's donor card or a comparable document.<sup>66</sup> Put another way, your family has more control over the disposition of your organs than you do, even when you explicitly state a willingness to donate. This lack of attention to donative intent explains why organ donation awareness

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60. See, e.g., Susan J. Landers, *Closing the Gap on Supply and Demand for Organ Donation*, AM. MED. NEWS, Mar. 12, 2001, at 1 (stating that after Health and Human Services Secretary Tommy Thompson launched a donation awareness campaign, "[p]hysicians and patient advocacy groups cheered Thompson's announcement" and "[t]he AMA congratulated Thompson on his commitment").

61. Jennifer M. Krueger, *Life Coming Bravely Out of Death: Organ Donation Legislation Across European Countries*, 18 WIS. INT'L L.J. 321, 337 (2000).

62. *Id.* Complicating assessments of donative intentions, social psychological research has shown that there is a low correlation between people's expressed attitudes toward donation on surveys (usually high because it is considered socially desirable) and their actual willingness to donate. See Bahman Baluch et al., *Signing the Organ Donor Card: The Relationship Between Expressed Attitude, the Actual Behavior, and Personality Traits*, 141 J. SOC. PSYCH. 124, 126 (2001) ("The present findings generally imply that expressed attitudes toward organ donation, as measured by the Likert-type scale, cannot predict actual behavior.").

63. Sullivan, *supra* note 32, at 30.

64. See Wendler & Dickert, *supra* note 13, at 331.

65. David Orentlicher, *Organ Donation—The Willing Donor*, in ETHICS IN EMERGENCY MEDICINE 214, 217 (Kenneth V. Iverson et al. eds., 2d ed. 1995).

66. See Wendler & Dickert, *supra* note 13, at 331.

campaigns emphasize the need to tell one's relatives about the decision to donate. Referring to donation campaigns which emphasize family discussion, Robert Sullivan writes:

That is all myth and misconception. It is not the law under either the 1968 or the 1987 UAGA! . . . It is a simple matter to correct the message and to change the policy. No amendment of the law, no new proposal to expand the procurement process is required. It is only necessary to accept and follow the law as it is—an unrevoked, signed donor card is a valid gift.<sup>67</sup>

Many would consider it even more disturbing that some OPOs are willing to procure organs with family consent even when doing so runs counter to the wishes expressed by the deceased on a donor card.<sup>68</sup> Recent survey results on donation consent practices published in the *Journal of the American Medical Association* show that nearly half of all OPOs are willing to "procure organs despite written objection by the deceased,"<sup>69</sup> thus offending "both the spirit and the explicit commands of the UAGA."<sup>70</sup> Describing the survey, Alexander Capron writes that "data suggest that OPOs do not follow the law, that their procurement practices vary one from another in unpredictable ways, and that the justifications given by [OPOs] for their practices bear little relationship to those practices."<sup>71</sup> Overall, these survey findings "should be disconcerting to anyone concerned with organ transplantation."<sup>72</sup> Proposals that encourage OPOs to follow current laws are both desirable and politically feasible.

### C. Improved Methods of Request

Given our actual organ procurement practices, it is clear that the organ supply is highly dependent on requests made to families. Such requests are made to families when they have recently lost a loved one and must, while grieving, quickly decide whether or not to donate. Perhaps, then, it is not surprising that *less than half of all families agree to donate*.<sup>73</sup> Research has shown that donation rates can be increased by improving the ways in which health care professionals approach families that are about to make donation decisions.<sup>74</sup> Such improvements represent relatively uncontroversial

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67. Sullivan, *supra* note 32, at 31.

68. Such a practice is perhaps morally justifiable to the extent that it saves a life. See *infra* text accompanying notes 118-26.

69. Capron, *supra* note 19, at 335.

70. *Id.*

71. *Id.*

72. *Id.*

73. Laura A. Siminoff & Kata Chillag, *The Fallacy of the 'Gift of Life,'* 29 HASTINGS CENTER REP. 34, 35 (1999).

74. One reason for this is that 55% of families say that they made their donation

ways of increasing donation.

Families are more likely to donate if they have a good relationship with the health care professional who cared for the deceased patient,<sup>75</sup> and if they are contacted as part of their decision-making process by people trained to make such requests.<sup>76</sup> It helps if organ procurement specialists actively try to dispel myths and misconceptions about organ donation and address family concerns about the effects of donation on funeral arrangements.<sup>77</sup> Families are also more likely to donate if they are told in advance that a request will be made, presumably because this gives them a chance to prepare emotionally for the decision.<sup>78</sup> Not surprisingly, "asking apologetically or mentioning that one is legally required to ask is likely to result in a refusal."<sup>79</sup>

#### D. Required Request

Before family members can accept or deny a request for donation, they need to be asked. One reason that the organ supply is lower than it should be is that medical personnel do not always ask for donations from families of eligible donors. In 1985, Oregon passed a statute *requiring* hospital personnel to seek organ donations from surviving family members.<sup>80</sup> Such "required request" statutes typically mandate that hospital personnel ask families of eligible donors to donate their loved ones' organs and that personnel certify that the request was made in medical records and on death certificates.<sup>81</sup> The UAGA of 1987 includes required request provisions<sup>82</sup> and within five years of the passage of the Oregon statute, most states had adopted a similar rule.<sup>83</sup>

Compliance with required request laws, however, has been somewhat disappointing. A 1995 study found that 13.5% of families

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decision at the time of initial request. Laura A. Siminoff et al., *Factors Influencing Families' Consent for Donation of Solid Organs for Transplantation*, 286 J. AM. MED. ASS'N 71, 72 (2001).

75. *See id.* at 76.

76. *See id.* (indicating that "involvement of the family with a professional from the OPO is critical" and "[t]hat the time spent with the OPO coordinator was a strong factor associated with the decision to donate").

77. *See id.* at 77.

78. *See id.* at 76.

79. *Id.*

80. OR. REV. STAT. § 97.268 (1990) (repealed 1995).

81. *See Sullivan, supra* note 32, at 23.

82. *Id.* at 28.

83. *Id.* at 24; *see also* NAT'L ATTORNEYS' COMM. ON TRANSPLANT AWARENESS, INC., ORGAN AND TISSUE DONATION AND TRANSPLANTATION: A LEGAL PERSPECTIVE, <http://www.transweb.org/reference/articles/donation/nacta.html> (last visited Aug. 25, 2003) ("By 1988, 44 states had passed their own 'required request' legislation.").



of eligible cadaveric donors were never even asked to make a donation.<sup>84</sup> While the United States is doing better than Canada, where 25% of such families were never asked to donate,<sup>85</sup> there is still substantial room to increase request rates.

On the other hand, it is possible that families which are not approached for donation have been intentionally avoided because medical professionals deem the family unlikely to donate. Approaching those families may hardly increase donations at all. This concern forms part of the opposition to required request laws, where some have argued that they "impos[e] too great a burden on physicians and families"<sup>86</sup> and do not increase donation.<sup>87</sup> It would, therefore, be better to have a reliable, coordinated system of recording donor intentions while donors are still competent to make decisions.<sup>88</sup> If such a system were widely utilized, families would not be forced so frequently to make donation decisions for deceased relatives.

#### *E. Mandated Choice*

Mandated choice programs would require competent adults to decide whether or not they are willing to become organ donors.<sup>89</sup> Such programs seek to relieve families of much of the burden of making donation decisions and place it where it belongs—on future donors who are still competent to make decisions. In its most extreme version, one might be required to officially list oneself as a donor or a non-donor much as young men are obligated to register for the Selective Service.

Actual efforts to make people indicate donation preferences have been much more tentative. For example, the UAGA of 1987 requires hospitals to ask admitted patients if they want to donate their organs.<sup>90</sup> This does not force people to state their wishes, but it does make them consider the issue and will probably get most people to express some sort of preference. Unfortunately, such hospital questionnaires will not reveal the intentions of some of the most frequent organ donors, namely, those who die from injuries in traumatic motor vehicle accidents and are usually incapable of

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84. Siminoff et al., *supra* note 74, at 71.

85. Anita Dubey, *Overcoming Barriers to Organ Donation: Strong Support Needed for Successful Programs, Experts Say*, WEBMD CAN. MED. NEWS, Apr. 24, 2001, at 1.

86. Sullivan, *supra* note 32, at 24.

87. Council on Ethical and Judicial Affairs of the Am. Med. Ass'n, *Strategies for Cadaveric Organ Procurement*, 272 J. AMER. MED. ASS'N 809, 810 (1994).

88. See *infra* text accompanying notes 145-48.

89. See generally VEATCH, *supra* note 23, at 175-81 (discussing the relative merits of mandated choice).

90. UNIF. ANATOMICAL GIFT ACT § 5 (1987).

making donation decisions by the time they enter the hospital.

Unfortunately, without some non-altruistic incentive to donate, mandated choice proposals may have the effect of reducing the organ supply. Those forced to decide whether or not to donate may err on the side of perceived caution and withhold consent. For example, Texas instituted a program requesting all applicants for driver's licenses to state their donation preferences. Early data from the program suggested that the refusal rate was as high as 80%.<sup>91</sup> While waiting for a license at a motor vehicle office, one is usually not in great spirits, and the setting is not conducive to making important postmortem decisions. If people were instead approached under better circumstances, a mandated choice program could go a long way toward respecting the wishes of the deceased and reducing stress on grieving families. It may not, however, do much, by itself, to ameliorate the organ shortage.

#### F. Presumed Consent

One way to almost certainly increase organ donation is to establish a policy which presumes that people consent to donate unless they have expressed contrary intentions. Thus, those who wish not to become organ donors would have to "opt-out" by officially registering opposition to donation, perhaps by telling their families about their refusal to donate or by carrying a "non-donor card."

A policy of presumed consent is already part of our legal regime in various respects. For example, to the extent that we allow family donation decisions to represent the will of the deceased, we are making a presumption about consent. In effect, we presume that decedents grant their families authority to make donation decisions, unless the decedent expresses his or her own donative intentions.<sup>92</sup>

In addition, several states incorporate some kind of presumption of consent into their organ donation regimes. Many states have laws that give medical examiners the authority, during the course of autopsies, to remove corneal tissue for donation without explicit

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91. Laura A. Siminoff et al., *Public Policy Governing Organ and Tissue Procurement in the United States: Results from the National Organ and Tissue Procurement Study*, 123 ANN. INTERN. MED. 10, 16 (1995).

92. Whether this is actually a presumption of consent is debatable since the family of the recently-deceased have "quasi-property" interests in the deceased's body. 22A AM. JUR. 2D *Dead Bodies* § 3 (1988) (noting that these interests "may include rights to possession and custody of the body for burial, to prevent the corpse from disturbances after burial, or to remove it to a proper place") (citations omitted). Thus, from one perspective, family organ donation decisions are exercises of familial property rights in deceased bodies. The explanation for such familial property interests, however, probably stems from the view that family preferences for the deceased provide our best surrogate for what would have been the deceased's actual preferences.

consent from anyone.<sup>93</sup> State legislatures with such laws may have reasoned that, since tissue is permanently removed during the autopsy process anyhow and the removal of corneas can substantially help living people without noticeably changing the appearance of a dead body, the presumption in favor of consent is acceptable.<sup>94</sup> In *State v. Powell*,<sup>95</sup> the Florida Supreme Court found such a statute constitutional under state law because it promoted rational state objectives and required "an infinitesimally small intrusion which does not affect the decedent's appearance."<sup>96</sup>

Some states give medical examiners authority to remove more than just corneas.<sup>97</sup> A key difference between the 1968 UAGA and the 1987 UAGA is that the former required some form of explicit authorization to use bodies and bodily organs<sup>98</sup> while the latter permits medical examiners to remove visceral bodily organs (like hearts and lungs) when a "reasonable effort" is made to obtain authorization, and there is no knowledge of objection from the decedent or the decedent's family.<sup>99</sup> However, medical examiners are reluctant to use organs without family consent, even in states where doing so is permitted. For example, in the first year after medical examiners were given presumed consent authority in Texas, it was only used twice.<sup>100</sup>

Many commentators have sought to extend presumptions of consent beyond the limited case of medical examiner autopsies,<sup>101</sup> and some states have considered legislation to implement thoroughgoing presumed consent policies,<sup>102</sup> like those already in place in many

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93. See, e.g., DEL. CODE ANN. tit. 29, § 4712 (2002); FLA. STAT. ANN. § 765.5185 (West 2002); MICH. COMP. LAWS ANN. § 333.10202 (West 2001).

94. CURRAN ET AL., *supra* note 14, at 740.

95. 497 So. 2d 1188 (Fla. 1986).

96. *Id.* at 1191. *But cf.* Brotherton v. Cleveland, 923 F.2d 477, 482 (6th Cir. 1991) (holding that the wife of a decedent could raise a section 1983 claim for wrongful removal of her husband's corneas after she expressed a contrary preference).

97. For more information, see generally the morbidly-titled piece, Erik S. Jaffe, Note, "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 (1990).

98. UNIF. ANATOMICAL GIFT ACT §§ 2, 4 (1968).

99. UNIF. ANATOMICAL GIFT ACT § 4 (1987).

100. CURRAN ET AL., *supra* note 14, at 751.

101. See, e.g., PAUL T. MENZEL, STRONG MEDICINE 169-82 (1990); Theodore Silver, *The Case for a Post-Mortem Organ Draft and a Proposed Model Organ Draft Act*, 68 B.U. L. REV. 681 (1988).

102. See Andis Robeznieks, *Texas Mulls Policy for Organ Donation by Presumed Consent*, AM. MED. NEWS, Apr. 28, 2003, available at [http://www.ama-assn.org/sci-pubs/amnews/pick\\_03/prsc0428.htm](http://www.ama-assn.org/sci-pubs/amnews/pick_03/prsc0428.htm); see also VEATCH, *supra* note 23, at 169 (describing proposed legislation in Maryland and Pennsylvania to implement presumed consent on a statewide basis).

other countries. For example, Austria, Belgium, Luxembourg, and Slovenia all use presumed consent.<sup>103</sup> Typically, these countries permit procurement of organs from any eligible cadaver so long as the individual had not expressly declined consent while alive, unlike the hybrid system in the U.S. of opt-in donation and familial decision-making. Yet, even in countries with presumed consent, the presumption is usually not strictly enforced, and doctors still seek to discuss the matter with the families of the deceased.<sup>104</sup> This may explain why donation rates under presumed consent regimes, though substantially higher than those in the United States, are not staggeringly better. Bioethicist Arthur Caplan estimates that donation rates in countries with presumed consent “are about 15 percent higher than those of the best American organ procurement organizations.”<sup>105</sup>

In the U.S., there is substantial opposition to a presumption of consent.<sup>106</sup> It is a mistake, therefore, to presume consent in this country if we take that presumption to actually reflect people’s preferences:

Social survey evidence makes clear that if we assume people would agree to having their organs procured if they were asked, we would be wrong something like 30-50 percent of the time. A 1993 Gallup polls show that only 37 percent of Americans are “very likely” to want their organs transplanted after their death, and only 32 percent are “somewhat likely.” Furthermore, only 55 percent are willing to grant formal permission for organ removal.<sup>107</sup>

It is difficult to formulate exactly whose interests are harmed when we procure organs from those who had preferred not to donate. Those likely to be the primary complainants are deceased. However, if we believe it possible to harm the interests of the deceased (or the interests of their survivors), we will find a system of presumed consent quite imperfect. While it might be better than our current system, it is certainly worse than a system which similarly increases organ donation without contravening our interests in bodily autonomy.

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103. EUROTRANSPLANT, LEGISLATION, at <http://www.eurotransplant.nl/index.php?id=legislation> (last visited Aug. 25, 2003).

104. Krueger, *supra* note 61, at 331.

105. Randi Hutter Epstein, *How Diplomacy in Handling Death Can Save Lives*, N.Y. TIMES, Aug. 19, 2003, at F5.

106. VEATCH, *supra* note 23, at 170 (indicating “that only 38 percent of Americans agree with presumed consent” and that “another survey shows that number to be only 7 percent”).

107. *Id.* at 170 (citing data from THE GALLUP ORGANIZATION, INC., *supra* note 6, at 4, 15).

