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# Kidneys, Cash, and Kashrut: A Legal, Economic, and Religious Analysis of Selling Kidneys

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# ARTICLE

## KIDNEYS, CASH, AND KASHRUT: A LEGAL, ECONOMIC, AND RELIGIOUS ANALYSIS OF SELLING KIDNEYS

*Robert Steinbuch\**

### TABLE OF CONTENTS

I.	INTRODUCTION .....	1531
II.	CURRENT APPROACHES TO ADDRESSING KIDNEY DISEASE .....	1534
	A. <i>Kidney Dialysis Is Insufficient</i> .....	1534
	B. <i>Kidney Transplants</i> .....	1536
	1. <i>The Science of Transplantation</i> .....	1538
	2. <i>Cadaveric Kidney Transplants</i> .....	1539
	3. <i>The Cadaveric Kidney Distribution System</i> .....	1545
	4. <i>Living Kidney Donations</i> .....	1548
III.	THE 800-POUND GORILLA: SELLING KIDNEYS.....	1552
	A. <i>Selling Kidneys Is Not Allowed, but Some "Compensation" Is</i> .....	1557
	B. <i>Minor and Incompetent "Altruism"</i> .....	1558
	C. <i>The Sale of Kidneys in International Markets</i> .....	1559

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D.	<i>Religious Position on Kidney Sales</i> .....	1566
1.	<i>Donating Kidneys Under Jewish Law</i> .....	1569
2.	<i>Jewish Law on Payment to the Organ Donor</i> .....	1575
E.	<i>Nonreligious Objections to Paying Organ Providers</i> .....	1577
1.	<i>The Concern that a Kidney Market Will Displace Altruistic Donations</i> .....	1579
2.	<i>The Concern that Legalizing the Sale of Kidneys Will Compromise Human Dignity</i> .....	1581
3.	<i>The Concern for Economic “Coercion” of the Poor</i> .....	1584
4.	<i>Distributional Concerns</i> .....	1590
5.	<i>The Concern that Legalizing the Sale of Kidneys Will Result in a Decrease in Kidney Quality</i> .....	1593
6.	<i>The Concern that Legalizing the Sale of Kidneys Will Result in Excessive Risk to Kidney Sellers</i> .....	1594
IV.	PROPOSED NATIONAL KIDNEY-SALES SYSTEM .....	1597
A.	<i>Empower UNOS—and Only UNOS—to Purchase Kidneys</i> .....	1600
B.	<i>Restrict Directed Donations to Related Donors and Those with an Existing Relationship to the Recipient</i> .....	1601
C.	<i>Price Floor</i> .....	1602
D.	<i>Provide Payment over Several Years; Lifetime Government-Funded Supplemental Health Insurance; Minimum Waiting Period; and Seller’s Right to Rescind the Agreement</i> .....	1604
E.	<i>Exempt Creditors and Government from Considering the Value of Debtors’ Kidneys for the Purposes of Debt Obligation and Welfare Qualification</i> .....	1605
F.	<i>Require Sellers to Be a Minimum Age, Medical Screening, and Independent Oversight</i> .....	1606
V.	CONCLUSION .....	1606

## I. INTRODUCTION

On September 2, 1999, a Florida man identifying himself as “hchero” attempted to auction one of his functioning kidneys by posting it on eBay.com for a starting bid of \$25,000.<sup>1</sup> Before eBay officials shut down the auction, the highest bid had reached \$5,750,100.<sup>2</sup>

Nearly every country in the world is experiencing a growing shortage of transplantable kidneys.<sup>3</sup> In the United States, where shortages of kidneys are far greater than for any other transplanted organ,<sup>4</sup> the chances of patients with chronic renal failure receiving a kidney transplant are slim to none.<sup>5</sup> Currently, over 77,000 patients in the United States are waiting on the national transplant list<sup>6</sup> to receive one of only 15,000

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1. Kelly Lobas, *Living Organ Donations: How Can Society Ethically Increase the Supply of Organs?*, 30 SETON HALL LEGIS. J. 475, 502–03 (2006); Amy Harmon, *Auction for a Kidney Pops Up on Ebay’s Site*, N.Y. TIMES, Sept. 3, 1999, at A13.

2. Lobas, *supra* note 1, at 502–03. Lines and long waits predictably form in markets when prices are capped or sales are forbidden. Posting of Richard A. Epstein to The University of Chicago Law School Faculty Blog, *Organ Donations: Sorting or Queuing?*, [http://uchicagolaw.typepad.com/faculty/2006/05/organ\\_donations.html](http://uchicagolaw.typepad.com/faculty/2006/05/organ_donations.html) (May 31, 2006, 15:29 CST).

3. “A shortage is defined as an excess of the quantity of a good demanded over the quantity supplied at a given price.” T. Randolph Beard & David L. Kaserman, *On the Ethics of Paying Organ Donors: An Economics Perspective*, 55 DEPAUL L. REV. 827, 828 (2006). Long lines for kidney transplants commonly exist in other countries besides the United States. See Gary S. Becker & Julio Jorge Elías, *Introducing Incentives in the Market for Live and Cadaveric Organ Donations*, J. ECON. PERSPECTIVES, Summer 2007, at 3, 7–8 (illustrating that Germany, Spain, and the United Kingdom all have large waits for organs); Madhav Goyal et al., *Economic and Health Consequences of Selling a Kidney in India*, 288 J. AM. MED. ASS’N 1589, 1589 (2002) (“[N]early every country has a shortage of kidneys for transplantation.”). Between 15%–30% of European patients on a waitlist for a kidney die before receiving a transplant. Cathy Johnson, *Eastern Europeans Selling Kidneys for Cash*, ABC SCI. ONLINE, Aug. 7, 2003, <http://www.abc.net.au/science/news/stories/2003/917832.htm>. Approximately 50,000 people worldwide die each year waiting for a kidney. Michael Finkel, *Complications*, N.Y. TIMES, May 27, 2001, (Magazine), at 26.

4. See Michael B. Gill & Robert M. Sade, *Paying for Kidneys: The Case Against Prohibition*, 12 KENNEDY INST. ETHICS J. 17, 18 (2002) (noting that the “discrepancy between kidney supply and need is the greatest” of all organs). Of the patients awaiting organ transplants, those needing a kidney transplant are among the ones most likely to die waiting, followed by those anticipating liver and heart transplants, respectively. See MICHELE GOODWIN, *BLACK MARKETS: THE SUPPLY AND DEMAND OF BODY PARTS* 43 (2006) (displaying that, since 1996, more people have died from kidney failure on the waitlist than any other individual organ).

5. See GOODWIN, *supra* note 4, at 186 (showing that kidney demand increases yearly while the donations, both living and deceased, remain steady); E.A. Friedman & A.L. Friedman, *Payment for Donor Kidneys: Pros and Cons*, 69 KIDNEY INT’L 960, 960–61 (2006), available at <http://www.nature.com/ki/journal/v69/n6/full/5000262a.html> (noting that “17 people die each day waiting for transplants that cannot take place because of the shortage of donated organs”).

6. Organ Procurement and Transplantation Network, <http://www.optn.org/>

kidneys,<sup>7</sup> and the number of waitlist patients is expected to reach 100,000 within a few years.<sup>8</sup> Because the average wait time has increased to five years,<sup>9</sup> seven percent of patients on the list die each year before ever receiving a kidney.<sup>10</sup> The list is about double the length it was just one decade ago,<sup>11</sup> and the ratio of recipients to donors continues to grow more disparate each year.<sup>12</sup>

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latestData/rptData.asp (follow "DATA" tab; then follow "View Data Reports" hyperlink; then follow "National Data" hyperlink; select "candidates;" then follow the "Overall by Organ" hyperlink; then follow "kidney" hyperlink) (last visited Jan. 31, 2009). This number does not include renal patients never added to the waitlist, those who died on dialysis, or others with limited access to medical care. Michele Goodwin, *Altruism's Limits: Law, Capacity, and Organ Commodification*, 56 RUTGERS L. REV. 305, 311 (2004).

7. Goyal et al., *supra* note 3, at 1589.

8. Sean Arthurs, Comment, *No More Circumventing the Dead: The Least-Cost Model Congress Should Adopt to Address the Abject Failure of Our National Organ Donation Regime*, 73 U. CIN. L. REV. 1101, 1110–11 (2005).

9. On average, patients waiting for a cadaveric organ spend between five and seven years on the waitlist. Abdallah S. Daar, *The Case for a Regulated System of Living Kidney Sales*, 2 NATURE CLINICAL PRAC. 600, 600 (2006), available at <http://www.nature.com/ncpneph/journal/v2/n11/pdf/ncpneph0320.pdf>; see also Larry Rohter, *Tracking the Sale of a Kidney on a Path of Poverty and Hope*, N.Y. TIMES, May 23, 2004, at N1 (mentioning an average wait time of five years). Every four hours, one candidate on the list dies awaiting a kidney transplant. GOODWIN, *supra* note 4, at 44. Of those who live to see their turn for a transplant, many have become too weak and are no longer in the physical condition suitable to withstand organ transplantation. The average wait for a kidney transplant is estimated to exceed ten years by the end of this decade. Finkel, *supra* note 3, at 31.

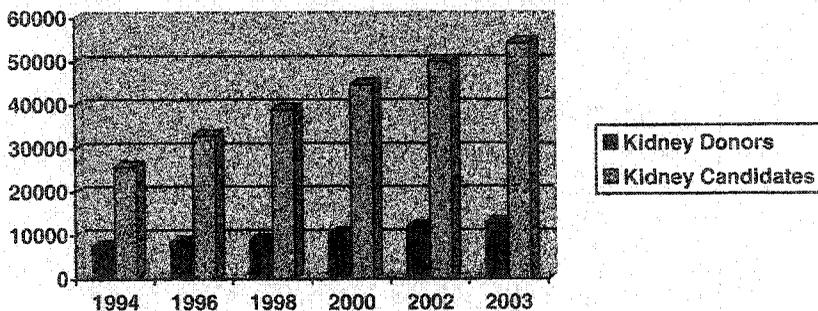
10. See GOODWIN, *supra* note 4, at 7, 43 (noting that every day 18 patients die while on the UNOS organ waitlist before the anticipated organ is ever transplanted, and every day 110 patients are added to the list); Daar, *supra* note 9, at 600 (commenting that of the 90,000 patients on the waitlist, 6,000 die each year). "Between 1989 and 1992, . . . 10,000 people died while waiting for an organ transplant." Curtis E. Harris & Stephen P. Alcorn, *To Solve a Deadly Shortage: Economic Incentives for Human Organ Donation*, 16 ISSUES L. & MED. 213, 227 (2001); see also UNITED NETWORK FOR ORGAN SHARING ETHICS COMM., FINANCIAL INCENTIVES FOR ORGAN DONATION: A REPORT OF THE PAYMENT SUBCOMMITTEE, <http://www.unos.org/Resources/bioethics.asp?index=3> [hereinafter UNOS REPORT] (noting that in 1992 alone, 2,567 patients died while waiting for an organ transplant); Arthur J. Matas & David E.R. Sutherland, *The Importance of Innovative Efforts to Increase Organ Donation*, 294 J. AM. MED. ASS'N 1691, 1691 (2005) (acknowledging a death rate of 7% per year on the waitlist); *Psst, Wanna Buy a Kidney?*, ECONOMIST, Nov. 16, 2006, at 15, (proclaiming that in 2005, 4,039 patients died while on the waitlist); Rohter, *supra* note 9, at 8 (noting that in 2003, approximately 3,300 out of 60,000 patients died while waiting for a kidney). The number of patients who die on the waitlist actually understates the number of patients affected by the kidney shortage because many patients are removed from the list when they become too weak to withstand transplantation. See DAVID L. KASERMAN & A.H. BARNETT, THE U.S. ORGAN PROCUREMENT SYSTEM: A PRESCRIPTION FOR REFORM 34 (2002).

11. From 1993 to 2003, the number of kidney transplant candidates in the United States increased from 19,046 to 47,831. Arthur J. Matas et al., *Morbidity and Mortality After Living Kidney Donation, 1999-2001: Survey of United States Transplant Centers*, 3 AM. J. TRANSPLANTATION 830, 831 (2003). "As of July 17, 2005, 62,550 Americans waited for kidneys." GOODWIN, *supra* note 4, at 44; see *id.* at 42 (showing that from 1994 to 2003, the kidney waitlist grew from 25,852 to 57,211).

12. See GOODWIN, *supra* note 4, at 42.

Moreover, the longer patients are forced to wait before receiving these transplants, the greater the costs grow in keeping these individuals alive on dialysis.<sup>13</sup>

In this Article, I discuss the current approaches to treating kidney disease and focus on the most viable of the alternatives—kidney transplants. After reviewing the current medical literature, I examine the most controversial, yet most promising, option for providing sufficient kidney transplants for all who need them—paying donors. Thereafter, I present an analysis of religious thought on paying kidney donors, with a focus on the most jurisprudential religion—Judaism. I then discuss the other significant medical, ethical, and economic arguments both in favor of and against this proposal, and provide throughout my analysis of each of these arguments. I conclude that paying kidney donors is proper and would alleviate the needless suffering that currently occurs as a result of the severe shortage of transplantable kidneys that exists in our current donation-



GOODWIN, *supra* note 4, at 44. The median number of days spent on the national waitlist for a transplantable kidney has increased substantially. *Id.*; see also Christy M. Watkins, *A Deadly Dilemma: The Failure of Nations' Organ Procurement Systems and Potential Reform Alternatives 4* (The Berkeley Electronic Press, Working Paper No. 304, 2004), available at <http://law.bepress.com/expresso/eps/304> (noting that the waiting time has increased 141% from 1988 to 1995). The wait for a donor kidney in 1994 was 836 days; by 2000, the wait had increased to 1,199 days. GOODWIN, *supra* note 4, at 44; Matas et al., *supra* note 11, at 831 (noting that the median amount of time patients spent on the waitlist for a kidney transplant from 1993 to 2003 increased from 514 days to more than 1,131 days). Moreover, the organ waitlist grew five times as fast as the number of organs donated between 1990 and 1999. Finkel, *supra* note 3, at 31. One contributing factor to the growing disparity might be the fact that insurance and third party coverage of organ transplants became more common during the 1970s and 1980s, causing an increase in the number of patients waiting for organ transplants. Margaret R. Sobota, Note, *The Price of Life: \$50,000 for an Egg, Why Not \$1,500 for a Kidney? An Argument to Establish a Market for Organ Procurement Similar to the Current Market for Human Egg Procurement*, 82 WASH. U. L.Q. 1225, 1228 (2004).

13. See KASERMAN & BARNETT, *supra* note 10, at 33–35.

only system. Thereafter, I detail a proposal for creating a system to regulate the sale of kidneys that enlists the existing nonprofit kidney distribution organization to serve as a clearinghouse for both the purchase and distribution of commercial kidneys. As this Article will show, even though kidneys would be purchased in a regulated market under this proposal, they would not be sold through market mechanisms. Their distribution would occur the very same way as today, based on need and matching criteria.

## II. CURRENT APPROACHES TO ADDRESSING KIDNEY DISEASE

The kidneys consist of two reddish-brown, bean shaped organs located on both sides of the spine under the diaphragm.<sup>14</sup> They remove waste from the body through the urine and help regulate blood pressure, volume, and electrolyte composition.<sup>15</sup> Kidney failure (a.k.a. renal failure) occurs when the kidneys cannot adequately remove waste and maintain the correct electrolyte balance.<sup>16</sup> Many disorders can cause chronic kidney failure—typically resulting in various secondary problems such as fatigue, a drop of red blood cells, and heart problems.<sup>17</sup> The treatment for kidney failure is dialysis, transplantation, or both.<sup>18</sup>

### A. *Kidney Dialysis Is Insufficient*

Dialysis performs the basic function of the kidneys by essentially washing the patient's blood.<sup>19</sup> In 2006, more than 350,000 patients throughout the United States were routinely undergoing dialysis treatment, and that number continues to grow rapidly.<sup>20</sup> Dialysis patients spend much of their time struggling merely to survive.<sup>21</sup>

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14. Organ Procurement and Transplantation Network, Organ Datasource > Kidney, <http://www.optn.org/organDatasource/about.asp?display=Kidney> (last visited Jan. 31, 2009).

15. *Id.*

16. *Id.*

17. *Id.*

18. *Id.*

19. MedlinePlus, Dialysis, <http://www.nlm.nih.gov/medlineplus/dialysis.html> (last visited Jan. 31, 2009).

20. Richard Pérez-Peña, *As Diabetes Destroys Kidneys, New York Lags in Dialysis Care*, N.Y. TIMES, Dec. 28, 2006, at A1, (reporting that in 1980, less than 50,000 U.S. patients were on routine kidney dialysis, but by 2006, the number of patients had increased to more than 350,000). Furthermore, whereas diabetes was the leading cause of kidney failure in 1980 for fewer than 6,000 of the patients on dialysis, in 2006, the number of patients on dialysis as a result of diabetes approached 150,000. *Id.*

21. *See id.*

“At a typical dialysis center, patients come in three times a week, typically for four hours at a time. They sit in rows of recliners, dozing, watching television—anything to take their minds off the machines, needles, and tubes that siphon blood from their bodies, clean it of impurities like urea, and pump it back in.”<sup>22</sup>

Burdening side effects include fatigue, cramps, and thirst—making employment virtually impossible.<sup>23</sup> A patient might lose fifteen pounds in a single treatment session.<sup>24</sup> Dialysis patients are hospitalized fifteen days on average out of every year, during which time roughly twenty percent die.<sup>25</sup> “I want to say it’s a rough life, but it hardly is a life,” explained Denise Bembury, a patient in Brooklyn undergoing dialysis, “I wouldn’t put this on anybody.”<sup>26</sup> There are no rules governing who can own or operate a dialysis center. While doctors manage some, individuals with little background in healthcare control others.<sup>27</sup>

Perhaps most troubling, dialysis can only sustain a patient’s life for a limited time.<sup>28</sup> Patients face an increasing risk of death each year they remain on dialysis.<sup>29</sup> And for those patients low on the national waitlist for a kidney transplant, continued dialysis results in diminished post-transplantation outcomes.<sup>30</sup>

Moreover, dialysis treatment is expensive—costing more than \$65,000 per patient per year, not including pharmaceutical costs.<sup>31</sup> Over the course of seven years, the average dialysis patient will spend at least \$450,000 for treatment.<sup>32</sup> The federal government supplements much of these expenses through Medicare’s End Stage Renal Disease Program.<sup>33</sup>

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22. *Id.*

23. *Id.*

24. Finkel, *supra* note 3, at 26.

25. Pérez-Peña, *supra* note 20.

26. *Id.* Faced with having to increase his time on dialysis before his kidney donor came forward, playwright Neil Simon decided, “I didn’t want to live my life anymore.” Sally Satel, *Desperately Seeking a Kidney*, N.Y. TIMES, Dec. 16, 2007, (Magazine), at 62.

27. Pérez-Peña, *supra* note 20.

28. More than 20% of dialysis patients die each year. See Mark F. Anderson, *The Future of Organ Transplantation: From Where Will New Donors Come, To Whom Will Their Organs Go?*, 5 HEALTH MATRIX 249, 281 (1995).

29. See KASERMAN & BARNETT, *supra* note 10, at 33, 35 (discussing transplant candidates’ decreasing health and increased risk of death after time spent on dialysis); Eugene Volokh, *Medical Self-Defense, Prohibited Experimental Therapies, and Payment for Organs*, 120 HARV. L. REV. 1813, 1832 (2007) (stating those on transplant waitlists have a 6% risk of death each year).

30. Matas & Sutherland, *supra* note 10, at 1691.

31. GOODWIN, *supra* note 4, at 39, 158.

32. *Id.* at 159.

33. See *id.*

### B. *Kidney Transplants*

Kidney transplants are the medically preferred alternative to long-term dialysis for kidney failure. Performed for the first time in 1936,<sup>34</sup> kidney transplants are the most common type of organ transplant,<sup>35</sup> and the procedure has been well studied.<sup>36</sup> Since 1983, when doctors introduced the immunosuppressant cyclosporin, transplantation has been the preferred method for addressing chronic renal failure.<sup>37</sup> Recent studies demonstrate that kidney transplantation extends life well beyond that expected from dialysis.<sup>38</sup> The typical patient will live approximately ten to fifteen years longer with a kidney transplant than if she remained on dialysis.<sup>39</sup> Patients who receive a kidney transplant in their twenties can expect to live thirty years longer than if they remained on dialysis.<sup>40</sup> The life-extending benefits inversely relate to age.<sup>41</sup> Moreover, patients

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34. Though ultimately unsuccessful, in 1936 surgeons performed the first kidney transplant in the Soviet Union using a kidney taken from a cadaver. Harris & Alcorn, *supra* note 10, at 214. Then, in 1947, surgeons temporarily stitched a kidney to a patient's arm while the patient's original kidney took time to recover. In 1954, doctors performed the first successful, permanent kidney transplant in Boston on Christmas Eve. Arthurs, *supra* note 8, at 1104.

35. Gill & Sade, *supra* note 4, at 18. At least twenty-five human organs are transplantable, including the kidneys, heart, lungs, and corneas. See Donny J. Perales, Comment, *Rethinking the Prohibition of Death Row Prisoners as Organ Donors: A Possible Lifeline to Those on Organ Donor Waiting Lists*, 34 ST. MARY'S L.J. 687, 688 (2003).

36. See Perales, *supra* note 35, at 689 ("Today, organ transplant surgery is no longer considered an extremely risky procedure; instead medical professionals view it as a common surgical operation.").

37. In 1983, when Swiss researchers discovered the compound immunosuppressant cyclosporin in a Norwegian soil sample, transplantation quickly became the safest method for addressing chronic renal failure. Cyclosporin blocks the body's natural rejection to the transplanted organ without also shutting down the body's immunological defense against other foreign bodies. As a result, transplant success rates surpassed 90%. Arthurs, *supra* note 8, at 1104–05.

38. See Mordechai Halperin, *Organ Transplants from Living Donors*, in 1 JEWISH MEDICAL ETHICS 407, 407–08 (2004). Mortality rates of renal patients who timely receive transplants are between 50–80% lower than those of renal patients who remain on dialysis for long periods. See Becker & Elías, *supra* note 3, at 15.

39. See Mordechai Halperin, *On Selling Tissues and Organs*, 8 B'OR HA'TORAH 45, 46 (1993) (suggesting that due to medical advances, kidney transplant patients generally live longer); Matas & Sutherland, *supra* note 10, at 1691 ("The mortality rate decreases dramatically following transplantation."); Gabriel C. Oniscu, Helen Brown & John L.R. Forsythe, *Impact of Cadaveric Renal Transplantation on Survival in Patients Listed for Transplantation*, 16 J. AM. SOC'Y OF NEPHROLOGY 1859, 1862 (2005) (concluding that the average life span for those on dialysis was 5.84 years, compared with 17.19 years for transplant patients).

