Cashing In On the Transplant List: An Argument Against Offering Valuable Compensation for the Donation of Organs

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INTRODUCTION

In a landmark operation on December 23, 1954, surgeon Joseph Murray demonstrated that organ transplantation was possible. Murray removed one of Ronald Herrick’s two kidneys, and placed it in Richard Herrick, his identical twin brother dying of kidney failure. Richard’s immune system did not identify his brother’s tissue as foreign because they were identical twins. Initially, rejection of transplanted organs threatened organ transplantation. In

1. Jennifer Hurley earned a BA in Psychology from the University of Richmond in 2001 and anticipates graduating with a JD from Suffolk University Law School in May 2004. This Note is dedicated to Allan. His strength and perseverance provided the inspiration for this Note.


3. The Living Bank at http://www.livingbank.org/transplantation.html. The Living Bank is the oldest and largest donor education organization in the country and the only national one that keeps computerized records of donor data for future retrieval in an emergency. Id. The mission of the Living Bank is to motivate and facilitate the commitment of enough organ and tissue donors so that no one must die or suffer for lack of a donation. Id.

4. Id.

1983 the anti-rejection drug, Cyclosporine was developed and the number of organ transplants increased significantly.\(^6\) The significant increase in the number of transplants performed each year is directly attributed to the discovery of Cyclosporine.\(^7\) The success of organ transplants has led to a greater demand for available organs.\(^8\) The current demand for transplantable organs exceeds the available supply.\(^9\) As of September 2000, the number of organs needed by patients on the United Network for Organ Sharing (UNOS) waiting list was over 76,000.\(^10\) As of November 30, 2003, that number had increased to 83,545.\(^11\)

Efforts have been targeted at expanding the supply of transplantable organs rather than to identify ways to decrease the demand.\(^12\) Consequently, the stated objective of many regulations purporting to address organ transplantation is to increase the number of donors.\(^13\) Currently, there are two viable sources of human organs for transplantation: living donors and post mortem donors.\(^14\) Live donors may only donate those organs that they can survive without.\(^15\) Thus, cadavers represent the primary source of transplantable organs.\(^16\) Each year, approximately 4,500 organs are procured from cadavers and used in transplant procedures.\(^17\) The continuing demand

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6. See Id. In 1983, J.F. Borel at the Sandoz Pharmaceutical Corporation discovered the immunosuppressive drug, Cyclosporine. The FDA gave its approval for the marketing of cyclosporine in 1983. By 1989, it was administered alone or in conjunction with other pharmaceuticals to nearly all persons receiving a transplanted organ and was recognized as one of the key factors contributing to the growth of organ transplantation from the early 1980s through 1990. See also, Paul A. Keown, Molecular and Clinical Therapeutics of Cyclosporine in Transplantation, 1 Immunosuppression In Transplantation 10 (1999).


9. Id.


12. See Anderson, supra note 5. Efforts to reduce the demand for organs would involve a broad array of public health efforts such as decreasing the risks of heart disease through proper diet and exercise, treating the hepatitis virus, and preventing alcoholism and drug abuse in order to avoid liver damage.


14. Id.

15. Id.

16. See id.

17. See David E. Jeffries, The Body as Commodity: The Use of Markets to Cure
for transplantable organs greatly exceeds the present supply. 18 Experts have noted that they anticipate the number of available organs to remain constant, while the demand will continue to increase consistent with longer survival rates, thus creating a striking deficit between supply and demand. 19 Potentially, each donor can help as many as fifty recipients. 20

The United States suffers from a precariously low reserve of organs that are available for transplant. Perhaps even more dangerous to the general welfare of the American public is the threat of offering economic compensation to encourage organ donation. First, this Note is aimed at acquainting the reader with the development of regulations designed to promote organ donations suitable for transplant in the United States. Secondly, this Note explores the support for the prohibition against offering economic compensation for organ donations. In light of proposed regulations purporting to experiment with offering economic compensation for donating organs, the potential for exploitation of the poor and indigent is discussed at length. The reasoning behind the original prohibition relating to offering economic compensation for organ donation is also explored. This note concludes that regulations should not be enacted to repeal current prohibitions against offering valuable consideration for organs and human tissue; but rather to continue to promote organ donation within the existing regulatory framework.

Organ Donation Laws

The organs that can be taken from a single donor include the heart, lungs, kidneys, liver, pancreas, corneas and small intestine; see also Hoffman supra Note 17 at 345. One donor can:
donate kidneys;
donate their heart, liver, lung or pancreas;
donate their corneas;
donate bone or bone marrow;
donate skin;
provide healthy heart valves.


18. See Jeffries, supra note 17; See also, MONT. CODE ANN. §72-17-102 (2002)
A problem common to all organ transplantation programs as well as to the well-established programs in tissue banking is the significant chasm between the need for the organs and tissues and the supply of donors. Despite the substantial support for transplantation and a general willingness to donate organs and tissues after death, the demand far exceeds supply. 19


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The historical basis for organ donation laws originates from the common law concept that one may not have a property interest in a cadaver.\(^{21}\) State courts continue to uphold this basic assumption; yet, many recognize a “quasi-property right” in the relatives of the deceased, allowing them to gain control of the body following death for the purpose of proper disposition of the remains.\(^{22}\) As organ transplant technology advanced and the demand for transplantable organs continued to grow, the common law proved to be inadequate to address the myriad of issues related to organ transplantation.\(^{23}\)

Many states began to enact statutes that regulated the donor process by establishing guidelines for whom may become a donor.\(^{24}\)

\(^{21}\) See Daphne D. Sipes, Does It Matter Whether There is Public Policy or Presumed Consent in Organ Transplantation?, 12 WHITTIER L. REV. 505, 508 (1991); See also, Hoffman, supra note 17 at 354.