### G. Financial Incentives

One way to encourage people to affirmatively agree to donate is to offer them financial compensation. If appropriately designed, a system of financial incentives can increase organ donation without contravening respect for bodily autonomy. While many critics fear that any such incentives will unacceptably commercialize human body parts, most of us are unfazed by the behind-the-scenes commerce in human organs and tissue that goes on everyday.<sup>108</sup> For example, donation of bone, tendon, and skin from a single donor can generate as much as \$70,000 in services fees,<sup>109</sup> none of which goes to the donor or the donor's family. The real issue, some argue, is who should be compensated when organs and tissue are transplanted and not whether there should be compensation at all. As Julia Mahoney forcefully states:

[M]oney changes hands at numerous points in the chain of distribution from tissue source to ultimate consumer: Transplant patients pay to receive organs, fertility patients purchase ova and sperm, and biotechnology firms sell products derived from human cells. Indeed, it is virtually impossible to imagine how human biological materials would be distributed if commerce in such materials were prohibited. . . . As now conducted, then, the debate over the commercialization of the human body is not about commercialization at all, but rather about how the financial benefits available will be apportioned.<sup>110</sup>

Though one can argue that organ transplant patients pay only for transplant services and not for the organs themselves, this argument "is no more persuasive than contending that restaurants sell not food, but only 'dining services.'"<sup>111</sup>

A wide variety of proposals have been offered to apportion some of the financial benefits from trade in organs and tissue to the individuals and families that supply the essential materials. Some have proposed financial compensation for families of organ donors through either payment of funeral expenses<sup>112</sup> or reductions in federal income tax.<sup>113</sup> These are the sorts of proposals that the AMA thinks

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108. Naomi Freundlich, *All of Me*, N.Y. TIMES MAG., Mar. 16, 2003, at 94 ("The total trade in human tissue transplants is hard to pin down, but estimates are as high as \$1 billion.").

109. *Id.*

110. Julia D. Mahoney, *The Market for Human Tissue*, 86 VA. L. REV. 163, 165 (2000) (citation omitted).

111. *Id.* at 182.

112. See, e.g., Fred Charatan, *Pennsylvania Plans to Reward Organ Donation*, 318 BRIT. MED. J. 1371 (1999).

113. See, e.g., James V. Hanson & Felicia Cohn, *Putting a Price on Organ Donations*, N.Y. TIMES, June 12, 2001, at F6.

are most in need of further research. However, they are probably the least desirable. By compensating surviving family members, we give them an incentive to contravene the wishes of the deceased. Furthermore, we reward them for offering up their relative's organs, though it is by no means clear that the actual sacrifice is made by survivors.<sup>114</sup> Other contemplated financial incentive schemes would compensate those who commit to donate while they are still alive should they die with organs eligible for transplantation.<sup>115</sup>

Each proposed financial incentive scheme needs to be evaluated independently, and the AMA should be praised for boldly encouraging this path of exploration. Yet, it would be a mistake to consider financial incentives and not priority incentives. If nothing else, financial incentive plans are likely to face substantial, perhaps insurmountable political opposition. The NOTA of 1984 made it illegal to "knowingly acquire, receive, or otherwise transfer any human organ for valuable consideration for use in human transplantation if the transfer affects interstate commerce,"<sup>116</sup> though the statute permits reasonable payments to hospitals and physicians as compensation for their professional services.<sup>117</sup> Given the entrenchment of anti-compensation policies in organ donation law, financial incentive programs, while certainly worth considering, face serious uphill battles. I return to discuss, and in many ways defend, financial incentive schemes in Part V.

#### H. Routine Salvage

I save for last a somewhat more detailed discussion of one of the most dramatic and effective means of increasing the organ supply. It can best be understood by first examining some of the ethical issues underlying organ donation.

A familiar tool of bioethical inquiry has us imagine an out-of-

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114. Instructive in this regard is a story from transplant surgeon Thomas G. Peters. Upon requesting consent to procure organs from the older brother of a recently deceased patient, the brother replied, "I hated that s.o.b.! Go ahead and cut him . . . take his organs! Where do I sign?" Thomas G. Peters, *Life or Death: The Issue of Payment in Cadaveric Organ Donation*, in THE ETHICS OF ORGAN TRANSPLANTS 196, 198 (Arthur L. Caplan & Daniel H. Coelho eds., 1998).

115. On the variety of ways to structure financial incentives, see Lloyd R. Cohen, *Increasing the Supply of Transplant Organs: The Virtues of a Futures Market*, 58 GEO. WASH. L. REV. 1, 33 (1989); Gregory S. Crespi, *Overcoming the Legal Obstacles to the Creation of a Futures Market in Bodily Organs*, 55 OHIO ST. L.J. 1, 29-37 (1994).

116. 42 U.S.C. § 274e(a) (2000).

117. *Id.* § 274e(c)(2). Prohibited payments do "not include the reasonable payments associated with the 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 donation of the organ." *Id.*

control trolley speeding toward some person tied to its tracks. We can flip a switch in order to divert the trolley to a second track, but doing so will unfortunately cause the trolley to hit some other person or group of people. These "trolley problems" test our intuitions about the kinds of actions we are morally permitted to take to achieve certain outcomes.<sup>118</sup> I will offer some trolley problems that are much more straightforward than those typically posed.

### *The Unknown Corpse*

Suppose an out-of-control trolley is speeding toward a person tied to the trolley tracks. One can divert the trolley to another track, thus saving the person's life, but hitting an already dead body lying for some reason on the second track. The impact with the trolley will unaesthetically crush the corpse. Given these circumstances, is it permissible to divert the train toward the corpse?

We are asked to choose between saving a human life and crushing a deceased one. Unpleasant as the choice may be, the solution is obvious. Clearly, we may save a human life by allowing a trolley to run over a dead body. Our intuition likely goes further to say that it would be immoral *not* to divert the train, since it is morally blameworthy to be capable of saving a living human being but to choose instead to spare a lifeless corpse. Thus, a principle underlying this trolley problem is that some sort of desecration, trespass, or invasion of a dead body is permitted (and perhaps morally required) in order to save a life.

Now, however, let us make the trolley problem slightly harder:

### *The Spiritual Corpse*

Suppose once again that a trolley is going to hit a living person unless it is diverted toward a body lying dead on its tracks. This time, however, you are aware that when the dead person was alive, he filled out a form emphatically stating his wish to be buried intact, declaring a religious objection to any form of bodily desecration. Furthermore, relatives of the deceased are standing nearby telling you not to damage their loved one's body. If the trolley runs over the dead body, it will, of course, crush it.

Now that you know something about the dead body, it makes

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118. For a collection of essays with extensive discussion of trolley problems, see generally KILLING AND LETTING DIE (Bonnie Steinbock & Alastair Norcross eds., 2d. ed. 1994).

your choice slightly more difficult. You must choose between saving a human life and overriding both the expressed preferences of a deceased person and the expressed preferences of his relatives. Does the new information change your decision to divert the track? Not at all. Surely it would still be permissible to divert the trolley and may even be morally obligatory. When the trolley hits the dead body, it will violently crush it and create an unpleasant mess; it will also upset the surviving relatives of the deceased. But, this seems like a small price to pay to save a life.

There is a not-so-subtle analogy between these trolley problems and cadaveric organ donation. In the trolley problems, a living person watches as the trolley ominously speeds toward him, just as those waiting to receive an organ watch their serious, usually life-threatening diseases grow progressively more deadly. We can save a life in the trolley problem by taking an action which violates the integrity of a dead body, much as the lives of organ recipients can be saved by procuring organs from a dead person who was unwilling to donate. In the trolley problems, we thought it morally permissible to desecrate a dead body even when consent to desecrate is specifically and intentionally withheld. If we think organ donation is sufficiently analogous, then it seems morally permissible to transplant organs from a dead body, even without consent from the deceased or the deceased's family.

The trolley problem is not perfectly analogous to organ donation. When we look more carefully at the considerations underlying the analogy, however, the merits of organ donation seem even more manifest than the merits of trolley diversion. First, bodies used in organ donation typically save not one life but several, since each donor body has the potential to save six or more lives.<sup>119</sup> So, if the numbers count, the gains to be had from donating the organs of one person are more than the gains to be had from diverting the trolley. Second, the costs to the deceased (to the extent that we recognize such costs at all) and his or her family are much smaller in the case of organ donation than in the case of trolley diversion. When a cadaver is used for organ donation, the body is not nearly as damaged as it would be if run over by a trolley. Cadavers that have had organs removed can still be used in open casket funerals and will not likely look any different than they would have had they not been

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119. Richard Perez-Pena, *Downside to Fewer Violent Deaths: Transplant Organ Shortage Grows*, N.Y. TIMES, Aug. 19, 2003, at B1 (stating that a healthy young donor "is likely to have a usable heart, pancreas, liver, two kidneys, two lungs and intestines . . . enough to save a half-dozen or more lives in some cases"); cf. Bucklin, *supra* note 17, at 324 (stating that 3.37 organs are recovered on average per cadaveric donor).



used for organ donation at all.<sup>120</sup>

Perhaps, then, the difference between organ donation and our trolley problems is that, in organ donation, body parts are *intended* to be used by others, while in our trolley problems, the desecration of a body was just an unfortunate, though foreseen, consequence of our need to save a life.<sup>121</sup> The so-called “doctrine of double effect” attempts to highlight the moral difference “between what a man foresees as a result of his voluntary action and what, in the strict sense, he intends.”<sup>122</sup> But this distinction will not take us very far, as demonstrated by this grisly example:

### *The Corpse as Object*

It is wartime and doctors are tending to patients near enemy lines. Army doctors are performing open heart surgery on a soldier with a bullet wound. During the surgery, the patient dies and resuscitation efforts prove fruitless. Just after the head surgeon gives up and declares the soldier dead, a ferocious dog, perhaps trained by enemy forces, enters the surgery area and attacks one of the doctors. Others in the room struggle to remove the hungry dog but to little avail. To save the life of the doctor being attacked, one of the other doctors pulls out the heart of the dead soldier and throws it at the dog in order to offer it some other source of food. Miraculously, the plan works and all escape while the dog is temporarily distracted by the unusual piece of flesh.

In this example, the *use* of an organ is not merely the foreseeable consequence of an attempt to save a life. In order to work, the doctor intended that the organ would be *used* to distract the dog. In our prior examples, we would be quite happy if the dead body on the diversion track simply disappeared or was never on the tracks in the first place. Desecration of a dead body in those examples was a foreseeable but unintended consequence of trolley diversion. But in

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120. CAL. TRANSPLANT DONOR NETWORK, RESOURCES & INFORMATION: FAQS, at <http://www.ctdn.org/resources/faqs.php> (last visited Aug. 25, 2003) (“The retrieval of organs is conducted like any other surgical procedure. In no way will organ donation interfere with an open casket funeral and families can proceed with the memorial service they have planned in a prompt manner.”).

121. A similar but slightly different objection is that in organ donation, unlike the trolley problem, one’s organs are actually used by someone else. While most of us view the use of our organs to save another’s life as a good thing, some might object on religious or aesthetic grounds to the idea that one’s body parts are placed inside another to serve some function that is not our own.

122. Philippa Foot, *The Problem of Abortion and the Doctrine of Double Effect*, in KILLING AND LETTING DIE 266, 267 (Bonnie Steinbock & Alastair Norcross eds., 2d ed. 1994).

this example, the use of the dead body and its organs was essential. Some kind of organ or other flesh had to be used in order to accomplish the intended result. Nevertheless, the use was morally permissible. You may desecrate a dead body, and even use its organs, regardless of the deceased's preferences, in order to save a life. Perhaps more astounding is that this intuition survived in this example, even though the doctor's action had but a small chance of working. Imagine how much more agreeably we would look upon lifesaving actions with higher probabilities of success.

Does it matter that we can see the victim in the trolley problems and in the attack dog example but cannot see the lives lost in the organ donation context when eligible cadavers are destroyed? It is hard to see how this could make a moral difference. Furthermore, we could easily arrange a trolley problem where the living person is unknown to us and is remote in time or place. Yet our intuition would remain that saving the life of an unknown person trumps the rights of the dead, including the right to bodily autonomy as expressed before death.

If we really accepted the analogy between these examples and organ donation, we could institute a policy where all bodies that are eligible to donate organs are used for donation regardless of anyone's donation preferences. Such a policy, sometimes called "routine salvage," would seek to transplant every medically eligible organ and would thereby maximize lives saved from organ donation. Under a system of routine salvage, organs are not the property of any person but are a shared common resource. In dicta in *Moore v. Regents of the University of California*,<sup>123</sup> the Supreme Court of California seemed to characterize the organ donation system exactly as a pooled resource:

It is certainly arguable that, as a matter of policy or morality, it would be wiser to prohibit any private individual or entity from profiting from the fortuitous value that adheres in a part of a human body, and instead to require all valuable excised body parts to be deposited in a public repository which would make such materials freely available to all scientists for the betterment of society as a whole. The Legislature, if it wished, could create such a system, as it has done with respect to organs that are donated for transplantation.<sup>124</sup>

Nevertheless, a routine salvage system would come at a substantial cost to the principle that the human body should ordinarily not be violated by the state without consent. This principle has been expressed by courts, at least in the context of live organ

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123. 51 Cal. 3d 120 (1990).

124. *Id.* at 159.

donation. In *McFall v. Shimp*,<sup>125</sup> a Pennsylvania judge wrote: "For a society which respects the rights of *one* individual, to sink its teeth into the jugular vein or neck of one of its members and suck from it sustenance for another member, is revolting to our hard-wrought concepts of jurisprudence."<sup>126</sup>

However, while it is a worthy goal to procure all useable organs, we could imagine a still-better solution in which everybody (or almost everybody) was *willing* to donate organs. This would maximize organs available for donation without having to frustrate the preferences of the deceased and their living relatives. So, while it might be morally permissible to send the trolley toward the body of the person who withheld consent, it would be still better to give some incentive to that person during his life to convince him to consent to bodily desecration when needed to save a life. Thus, we could both save a life and not violate anyone's preferences. To the extent that an incentive proposal can achieve nearly maximum levels of donor registration, then it will have most of the advantages of routine salvage without the disadvantages. At a minimum, we should try less extreme incentive programs first to determine if they can fill at least a substantial part of the supply gap.

#### IV. A PRIORITY INCENTIVE PROPOSAL

In this part, I sketch a proposal whereby adults who register to donate are given some priority to receive an organ should they someday need one. Priority incentives could be instituted either through our current government-sponsored organ distribution networks or through the creative efforts of private, social entrepreneurs who seek to demonstrate the benefits of priority incentives and convince policymakers that such a system can work.

While there are many reasons to support priority allocation, the most important reason is that doing so will increase the number of organs donated and the number of lives saved through transplantation. I take no strong position as to how much priority should be given to registered donors. I suggest, however, that priority could be calculated so that even those who do not register as organ donors are no worse off under a priority system than under our current allocation scheme.

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125. 10 Pa. D. & C.3d 90 (Allegheny County 1978). In this case, Robert McFall was suffering from a rare bone marrow disease and was desperately in need of a transplant from the only suitable donor, his first cousin, David Shimp. *Id.* at 90. McFall unsuccessfully sought a preliminary injunction to compel Shimp to undergo further tests associated with the transplant. *Id.* at 92.

126. *Id.*

A. *Priority Incentives Will Increase Organ Supply*

The principal reason to institute a priority allocation scheme is purely instrumental—doing so will increase the organs available to all. The altruistic motivation to donate has proven itself woefully insufficient, and while many preach that it should be sufficient, people on organ waiting lists are dying at an average rate of sixteen per day in the United States.<sup>127</sup>

Many people are ambivalent about donating and could be convinced to donate with just a small incentive to help them overcome the inertia which protects us from mulling over our own mortality. Though we need more empirical research, it is quite likely that if registered donors were granted priority to receive organs, we would sway many more people into the willing-donor category.<sup>128</sup>

The benefits of registering under a priority incentive program clearly exceed the costs. Even after registering, it is extremely unlikely that a registrant will donate organs because it is rare to die with organs medically eligible for transplantation. We have far more organ recipients than donors because each body used in transplantation provides organs to several individuals.<sup>129</sup> Under a priority scheme, potential donors can make the trade off between the very remote possibility of becoming an organ donor and the not-quite-so remote possibility of needing an organ. Understandably, neither the role of donor nor recipient is particularly appealing to think about. If you are in the latter category, your life is threatened, and if you are in the former category your life is over. But, under a priority system, you have an incentive to register because you are more likely to be rewarded by the system than made to contribute to it.