40. See Volokh, *supra* note 29, at 1832.

41. See Oniscu et al., *supra* note 39, at 1864 (illustrating that the life expectancy is greater for younger transplant patients).

who undergo kidney transplants generally have a better quality of life when compared to those who remain on dialysis,<sup>42</sup> regardless of the source of the organ donor.<sup>43</sup> In fact, “organ transplantation often restores the patient’s health to a level approximating that experienced before the onset of the disease.”<sup>44</sup>

The long-term success rate of a kidney transplant inversely relates to the length of time a patient undergoes dialysis treatment prior to the organ transplant.<sup>45</sup> Thus, transplant patients forced to wait for long periods on dialysis are more likely to be hospitalized and less likely to return to the workforce following their transplant.<sup>46</sup> “From the perspectives of the recipient, donor and society, [preemptive renal transplantation] is the optimal timing strategy, and should no longer be the minority approach for patients eligible for this surgical procedure with suitable donors.”<sup>47</sup> Indeed, going on dialysis before transplantation may increase the probability of kidney rejection;<sup>48</sup> kidney grafts tend to last about one year longer when patients receive immediate transplants without having to wait three to four years on dialysis.<sup>49</sup>

Transplantation is not only better than dialysis for the health of the patient, but it is also more cost effective.<sup>50</sup> The costs of kidney transplantation have steadily decreased, such that the procedure has become far less expensive than dialysis.<sup>51</sup> “The long-term cost savings of kidney transplantation over dialysis are

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42. See Goyal et al., *supra* note 3, at 1589 (“Compared with long-term dialysis, renal transplantation generally offers a longer life span and a better quality of life.”).

43. See L. Schlebusch, *Depression and Self-Report Disclosure after Live Related Donor and Cadaver Renal Transplants*, 75 S. AFR. MED. J. 490, 493 (1989) (noting that the enhanced quality of life experienced by patients is “irrespective of donor type”).

44. KASERMAN & BARNETT, *supra* note 10, at 2.

45. *Id.*; see also Becker & Elias, *supra* note 3, at 15 (“Longer waiting times on dialysis negatively impact the success rate of transplantation and patient survival.”).

46. See Anderson, *supra* note 28, at 253 & n.20 (explaining that dialysis often makes the patients feel tired and anemic, which also leads to unemployment).

47. Kevin C. Mange & Matthew R. Weir, *Preemptive Renal Transplantation: Why Not?*, 3 AM. J. TRANSPLANTATION 1336, 1339 (2003).

48. KASERMAN & BARNETT, *supra* note 10, at 35.

49. See Becker & Elias, *supra* note 3, at 15 (stating that the average time to graft failure increases when the patient undergoes a preemptive kidney transplant); Kevin C. Mange, Marshall M. Joffe & Harold I. Feldman, *Effect of the Use or Nonuse of Long-Term Dialysis on the Subsequent Survival of Renal Transplants from Living Donors*, 344 NEW ENG. J. MED. 726, 730 (2001) (concluding that preemptive transplantation of kidneys was associated with a significantly longer graft half-life).

50. The National Kidney Foundation of the United Kingdom has found that “kidney transplantation is very cost effective.” Beard & Kaserman, *supra* note 3, at 847.

51. Manikkam Suthanthiran & Terry B. Strom, *Renal Transplantation*, 331 NEW ENG. J. MED. 365, 369 (1994). In 1994, patients were charged roughly \$38,487 for a kidney transplant (calculated in 1988 dollars). *Id.*

well known,” says the American Diabetes Association.<sup>52</sup> Beginning one year after transplantation, the costs associated with patient care are approximately one-third what they are for long-term dialysis patients.<sup>53</sup> Indeed, “the financial break-even point for transplantation is reached only 2.7 years after a kidney graft.”<sup>54</sup> Whereas dialysis costs for a patient average \$450,000 for treatments, the costs for kidney transplantation approximate \$90,000.<sup>55</sup> Many have been quick to notice the potential savings,<sup>56</sup> which have been projected by one scholar to be over \$1 billion per year.<sup>57</sup>

1. *The Science of Transplantation.* Successful kidney transplants require blood-type compatibility between the donor and recipient, a high number of shared human leukocyte antigens (HLA), and “crossmatching” (discussed below).<sup>58</sup> After blood typing, doctors evaluate whether the donor’s and patient’s tissue match genetically.<sup>59</sup> People have blood and tissue proteins called antigens—HLAs—that are distinguishable like blood types.<sup>60</sup> Kidney transplant doctors examine six specific HLAs in each donor and recipient to determine the level of tissue matching.<sup>61</sup> The long-term success of kidney transplantation

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52. Beard & Kaserman, *supra* note 3, at 847.

53. See Robert Gaston et al., *Racial Equity in Renal Transplantation: The Disparate Impact of HLA-Based Allocation*, in *THE ETHICS OF ORGAN TRANSPLANTS: THE CURRENT DEBATE* 308, 309 (Arthur L. Caplan & Daniel H. Coelho eds., 1998) (citing Paul W. Eggers, *Effect of Transplantation on the Medicare End-Stage Renal Disease Program*, 318 *NEW ENG. J. MED.* 223, 223–29 (1988)).

54. Beard & Kaserman, *supra* note 3, at 847 (“After 2.7 years, the medical system saves about \$27,000 per year for each patient who has a transplant instead of remaining on dialysis.”).

55. GOODWIN, *supra* note 4, at 159. Additional costs for the transplant patient include two years of immunosuppressant medications totaling \$16,000 each year. Afterwards, the transplant patient and his or her health provider save roughly \$8,000 per year in dialysis costs. *Id.* Kidney transplants cost, on average, \$100,000 less than long-term dialysis. Volokh, *supra* note 29, at 1839.

56. See Arthurs, *supra* note 8, at 1111 (illustrating the rapid increase of names on the waitlist).

57. Avoiding the costs of dialysis for 3,469 renal patients (\$1,192,642,000) plus preventing 218 unnecessary deaths (\$149,548,000) nets an overall savings of \$1,342,190,000. Beard & Kaserman, *supra* note 3, at 848.

58. Thomas Peters, *Kidney Transplant Matching: What It Means*, <http://www.aakp.org/aakp-library/Kidney-Transplant-Matching/index.cfm> (last visited Jan. 31, 2009) (explaining that a kidney transplant requires blood-type matching, tissue (antigen) matching, and crossmatching to be successful).

59. *Id.*

60. *Id.*

61. The HLA system “is controlled by genes on the short arm of chromosome six. The HLA loci are part of the genetic region known as the Major Histocompatibility Complex . . . . The essential role of the HLA antigens lies in the control of self-recognition

historically has been directly related to the level of antigen compatibility between the donor and recipient.<sup>62</sup> However, while the best long-term outcomes may occur with a patient and donor who share all HLAs, i.e., a six-antigen match, immunosuppressives (anti-rejection drugs) now greatly reduce the importance of HLAs matches.<sup>63</sup> Further, even when all six HLAs match perfectly, the recipient must still undergo continuous immunosuppressive treatment to prevent his or her body's immune system from attacking the newly transplanted organ.<sup>64</sup>

Crossmatching is the last test performed on a kidney donor and a particular recipient. "The basic crossmatch test involves a mixing of cells and serum to determine whether or not the recipient of a kidney will respond to the transplanted organ by attempting to reject it."<sup>65</sup> These tests have contributed to the overall success of kidney transplantation today.<sup>66</sup>

Those patients living in the United States with end-stage renal disease (ESRD),<sup>67</sup> the stage of kidney disease requiring intervention, who choose to undergo a transplant rather than remain on dialysis have two options for kidney transplants: cadaveric or living.<sup>68</sup>

2. *Cadaveric Kidney Transplants.* ESRD patients in need of a kidney typically receive kidneys in America from cadaveric kidney donors—i.e., brain-dead donors whose organs are

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and thus defense against microorganisms." U. Shankarkumar, *The Human Leukocyte Antigen (HLA) System*, 4 INT. J. HUM. GENETICS 91, 91 (2004).

62. See Suthanthiran & Strom, *supra* note 51, at 369 (concluding that HLA-identical grafts had estimated half-lives of 26.9 years compared to 12.2 (for a sibling) and 10.8 (for a parent) for mismatched grafts). For patients who receive cadaveric organs, the benefits of HLA-matched kidneys are significant. The half-life of HLA-matched grafts was 17.3 years compared to 7.8 years for a mismatched graft. *Id.*; see also CATHERINE LYONS, ORGAN TRANSPLANTS: THE MORAL ISSUES 102 (1970) (stating that there is very strong reason to believe that "when a donor is unrelated, selection of the recipient on the basis of the tissue match can improve the prognosis" (quoting *Rushing Donor Organs Across Europe's Borders*, MED. WORLD NEWS, July 18, 1969, at 28–29)).

63. Peters, *supra* note 58.

64. Even when the patient and donor share all six antigens, other factors may cause the organ to be rejected. See John T. Makley & Richard Nicholas, *Clinical Aspects of Allograft Tissue*, in TRANSPLANTING HUMAN TISSUE: ETHICS, POLICY, AND PRACTICE 36, 37 (Stuart J. Youngner et al. eds., 2004).

65. Peters, *supra* note 58.

66. *Id.*

67. The leading cause of ESRD is insulin-dependent diabetes mellitus in European Americans, hypertensive nephrosclerosis in African Americans, and chronic glomerulonephritis in Hispanics and Asians. Suthanthiran & Strom, *supra* note 51, at 368.

68. Matas & Sutherland, *supra* note 10, at 1691.

harvested for transplantation.<sup>69</sup> Both the donor's cause of death and the health of his or her organs potentially limit the pool of cadaveric organ donors. Only a small percentage of individuals die in such a way that is conducive to cadaveric organ donations.<sup>70</sup> Ideally, the donor died in the hospital after an accident (e.g., car or motorcycle) so that nothing directly impairs donor organ functioning.<sup>71</sup> In addition, ideal donors are younger than fifty-five with kidneys that are free from infection and debilitating diseases.<sup>72</sup> Cadaveric donor organs must be quickly removed and stored in appropriate medical facilities. Unless these organs are transplanted within several hours of storage, they run the risk of suffering permanent damage and becoming unfit for transplantation.<sup>73</sup> The surgeon typically only has sixty minutes after a donor's death to retrieve the kidneys,<sup>74</sup> after which the kidneys must be delivered to the appropriate transplant center within eight hours of procurement.<sup>75</sup> Thus, only

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69. See Goyal et al., *supra* note 3, at 1589 (noting that cadaveric donors include, for example, brain-dead victims of car accidents); see also Gaston et al., *supra* note 53, at 308 (declaring that each year more than 23,000 Americans await a suitable cadaveric kidney); Andrew S. Levey et al., *Kidney Transplantation from Unrelated Living Donors: Time to Reclaim a Discarded Opportunity*, in *THE ETHICS OF ORGAN TRANSPLANTS: THE CURRENT DEBATE*, *supra* note 53, at 48, 48–49 (mentioning that most kidney transplantations in the past involved cadaveric kidneys because there was no risk of subsequent death to the donor).

70. Lloyd R. Cohen, *Directions for the Disposition of My Vital Organs*, 55 DEPAUL L. REV. 805, 806 (2006) (stating that fewer than 25,000 individuals per year could make suitable organ donors). In fact, only 1% of individuals die in a way that would make them suitable organ donors. See KASERMAN & BARNETT, *supra* note 10, at 9. And, this number decreases even more when analyzing potential availability, such that “[i]t is estimated that 30 to 50 cadaveric kidneys per million population are potentially available annually.” Suthanthiran & Strom, *supra* note 51, at 368; see also Anderson, *supra* note 28, at 252 (observing that “only certain of the deceased are appropriate donors”); CARLYLE C. RING, JR. & SHELDON KURTZ, REPORT TO THE COMMITTEE OF THE WHOLE, REVISED UNIFORM ANATOMICAL GIFT ACT 2 (2005), <http://www.law.upenn.edu/bll/ulc/uaga/2005AMAnatomicalReport.htm> (“Only a small percentage of potential donors die under circumstances that permit organ donation.”).

71. Shelby E. Robinson, Comment, *Organs For Sale? An Analysis of Proposed Systems for Compensating Organ Providers*, 70 U. COLO. L. REV. 1019, 1023 (1999). I have met several doctors who routinely refer to motorcycles as “donor-cycles.” Notwithstanding the gallows humor, the description is often accurate, because motorcycle drivers involved in fatal accidents are usually relatively young and were, prior to death, fairly healthy.

72. David E. Jefferies, Note, *The Body as Commodity: The Use of Markets to Cure the Organ Deficit*, 5 IND. J. GLOBAL LEGAL STUD. 621, 626 (1998) (“[I]t is preferable that cadavers be brain dead, but still have a beating heart, be younger than fifty-five, and have an organ free from infection or metastatic cancer.”).

73. Arthurs, *supra* note 8, at 1105–06.

74. Robert Steinbrook, *Organ Donation After Cardiac Death*, 357 NEW ENG. J. MED. 209, 210 (2007).

75. Zero antigen mismatch kidneys must be offered to the appropriate recipient transplant centers within eight hours of organ procurement for standard donors and four hours for expanded criteria donors. United Network for Organ Sharing, Organ

a very narrow timeframe exists during which a recipient must be matched with the organ, arrive at the hospital, and be readied for surgery.<sup>76</sup> Under these circumstances, recipients cannot undergo any significant presurgery anti-rejection medical treatment. ESRD patients on the national waitlist remain there until a matching cadaveric kidney is received; they get a kidney from a living donor through their own means; they get too ill to receive a transplant; or they die.<sup>77</sup>

Unfortunately, only twenty-five to fifty percent of even potential cadaveric donors ever become organ donors.<sup>78</sup> In 1968, the National Conference Commissioners on Uniform State Laws (NCCUSL) made an effort to increase the donations of cadaveric organs by drafting the Uniform Anatomical Gift Act (UAGA), which provides uniform regulation of organ donation and encourages cadaveric organ volunteerism.<sup>79</sup> The Patient Self Determination Act of 1991 requires hospitals to inform potential donors and their families of the option to designate whether or not they would like to donate their organs at death.<sup>80</sup> The UAGA left the decision as to whether to donate organs upon death to each individual.<sup>81</sup> The UAGA, a version of which has been adopted in every state,<sup>82</sup> provides that all persons over the age of eighteen may designate his or her organs by will or by another instrument for donation after death.<sup>83</sup> As a result, every state

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Distribution: Allocation of Deceased Kidneys, Policy 3.5.3.5 (2008), available at <http://www.unos.org/policiesandbylaws/policies.asp?resources=true>.

76. Arthurs, *supra* note 8, at 1106.

77. “[T]he national organ transplant waiting list . . . is more accurately a pool of individuals who have been referred for organ transplantation and are waiting to receive deceased donor organs.” Daniel T. Stimson, *Private Solicitation of Organ Donors: A Threat to the Fairness of the U.S. Organ Transplant System, or a Solution to the National Organ Shortage?*, 10 MICH. ST. J. MED. & L. 349, 355 (2006).

78. See KASERMAN & BARNETT, *supra* note 10, at 11.

79. Stimson, *supra* note 77, at 352–53; see also GOODWIN, *supra* note 4, at 111 (noting that the UAGA addresses deceased organ donations only). The comment to section 10 of the 1987 Uniform Anatomical Gift Act (UAGA) provides as follows:

Altruism and a desire to benefit other members of the community are important moral reasons which motivate many to donate. Any perception on the part of the public that transplantation unfairly benefits those outside the community, those who are wealthy enough to afford transplantation, or that it is undertaken primarily with an eye toward profit rather than therapy will severely imperil the moral foundations, and thus the efficacy of the system.

UNIF. ANATOMICAL GIFT ACT § 10 cmt., 8A U.L.A. 62 (1987).

80. See Arthurs, *supra* note 8, at 1113.

81. *Id.* at 1107.

82. Every state adopted some version of the UAGA by 1973. Steve P. Calandrillo, *Cash for Kidneys? Utilizing Incentives to End America's Organ Shortage*, 13 GEO. MASON L. REV. 69, 78 (2004).

83. UNIF. ANATOMICAL GIFT ACT §§ 2, 4, 8A U.L.A. 39–41, 45 (2006). Section 2 of

currently maintains organ donor registries, most of which involve either checking a box on one's driver's license application or filling out a donor card.<sup>84</sup> When an individual fails explicitly to make his or her wishes known before death, the UAGA provides that family members may step in to make the decision for him or her.<sup>85</sup>

To further this effort, amendments were made to the UAGA in 1987 both preventing relatives from revoking the decision of a deceased family member to donate his or her organs<sup>86</sup> and allowing the family to choose to donate the organs if the deceased had not expressly indicated a refusal to donate.<sup>87</sup> Furthermore, the amendments state that medical personnel may no longer be held criminally or civilly liable as long as they acted in good faith pursuant to the UAGA and other state laws.<sup>88</sup> Although the UAGA forbids payment to individuals for donating cadaveric organs, it does not mention anything about reimbursing living donors.<sup>89</sup>

In the past, many European countries, and just recently several South American countries, have adopted a presumed consent model for procuring organs for transplant.<sup>90</sup> Accordingly, those countries presume that, unless specified in writing, individuals agree to donate their organs at the time of death.<sup>91</sup> Under this model, individuals must affirmatively opt out to retain their organs upon death.

France adopted a presumed consent model in 1976, with the passage of the Caillavet Law, a statute requiring that all adults

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the UAGA states that "[a]ny individual of sound mind and 18 years of age or more may give all or any part of his body for any purpose specified . . . , the gift to take effect upon death." UNIF. ANATOMICAL GIFT ACT § 2, 8A U.L.A. 116 (1968), superseded by UNIF. ANATOMICAL GIFT ACT § 2, 8A U.L.A. 24-25 (1987). *See also* GOODWIN, *supra* note 4, at 178 (stating that body parts of a single cadaver can be worth more than \$220,000).

84. Stimson, *supra* note 77, at 352.

85. Arthurs, *supra* note 8, at 1107 (citing UNIF. ANATOMICAL GIFT ACT § 2(a) (1968), 8A U.L.A. 116 (2003)).

86. UNIF. ANATOMICAL GIFT ACT § 2(h), 8A U.L.A. 2 (1987); *see also* Calandrillo, *supra* note 82, at 78 (noting that "the statute was simplified to ensure that the donor's wishes were followed upon death rather than overridden by her next of kin").

87. UNIF. ANATOMICAL GIFT ACT § 3(a), 8A U.L.A. 3 (1987).

88. UNIF. ANATOMICAL GIFT ACT § 11(c), 8A U.L.A. 11 (1987).

89. Harris & Alcorn, *supra* note 10, at 223.

90. *Id.* at 224. Primarily, European countries have been the ones to implement the presumed consent model for procuring organs. Robinson, *supra* note 71, at 1031.

91. *See* Harris & Alcorn, *supra* note 10, at 224; Robinson, *supra* note 71, at 1031. Jim Cohan, a U.S. transplant coordinator, sometimes organizes transplants in countries that have presumed consent laws to take advantage of the greater availability of organs. Telephone Interview with Jim Cohan, U.S. Transplant Coordinator, in Sun Valley, Cal. (Jan. 29, 2009).

donate their organs at death unless they have affirmatively opted out during their lifetime.<sup>92</sup> Specifically, the Caillavet Law states:

Organs may be removed for therapeutic or scientific purposes from cadavers of persons who have not, during their lifetime, indicated their refusal to permit such a procedure. However, where the cadaver is that of a minor or of an incompetent person, organs may be removed for transplantation purposes only with the authorization of the person's legal representative.<sup>93</sup>

Some justify a presumed consent model through social contract theory,<sup>94</sup> requiring sacrifices for the "common good."<sup>95</sup> Despite an increase in the number of France's postmortem donors after enactment of the Caillavet Law, the presumed consent model fails to eliminate France's organ shortages,<sup>96</sup> as have similar models in other countries.<sup>97</sup>

A few countries reserve the right to harvest the organs of their constituents at the time of death regardless of whether or not they have received the donor's consent.<sup>98</sup> China and Serbia, for example, remove the organs of executed prisoners.<sup>99</sup> Officially sanctioned under Chinese law in 1984, the procedure is allowed in China under one of three circumstances: "(1) if the prisoner's body is not claimed; (2) if the prisoner has consented; or (3) if the prisoner's family has consented."<sup>100</sup> The U.S. State Department has expressed concern, however, that prisoners and their families are not given an opportunity to give meaningful consent.<sup>101</sup>

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92. Jefferies, *supra* note 72, at 636.

93. *Id.* (citation omitted).

94. GOODWIN, *supra* note 4, at 133–34 (explaining the presumed consent proponent's argument that the policy "maximizes a community good for the benefit of all people, with a relatively small collective burden").

95. See *Jacobson v. Massachusetts*, 197 U.S. 11, 27 (1905) (explaining the concept of "the common good" in the context of a challenge to the state's compulsory vaccination law).

96. See Jefferies, *supra* note 72, at 637 (noting that twelve years after the passage of the Caillavet Law, France still had relatively long waitlists for each transplantable organ).

97. In 1998, Austria's presumed consent model produced only 270 transplant kidneys, a relatively small number in comparison to the 1,116 waiting patients. *Id.* at 639.

98. See Harris & Alcorn, *supra* note 10, at 225 (referring to this type of system as a "nationalization of cadavers").

99. *Id.*

100. Jefferies, *supra* note 72, at 642–43.

101. See *Organs for Sale: China's Growing Trade and Ultimate Violation of Prisoner's Rights: Hearing Before the Subcomm. on International Operations and Human Rights of the H. Comm. on International Relations*, 107th Cong. 10–11 (2001) (statement of Michael E. Parmly, Principal Deputy Assistant Secretary of State, Bureau of Democracy, Humans Rights, and Labor) (expressing concern that the Chinese system of

The “mandated choice” model—not implemented anywhere—offers an alternative to the presumed consent model and its requirement that individuals wishing to keep their organs at death must opt out. It requires people either to opt in or to opt out of keeping their organs when they die.<sup>102</sup> That is, they must make an affirmative choice one way or the other about whether to donate.<sup>103</sup> Individual preference would be recorded on tax forms or driver’s licenses.<sup>104</sup> However, the costs and logistics of recording and later honoring every person’s individual donation preferences typically prove prohibitive.<sup>105</sup>

In yet another model, advocates propose a futures market for organ procurement, wherein potential donors receive payment for entering an agreement during their lifetime to give over the rights to remove their organs upon death.<sup>106</sup> Such a program would enable donors to sell removal rights to their organs in advance of death for harvest after death or to agree to sell their organs at death with all proceeds going to their heirs.<sup>107</sup> Much of the compensation paid out to potential donors in the first variant, however, would be wasted because most cadaveric kidneys prove unusable for transplantation.<sup>108</sup>

In the United States, even though the UAGA has simplified the process for donating cadaveric organs,<sup>109</sup> roughly half of the potential cadaveric donations take place each year.<sup>110</sup> Other recent initiatives increased the public’s knowledge of the importance and ease of electing to be organ donors,<sup>111</sup> but these efforts too have had little effect on the number of cadaveric donations<sup>112</sup> and have failed to satisfy the

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imprisonment contributes to the lack of meaningful consent by a prisoner’s family).

102. Robinson, *supra* note 71, at 1034.

103. *Id.* at 1032 (discussing the lack of choice inherent in a presumed consent system).

104. *Id.* at 1034.

105. *Id.*

106. *Id.* at 1037.

107. DAVID D. FRIEDMAN, LAW’S ORDER: WHAT ECONOMICS HAS TO DO WITH LAW AND WHY IT MATTERS 242 (2000).

108. Robinson, *supra* note 71, at 1043 (calling a futures market for organs “vastly inefficient”).

109. Stimson, *supra* note 77, at 353.

110. Anderson, *supra* note 28, at 256; Volokh, *supra* note 29, at 1832–33.

111. See Matas & Sutherland, *supra* note 10, at 1691 (listing numerous efforts to raise awareness for organ donation through public relations campaigns, improvements in the consent process, and other innovative means).