\(^{22}\) See Sipes, supra note 21 at 508; See also, Hoffman, supra note 17 at 354. See also, Andrew J. Love, Replacing our Current System of Organ Procurement with a Futures Market: Will Organ Supply be Maximized?, 37 JURIMETRICS J. 167, 167 (1997). See also, Whaley v. County of Tuscaloosa, 58 F. 3d 1111 (6th Cir. 1995) and Brotherton v. Cleveland, 923 F.2d. 477 (6th Cir. 1995)(holding that the next of kin may have an even stronger property interest in the dead body of a relative than the state cases would suggest, and that their dispositional authority might even go beyond mere control over burial); See also, Mansaw v. United States District for the Western District of Missouri, infra note 131 at 3.


\(^{24}\) See Fred H. Cate, Human Organ Transplantation: The Role of Law, 20 IOWA J. CORP. L. 69, 83 (1994). The first state to enact a statute permitting an individual to donate his organs was New York. Today, New York and a number of other states continue to have laws targeted at specifying limitations on organ transplantation, including limitations on those persons who may become donees and the purposes for which anatomical gifts may be made. See also, R.I. GEN. LAWS §42-11-13 (2002) Rhode Island Organ Transplant Fund; R.I. GEN. LAWS §40-8-2 (2002) Human Services; Medical Assistance; N.Y. [Organ Tissue and Body Parts Procurement and Storage] Law §4362 (2002); MONT. CODE ANN. §72-17-202 (2002) (Persons who may become donees and the purposes for which anatomical gifts may be made); Mont. Code Ann. §17-17-103 (2002); MONT. CODE ANN. §17-17-102 (2002); MO. REV. STAT. §172.875 (2002); MASS. GEN. LAWS ch. 113 §§8 (2002) (Gifts of human bodies, organ and tissues; persons authorized to make; rights created:

A person of sound mind and who is 18 years of age or older may make a gift of all or any part of his body for any purposes specified in section nine, said gift to take effect upon his death or in the case of a living donor at such time prior to his death as he may specify in accordance with the requirements of subsection (b) of section ten, so long as such donation does not jeopardize in any way the life and health of the donor.

Initially, many states enacted statutes and regulations pertaining to organ transplantation that were ambiguous and irreconcilable to one another. In order to promote an analogous and extensive system of regulation, the National Conference of Commissioners on Uniform State Laws (NCCUSL) met in 1968 and drafted the Uniform Anatomical Gift Act (UAGA). In 1984, UAGA was supplemented by the National Organ Transplant Act (NOTA). As recently as 1998, these regulations were improved upon by the enactment of the Organ Procurement and Transplantation Network (OPTN).

THE UNIFORM ANATOMICAL GIFT ACT

In enacting the UAGA, the NCCUSL was cognizant of the many competing interests influencing organ transplantation. In promulgating the Act, the UAGA addressed these concerns by posing twelve questions. As many scholars note and as is evidenced by the

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25. See Sipes, supra note 21 (discussing promulgation of Uniform Anatomical Gift Act.)
26. See id. The UAGA was drafted by the NCCUSL and was presented by Congress in an effort to achieve uniformity among state laws pertaining to organ donation.
27. See id.
28. See 42 C.F.R. §§121.1-121.12 (2000); see also, 63 Fed. Reg. 16296 (April 2, 1998) (setting forth the final rule governing the Organ Procurement and Transplantation Network, which performs a variety of functions related to organ transplantation under contract with HHS.) id. In combination with a new National Organ and Tissue Donation Initiative, this rule is intended to improve the effectiveness and fairness of the Nation’s transplantation system and to further the purposes of the National Organ Transplant Act of 1984, as amended. See id. These objectives include: encouraging organ donation; developing an organ allocation system that functions as much as technologically feasible on a nationwide basis; providing the basis for effective Federal oversight of the OPTN, as well as for implementing related provisions in the Social Security Act; and providing better information about transplantation to patients families and health care providers. See id.
29. See Moore, supra note 7. Among the interests that the drafters sought to address included protecting the expectations of the potential donor and his or her family, while drafting organ donation regulations to satisfy the increasing demand for donations.

Who may during his/her lifetime make a legally effective gift of his body or a part thereof?
What is the right of the next-of-kin, either to set aside the decedent’s expressed wishes, or themselves to make the anatomical gifts from the dead body?
Who may legally become donees of the anatomical gift?
For what purposes may such gifts be made?
How may gifts be made, such as by will, by writing, by a card carried on the
subsequent regulations designed to enhance the UAGA, this particular regulation should be understood to require regular modifications and amendments to address society’s evolving needs and concerns.\footnote{Wayne L. Anderson & Janolyn D. Copeland, Legal Intricacies of Organ Transplantation: Regulations and Liability, 50 J. M O . B. 139, 140 (1994); see also, Hoffman, supra note 17 at 355.}

The UAGA successfully achieved its stated purpose of achieving uniformity among state laws pertaining to organ donation.\footnote{See Cate, supra note 24. The UAGA has undergone minor modifications in some states. \textit{Id.} Presently, the most apparent modifications relate to defining death, outlining procurement protocol and prohibiting the sale of organs. \textit{Id.}} Four years after its inception, every state and the District of Columbia had adopted some version of the 1968 UAGA.\footnote{32. See \textit{id.}}