More importantly, the actual rewards of registering under a priority scheme (and thereby increasing one's life expectancy) far outstrip the costs, if any, of having some organs removed after death. Despite the discomfort one may have about registering to donate, an actual donation will only be made when one is dead and unaware, while the process of needing an organ occurs only while one is alive and usually very much aware.

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127. Japsen, *supra* note 4 (noting that “[n]early 6,000 Americans—an average of 16 a day—die each year”).

128. There is some evidence that donors are better motivated by self-interest than altruism. For example, a study on the effectiveness of two different kinds of organ donor public service announcements found that those emphasizing benefits to the registrant were more effective in increasing willingness to donate than were announcements emphasizing benefits to future organ recipients. See Barbara E. Nolan & Patrick J. McGrath, *Social Cognitive Influences on the Willingness to Donate Organs*, in *ORGAN DONATION AND TRANSPLANTATION: PSYCHOLOGICAL AND BEHAVIORAL FACTORS* 25, 25 (James Shanteau & Richard Jackson Harris eds., 1990).

129. See *supra* note 119.

The importance of increasing organ supply can hardly be overstated. Doing so will save lives by making more organs available. Those who receive priority are helped for obvious reasons. And, depending on the extent of the priority involved, it can help those who do not receive priority if donations induced by a priority system sufficiently increase organ supply to offset their reduced priority. An increased organ supply will also improve the quality of life of those who need an organ, not necessarily to live, but to live free of debilitation. Most notably, this group includes many of those who spend hours each week undergoing the ordeal of kidney dialysis.<sup>130</sup> Lastly, increasing the supply of cadaveric organs will reduce pressure on living people to donate kidneys or parts of other organs to their relatives or friends on waiting lists, in operations that can generate significant health risks to donors and the potential for deep intrafamilial strife.<sup>131</sup>

*B. Priority Incentives Are Not "Valuable Consideration"*

NOTA, which makes it illegal to "knowingly acquire, receive, or otherwise transfer any human organ for valuable consideration,"<sup>132</sup> poses a significant obstacle to the creation of financial incentive schemes, like those that the American Medical Association seems to think most worthy of study.<sup>133</sup> In contrast, NOTA should not pose a legal obstacle to the creation of priority incentives.

Under a priority incentive system, registered donors do get something of value. However, as a matter of statutory interpretation, it is unlikely that priority organ receipt is the kind of "valuable consideration" that would violate NOTA. Congress passed NOTA as a response to efforts to purchase organs<sup>134</sup> not to gain priority

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130. See MacDonald, *supra* note 25, at 177. The author quotes the following testimonial from a dialysis patient:

[The dialysis] machine takes the place of my irresponsible kidneys. . . . Once everything is connected, the tubing that I'm tethered to allows me to walk about 10 feet in any direction. I can go to the bathroom and wash my hands, but if I'm cold I can't reach the bathroom windows. I can go to the refrigerator for something to eat or drink, but I can't reach the stove. I feel like a dog on a short leash, confined to the backyard. . . . Peritoneal dialysis is a rather long process. It takes about twelve hours to complete the treatment. I spend half of a twenty-four hour day connected to a machine. Day after day, each and every day.

*Id.* (alteration in original). There is also evidence that suicide rates are much higher among dialysis patients. See Cohen, *supra* note 115, at 38 n.110.

131. See *supra* notes 21, 26. Also, at about \$500,000, live liver transplants can cost twice as much as cadaveric liver transplants. Carmichael, *supra* note 21, at 53.

132. 42 U.S.C. § 274e(a) (2000).

133. See *supra* notes 1-4 and accompanying text.

134. ANDREW KIMBRELL, THE HUMAN BODY SHOP 30 (1993) (describing the economic

allocation. For example, the title of the relevant section of NOTA is "Prohibitions of organ purchases," suggesting that Congress was focusing on monetary transactions.<sup>135</sup> Thus, it was probably not the intent of Congress to preclude priority incentives.

Even without reference to congressional intent, however, one can argue that registration in a priority incentive scheme is not the knowing transfer of "any human organ" for valuable consideration. First, at no point in time is a human organ ever actually exchanged or promised to be exchanged for something of value. At the time of registration, participants are submitting to the mere possibility of transferring an organ. Then, at the time that organs are actually transferred under a priority allocation, the transferor has died and cannot then be receiving consideration for his organ because cadavers do not value anything. Second, if "consideration" is understood according to its typical meaning in the law of contracts, priority incentives do not involve an exchange for consideration, because those who register can unilaterally change their minds until death.<sup>136</sup> Thus, it is unclear if registrants in a priority incentive scheme have made any legally enforceable agreement at all.<sup>137</sup>

Furthermore, the position of the organ donation community seems to be that priority incentives would not violate NOTA. For example, an UNOS ethics committee has taken the position that priority incentives could be implemented without changing existing legislation.<sup>138</sup> In addition, incentives for live organ donation that are structurally analogous to priority incentives have not been said to violate NOTA. For example, a UNOS-approved program called "Hope Through Sharing" is designed to help a person who would like to donate a kidney to a relative in need but cannot because of organ incompatibility.<sup>139</sup> Such a person can instead donate a kidney to a

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concerns which prompted the legislation). See S. REP. NO. 98-382, at 2, *reprinted in* 1984 U.S.C.C.A.N. 3975 (stating the intent of NOTA to "make the buying and selling of human organs unlawful").

135. 42 U.S.C. § 274e (2000).

136. Registrants in a priority program give up no legal rights and suffer no legal detriment. See RESTATEMENT (SECOND) OF CONTRACTS § 71 (1981) ("To constitute consideration, a performance or a return promise must be bargained for. . . . A performance or return promise is bargained for if it is sought by the promisor in exchange for his promise and is given by the promisee in exchange for that promise.").

137. The difficulty in crafting a legally enforceable agreement to create priority incentives is but one of many advantages of having a national priority incentive scheme rather than a series of private agreements created by contract. See *infra* text accompanying notes 163-88.

138. UNOS ETHICS COMMITTEE, *supra* note 5 (stating that a "trial" of priority incentives "could be implemented without requiring any alteration in existing legislation, unlike other mechanisms under discussion").

139. Jay Lindsay, *Kidney Donors Can Indirectly Aid Kin*, CHI. TRIB., Apr. 12, 2001, at 21.

non-relative on the waiting list who is a better match. In exchange, the donor's relative is granted higher priority on the waiting list for a cadaveric organ.<sup>140</sup> In effect, donors in this program exchange organs for something valuable—namely, priority for their relatives.<sup>141</sup> Since this program is widely believed to comply with NOTA, it seems that priority incentives should be similarly viewed.<sup>142</sup>

### C. A Government-Sponsored Approach

In any event, should a priority incentive program be created at the national level, the federal government can amend NOTA to clarify the valuable consideration language, even if such a clarification is unnecessary. Alternatively, if priority incentives were created through administrative regulation, the Department of Health and Human Services' interpretation of NOTA would be given substantial deference.<sup>143</sup> A uniform national priority incentive scheme would have the greatest credibility and legitimacy and would be the easiest to advertise widely across the nation.<sup>144</sup>

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140. *Id.*

141. Press Release, Tufts-New England Medical Center, Tufts-New England Medical Center Unveils First-in-Nation Transplant Exchange Program (Apr. 11, 2001), available at <http://www.nemc.org/home/news/pressrel/2001/01041101.htm> ("Although transplants are expedited, the new UNOS-approved system does not supercede transplants to patients with medical emergencies or those with special matching considerations, including individuals needing multiple organs . . . . These situations account for only about 2 percent of the cases.").

142. General Counsel for UNOS has issued a legal opinion arguing that such programs do not violate NOTA's valuable consideration provisions. See Williams Mullen, *Intended Recipient Exchanges, Paired Exchanges and NOTA § 301*, [http://www.unos.org/shareddownloadables/301\\_nota.pdf](http://www.unos.org/shareddownloadables/301_nota.pdf) (Mar. 7, 2003). Moreover, as discussed, UNOS has its own policy of giving priority to live kidney donors who subsequently need a transplant. See *supra* note 22.

143. See *Chevron, U.S.A., Inc. v. Nat'l Res. Def. Council, Inc.*, 467 U.S. 837 (1984) (deferring to the Environmental Protection Agency's reasonable interpretation of an ambiguous statute); see also Antonin Scalia, *Judicial Deference to Administrative Interpretations of Law*, 1998 DUKE L.J. 511 (1998) (discussing the implications of *Chevron*).

144. In 1987, Singapore enacted the Human Organ Transplant Act (HOTA) which both presumes consent and offers priority incentives to deter opt-outs. See HUMAN ORGAN TRANSPLANT ACT (1987), available at <http://www.lawnet.com.sg/freeaccess/HOTA.htm>; Bernard Teo, *Organs for Transplantation: The Singapore Experience*, HASTINGS CTR. REP. 10, 10-13 (Nov.-Dec. 1991). HOTA presumes the willingness to donate kidneys of mentally competent non-Muslim Singaporeans between ages 21 and 60 who die in accidents. HUMAN ORGAN TRANSPLANT ACT § 5(2). HOTA also uses priority incentives to discourage opting-out. Those who opt-out and those who are presumed to opt-out (namely, Muslims who have not opted-in) have reduced priority should they need kidney transplants. *Id.* §12(1)(a) (providing that "a person who has not registered any objection . . . shall have priority over a person who has registered such objection").

The scope of Singapore's program is quite small. During the six-year period from

Here are some high level steps, not necessarily in chronological order, that would help establish a priority incentive program in the United States:

### 1. Establish National Donor Registry

An organ donor registry records an individual's willingness or unwillingness to donate organs and other tissue at death. Twenty states already have donor registries, and proposed legislation will likely increase that number.<sup>145</sup> A donor registry of some sort is essential to the creation of a priority incentive scheme, as it allows people to record their donation preferences and make themselves eligible for priority allocation. It is not essential for a priority incentive program that we have a truly national donor registry run by the federal government, but we would need a registry that is national in scope. This could potentially include a highly-linked set of state registries, provided that registration is available to everyone.

Even under our current system of allocation, a national donor registry would reduce the stressful decisions made by grieving relatives, save precious time in transplanting organs from donors to recipients, and otherwise facilitate and perhaps increase organ donation.<sup>146</sup> For example, if a potential donor body enters a hospital without a donor card or advance directive, the hospital can use other forms of identification to consult a registry and determine the deceased's donation preferences. A further advantage of a donor registry relates to the fears some have that their organs will be prematurely procured from their still-living bodies when medical professionals learn that they are carrying an organ donor card. While this fear is unfounded,<sup>147</sup> it may serve to reduce donor registration. By establishing a confidential registry, we can require that a person be declared dead before his status as an organ donor is revealed to medical professionals.<sup>148</sup> Thus, by promoting confidence in the organ donation system and by helping to respect the wishes of the recently deceased, donor registries should be supported both by those who are

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1996 to 2001, on average, fewer than fourteen cadaveric kidney transplants involved organs procured under HOTA. Singapore Ministry of Health, *Proposed Amendments to the Human Organ Transplant Act, Public Consultation Paper*, available at <http://app.moh.gov.sg/our/our030202.asp> (last visited Aug. 25, 2003). However, Singapore is considering expanding HOTA to include livers and corneas and to permit organ procurement from those who die under a wider variety of circumstances. *Id.*

145. See U.S. DEPT OF HEALTH AND HUMAN SERVS., *supra* note 11, at iii.

146. See, e.g., Wendler & Dickert, *supra* note 13, at 333 (reporting survey data on OPO procurement consent practices which "provide some support for efforts to create a national computerized registry of individuals' donation wishes").

147. Peters, *supra* note 5, at 179.

148. *Id.* (advocating a donor registry that "can be tapped only by authorized medical personnel after the person has been declared brain dead").



willing to donate and those who want to make it clear that they are not.

Unlike donor registration under a mandated choice program,<sup>149</sup> however, those who register under a priority allocation system will have a clear incentive to register as donors—namely, to gain priority access to the organ supply. Such donors would be permitted to change their preferences, and their corresponding priority to receive organs, at any time before death. As a practical matter, a registry is needed under a priority incentive program to avoid adverse selection of donors in the pool of priority recipients. Without a registry, anyone who developed a need for an organ could immediately declare a willingness to donate and thereby claim priority access. Everyone on a waiting list would lay claim to priority, thereby eliminating the effect of the priority on allocation. Furthermore, the registration of those on organ waiting lists will do little to increase the supply of lifesaving organs, since those on organ waiting lists are suffering from serious health problems that typically make their organs ineligible for cadaveric donation. We cannot induce organ supply by encouraging those in need of organs to list themselves as donors. Therefore, eligibility for priority allocation requires more than just having recently declared a willingness to donate.

One way to sidestep this problem is to limit the preference to those who are eligible to donate at the time they enter the registry, as determined by a medical examination.<sup>150</sup> A far better and more politically appealing approach would simply require people to register an intent to donate by a certain age, say eighteen.<sup>151</sup> If people register by eighteen, regardless of their health status or eligibility to donate, they will be eligible for preference. After this “freebie” registration, they can register at any time (even if a medical condition later makes them ineligible to donate), but they must wait some period of time, perhaps a couple of years depending on the organ, in order to be eligible for priority for that organ. This means that one cannot develop a need for an organ, switch one’s donation preference, and then immediately get priority. Rather, some period of

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149. *See supra* text accompanying notes 89-91.

150. This would exclude people who actively need organs (and are thereby usually ineligible to donate) from receiving priority unless they announced their willingness to donate before their ineligibility was discovered. Such a policy would also exclude many of those who were born, for example, with hepatitis B, HIV, or other diseases that typically make them poor sources of donor organs. Such an approach is unnecessarily exclusive and stigmatizing for a government-sponsored program.

151. I do not address the difficult question of whether children should participate in a priority allocation system. Perhaps we would allow them to participate based on registration decisions made by their parents.

time must pass while one is a registered donor without priority.<sup>152</sup>

The registry can also accommodate those who, for whatever reason, would like to register to donate but would prefer not to participate in the priority allocation system, as there is no reason to alienate any potential donors. The registry could give such donors an option to declare that they are willing to donate but do not wish to receive priority should they ever need it. They may also declare that their organs, should they ever be needed, ought not be allocated according to a formula which provides for priority allocation. Thus, those who cling to the alleged altruism under the status quo system of allocation can turn down a donation incentive, making their gift of life all the more altruistic.

## 2. Promote Awareness of Registry and Priority Allocation

In conjunction with the creation of a registry that is national in scope, efforts must be made to advertise the registry and to make people aware that registered donors get slightly higher preference than those who fail to register or register as unwilling to donate. It would be unfortunate for one person to receive less priority than someone else simply because education efforts reached the second person and not the first. On the other hand, to the extent that the priority program induces donation enough to offset the detriment of having lower priority, then even an uninformed person who is not registered but was willing to donate will still have benefited, with respect to the person's life expectancy, from the existence of the priority program. From a cost perspective, it would also be much easier to educate people about donation in the context of a priority program than it is to educate them now. With a priority program in place, people suddenly have an incentive to pay attention since the decision to register can now improve one's life expectancy. News media that perpetually address our fears of death and illness will offer free coverage explaining, albeit at some level of generality, that registered organ donors have priority in receiving organs and that "you, too, can have that priority by following these simple steps to register."

## 3. Respect Premortem Donation Decisions

To make a priority incentive system workable, premortem decisions to donate must be respected. We cannot grant priority to a

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152. For simplicity, when I refer to registered donors, I will assume that they are registered donors *with* priority. An issue related to this waiting period concerns the initial implementation of the program. It might be best to announce the commencement of the priority allocation a couple of years in advance. This would provide time to educate the public and allow people to register before organs are actually distributed according to a priority formula.

registered donor if the effect of that registration can later be trumped by dissenting relatives. Similarly, if we want a donor registry which is meaningful and trustworthy, we must also respect premortem decisions not to donate.

The current failure to consistently respect premortem donation preferences may stem from the absence of a party to defend the decedent's autonomy interest. When the process fails, the decedent is obviously in no position to sue, and those who would ordinarily sue on his behalf, his family, are the ones who ultimately made the decision either to consent or to refuse to donate. It is likely that some regulatory solution may be necessary, as others may have difficulty establishing standing to sue.<sup>153</sup> For example, state legislatures could grant organ donation organizations the right to sue on behalf of decedents whose clearly expressed donation preferences were ignored.