112. See Arthurs, *supra* note 8, at 1114 (acknowledging that in 1996, the “waves of public initiatives” increased the donation rate by 1% while the waitlist grew by 250%);

growing demand for kidney transplants.<sup>113</sup> This, however, is not an indictment of these programs. The critical issue is that even if all eligible cadaveric donors donated, the kidney supply would still fall far short of the number of kidneys needed to meet the demand of the American population with kidney failure seeking a transplant.<sup>114</sup> If potential cadaveric organ donors were fully exhausted as a supply source for organ transplants, the current number of cadaveric organ donations would likely only double.<sup>115</sup>

3. *The Cadaveric Kidney Distribution System.* Initially, and through the early 1980s, a disorganized assortment of groups called organ procurement organizations (OPOs), created by individual hospitals equipped with transplant centers, oversaw the procurement and allocation of transplant organs.<sup>116</sup> Without any federal supervision for allocating the organs or organizing patient and donor data, these OPOs collected cadaveric transplant organs from local hospitals and transplanted them into their own patients.<sup>117</sup> This local arrangement continued for more than a decade.<sup>118</sup>

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Matas & Sutherland, *supra* note 10, at 1691.

113. See Robert D. Truog, *The Ethics of Organ Donation by Living Donors*, 353 NEW ENG. J. MED. 444, 444 (2005) (arguing that cadaveric organs have failed to meet the growing demand for organ transplants). Even with the marketing efforts encouraging people to sign donor cards, between 1990 and 1999 the organ waitlist grew five times as fast as the number of organs donated. Finkel, *supra* note 3, at 31; see also UNOS REPORT, *supra* note 10 (“Few could argue that the number of cadaveric organs procured by the current system has failed to meet the demands that exist today.”); Friedman & Friedman, *supra* note 5, at 960 (explaining that state driver’s license registries, together with intensive public relations campaigns, celebrity endorsements, and National Kidney Foundation efforts, have done nothing over the past decade to significantly increase the number of cadaveric kidneys transplants performed in the United States).

114. See Matas & Sutherland, *supra* note 10, at 1691 (noting that even “if all potential deceased donors became actual deceased donors, there would still be a shortage of organs”).

115. David Kaserman, *Markets for Organs: Myths and Misconceptions*, 18 J. CONTEMP. HEALTH L. & POL’Y 567, 568 (2002); see also KASERMAN & BARNETT, *supra* note 10, at 4 (“Given the likely number of potential cadaveric organ donors, a more effective procurement policy could, in principle, increase collections by two- or even threefold.”).

116. Stimson, *supra* note 77, at 354–55.

117. Martha W. Anderson & Scott Bottenfield, *Tissue Banking—Past, Present, and Future*, in TRANSPLANTING HUMAN TISSUE: ETHICS, POLICY, AND PRACTICE 14, 20 (Stuart J. Youngner et al. eds., 2004). Until 1985, each organ procurement organization (OPO) drafted its own allocation and procurement policies. Because OPOs typically served only a single transplant hospital, surgeons within each hospital were usually the ones to resolve whatever ethical issues arose. Even in larger cities like Boston, New York City, Dallas, and Los Angeles, allocation and procurement issues were resolved without federal oversight. Jeffrey Prottas, *Ethics of Allocation: Lessons from Organ Procurement History*, in TRANSPLANTING HUMAN TISSUE: ETHICS, POLICY, AND PRACTICE, *supra*, at 120, 121.

118. Prottas, *supra* note 117, at 121.

However, in the early 1980s, success rates of transplant procedures improved such that the demand for organ transplants began to overwhelm the supply of organs that were available.<sup>119</sup> Both “a series of public appeals by desperate families seeking organs and financial assistance for transplants’ and ‘the appearance of a commercial market for transplant organs’” helped Congress identify organ allocation problems that desperately needed addressing.<sup>120</sup>

Pursuant to the National Organ Transplant Act (NOTA), Congress created the Organ Procurement and Transplantation Network (OPTN) to streamline the allocation of organs throughout the country<sup>121</sup> and chose the United Network for Organ Sharing (UNOS), a central registry of potential kidney recipients, to administer the OPTN.<sup>122</sup> UNOS is a private, nonprofit group operating out of Richmond, Virginia and is dedicated to raising the number of organ donors.<sup>123</sup> It primarily oversees the national organ transplant waitlist.<sup>124</sup> Under contract with the Department of Health and Human Services, UNOS links up all the transplant centers and regional OPOs to a centralized computer system.<sup>125</sup> Whereas transplant hospitals were initially given the option of OPTN membership, the Omnibus Budget Reconciliation Act of 1986 made federal funding for Medicaid and Medicare contingent upon compliance with UNOS allocation policies.<sup>126</sup>

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119. *Id.*

120. Robinson, *supra* note 71, at 1028 (quoting Ann McIntosh, *Regulating the “Gift of Life”—The 1987 Uniform Anatomical Gift Act*, 65 WASH. L. REV. 171, 174 (1990)).

121. Organ Procurement and Transplantation Network (OPTN) Charter, Art. II, [http://www.optn.org/ContentDocuments/OPTN\\_CHARTER\\_II\\_-\\_NOV\\_04.doc](http://www.optn.org/ContentDocuments/OPTN_CHARTER_II_-_NOV_04.doc) (last visited Jan. 28, 2009) (“The primary purposes of the OPTN are to operate and monitor an equitable system for allocating organs donated for transplantation; maintain a waiting list of potential recipients; match potential recipients with organ donors according to established medical criteria for allocation of organs and, to the extent feasible, for listing and de-listing transplant patients; facilitate the efficient, effective placement of organs for transplantation; and increase organ donation.”). Title II of the National Organ Transplant Act (NOTA) established the OPTN to help pair donor organs with the most suitable organ recipients anywhere in the United States. Arthurs, *supra* note 8, at 1108.

122. United Network for Organ Sharing (UNOS), Organ Donation and Transplantation, <http://www.unos.org/whoWeAre/theOPTN.asp> (last visited Jan. 31, 2009).

123. Steinbrook, *supra* note 74, at 210.

124. Stimson, *supra* note 77, at 350–51, 355.

125. Watkins, *supra* note 12, at 11.

126. GOODWIN, *supra* note 4, at 97 (stating that OPOs and all hospitals performing transplant operations must adhere to UNOS allocation policies to receive Medicaid and Medicare funding).

Transplant centers decide which patients will get onto the waitlist by running candidates through a series of tests to evaluate their social support system and health.<sup>127</sup> Every time one of the regional OPOs receives a transplantable organ, prospective recipients on the waitlist are ranked according to criteria that UNOS has specified, “including blood type, HLA type,<sup>128</sup> length of time waiting [on the list], medical urgency, and distance from the donor” in order to determine which candidate will receive the organ transplant.<sup>129</sup>

Due to the overwhelming shortage of kidneys, often more than one transplant candidate turns out medically compatible with and ready to receive a particular kidney.<sup>130</sup> When this happens, transplant personnel must further prioritize patients, and they do this by assessing their social worth.<sup>131</sup> “Criteria include some family-related considerations such as marital status and number of dependents; other criteria are income, educational background, employment record, relationship to authority figures, past irresponsible behavior, and intelligence.”<sup>132</sup> Rather than paying for their transplant organ with cash, recipients must pay for it with time,<sup>133</sup> often more of it than they have to spend.<sup>134</sup> A policy that chooses which patients live and die based on their social status likely results in inequitable outcomes.<sup>135</sup> And, while giving priority to patients with medical urgency or waitlist seniority typically directs transplants to patients who are in the most immediate need,

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127. Watkins, *supra* note 12, at 11.

128. See GOODWIN, *supra* note 4, at 102–03 (“UNOS has developed a process that prioritizes kidney transplants based on HLA matching between donor and recipient. A point value system is used to determine the compatibility or ‘matching’ between a kidney donor and her potential recipient. The system strongly favors a perfect match over all other possible combinations . . .”).

129. Stimson, *supra* note 77, at 355. Similar to its authorization of UNOS, NOTA’s provisions allow for the establishment of the National Marrow Donor Program (NMDP). UNOS regulates the allocation of transplant organs from deceased donors, and the NMDP oversees bone marrow transplants from living donors. However, instead of maintaining a list of prospective transplant recipients as UNOS does, the NMDP maintains a national registry of prospective transplant donors that can be searched for HLA compatibility each time there is a patient who needs a bone marrow transplant. *Id.* at 356.

130. Jefferies, *supra* note 72, at 626.

131. *Id.*

132. *Id.*

133. Posting of Richard A. Epstein, *supra* note 2. Often, however, the time patients spend on the waitlist amounts to deadweight loss because many of them receive nothing in return. *Id.*

134. See Michele Goodwin, *Precious Commodities: An Introduction*, 55 DEPAUL L. REV. 793, 793 (2006) (stating that roughly every hour a patient on the national organ transplant waitlist dies before receiving a transplant).

135. Jefferies, *supra* note 72, at 626.

these transplanted kidneys benefit these patients for fewer years than if they were transplanted into healthier patients on the list for less time.<sup>136</sup>

4. *Living Kidney Donations.* Cadaveric donors are not the only source of transplant organs.<sup>137</sup> Living donors also supply organs for patients with ESRD,<sup>138</sup> because individuals can function well with a single kidney.<sup>139</sup> In fact, the number of living kidney donations for the first time surpassed the number of cadaveric kidney donations in 2001.<sup>140</sup>

136. See Posting of Richard A. Epstein, *supra* note 2 (“Seniority is not an attractive criterion for organ allocation.”).

137. Anderson, *supra* note 28, at 280.

138. Lobas, *supra* note 1, at 484 (“Living organ donations are possible for a single kidney . . . [However,] UNOS and the National Kidney Foundation standards governing transplant procedures require doctors to ensure that the benefits of transplantation to the recipient will outweigh the risks to the donor. In addition, doctors may not transplant an organ if the recipient faces a ‘clinically hopeless situation.’”).

139. See Anderson, *supra* note 28, at 280 & n.108 (“The somewhat limited information available suggests that long-term renal function for people with only one kidney remains good.”); Sobota, *supra* note 12, at 1229 (asserting that living organ donors primarily contribute kidneys, although more recently they have also begun to donate livers). Living donors can function just fine after the removal of a kidney. Removal of other organs, such as the heart, lungs, or pancreas would substantially injure or kill the donor. Halperin, *supra* note 38, at 407.

140. GOODWIN, *supra* note 4, at 41.

#### Kidney Donations: 1988-2004

	<i>Cadaveric</i>	<i>Living</i>	<i>Total</i>
1988	3,876	1,812	5,688
1989	3,810	1,903	5,713
1990	4,306	2,094	6,400
1991	4,268	2,394	6,662
1992	4,276	2,535	6,811
1993	4,609	2,851	7,460
1994	4,797	3,009	7,806
1995	5,002	3,387	8,395
1996	5,036	3,670	8,706
1997	5,082	3,929	9,011
1998	5,338	4,410	9,748
1999	5,386	4,692	10,078
	<i>Cadaveric</i>	<i>Living</i>	<i>Total</i>
2000	5,489	5,447	10,936
<b>2001</b>	<b>5,528</b>	<b>6,012</b>	<b>11,540</b>
2002	5,636	6,236	11,872
2003	5,754	6,461	12,215
2004	6,326	6,648	12,974

*Id.*; see also Lobas, *supra* note 1, at 484 (“New technology and changing public attitudes partially account for the rise in living organ donations, which now outnumber cadaver donations.”).

Dr. Joseph Murray performed the first successful living kidney transplant in 1954 by removing an identical twin's kidney and transplanting it into the patient's twin brother.<sup>141</sup> For years, living kidney donors were made up solely of family members directing kidneys usually to their parents, siblings, and children.<sup>142</sup> To this day, living donations tend to be directed to relatives, friends, and other acquaintances.<sup>143</sup>

Before 1983, when scientists introduced cyclosporine to the market, transplants from related donors significantly outperformed those from nonrelated donors.<sup>144</sup> However, as immunosuppressives began to improve unrelated transplants, doctors soon became willing to accept directed donations from strangers discovering, for example, a recipient's need from a news story, and eventually included nondirected donations as well.<sup>145</sup>

Living transplant kidneys have several advantages over cadaveric kidneys. Patients live longer and organ grafts last longer when the organ is transplanted from a living as opposed to a cadaveric donor.<sup>146</sup> The success rate for transplants from living donors significantly surpasses that for kidneys transplanted from cadaveric donations, with 54.4% of living-donated transplants still functioning a decade after transplantation as compared to 36.4% for the same regarding cadaveric-donated transplants.<sup>147</sup> In fact, not only do living donor transplants have a higher survival rate than cadaveric grafts with a similar HLA mismatch,<sup>148</sup> cadaveric grafts with superior HLA matching to transplants between unrelated living donors still have inferior survival

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141. Sobota, *supra* note 12, at 1225.

142. Anderson, *supra* note 28, at 280.

143. Over 98% of living organ donations are either directed to relatives or acquaintances or are paired exchange donations, in which two donors direct one of their kidneys to the relative or acquaintance of each other. Volokh, *supra* note 29, at 1834; see also Arthur J. Matas et al., *Nondirected Donation of Kidneys from Living Donors*, 343 NEW ENG. J. MED. 433, 435 (2000) (“[B]etween 1994 and 1998, there was a 38 percent increase, from 3009 to 4156, in the number of transplants from living donors in the United States. The acceptance of organs from emotionally related donors accounts for much of the increase.”).

144. Lobas, *supra* note 1, at 487. Even so, strangers make up only approximately 1% of living kidney donors in the United States. *Id.*

145. *Id.* (noting that nondirected organ donations allow transplant hospitals to direct the organs to renal patients according to their placement on the waitlist).

146. Matas et al., *supra* note 143, at 434–35; Matas et al., *supra* note 11, at 831.

147. Katherine M. Brown et al., *Influence of Donor C3 Allotype on Late Renal-Transplantation Outcome*, 354 NEW ENG. J. MED. 2014, 2015 (2006).

148. Paul I. Terasaki et al., *High Survival Rates of Kidney Transplants from Spousal and Living Unrelated Donors*, 333 NEW ENG. J. MED. 333, 333 (1995).

rates.<sup>149</sup> Richard Rohrer, the chief of transplant surgery at New England Medical Center in Boston, noted that while “[a] person who receives a living-donor kidney has a reasonable hope of a lifetime of kidney function . . . [a] person with a cadaveric kidney has a reasonable hope of a decade of kidney function.”<sup>150</sup> Whereas the median lifetime of a cadaveric kidney is roughly eleven years, kidneys transplanted from living donors generally last more than twenty years.<sup>151</sup> Because an overwhelming proportion of living kidneys continue to come from the recipient’s relatives,<sup>152</sup> unrelated living donors present the most valuable potential for increasing the supply of donors in the future.<sup>153</sup>

Living donations offer the additional advantage of allowing the kidney recipient sufficient time to make preparations for the transplantation well in advanced of the procedure, reducing the likelihood that complications will arise during the operation by optimizing the recipient’s medical condition for the surgery.<sup>154</sup> This is largely because, for kidneys transplanted from living donors, immunosuppressive therapy can be administered to the kidney recipient well in advance of the operation. This increases the effectiveness of the transplant,<sup>155</sup> whereas these drugs can only be administered at the time of the transplant in the case of a cadaveric donor.<sup>156</sup> With living donors, both the organ donor and recipient undergo their part of the procedure in the same hospital so that, once the kidney is removed, the surgeon can immediately

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149. *Id.* at 334; see also Jean-Paul Souillou, *Kidney Transplantation from Spousal Donors*, 333 NEW ENG. J. MED. 379, 380 (1995) (noting that a ban on the purchase and sale of organs severely limits use of unrelated living donors).

150. Finkel, *supra* note 3, at 28.

151. *Id.*

152. See Lobas, *supra* note 1, at 485 (“[T]oday most living organs still come from related donors.”); see also Harris & Alcorn, *supra* note 10, at 230 (“There are . . . two cases reported in 1999 in which individuals made an undirected donation of a kidney.”); Volokh, *supra* note 29, at 1834 (stating that living organ donors who direct an organ anonymously to strangers make up less than 1.5% of all organ donors).

153. Matas & Sutherland, *supra* note 10, at 1691.

154. See Organ Procurement and Transplantation Network, About Donation > Living Donation, <http://www.optn.org/about/donation/livingDonation.asp> (last visited Jan. 31, 2009) (“[Living donation] [t]ransplant surgery can be scheduled at a mutually-agreed upon time rather than performed as an emergency operation.”).

155. Levey et al., *supra* note 69, at 50; Matas et al., *supra* note 11, at 831 (stating that preemptive kidney transplants, which are generally more successful than those occurring after the patient has endured dialysis, are much more likely the result of living rather than cadaveric kidney donors).

156. Levey et al., *supra* note 69, at 50.

transplant it into the recipient.<sup>157</sup> This, combined with the extra preparation time, reduces transplantation complications.<sup>158</sup>

Living donations—like cadaveric ones—are cost effective, given that, overall, transplantations cost less than dialysis. Moreover, the recipient's insurance company usually covers the full amount of the donor's medical bills,<sup>159</sup> including the costs of the donor's medical evaluation and her medical care during and after the transplant procedure.<sup>160</sup>

As the kidney shortage worsens, surgeons increasingly transplant older, less viable cadaveric kidneys,<sup>161</sup> and are often forced to perform surgery at a time that is suboptimal for a patient's transplant success because matching cadaveric kidneys often become available at a moment that was unforeseen and remain transplantable for only a very limited period.<sup>162</sup> Raising the number of living kidney donations is the best way to meet the demand of those who need kidney transplants.<sup>163</sup> Currently, fewer than 7,000 Americans donate a living kidney each year.<sup>164</sup> Of course, many more living Americans (and foreign donors) could donate kidneys to those in need.<sup>165</sup>

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157. Sobota, *supra* note 12, at 1230.

158. Levey et al., *supra* note 69, at 50.

159. Lobas, *supra* note 1, at 490.

160. See Sobota, *supra* note 12, at 1228 (noting that many private insurance companies provide coverage for the costs of organ transplants). *But see* Lobas, *supra* note 1, at 490–91 (stating that the “acquisition fee” charged to the recipient's insurance company does not include costs associated with annual physicals the donor receives, travel or lodging expenses, or lost wages, though the recipient of the organ may reimburse the donor for these costs without violating the law prohibiting organ sales).

161. *Psst, Wanna Buy a Kidney?*, *supra* note 10, at 15. To help offset the current kidney shortage, transplant doctors have increasingly accepted what previously have been labeled “marginal” kidneys from “expanded criteria donors” that are geriatric, hypertensive, and proteinuric. Friedman & Friedman, *supra* note 5, at 960.

162. Posting of Gary Becker to The Becker–Posner Blog, Response on Whether Organs Should Be Purchased and Sold, [http://www.becker-posner-blog.com/archives/2006/01/response\\_on\\_whe.html](http://www.becker-posner-blog.com/archives/2006/01/response_on_whe.html) (Jan. 14, 2006, 19:04 EST) (“Surgeons and hospitals fight sometimes over who has access to available organs, they see many patients die because they cannot get organs, and they often must perform a transplant surgery at a time that is not optimal for a person receiving the transplant because a matching organ becomes available at a particular moment.”).

163. See Matas et al., *supra* note 143, at 435 (asserting that in order to alleviate the problem of lengthy waitlists for cadaveric kidneys, many transplantation centers began using organs from living, “emotionally related” donors, such as a spouse or a close friend); Matas et al., *supra* note 11, at 831 (“One potential solution to [the rising number of patients on the waitlist for a kidney] is to increase the number of [living donor] transplants.”).

164. See Volokh, *supra* note 29, at 1832 (“Each year, only about 6,500 living Americans donate kidneys . . .”).

165. See Finkel, *supra* note 3, at 30 (“In truth, there is actually a global surplus of kidneys—sellers in India and Iraq literally line up at hospitals, often willing to part with

The national kidney procurement system for living donations currently comprises two independent systems: the altruistic donor network and the private, loosely regulated (often illegal) supply of commercial-living kidneys.<sup>166</sup>

### III. THE 800-POUND GORILLA: SELLING KIDNEYS

Like nearly every country,<sup>167</sup> the United States bans the sale of human organs.<sup>168</sup> This ban has effectively imposed a zero-dollar price ceiling.<sup>169</sup> Even though such transactions were not officially forbidden in all states until 1984, no evidence exists of domestic organ sales taking place before then.<sup>170</sup> However, a free market for organs in the United States almost became a reality in 1983 when H. Barry Jacobs, a man from Virginia, founded the International Kidney Exchange Limited so he could broker kidneys from living donors he planned to find in third-world countries.<sup>171</sup> As a broker, Jacobs planned to pay healthy kidney donors up to \$10,000, a cost which the recipients would assume in addition to a \$2,000–5,000 brokerage fee.<sup>172</sup> But, shortly after Jacobs announced his business plan, the State of Virginia banned the sale of organs and the U.S. Congress soon followed suit.<sup>173</sup>

The 1984 National Organ Transplant Act (NOTA) forbids the exchange of transplantable organs for “valuable consideration.”<sup>174</sup> Congress firmly rejected the idea of an organ

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a kidney for less than \$1,000 . . .”).

166. See GOODWIN, *supra* note 4, at 169 (noting that underground kidney sale systems flourish).

167. Calandrillo, *supra* note 82, at 86.

168. Richard V. Grazi & Joel B. Wolowelsky, *Jewish Medical Ethics: Monetary Compensation for Donating Kidneys*, 6 ISR. MED. ASS'N J. 185, 185 (2004) (“In 2000, the Consensus Statement on the Live Organ Donor reported that ‘direct financial compensation for an organ from a living donor remains controversial and illegal in the United States . . .’” (internal citation omitted)). For a thorough examination of prohibitive U.S. legislation, see Henry Hansmann, *The Economics and Ethics of Markets for Human Organs*, 14 J. HEALTH POL. POL'Y & L. 57, 58–60 (1989).

169. Calandrillo, *supra* note 82, at 85.

170. Arthurs, *supra* note 8, at 1107.

171. Harris & Alcorn, *supra* note 10, at 231. Jacobs planned to procure the kidneys he would broker from indigents living in third world countries. Robinson, *supra* note 71, at 1036.