The provisions of the UAGA provide that any eighteen-year-old has the legal right to decide whether to donate all or part of their bodies after their death.\footnote{33. See \textit{id.}} The decision to donate their organs is shared by the donor and his or her immediate relatives or other person standing in a fiduciary capacity.\footnote{34. See Uniform Anatomical Gift Act §2(a), reprinted in Statutory Regulation of Organ Donation in the United States, 4 (R.Hunter Manson ed., 2d ed. 1986).} The donor may bequeath a post mortem donation through any written document to any one particular person or group of people.\footnote{35. See Uniform Anatomical Gift Act §2(b), at 4. The people who may make the decision on behalf of the donor are listed in order of priority: “the spouse, an adult son or daughter, either parent, either parent, an adult brother or sister, guardian of the person of the decedent at the time of his death or any other person authorized or under obligation to dispose of the body.” \textit{Id.}} At any time before the donor’s

person, or by the telegraphic or recorded telephonic communications? How may a gift be revoked by the donor during his lifetime? What are the rights of survivors in the body after removal of the donated parts? What protection from legal liability should be afforded to surgeons and others involved in carrying out anatomical gifts? Should such protection be afforded regardless of the state in which the document is executed? What should the effect of an anatomical gift be in case of conflict with laws concerning autopsies? Should the time of death be defined by law in any way? Should the interest in preserving life by the physician in charge of the decedent preclude him from participating in the transplant procedure by which the donated tissue or organ is transferred to a new host? See also, Hoffman, supra note 17 at 354.

32. See \textit{id.}
death, he or she may amend or revoke the document purporting to express his or her desire to donate.\textsuperscript{37}

When organs are donated under the UAGA, the regulation requires that the person retrieving the organs must avoid mutilating the body.\textsuperscript{38} Furthermore, under the UAGA, any person who acts under any anatomical gift law is protected from civil or criminal liability.\textsuperscript{39}

\begin{itemize}
\item presence of two witnesses who must sign the document is his presence. Today, the two witness requirement is no longer necessary unless the donor expresses his intent to donate verbally. \textit{Id.}
\item The donor may amend or revoke the written document at any time before his death, even if the document has already been delivered to the individual so designated to be the recipient of the donor’s organs. If the donor has designated a specific recipient and has delivered the document to the donee, he may revoke the gift by (1) delivering to the donee a signed statement, (2) making an oral statement in the presence of two witnesses that is communicated to the donee, (3) making a statement to any attending physician during a time of terminal illness or injury that is communicated to the donee, or (4) signing a card or other document that can be found on his person or in his effects. If the document has not been delivered to the donee, the donor may do any of these four steps or cancel the gift by destruction, cancellation, or mutilation of the document and any existing copies. \textit{See id.} \textsection{6(b)}.
\item If the donor made the gift by will, he may amend or revoke the gift using any of the four steps outlined above, or by doing so as provided in the laws regulating the amendment and revocation of a will. \textit{See id. See also}, Hoffman, supra note 17 at 356.
Despite the general success of the UAGA, the Act has been criticized on three major grounds. The first criticism principally relates to the ineffectiveness of the organ donor card system. The omits reference to acting under the laws of a foreign nation; Louisiana (LA. REV. STAT. ANN. §17:2357 (c) (West 1982)) [Louisiana protects persons from both civil and criminal liability if they act in good faith and without actual knowledge of revocation and in accord with the Louisiana UAGA or the laws of the state in which the state in which the gift document was executed]; Maine (ME. REV. STAT. ANN. tit. 22 §2907(3)(1980)); Maryland (MD. EST. & TRUSTS CODE ANN. §4-508(b)(1974)); Massachusetts (MASS. GEN. LAWS ANN. ch. 113, § 13(c) (West 1983); Michigan (MICH. COMP. LAWS ANN. §333.10108(3) (West 1980)); Minnesota (MINN. STAT. ANN. §525.927(3) (West 1975) [Minnesota adds that a person must also comply with the drivers’ license gift laws in order to escape liability]; Mississippi (MISS. CODE ANN. §41-39-45 (1981)) [Mississippi makes no mention of acting in accordance with the laws of another state or foreign nation and protects the actor only from liability for civil damages]; Missouri (MO. ANN. STAT. §194.270 (3) (Vernon’s 1983)); [Missouri only requires that a person act without negligence in order to escape liability] Montana [Montana makes no provision for non-liability]; Nebraska (NEB. REV. STAT. §71-4807(3) (1981)) [Nebraska does not mention acting in accord with the laws of a foreign country]; New Jersey (N.J. PUB. HEALTH LAWS ANN. §4306(3) (McKinney 1985)) [New York omits reference to acting under the laws of a foreign country]; New Mexico (N.M. STAT. ANN. 24-6-7(c)(1981)) [New Mexico does not make any reference to the gift laws of a foreign country]; New York (N.Y. PUBLIC HEALTH LAWS ANN. §4306(3) (McKinney 1985)) [New York omits reference to acting under the laws of a foreign country]; Nevada (NEV. REV. STAT. §451.580(3) (1985)) [Nevada substitutes “the state of Nevada for “another state or foreign country.”]; North Carolina (N.C. GEN. STAT. §130A-409(c) (Supp. 1983)); Ohio (OHIO REV. CODE ANN. §2108.08 (Page 1976) [Ohio omits reference to acting under the laws of a foreign country]; Oklahoma (OKLA. STAT. ANN. tit. 63, §2208(c) (West 1984)); Oregon (OR. REV. STAT. §97.290(3)(1983)) [Oregon substitutes acting “with probable cause” for “acting in good faith.”]; Pennsylvania (20 PA. CONS. STAT. ANN. §8607(c) (Purdon 1975)); Rhode Island (R.I. GEN. LAWS §23-18.5-7(c) (1985)); South Carolina (S.C. CODE ANN. 44-43-380 (c) (Law. Co-op. 1985)) [South Carolina omits reference to a foreign country and provides that civil immunity shall not extend to cases of “provable malpractice”]; South Dakota (S.D. CODIFIED LAWS ANN. §34-26-39 (1977); Tennessee (TENN. CODE ANN. §68-30-108 (c) (1983)); Texas (TEX. STAT. ANN. art. 4590-2 §8 (c) (Vernon 1976)); Texas protects individuals acting under the Texas UAGA if the prerequisites for an anatomical gift have been met under the laws in effect when the gift was made]; Utah (UTAH CODE ANN. §26-28-5 (1984)) [Utah requires that doctors have actual notice of revocation in order to be held liable and specifies only that such doctors shall not be liable in damages]; Vermont (VT. STAT. ANN. tit. 18, §5237(c) (Supp. 1984)); Virginia (VA. CODE §32.1-295 (D) (1985)); Washington (WASH. REV. CODE ANN. §68.08.560(3) (Supp. 1984-5)); West Virginia (W. VA. CODE §16-19-7(c) (1979)); Wisconsin (WIS. STAT. ANN. §155.06(7)(c) (West 1974 & Supp. 1984)); and Wyoming (WYO. STAT. §35-5-107(c) (1977)). All of these statutes are reprinted in Statutory Regulation of Organ Donation in the United States (R. Hunter Manson ed., 2d ed. 1986).