#### 4. Allocate Some Priority to Registered Donors

The key step in the process, of course, is to alter allocation formulas to give some priority to those patients on waiting lists who have made a prior commitment to donate. The amount of priority to assign will fall somewhere along a spectrum. At one extreme, the needs of anyone who registered to donate could trump the needs of anyone who did not, so that those who do not register are ineligible to receive an organ until every registered donor in need of that organ has received a successful transplant. At the other extreme, status as a registered donor could be the absolute last tiebreaker between two recipients who are otherwise equally eligible for an available organ. While the first approach is unnecessarily draconian and pays too little attention to the severity of a patient's need for an organ, the second approach is too impotent, since the current allocation system is sufficiently discriminating that true ties will rarely occur.

In between, there are virtually limitless formulas to allocate priority. There is, however, a guiding principle we might use to constrain these options. We might require any proposal to assign priority to be such that the distribution under the proposal is expected to be pareto superior to the one we have now.<sup>154</sup> If a proposal

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153. Under federal law (and often under similar state laws), judicial power is limited to "Cases" and "Controversies." See U.S. CONST. art. III, § 2, cl. 1. This provision has been interpreted to require a litigant to have personally suffered an injury in order to bring suit for redress and limits the ability of concerned individuals to sue for injuries to others. See generally LAURENCE H. TRIBE, *AMERICAN CONSTITUTIONAL LAW* § 3-14 (2d ed. 1988).

154. Distribution A is pareto superior to Distribution B if there is at least one person who is better off and no person who is worse off with Distribution A rather than Distribution B. RICHARD A. POSNER, *ECONOMIC ANALYSIS OF LAW* 13 (4th ed. 1992).

satisfies this condition, it means that as a result of the assignment of priority, someone's chances of getting an organ will improve without making anyone else's chances worse. If such a proposal were implemented, it would reduce the concern that a priority incentive scheme will harm those who are simply unaware of the priority program or feel that they were not given sufficient opportunities to register, since they will still share in the priority scheme's benefits, albeit less than if they had registered to donate.

Here is how it could work: We expect that upon creating a priority system, we will induce a certain amount of registration leading to a certain increase in the supply of organs available for donation. Assuming we can estimate this induced supply, we can distribute it so that even those without priority have, on average, a shorter expected waiting time than they had under the old system. In this way, we can reduce everyone's average expected waiting time (the measure by which most patients likely understand their predicaments). If we think a priority incentive will induce only a small supply increase, then we can give registered donors only a small amount of priority. If we think that priority incentives will induce a large increase in supply, we can make the priority incentive larger.

This approach can be easily illustrated by making some simplifying assumptions. Suppose that we have 100 people in need of a liver and expect that one liver can be made available to this group at the end of each month. It would take 100 months before every person in the group received a transplant, assuming, counterfactually, that no one dies during this period or receives a live donor transplant or otherwise leaves the pool. We begin by ranking those in the group according to our current allocative criteria. Whatever the result, we can make some generalizations about average expected waiting times. The average expected waiting time for everyone in the group is fifty months (because organs are available at a constant rate and fifty months bisects the total 100 month time period).

If, after we introduce priority, the average expected waiting time for each person in this group is less than fifty months, we have succeeded in creating a pareto superior organ distribution. To see this, suppose that we consider this same group, but instead of using current allocative criteria, we modify the criteria somewhat to reflect a priority allocation. We will assume that in this world of incentivized donation, we can supply 100 organs in just eighty months instead of 100 months, due to induced donations from the priority incentive scheme. At this point, the average expected waiting time (prior to assigning priority) will drop to forty months (which bisects the total time of 80 months). However, to reward the

commitment to donate made by some of those in the pool, we set the priority of registered donors such that they have a shorter waiting time than those without priority. We could do this by imagining the group split into two equally sized subgroups, one of which has priority and one of which does not. For the subgroup with priority, we shorten the average expected waiting time to, say, thirty-five months and make the average expected waiting time forty-five months for the others. Still, everyone benefits from the incentive program, because each subgroup has an average expected waiting time that is less than the fifty months it would have had under the old system. So in this example, registered donors have shortened their waiting time by over a year, and those not registered to donate have shortened their waiting time by five months.

*Example of a Pareto Superior Distribution Upon Instituting Priority Allocation*

Category of Patient	Average Expected Waiting Time
All Patients Under Current System	50 months
Registered Donors Under Priority System	35 months
Non-Registered Donors Under Priority System	45 months

As a practical matter, it would be quite complicated to guarantee a pareto superior distribution under a priority scheme. First, it will be difficult to estimate the induced supply caused by the incentive. Second, the amount of the induced supply will vary to some extent with the amount of priority given. For those on the border between donating and not donating, the amount of priority that donors actually receive may affect their decision to participate. Public health experts and statisticians would be left with the daunting task of calculating the amount of priority to give based on an estimate of induced donations where the level of induced donations depends on the amount of priority given. Third, it would be difficult to determine the size of the groupings at which to apply the pareto principle in estimating patients' average expected waiting times. If categories were very specific—for example, severely ill liver patients in a particular locality with a particular blood and tissue type—small sample sizes would make it difficult to develop accurate estimates. On the other hand, if categories were very large, it would be difficult to guarantee that everyone's average expected waiting time has decreased; some would argue that they were grouped for purposes of

applying the principle in a way that does not adequately reflect the urgency of their needs.

Of course, it would be difficult to actually construct a priority system that guarantees a pareto superior distribution. Nevertheless, as a guiding principle, it could serve as a not entirely arbitrary way to constrain the amount of priority to assign so that those who refuse to register to donate will still benefit from the switch to a priority incentive system.

#### *D. Priority Incentives Are Not Unfair*

Any proposal to modify organ allocation necessarily raises questions about fairness. In this regard, the following groups of people can be separately considered: (1) those who register under a priority proposal; (2) those who do not register but are also unwilling to receive an organ; (3) those who do not register but would accept an organ if they needed it; and (4) those who would register but for their lack of awareness of the program.

As a preliminary matter, we need not worry about the first two groups. The first category of people describes those who would choose to register under a priority proposal. They will have made a decision to help their fellow humans and perhaps themselves at the same time. It is implausible to think that a person would feel coerced into registering against his wishes. While some may argue, for example, that offering financial incentives for live kidney donation would disproportionately force the poor into donating organs,<sup>155</sup> no similar argument can be made in the priority context. Currently, every person has the right to keep his organs undonated at death and should be permitted to trade this right for waiting list priority. Unlike financial incentives, we need not worry that priority incentives will have discriminatory effects based on wealth, class, race, or even health status. Assuming that awareness efforts are sufficiently effective, each person may simply decide if he values a small increase in his life expectancy more than a small possibility of being a postmortem organ donor.

The second category of people not harmed by priority allocation describes those who oppose both organ donation and organ transplantation.<sup>156</sup> Many Christian Scientists, for example, will neither donate organs nor receive organs, even to treat life-

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155. See Shelby E. Robinson, *Organs for Sale? An Analysis of Proposed Systems for Compensating Organ Providers*, 70 U. COLO. L. REV. 1019, 1040-41 (1999) (claiming that the prevailing view is that financial incentives would disproportionately force the poor to donate organs).

156. Of course, if they are more than just personally opposed to organ donation and actually disapprove of the act of organ donation, then they will perceive themselves as harmed by any proposal that induces more donations.

threatening disease. Whether or not we agree with such views, they do have a respectable consistency. Because of this consistency, such Christian Scientists will neither increase nor decrease the supply of organs available. Contrary to popular myth, most religions do not oppose organ donation.<sup>157</sup> However, to the extent that religions or belief systems do oppose donation, few would approve of organ receipt, yet oppose donation.

Ostensibly of more concern are those who would take an organ but would not donate one. Nearly half of those who would not donate organs would still accept an organ if they needed one.<sup>158</sup> These people are willing to benefit from a common resource without investing anything to create it. On Monday, Alfred can express his religious or aesthetic opposition to organ donation, and on Tuesday, perhaps after being diagnosed with life-threatening liver failure, immediately enter a waiting list for a new liver. Betty, on the other hand, may have expressed a lifelong willingness to donate, may have encouraged her family and friends to declare their intentions to donate, and, under the current system, will enter the waiting list under the same terms and with the same waiting time as Alfred. If we are skittish at all about giving Betty preference over Alfred, we must remember that the entire system of organ donation depends on donors and families of donors who are more like Betty than they are like Alfred. In a world of Alfreds, there would be no organ donation at all.

People like Alfred typically hold inconsistent views.<sup>159</sup> Both cadaveric donors and transplant patients have their bodies opened and have organs removed. Thus, the processes of donation and receipt are, in a certain sense, quite similar. It is difficult to think of religious and aesthetic principles of general application that would prohibit donation but not receipt. Of course, the fact that a person holds inconsistent beliefs does not give us strong grounds for limiting his access to lifesaving resources. However, we do have grounds to create incentives that make people like Alfred reconsider their

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157. See U.S. CONG., OFFICE OF TECH. ASSESSMENT, NEW DEVELOPMENT IN BIOTECHNOLOGY: OWNERSHIP OF HUMAN TISSUES AND CELLS—SPECIAL REPORT 143 (1987); see also Laurence J. O'Connell, *The Religious and Spiritual Perspective Toward Human Organ Donation and Transplantation*, in *THE ETHICS OF ORGAN TRANSPLANTATION* 277 (Wayne Shelton & John Balint eds., 2001).

158. THE GALLUP ORGANIZATION, INC., *supra* note 6, at 12. Surely this number would be even higher among those who discover that they actually need a transplant in order to live.

159. Alfred's view is not necessarily inconsistent, for example, if he feels that the organ donation system or the health care system, in general, will treat him worse than others. Similarly, Alfred might refuse to donate because he finds the thought of being buried without an organ to be terrifying. Yet, it is not inconsistent for him to receive an organ from a person who is perfectly comfortable with organ donation.

position, especially when their position can cost several human lives.

By contrast, we *do* need to worry about those who would donate but are simply unaware of the priority incentive or suffer from misconceptions about organ donation. To that extent, we would need significant efforts to educate people. But we can take comfort for a few reasons. First, as mentioned, the public attention surrounding a priority program would likely generate more interest in and awareness of registration and, subsequently, would generate more registration than there is currently. Second, if a pareto superior distribution principle is used to distribute organs, those that are unaware of the priority program will fare no worse than they do under the current system and will often fare better. Third, even if some other allocation principle is used, this group *may* fare better under a priority incentive scheme, depending on the extent of induced donation and the way that induced donation is distributed.

For example, if enough donations were induced so that there were no longer an organ shortage, then even a priority scheme which did not seek to guarantee any particular distributional result would still be pareto superior to our current system. While this result is unlikely, to the extent we move in that direction, it is at least possible that waiting times can be brought down for everyone. While over 82,000 people are currently on organ waiting lists in the United States, 7,000 to 23,000 bodies eligible for donation are not used each year.<sup>160</sup> Each of these bodies could have provided life-saving organs to several people.<sup>161</sup> If a priority program could induce a significant increase in the number of bodies donated, it is within the realm of possibility that, over time, people would no longer have to die for want of a donor organ.<sup>162</sup>

#### *E. A Social-Entrepreneurial Approach*

In the absence of a national government-sponsored priority incentive program, private individuals have sought to create their own priority incentives through the mutual agreement of a group of

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160. See *supra* notes 12, 16 and accompanying text.

161. See *supra* note 119.

162. This is especially true if technological advances can reduce our need for human replacement organs. For example, in 2001 surgeons implanted the first self-contained artificial heart in a human, and, though the patient died soon thereafter, the results were considered better than expected. See Lawrence K. Altman, *Surgeons Elated by Heart Patient*, N.Y. TIMES, July 5, 2001, at A1. This patient received an artificial heart because his condition made him a poor candidate for a transplanted human heart. *Id.* We can easily imagine, however, a gradual transition process in which artificial organs are relied on for a larger patient class. Further in the future, we may see "the application of new technologies for growing human pluripotent stem cells that . . . allow the manufacture of replacement organs and tissues autologous to their recipients." Capron, *supra* note 19, at 334.



organ donors.<sup>163</sup> In May 2002, David Undis launched "LifeSharers," an organization designed to implement just such a program.<sup>164</sup> Those who register with LifeSharers agree to donate their organs to other members in need.<sup>165</sup>

Should a LifeSharers member ever need an organ, like non-members, he begins the process by joining the UNOS waiting list. If, however, a LifeSharers member dies with organs eligible for transplantation, the LifeSharers member highest on the UNOS waiting list is supposed to get access to those organs before any non-members. If no LifeSharers member needs organs available from another member, the organs are allocated according to the traditional system.<sup>166</sup> Because members can draw organs from both members and non-members, in exchange for joining, they have a slightly higher chance of receiving an organ than do non-members.

There are currently over 1500 people who have joined LifeSharers.<sup>167</sup> Membership is free and can be canceled without penalty, except for the loss of one's priority status.<sup>168</sup> Though the organization is small and has yet to play a role in the actual allocation of an organ, LifeSharers hopes to "correct an inequity in the current organ allocation system, which gives about 80% of all organs to people who haven't agreed to donate their own organs."<sup>169</sup>

A privately-operated incentive program like LifeSharers has great flexibility in setting eligibility requirements for joining.<sup>170</sup>

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163. An early precedent for this kind of mutual insurance pool combined priority and financial incentives. In 1985, soon after NOTA was passed, then-Senators Al Gore and John Heinz called upon the Justice Department to investigate whether NOTA had been violated by a group called the "Transplant Society." Margaret Engel, *Insurance Firm's Organ Transplant Idea May Be Investigated*, WASH. POST, Sept. 9, 1985, at A5. The Transplant Society planned an insurance system in which those willing to donate their organs would receive priority in receiving organs, and, if their organs were eventually harvested, \$10,000 would be donated to their favorite charity. *Id.* A news search did not reveal how the matter was resolved. Had the group avoided use of a financial incentive, it would have received much less scrutiny.

164. LIFESHARERS, FAQ, at <http://www.lifesharers.com/faq.asp> (last visited Aug. 25, 2003).

165. LIFESHARERS, HOW IT WORKS, at <http://www.lifesharers.com/howitworks.htm> (last visited Aug. 25, 2003).

166. *Id.*

167. LIFESHARERS, *supra* note 164.

168. *Id.*

169. Press Release, LifeSharers, LifeSharers Responds to Concerns Voiced by UNOS (Mar. 7, 2003), at <http://www.LifeSharers.com/pressrelease20030307.htm>.

170. For example, LifeSharers could seek an actuarial match between the likelihood that a participant's organs will be medically appropriate for transplantation and the likelihood that the participant will need an organ. Similarly, the pool could require health examinations as a condition of initial entry to make sure that all participants have organs eligible for donation and no then-existing transplant needs. Or, to save

Wisely, LifeSharers is quite inclusive, allowing anyone to join (including children who are registered by a parent or legal guardian).<sup>171</sup> To discourage members from waiting until they actually need an organ to join, LifeSharers members do not become eligible for priority receipt of an organ until 180 days after they register.<sup>172</sup>

To effectuate a priority allocation among its members, LifeSharers takes advantage of provisions in both incarnations of the UAGA which permit donors to direct their organ donations in various ways. The UAGA of 1987, for example, allows donations to “a designated individual for transplantation or therapy needed by that individual.”<sup>173</sup> Typically, this provision is used for live organ donations, where a donor specifies that he is donating, for example, his kidney to his brother. Interestingly, however, the provision refers to a “designated individual” and not a “named individual.” Capitalizing on this difference, a LifeSharers member designates that each of his organs goes to “that LifeSharers member who is the most suitable match as defined by the criteria in general use at the time of my death.”<sup>174</sup> LifeSharers hopes and expects that OPOs will honor this direction by giving organs donated by LifeSharers member to the highest ranked LifeSharers member on the UNOS waiting

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costs, it could investigate just those participants who subsequently enter the waiting list for an organ in order to verify that they were unaware of this need at the time they joined.

171. Press Release, LifeSharers, Parents Are Improving Transplant Odds for Their Children (Jan. 16, 2003), at <http://www.lifesharers.com/pressrelease20030116.htm>.

172. LIFESHARERS, *supra* note 165. Given that the average waiting period for certain organs can be several years, in order to get people to join before they actually need an organ, LifeSharers might consider lengthening the wait for priority eligibility or using different waiting periods for different organs.