172. Harris & Alcorn, *supra* note 10, at 231.

173. *Id.*

174. 42 U.S.C. § 274e (a)–(b) (2000) (“It shall be unlawful for any person to knowingly acquire, receive, or otherwise transfer any human organ for valuable consideration for use in human transplantation if the transfer affects interstate commerce. . . . Any person who violates [this provision] shall be fined not more than \$50,000 or imprisoned not more than five years, or both.”); Daar, *supra* note 9, at 600. In

market by making it a felony to sell a human kidney, liver, heart, lung, pancreas, bone marrow, cornea, eye, bone, or skin in interstate commerce.<sup>175</sup> In enacting this prohibition, Congress expressed its concern that permitting organ sales would undermine the system of voluntary donations.<sup>176</sup> Unfortunately, in many ways this prohibition has actually jeopardized the recruitment process of donated kidneys by virtually eliminating more creative approaches to attracting donors.<sup>177</sup>

Prominent international bodies also view compensating organ donors as “unacceptable.”<sup>178</sup> In 1991, the World Health Assembly adopted a set of discretionary Guiding Principles that discourage the sale of human organs for transplantation.<sup>179</sup> According to these principles, available on the World Health Organization’s (WHO) website, “The human body and its parts

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addition, one year after the enactment of NOTA, the Ethics Committee of the Transplantation Society released a concurring Policy Statement concluding that “[n]o transplant surgeon/team shall be involved directly or indirectly in the buying or selling of organs/tissues or in any transplant activity aimed at commercial gain to himself/herself or an associated hospital or institute,” shortly after which several other countries as well as the World Health Organization (WHO) proposed similar bans. Friedman & Friedman, *supra* note 5, at 960. NOTA, the only federal law to regulate the acquisition, allocation, and transplantation of human organs, includes four main provisions: (1) Title I established a Task Force on Organ Procurement and Transplantation to evaluate the policies of organ procurement and transplantation; (2) Title II created the OPTN to help pair donor organs with the most suitable hopeful organ recipients anywhere in the United States; (3) Title II enables the Secretary of Health and Human Services to give grants to organ procurement organizations; and (4) Title III makes it “unlawful for any person to knowingly acquire, receive, or otherwise transfer any human organ for valuable consideration.” Arthurs, *supra* note 8, at 1108 (citing and quoting provisions found in 42 U.S.C. §§ 273, 274, 274e (2000)). Noticing that NOTA applies only to interstate commerce, the 1986 Task Force encouraged states to adopt it so that the legislation would extend to intrastate commerce as well. All fifty states responded by adopting in whole or in part the 1987 version of the UAGA, which included language identical to that in NOTA. While every state is currently aligned in its ban of organ sales, the Task Force’s report contains an implicit assumption that if a single state were to repeal or modify its adoption of the UAGA, that state could legally generate its own organ market so long as it did not implicate interstate commerce. *Id.* at 1110.

175. U.S. CONGRESS, OFFICE OF TECH. ASSESSMENT, NEW DEVELOPMENTS IN BIOTECHNOLOGY: OWNERSHIP OF HUMAN TISSUES AND CELLS—SPECIAL REPORT 75 (1987) [hereinafter U.S. CONGRESS SPECIAL REPORT].

176. *Id.* at 76.

177. See Harris & Alcorn, *supra* note 10, at 223 (arguing that the prohibition has “clos[ed] the door to innovative approaches such as estate tax relief, payment of expenses associated with donation such as lost wages, travel expenses, coverage of other existing medical bills, and funeral expenses”).

178. “[T]he Council of Europe, the Transplantation Society, the World Health Organization, and the World Health Assembly view commodification of body parts as ‘unacceptable.’” Watkins, *supra* note 12, at 29–30.

179. World Health Organization, Human Organ and Tissue Transplantation, [http://www.who.int/ethics/topics/human\\_transplant/en](http://www.who.int/ethics/topics/human_transplant/en) (last visited Jan. 31, 2009).

cannot be the subject of commercial transactions.”<sup>180</sup> In 2000, the World Medical Association stated that “[p]ayment for organs for donation and transplantation must be prohibited” because “[a] financial incentive compromises the voluntariness of the choice and the altruistic basis for organ donation” and “is inconsistent with the principles of justice.”<sup>181</sup> Accordingly, the Guiding Principles state that “giving or receiving payment (including any other compensation or reward) for organs should be prohibited.”<sup>182</sup> The only type of payment for organs that donors and recipients may exchange must not exceed “a justifiable fee for the services rendered.”<sup>183</sup> Even advertising the need for or the availability of an organ with the intent of offering or receiving payment is prohibited.<sup>184</sup> In addition, the Guiding Principles suggest organs should be distributed according to medical need without preference for the recipient’s financial status or level of insurance coverage.<sup>185</sup>

However, as a result of the overwhelming number of chronic renal patients lacking reasonable prospects of receiving a cadaveric or donated-living transplant, some organizations, including ones that have long opposed offering compensation to organ donors, have recently begun to at least consider offering some form of compensation.<sup>186</sup> The American Medical Association (AMA), UNOS, the American Society of Transplant Surgeons (ASTS), and OPSs have endorsed “limited studies” to evaluate the potential of offering financial incentives to increase the number of donors.<sup>187</sup> In June 2002, the AMA approved a pilot program to determine whether monetary incentives for organs would increase the supply of transplantable organs.<sup>188</sup> And, just

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180. World Health Organization, Draft Guiding Principles on Human Organ Transplantation, Guiding Principle 5, [http://www.who.int/ethics/topics/transplantation\\_guiding\\_principles/en/print.html](http://www.who.int/ethics/topics/transplantation_guiding_principles/en/print.html) (last visited Jan. 31, 2009).

181. The World Medical Association, Statement on Human Organ Donation and Transplantation, ¶ 30, <http://www.wma.net/e/policy/wma.htm> (last visited Jan. 31, 2009).

182. World Health Organization, *supra* note 180, at Guiding Principle 5.

183. *Id.* at Guiding Principle 8.

184. *Id.* at Guiding Principle 6.

185. *Id.* at Guiding Principle 9.

186. Arthurs, *supra* note 8, at 1118. The Ad Hoc Committee for Solving the Intractable Organ Shortage, a group formed by University of Pittsburgh scientist Harold Kyriazi, has proposed “rewarded gifting” that would compensate family members for allowing the organs of their deceased relatives to be harvested. Cohen, *supra* note 70, at 810.

187. Arthurs, *supra* note 8, at 1118.

188. GOODWIN, *supra* note 4, at 153; Daar, *supra* note 9, at 600. “In a call endorsed by both the American Society of Transplant Surgeons and [UNOS], the AMA stated that the ‘time has come’ and that ‘[t]here is enough evidence in favor of employing some form of financial incentive to justify the implementation of a pilot program.’” Arthurs, *supra*

recently, a group of renowned scientists, doctors, academics, and clerics, among others, came together to form the Ad Hoc Committee for Solving the Intractable Organ Shortage, the first organization in the United States created with an agenda to legalize the use of monetary payments to incentivize organ donations.<sup>189</sup>

The ASTS has generally objected to the buying, selling, or brokering of organs, believing that organ donations from living and cadaveric donors should be exclusively altruistic acts.<sup>190</sup> ASTS approves of “the directed donation of deceased donor organs to individual family members, friends, and individuals in which there is a pre-established relationship” through “communities (school, place of worship, place of employment or other organizations)” or “via [I]nternet websites.”<sup>191</sup> Where no such relationship exists, ASTS supports the transplant of donated organs in accordance with UNOS’s waitlist policies and procedures.<sup>192</sup>

Similarly, while UNOS encourages patients with kidney disease to seek directed donations from living individuals they know, it disfavors patients soliciting organs from strangers, out of concern that such pleas could lead both to under-the-table sales as well as to an inequitable distribution of organs.<sup>193</sup> Even when the organ is donated by an outright gift, a number of transplant surgeons have refused to perform the transplant when the donor and recipient are strangers rather than friends or family members.<sup>194</sup> These concerns and objections notwithstanding, strangers have successfully engaged in Internet-facilitated transplants.<sup>195</sup> In addition, MatchingDonors.com, a for-profit website, enables “stranger” organ donors to pick a recipient registered with the site based on the profile they provide.<sup>196</sup>

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note 8, at 1118 (quoting AMERICAN MEDICAL ASSOCIATION, REPORT 4 OF THE COUNCIL ON SCIENTIFIC AFFAIRS: INCREASING ORGAN DONATION, H-370.979 FINANCIAL INCENTIVES FOR ORGAN PROCUREMENT (2002)).

189. Arthurs, *supra* note 8, at 1118–19.

190. *Statement on Directed Donation and Solicitation of Organs*, AM. SOC’Y TRANSPLANT SURGEONS (Arlington, Va.), Oct. 23, 2006, available at <http://www.ast.org/Tools/Download.aspx?fid=269>.

191. *Id.*

192. *Id.*

193. Stimson, *supra* note 77, at 351, 355.

194. Posting of Richard A. Epstein, *supra* note 2.

195. Lobas, *supra* note 1, at 498.

196. *Id.*

The biggest concerns with donor–recipient Internet solicitation are that it can hide the sale of kidneys<sup>197</sup> and that Internet “matching” interferes with the fair allocation of organs.<sup>198</sup> Some ethicists compare Internet exposure to commercializing organs.<sup>199</sup> Arthur Caplan, a bioethicist at the University of Pennsylvania, believes that just as a fair organ system disallows donated-organ allocation to the highest bidder, so too the system should prohibit these organs from going to individuals attracting the most publicity.<sup>200</sup> Indeed, this is effectively a form of high-bid kidney purchase, because rich would-be recipients will have a significant advantage in expending sums to advertise their plights. And this undermines the hierarchy of need as specified by relative placement on the UNOS waitlist.<sup>201</sup> Indeed, UNOS has stated that MatchingDonor.com “subverts the equitable allocation of organs for transplantation.”<sup>202</sup>

ASTS does make an exception to its objection to stranger-donated kidneys with its acceptance of “Live Paired Donation,” programs, which facilitate organ donations to strangers when two living donors are medically incompatible with their potential recipients but match the other’s desired recipient.<sup>203</sup> ASTS supports donations where “there are two willing living donors who each turn out to be incompatible with their desired recipient but compatible with the other donor’s desired recipient.”<sup>204</sup> Supporters of this model assert that UNOS should encourage paired exchanges by keeping a list not only of patients in need of organ transplants but also of individuals willing to donate on behalf of the hopeful recipients and their antigen compatibility information.<sup>205</sup>

With altruism the only incentive, simply too few people donate kidneys to meet the increasing demand of those needing a

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197. *See id.* at 498–99.

198. *Id.* at 499.

199. *Id.*

200. *Id.*

201. *See id.* (“[Experts] say it is unfair to give an edge to people who are simply better at recruiting donors over others who are sicker and ranked higher on the national waiting list.”).

202. *Id.* at 501 (citation omitted).

203. *Statement on Paired Kidney Donation*, AM. SOC’Y TRANSPLANT SURGEONS (Arlington, Va.), May 29, 2007, available at <http://www.ast.org/Tools/Download.aspx?fid=423>.

204. Lobas, *supra* note 1, at 502 (quoting ROBERT M. VEATCH, *TRANSPLANTATION ETHICS* 186 (2002)).

205. *Id.*

replacement.<sup>206</sup> Americans are voicing their desire for a legal alternative to the current system and stretching the limitations currently imposed upon them.<sup>207</sup>

A. *Selling Kidneys Is Not Allowed, but Some “Compensation” Is*

While selling kidneys is prohibited, some states offer tax deductions to families for donating the organs of their deceased relatives or to donors themselves for living donations.<sup>208</sup> In 2004, Wisconsin became the first state to begin offering living kidney donors a tax deduction to cover expenses incurred from donation.<sup>209</sup> Since then, Indiana, New York, and New Jersey have adopted legislation allowing donors to receive tax deductions and New Mexico and Pennsylvania are currently considering similar legislative models.<sup>210</sup>

Likewise, living organ donors may also receive reimbursement for medical bills and other related expenses resulting from the transplant procedure.<sup>211</sup> In 2000, Congress

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206. See GOODWIN, *supra* note 4, at 10 (“[I]f altruistic procurement is designed to meet the overwhelming need for organs, it is a numerical failure.”); *Psst, Wanna Buy a Kidney?*, *supra* note 10, at 15 (“Unsurprisingly, with altruism the only incentive, not enough people offer.”).

207. See GOODWIN, *supra* note 4, at 153 (“As evidenced by Americans traveling abroad to procure organs, and numerous studies, the desire for an appropriate legal alternative organ procurement system, which addresses our tissue demand or shortage, is apparent.”).

208. Arthurs, *supra* note 8, at 1114; Daar, *supra* note 9, at 600.

209. Arthurs, *supra* note 8, at 1102. Wisconsin offers living kidney donors a \$10,000 tax rebate. Sue Rabbitt Roff, *Thinking the Unthinkable: Selling Kidneys*, BRITISH MED. J., July 1, 2006, at 51, 51. Wisconsin’s Assembly Bill 477 incentivizes kidney donations from living, not cadaveric donors. Arthurs, *supra* note 8, at 1125.

210. Arthurs, *supra* note 8, at 1102.

211. 42 U.S.C. § 274e(c)(2) (2000) (“The term ‘valuable consideration’ does 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 the donation of the organ.”); see also Daar, *supra* note 9, at 600 (noting that “[r]ecipients can legally reimburse the living donors for medical bills and other expenses”); Roff, *supra* note 209, at 51 (“In the . . . United States living donors currently have their expenses related to the operation and recovery reimbursed by the NHS, Medicare, or insurance companies (or in the state of Wisconsin by tax rebates to the value of \$10,000).”); Organ Procurement and Transplantation Network, About Donation > Living Donation, <http://www.optn.org/about/donation/livingDonation.asp> (last visited Jan. 31, 2009) (“Health insurance coverage varies for living donation. If the recipient is covered by a private insurance plan, most insurance companies pay 100 percent of the donor’s expenses. If the recipient is covered by Medicare’s end-stage renal disease program, Medicare Part A pays all of the donor’s medical expenses, including preliminary testing, the transplant operation, and post-operative recovery costs. Medicare Part B pays for physician services during the hospital stay. Medicare covers follow-up care if complications arise following the donation.”).

acted to encourage living organ donors by allowing compensation for travel and living expenses incurred as a result of organ donation.<sup>212</sup> In addition, federal as well as private employers often furnish employees with several weeks of leave after undergoing an organ donation.<sup>213</sup> These reimbursement models, however, more accurately resemble compensation for expenses than a market based on the sale of a commodity.<sup>214</sup>

### B. *Minor and Incompetent "Altruism"*

Similarly, parents stretching the parameters of the altruistic-donor model have sought to provide consent to the donation of a child's kidney for a sibling or other close relative.<sup>215</sup> Courts disagree over whether parents may authorize the removal of a kidney from one of their minor or incompetent children for the benefit of a sibling.<sup>216</sup> In 1969, the Kentucky Court of Appeals was the first jurisdiction in the United States to publish an opinion addressing whether parents may substitute their judgment for that of their child in the decision to remove the child's kidney for implantation in a sibling.<sup>217</sup> The court found it to be in the best interest of a twenty-seven-year-old incompetent child to donate a kidney to his older brother because "emotionally and psychologically . . . his well-being would be jeopardized more severely by the loss of his brother than by the removal of a kidney."<sup>218</sup>

Following the court's decision, in 1972 the Connecticut Superior Court expanded Kentucky's *Strunk* ruling to include child donors who are minors.<sup>219</sup> In *Hart v. Brown*, the parents of

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212. Harris & Alcorn, *supra* note 10, at 222–23.

213. Roff, *supra* note 209, at 51.

214. See Harris & Alcorn, *supra* note 10, at 223 ("Though far from a general reversal of a prohibition on the sale of organs, HR 2418 does signal a willingness to acknowledge the role that limited financial compensation can play in organ donations."); see also Roff, *supra* note 209, at 51 ("The service model is well established in the payment of research subjects for their time and loss of earnings . . . and the risk factor and unpleasantness of the procedures they are subjecting themselves to.")

215. GOODWIN, *supra* note 4, at 71.

216. *Id.* Australian law prohibits transplantation of nonregenerative material from a living minor child. Although the Australian Law Reform Commission proposed allowing such transplantation on condition, for example, that the procedure benefits a member of the child's immediate family and that the procedure is approved by a committee that includes a judge and two other people, the states' legislatures rejected the recommendation. Daniel Sinclair, *Kidney Donations from the Legally Incompetent in Jewish and Comparative Law*, 27 *ISR. L. REV.* 588, 597–98 (1993).

217. *Strunk v. Strunk*, 445 S.W.2d 145 (Ky. Ct. App. 1969).

218. *Id.* at 146.

219. *Hart v. Brown*, 289 A.2d 386, 390–91 (Conn. Super. Ct. 1972).

seven-year-old twins sought a declaratory judgment from the court authorizing the removal of a kidney from one daughter for implantation in the other.<sup>220</sup> The court determined that it would be of “immense benefit” for the child to take part in the donation to her sister and that the child’s happiness was largely determined by the happiness of her family, so that her parents should be permitted to substitute their legal judgment for their child regarding the donation.<sup>221</sup> The biggest concern with such “altruistic” donations, in addition to their insignificant ability to address the shortage of kidneys, is that they may lack legitimate informed consent.

### C. *The Sale of Kidneys in International Markets*

Growing demand and increasingly long wait periods for transplantable kidneys are driving “transplant tourism.”<sup>222</sup> Only very few countries legalize the sale of organs.<sup>223</sup> However, patients who feel unable to remain on cadaveric-kidney waitlists in their own countries and who possess resources to shop for organs overseas often undertake transplant surgery in third-world or developing countries from either cadaveric donors (in presumed-consent states) or, more often, from living donors.<sup>224</sup>

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220. *Id.* at 386–87.

221. *Id.* at 389, 391.

222. See GOODWIN, *supra* note 4, at 10–11 (noting that the altruistic organ donor model is concealing the surge in black market shopping, commonly referred to as “transplant tourism” or “organ tourism”); Abraham McLaughlin, Ilene R. Prusher & Andrew Downie, *What is a Kidney Worth?*, CHRISTIAN SCI. MONITOR, June 9, 2004, available at <http://www.csmonitor.com/2004/0609/p01s03-wogi.html> (chronicling the experiences of three men in the “transplant tourism” market: an unemployed Brazilian, an ailing Israeli, and a South African investigator who helped bust an organ trafficking ring).

223. See Calandrillo, *supra* note 82, at 86 (“It is illegal in nearly all developed nations to sell or buy a human organ—only in Iran and Pakistan is there a legal market.”); Finkel, *supra* note 3, at 28 (stating that the sale of human organs is legal in Iran); Declan Walsh, *Transplant Tourists Flock to Pakistan, Where Poverty and Lack of Regulation Fuel Trade in Human Organs*, GUARDIAN, Feb. 10, 2005, <http://www.guardian.co.uk/pakistan/Story/0,2763,1409415,00.html> (discussing the thriving industry of organ sales in India).

224. GOODWIN, *supra* note 4, at 184, 189 (asserting that “[o]rgan suppliers hail from primarily Pakistan, India, South Africa, Peru, Romania, Bolivia, and Brazil” and that, before the war, the going rate in Iraq for a transplant kidney was approximately \$750, while a kidney sold during the same period by a U.S. donor could sell for \$30,000); Alfred Cohen, *Sale or Donation of Human Organs*, 52 J. HALACHA 37, 38 (2006) (asserting that patients with resources to purchase organs from the black market usually receive an organ more quickly than patients on the national waitlist); Johnson, *supra* note 3 (stating that in Eastern Europe, donors are typically young males from rural areas, aged eighteen to twenty-eight, who because of economic hardships part with one of their kidneys for as little as \$2,500–3,000); see also Friedman & Friedman, *supra* note 5, at 961 (stating that Organs Watch, a privately owned transplant monitoring organization, estimates that

Officials from the Philippines are actively seeking to lure in international demand for transplant organs.<sup>225</sup> “What’s happening now is absurd. Airplanes are leaving every week. I’ve seen 300 of my patients go abroad and come back with new kidneys . . . it’s a free-for-all,” remarked the late Michael Friedlaender, a transplant nephrologist at Hadassah University Hospital in Israel.<sup>226</sup>

Because patients who purchase kidneys in the international market typically receive kidneys from living donors, their kidneys typically function longer than those who await the legal transplant of cadaveric kidneys from the UNOS waitlist in the United States.<sup>227</sup>

Given the overwhelming number of lives at stake, many patients, doctors, and organ brokers remain undeterred by the criminalization of the exchange of cash for kidneys.<sup>228</sup> Despite

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“thousands of illegal transplants occur every year bought by patients from the Persian Gulf states, Japan, Italy, Israel, the US and Canada supplied by donor nations, including India, Pakistan, Turkey, Peru, Mexico, Romania, and South Africa” (internal quotations omitted); Telephone Interview with Jim Cohan, *supra* note 91 (stating that patients may choose whether they want a cadaveric or living donation, and the coordinator will accommodate the recipients’ desires).

225. Angela F. Domingo & Edsel Maurice T. Salvana, Letter to the Editor, *Solicitation of Deceased and Living Organ Donors*, 356 NEW ENG. J. MED. 2427, 2427–28 (2007) (asserting that an undersecretary of health in the Philippines proposed increasing the price of kidneys there from \$3,000–4,000 each and increasing the number of transplants hospitals are allowed to make available to international patients from 10% of the country’s transplants to 20%).

226. Friedman & Friedman, *supra* note 5, at 961.

227. See Finkel, *supra* note 3, at 28 (noting that living sellers are usually demanded and only occasionally are cadaver kidneys sold on the black market). Dr. Friedlaender, a nephrologist at Hadassah University in Jerusalem, found that when he compared black market kidney transplants with those performed legally, the percentage of illegal transplants still functioning after one year was slightly higher than the percentage of those performed in his own hospital and even in many U.S. hospitals. The reason for this difference, he says, is the benefit of transplanting kidneys from living donors.

“After I realized that,” Friedlaender says, “I softened my stance. Examining . . . 300 [of my] patients [who went abroad and came back with new kidneys] brought me down from my high horse of ethics. Now I’m more practical. My patients don’t want my opinion on whether or not buying a kidney is moral—they want to know if it’s safe. And I have to say that it is. It’s as safe as having a transplant at a U.S. hospital. I realized that I had no right to actively stop my patients from going. I realized that it may be harming them not to go. So when they ask, I tell them, ‘Yes, you should go.’”

*Id.* at 31.

228. Calandrillo, *supra* note 82, at 87. Jim Cohan, a U.S. organ transplant coordinator, was arrested in Italy for his efforts. After waiting six months in an Italian prison while his attorneys pursued legal proceedings to secure his freedom, Mr. Cohan was released. He discontinued his organ transplant coordination business for two years, and upon resumption, no longer travels overseas in facilitating organ transplants. Telephone Interview with Jim Cohan, *supra* note 91.

attempts by the United Nations to curb the international and black market for organ procurement,<sup>229</sup> and even though many patients turn to this option only as a last ditch effort to save their lives,<sup>230</sup> the international market for organs is growing at a rapid pace<sup>231</sup> due to the high demand<sup>232</sup> of this highly price-inelastic medical commodity. As a result, donors selling organs into the black market receive less now for a kidney than they once did,<sup>233</sup> sometimes less than promised.<sup>234</sup> Donors in India now accept less than \$2,000 for a kidney, “a bargain for a rich American or European, but a sizeable sum considered from the perspective of a slum dweller living in poverty.”<sup>235</sup> Of course, this does not mean that the recipient is also paying less to receive the kidney. In fact, just the opposite is occurring because middlemen often exploit the unregulated nature of the system.<sup>236</sup> Organ recipients

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229. GOODWIN, *supra* note 4, at 185 (explaining that in an effort to curb the organ black market, the WHO issued nonbinding antitrafficking protocols in 1991 that were adopted by 192 countries, including the United States).

230. One woman from Brooklyn, N.Y., who as a last resort located a kidney through an international organ broker, explained, “I had been on dialysis for 15 years and on two transplant lists for 7.” She was initially concerned that securing a kidney from the international market might be illegal, but “[n]othing was happening, and my health was getting worse and worse.” The years of dialysis had weakened her heart and lungs, and she had personally known four other women who died while waiting for a kidney transplant. Finally, the woman said, “my doctors told me to get a kidney any way I could,” or prepare to die. Rohter, *supra* note 9; see also GOODWIN, *supra* note 4, at 186 (asserting that the slim odds of receiving a kidney transplant in the United States motivates candidates to participate in the black market for transplant kidneys).