40. See Andrew C. McDonald, Organ Donation: The Time has Come to Refocus the Ethical Spotlight, 8 STAN. L. & POL’Y REV. 177, 180 (1997). See also, Hoffman, supra note 17 at 356-358.

41. See Cate, supra note 24. Generally the American public approves of organ donor cards yet most do not carry them. Id. Furthermore, even in the presence of a signed donor card, removal of organs usually does not occur without the consent of
second criticism relates to the failure to sufficiently define the time of
death of a patient for purposes of organ retrieval.\textsuperscript{42} The third
criticism of the UAGA is its inability to effectively increase the
number of available organs.\textsuperscript{43} These inadequacies contributed to the
drafting of a new UAGA, which was adopted by the NCCUSL in
1987, and by the American Bar Association in 1988.\textsuperscript{44}

In 1987, the UAGA adopted the system of “routine inquiry and
required request”.\textsuperscript{45} This system requires that health care providers
inquire of each patient whether they are a donor and to request
written confirmation of their intent to donate.\textsuperscript{46} Law enforcement
officers, and other emergency and hospital personnel are required to
make every reasonable effort to locate information specifying the
individual patient’s wishes.\textsuperscript{47} Failure to conduct a reasonable search
may result in administrative sanctions, as opposed to criminal or civil
penalties.\textsuperscript{48}

The 1987 UAGA prohibits the commercialization of organs by
proscribing the purchase or sale of body parts for “valuable
consideration, if the removal of the part is intended to occur after the
death of the decedent.”\textsuperscript{49} Within the meaning of the Act, valuable
consideration includes “reasonable payment for the removal,
processing, disposal, preservation, quality control, storage,
transportation, or implantation of a part.”\textsuperscript{50}

the family. \textit{Id.}. Doctors are reluctant to become the target of family opposition to
the removal of organs and consequently abide by their wishes despite the
provisions of the UAGA releasing the physician from liability. \textit{See} Uniform
National Gift Act §7, reprinted in Statutory Regulation of Organ Donation in the
note 17 at 356-358.

42. \textit{See} Uniform Anatomical Gift Act §7(b), reprinted in Statutory Regulation of
Section 7(b) of the UAGA states only that death shall be determined by the
attending physician. To alleviate fears that a physician will have conflicting
interests in helping his patient survive and in procuring organs for transplant, the
UAGA provides that the attending physician shall have no part in obtaining the
organs. \textit{See also}, Hoffman, \textit{supra} note 17 at 356-358.

43. \textit{See} Moore \textit{supra} note 7.
44. \textit{See} Cate \textit{supra} note 24. \textit{See} Hoffman, \textit{supra} note 17 at 358.
45. \textit{See} id.
46. \textit{See} id.
47. \textit{See} Uniform Anatomical Gift Act (1987), §5(c), 8A U.L.A. 19, 47 (1993);
\textit{see also}, Hoffman, \textit{supra} note 17.
48. \textit{See} id.
49. \textit{Id.} §10 (a), at 58.
50. \textit{Id.} §10 (b) at 58.
The National Organ Transplant Act

The National Organ Transplant Act (NOTA) was effectuated to regulate organ transplantation on the federal level. In 1984, Congress promulgated the Act to establish federal guidelines to the organ transplantation process. The primary purpose behind NOTA was to ensure an equitable nationwide system for the distribution of organs.

NOTA is founded on six basic objectives. The first objective established a task force on organ procurement and transplantation that is comprised of twenty-five members who study a broad range of medical, legal, ethical, economic and social issues related to organ procurement and transplantation. The second purpose compels the Secretary of Health and Human Services to convene a conference relating to the potential for establishing a national registry of voluntary bone marrow donors. The third purpose created the division of Organ Transplantation. The fourth goal empowers the Secretary to make grants for the planning, creation, initial operation and expansion of organ procurement organizations. The fifth objective obligates the Secretary to contract for an Organ Procurement and Transplantation network and a Scientific Registry. The sixth objective forbids the purchase and sale of human organs for valuable consideration.

By prohibiting the sale of organs in interstate commerce, Congress effectively protected indigent and ostracized persons from becoming an exploited source of organ donations. Further the task force on

52. See id.
53. See id.
55. See id See also, Hoffman, supra note 17 at 359.
56. See id at §410(a). See also, Hoffman, supra note 17 at 359.
57. See id at §375. See also, Hoffman, supra note 17 at 359.
59. See id at §372. See also, Hoffman, supra note 17 at 359.
60. See id at §301. See also, Hoffman, supra note 17 at 359.
61. See National Organ Transplant Act of 1984 at §301. Anyone caught in the purchase or sale of organs commits a felony punishable by a fine of $50,000 and/or five years imprisonment. Id. Furthermore, it appears that Congress’ fears were
organ transplantation created under the Act conducts comprehensive reviews of the medical, legal, ethical and social issues presented by human organ procurement.\textsuperscript{62} Unfortunately, the lack of any real enforcement and supervision of the system has failed to lead to a significant increase in donated organs.\textsuperscript{63}