173. UNIF. ANATOMICAL GIFT ACT § 6(a) (1987). In 1983, then-President Ronald Reagan created controversy by making a radio appeal to the nation for a liver to be donated to a particular eleven-month-old girl. Mark D. Fox, *The Uniform Anatomical Gift Act*, in ORGAN AND TISSUE DONATION: ETHICAL, LEGAL, AND POLICY ISSUES 43, 44 (Bethany Spielman ed., 1996).

174. LIFESHARERS, *supra* note 165. Strictly speaking, LifeSharers members agree to donate their “organs and tissue” upon death. LIFESHARERS, JOIN HERE, at <https://www.lifesharers.com/enroll.asp> (last visited Aug. 25, 2003) (emphasis added). LifeSharers does this because many of those ineligible to donate bodily organs due to a variety of medical conditions can often still contribute bodily tissue, such as bone or cartilage. Telephone Interview with David Undis, Executive Director, LifeSharers (July 31, 2003); see also LIFESHARERS, *supra* note 165 (“Everybody’s got something that can be useful for transplantation, therapy, or medical research.”). The policy, therefore, contributes to LifeSharers broad efforts at inclusivity. It has the unfortunate consequence, however, of implying that almost all LifeSharers members are supposed to become tissue donors at death, since nearly everyone is eligible to donate tissue. By contrast, it is rare for a person to die with organs eligible for transplantation. Such a policy may alienate those who are willing to donate an organ in order to save a life but not willing to donate tissue that could be used, for example, in cosmetic surgery.

list.<sup>175</sup> According to LifeSharers, when an organ becomes available:

If the organ is from a LifeSharers member, the LifeSharers members (if any) on the UNOS waiting list for that organ get preferred access to it. The OPO must offer the organ to them first. [OPOs] can obtain a list of these members from LifeSharers. If you are the highest-rated LifeSharers member on the UNOS waiting list, the OPO will offer your transplant center the organ. If your transplant center accepts the organ, it will be harvested and sent to your center for your operation. If they reject it, the OPO will contact the transplant center for the next-highest-ranking LifeSharers member (if any) on the waiting list. If the organ is not accepted for any LifeSharers member, it will be offered to non-members.<sup>176</sup>

Because no LifeSharers member has yet become an organ donor, the process has not been put to the test. It is, therefore, unsettled whether UNOS and regional OPOs will cooperate with LifeSharers' plan.

At least as of February, 2003, UNOS had no plans to challenge the legality of LifeSharers.<sup>177</sup> At the same time, however, the UNOS Ethics Committee declined to offer its support.<sup>178</sup> Mark Fox, chairman of the committee, has said of LifeSharers: "Our concern is that it essentially undermines the established organ allocation system by creating a kind of special class of 'LifeSharers members' that receive special consideration."<sup>179</sup>

LifeSharers offers two replies. First, LifeSharers notes that the UNOS-supported "Hope Through Sharing" program<sup>180</sup> uses willingness to donate as a criterion in organ allocation. According to LifeSharers, "[b]y endorsing Hope Through Sharing, UNOS has shown a willingness to deviate from the use of clinically-relevant

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175. If this procedure is challenged, LifeSharers may have alternative procedures to accomplish a similar result. For example, the UAGA of 1987 provides that an anatomical gift can be made to a physician or surgeon. UNIF. ANATOMICAL GIFT ACT § 6(a). If so, it may be possible for LifeSharers members to agree to donate their organs to a particular physician or surgeon affiliated with LifeSharers who would subsequently effectuate an allocation aligned with LifeSharers' mission.

176. LIFE SHARERS, *supra* note 165.

177. Sameh Fahmy, *Share, and Share Alike*, THE TENNESSEAN, Feb. 18, 2003, at 1D. This could change, of course, particularly when an OPO is eventually called upon to allocate an organ from a LifeSharers donor.

178. Press Release, LifeSharers, LifeSharers Responds to Concerns Voiced by UNOS (Mar. 7, 2003), at <http://www.lifesharers.com/pressrelease20030307.htm>; see also UNOS ETHICS COMMITTEE, OPTN/UNOS ETHICS COMMITTEE REPORT TO THE BOARD OF DIRECTORS (Nov. 14-15, 2002), available at [http://www.unos.org/members/docs/report\\_3.doc](http://www.unos.org/members/docs/report_3.doc) ("[T]he Committee declined to endorse the mission of the LifeSharers organization as such an action is beyond the scope of its charter.").

179. Fahmy, *supra* note 177.

180. See *supra* text accompanying notes 139-42.

characteristics in allocating organs, and we hope it will honor that precedent with respect to LifeSharers.”<sup>181</sup> LifeSharers could also argue that it does not undermine the established allocation system because that system permits donors to direct their organs in certain ways, one of which is to those individuals who also agree to donate to a mutual organ pool.<sup>182</sup>

Second, as to Dr. Fox’s concerns about creating a special class of LifeSharers members, LifeSharers notes that membership is free and open to everyone. People can join using the Internet at a public library, or they can send a handwritten letter.<sup>183</sup> “No one is excluded from joining LifeSharers, and LifeSharers does not discriminate on the basis of race, color, religion, sex, national origin, age, physical handicap, health status, marital status, or economic status.”<sup>184</sup> While not everyone is aware of LifeSharers, LifeSharers is trying both to spread organ donation awareness and to increase membership.

No doubt, UNOS also fears the formation of organizations similar to LifeSharers but with less admirable motives. For example, on very rare occasions, people have sought to use directed donation provisions in the UAGA to donate organs only to members of a particular “race, religion, gender, sexual orientation, or disease group.”<sup>185</sup> It is a matter of dispute whether such donations should be prohibited, even though doing so may lead to a net loss of organs and, hence, a net loss of life.<sup>186</sup> Yet, even if it is difficult to craft policy to easily distinguish desirable and undesirable directed donations, it seems unfortunate to use this as a basis for prohibiting the

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181. Press Release, LifeSharers, *supra* note 178.

182. More mischievously, LifeSharers could take the position that it *does* undermine the established organ allocation system and that it does so to correct a major deficiency in that process.

183. Telephone Interview with David Undis, Executive Director, LifeSharers (Apr. 2, 2003).

184. Press Release, LifeSharers, *supra* note 178.

185. VEATCH, *supra* note 23, at 392 (describing an instance where family members of a Ku Klux Klan sympathizer sought to make his organs available for “donation to White recipients only”). UNOS has taken a position against such directed donation, seeking to add the following language to the UAGA: “Donation of an organ may not be made in a manner which discriminates against a person or class of persons on the basis of race, national origin, religion, gender or similar characteristic.” UNOS BOARD OF DIRECTORS, DIRECTED DONATION REFERENCE STATEMENT (June 1996), *available at* <http://www.unos.org/resources/bioethics.asp?index=10>; *see also* Stephanie Strom, *Giving of Yourself, Literally, to People You’ve Never Met*, N.Y. TIMES, July 27, 2003, at WK3 (describing a white man who specified that his kidney be donated “to ‘a low-income African American’ because African-Americans have greater difficulty getting kidneys from family members”).

186. *See* VEATCH, *supra* note 23, at 393-411 (criticizing discriminatory directed donation even though “everyone below the privileged recipient is actually made better off because of the discrimination” because “[t]hey all move up on the waiting list”).

admirable aims of LifeSharers.

Still, the size and scope of a national priority incentive program would give it several advantages over a private program.<sup>187</sup> First, it may take a long time until an organization like LifeSharers can attract enough members to create a priority incentive strong enough to induce substantial registrations from those who are otherwise reluctant to donate. Meanwhile, a change in the UNOS allocation formulas could alter incentives practically overnight, and UNOS has an established network to make the public aware of a national priority program. Second, a non-profit organization like LifeSharers, which is run on charitable donations, may not be well equipped to run an organization with a requisitely large membership, and NOTA makes it difficult to charge membership fees. Third, for LifeSharers to best accomplish its objectives, UNOS will have to cooperate, and such cooperation must be smooth and effective given the short time available to make organ allocation decisions. Fourth, those who register to donate probably ought not receive absolute priority over those who do not. If they did, a very sick person in the private organ pool who is a poor match for a LifeSharers organ could get the organ before a comparatively less sick person who is a much better match for the organ but is not a LifeSharers member. LifeSharers argues that it is not required to give a LifeSharers organ to a member that is not a "suitable match,"<sup>188</sup> but this policy would have to be worked out in more detail. It is an advantage of a national priority scheme that it can more easily make willingness to donate one of several factors in organ allocation. Fifth, a government-sponsored incentive program can better ensure compliance with the obligation of participants to donate than can a private organization like LifeSharers. Finally, with a national priority incentive scheme, everyone who registers to donate receives priority on equal terms, regardless of whether or not he is aware of programs like LifeSharers.

Given these concerns, an organization like LifeSharers may serve its highest role by prodding policymakers to create a national priority incentive program. LifeSharers can generate momentum to institute such a change either by demonstrating the popularity of priority incentives or by making policymakers fear losing control over organ allocation as more and more organs bypass the government's allocation monopoly.

## V. A RESPONSE TO TWO CRITIQUES OF DONATION INCENTIVE

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187. This position is taken in Schwindt & Vining, *supra* note 5, at 730-35. LifeSharers' Executive Director agrees, assuming that priority incentives under a national program are strong enough to induce sufficient donations. Telephone Interview with David Undis, *supra* note 183.

188. Telephone Interview with David Undis, *supra* note 174.

## PROGRAMS

Those who favor the status quo system of organ donation tout the opportunities it creates for altruistic behavior. They argue that donation incentives, be they financial or priority-based, give people non-altruistic reasons to donate and arguably weaken the altruistic framework at the core of our current system. Many also argue against donation incentives out of fear that they will turn human organs, and ultimately humans themselves, into commodities. Such commodification, so the argument goes, eviscerates important qualities of human personhood. In this section, I respond to these critiques and attempt to reveal the stunning hypocrisy of our entrenched system of organ donation which, in the name of altruism and human dignity, leads to unnecessary, preventable pain and death.

A. *The Altruism Argument Against Financial and Priority Incentives*

Under the current system, donation is supposed to be principally motivated by altruism—awareness campaigns encourage us to register to make a “gift of life.”<sup>189</sup> Staunch defenders of the gift of life metaphor challenge any donation arrangement not based purely on altruistic donation. They frequently cite Richard Titmuss’s in-depth study of blood donations in England and the United States,<sup>190</sup> which argued that voluntary systems of blood donation wasted less blood and were safer than commercial systems.<sup>191</sup> Titmuss also argued that a completely voluntary system of blood donation nurtures altruistic tendencies, while a paid system encourages coercion and constraint.<sup>192</sup> Speaking of unpaid blood donors, Titmuss wrote:

As individuals they were, it may be said, taking part in the creation of a greater good transcending the good of self-love. To “love” themselves they recognized the need to “love” strangers. By contrast, one of the functions of atomistic private market

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189. See, e.g., Paul Lauritzen et al., *The Gift of Life and the Common Good*, 31 HASTINGS CENTER REP. 29, 29-35 (2001); GIFT OF LIFE DONOR PROGRAM, GIFT OF LIFE DONOR PROGRAM, at [http://www.donors1.org/index\\_flash.html](http://www.donors1.org/index_flash.html) (last visited Aug. 25, 2003).

190. RICHARD M. TITMUSS, *THE GIFT RELATIONSHIP: FROM HUMAN BLOOD TO SOCIAL POLICY* (1971).

191. *Id.* at 22, 154-55.

192. *Id.* at 239. Titmuss wrote:

[A]s this study has shown comparatively, private market systems in the United States and other countries not only deprive men of their freedom to choose to give or not to give but by so doing escalate other coercive forces in the social system which lead to the denial of freedom . . . .

systems is to "free" men from any sense of obligation to or for other men regardless of the consequences to others who cannot reciprocate.<sup>193</sup>

According to Titmuss, "in the free gift of blood to unnamed strangers [there is] no contract of custom, no legal bond, no functional determinism, no situations of discriminatory power, domination, constraint or compulsion, no sense of shame or guilt, no gratitude imperative and no need for the penitence of Chrysostom."<sup>194</sup> It is argued that these sorts of benefits apply to organ donation as well.<sup>195</sup>

### 1. The Consequentialist Defense of Altruistic Donation

There are at least two kinds of arguments to defend the gift-giving aspect of our current organ donation regime. The consequentialist argument says that an altruistic policy of organ donation actually maximizes the total number of organs available for transplantation. For example, it has been argued that gift-giving by some encourages gift-giving by others.<sup>196</sup> If donation is viewed as socially appropriate and socially expected, the hope is that more people will donate. This argument says that altruistic organ donation promotes altruistic organ donation through a virtuous cycle. Furthermore, many would be so opposed to the idea of financial or other non-altruistic incentives that the mere existence of such

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193. *Id.*

194. *Id.*

195. See, e.g., Edmund D. Pellegrino, *Families' Self-Interest and the Cadaver's Organs: What Price Consent*, in THE ETHICS OF ORGAN TRANSPLANTS 205-06 (Arthur L. Caplan & Daniel H. Coelho eds., 1998) (citing Titmuss to support altruistic organ donation).

Titmuss's claims have been challenged on both empirical and philosophical grounds. See, e.g., Kenneth J. Arrow, *Gifts and Exchanges*, 1 PHIL. & PUB. AFF. 343 (1972); Harvey M. Sapolsky & Stan N. Finkelstein, *Blood Policy Revisited: A New Look at 'The Gift Relationship'*, 46 PUB. INT. 15 (1977). But accepting Titmuss's claims as true, reliance on his study in the context of cadaveric organ donation is misplaced. First, one of the biggest benefits of a voluntary system of blood donation that Titmuss observed was that the quality of blood was higher from volunteers whereas paid donors tended to be poorer and had a greater incentive to lie about whether or not they had hepatitis or other then-undetectable diseases transmitted by blood. TITMUSS, *supra* note 190, at 154-55. For obvious reasons, organ quality among cadavers will not be influenced by donation incentive schemes, and nowadays, medical scientists are quite capable of assessing organ quality before an organ is used in transplantation. Second and more importantly, there is no life threatening shortage of blood, but there is a life threatening shortage of organs. Altruistic gift-giving has failed to furnish a sufficient incentive to encourage donor registration.

196. See EDWARD W. NELSON ET AL., UNITED NETWORK FOR ORGAN SHARING ETHICS COMMITTEE, FINANCIAL INCENTIVES FOR ORGAN DONATION (1993), available at <http://www.unos.org/Resources/bioethics.asp?index=3> ("[I]t has been suggested that donation rates could decrease under [a financial incentive] system due to a backlash and losses from the current donor pool based on pure altruistic giving.").

incentives would cause organ donation rates to decline. This argument assumes one might reason as follows: "I was going to donate my organs at death in exchange for nothing at all should they ever be needed, but since you are going to offer me allocation priority should I ever need it (or since you're going to offer my family \$10,000 should my organs ever be used after my death), I am instead going to deny my organs to everyone."

The consequentialist defense of altruistic donation focuses less on the meaning of gift-giving to society and more on its effects on the supply of organs available for donation.<sup>197</sup> Of course, if it were true that altruistic gift-giving makes more organs available for transplant than would incentive schemes, we would have a compelling reason to maintain the status quo emphasis on altruistic donation. In fact, this view flies in the face of any reasonable understanding of human nature and behavior, and there is no good empirical evidence to support it.<sup>198</sup>

## 2. The Deontological Defense of Altruistic Donation

A better argument in favor of altruistic donation implicitly admits that altruistic giving leads to less organ donation than incentivized giving.<sup>199</sup> More importantly, proponents of this view argue, altruistic donation is preferable to incentivized giving because it connects unrelated people and communities through unselfish support and kinship.<sup>200</sup> Advocates of this position do not deny that if we give people an incentive to register to donate, we will increase

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197. A similarly farfetched consequentialist position could argue that altruistic organ donation better promotes total social welfare than does incentivized donation, even if altruistic donation harms waiting list patients, because altruistic organ donation encourages positive altruistic behavior in other walks of life.

198. See THE GALLUP ORGANIZATION, INC., *supra* note 6, at 43 (indicating that financial incentives make more than twice as many people more likely to donate than they make less likely to donate). Thus, even if financial incentives offer only a slight inducement to donate, it is likely that they would have a net positive effect on organ supply.