231. See Daar, *supra* note 9, at 600 (noting that the organ black market is growing rapidly throughout the developing world; specifically, transplant centers have been “documented in the Philippines, Iraq, China, India, South Africa, Turkey, Eastern Europe, and elsewhere”); Johnson, *supra* note 3 (declaring that the organ black market is growing rapidly throughout Eastern Europe and explaining that increasingly longer wait periods for legal transplantable kidneys are causing patients in large numbers to seek out kidneys from the international markets).

232. Daar, *supra* note 9, at 600 (“The situation is very easy to understand: an unquenchable demand meets a supply that can save lives.”); Goodwin, *supra* note 134, at 793 (declaring that “[t]he current demand for [human transplant organs] is far greater than it has been at any other time in human history”).

233. Brazilian donors trafficking their kidneys into South Africa receive less now than they did before. Whereas organ brokers initially paid them as much as \$10,000—more than a decade’s wages—to traffic one of their kidneys into South Africa, Alberty José da Silva, a Brazilian who traveled to South Africa in approximately 2004 to donate his kidney, was paid a mere \$6,000. By November 2004, so many residents in the Recife slums of Brazil began donating one of their kidneys to middlemen that the going rate plummeted to just \$3,000. Rohter, *supra* note 9.

234. Calandrillo, *supra* note 82, at 90 (“[A] landmark 2002 study of illegal kidney sales in India revealed . . . that [donors] were paid on average one-third less than that which they were promised.”).

235. Watkins, *supra* note 12, at 34–35 (quoting STEPHEN WILKINSON, BODIES FOR SALE: ETHICS AND EXPLOITATION IN THE HUMAN BODY TRADE 105 (2003)).

236. See Daar, *supra* note 9, at 600 (explaining that donors and recipients will suffer

often pay outrageously more for transplant organs than donors receive<sup>237</sup> because traffickers and doctors pocket most of the fees.<sup>238</sup> High fees result partly from the high risk involved in bringing together the often illegal transaction.<sup>239</sup> Jim Cohan, an organ transplant coordinator in California who schedules organ transplantations, charges \$90,000 to arrange a kidney transplant, which includes airfare and local travel costs, a companion ticket, the surgery, and the kidney.<sup>240</sup> Because such transplants are not typically covered by insurance, black market organs are generally transplanted only in patients able to afford the prices, regardless of need.<sup>241</sup>

The Internet and certain clinics that purchase organs directly from the donor are, however, helping to reduce costs to the recipients in these international transactions by eliminating the middleman.<sup>242</sup> Internet websites and chat rooms now make it

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if legislation does not check the problem).

237. See Daar, *supra* note 9, at 600 (asserting that the Overseas Medical Services in Calgary, Canada charge roughly \$32,000 to organize an organ transplant from a living donor in Pakistan); Finkel, *supra* note 3, at 30 (reporting that kidney donors in India and Iraq are often willing to accept less than \$1,000 to part with one of their kidneys.); McLaughlin et al., *supra* note 222 (showing that a Brazilian donor received \$6,000 of the \$45,000 the Israeli recipient paid for a kidney transplanted in South Africa); Rohter, *supra* note 9 (stating that Alberty José da Silva was paid merely one-tenth of the amount the recipient was charged); Johnson, *supra* note 3 (noting that in Eastern Europe, recipients of kidney transplants pay ten times more than the mere \$2,500–3,000 donors receive).

238. Johnson, *supra* note 3 (revealing doctors and traffickers as the key beneficiaries). According to Jim Cohan, living kidney donors who sell one of their kidneys over the black market receive only a very small portion of the recipient's total fee. They receive anywhere from \$800 to at most \$10,000 for a donation. Even the broker of the transaction takes a modest cut, somewhere around 10%. The majority of the donor's fee, insists Cohan, goes to the transplant surgeons. Finkel, *supra* note 3, at 30.

239. Transplant surgeons demand such high fees for performing illegal transplant procedures because with each performance they risk their career. Even transplant brokers expose themselves to risk of being arrested, although almost no one worldwide has ever been convicted of organ trafficking. For this reason, California broker Jim Cohan no longer accompanies his kidney sellers for their kidney removal. "I do everything on the phone and on the Internet," he says. "I talk with doctors. I tell doctors about me, and doctors tell their kidney patients. I don't buy organs; I don't sell organs—I'm really just the producer. I produce operations. I just bring all the parties together. And I've never had any of my clients die." *Id.*

240. Telephone Interview with Jim Cohan, *supra* note 91.

241. Robert Berman, *Selling Organs Should Be Legal*, THE JERUSALEM POST, Aug. 10, 2005, at 15 ("[T]he existing black market is ensuring that [the organs] go only to those who can afford the inflated prices.").

242. See Kevin O'Flynn, *Wanted*, THE MOSCOW TIMES, Dec. 8, 2006 ("One seller [in Russia] called Extreem, who looks like he just walked off the stage of Krasnaya Shapochka, created his own web site where he shows off his buff chest to possible clients and to the surgeon who will do the cutting. He is offering his kidney for \$20,000, one of the lower prices of those on sale. . . . There are buyers advertising too, and there are kidney pimps on the English web sites. Others simply want to buy a kidney for their

possible for organ donors and recipients to independently negotiate their own arrangements for transplantation.<sup>243</sup>

Black markets are legally, economically, and socially undesirable.<sup>244</sup> Organ transplantation lacks international uniformity,<sup>245</sup> and countries supplying kidney surpluses invariably adhere to the loosest standards for organ trade.<sup>246</sup> Insurance does not fund these transplants,<sup>247</sup> and black markets often produce organized crime.<sup>248</sup> Kidney sellers risk submitting to the procedure in unhygienic facilities and typically receive minimal or no medical treatment after selling the organ.<sup>249</sup> As a result, many are forced to return to poor living conditions and hard manual labor with deteriorating health.<sup>250</sup> Many once

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relatives. Andrei from Kiev wants one for his daughter, while someone from Izhevsk is offering \$20,000 to buy a kidney for his sister.”); *see also* Goyal et al., *supra* note 3, at 1590 (noting that in response to the concerns that middle men keep a large portion of the payment and often misrepresent to patients what a nephrectomy will involve, some transplantation clinics purchase organs directly from donors).

243. *See* Lobas, *supra* note 1, at 498 (noting that as of November 2004, there were three documented cases of Internet-facilitated organ transplants).

244. *See* GOODWIN, *supra* note 4, at 172 (explaining that because black markets are unregulated and difficult to police, they tend to result in the abuse of vulnerable populations and promote unethical conduct).

245. Many nations have no legal standards at all for the organ trade; in countries where legislation does exist, standards are substantially inconsistent, for example, concerning the regulation of living and cadaveric organ donation, organ trade and penalization, and brain death. Watkins, *supra* note 12, at 16.

246. Jefferies, *supra* note 72, at 625.

247. *See* Daar, *supra* note 9, at 600 (asserting that in the developing world living donation is the only option and “often has to be paid for by the recipient”); McLaughlin et al., *supra* note 222 (noting an exception whereby Israeli health insurance reimburses patients for medical procedures that are performed outside the country).

248. *See* Daar, *supra* note 9 (explaining how after a black market is created “[m]iddlemen exploit the situation and organized crime moves in”).

249. *See* GOODWIN, *supra* note 4, at 185–86 (asserting that organ donors of the black market risk undergoing the procedure in a hospital that is not clean and rarely receive medical follow-up); Rohter, *supra* note 9 (noting that while recipients of trafficked kidneys in South Africa remain under intense medical supervision and receive detailed records of the transplant procedure, donors, on the other hand, are monitored “for a maximum of three days,” according to one South African investigator); Johnson, *supra* note 3 (explaining that the removal surgeries often take place at night at rented facilities).

250. *See* Calandrillo, *supra* note 82, at 94 (citing a recent study showing that the majority of black market kidney sellers in India had deteriorating health); David J. Rothman, *Ethical and Social Consequences of Selling a Kidney*, 288 J. AM. MED. ASS’N 1640, 1641 (2002) (reporting that 87% of kidney donors report a deterioration in their health following the procedure); Johnson, *supra* note 3 (“Donors have no medical follow-up, and their health often deteriorates as they return to a lifestyle involving poor living conditions and hard physical labour.”). José Carlos da Conceicao da Silva, a Brazilian manual laborer who hauls produce, said, “For me, the complications began almost immediately.” He also said that three days after his kidney was removed, he required an additional surgery on one of his lungs. Since returning to Brazil, he says, his general health has worsened. He said, “I’m tired all the time and can’t lift heavy weights, which I have to be able to do if people are going to hire me. . . . My blood pressure goes up and

desperate to sell one of their kidneys in black markets now regret making the decision.<sup>251</sup>

Many countries, such as Israel, India, South Africa, Turkey, China, Russia, Iraq, Argentina, and Brazil, do not stringently enforce their legislation banning the sale of organs.<sup>252</sup> For instance, Japanese often buy organs in the Philippines; Israelis have often purchased organs in Turkey or former Soviet Union states; people of the Arabian Gulf countries buy organs in India; and people of Malaysia often acquire organs in China.<sup>253</sup> India has banned kidney sales since 1994, but patients continue to locate donors willing to accept payment in exchange for donating a kidney.<sup>254</sup> Donors avoid legal consequences by simply signing an affidavit swearing they have not received any payment.<sup>255</sup> Mumbai alone generated approximately \$10 million dollars in 2001 from kidney sales.<sup>256</sup> In fact, even though Israel has limited the source of domestic organ procurement to altruistic donations,<sup>257</sup> Israeli health insurance currently *reimburses* patients for some, if not all, of the costs associated with brokered kidney transplants performed outside of Israel's borders.<sup>258</sup> Israel

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down, and I feel pain and numbness where the scar from the operation is." Rohter, *supra* note 9.

251. See Calandrillo, *supra* note 82, at 95–96 (noting that of the sellers in India's black market kidney trade, four out of five would not recommend selling kidneys to others).

252. See Rothman, *supra* note 250, at 1641 (explaining that by allowing patients to purchase organs abroad, countries avoid addressing cultural objections to paid donations—citing Japanese patients going to the Philippines, Israeli patients going to Turkey and former Soviet Union countries, patients in the Gulf States going to India, and Malaysian patients going to China as examples); Finkel, *supra* note 3, at 28 (noting that China, India, Iraq, Israel, Russia, and Turkey turn a blind eye to the involvement of their citizens in the sale of organs); Rohter, *supra* note 9 (noting that there is no law against trafficking human organs in Israel and that some international organ brokers openly solicit organ recipients in Israeli newspapers and radio stations).

253. Rothman, *supra* note 250, at 1641. Despite having illegalized organ sales in 1995, India is infamous for selling organs on the black market; there is also extensive organ trafficking from Moldova in Eastern Europe to Israel through Turkey. Watkins, *supra* note 12, at 34–35.

254. Calandrillo, *supra* note 82, at 88.

255. *Id.*

256. *Id.*

257. The number of altruistic donations in Israel is remarkably low despite a waitlist for kidneys that grows at a rate of 20% each year. In fact, according to one commentator, "organ donation rates in Israel are among the lowest in the developed world" partly due to the belief by some Israelis that the Jewish law forbidding desecration of the human body outlaws organ donation. GOODWIN, *supra* note 4, at 187–88 (quoting Rohter, *supra* note 9 (noting that despite concern by some that Jewish law may forbid organ donation, Israeli citizens strongly oppose a bill drafted by the Health Ministry that would make trafficking organs illegal)).

258. Finkel, *supra* note 3, at 28. Even though Israeli health insurance companies are not technically permitted to reimburse patients for illegal surgeries, they currently

essentially relieves the country's demand for transplant kidneys by funding the export of its transplant patients.<sup>259</sup> One health ministry ordinance currently permits "Israelis who go abroad for transplants to be reimbursed as much as \$80,000."<sup>260</sup> Patients traveling abroad to buy trafficked organs "save the country a lot of money," said a kidney specialist in Israel, "not only in terms of what doesn't have to be spent on dialysis, but also by opening places for other people who are on the list."<sup>261</sup> According to one transplant coordinator at an Israeli hospital, nearly twenty-five percent of the hospital's patients receiving post-transplant kidney care purchased their new kidney from a stranger.<sup>262</sup> Unfortunately, however, Israel's policy does not regulate the source of the kidney transplants or the manner in which the kidneys are procured.<sup>263</sup>

Black market organ trade occurs not only in foreign countries but in America as well. Held unaccountable to a national transplant screening board, each U.S. hospital has the discretion to establish its own living donor requirements.<sup>264</sup> Some hospitals even implement a "don't ask, don't tell" policy with respect to a donor's relationship to foreign recipients.<sup>265</sup> Organ brokers know which hospitals overlook whether a donor-recipient relationship exists, so foreign patients often arrive at the hospital with a willing but unrelated donor who will at some point receive cash.<sup>266</sup> In 2001, dozens of Moldavians allegedly entered the United States to sell their kidneys.<sup>267</sup>

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reimburse patients up to \$70,000 for medical procedures performed outside of Israel. Israeli government and health officials respond that there is little they can do to control what a patient does outside of the country's territory. McLaughlin et al., *supra* note 222. Likewise, despite banning organ sales domestically, many Middle Eastern countries give their blessing to citizens traveling to Pakistan to arrange an organ transplant. For instance, Saudi Arabia has prohibited the sale of organs within the country, but the Islamabad embassy assists citizens with transplant arrangements who wish to receive one in Pakistan. Declan Walsh, *Transplant Tourists Flock to Pakistan, Where Poverty and Lack of Regulation Fuel Trade in Human Organs*, GUARDIAN, Feb. 10, 2005, <http://www.guardian.co.uk/world/2005/feb/10/pakistan.declanwalsh>.

259. See GOODWIN, *supra* note 4, at 188.

260. Rohter, *supra* note 9.

261. *Id.*; see also Finkel, *supra* note 3, at 28 (stating that Israeli insurance companies are willing to reimburse renal patients for kidney transplants because the transplant is less expensive than dialysis).

262. Finkel, *supra* note 3, at 28.

263. GOODWIN, *supra* note 4, at 188.

264. Calandrillo, *supra* note 82, at 88.

265. *Id.*

266. *Id.*

267. *Id.* at 89.

*D. Religious Position on Kidney Sales*

Religious authorities diverge about whether individuals are permitted to donate their organs. Some outright oppose organ transplants<sup>268</sup> while others remain careful to voice their approval.<sup>269</sup> The majority of major world religions, however, hold a neutral tone towards the individual's decision to donate,<sup>270</sup> despite sometimes imposing a few stipulations.<sup>271</sup> When it comes to permitting individuals to sell their organs, however, the perspectives of religious authorities align more closely. For the most part, even those who do not oppose organ donations disapprove of the sale of organs. For instance, the U.S. Conference of Catholic Bishops held that "[t]he transplantation of organs from living donors is morally permissible . . . [but] the freedom of the prospective donor must be respected, and

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268. American Red Cross, Tissue Donation: Statements from Various Religions, <http://www.redcross.org/donate/tissue/relgstmt.html> (last visited Oct. 18, 2008) (also on file with the Houston Law Review) (reporting that most Roma oppose tissue and organ donations because they believe that for one year after death, a person's soul retraces its steps; in order for this to occur, they think that all of the body's parts must remain intact as they believe the soul takes on a physical shape). The Shinto disapprove of organ donation because it damages the donor's body. Watkins, *supra* note 12, at 10.

269. American Red Cross, *supra* note 268. Presbyterians, in particular, encourage organ donations. The Episcopal Church passed a resolution in 1982 observing the life-saving advantages of donating blood, tissue, and organs and encouraged all Christians to donate them "as part of their ministry to others in the name of Christ, who gave His life that we may have life in its fullness." Roman Catholics recognize organ donation as an act of charity, fraternal love, and self sacrifice, and "encourage donation as an act of charity[,] " explains Father Leroy Wickowski, Director of the Office of Health Affairs of the Archdiocese of Chicago, who also noted that organ donation "is something good that can result from tragedy and a way for families to find comfort by helping others" and cautioned "that the organs are removed only after death and that people's wishes are respected." *Id.*

270. For example, organ and tissue transplants are not inconsistent with the teachings of the Church of Christ (Disciples of Christ), Church of Christ (Independent), Hinduism, or Independent Conservative Evangelicals. The Greek Orthodox Church does not disapprove of organ donations when the organs are used to improve the quality of human life, for example, when they are transplanted or are used for research that will lead to improvements in preventing or treating diseases. Seventh-Day Adventists believe individuals have a right to donate or receive an organ when doing so will help restore one of the senses or will prolong the quality of life. On the other hand, Buddhists believe that donating an organ is a matter of individual choice because there is nothing written in Buddhist teachings prohibiting it. While Jehovah's Witnesses do not encourage donating organs, they believe the decision is for the individual to make. Christian Scientists and Mormons also believe that the decision whether or not to donate an organ is a matter of individual choice. *Id.*

271. The Amish consent to organ transplants only when it is certain that the recipient will benefit from the procedure. Similarly, Baptists generally approve when the procedure offers medical hope for the recipient without seriously endangering the donor. The Muslim Religious Council has stipulated that organ transplants are acceptable provided donor's written consent is secured in advance and so long as the organ is transplanted immediately and not stored in an organ bank. *Id.*

economic advantages should not accrue to the donor."<sup>272</sup> Of the same mind, Catholic theologians Benedict Ashley and Kevin O'Rourke explain that "if society is to live in a humane manner, generosity and charity, rather than monetary gain and greed, must serve as the basis for donation of functioning organs."<sup>273</sup>

Similarly, Bishop Dimitrios of Xanthos expressed, "The Greek Orthodox Church accepts the possibility of any kind of transplant, if it is not a commercial transaction. Only philanthropy constitutes a proper motive for giving and receiving organs. Otherwise it commodifies human organs and thus deprives the action of ethical quality."<sup>274</sup> Likewise, the Board of Social Responsibility at the Church of Scotland "totally endorses the moral judgment of the British Parliament in passing a Bill which makes it a criminal offence to buy, sell, or advertise human organs."<sup>275</sup> The Board concluded that "[i]f the tissue or organ to be donated is the gift of G[-]d and if the imperative of the Gospel is to love our neighbor unconditionally, then donation must be made freely on the grounds of need, not conditionally on the grounds of creed, or lucratively on the grounds of greed."<sup>276</sup> And, Bishop Tom Breidenthal compared organs sales to prostitution, explaining that for Episcopalians, while "sell[ing] a kidney to a needy recipient is better than selling one's body as a sexual object, because the purpose of the sale is better . . . the selling remains morally wrong—indeed, it may even be more wrong, since the need of the sick person is an example of what G[-]d (who alone 'owns' our bodies) intends us to use our bodies for, namely, to glorify G[-]d and serve our neighbor."<sup>277</sup>

In 1996, a committee of scholars from all the major Muslim Schools of Law in Great Britain determined that "[h]uman organs should be donated and not sold. It is prohibited to receive a price for an organ."<sup>278</sup> In fact, the prominent Muslim lecturer Muhammad Al-Munajjid stated there that the Islamic Fiqh Council had issued a *fatwa* (religious ruling) holding that "[i]t is not permitted to trade in human organs under any circumstances. But the question of whether the beneficiary may

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272. Grazi & Wolowelsky, *supra* note 168, at 185.

273. *Id.*

274. *Id.*

275. *Id.*

276. *Id.*

277. *Id.*

278. *Id.*

spend money to obtain an organ he needs, or to show his appreciation, is a matter which is still under scholarly debate.<sup>279</sup>

The Jewish perspective on selling organs directly contrasts trends developing in other major world religions.<sup>280</sup> Unlike secular medical ethics, which seek to turn ethical principles into law, Jewish medical ethics operate in the reverse by distilling ethical principles from already-existing law.<sup>281</sup> Documents compiling the Jewish perspective on health practices date as far back as 3,000 years.<sup>282</sup> Instead of categorically either forbidding or allowing new medical technologies,<sup>283</sup> Jewish authorities carefully evaluate the consequences of new medical advancements on a case-by-case basis.<sup>284</sup> However, because the *posekim* (rulings) of previous generations could not have addressed every possible medical advancement and because contemporary rabbinic authorities and courts lack hierarchical structure, clear *halakhic* (Jewish law) precedent pertaining to medical issues rarely exists.<sup>285</sup> Thus, the modern rulings must both locate relevant source material and apply the material to modern medical issues.<sup>286</sup>

From the Jewish perspective, organ transplantation presents complex issues involving analysis of many *halakhic* duties.<sup>287</sup> To determine whether Orthodox Jewish law permits the

279. *Id.*

280. See Michael J. Broyde, *Pre-Implantation Genetic Diagnosis, Stem Cells and Jewish Law*, TRADITION, Spring 2004, at 54, 58–59 (explaining how the Jewish approach is in “direct tension” with two trends: “to seek to limit the ability of science to change fundamentals of nature” and “to defer to individual choices and abhor governmental regulation”).

281. See Lord Immanuel Jakobovits, *The Role of Jewish Medical Ethics in Shaping Legislation*, in MEDICINE AND JEWISH LAW 1, 2–3, 13–14 (Fred Rosner ed., 1990) (referencing occasions in which Jewish religious views were invited to aid in formulating official policies on new legislation); Susan L. Mayer, *Thoughts on the Jewish Perspective Regarding Organ Transplantation*, 7 J. TRANSPLANT COORDINATION 67, 67 (1997) (stating that according to Rabbi Immanuel Jakobovits, the term “Jewish medical ethics” came about in the 1950s as a response to the increasing number of organ transplantations).

282. See Mayer, *supra* note 281, at 68 (“Jewish medical ethics represents the wisdom and intellectual labor of millennia, stretching from the Old Testament and Talmud through the codes of Jewish law to the most recent rabbinic essays and Responsa.”).

283. See, e.g., Broyde, *supra* note 280, at 56 (“Jewish law insists that new technologies . . . are neither categorically prohibited nor categorically permissible.”).

284. *Id.*

285. Edward Reichman, *Uterine Transplantation and the Case of the Mistaken Question*, TRADITION, Summer 2003, at 20, 20. There is no central authority to promulgate Jewish rulings because contemporary rabbinic authorities and courts lack hierarchical structure. Richard V. Grazi & Joel B. Wolowelsky, *Nonaltruistic Kidney Donations in Contemporary Jewish Law and Ethics*, 75 TRANSPLANTATION 250, 251 (2003).

286. Reichman, *supra* note 285, at 20.

287. Mayer, *supra* note 281, at 67.

buying and selling of organs, two distinct questions must be answered: first, whether Jewish law authorizes the transfer of human organs from one individual to another, and second, whether Jewish law authorizes the kidney donor to be paid for the removed kidney.<sup>288</sup>

1. *Donating Kidneys Under Jewish Law.* Under American law, there generally is no requirement to save the life of someone unless one has assumed a duty of care to the individual in need. This concept has been demonstrated in the context of tissue donation. For example, in 1978, David Shimp of Pennsylvania agreed to donate bone marrow for a transplant of his terminally ill cousin, Robert McFall, but then reneged on the agreement.<sup>289</sup> When McCall filed suit to compel his cousin to go through with the donation, the court ruled that “[t]he common law has consistently held to a rule which provides that one human being is under no legal compulsion to give aid or to take action to save another human being or to rescue.”<sup>290</sup> In fact, Minnesota and Vermont are the only states that have enacted Good Samaritan statutes imposing a penalty for failure to intervene with life-saving assistance when in a position to help someone in need, but even those statutes do not require invasion of the person’s body without his or her consent.<sup>291</sup>

In Western culture, such acts of helping others are commonly classified as charity. Jewish law, on the other hand, *requires* one to help a person who is in need.<sup>292</sup> Whereas charity

288. Goodwin, *supra* note 134, at 796 (citing Steven H. Resnicoff, *Supplying Human Body Parts: A Jewish Law Perspective*, 55 DEPAUL L. REV. 851, 853 (2006)).