Arguably, NOTA’s most profound contribution to the organ transplant process was the establishment of a system for matching those in need of organs with transplantable organs.\textsuperscript{64} The Act created the Organ Procurement and Transplantation Network (OPTN) to supervise the allocation of organs throughout the country.\textsuperscript{65} The United Network for Organs Sharing (UNOS) administers the OPTN.\textsuperscript{66}

NOTA is credited with establishing regional organ procurement organizations (OPO).\textsuperscript{67} Under the NOTA requirements, each OPO is obligated to “engage in a systematic effort to acquire all usable organs from potential donors, preserve these organs, and arrange and transport them to transplant centers within the OPO’s area.”\textsuperscript{68}

While admirable, the efforts of the UAGA and the NOTA alone were insufficient to solve the growing organ paucity in the United States.\textsuperscript{69} Thus, in 1998, OPTN was revised in an effort to improve

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\item See Robinson supra note 13 at 1029. NOTA has been criticized for allowing the task force too much discretion in determining issues in need of resolve and ignoring issues relating to the organ deficit. \textit{Id.} Critics have alleged that NOTA demonstrates Congress’ efforts to expand the role of the federal government in organ procurement rather than increasing the number of available organs. \textit{Id.}
\item See Douglass supra note 51 at 211.
\item See Robinson supra note 13.
\item See id.
\item See \textit{id.} See also, Gail L. Daubert, \textit{Politics, Policies and Problems with Organ Donation: Government Regulation Needed to Ration Organs Equitably}, 50 Admin. L. Rev. 459 (1998). In 1998, the Department of Health and Human Services proposed regulations that would ensure that UNOS “develop an organ allocation system that functions on a national rather than a local-regional basis and gives preference to the most medically urgent patients, defined as those who are very ill, but who, according to their physician, have a reasonable likelihood of post-transplant survival.”
\item See Robinson supra note 13 at 1030 (quoting Charles K. Hawley, \textit{Antitrust Problems and Solutions to Meet the Demand for Transplantable Organs}, 1991 U. ILL. L. Rev. 1101, 1103-1105 (1991)).
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upon the organ donation process in the United States and to supplement the earlier regulations so that they might reach the breadth of their purported potential, in an Act called the “Final Rule.”\(^\text{70}\) The Clinton administration ordered the organ-sharing network to construct a more effective distribution system.\(^\text{71}\) If the organ-sharing network failed to construct a more effective system, the Secretary of Health and Human Services threatened to take the appropriate measures to amend it.\(^\text{72}\) Consequently, as a result of the “Final Rule,” officials and doctors with local organ procurement organizations have begun to pressure their state legislatures to pass laws that would keep organs within state boundaries.\(^\text{73}\)

**The Final Rule**

In 1998, the Department of Health and Human Services released what it called the “Final Rule.”\(^\text{74}\) The Final Rule’s objectives are based on encouraging organ donation, facilitating a nationwide organ allocation system, establish the foundation for effective Federal oversight of the OPTN and to provide comprehensive information about transplantation to patients, families and health care providers.\(^\text{75}\) Under the Final Rule, the OPTN is required to develop equitable allocation policies that provide transplant material to those with the greatest urgency in accordance with prudent medical judgment.\(^\text{76}\) The Final Rule is designed to ensure that all similarly situated patients are afforded an equal opportunity at procuring matching organs, wherever they may live in the United States.\(^\text{77}\) The Act promises that mere location will not be a determining factor in securing a place on the list.\(^\text{78}\) Under this Act, objective principles related to medical status and need govern the allocation of organs.\(^\text{79}\)

Under the Final Rule, “human organs donated for transplantation


\(^{72}\) See id.

\(^{73}\) See id.


\(^{76}\) See id.

\(^{77}\) See 3 Fed. Reg. 16296 (1998);See generally, Block et al, supra note 74.

\(^{78}\) See 3 Fed. Reg. 16296 (1998); See generally, Block et al, supra note 74.

\(^{79}\) See 63 Fed. Reg. 16296 (1998); See generally, Block et al, supra note 74.
are a public trust.” Consequently, the government argued that it must control the process to “ensure that donated material is equitably allocated among all patients,” without regard to their economic status. The preamble of the Final Rule states that, “at the national level, the current policies treat patients inequitably because they create enormous geographic disparities in waiting time.” The tenet that donated organs are a national resource implies that to the extent technically and practically achievable, any citizen or resident of the United States in need of a transplant should be considered as a potential recipient of an available organ regardless of geographic location.

The Secretary of the Department of Health and Human Services has identified three major effects of the Rule. “First, it establishes terms of public oversight and accountability for the entire organ transplantation system, and the OPTN in particular.” This reform creates major public benefits in the categories of ‘good government’ in preserving public trust and confidence in organ allocation, and assuring the rule of law.” The benefits of the proposed rule are substantial and its impact may be realized in future problems avoided, rather than the current dilemmas that need to be resolved.

Second, this rule requires “a system of patient-oriented information on transplant program performance.” The Secretary maintained that the new rule would inform patients and physicians of the number of transplants, the amount of waiting time for a transplant, and the percentage of times that a transplant center denies the transplant of organs for non-traditional reasons. Finally, patients, physicians and families must have access to relevant information to facilitate the comparison of actual center performance with these objectives.