199. See, e.g., Pellegrino, *supra* note 195, at 206 ("For patients to die waiting for an available lifesaving organ is an indictment of the level of altruism in our society, but not a sufficient reason for eliminating altruism itself.").

200. Speaking of our blood donation system, Thomas Murray writes:

It is a massive effort at giving to strangers. Roughly eight million Americans donate each year. In its scale, its lack of monetary rewards, and its distance between donor and recipients, the whole-blood procurement system in the U.S. is a remarkable example of impersonal gifts. It suggests something very important that a society would be so generous in this realm and would reject so clearly a market approach to the supply and distribution of a good.

Thomas H. Murray, *Gifts of the Body and the Needs of Strangers*, 17 HASTINGS CENTER REP. 30, 36 (APR. 1987). "Giving blood to strangers is not just any gift, but a vital one that expresses and affirms our bonds with those strangers." *Id.*



*total* organ donation, but they bemoan the reduction in *altruistic* organ donation it will cause and believe society will be the worse for it.<sup>201</sup> This view does require us to see the societal merits of altruistic donation as an end in itself, since the view cannot be justified solely by appeal to its effects on the organ supply.

### 3. Where is the Altruism?

The much-vaunted altruism in our current organ donation system, however, is not so easy to find.<sup>202</sup> To act altruistically, one must act with an appropriate other-regarding motivation.<sup>203</sup> For example, if I offer a "gift" solely to receive something better in return, rather than making a gift, I have made an investment. Similarly, if I offer a "gift" solely because I am socially expected to, I have again made more an investment than an altruistic transfer. Conversely, the mere fact that a particular gift will generate more self-regarding benefits than self-regarding costs for the giver does not necessarily negate the giver's altruistic, other-regarding motivations. Without offering a detailed explanation of all the necessary and sufficient conditions for altruism to flourish, it is clear that gift-giving is only altruistic if it is done with an altruistic motivation.

The requirement that altruistic gifts be altruistically motivated presents a challenge to defenders of the status quo system of cadaveric donation. Obviously, cadavers cannot act altruistically since they can neither act nor have motivations. This seemingly obvious point is clearly not reflected in the rhetoric which proclaims cadaveric organ donors as heroes, even when the proclamation gives no regard to whether the deceased donor actually played any role in the decision to use his organs.<sup>204</sup>

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201. See, e.g., Pellegrino, *supra* note 195, at 205-06 ("To create a deliberate conflict between altruism and self-interest is to reduce our freedom to make a gift to a stranger. This . . . has serious destructive effects, ethical and nonethical, on the whole of a society.") (citations omitted).

202. Cadaveric organ donation represents an extremely impersonal kind of gift-giving, as cadaveric organ donors never know the recipient of their gifts. Concerning voluntary donations to blood banks, Kenneth Arrow writes that they represent "an expression of impersonal altruism [that] is as far removed from the feelings of personal interaction as any marketplace." Arrow, *supra* note 195, at 360. Arrow's statement is all the more true for cadaveric organ donation. A blood donor is at least aware that he is making a gift, but an organ donor, at most, knows only that he is gifting a negligible probability of making a gift.

203. See generally THOMAS NAGEL, *THE POSSIBILITY OF ALTRUISM* (1978).

204. MARK O'BRIEN, SON DIES, FATHER WORKS SO OTHERS MAY LIVE, at [http://www.nsagifttolife.org/opinion\\_article.htm](http://www.nsagifttolife.org/opinion_article.htm) (last visited Aug. 25, 2003) (quoting Charles McCluskey, executive director of the Organ Procurement Program, stating that a cadaveric donor who never signed an organ donation card nor discussed the matter with his family was "a hero' in the eyes of recipients"). The rhetoric of heroism plays a large role in programs aimed at encouraging donor registration with many

To the extent that cadaveric donors act altruistically at all, they do so when they agree to donate their organs upon death, making the decision while they are still alive and capable of both acting and having motivations. Yet, even when people pledge to donate their organs, they have hardly demonstrated altruistic behavior of heroic proportions, given the extraordinarily low probability that any particular organ pledger will ever actually donate an organ.<sup>205</sup> Furthermore, if you believe that registering to donate is morally required, as hinted at by our trolley problems in Part III, registering to donate seems less like supererogatory altruism and more like quotidian moral duty.<sup>206</sup>

Assuming donation is not morally required, signing a donor card does demonstrate some altruistic behavior. But such altruism hardly claims responsibility for much donation in our current system since most people do not express their donation preferences and, even when they do, doctors still refuse to transplant organs without family consent.<sup>207</sup>

Perhaps it is better to consider whether virtue accrues to those who donate the organs of their loved ones. Yet, it seems hard to understand why they should accrue moral credit for donating someone else's body parts. Organ donation does not interfere with burial or other death rituals, and as Joel Feinberg has noted, "it is difficult to understand how the thought of bodies having their organs removed before burial can be more depressing than the thought of them festering in the cold ground or going up in flames."<sup>208</sup>

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advocates using slogans like, "Be a hero for life." See, e.g., MD. MOTOR VEHICLE ASS'N, THE ORGAN DONOR PROGRAM, at <http://mva.state.md.us/MVAProg/ORGAN/default.htm> (last visited Aug. 25, 2003).

205. There is significant philosophical literature on "moral luck" which argues that the moral credit or blame for one's actions need not be limited by the intentions of the actor. If we accept this view, one could argue that a pledger whose organs are actually used is "morally lucky" and deserves credit beyond that of someone else who made an equally sincere pledge to donate but whose organs, as fate would have it, are never actually used.

Yet, even those who believe that our moral credit and blame for some outcome outstrips our control over the outcome would likely still agree that a donor cadaver cannot be morally lucky where the donor neither acted nor held intentions concerning organ donation. For a collection of essays on this subject, see MORAL LUCK (Daniel Statman ed., 1993). For an argument against the existence of genuine moral luck, see Adam J. Kolber, *The Moral of Moral Luck* (1996) (unpublished senior thesis, Princeton University) (on file with author).

206. See Peters, *supra* note 5, at 167-77 (arguing that consent to organ donation "is not an act of charity" but "a moral duty of substantial stringency").

207. See *supra* text accompanying notes 63-72.

208. Joel Feinberg, *The Mistreatment of Dead Bodies*, 15 HASTINGS CENTER REP., 31, 36 (Feb. 1985). The supposed necessity of a ritual burial can, however, have a dramatic hold on the human psyche. In the famous criminal procedure case *Brewer v.*

Nevertheless, survivors do make a valuable contribution when we ask them to carefully consider the preferences of their recently deceased relative when they would much prefer to be grieving in private without interference from medical personnel. Thus, families and other survivors do make a substantial sacrifice. But, the sacrifice they make is independent of any actual organ transfer. The family is supposed to be deciding the preferences of the deceased (at least when the deceased was an adult). Therefore, upon thoughtfully deciding, family members have made the same sacrifice whether or not they choose to donate. Furthermore, the sacrifice made by family members derives from our inability to give people appropriate incentives to register their own donation preferences while alive and from our concomitant lack of steadfastness in honoring those preferences when made. We should hardly take credit for the sacrifices made by families that arise largely as an artifact of an imperfect donation system which we impose upon grieving families during their private moments of mourning.

When parents donate a child's organs, it is perhaps easier to see heroic altruism in action. Though a parent is still donating someone else's body parts, if the child is very young, the parents' decision and the child's decision are arguably one and the same. Margaret Jane Radin offers this eloquent example:

Imagine the case of grief-stricken parents being asked to donate the heart of a brain-dead child to a newborn victim of congenital heart disease in a distant hospital. The parents are being asked to give up the symbolic integrity of their child and face immediately the brute fact of death. The act of donating the heart may be one of those distinctively human moments of terrible glory in which one gives up a significant aspect of oneself so that others may live and flourish.<sup>209</sup>

But even if we were to credit parents for donating their children's organs, Radin's vignette identifies little altruistic behavior. First, the example is somewhat misleading, because, as noted, the parents must "face immediately the brute fact of death" when asked to donate whether or not they ultimately decide to do so. Second, donations from young children account for only a portion of the entire pool of organs donated. Third, we may question why Radin is so solicitous of parents' desire to maintain their child's symbolic integrity, when there is another child's symbolic and *actual* integrity at stake here.

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*Williams*, 430 U.S. 387 (1977), an accused murderer was prompted to reveal the location of a murder victim when police officers warned him that "the parents of this little girl should be entitled to a Christian burial." *Id.* at 393. Granted, the accused was mentally ill and quite susceptible to persuasion. See *id.* However, he was cajoled by a concept deeply rooted in many religious traditions.

209. MARGARET JANE RADIN, *CONTESTED COMMODITIES* 97 (1996).

Radin praises "those distinctively human moments of terrible glory in which one gives up a significant aspect of oneself so that others may live and flourish."<sup>210</sup> Yet, only about half of these stories end with such human moments.<sup>211</sup> The other half end with distinctively inhumane moments of indecision, uncertainty, and perhaps even selfishness in which another child dies because parents made a decision, not of terrible glory, but of terrible consequences.

Altruism in the current system is also elusive because alternative, non-altruistic behaviors are illegal. When laws and regulations prevent or otherwise hinder organ sales or other mutually advantageous transactions, they reduce opportunities to act non-altruistically. It is, therefore, not surprising that some people choose to donate. But surely the altruism inherent in a gift is partly a function of what the giver forgoes by making the gift. If a person donates to charity a tattered old t-shirt which he would otherwise throw away, we have relatively little evidence that the donor had an other-regarding motivation, and so he probably gets little credit for making the gift. In contrast, when a homeless person takes a few coins out of his jar to help another homeless person with fewer coins, he demonstrates a substantial other-regarding motivation, since he likely very much values that with which he parts.

Current law saps organs of their market value, which reduces the opportunity costs of those who decide to donate. Thus, there is less evidence for other-regarding motivations in our current system than there would be under incentive schemes. To witness truly altruistic behavior, we should give people non-altruistic opportunities. Those who persist in altruistic donation will show that their altruism was not just an artifact of their limited range of self-injuring options.

No donation incentive program requires people to accept the benefits of participation. Under a priority incentive scheme, one could pledge to donate organs and specifically disavow any beneficial priority received. Or, under a financial incentive program, one could refuse compensation or donate the money to charity. Thus, even under incentive schemes, there are still opportunities for purely altruistic donation.

Radin thinks the matter is more complicated than that. According to Radin, the existence of incentive schemes may sully the nature of even purely altruistic donation. Consider how she extends her preceding example:

But now imagine the experience if the grieving parents know that the market price of hearts is \$50,000. There seems to be a

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210. *Id.*

211. See *supra* text accompanying note 73.

sense that the heroic moment [of purely altruistic donation] now cannot be, either for them to experience or for us to observe, in respect and perhaps recognition. If the parents take the money, then the money is the reason for their action; or at best neither we nor they themselves will ever know that the money was not the reason for the action.<sup>212</sup>

Contrary to Radin, however, just because a family accepts money to donate does not mean that the money was the reason for the action. Nor is it true that it is impossible to know if the family had some other driving motivation. Radin allows too little opportunity for the family members to introspect and simply ask themselves to consider their reasons for donating (which may or may not relate to the financial incentive) and to consider how they would have acted without the incentive. Similarly, we can and must reach our own conclusions as to what *we think* motivated the family's decision, just as we must do when no incentives are involved. For example, in the non-incentive example, Radin suggests that we are capable of appreciating the "terrible glory" of the parents who decide to donate.<sup>213</sup> But how do we know that the family was so concerned with the "symbolic integrity"<sup>214</sup> of their child? Perhaps the parents donated to avoid feelings of guilt from not donating, or they appreciated the positive social consequences of being viewed as parents who made a "gift of life." We can only understand their decision by extrapolating the beliefs of the parents from their actions and from whatever else we know about them. Thus, we could quite easily determine that certain parents who donated their child's organs under a financial incentive scheme would have done so even in the absence of a non-altruistic incentive.

Radin fears, however, that if the parents "don't take the money, then their act can seem like transferring 'their' \$50,000 to the transplant recipient."<sup>215</sup> She goes on to qualify this statement and question whether "once something is monetized for some it is monetized for all."<sup>216</sup> But, even if donating an organ becomes viewed as donating \$50,000, does that mean, as Radin suggests, that "[n]o matter what choice the parents make, the opportunity for a pure act of caring is foreclosed"?<sup>217</sup>

It is not at all clear why a donation of money is less of a pure act of caring than a donation of an organ.<sup>218</sup> A donation of \$50,000 is not

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212. RADIN, *supra* note 209, at 97.

213. *Id.*

214. *Id.*

215. *Id.*

216. *Id.*

217. *Id.*

218. I shall argue in the next section that, as a matter of social policy, according to

such a valuable gift if viewed only as a way of purchasing a luxury item like a fancy sports car. If, however, money is viewed as a way of purchasing a life-saving organ, a donation of \$50,000 becomes quite valuable. When money becomes commensurable with a life-saving organ, rather than viewing the value of organs as infected by a relationship to money, we can view money as more valuable because of its ability to buy something that is truly important.

Also, if viewing some donation in terms of its dollar value is enough to make the donation impure, then even donations under the current system may be impure, since every donation has a counterfactual market value (a market value in a world where the donated item could have been sold). Perhaps while agreeing to donate, a donor says to himself, "I will gratuitously donate my relative's organs because the law prohibits me from selling them to a fertilizer company." Donation from this individual is not very altruistic at all, even though his motivation is sullied only by his beliefs about how he would act under counterfactual circumstances. Certainly, the motivation of this donor (under our current scheme) is less pure than the motivation of the donor who declines \$50,000 (under a financial incentive scheme) but donates his relative's organs anyhow. Thus, even if we prohibit the exchange of organs through markets, we can never prohibit organs from having a counterfactual market value, and we can never be sure that those who do donate under an "altruistic" scheme, in fact, have altruistic motivations of real significance.

#### 4. Altruism Embedded in Social Policy

Perhaps the altruism of our current system derives not so much from discrete altruistic actions but rather, as some have argued, from a social policy that is designed to reflect and contribute to community connectedness through the mutual kindness of strangers.<sup>219</sup> In a sense, it is our decision as a society to supply organs as we do that is a kind of gift, and it is our group decision which has positive benefits for the community as a whole.

Such a view, however, raises motivation problems of a different sort. The primary beneficiary of our altruistic endeavor is supposed to be the organ waiting list community. Yet, almost everyone agrees that an incentive program would encourage more donation than would a purely altruistic approach. Those who need organs in order to survive would almost certainly prefer more organs "unfortunately"

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the way Radin understands acts of caring, waiting list patients—the purported beneficiaries of our altruistic caring—would prefer more frequent acts of less caring organ donation than less frequent acts of more caring organ donation. See *infra* text accompanying notes 219-26.

219. See *supra* note 200.

made available by incentivized donors rather than fewer organs "fortunately" made available by altruistic donors. Virtually all of those on a waiting list will prefer an organ donation system which maximizes their life span by increasing the probability they will receive an organ. So the gift of altruistic donation that we make to the waiting list community is less desirable from its perspective than other approaches we could take.

It is as if the institution of organ donation is being used as a means to further another goal not specifically related to organ donation. Yet this other goal, the proliferation of community-wide altruism, is undercut almost entirely by the fact that it comes at a huge cost to the intended beneficiaries of our gift of life. There is more than a mere tradeoff between lives lost under the current system and the promotion of societal altruism. Rather, societal altruism, understood as a positive side-effect of some social policy, is greatly undermined when we knowingly seek societal altruism at the expense of human lives. The societal altruism argument, therefore, fails on its own terms.

The following examples illustrate this point. In the first scenario, it is appropriate to balance the positive effects of altruism with other goals, like effective resource allocation.

#### *Balanceville's Garage Sale*

Balanceville is a small, rural community of thirty families near formerly prosperous coal mines. For a period of several years, the village held an annual garage sale where residents found that they could inexpensively buy items they needed, sell their junk, and keep village money circulating locally. The plan was quite successful at creating an effective system of resource allocation.

One year, the village decided that instead of having an annual garage sale where residents treat each other as customers, they would have an annual gift exchange. Residents would simply give items to other families. Due to the small size of the community, the process was quite successful. Even though residents did not always get what they needed and the resource allocation was not as good as it used to be, they preferred this system because it better promoted community spirit.