289. See GOODWIN, *supra* note 4, at 63–65 (describing McFall and Shimp as not only cousins but good friends and revealing that after a long search it was determined that Shimp was the only suitable donor).

290. *McFall v. Shimp*, 10 Pa. D. & C.3d 90, 91 (Pa. Com. Pl. 1978).

291. See MINN. STAT. ANN. § 604A.01 (West 2000) (“A person at the scene of an emergency who knows that another person is exposed to or has suffered grave physical harm shall, to the extent that the person can do so without danger or peril to self or others, give reasonable assistance to the exposed person. Reasonable assistance may include obtaining or attempting to obtain aid from law enforcement or medical personnel.”); VT. STAT. ANN. tit 12, § 519 (1973) (“A person who knows that another is exposed to grave physical harm shall, to the extent that the same can be rendered without danger or peril to himself or without interference with important duties owed to others, give reasonable assistance to the exposed person unless that assistance or care is being provided by others.”).

292. See *Exodus* 23:4 (“[Y]ou must take it back to him . . . .”); *Leviticus* 19:18 (“Love your neighbor as yourself.”); Elliott N. Dorff, *Choosing Life: Aspects of Judaism Affecting Organ Transplantation*, in ORGAN TRANSPLANTATION: MEANINGS AND REALITIES 168, 181–82 (Stuart J. Youngner et al. eds., 1996) (“[F]or Judaism, helping others is part of one’s duty to G[-]d and to one’s fellow human beings.”); Aaron L. Mackler, *Respecting Bodies and Saving Lives: Jewish Perspectives on Organ Donation and Transplantation*, 10

suggests acts that are performed beyond one's call of duty, *zedakah*, monetary assistance, and *hesed*, the Jewish term used to describe any other type of assistance, are obligations both to G-d and to other individuals.<sup>293</sup> These obligations are most essential when a human life might be saved (*pikuah nefesh*).<sup>294</sup> In the Jewish tradition, humans have a role on Earth to "improve the world in the image of the Divine"<sup>295</sup> and to safeguard against destruction and illness.<sup>296</sup> Given that the body is G-d's property,<sup>297</sup> saving human life is one of the most fundamental *mitzvahs* (Jewish commandments) of *halacha*.<sup>298</sup> Indeed, it is the most

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CAMBRIDGE Q. OF HEALTHCARE ETHICS 420, 421 (2001) (explaining that Judaism teaches that "G[-]d has entrusted humans with the power and responsibility to feed the hungry, comfort the afflicted, and heal the sick"). According to Deuteronomy 22:2, humans should restore what has been lost, which has been interpreted to include lost health and function. *Deuteronomy 22:2*.

293. The Jewish concepts *zedakah* and *hesed* are distinct from charity. *Charity* is a Latin word that means "affection" or "love," and it signifies actions motivated by affection that exceed one's obligations. Therefore, those who are charitable are characterized as virtuous individuals. *Zedakah*, on the other hand, the Hebrew word used to describe financial assistance that is given to others who are in need, derives from the root meaning "justice." In Judaism, helping other people is an obligation one has to G-d and other individuals rather than an act that is beyond one's call of duty. Nevertheless, one can still feel good about performing *zedakah*, but unlike charitable individuals who may delight in exceeding society's expectations of them, the enjoyment stems from fulfilling one's duty. This does not mean that *zedakah* cannot also be motivated by affection. It just means that, regardless of such affection, Judaism requires individuals to give it whether they want to or not. Somewhat similarly, *hesed*, which originally meant "an act done out of loyalty to one's fellow," is now also used to describe acts of kindness, care, and concern. Therefore, by definition, acts of *hesed* are less binding on Jewish people than are acts of *zedakah*, yet they still exact some degree of duty beyond that suggested by the word charity. Dorff, *supra* note 292, at 181–82.

294. Mackler, *supra* note 292, at 421; *see also* *Leviticus 19:16* ("[D]o not stand upon the blood of your neighbor . . ."); Goodwin, *supra* note 134, at 796 ("[U]nlike common law, Jewish law imposes an affirmative duty to save a person's life through one's direct intervention or through the use of one's resources.").

295. Broyde, *supra* note 280, at 58. The spirit of the requirement is captured in the Talmudic passage regarding the creation of Adam: "[A]nyone who destroys a single person from the children of man [Adam] is considered by Scripture as if he destroyed an entire world, and whoever sustains a single person from the children of man is considered as if he sustained an entire world." *See* Talmud, *Sanhedrin 37a*.

296. *See, e.g.,* Broyde, *supra* note 280, at 58 ("Tampering with nature is part of the human mission in the Jewish tradition; curing illness is one facet of that mission."). The primary *mitzvah* to save someone's life or preserve their health, if possible, is derived from the biblical mandate to return a lost object. *See Deuteronomy 22:2* ("[T]hen you shall give it back to him . . .").

297. *See Deuteronomy 22:2*.

298. The commandment to preserve life is derived from *Leviticus 18:5*, which says, "You shall keep My laws and My rules, by the pursuit of which man shall live . . ." The Sages have since deduced from this verse, "You shall live by them, but not die by them," implying that one of the main purposes of the commandment is to preserve human life. Halperin, *supra* note 38, at 411; *see Leviticus 19:16* ("Do not go about as a talebearer among your fellows. Do not stand upon the blood of your neighbor: I am the Lord."); J. D. Kunin, *The Search for Organs: Halachic Perspectives on Altruistic Giving and the Selling*

superior requirement of all but three prohibitions of Jewish law: worshipping false gods, certain illicit sexual actions, and causing injury or death to innocent people.<sup>299</sup>

It might, therefore, appear at first impression that *halacha* not only condones organ donation to save lives but, perhaps, even requires it.<sup>300</sup> The decision to donate one's organ, however, involves balancing *halakhic* obligations.<sup>301</sup>

The primary conflicting obligation to mandating donating organs under Jewish law derives from the *mitzvah* to preserve one's own life, which includes the responsibility to avoid self-injury.<sup>302</sup> Thus, "If A's life is in danger and B can save A without endangering his own life, he must do so. If B can only save A by sacrificing his own life, he may not do so."<sup>303</sup> However, one may, indeed must, risk self-injury for the purpose of rescuing someone else if the risk to oneself is only minimal<sup>304</sup> and when the

*of Organs*, 31 J. MED. ETHICS 269, 269 (2005) (interpreting Leviticus 19:16 and explaining that Maimonides states, "[a]nybody who is able to save someone else and fails to do so transgresses the mitzvah of 'Do not stand idly by the blood of your brother.'"); Mackler, *supra* note 292, at 421–22 ("Saving a life justifies virtually any action that is otherwise prohibited by Judaism. . . . Furthermore, violating provisions of Jewish law in order to save a life is not only permitted but required."). Moses Nahmanides, a medieval physician and rabbi wrote, "[s]aving life is a great mitzvah [commandment]. Who approaches it with alacrity is praised, who hesitates is despicable, who questions it is guilty of murder, and certainly so, one who despairs and does not do it." *Id.* at 422.

299. Halperin, *supra* note 38, at 411–12.

300. Kunin, *supra* note 298, at 269.

301. *See id.*

302. 1 DAVID DAUBE, *Talmudic Law*, in COLLECTED WORKS OF DAVID DAUBE: STUDIES IN COMPARATIVE LEGAL HISTORY 44, 55–56 (Calum M. Carmichael ed., 1992); FAITEL LEVIN, HALACHA, MEDICAL SCIENCE AND TECHNOLOGY: PERSPECTIVES ON CONTEMPORARY HALACHA ISSUES 78–79 (1987); J. David Bleich, *Survey of Recent Halakhic Periodical Literature*, TRADITION, Spring 1993, at 59, 60–61; Cohen, *supra* note 224, at 43–44 ("[I]t is forbidden for a person to intentionally cause physical damage to his own body."); Kunin, *supra* note 298, at 269; Mayer, *supra* note 281, at 70.

303. Halperin, *supra* note 38, at 412.

304. The Jerusalem Talmud teaches that one is obligated to help a person in definite danger when the risk of injuring oneself is merely potential. As new issues arise, *halakhic* authorities rely on precedent from the Talmud much as secular courts rely on precedent from prior court rulings. Kunin, *supra* note 298, at 270; *see also* LEVIN, *supra* note 302, at 81–82 ("Where nothing [substantial] is given of the body and only a minimal possibility of danger to life exists, the Torah's injunction 'Do not stand by your brother's blood!' is applicable: life-saving must be undertaken."); Cohen, *supra* note 224, at 45–46 (noting that some *polkim* (deciders of Jewish law) feel that it is required for one to be willing to save the life of another when pain is the only risk involved); Reichman, *supra* note 285, at 22 (declaring that a donor's obligation includes subjecting herself to a certain amount of risk); Sinclair, *supra* note 216, at 590 (asserting that one is permitted to risk minor self-injury for the sake of saving someone else's life); American Red Cross, *supra* note 268 ("Judaism teaches that saving a human life takes precedence over maintaining the sanctity of the human body.").

rescuer's need is substantial.<sup>305</sup> Thus, blood donations are *halakhically* required.<sup>306</sup> Several authorities also maintain that less than a fifty percent risk of harm or death to the rescuer is minimal risk for the purposes of saving another's life,<sup>307</sup> as it might be with saving someone from drowning.<sup>308</sup> On the other hand, Jewish law does not require one to undergo *substantial* risk of injury or death to save a life.<sup>309</sup> Where risk of endangering oneself is high, rescuing someone from death constitutes the act of a "pious fool."<sup>310</sup> Jewish law applies the same reasoning to the decision to undergo medical treatment that will save someone else's life.<sup>311</sup>

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305. See Cohen, *supra* note 224, at 40 (asserting that the *Yerushalmi*, *Terumot* orders that one must attempt to save the life of someone in definite danger of dying when the risk of harm from the rescue is merely potential); Halperin, *supra* note 39, at 48 (noting that Rabbi Akiba concluded in the Mishna that there is an exception to the prohibition against self-injury when there is "great need"); Halperin, *supra* note 38, at 412, 419 (noting that *halakhic* authorities reject the teaching of the Palestinian Talmud that an individual must save the life of another person when there is risk of endangering but not of sacrificing his own life, and that while one may injure himself for a "great" benefit, one must not allow self-injury for only a minor benefit).

306. Halperin, *supra* note 38, at 413–14.

307. Sinclair, *supra* note 216, at 590.

308. See LEVIN, *supra* note 302, at 80 (repeating the Torah's instruction, "Do not stand by your brother's blood!" and stating it is universally interpreted to mean that one must, for example, save someone in danger of drowning or at the mercy of a criminal).

309. See Grazi & Wolowelsky, *supra* note 168, at 186 (asserting that Leviticus 25:36 instructs, "Your brother shall live with you," which should be taken to mean that his life does not take precedence over one's own and should not therefore be saved at the expense of sacrificing one's own life); Halperin, *supra* note 39, at 47 (asserting that no one is obligated to donate an organ to save the life of someone else); Kunin, *supra* note 298, at 269–70 (recounting that Rabbi David ben Rabbi Shlomo Ibn (Abi) Zimra (RaDBaZ) wrote, "[In trying to save another life,] if there is any doubt of threat to [your] life, [saving another's life over your own] is piety of idiocy because your possible danger takes precedence over your fellow man's definite danger."); Sinclair, *supra* note 216, at 589–90 ("The generally accepted position is that an individual is not obligated to risk life or limb in order to save another person from certain death."). Only the Jerusalem Talmud requires one to undertake substantial risk to save the life of another person. Hagahot Maimaniyot, a commentary on Rambam, taught that one may be obligated under the Jerusalem Talmud to attempt to save the life of someone in need, even when such attempted rescue could seriously endanger the rescuer. In particular, he argues that saving the life of someone who is in definite danger is required whenever the risk of harm from attempting rescue is merely potential, the reason being that the need of the one at risk of losing his or her life is of greater value than that of the rescuer. By his reasoning, one would be *required* to donate a kidney to save the life of a renal patient, despite the risk of harm to the donor. However, this is a minority view. LEVIN, *supra* note 302, at 78–79.

310. LEVIN, *supra* note 302, at 81 (citing noted rabbis of the fifteenth century).

311. See Sinclair, *supra* note 216, at 589–90 (arguing that because a person does not own his or her life, the person is required to participate in a life saving medical procedure unless the risk of harm is high or when coercion is used so that its negative consequences outweigh the treatment's positive results).

Donating a kidney, however, differs from many other life-saving methods referenced in Jewish texts.<sup>312</sup> When a person dives into water to rescue someone from drowning, even if the rescue proves unsuccessful, the diver's body will remain in one piece. Therefore, since the diver will most likely survive the rescue and remain intact, Jewish law requires that he or she attempt to save the person from drowning. Kidney donations differ in that even if the donor remains perfectly healthy after the procedure, the donor will no longer be whole because he or she will be missing a kidney.<sup>313</sup> Jewish law restricts disfiguring or dismembering the human body. This obligation derives from the requirement ordering immediate burial of the dead without removing the organs from the body, known as *nivul hamet* or "desecration of the dead body."<sup>314</sup> Jewish law generally requires near immediate burial of the dead out of respect for the human body.<sup>315</sup> Indeed, belief in an afterlife where "spirits . . . look like the embodied people they were in life" contributes to the reluctance among the more conservative members of the Jewish faith to approve of organ donations.<sup>316</sup> However, Jewish tradition believes that it was G-d who donated the first body part by removing Adam's rib and transferring it to Eve in her creation.<sup>317</sup> Rabbi Yechezkel Landau, a prominent Rabbinical authority of the eighteenth century, thus concluded that the obligation to save human life transcends the biblical prohibition on dismembering the body's parts.<sup>318</sup> For example, he ruled that even though the *Halacha* usually forbids autopsies, they are permitted for ascertaining the cause of death when used to save a human life in imminent danger. Moreover, the self-injury that most impacts the *halakhic* prohibition is that harm that has no

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312. LEVIN, *supra* note 302, at 81.

313. *Id.*

314. Shabtai A. Rappoport, *Medicine and Halacha, The Deceased, the Family and Organ Donation*, <http://www.daat.ac.il/daat/refua/donation.htm> (last visited Jan. 31, 2009); see also *Deuteronomy* 21:22–23 ("[Y]ou must not let his corpse remain on the stake overnight, but must bury him the same day.").

315. See Mackler, *supra* note 292, at 422 (explaining how the Jewish tradition values respect for the human body, commanding certain requirements after death including burial of the body as soon as possible).

316. GOODWIN, *supra* note 4, at 128.

317. See Reuven P. Bulka, *Psychology, Halakhah, and Organ Transplantation*, *TRADITION*, Winter 1989, at 3, 3 (describing this first surgery as a "unique form of transplantation").

318. See Daniel Eisenberg, *Sanctity of the Human Body: Do We Own Our Bodies or Are They Only Out on Loan?*, *AISH.COM*, Jan. 13, 2003, [http://www.aish.com/societyWork/sciencenature/Sanctity\\_of\\_the\\_Human\\_Body1.asp](http://www.aish.com/societyWork/sciencenature/Sanctity_of_the_Human_Body1.asp) (recounting the opinion of Rabbi Landau that a transplant should not be done unless "an identifiable human life may be saved").

countervailing benefit.<sup>319</sup> Because donating a kidney will improve or save the life of another individual, authorities generally believe that it should not be considered self-mutilation within the context of Jewish law.<sup>320</sup>

Rabbi David ben Rabbi Shlomo Ibn (Abi) Zimra, known as the acronym RaDBaZ, was a noted Rabbi of the fifteenth century.<sup>321</sup> The RaDBaZ analyzed the issue of what to do if a ruler threatened to kill someone unless another would cut out a nonvital organ.<sup>322</sup> Quoting Proverbs 3:17, which says that the Torah's<sup>323</sup> "ways . . . are ways of pleasantness," the RaDBaZ ruled that *Halacha* does not require one to amputate a body part for the sake of saving someone else's life; however, he suggested it would certainly be a "pious act" to willingly sacrifice the body part, unless its removal endangered the donor, in which case the donor would be dismissed as a "pious fool."<sup>324</sup>

Therefore, given that the weight Jewish law affords saving lives and healing the injured, most Jewish authorities allow kidney donations because the benefits greatly outweigh the

319. See Kunin, *supra* note 298, at 271 (noting that Rabbi Feinstein permits cosmetic surgery as *halakhically* acceptable because its intended purpose is to improve rather than to injure the individual). Admittedly, however, cosmetic surgery differs from organ donation because whereas the injury from cosmetic surgery itself directly benefits the individual undergoing cosmetic repair, the injury incurred from donating an organ benefits only the organ recipient. See Cohen, *supra* note 224, at 44 (explaining Rabbi Feinstein's view that injuring oneself in a degrading manner is not permitted while self-injury is allowed when there is a benefit); Halperin, *supra* note 39, at 48 (discussing Jewish opinions as well as the Torah commandment of *bal tashchit*, prohibiting unnecessary self-mutilation causing permanent damage).

320. Kunin, *supra* note 298, at 270 (reporting that according to a U.S. national survey, the mortality rate of those donating a kidney was only 0.03%).

321. Chabad.org, Rabbi David Ibn Zimra (RaDBaZ)—Early Achronim, [http://www.chabad.org/library/article\\_cdo/aid/112491/jewish/Rabbi-David-Ibn-Zimra-RaDBaZ.htm](http://www.chabad.org/library/article_cdo/aid/112491/jewish/Rabbi-David-Ibn-Zimra-RaDBaZ.htm) (last visited Jan. 31, 2009).

322. Grazi & Wolowelsky, *supra* note 168, at 186.

323. The Torah refers to the first five books of the Old Testament, which is believed by more observant Jews to have been dictated by G-d to Moses on Mt. Sinai when G-d gave the tablets containing the Ten Commandments. STEPHEN M. WYLEN, *THE SEVENTY FACES OF TORAH* 8 (2005) (explaining in detail this "standard belief" among Jews).

324. LEVIN, *supra* note 302, at 79 (stating that one is entitled to prioritize his own life over that of others); Cohen, *supra* note 224, at 45 ("[The Torah's] ways are ways of pleasantness . . . and it is necessary that the laws of our Torah will accord with reason and rational thought. How could it occur to us that a person should allow his eyes to be blinded or his hands to be cut off . . . so that his friend should not be killed? Therefore, I cannot countenance any ruling [such as] this, other than an act of outstanding piety [*midat chassidut*]. Blessed is the portion of one who can withstand this; however, if there is [even] a possible danger to his life [in the procedure], then he is a pious fool [*chassid shoteh*], for the potential danger to his own life takes precedence over the certain [danger] for his friend." (quoting the RaDBaZ at the end of his *teshuva*)); Grazi & Wolowelsky, *supra* note 168, at 186.

risks.<sup>325</sup> While it certainly is not obligatory to donate an organ, donating a kidney constitutes an act of piety.<sup>326</sup>

2. *Jewish Law on Payment to the Organ Donor.* Jewish law does not permit payment for performing a *mitzvah*.<sup>327</sup> For instance, one may not receive payment for sharing information about the Torah.<sup>328</sup> This principle extends beyond teachings of the Torah; it applies also to carrying out the commandments of the Torah.<sup>329</sup> Because the Torah commandments include healing the injured, one may not seek payment for the specific acts of healthcare.<sup>330</sup> The Torah, however, makes an exception for receiving payment for performing a *mitzvah* when the individual would otherwise be forced to carry out the *mitzvah* at his or her own expense.<sup>331</sup> Thus, doctors can be paid for their time (*sechar bataala*) as well as expenses.<sup>332</sup> From this, Jewish law derives that the suffering a donor necessarily incurs throughout the donation process secures the donor the right to demand compensation, despite fulfilling a *mitzvah*.<sup>333</sup> Even were Jewish doctors prohibited by Jewish law from charging patients,<sup>334</sup> organ donors differ in that they have not assumed a previous obligation to provide healthcare—like doctors have.<sup>335</sup>

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325. See, e.g., Dorff, *supra* note 292, at 182 (“When the danger is not great . . . then people *may* donate an organ, and it is, in those circumstances, an honored, godly thing to do.”); Mayer, *supra* note 281, at 70 (“Kidney donations are permitted because of the overriding consideration of saving a life.”); Reichman, *supra* note 285, at 22 (“Living organ donation, for organs such as kidneys, is a common, halakhically sanctioned practice.”). The same standard does not apply to children or the mentally incompetent under Jewish law. See Bleich, *supra* note 302, at 69 (recognizing a “best interest standard” for minors and mentally incompetent persons).

326. See Cohen, *supra* note 224, at 48 (“[D]onating an organ to save someone else’s life, while not mandatory, is nevertheless a great mitzvah . . . .”); Halperin, *supra* note 38, at 414 (“[D]onating a kidney for lifesaving purpose . . . is not obligatory.”).

327. Cohen, *supra* note 224, at 49.

328. Halperin, *supra* note 38, at 420.

329. *Id.*

330. *Id.* at 421.

331. See *id.* (noting that a healer may receive compensation for his expenses, time, and anything given to the patient during the healing process). Donating an organ strictly for financial gain is disallowed. Cutting one’s hair for commercial purposes is not forbidden because it is not self-injury. Donating blood falls somewhere in the middle, because a blood donor feels only slight discomfort. Halperin, *supra* note 39, at 49.

332. See Cohen, *supra* note 224, at 50 (explaining that helping someone is a mitzvah, but a doctor or anyone else may demand to be paid if he or she is not prepared to do it without pay); Halperin, *supra* note 38, at 421 (“[T]he fulfillment of a commandment does not require that the healer spend his own money for the patient.”).

333. Halperin, *supra* note 38, at 421.

334. Some argue that one may not receive payment for the actions he or she is obligated to perform. *Id.*

335. *Id.* at 421–22.

Moreover, while one may not be paid *for* performing a *mitzvah*, receiving compensation *while* performing a *mitzvah* is not prohibited as long as the individual has some nonremunerative motive to perform the *mitzvah*.<sup>336</sup> In fact, when an organ recipient can offer repayment for damage caused to the donor, he or she must do so.<sup>337</sup> The *poskim* “fram[e] the payment as the ‘fine’ imposed on someone who commits a bodily assault on another, which includes payment for pain and suffering in addition to medical expenses and lost income.”<sup>338</sup> Moreover, Jewish law recognizes the complexity of motivations in obtaining compensation when performing a *mitzvah*. For example, if a destitute father hoping to help cure his child’s sickness would be willing to give her a kidney, should Jewish law allow him to sell a kidney to pay for her medical care?<sup>339</sup> Separating oblique altruism from the financial gain may prove difficult.<sup>340</sup> As a consequence, the late Chief Rabbi of Israel, Shlomo Goren, concluded that there is “no *halakhic* basis on which to prohibit one from donating a kidney in consideration of financial gain.”<sup>341</sup>

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336. Kunin, *supra* note 298, at 272; *see also* Grazi & Wolowelsky, *supra* note 285, at 251 (“[T]he religious value of a *mitzvah* . . . is not obviated by the absence or diminution of proper motivation.”).