Third, this rule will improve equity by “creating performance goals against which the OPTN can reform current policies.” Benefits accrue equitably to members of society at large, to donor families, to transplant candidates, and to transplant recipients. The Secretary

81. See id.
83. Id.
84. See Fed. Reg. 16324 (1998); See generally, Block et al. supra note 74.
86. See Fed. Reg. 16324 (1998); Block et al, supra note 74.
89. See Fed. Reg. 16324 (1998); See generally, Block et al, supra note 74.
90. See Fed. Reg. 16324 (1998); Supra note 74.
regarded a system that allocates organs to those most in need grounded on sound medical judgment, as a reasonable and profound benefit to society. 93

The Final Rule mandates all organ allocation policies and procedures must be in accordance with sound medical judgment. 94 The objective of these policies and procedures is to allocate organs among transplant candidates based on decreasing medical urgency. 95 Under existing policy, donors are afforded the option to designate the donees of their organs regardless of their medical urgency. 96

NEW PROPOSALS

Despite these regulations aimed at promoting organ donation, demand continues to far exceed supply. 97 At its June 2002 annual meeting, the American Medical Association House of Delegates voted to encourage organ procurement agencies and transplant centers to study the use of financial incentives to increase organ donation. 98 In its proposal, the AMA expressed concern with the alarming shortage of donor organs. 99 It noted that current initiatives and educational campaigns aimed at motivating individuals to become donors, and ensuring that their families understand and follow through on their intentions, have failed to significantly increase organ donation rates. 100 The AMA emphasized that this new policy does not encourage financial incentives, but rather the study of motivators on cadaveric organ donation. 101 In contrast, in October 2002, the board of directors of the National Kidney Foundation voted

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93. See Fed. Reg. 16324 (1998); See generally, Block et al., supra note 74.
95. See id.
96. See id see also generally, Block, et al, supra note 74.
98. Id. The AMA proposal was limited to a study of cadaveric organ donations and would not include living donors. Furthermore, it is noted that studies should only be implemented after: 1) protocols, which meet all ethical standards and scientific design requirements that are generally applied to research, have been reviewed and approved by appropriate oversight bodies, such as Institutional Review Boards, and Congress has waived legal prohibition; and 2) guidance and advice have been sought from the particular population under study to ensure that the proposed research is consistent with their needs, values and mores.
99. Id.
100. Id.
101. Id. Apart from the organ brokerage on the free market, additional economic incentives may include an organ futures market, tax deductions and health insurance reduction. Id.
unanimously to oppose any attempt to legalize financial incentives for organ donations.\textsuperscript{102}

Regulation that would give the U.S. Department of Health and Human Services Secretary authority to conduct financial incentive studies is now before the federal legislature.\textsuperscript{103} If this regulation passes, it would effectively overturn the provisions of the 1984 National Organ Transplant Act prohibiting offering any valuable consideration to donors for their organs.\textsuperscript{104}

Offering valuable consideration for organ donations will inevitably lead to a host of unnecessary ethical and moral problems.\textsuperscript{105} Consider that in 1983, a Virginia surgeon announced the formation of a company to solicit healthy individuals for the sale of a kidney and the subsequent brokering of the organ for a transplant procedure.\textsuperscript{106}

Within six months, Virginia enacted legislation prohibiting the sale of human organs.\textsuperscript{107} In 1984, the federal government also acted by

\textsuperscript{102} See Jackson supra note 97. It opposed even nominal payments that might indicate to people in other countries that there was support for the organ trade. \textit{Id.}

The concept of financial and other incentives for post-mortem organ donations received consideration at an international congress titled “Ethics in Organ Transplantation,” which was held from December 10, 2002 through December 13\textsuperscript{th}. \textit{See} Carey Goldberg, \textit{Fiscal Incentive Weighed to Boost U.S. Organ Supply}, Boston Globe, October 8, 2003 at A1. Dr. Francis L. Delmonico, a Massachusetts General Hospital transplant surgeon who is active in the National Kidney Foundation, said financial incentives “inevitably raise many of the same ethical problems inherent in the outright buying and selling of organs.” \textit{Id}. Delmonico states that “any attempt to assign a monetary value to the human body or its body parts, even in the hope of increasing organ supply diminishes human dignity and devalues the very human life we seek to save.” \textit{Id}. Delmonico also warns that “payments could undermine the integrity of the donor pool and would give relatives incentives to cover up flaws in a potential donor’s medical history to get the money.” \textit{See id}.\textsuperscript{108}

\textsuperscript{103} Transplant Communications, Inc. \textit{Time has Come for Study of Incentives}, Transplant News, September 13, 2002; \textit{See also}, 67 F.R. 55407 (August 29, 2002).

\textsuperscript{104} \textit{See} Transplant Communications, supra note 103.

\textsuperscript{105} \textit{See} Barbara Indech, \textit{The International Harmonization of Human Tissue Regulation: Control Over Human Tissue Use and Tissue Banking in Selecting Countries and the Current State of International Harmonization Efforts}, 55 \textit{FOOD & DRUG L.J.} 343, 344-348 (2000).

\textsuperscript{106} Jackson supra note 97. \textit{See also}, Curtis E. Harris, To Solve a Deadly Shortage: Economic Incentives for Human Organ Donation, 16 \textit{ISSUES L. & MED.} 213 (2001). A free market in organs was a serious reality in 1983 when a Virginia man, H. Barry Jacobs founded International Kidney Exchange Ltd. His company proposed to act as a broker, representing those in need of an organ and finding those willing to sell. Jacobs offered to pay up to $10,000 for a healthy kidney, all related expenses and a brokerage fee of $2,000 to $5,000 a kidney. Jacobs intended not only to recruit sellers in America, but also to look to Third World sources as well. Acknowledging that informed consent for illiterates would be difficult, he planned to videotape consent.