It is plausible that Balanceville's new altruistic system of exchange offers benefits that offset its deficiencies in allocating resources. This is another way of saying that, sometimes, "it's the thought that counts." But consider this variation:

#### *Resourceville's Fundraiser*

Resourceville is a small, rural community of thirty families near formerly prosperous coal mines. Some of the children in the community have a rare disease resulting from the leakage of chemicals used in the mining process. A few years ago, the village decided to host an annual fundraiser where each family would simultaneously hold a garage sale, and 10% of all revenue would be used to support the sick children. This system worked out well with respect to resource allocation and also generated considerable funds for the children.

One year, Resourceville decides instead to turn the fundraiser into an annual gift exchange. Families were encouraged to give gifts to each other but were also encouraged to give gifts that would be used specifically to support the sick children. Resource allocation was not quite as good as it was under the garage sale system. Furthermore, the children received significantly less than they did under the previous system. Now, the members of the village are to vote on what system to use in future years. Assume that under the gift exchange fundraiser, families would give more to the sick children than they did this year but that it is very unlikely to reach the same level of giving that would occur through the garage sale revenue system.

In this case, Resourceville needs to decide on one of two fundraising systems. But here, we ought not balance the benefits of altruistic giving with the reduced funding for the children. The knowledge that the new fundraiser is inferior to the old, assuming this knowledge is available to members of the village, infects the entire gift exchange and undermines its altruistic benefits. If the gift exchange was created for the purpose of helping sick children, then it will and ought to be evaluated primarily on its ability to generate resources for that purpose. Why should the community feel good about gift-giving when it knows that such a system will provide less to the very people which prompted the gift exchange in the first place? To choose the gift exchange in future years is to use the fundraiser as a means to promote a goal that comes at a cost to the sick children.<sup>220</sup> How can that cost be viewed as offset by the benefit of positive community sentiment? By analogy, the altruistic goals of our current system of cadaveric organ donation are undermined entirely by the fact that our system is clearly inferior to others in achieving our primary goal.

These examples illustrate the point that a gift is assessed not in

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220. Should it matter that Resourceville used the garage sale system first and then switched to the gift exchange program? It is hard to see why the order should matter. So long as people know that the garage sale system better serves the sick children without adding to the burden of villagers in any significant way, it is hard to defend the use of the gift exchange program.



a vacuum but in the context of the gift's intended effect on its recipient. Foolish giving is only virtuous if the giver truly is a fool. But if a person knows that he is giving foolishly, this fact detracts from the quality of the gift. In O. Henry's famous short story, *The Gift of the Magi*,<sup>221</sup> Della and her husband, Jim, are a young, cash-strapped couple purchasing Christmas gifts for each other.<sup>222</sup> Della sells her long beautiful hair to buy a watch strap for her husband who, unbeknownst to her, sold his watch to buy Della a set of fine combs for her hair.<sup>223</sup> We can imagine no worse allocation of resources for Della and Jim, and therein lies the tragic beauty of the story. Each gives something of tremendous personal value to buy something believed to be of tremendous value to his or her partner. But this tragic beauty would be utterly shattered if we imagine that Jim discovered his wife's plan to sell her hair and bought her the combs anyhow. The symbolic meaning of Jim's gift would evaporate entirely. Likewise, policymakers are aware that altruistic donation leads to a less desirable allocation of resources than could be achieved with incentives, and this awareness largely eviscerates the virtue of the current system.

### 5. The Tyranny of the Gift

Lastly, even if we do isolate some wonderfully altruistic component of our current organ donation scheme, it is not as though altruistic behavior is incontrovertibly desirable. One problem with altruistic organ donation is that it is almost entirely non-reciprocal. From one perspective, that is what makes organ donation an act of incomparable, other-regarding sentiment. But there is a less attractive element to one-sided giving. If two people are on a first date, and one begins the date by offering a very expensive gift, the other should rightfully be hesitant to accept. Doing so may create an undesirable expectation of reciprocity. And the inability to or undesirability of reciprocating is a good ground to decline the gift.

In the case of cadaveric organ donation, reciprocity is almost impossible. We might think that the feeling of obligation to reciprocate would disappear, however, when one's gift-giver has died. In fact, researchers have noted a kind of "tyranny"<sup>224</sup> in organ giving where recipients are distressed by their inability to meaningfully offer reciprocal gifts to their benefactors. Such concerns have led

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221. O. HENRY, *The Gift of the Magi*, in *THE GIFT OF THE MAGI AND OTHER STORIES* 191 (William Morrow 1997).

222. *Id.* at 199-200.

223. *Id.*

224. RENEE C. FOX & JUDITH P. SWAZEY, *SPARE PARTS: ORGAN REPLACEMENT IN AMERICAN SOCIETY* 40 (1992).

most organ transplant teams not to reveal the identity of cadaveric organ donors to organ recipients:

During the early years of human organ transplants, medical teams were inclined to reveal the identities of the donors of cadaver organs, their recipients, and their families to one another, and to provide them with details about each other's backgrounds and lives. . . . However, with the passage of time and increased clinical experience, transplant teams became more wary about the information they conveyed. A little-discussed policy of anonymity surrounding cadaver transplants gradually developed. The transplanters were discomfited by the way in which recipients, their kin, and donor families personified cadaver organs, and about how many of them not only arranged to meet but tried to become involved in each other's lives as if they were indebted and related to one another. These interactions were major factors that led most transplant units to establish the normative practice of not telling the recipient about the donor or the donor's family about the recipient.<sup>225</sup>

And just as recipients seek to repay their donors, donor families sometimes seek to overly identify with the recipients of their loved one's organs or to seek recognition from the recipient. As one doctor notes:

We've had instances where the donor family has gotten in touch with the recipient family; sometimes that's good and sometimes that's bad. Mostly we think its bad. Donor families think that when they donate something, certainly the heart—the loved one lives on in some way. But a donation is a gift. When you give somebody a gift, you don't ask them, "How's my chess set that I gave you? How's the basketball I gave you?" The same is true with organs. We don't want people saying, "How's Johnny's heart? Are you taking good care of it?" Some people feel that just because you have their brother's heart in you, they have some influence over your life. And we don't like to foster that feeling at all. We like to keep them very removed from each other.<sup>226</sup>

Although we do not need to draw any strong conclusions from the "tyranny" associated with altruistic organ donation, it does provide a valuable counterpoint to those who consider altruistic behavior to be an unqualified good.

With a priority incentive program, those who receive an organ from a priority-eligible donor will know that the donor received some benefit in life from declaring his willingness to donate. Similarly, a

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225. *Id.* at 37.

226. INA YALOF, *LIFE AND DEATH: THE STORY OF A HOSPITAL* 55-56 (1990).

recipient who is priority eligible will know that he has given something up in order to receive priority. In a world with priority incentives, donor and recipient have both benefited from their arrangement, and no one need feel indebted for eternity.

*B. Commodification as Harmful to Personhood*

Defenders of the status quo also criticize donation incentives for creating an undesirable commodification of bodies and body parts. Financial incentive schemes are particularly castigated, but a commodification critique has been leveled at priority incentives as well. Alexander Capron charges that an allocation system that prioritizes those who have expressed a willingness to donate "not only commodifies organs in a way that clearly invites a full-fledged market, but it abandons the whole idea of voluntariness that has been at the heart of the transplant system."<sup>227</sup> Those who press such critiques fear that incentives, whether financial or priority-based, will debase the value of the human body and encourage social isolation and disconnectedness. Worse yet, anti-commodificationists warn that commodification of one area of life, while not necessarily bad in and of itself, can spread to other more delicate arenas.

In her book, *Contested Commodities*,<sup>228</sup> Margaret Jane Radin warns of the dangers of treating too many aspects of human life as open for purchase or sale. When we treat our bodies and our relationships with others as marketable commodities, according to Radin, we risk losing sight of our individual self-worth, and we risk turning healthy, fulfilling relationships with people into anonymous, discrete, relatively meaningless transactions.<sup>229</sup> The advantages that markets can have in efficiently allocating certain resources sometimes come at a cost to our relationships with others and to ourselves, and this cost is so fundamental that it should not simply be weighed along with other factors in the economist's utilitarian-style calculus.<sup>230</sup>

Radin is particularly critical of those law and economics scholars

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227. A.M. Capron, *More Blessed to Give Than to Receive?*, 24 TRANSPLANTATION PROC. 2185, 2185 (1992); see also Laurie G. Futterman, *Presumed Consent: The Solution to the Critical Donor Shortage*, in THE ETHICS OF ORGAN TRANSPLANTS 161, 165 (Arthur L. Caplan & Daniel H. Coelho eds., 1998) ("Proposals such as future contracts, rewarded giving, and direct financial gain imply some form of organ commerce.") (emphasis added, citations omitted).

228. RADIN, *supra* note 209.

229. If life becomes commodified to the extreme, Radin notes: "All social interactions are conceived of as free market exchanges. . . . In the framework of universal commodification, the functions of government, wisdom, a healthful environment, and the right to bear children are all commodities." *Id.* at 2-3.

230. *Id.* at 3-6 (criticizing the methodology of many law and economics scholars).

who would treat all exchange as the sale or trade of fungible commodities.<sup>231</sup> When the laws of supply and demand come to dominate our thinking such that all of human behavior is viewed in terms of market transactions, we have embraced the idea of “universal commodification.” The “archetype of universal commodification presents a one-dimensional world of value. From the perspective of universal commodification, all things desired or valued—from personal attributes to good government—are commodities.”<sup>232</sup>

Radin famously distinguishes between two different kinds of property that help us to determine when commodification is particularly inappropriate. “Fungible property,” refers to “property that we do not understand to be justifiably bound up with the self, but rather understand to be separate from the self in the sense that [it is] not implicated in self-constitution.”<sup>233</sup> Among my fungible property, I count my television, my toaster, and the Eisenhower silver dollar that I recently bought at a coin shop. None of these items is uniquely attached to me in any important way. In contrast, “personal property” refers to “property that we understand to be bound up with the self in a way that we understand as morally justifiable.”<sup>234</sup> Among my personal property, I count my collection of family videos, my stand-up comedy routine, and the Eisenhower silver dollar that was given to me by my grandfather shortly before his death. So, for example, while I would sell my recently-purchased silver dollar for some price a little higher than its market value, I would refuse to do the same for the silver dollar from my grandfather, even though I consider the silver dollars identical in all of their current physical properties. And, of course, property may have mixed features of Radin’s two categories:

In human life as we know it, self-constitution includes connectedness with other human beings and also with things in the world, with a home, for example. . . . When an item of property is involved with self-constitution in this way, it is no

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231. *Id.* at 4 (discussing analyses by Richard Posner and Gary Becker which “straightforwardly speak[] of children as a commodity”).

232. *Id.* at 2. According to Radin, under universal commodification, “the person is a commodity-holder: universal commodification describes in monetary terms all things of value to the person—including personal attributes, relationships, and religious and philosophical commitments.” *Id.* Radin conceives “of commodification not as an either/or proposition, but rather as existing on a continuum, from complete commodification to complete noncommodification.” Margaret Jane Radin, *Response: Persistent Perplexities*, 11 KENNEDY INST. OF ETHICS J. 305, 305 (2001). Thus, Radin might consider priority incentives to be an interesting example of what she calls “incomplete commodification.” *Id.*

233. RADIN, *supra* note 209, at 58.

234. *Id.*

longer wholly “outside” the self, in the world separate from the person; but neither is it wholly “inside” the self, indistinguishable from the attributes of the person. Thus certain categories of property can bridge the gap or blur the boundary between the self and the world, between what is inside and what is outside, between what is subject and what is object.<sup>235</sup>

Radin is more concerned with the commodification of personal property than fungible property, since the former is invested with our personal identity and when we turn it into a market good, there is a sense, she argues, in which we, as people, become market goods.<sup>236</sup>

To some commentators, cadaver organs are exactly the sorts of items that are invested with self-constitution and human meaning. For example, Leon Kass, chairman of the President’s Council on Bioethics,<sup>237</sup> writes that by “[s]elling our bodies, we come perilously close to selling out our souls.”<sup>238</sup> Echoing a concern about market discourse which we return to later, Kass writes, “[t]here is even a danger in contemplating such a prospect—for if we come to think about ourselves like pork bellies, pork bellies we will become.”<sup>239</sup> And part of his concern with being a pork belly is that it may cause us to lose sight of uniquely special qualities of human nature: “The idea of commodification of human flesh repels us, quite properly I would say, because we sense that the human body especially belongs in that category of things that defy or resist commensuration—like love or friendship or life itself.”<sup>240</sup>

### 1. Response to Anti-Commodificationists in the Priority Context

A big advantage of priority incentives is that they do not commodify organs to the same extent that financial incentives do.

235. *Id.* at 57.

236. *See id.*

237. THE PRESIDENT’S COUNCIL ON BIOETHICS, ADVISING THE PRESIDENT ON ETHICAL ISSUES RELATED TO ADVANCES IN BIOMEDICAL SCIENCE AND TECHNOLOGY, at <http://www.bioethics.gov> (last visited Aug. 25, 2003).

238. Leon Kass, *Organs for Sale? Propriety, Property and the Price of Progress*, 107 PUB. INT. 65, 83 (1992); *see also* KIMBRELL, *supra* note 134, at 35. Kimbrell quotes ethicist William May as follows:

If I buy a Nobel Prize, I corrupt the meaning of the Nobel Prize. If I buy an exemption from the draft, which was permitted in the Civil War, I corrupt the meaning of citizenship. If I buy and sell children, I corrupt the meaning of parenthood. And if I sell myself, I corrupt the meaning of what it is to be human.

*Id.*

239. Kass, *supra* note 238, at 83.

240. *Id.* at 81.

While the commodification critique of financial incentives seems overblown, it does count as a plus for priority incentives that they are largely immune from such concerns. This is important either because commodification concerns have some kernel of truth or because many people, including those with a political voice, think that they do.<sup>241</sup>

Something is often thought to be commodified when it can be traded on a market, much as we trade barrels of oil or television sets. Commodities are typically commensurable (they can be compared and ranked in value), fungible (they can be substituted one for the other), and monetizable (they can be sold and converted into dollars).<sup>242</sup> When we allow a person to trade a commitment to donate in exchange for priority organ receipt, we have steered clear of at least two of these three features of commodities. Under a priority incentive scheme, one's priority is not monetizable; you cannot sell your priority for dollars (though we could imagine such a scheme). Similarly, priority to receive an organ is not fungible with a commitment to donate an organ. The two are simply not the same kind of thing in the way that a machine engineered can opener is like every other can opener from the same factory line.

Arguably, priority incentive schemes do promote a kind of commensurability, raising the fear that items of personal significance will be debased when they can be ranked in value with other items. For example, anti-commodificationists take offense to baby-selling since the practice may lead to an inference that a baby is only worth the amount of money it can fetch on a market.<sup>243</sup> These concerns can be extended beyond just exchanges for cash. If a free market exchange of babies were permitted, one might infer that the value of a certain baby was roughly commensurate to the value of the baby with whom it is exchanged.

In the case of priority incentives, however, it is hard to see the harm in the inference at stake. Those who are induced to donate by priority incentives may do so because they value the priority of receiving an organ more than they value the right to not donate (or the right to not express a view as to willingness to donate). We can then infer from the decision to join a priority incentive program that

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241. For example, Al Gore, when he was a member of the House of Representatives from Tennessee, said that "our system of values isn't supposed to allow the auctioning off of life to the highest bidder . . . . It erodes the distinction between things and people." Melissa M. Perry, *Fragmented Bodies, Legal Privilege, and Commodification in Science and Medicine*, 51 ME. L. REV. 170, 185 (1999); see also KIMBRELL, *supra* note 134, at 30 (quoting then-Senator Gore's concern, in arguing for legislation banning organ sales, that "[p]eople should not be regarded as things to be bought and sold like parts of an automobile").

242. See RADIN, *supra* note 209, at 118-20 (describing indicia of commodification).

243. *Id.* at 97-98.

the registrant values receiving priority more than he disvalues the potential obligation to donate an organ. But such an inference is harmless and is unlikely to raise the ire of anti-commodificationists.