337. JOSEPH CARO, SHULCHAN ARUCH § 426 (Marcus ed., 1995) (“But, if he [the one being saved] has money to save himself, he must pay it to his friend [the one who saved him].”); 12 ARYEH KAPLAN, THE TORAH ANTHOLOGY, LEVITICUS – II, at 27 (Aryeh Akplan ed., Moznaim Publishing 1990) (“[I]f one sees his neighbor in danger and has the ability to do something, he must do everything in his power to help him. . . . If one spends money to save his neighbor’s life, and his neighbor has the ability to repay him, the neighbor has an obligation to do so.”); MAIMONIDES, MISHNE TORAH, BOOK OF DAMAGES, 510–11, 511 n.45 (Moznaim Publishing 1997) (“Whenever a person can save another person’s life, but he fails to do so, he transgresses a negative commandment, as [Leviticus 19:16] states: ‘Do not stand [idly by] while your brother’s blood [is at stake]. . . .’ Needless to say, the person whose life was saved must afterwards reimburse the person who saved it for the expenses he undertook.”); *Hagahot Mordekhai, Sanhedrin*, sec. 718 (declaring that a person may cut off the limb of another in order to save his own life “but must pay him the value of his hand”); *Rosh, Baba Kamma* 6:12; *Sanhedrin* 8:12 (noting that the victim whose life has been saved must compensate the rescuer for expenses); *Tur Shulhan Arukh, Choshen Mishpat* 426:1 (again declaring that a person may cut off the limb of another in order to save his own life); Grazi & Wolowelsky, *supra* note 168, at 187 (“A person who is injured by another is allowed to collect not only for his medical expenses and lost income, but also for pain and suffering. One who volunteers to be injured in order to save another does not forfeit similar compensation.”).

338. Grazi & Wolowelsky, *supra* note 285, at 252. The late Chief Rabbi of Israel, Shlomo Goren, wrote that receiving financial compensation for donating an organ does not lessen the *mitzvah*. He believed that the payment does not make it less commendable. *See* Grazi & Wolowelsky, *supra* note 168, at 186.

339. *See* Grazi & Wolowelsky, *supra* note 168, at 187 (discussing the different views on this issue).

340. *Id.*

341. *Id.* at 186 (emphasis added).

While Jewish law permits compensation for organ donation, it concurrently warns against using wealth and power to improperly influence others into making unwise decisions.<sup>342</sup> And it recognizes that those desperate for money more commonly ignore adverse medical effects.<sup>343</sup> Without full consideration of the donation's medical consequences, donor consent will be invalid.<sup>344</sup> However, while "[s]elling organs does involve an ethical problem [for those that are desperate], . . . it is one that relates to the general society and not to the individual buyer or seller," notes Shafran, director of the Jerusalem Rabbinat's Department of *Halakaha* and Medicine.<sup>345</sup> "This is a question of society's ethics," continues Shafran, "but it involves no technical halakhic prohibition."<sup>346</sup> Even Yisrael Meir Lau, former Chief Rabbi of Israel, who has expressed concern that a market for transplant organs will enable exclusively the well-off to receive organ transplants, admits that providing financial compensation to organ donors does not violate Jewish ethical considerations.<sup>347</sup> The poor often experience disadvantages in competing for limited resources.<sup>348</sup> Government regulation of legal kidney sales, in Rabbi Lau's opinion, most effectively avoids the current exploitation in the black market transplant organ industry.<sup>349</sup>

#### *E. Nonreligious Objections to Paying Organ Providers*

Transplant tourism has given rise to fierce debates, inter alia, among ethicists, lawyers, doctors, and economists about legalizing and regulating the sale of kidneys.<sup>350</sup> Several proposals have been put forth in the past to adopt a free market allowing organs to be sold for whatever price consumers will pay.<sup>351</sup> Americans, in particular, prefer free market systems over models of altruism,<sup>352</sup> and the majority of Americans approve of offering

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342. Cohen, *supra* note 224, at 64.

343. Halperin, *supra* note 38, at 423.

344. *Id.*

345. Grazi & Wolowelsky, *supra* note 168, at 187.

346. *Id.*

347. *Id.*

348. *Id.*

349. *Id.*; see also Halperin, *supra* note 38, at 422 (recommending legislative regulation of kidney sales to prevent exploitation of the poor).

350. See Friedman & Friedman, *supra* note 5, at 961 (illustrating that associations and professionals can be found on all sides of the debate); Rohter, *supra* note 9 (citing disagreement among groups that believe selling organs will extend autonomy and groups that fear it will promote coercion).

351. Harris & Alcorn, *supra* note 10, at 214.

352. See Jefferies, *supra* note 72, at 653 ("[The] free market system enjoys its

organ donors compensation.<sup>353</sup> But, ethical objections and the potential for abuse in an open market for organs have to date prevented such a payment system.<sup>354</sup>

The objections are myriad. “Among the[m] [] are that a market will drive down altruism and deter such donors from giving at all; children will murder their parents for organs; that dirty tissue will enter the organ pool; and commoditization will be ‘like slavery.’”<sup>355</sup> Proposals to compensate organ donors trigger thoughts of “an impoverished third-world mother selling her organs to a distant multimillionaire whose financial wherewithal has enabled him to bypass any national waitlist.”<sup>356</sup> Many consider compensating kidney providers immoral.<sup>357</sup> Distributive justice often also forms the basis for objection. According to The Transplantation Society,<sup>358</sup> “Organs and tissues should be freely given without commercial consideration or commercial profit.”<sup>359</sup> The arguments against generating a market system for kidneys, however, generally do not rest in economics.<sup>360</sup>

By criminalizing organ sales, NOTA has attempted to increase altruistic donations, eliminate commoditization of the human body, and prevent exploitation.<sup>361</sup> However, these benefits must be balanced “against the thousands of Americans dying on waitlists who [are] sacrificed for these ideals.”<sup>362</sup> Altruistic donations have failed at meeting the demand for kidney

greatest popularity in the United States. Americans accept the market as an alternative to altruistic systems and the coercive power of the state.”).

353. See Watkins, *supra* note 12, at 24 (noting that some 52% of Americans supported paying organ donors, 5% had reservations, and 2% considered it “immoral or unethical”).

354. Harris & Alcorn, *supra* note 10, at 214.

355. GOODWIN, *supra* note 4, at 151; see also Becker & Elías, *supra* note 3, at 22 (“[A]nother argument raised against paying for organs is that it might reduce the supply of organs for altruistic reasons.”).

356. Arthurs, *supra* note 8, at 1121.

357. Robinson, *supra* note 71, at 1042.

358. The Transplantation Society, Vision Statement, <http://www.transplantation-soc.org/policy.php> (last visited Jan. 31, 2009) (“The Transplantation Society will provide the focus for global leadership in transplantation [with]: [the] development of the science and clinical practice[,] scientific communication[,] continuing education[,] [and] guidance on the ethical practice . . .”).

359. Michael Abecassis et al., *Consensus Statement on the Live Organ Donor*, 284 J. AM. MED. ASS’N 2919, 2925 (2000); Friedman & Friedman, *supra* note 5, at 961 (stating that medical associations worldwide generally discourage offering compensation for human organs).

360. See Jefferies, *supra* note 72, at 654 (noting that most arguments opposing a market in organ donation are philosophical rather than economic).

361. Watkins, *supra* note 12, at 26.

362. *Id.* (quoting Michael Davis, *Market for Human Organs: How Much Is That Kidney in the Window?*, THE VANDERBILT TORCH, Feb. 13, 2002, at 1).

transplants.<sup>363</sup> The ban on organ sales places a substantial burden on people's access to medical care.<sup>364</sup> Continuing the altruistic model of procurement essentially means that we would rather accept the deaths resulting from the failure to supply an adequate number of organs than offer compensation to donors.<sup>365</sup> The concern for personal autonomy is preserved at the expense of failing to eliminate the organ supply shortage.<sup>366</sup> "Paying for organs is morally odious, mainly to those who are not dying to get one."<sup>367</sup>

1. *The Concern that a Kidney Market Will Displace Altruistic Donations.* Some fear that once kidneys are priced, altruistic donors will likely drop out of the market or, instead, become organ sellers themselves.<sup>368</sup> "There is concern that a system which allows payment for transplantable organs will deter a voluntary donor who considers a payment system unethical or unsavory."<sup>369</sup> Critics cite, for instance, that in Kuwait, "several well-matched relatives of potential recipients . . . withdrew their offer of donation after they learned that their relatives [could] go to India and buy a kidney in the market place."<sup>370</sup>

But allowing a market for human organs would not require donors to accept compensation for their organs; they could and, more importantly, would often still donate freely.<sup>371</sup> As evidence of this fact, we need only examine the market to compensate donors of blood products, which has not hindered those who wish to donate blood voluntarily.<sup>372</sup> Nonprofit institutions collect

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363. *Id.*

364. Volokh, *supra* note 29, at 1835–36.

365. Goodwin, *supra* note 134, at 794.

366. Jefferies, *supra* note 72, at 651.

367. Berman, *supra* note 241, at 15.

368. Anderson, *supra* note 28, at 300.

369. Robinson, *supra* note 71, at 1039.

370. See MARK J. CHERRY, KIDNEY FOR SALE BY OWNER: HUMAN ORGANS, TRANSPLANTATION, AND THE MARKET 14 (2005) (quoting G.M. Abouna et al., *Commercialization in Human Organs: A Middle Eastern Perspective*, TRANSPLANTATION PROCEEDINGS, 1990, at 918, 919).

371. See Magda Slabbert & Hennie Oosthuizen, *Commercialization of Human Organs for Transplantation: A View from South Africa*, 24 MED. & L. 191, 198 (2005) (pointing out that although some are paid to work, there are still those who volunteer).

372. See GOODWIN, *supra* note 4, at 152 ("Blood market and donor systems illuminate the false dichotomy that suggests that voluntary donation and compensation for biological resources cannot mutually exist."); Sobota, *supra* note 12, at 1246 (reasoning that there is nothing to suggest a reduction of altruistic blood donations, even though donors have the option to receive compensation).

roughly fourteen million units of blood a year.<sup>373</sup> Similarly, the market system for producing eggs has not precluded altruistic incentives for donations.<sup>374</sup> It coexists with altruism and functions more effectively than an altruistic model alone would at satisfying the demand for eggs.<sup>375</sup> No valid empirical evidence demonstrates that any possible drop in altruistic donors would not be significantly offset by the gain in organs obtained from permitting kidney sales.<sup>376</sup> Indeed, there can be little debate that “the greater the payment, the greater the increase in transplantable organs.”<sup>377</sup>

Similarly, some worry that the psychic benefits should be protected at the cost of preventing payment for kidneys. Kidney donors, however, would likely experience positive feelings about making a contribution notwithstanding the receipt of compensation. Many transplant surgeons certainly feel gratified when they save a patient’s life even though they receive remuneration.<sup>378</sup> Critics of the all-volunteer U.S. Army at one time claimed that paying people to join the army would drive away those who would join for other, perhaps patriotic, reasons.<sup>379</sup> But instead, people enlist in the U.S. Army for all sorts of reasons—some economic, some not.<sup>380</sup> Indeed, after the terrorist attacks on 9/11, interest in volunteering in the U.S. armed forces surged as a result of renewed patriotic convictions.<sup>381</sup>

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373. GOODWIN, *supra* note 4, at 152 (stating that 45% is donated to the Red Cross, 42% to blood banks, and just under 12% to hospitals).

374. *Id.* at 181–82.

375. Moving to an altruistic model would severely diminish the number of donors and, as a result, lead to longer waitlists, and inequitable rationing. *Id.* at 182.

376. Two studies conducted in the context of blood donations indicate that compensation is more likely to attract donors than to repel them. One survey reveals that donors who feel encouraged by compensation to donate blood substantially outnumber donors stating they would feel discouraged. Russell Korobkin, *Buying and Selling Human Tissues for Stem Cell Research*, 49 ARIZ. L. REV. 45, 48 (2007). In another survey, 76% of New Zealand blood donors said they would continue to donate even if compensation were paid to other donors, whereas only 7% said they no longer would. *Id.* at 60. Moreover, to the extent that allowing kidney sales diminishes altruistic donations, the drop in altruistic donations will most likely be “because some former volunteers would decide to sell their organs.” CHARLES C. HINKLEY II, MORAL CONFLICTS OF ORGAN RETRIEVAL: A CASE FOR CONSTRUCTIVE PLURALISM 107 (2005). Therefore, the likely “loss” of altruistic donations resulting from a payment system would *not* result in any loss in the total number of kidneys made available to patients.

377. HINKLEY, *supra* note 376, at 107.

378. Volokh, *supra* note 29, at 1835 n.102.

379. Becker & Elias, *supra* note 3, at 22.

380. *Id.*

381. Rick Hampson, *9/11 Recruits: They Enlisted When USA Was Under Fire*, USA TODAY, Sept. 9, 2005, [http://www.usatoday.com/news/nation/2005-09-08-9-11-recruits-cover\\_x.htm](http://www.usatoday.com/news/nation/2005-09-08-9-11-recruits-cover_x.htm).

2. *The Concern that Legalizing the Sale of Kidneys Will Compromise Human Dignity.* Critics also oppose compensating kidney donors out of a reluctance to commodify the human body because doing so, they say, dehumanizes society.<sup>382</sup> The suggestion is that “the human body especially belongs in that category of things that defy or resist commensuration—like love or friendship or life itself.”<sup>383</sup> According to philosopher Immanuel Kant, “a human being is not entitled to sell his limbs for money, even if he were offered ten thousand thalers for a single finger.”<sup>384</sup> However, we already commodify our bodies all the time. We have gone so far as to determine the worth of our body parts for compensation models pertaining to accidents covered by workers’ compensation, tortious and criminal injury, and injury obtained during military service.<sup>385</sup> Admittedly, these are *post-hoc* payment systems, but we also commodify other body parts for direct sale, such as blood products, sperm, ova, skin, hair, and even saliva.<sup>386</sup> The prohibitions of NOTA do not include the sale of

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382. UNOS REPORT, *supra* note 10; Abecassis et al., *supra* note 359, at 2925; Stimson, *supra* note 77, at 360; Andrew Wancata, Note, *No Value for a Pound of Flesh: Extending Market-Inalienability of the Human Body*, 18 J.L. & HEALTH 199, 204 (2003) (referencing University of Southern California law professor Margaret Radin, who argues that “[b]y making something nonsalable we proclaim that it should not be conceived of or treated as a commodity”) (quoting Margaret Jane Radin, *Market-Inalienability*, 100 HARV. L. REV. 1849, 1855 (1987))).

383. Volokh, *supra* note 29, at 1843 (quoting Leon R. Kass, *Organs for Sale? Propriety, Property, and the Price of Progress*, 107 PUB. INT. 65, 81 (1992)); *see also* Korobkin, *supra* note 376, at 55–56 (comparing the selling of human tissue to the selling of human babies); Satel, *supra* note 26, at 64 (“Organ donation, we are told, should be the ultimate gift: the ‘gift of life,’ a sublime act of generosity. The giver—whether living or deceased—must not expect to be enriched in any way.”).

384. Noam J. Zohar, *Toward Justice in the Organ Trade*, 27 ISR. L. REV. 541, 558 (1993) (quoting IMMANUEL KANT, LECTURES ON ETHICS 124 (Louis Infield trans., 1963)) (explaining Kant’s reasoning as follows: by exchanging one’s finger to turn a profit, an individual treats him- or herself as a means only rather than as an end); *see also* JAMES STACEY TAYLOR, STAKES AND KIDNEYS: WHY MARKETS IN HUMAN BODY PARTS ARE MORALLY IMPERATIVE 16 (2005).

385. Roff, *supra* note 209, at 51 (reporting that the U.K. Criminal Injuries Compensation Authority provides victims £2,500 (\$4,848) for a fractured tailbone, £3,800 (\$7,369) for a hernia, and £22,000 (\$42,662) for the loss of a kidney; in addition, the Marshall Islands nuclear claims tribunal have paid, *inter alia*, \$75,000 for kidney cancer).

386. *See* GOODWIN, *supra* note 4, at 181 (noting that federal law forbids the sale of human organs, but not sperm and ova); Becker & Elias, *supra* note 3, at 21 (“[I]f women can be paid to host the eggs of other women and bear their children—as they can in the United States—why cannot men and women get paid for selling their organs to save the lives of others?”); Harris & Alcorn, *supra* note 10, at 213, 230–31 (revealing that there is currently a thriving market for human blood, tissue, and reproductive cells and stating that women are compensated between \$4,000 and \$35,000 for egg donations); Roff, *supra* note 209, at 51 (“The UK is one of the minority of countries that still rely on predominantly voluntary donations of blood.”); Sobota, *supra* note 12, at 1236 (“[M]arkets for human body parts already exist, specifically for blood, blood products, sperm, eggs,

human “tissues” and “cells” sold for research, commercial, or other purposes.<sup>387</sup> In fact, “[Eighty-five] percent of blood plasma donors are paid for their donations.”<sup>388</sup>

Sperm and eggs, too, are actively purchased and sold.<sup>389</sup> Reproductive fertility has become a \$3 billion industry.<sup>390</sup> Similarly, a Google search for “egg donation + compensation” returns approximately 41,500 results.<sup>391</sup> Sperm donors typically receive \$45 for a single donation or \$200 per week for six months of weekly donations, with the highest bids reaching \$15,000 for a single donation.<sup>392</sup> Ova, on the other hand, command a higher selling price due to their greater scarcity and because fewer women agree to part with their eggs without significant compensation.<sup>393</sup> Fertility centers throughout the United States compensate women an average of \$5,000 per egg donation,<sup>394</sup> and some hopeful parents pay women who possess rare and sought-after genetic traits, such as high intelligence or attractiveness, as much as \$100,000 for a single egg harvest.<sup>395</sup> In contrast, Britain

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and even human hair.”); Wancata, *supra* note 382, at 221 (identifying gametes as alienable personal property that can be bought and sold as a market commodity); Joshua Weisman, *Organs as Assets*, 27 ISR. L. REV. 610, 615 (1993) (noting that some states permit the sale of blood and blood products); Jodie Snyder, *The High Price of Women's Eggs: Young Donors Get Lucrative Offers as Couples Seek Fertility Assistance*, ARIZONA REPUBLIC, May 30, 2006, at 1A (estimating that reproductive fertility assists in roughly 50,000 babies each year). Note that some oppose even selling tissue. See HINKLEY, *supra* note 376, at 110 (“I am inclined to think that selling blood, eggs, and semen is immoral when retrieved from living persons.”).

387. U.S. CONGRESS SPECIAL REPORT, *supra* note 175, at 76. Although Congress explicitly prohibits property rights in human organs, it has made an exception in NOTA for tissues that can be replenished, such as blood and sperm. Jefferies, *supra* note 72, at 632. Similarly, nearly every state statute exempts human readily renewable tissues. See Gloria J. Banks, *Legal & Ethical Safeguards: Protection of Society's Most Vulnerable Participants in a Commercialized Organ Transplantation System*, 21 AM. J.L. & MED. 45, 73 (1995) (citing specific state statutes).

388. Arthurs, *supra* note 8, at 1108. Additionally, payment for surrogate motherhood is legal. Finkel, *supra* note 3, at 32. And, courts have even recognized that body parts can generate income. In *Hess v. Commissioner*, for example, the U.S. Tax Court allowed the stripper known as “Chesty Love” to deduct the expense of her breast implants as a “stage prop.” *Hess v. Comm’r*, No. 11036-92S, 1994 T.C.M. 88, at \*3–5 (Mar. 30, 1994).

389. Recruitment for sperm and egg donations currently appear on websites, bus kiosks, and in magazines and college newspapers. GOODWIN, *supra* note 4, at 160; Sobota, *supra* note 12, at 1242.

390. Snyder, *supra* note 386.

391. Korobkin, *supra* note 376, at 57.

392. Wancata, *supra* note 382, at 221.

393. See Debora Spar, *The Egg Trade—Making Sense of the Market for Human Oocytes*, 356 NEW ENG. J. MED. 1289, 1290–91 (2007) (discussing the reasons why women would not volunteer to donate their eggs).

394. *Id.* at 1289.

395. Korobkin, *supra* note 376, at 49; Joel Schwarz, *Women Who Have Donated Eggs Sought for National Study*, U. WASH. OFF. NEWS & INFO., Aug. 24, 2004,

currently experiences a shortage in eggs for fertility treatment exactly because donors are prohibited from receiving payment beyond reimbursement for reasonable expenses.<sup>396</sup>

Opponents of organ markets tend to point out the renewable nature of legally marketable body parts, usually referred to as tissue—in contrast to organs.<sup>397</sup> Even the U.S. legal system has adopted this position by refusing to recognize a property interest in human tissues and by treating the sale of blood products as the sale of services rather than as the sale of goods.<sup>398</sup> This distinction, however, is inaccurate at best, as some organs are renewable and some tissues are not.<sup>399</sup> For instance, a transplanted liver section grows until it reaches normal size.<sup>400</sup> And, a woman's eggs are *not* renewable; women possess only a fixed quantity of eggs.<sup>401</sup> Yet, the law permits commercial transactions involving them. Like eggs, each individual possesses a limited supply of kidneys. And donors of kidneys—like donors of eggs—continue to live full and productive lives after donation.<sup>402</sup> Moreover, should a donor's remaining kidney one day fail, a donor could replenish it in a commoditized system by obtaining an available kidney pursuant to the allocation method developed.<sup>403</sup> Thus, the kidney is effectively “renewable” through a market system.

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<http://uwnews.org/article.asp?articleID=5358>; see also Snyder, *supra* note 386 (noting that some recipients pay larger fees if the donor has high standardized exam scores or graduated from an ivy-league school); Spar, *supra* note 393, at 1289 (identifying one advertisement promising \$25,000 for eggs of a “tall, athletic woman”).

396. Spar, *supra* note 393, at 1291.

397. See, e.g., MICH. COMP. LAWS. ANN. § 333.10204 (West 2006) (excepting “whole blood, blood plasma, blood products, blood derivatives, other self-replicating body fluids [and] human hair”). Virginia legislation has grouped ova with renewable tissues and excludes them from the ban on purchasing or selling human body parts. See VA. CODE ANN. § 32.1-289.1 (repealed 2007) (excepting “hair, ova, blood, and other self-replicating body fluids”).

398. Sobota, *supra* note 12, at 1236–37.

399. *Id.* at 1236.

400. American Liver Foundation, Liver Transplant <http://www.liverfoundation.org/education/info/transplant> (last visited Jan. 31, 2009) (“Once transplanted, a piece of a healthy liver can grow into a normal-size liver.”).

401. EMILY JACKSON, REGULATING REPRODUCTION: LAW, TECHNOLOGY AND AUTONOMY 165–66 (2001) (“[E]ach woman has a finite, if large, number of eggs . . .”); Sobota, *supra* note 12, at 1227. Though females cannot generate additional ova, each female is born with a substantial number such that there is no realistic chance she will run out, even if she donates some of them. See Press Release, Letisia Marquez, UCLA Study Finds that Sperm Donors Are Less Valued than Egg Donors (May 23, 2007) (on file with Houston Law Review).

402. Arthurs, *supra* note 8, at 1109.

403. See Zohar, *supra* note 384, at 561 n.36 (“[T]he vendor could in principle buy back . . . a kidney, should the spare kidney fail.”).