\textsuperscript{107} \textit{See} Harris supra note 106.
establishing the National Organ Transplant Act.\textsuperscript{108} The potential for exploiting this particular market will be reintroduced by repealing the current laws prohibiting offering valuable consideration for organ donations.\textsuperscript{109}

Currently there is a lack of empirical evidence to conclusively establish that offering economic incentives will promote organ donations.\textsuperscript{110} Yet, there is clear evidence demonstrating economic incentives for donating parts of the human body will lead to exploitation of underprivileged groups.\textsuperscript{111}

At one time, offering valuable consideration for blood and plasma donations was commonplace.\textsuperscript{112} Throughout the 1960s, individuals were routinely exploited by regularly selling their blood and plasma to blood manufacturers.\textsuperscript{113} Not all those who sold their plasma were exploited.\textsuperscript{114} Some donors with rare blood types or immunity factors could sell their plasma at a premium.\textsuperscript{115} The more persistent reality

\textsuperscript{108} Id. \\
\textsuperscript{109} See id. See also, 42 U.S.C. 273. Included among the provisions of the act was the criminalization of organ sales and purchases. The act used the power to regulate interstate commerce prohibited any person to knowingly acquire, receive or otherwise transfer any human organ for valuable consideration for use in human transplantation. Id. The term “human organ” was defined as “human/fetal kidney, liver, heart, lung, pancreas, bone marrow, cornea, eye, bone, and skin or any subpart thereof.” Id. The federal prohibition did not reach all transactions involving human tissue. Such bodily components as blood, sperm and eggs were not within its scope. Id.

\textsuperscript{110} See generally Jackson, supra note 97.

\textsuperscript{111} See Douglas Starr, Blood: An Epic History of Medicine and Commerce, (Knopf, 1998)

\textsuperscript{112} See id.

\textsuperscript{113} See id. Plasmapheresis proved invaluable to the drug industry, allowing manufacturers to harvest greater volumes of the raw plasma they desired. Id. Donors were able to sell their plasma up to 104 times a year. Id. Stuart Bauer, a writer for New York magazine investigated the world of plasma vendors by becoming one himself. Id. After a loved one died of transfusion related hepatitis, Bauer went undercover, donning old clothes and selling his plasma thirteen times over a period of seven weeks. Id. His account was one of “avaricious doctors and of the winos, addicts, malnourished and destitute whose plasma they farmed at the center in Times Square. Id. He described a scene in which the doctor at the center finds an elderly donor lying dead and remarks that during his years of association with the center the man had donated almost half a million cubic centimeters of blood.” Id.

\textsuperscript{114} Id.

\textsuperscript{115} Id. This was especially true of women who had developed a sensitivity to the Rh factor, the condition in which a baby with Rh-positive blood triggers an immune reaction in its Rh-negative mother. Id. Two scientists had shown that an Rh-negative woman could be immunized against the disease by injecting her with Rh antibodies immediately after the birth of her first Rh positive child, and by the late 1960s this injection became economically available. Id. Dorothy Garber of Miami, Florida, had such a high concentration of the “Big D” antibody, that she was able to earn more than $80,000 a year. Id.
was that there were thousands of less fortunate sellers; the unemployed, indigent, and substance-addicted often lined up outside donation centers to sell their plasma for ten dollars a pint.116

Prisoners were the most ostracized group of donors, whom became an important source of plasma-derived products, mainly gamma globulin.117 A dangerous situation developed in which drug companies maintained reasonably safe and hygienic prison centers but the subcontractors who supplied them often did not.118 The most notorious of these cases involved a group of facilities situated in prisons that were owned by an Oklahoma physician named Austin R. Stough.119 Stough was a prison doctor for the Oklahoma State Penitentiary when he became aware of the emerging market for plasma.120 He opened a plasma center in the penitentiary and began injecting volunteer prisoners with antigens for several diseases, collected their hyperimmune plasma and sold it as raw material to the major biologics firms.121 These firms and even the federal government turned a blind eye to the prisoner’s health and well-being and reasoned that what happened to the prisoners was not their concern.122

There are no safe guards currently in effect with regards to the proposed regulation purporting to experiment with offering economic consideration for donating organs that would prevent the exploitation that plagued the blood industry.123 The poor and indigent may once again be targeted to donate their bodies for cash.124

Adequate consideration must also be afforded the concept: How

116. Id., the director of a South Carolina plasma center run by Cutter Laboratories wrote in an undated memo: “A high percentage of our donors are either illiterate or functionally illiterate. . . . they have great difficulties reading words with more than two syllables and even more trouble understanding the meaning of those words I am fairly sure most of the other Plasmacenters have the same problems.” Id.
117. Starr supra note 111. “Gamma globulins can be fractionated from anybody’s plasma, but the best way to gather them is to find someone who has been exposed to a disease and has produced a high concentration of the antibodies in question.” Id.
118. Id.
119. Id.
120. Starr supra note 111.
121. Id. By the mid 1960s Stough had set up centers in five prisoners in the South and was supplying the raw material for approximately 25% of the nation’s hyperimmune gamma globulin.Id. Stough ran a careless and reckless operation, often risking the lives and health of the prisoners in exchange for access to the plasma. Id.
122. Starr supra note 111.
123. See Transplant Communications supra note 103.
124. Starr supra note 111.
can we sell that which we don’t own? One of the most well known cases that ruled on the possible property interests in human tissue is Moore v. Regents of the University of California. Moore’s doctors had taken away some of his cells during the removal of his spleen and because the cells were unique and potentially possessed scientific and commercial value, they were used to conduct research. Without Moore’s consent, the doctor’s patented a very lucrative cell line from his cells for his own research purposes. The California Supreme Court held that after removal, Moore owned neither his cells nor the cell lines produced outside of his body.