## 2. Response to Anti-Commodificationists More Generally

Even beyond the priority incentive context, fears of turning cadaveric organs into commodities are overblown. First, cadaver organs are not so intimately intertwined with unique features of our personalities that we need worry if donation incentives, be they priority-based or financially-based, impart certain commodity-like characteristics to cadaver organs. Second, cadaver organs must have certain characteristics of commodities to permit organ transplantation at all. It is only to the extent that our internal organs are commensurable and fungible with those of others that we can have organ transplants and a science of medicine in the first place. Thus, we should be glad that our organs have certain commodity-like characteristics, since we usually label the opposite situation as disease.

If we were concerned about treating organs as commensurable, fungible property, we should not even allow people to make gifts of their organs.<sup>244</sup> Yet, Leon Kass and other anti-commodificationists have no objection to purely altruistic organ donation. Granted, a person may feel a special connection to his own organs that he does not feel to identical organs of another person. But do we really want to embrace and encourage the idea that our organs have some special meaning which makes them intimately connected with our identities?

## 3. The Dangers of Noncommodification

On the contrary, to the extent that we accept the underlying premises of the personhood argument, we do more damage to ourselves as persons when we elevate cadaveric organs to the special place of honor reserved for property that should be inalienable through market exchange. The point may be illustrated by noting that we are perfectly willing to replace parts of our bodies with artificial parts and that doing so should not be thought of as an affront to our humanity. Cardiac pacemakers have been in use since the 1950s to correct arrhythmic heartbeats.<sup>245</sup> Such arrhythmias may be due to a diseased sinus node, a small bit of tissue which helps to

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244. Cf. RICHARD A. EPSTEIN, *ORGAN TRANSPLANTATION: OR, ALTRUISM RUN AMUCK* 11 (1993) (noting that certain extreme anticommodification positions would appear to limit organ donation as well as sales).

245. See, e.g., Al Sokol, *Tiny Implant a Lifesaver for Many*, *TORONTO STAR*, Oct. 17, 1997, at E1.

regulate the heart's electrical activity. Should a pacemaker recipient consider himself any less human, any less the person than he had been before receiving the pacemaker? We could imagine that someone would so view himself, tortured with cartoonish science fiction imagery implying that he is now part human, part machine. But surely that is an unnecessarily grim view. A more appropriate conception of our identities would have us focus on our thoughts, perceptions, and actions, making our physical bodies important only to the extent that they affect these more important aspects of personal identity. The idea that cadaver organs should not be bought and sold as commodities suggests that there is something about our organs that is intimately connected to our identities that serves to remove them from the category of marketable, fungible property. This is odd, however, since once we die, our bodily organs can have no effect on our identities. To the extent that dead people have identities at all, they are purely historical, residing in the memories of survivors.

Similarly, a person need not experience a serious distortion of his personal identity when he develops a diseased organ or a missing limb, since these material items need not define a person. When a person has a leg amputated and receives a prosthetic leg, we no doubt expect this experience to change him in important ways. It will likely alter his lifestyle, his freedom of motion, and his relationships with others. But, to the extent that he is changed as a person from receiving a prosthetic leg, it is not because his leg has been replaced by some fungible mass-produced commodity in the form of a prosthesis. Rather, his life is changed because *there is no* currently manufacturable prosthesis that is fungible with his former leg. Artificial organs and natural organs, to the extent that they are perfectly fungible, are equally valuable to us. And just as artificial organs are not vested with special aspects of our identity, our natural organs need not be either.<sup>246</sup>

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246. New medical advances will soon present a vivid challenge to the view that human body parts are not invested with special aspects of human personality. Dr. Peter Butler, a consulting plastic surgeon at the Royal Free Hospital in London claims that "technology is now in place for surgeons to perform a full-face transplant." Charles Siebert, *Making Faces*, N.Y. TIMES MAG., Mar. 9, 2003, at 34. Such transplants would help "someone whose natural face has been severely disfigured either by disease or an accident." *Id.*

As an empirical matter, surgeons would only transfer "the skin envelope" of the face perhaps with some underlying muscle. *Id.* The recipient's bone and cartilage would still largely determine his outward appearance, such that donor and recipient would look far from identical. *Id.* If, however, there really were face transplants of the sort in science fiction, we might entertain the notion that our faces are invested with a bit of personhood and that we ought not part lightly with rights to our postmortem visage. *Id.*



Anti-commodificationists would have us prohibit the sale of cadaveric organs claiming that they are intimately connected with what it means to be human. This suggestion, however, is flawed because it overidentifies humans with unimportant features of their lives. The important aspects of our humanity have nothing to do with our physical parts:

I view my uniqueness as a person as more related to intellectual products than my bodily products. (Definitions of personhood, for example, rarely revolve around the possession of body parts, but rather focus on sentience or other cognitive traits.) Arguably, it commercializes me less as a person to sell my bone marrow than to sell my intellectual products. Thus, I do not view payment of body parts as commercializing people.<sup>247</sup>

### C. *Rhetoric and the Slippery Slope*

So far I have addressed commodification concerns only in the context of cadaveric donation. By contrast, live organ donors are asked to part with a kind of fundamental personal property. Live donors, by risking serious illness and sometimes even death, give up more than just a carbon-based organ—they give up some of their health and life expectancy. While there are reasons to question the commodification critique in the context of live organ donation as well, we cannot dismiss these concerns as easily as we could in the context of cadaveric donation.

Because I advocate priority incentives for cadaveric donation, this issue does not directly present a problem. However, even if we agree that cadaveric organs are not and should not be viewed as deeply invested with our personal attributes, some might fear that treating cadaveric organs as commodities will lead us to treat live organs as similarly devoid of important features of human personhood. If we develop a discourse which commodifies cadaveric organs, some would say, this discourse will eventually be used to describe all organ transactions.<sup>248</sup> Thus, if commodifying cadaveric

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Interestingly, in a hospital survey of 120 people at Dr. Butler's hospital, "one-third of them doctors, one-third nurses, and one-third laypeople," the majority said they would accept someone else's face if they needed such a transplant. *Id.* "No one, however, not even [Dr. Butler's] closest colleagues, said they would donate their own." *Id.* Thus, incentives for face donations might be almost *required* in order to have any supply at all.

247. Lori B. Andrews, *My Body, My Property*, 16 HASTINGS CENTER REP. 28, 35 (1986).

248. This is the so-called "domino theory" of market rhetoric. Radin describes the domino theory (which she does not endorse in its strong form) as holding "that there is a slippery slope leading from toleration of any sales of something to an exclusive market regime for that thing; and there is a further slippery slope from a market regime for some things to a market regime encompassing everything people value."

donation leads us to commodify live donation, some would argue, we need to be careful about commodifying cadaveric donation as well.

There are several problems with such slippery slope arguments, yet they are notoriously difficult to refute. They rely on hard-to-assess empirical claims about the way that a complex social network will respond to a change in policy. Before life insurance became a common feature of the financial landscape, some thought it would unacceptably put a price on human life.<sup>249</sup> These fears were overstated. Most people recognize that life insurance is designed to play an important role in family financial planning, not to turn people into paychecks. Similarly, I think we can count on people to understand that the sacrifice made by live organ donors is different in kind than the sacrifice (if any) made by cadaveric donors. To the extent that such concerns survive, however, it counts as an advantage of priority incentives that fears about the expansion of market rhetoric are typically only applied to financial incentives.

#### *D. Organ Fetishism in "Secular" Donation Policy*

It is difficult to understand U.S. policy restricting cadaveric donation incentives in secular terms. To illustrate, consider some imaginary subgroups in the United States in disagreement over the appropriate ways to treat dead bodies. "Territes" believe dead bodies should be buried underground with all of their organs intact. They believe that cremation should be illegal since cremation desecrates the body and thereby threatens to undermine respect for the sanctity of life. In contrast, "Cremites" believe that dead bodies should be cremated in order to properly recognize a circle of life and a connection between humans and nature. Cremites believe that burial should be illegal because burial leads people to focus on the physical, human world to the neglect of our non-physical human essence.

Despite the seemingly opposite symbolic meaning of cremation and burial, the law permits both, and most would agree that neither of these groups has a claim on the other to alter its beliefs and practices. Certainly, neither presents a legal argument for prohibiting the other's death rituals. Furthermore, we need not resolve whether the Territes and Cremites defend their beliefs on religious, moral, or aesthetic grounds. We recognize an autonomy interest that allows individuals and their families some freedom in deciding whether their dead bodies should undergo a particular mystical ritual or none at all.<sup>250</sup>

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RADIN, *supra* note 209, at 99-100.

249. Mahoney, *supra* note 110, at 212 (noting that commodification concerns about life insurance were "advanced and surmounted").

250. Some have gone so far as to convert the deceased into jewelry. In Canada, the

Imagine now a person named Smith, who works as a small-stakes commodities trader. Smith seeks to lead an active, purposeful existence while he is alive but believes (perhaps tautologically) that life ends at death. He thinks that the bodies and organs of dead people deserve no more symbolic or mystical respect than we give to the clothing of the deceased. Since affording such respect to dead bodies and body parts means acknowledging some sort of non-physical world, Smith would like to have his body disposed of without ritual. Furthermore, he would like to make his organs available upon his death should they be useful in transplantation to promote the health and well-being of someone still alive. Believing that his organs are no different than anything else he might have of substantial value in promoting life and health, he would like to sell the right to his body after he dies. Unlike the wishes of the Territes and the Cremites, however, Smith cannot make his preferred arrangements for his remains without violating the law.

The commodification argument says that if we treat the human body as a mere commodity, we will debase important features of our personal identity. Yet this argument is similar in form to those exchanged by the Territes and the Cremites. The commodification argument requires us to recognize something special about cadaver body parts which make them different than the commodities that we trade every day. The argument differs, however, from the Territe and Cremite arguments in that it lies at the heart of our current (presumably secular) organ donation policy. Hence, unlike the imaginary arguments of the Territes and Cremites, it actually does restrict people's freedom to dispose of their bodies.

Referring to markets for cadaver organs, anti-commodificationists have argued that "those whose organs and tissues are taken in the context of a financial reward are 'sources,' not donors" and that "one could argue that once the donation occurs, particularly of multiple organs, the body is treated as 'a thing,' often with total failure by the procurement team to maintain the individual dignity of the donor."<sup>251</sup> However, notions of what it means to treat a dead body with dignity are hardly universal. Until the

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remains of eighty-year-old Edna MacArthur "were compressed into a 3-gram sample and flown to Italy where an Italian firm use[d] intense heat to incorporate the remains into carbon used to craft a diamond" to be made into a ring for MacArthur's granddaughter. CNN.com, *Family Turns Grandma Into Diamond*, at <http://asia.cnn.com/2002/WORLD/12/31/offbeat.canada.diamond.ap> (Dec. 31, 2002). Interestingly, the diamond cost the family just over 2,000 U.S.D., which is well below the cost of a traditional burial. *Id.*

251. A.L. Caplan et al., *Financial Compensation for Cadaver Organ Donation: Good Idea or Anathema?*, in *THE ETHICS OF ORGAN TRANSPLANTS* 220 (Arthur L. Caplan & Daniel H. Coelho eds., 1998).

1960s, the Wari', a native people of the Amazon rain forest, engaged in a practice known as funerary cannibalism. At funerals, the Wari' "consumed members of their own group who died naturally . . . out of affection and respect for the dead person and as a way to help survivors cope with their grief."<sup>252</sup> According to anthropologist Beth Conklin who studies the Wari', "in the past, the idea of leaving the body of a loved one in the dirt and letting it rot was as repulsive to the Wari' as the idea of eating human flesh is to us."<sup>253</sup> It is a challenge, indeed, for anti-commodificationists to offer secular, generalizable principles to govern the "dignified" treatment of cadaveric donors.

## VI. CONCLUSION

It is important that we not allow inertia to guide organ allocation policy forever. If we already had a priority incentive system, I strongly suspect that it would have very limited opposition. Such an incentive scheme would promote organ supply and save lives while better respecting the contribution made by those who register to donate. Priority incentive schemes do not favor registered donors because registered donors are somehow more virtuous than others; rather, they favor registered donors in order to create an incentive to join a mutual insurance pool. Those who deliberately decline to join are not entitled to the full benefits of others' contributions.

As a guiding principle, we might seek to create a priority distribution that is pareto superior to our current distribution. Priority incentives are sufficiently flexible such that we can adjust the level of priority distributed to make virtually everyone share in the benefits. Alternatively, we might decide to more aggressively induce donations. Either way, such decisions will be better informed after conducting empirical research to understand the magnitude of the relationship between the amount of priority we allocate and the amount of donor registration we induce.

Priority incentives can potentially be attacked from two sides—by those who say such incentives are too commercial and by those who say they are not commercial enough. Those who find them too commercial argue that priority incentives reduce both altruistic behavior and *opportunities* to act altruistically. I have argued that they will certainly not reduce opportunities to act altruistically, because they will increase donors' range of opportunities. Furthermore, they do not necessarily reduce altruistic behavior,

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252. Press Release, Vanderbilt University, Giving Cannibalism a Human Face (Aug. 15, 2001), available at [http://www.exploration.vanderbilt.edu/print/pdfs/news/news\\_cannibalism.pdf](http://www.exploration.vanderbilt.edu/print/pdfs/news/news_cannibalism.pdf).

253. *Id.*

since those with priority are still making a donation, they are just donating to a pool that limits access. If I throw a dinner party for all of my friends who have supported me during a difficult year, I am still acting altruistically, even though I limit the scope of my generosity to people with whom I share a reciprocal giving relationship. Furthermore, even if priority incentives were to reduce altruistic behavior, the altruism in our current system is not nearly so robust and easy to identify as is commonly suggested, and altruistic donation is by no means an unadulterated good, especially when we observe how a fixation on altruistic donation costs human lives.

Those who find donation incentives too commercial also argue that they reduce human flourishing. I noted that this commodification critique is not applicable to *priority* incentives and is not very convincing in the context of financial incentives. Cadaveric organs are best thought of as tools to human flourishing that are substitutable with any equally effective tool, like an artificial organ. When a person risks his health and life expectancy to donate an organ while still alive, he does give up something deeply personal. However, when a person agrees to sell rights to his postmortem organs or to exchange such rights for in-kind compensation, he has made a deal to promote the human flourishing of someone else who would not otherwise have long to flourish.

A challenge to priority incentives from the opposite direction would say that they are not commercial enough—that they would not provide as strong of an incentive to register to donate as would financial incentives. I have focused less on this perspective because, as I have noted, financial incentives are not at all incompatible with priority incentives, since both programs can be combined. Also, what little empirical data is available on the subject suggests that financial incentives, unless substantial, may not have a very powerful effect on rates of donation.<sup>254</sup> Importantly, priority incentives offer something that financial incentives typically do not. Most financial incentive programs limit commerce in organs to the payment of those who donate or agree to donate. No politically-acceptable financial incentive program on the horizon allows wealthier people to purchase better access to the cadaveric organ supply. So long as that is true, a priority program will incentivize donors with something money cannot buy—namely, preferred access to the organ supply. From that perspective, priority incentives may do much more to incentivize donation than financial incentives. Furthermore, priority incentives are essentially cost free—another factor which makes them more politically appetizing than financial

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254. See *supra* note 6 and accompanying text.

incentives.

A further advantage of priority incentives is that they are less subject to commodification concerns than are financial incentives. Priority incentives do not so much raise the ire of anti-commodificationists—a plus from a political perspective, even if we doubt the force of their critique. Also, some object to financial incentive schemes because they create differential incentives based on wealth. In all likelihood, under a financial incentive scheme, cadaveric organs would disproportionately be supplied by families with less wealth because they would most value whatever monetary compensation is offered. A priority incentive scheme is much less likely to have wealth-based distributional effects. In fact, under a priority incentive scheme, cadaveric organs may be disproportionately supplied by hypochondriacs and those who are otherwise anxious about their health—a group thought to need less protection than the poor and, if anything, probably has above average wealth.

Priority incentives mix sound, equitable policy with at least plausible aspirations for political success. They would expand control over our own bodies by increasing our freedom to make agreements directing the disposition of our remains. Some anti-commodificationists would limit these freedoms with ostensibly secular principles rooted in human dignity. In fact, such views reflect a kind of organ fetish that asks us to treat cadaveric body parts as having mystical power. So long as we trust people to recognize the very obvious differences between cadavers and living humans, we should not fear that commodification of the former will commodify the latter. Such fears are particularly harmful in the context of organ donation where the fetishistic treatment of dead bodies causes us to discard vital organs that would otherwise save lives.

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