Legal scholars have suggested that the right to sell organs is a constitutionally protected liberty interest. However, the case of Mansaw v. U.S. District Court suggests otherwise. In this case, a young boy sustained a gunshot wound to his head and was declared brain dead when he arrived at the hospital. One of his parents signed a written consent allowing her son’s organs and tissues to be harvested. However, his other parent was not asked for his consent and indicated that if he were asked, he would not have signed. The court found that both parents had a constitutionally protected “property interest” in a minor child’s body. The court emphasized that these property rights should not be considered more constitutionally “essential.” “When compared with the rights of privacy, of liberty, etc., property rights, particularly the minimal property right presented here may fairly be described as a low right on the constitutional totem pole.” Thus, the court held that any constitutionally protected liberty interest that a parent may have in a

125. See Jackson supra note 97.
126. See generally, Moore v. Regents of the Univ. of Cal, 51 Cal. 3d 120 (Cal. 1990)
127. See id.
128. See id.
129. See id at 174. Other cases, however, have declared that blood and preembryonic cells may be bought, sold, donated, and devised by will, all of which are characteristics traditionally embodied in property law.
130. See Jackson supra note 97.
132. Id.
133. Id.
134. See id at 3. The boy’s father was not married to his mother at the time of the boy’s death. However they shared joint custody.
135. See id. See also, Whaley v. County of Tuscola, 58 F.3d 1111(6th Cir. 1995). See also, Brotherton v. Cleveland, 923 F.2d. 477 (6th Cir. 1995).
136. See Brotherton, supra note 135 at 481.
137. Mansaw supra note 131 (describing the state’s legitimate and compelling interest to protect the rights of the living.)
minor child dies with the child.  

**FUTURE SOURCES OF ORGAN DONATION**

With over 80,000 people currently on the national UNOS waiting list, it is illogical to assume that the existing regulations are adequately promoting organ donation. Under existing regulations, it is illegal to offer valuable consideration for organ donations. Presumably, the law is unlikely to change until the moral and ethical objections cited are adequately considered and addressed.

Within the existing regulations, there are multitudes of ways to promote organ donations. One organization, Lifesharers has abided by the existing federal regulations and has still developed a mechanism to promote organ donations. Lifesharers provides an incentive to donate, by directing the donation of organs and tissue first to members of the nonprofit organization. Lifesharer’s members join the organization for free and confer preferred access to their organs and tissue to other members. Lifesharers does not purport to interfere with the UNOS list. If an organ becomes

138. *Id.*
140. 42 U.S.C. 273
141. *See* Jackson *supra* note 97.
143. *See* id.
144. *See* id.
145. *See* id.
146. *See* id. “If you have an organ that is failing, there may be several treatment options, including an organ transplant. If you and your doctor decide to pursue a transplant, you will have to find a transplant center that will agree to treat you. If you are accepted by a transplant center, you will become part of the nationwide organ distribution system (OPTN). It is operated by the United Network for Organ Sharing (UNOS). UNOS maintains a national waiting list of eligible transplant patients awaiting organs, and establishes policies that decide who gets offered which organs. When an organ becomes available, the local organ procurement organization (OPO) gathers relevant information about the donor and enters it into the computer program maintained by the UNOS Organ Center. This program generates a ranked list of potential recipients from the UNOS waiting list. If you are the highest ranking person on the waiting list, the OPO will contact your transplant center. Your transplant center will then decide whether to accept the organ. If they reject it, the OPO will contact the transplant center for the next-highest ranking patient on the waiting list. If you are a Lifesharers member, you go through the exact same process to get on the waiting list. You also send an email to info@lifesharers.com. When an organ becomes available, your chances of getting it depend on your ranking on the UNOS waiting list and on whether the donor is a Lifesharers member. If the organ is not from a Lifesharers member, the process of
available on the national waiting list, the Lifesharers members (if any) has preferred access to it and the Organ Procurement Organization will offer the organ to them first.\textsuperscript{147} As Professor Richard Epstein notes, “Lifesharers is an ingenious effort to harness the collective efforts of many individuals to increase the supply of usable organs; It gives preference in case of need to those who are willing to make their organs available to others.”\textsuperscript{148} As of February 28, 2003, Lifesharers had 552 members, which was a 53\% increase over January’s total of 361; as of October 31, 2003, there are approximately 1743 members.\textsuperscript{149} This organization appears to have the potential to thrive by providing the important incentive for individuals to act within their own self-interests without offering economic incentives to promote donation.\textsuperscript{150}

CONCLUSION

Legislation should not be enacted to repeal current prohibitions against offering valuable consideration for organs and human tissue, as it will only serve to exploit those in need. By offering economic incentives to promote organ donations, we are encouraging the dangerous practice of organ brokerage. Undoubtedly we need to recognize the inherent need for incentives to donate. Offering valuable consideration appears to be an oversimplified solution to sufficiently address such a complex situation. Lifesharers.com has demonstrated that through the use of creative innovations, the organ deficit may be addressed without introducing the added conflicts presented by offering economic compensation for body parts. History has consistently shown us that those individuals who are potentially the most likely to donate will be those who cannot afford any other options. The potential exploitation of the poor and indigent cannot be overemphasized. Furthermore, to permit families to “cash in” on the organs of their deceased loved ones will inevitably lead to a host of determining who gets it is exactly the same as above. The OPO will offer your transplant center the organ if you are the highest ranking person on the UNOS waiting list. If the organ is from an Lifesharers member, the Lifesharers members on the UNOS waiting list for that organ get preferred access to it. Note however, there is a provision in the membership agreement that specifies that donors can designate that their organs go to members of their family over other Lifesharers members.” \textit{Id.}

\textsuperscript{147} See http://lifesharers.com (last visited November 30, 2003).
\textsuperscript{148} See id.
\textsuperscript{149} See \textit{id.} See also, Email from Professor Cohen to Jennifer Hurley on March 8, 2003, 18:37:04 EST (on file with author). stating that Lifesharers.com had approximately 600 members.
\textsuperscript{150} See http://lifesharers.com (last visited November 30, 2003).
unnecessary problems. Most importantly, there will no longer be any sense of autonomy of oneself and their bodies. Rather, individuals will be considered as mere vessels of valuable goods.

The current laws prohibiting offering economic consideration should not be repealed. Rather, creative solutions within the realm of the existing regulations to this devastating problem should be sought out and pursued.