Furthermore, the assertion that the sale of these tissues constitutes a service rather than a sale of property presents a false dichotomy. Those who buy sperm, eggs, blood, and any other "tissue" are interested not in the process that produced the product but, rather, desire to obtain the underlying biological material. Moreover, one can just as easily characterize the sale of a kidney as a service, wherein payment compensates for the inconvenience, time, and discomfort associated with the donation, rather than the kidney itself. This purely rhetorical distinction merely functions to justify an existing illegitimate division.

Finally, some point to the prohibitions on selling sex as a prostitute, selling oneself into slavery, or committing suicide as evidence that we restrict the commercialization of the human body.<sup>404</sup> Again, this argument is misplaced. The law prohibits prostitution and voluntary slavery not because the body or body parts are transacted, but, rather, because of a social distaste for the underlying *activity*. Indeed, the prohibition on suicide demonstrates this point, as it implicates no financial transaction at all. Of course, equating kidney sales with prostitution, slavery, and suicide woefully undervalues the social benefit of the first.

3. *The Concern for Economic "Coercion" of the Poor.* Some argue that the tantalization of remuneration will "coerce" the poor so as to foreclose them from making a truly voluntary decision to sell a kidney.<sup>405</sup> The claim, essentially, is that the poor cannot act rationally in the face of the potential for significant compensation. The argument not only demeans the ability of poor people to think for themselves, it indeed contradicts how we otherwise treat their right to make difficult decisions concerning their lives and health.

The destitute, however, often work significantly more risky and unpleasant jobs relative to the well-off. Coal mining, for instance, is dangerous and associated with reduced lifespan.<sup>406</sup> No one seriously responds that instead of allowing those with limited resources to work these jobs, only altruists or wealthy individuals

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404. See GOODWIN, *supra* note 4, at 149–50 (suggesting that opponents of a market in human organs could relate purchasing organs to buying sex from a prostitute because in both situations, the purchaser has degraded themselves); Weisman, *supra* note 386, at 616 (listing one "additional reason that has been offered" against the market in human organs idea as the fact "that human dignity must be safeguarded").

405. See Banks, *supra* note 387, at 86 ("When people are forced to sell their organs as a means to support themselves or other family members, the voluntary nature of the transplantation is tainted, if not destroyed.").

406. Korobkin, *supra* note 376, at 54.

should perform such work.<sup>407</sup> Soldiers, “coal miners, bridge builders, firemen, police, and bomb disposal experts—all take risks for differing degrees of societal benefit and financial reward.”<sup>408</sup> Similarly, we are hard-pressed to distinguish between prohibiting individuals from selling kidneys and allowing them to receive compensation for volunteering as subjects in drug trials.<sup>409</sup>

Generally, economic security inversely relates to the value potential donors place on future compensation from selling kidneys.<sup>410</sup> If the concern is that those living in poverty lack real choice because of their financial situation, a decrease in their economic prospects is ultimately unhelpful.<sup>411</sup> “Trying to end exploitation by prohibition is rather like ending slum dwelling by bulldozing slums: it ends the evil in that form, but only by making things worse for the victims.”<sup>412</sup>

Instead of restricting employment choices in risky jobs only to the well-off, the solution has been to make such work environments as clean and as safe as possible and often offering the workers a premium for undergoing the excessive risk.<sup>413</sup> For instance, the concern for unskilled laborers desperate enough to work twelve-hour days in miserable conditions for less than minimum wage led to laws that govern such employment—not

407. *Id.*

408. Berman, *supra* note 241, at 15. For instance, whereas the death rate from donating a kidney is 0.03%, the mortality rate of commercial fishing is 0.1%, steel erecting 0.041%, and roofing 0.025%. Moreover, the risk of harm from dangerous employment is many times underrepresented because employees do not always report their injuries out of fear of punishment from their employers. See TAYLOR, *supra* note 384, at 126–27, 130.

409. Relatively poor individuals are usually the ones who participate in drug trials because the procedure is inconvenient, painful, and entails some risk. Even so, public policy encourages payment to these people because of the benefits. Gill & Sade, *supra* note 4, at 34.

410. J. Radcliffe-Richards et al., *The Case for Allowing Kidney Sales, in THE ETHICS OF ORGAN TRANSPLANTS: THE CURRENT DEBATE*, *supra* note 53, at 224, 226.

You think you're telling me something? Like, what, boxing is dangerous, something like that? You don't think working triple shifts and at night on a scaffold isn't just as likely to get a man killed? What about all those guys who died last week living in cardboard shacks to save on rent money just to feed their family, 'cause guys like you have not quite figured out a way yet to make money off of watching that guy die? But in my profession—and it is my profession—I'm a little more fortunate.

CINDERELLA MAN (Universal Pictures 2005) (quoting Russell Crowe as he portrays depression-era heavyweight Jim Braddock).

411. See Radcliffe-Richards et al., *supra* note 410, at 225–26 (“If our ground for concern is that the range of choices is too small, we cannot improve matters by removing the best option that poverty has left, and making the range smaller still.”).

412. *Id.* at 226.

413. Korobkin, *supra* note 376, at 54.

the prohibition of it, which would leave these people worse off.<sup>414</sup> Such regulations are part of a larger scheme to get those in poverty hired at jobs with minimally decent conditions and, until then, to provide welfare and job training.<sup>415</sup> While certainly not perfect, the system aims to expand opportunities, not eliminate them. And the same could be designed for kidney sales programs, so as to guarantee donors a minimum level of safety and compensation, meaning "reasonable" people of any income level could support the decision to donate.<sup>416</sup>

Moreover, there is a philosophical difference between donating a kidney in response to an offer as a means for earning needed income and donating a kidney in response to coercive threats.<sup>417</sup> Whereas threats resemble anything but a true offer because they constrict a person's range of options, offers of income actually enhance freedom.<sup>418</sup> With an offer, the force compelling the donor or laborer to act is not the offer itself, but rather the alternative of remaining in a grim environment with a scarcity of opportunities.<sup>419</sup> Accordingly, allowing people to sell their kidneys does not coerce them because it *broadens* rather than *restricts* their options.<sup>420</sup> Offering people money to make a choice they would not otherwise make is not coercive,<sup>421</sup> it is why most people demand compensation for employment. Simply, the joy of the act alone does not suffice to motivate individuals to perform. The payment acts as an additional, if not the only, incentive. Where uncompensated donors must decide whether the benefit of extending the life of another person justifies the inconveniences and risks of undergoing surgery and continuing life with only one kidney, compensated donors simply undertake

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414. Gill & Sade, *supra* note 4, at 34.

415. *Id.*

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If the rich are free to engage in dangerous sports for pleasure, or dangerous jobs for high pay, it is difficult to see why the poor who take the lesser risk of kidney selling for greater rewards—perhaps saving relatives' lives, or extricating themselves from poverty and debt—should be thought so misguided as to need saving from themselves.

Finkel, *supra* note 3.

417. Zohar, *supra* note 384, at 554.

418. *Id.*

419. *Id.*

420. See TAYLOR, *supra* note 384, at 52.

421. See Korobkin, *supra* note 376, at 51 ("As long as the donor is fully informed of the risks and inconveniences involved and may choose to make the donation or not, the decision is an equally voluntary one in both cases.").

the same analysis with the additional consideration of receiving payment.<sup>422</sup>

Interestingly, the data regarding women who choose to sell their eggs shows that they are not typically poor, and the amount they receive for each donation does not suggest an “undue inducement to undergo the medical risks involved.”<sup>423</sup> While this analogy is not perfect—because I suspect that purchasers of eggs often incorrectly associate the genetic makeup of the donors with their social status—we, as a society, nonetheless, do not object morally or legally to women undertaking the complex and painful process of egg donation. Unfortunately, when someone “needs” money, critics hold suspect his decision to sell biological material, but when others do not “need” the money, critics presume valid their decisions. In the latter case, the “need” or incentive must be great enough to motivate the transaction; otherwise, the act would have been done for free. Further, if the latter does not “need” the remuneration, we could perhaps conclude that the compensation would be disposed of on less critical expenditures. By this analysis, we should be *more* willing to allow the individual in true “need” to undertake the “risky” behavior than the one seeking to make the more frivolous purchase with the proceeds.

We must further not ignore that our current altruistic system already suffers from forces that critics should recognize as at least equally as “coercive” as financial incentives. Specifically, social forces may influence the decision to donate one’s organ, whether for compensation or not. For example, related donors may feel significant pressure from family members to “donate” a kidney for a family member in kidney failure.<sup>424</sup> While one who receives financial compensation may feel the pressure from his or her economic situation to part with a kidney, the individual moved by “altruistic” motives might be equally constrained.<sup>425</sup>

For example, the director of renal transplantation at Massachusetts General Hospital, Francis Delmonico, faced an “altruistic donor” who had written that he shouldered the burden of severe pressures from a family member to donate part of his liver to his only sibling.<sup>426</sup> The circumstance saddled his

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422. *Id.*

423. Sobota, *supra* note 12, at 1245–46.

424. See Korobkin, *supra* note 376, at 53 (“[P]otential donors might perceive that a refusal to donate will be punished with social ostracism.”).

425. Kunin, *supra* note 298, at 270; Weisman, *supra* note 386, at 617.

426. Brian Vastag, *Living-Donor Transplants Reexamined: Experts Cite Growing*

family with unbearable strains.<sup>427</sup> Not wishing to back family members into a corner to donate, some renal patients would much prefer the anonymity offered by a market system for kidneys.<sup>428</sup> Similarly, there are the cases of “a daughter who competed with her own mother to be the rescuer of another family member and a woman who told researchers that her motive for wanting to give a kidney to a stranger was to become ‘Daddy’s good girl.’”<sup>429</sup> “Then there is the ‘black-sheep donor,’ a wayward relative who shows up to offer an organ as an act of redemption, hoping to reposition himself in the family’s good graces. For others, donation is a sullen fulfillment of familial duty, a way to avoid the shame and guilt of allowing a relative to suffer needlessly and even die.”<sup>430</sup> In *McCall v. Shimp*, a cousin sought court intervention to compel his cousin to donate his bone marrow because he happened to be the only suitable donor for the transplant.<sup>431</sup> Indeed, the potential of donor “coercion” remains a crucial concern, particularly among spousal donors.<sup>432</sup>

If, however, a market eliminated the kidney shortage, then the family member could opt against donating her kidney and allow the relative to obtain it through the distribution mechanisms put into place for the market system.

Similarly, recipients often prefer to receive a kidney without having to use this social “coercion.” Recipients typically abhor the need to beg friends and relatives to donate.<sup>433</sup> Moreover, recipients often prefer *not* to maintain a relationship with the donor due to the desire to not feel an uncomfortable sense of obligation to the donor.<sup>434</sup> A commercial process would be near anonymous, if not completely anonymous, depending on the

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*Concerns About Safety of Donors*, 290 J. AM. MED. ASS’N 181, 182 (2003).

427. *Id.*

428. “I wanted my donor to be completely anonymous so I could avoid the treacherous intimacy of accepting an organ from someone I knew,” remarked one renal patient struggling to find a kidney donor. Satel, *supra* note 26, at 64.

429. *Id.* at 65.

430. *Id.*

431. *McFall v. Shimp*, 10 Pa. D. & C.3d 90, 90–91 (Pa. Com. Pl. 1978); *see also* *Curran v. Bosze*, 566 N.E.2d 1319, 1345 (Ill. 1990) (holding, similarly to *McFall*, that family members may not compel an individual to act altruistically).

432. Soulillou, *supra* note 149, at 379 (some jurisdictions, such as France, prohibit spousal donors); Terasaki, *supra* note 148, at 336 (spousal donations have an excellent success rate).

433. Telephone Interview with Sally Satel, M.D., Kidney transplant patient and advocate for creating a market for the purchase of kidneys, in Washington, D.C. (Jan. 22, 2008).

434. *Id.*

system developed.<sup>435</sup> This would benefit both donor and recipient by allowing each to feel free of any sense of obligation.<sup>436</sup>

Two related concerns involve the potential for (1) short-lived economic benefits from selling a kidney;<sup>437</sup> and (2) rash decisionmaking in deciding to sell a kidney. Although ninety-six percent of participants in a study involving 305 paid kidney donors from India admitted undergoing the surgery to pay off debt,<sup>438</sup> only one-quarter of them succeeded in doing so within six years after the operation.<sup>439</sup> “The people who give their kidneys spend all the money at once. Then afterwards they cannot work properly,” said a kiln owner in India whose workers are targeted for kidney donations.<sup>440</sup> Simple procedures, however, could vitiate the concerns that transient economic needs or desires will drive the decision to sell a kidney or that the donors will frivolously dispose of the resultant income.

For example, donors could receive payment in the form of annuities, compensation could be limited to noncash payments, such as tuition reimbursement, or payment could be deferred through contributions to a retirement account.<sup>441</sup> Similarly, we can “(1) set a minimum sum for kidneys; (2) prohibit [poor] persons . . . from being sellers; (3) only allow federally licensed agencies to buy kidneys; (4) impose a six-month waiting period . . . and permit sellers to rescind the agreement at any time; (5) require sellers to be [a minimum] . . . age; and (6) require” medical screening and independent oversight.<sup>442</sup> These devices appear paternalistic. They are, in part. But this

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435. *Id.*

436. *Id.*

437. GOODWIN, *supra* note 4, at 203 (commenting that among the false and harmful stereotypes of certain historically disadvantaged groups is that they are unable to responsibly manage large amounts of money); Goyal et al., *supra* note 3, at 1591 (noting that most of the money kidney donors receive in payment for the donation is spent on debt, food, and clothing).

438. Goyal et al., *supra* note 3, at 1591.

439. Walsh, *supra* note 223.

440. *Id.*

441. Telephone Interview with Sally Satel, *supra* note 433.

442. HINKLEY, *supra* note 376, at 111 (internal citation omitted); *see also* R.R. v. M.H., 689 N.E.2d 790, 796–97 (Mass. 1998) (holding that a surrogacy contract was void because contrary to public policy, the “agreement was induced by the payment of money,” and the mother was not given a reasonable amount of time after the birth of her child to reflect on her decision to part with the child); Banks, *supra* note 387, at 87 (“Organ providers in a commercial market should . . . be required to undergo a physical examination to verify that they are healthy and that the proposed organ transplant will not cause their death or an unreasonable diminished capacity of life.”); Posting of Gary Becker, *supra* note 162 (noting long waitlists drive family members to make impulsive decisions regarding emergency organ donation).

paternalism is certainly less than that of wholly prohibiting kidney sales. Thus, all else being equal, this is a Pareto improvement.

Critics thereafter express a legitimate apprehension that if a market for the purchase of kidneys is allowed, creditors might require debtors to sell a kidney.<sup>443</sup> The concern that “[a] man with a \$50,000 kidney, like a man with \$50,000 in the bank, would not qualify for welfare”<sup>444</sup> reflects similar considerations. These issues, however, are easily addressed. The legislation legalizing kidney sales could easily prohibit creditors from considering debtors’ kidneys’ value, and the same for government evaluation of applicants’ qualification for welfare and similar programs. Indeed, statutes routinely do this for much more mundane assets. For example, many states have a homestead exemption for bankruptcy petitioners, such that creditors can reach neither a debtor’s home nor the proceeds of its sale.<sup>445</sup> Under any reasonably designed legal kidney sale regime, no person would ever be compelled by law to sell a kidney, nor would qualifying for any government services require an applicant to do so.

“Selling organs does involve an ethical problem [regarding the poor], but it is one that relates to the general society and not to the individual buyer or seller.”<sup>446</sup> “It [may] reflect poorly on a society that it allows a person to reach such a desperate state that he [or she] must sell an organ to get out of financial debt or obtain necessary medical services; but outlawing such sales will not correct the underlying social inequities.”<sup>447</sup> Wishing away unpleasant choices does nothing to help the people who are in the position to make those choices.

*4. Distributional Concerns.* One of the most common objections to selling kidneys argues that such a system would allow the rich to exploit the poor<sup>448</sup> because “the poor will both give too many of their organs, and not have access to transplants.”<sup>449</sup> Accordingly, a Congressional Special Report

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443. See TAYLOR, *supra* note 384, at 61.

444. Bernard M. Dickens, *Morals and Legal Markets in Transplantable Organs*, 2 HEALTH L.J. 121, 130 (1994).

445. See, e.g., *In re Bading*, 376 B.R. 143, 146 (Bankr. W.D. Tex. 2007).

446. Grazi & Wolowelsky, *supra* note 168, at 187.

447. *Id.*

448. Radcliffe-Richards et al., *supra* note 410, at 224. Donor exploitation is “the single most important and widely deployed moral concept in the body commodification debate.” Watkins, *supra* note 12, at 33 (quoting WILKINSON, *supra* note 235, at 1).

449. Posting of Gary Becker, *supra* note 162; see also Weisman, *supra* note 386, at 616 (discussing the argument that creating a free market for organs in which the bodies of

states the objection that organs would be sold by the poor only for the benefit of the rich<sup>450</sup>—with the costs borne exclusively by the poor.<sup>451</sup> For example, Nancy Scheper-Hughes, an anthropologist who studies international kidney sales, argues that allowing compensation for organ sales permits “one relatively privileged population [to] claim property rights over the bodies of the disadvantaged.”<sup>452</sup> But, the critical error in this reasoning is that even if individuals have the opportunity to be *paid* for kidneys, it does not follow that transplant recipients may *buy* kidneys on the open market.<sup>453</sup> These represent two distinct issues. A regulated system to buy kidneys, as discussed below, could be coupled with a distribution scheme modeled after the existing method currently employed by UNOS. One critical distinction, however, of a kidney-for-sale system is that, while UNOS would continue matching donors with recipients (this time living donors),<sup>454</sup> and the payments would come from insurance schemes, the waitlist for kidneys would likely be eliminated.

This discussion, however, raises a related concern about the distributional equity of selling kidneys—whether permitting kidney sales would actually create distributional benefits to the historically underprivileged. Interestingly, permitting the sale of kidneys will likely offer minorities greater access to kidneys.

Positive blood and antigen matching are more likely to occur when the transplant donor and recipient are ethnically similar.<sup>455</sup> As a consequence, African Americans wait longer on the national organ waitlist than any other ethnic group and are the most likely to die while on the list (before ever receiving the anticipated organ).<sup>456</sup> In fact, they wait twice as long for a donor

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the poor will be used as a stockpile of parts to supplement the bodies of the rich should be prevented even in cases where the poor have given their consent).

450. U.S. CONGRESS SPECIAL REPORT, *supra* note 175, at 76.

451. See GOODWIN, *supra* note 4, at 197 (propounding the concern of commentators that in an organ market, while African Americans would comprise the majority of donors, European Americans would make up a large number of the recipients); Stimson, *supra* note 77, at 363 (acknowledging the argument that organ solicitation will benefit those with the most money); see also Jeffrey P. Kahn, *Is There a Difference Between Selling Eggs and Selling Kidneys?*, CTR. FOR BIOETHICS, May 1998, [http://www.bioethics.umn.edu/publications/ethics\\_matters.html](http://www.bioethics.umn.edu/publications/ethics_matters.html) (expressing concern about the exploitation of potential donors).

452. Friedman & Friedman, *supra* note 5, at 961 (quoting National Organ Transplant Act, Pub. L. No. 98-507, 98 Stat. 2339 (1984)).

453. Gill & Sade, *supra* note 4, at 19.

454. See *supra* note 129 and accompanying text.

455. GOODWIN, *supra* note 4, at 199; Gaston et al., *supra* note 53, at 312 (“It is clear that profound racial differences exist in antigen expression.”).

456. GOODWIN, *supra* note 4, at 44–45.

kidney as European Americans do.<sup>457</sup> African-American candidates receive a perfectly matched kidney only about one-tenth as often as European-American candidates do.<sup>458</sup> The waiting period for Hispanics and Asians is only slightly less troubling than for African Americans.<sup>459</sup> As a consequence, minorities frequently lack the opportunity to receive a transplant in the current altruistic system.<sup>460</sup>

The significance OPTN places on HLA matching limits racial minorities from accessing all but a very small portion of the kidney pool.<sup>461</sup> OPTN still prioritizes HLA matching due to the belief that antigen similarity between recipient and living related transplant donor increases the chance for graft survival,<sup>462</sup> notwithstanding recent evidence suggesting that the graft survival rate does not fluctuate significantly depending on the severity of antigen mismatch.<sup>463</sup> While matching “is very important, [it becomes] less important by the effective use of anti-rejection drugs.”<sup>464</sup> This issue is subject to much debate.<sup>465</sup> And, while other patients at high risk for antigen mismatch often receive equity points that level the playing field by improving access to renal transplantation despite their greater risk for graft loss, African-American patients often do not.<sup>466</sup> This is particularly important because the need for transplant kidneys among the African-American population is more disparate relative to European Americans than for any other organ.<sup>467</sup> Yet, kidneys are the only organs for which OPTN strongly favors HLA

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457. *Id.* at 45.

458. *Id.* at 103.

459. Asians wait approximately 1,550 days for an organ transplant, while Latinos wait for about 1,357 days. *Id.* at 45.

460. Goodwin, *supra* note 6, at 331.

461. Gaston et al., *supra* note 53, at 312 (“[U]sing HLA matching to allocate kidneys from a predominantly Caucasian donor population favors the Caucasian recipients and places . . . blacks at a disadvantage.” (quoting V.A. Lazda & M.E. Blaesing, *Is Allocation of Kidneys on Basis of HLA Match Equitable in Multiracial Populations?*, 21 *TRANSPLANT PROC.* 1415, 1416 (1989))).

462. *Id.* at 314.

463. *Id.*

464. GOODWIN, *supra* note 4, at 97 (quoting Telephone Interview with Jack Lynch, Community Affairs Director, Gift of Hope (July 7, 2005)). UNOS awards points to candidates based on HLA matching under the theory that it reduces the risk of organ rejection. However, advancements in antirejection medicines make this reasoning less persuasive. *Id.* at 97–99.

465. *Id.* Some doctors argue that 80% of African Americans could receive a kidney transplant from the general population. Goodwin, *supra* note 6, at 355.

466. Gaston et al., *supra* note 53, at 316–17.

467. *Id.* at 308.

matching as part of the allocation criteria.<sup>468</sup> “By doing so, Blacks are institutionally shut out in an altruistic system based on genetic or biological criteria that they could not possibly overcome”<sup>469</sup> however invalid those concerns may remain given advances in anti-rejection drugs.

Moreover, African Americans disproportionately suffer from ESRD; whereas African Americans make up approximately twelve percent of the general population, they represent thirty-four percent of patients waiting to receive a kidney transplant.<sup>470</sup> And even though African Americans currently represent thirty-four percent of patients suffering from ESRD in need of a kidney transplant, they make up only about twelve percent of all organ donors.<sup>471</sup> This mismatch particularly impacts the African-American community because, as discussed, the OPTN effectively requires that many African Americans receive a kidney from another African American in order to qualify for a transplant in the current altruistic system.

Therefore, while there is apprehension that offering payment to kidney donors will exploit historically underprivileged members of society, converting from the altruistic model to a market organ system may actually help alleviate some of the allocation inequities currently existing along ethnic lines under UNOS policies.<sup>472</sup> Because positive blood and antigen matching frequently occurs when the transplant donor and recipient are ethnically similar, African Americans would likely benefit from a kidney-for-sale system.<sup>473</sup>

5. *The Concern that Legalizing the Sale of Kidneys Will Result in a Decrease in Kidney Quality.* Another concern is that allowing payments for kidneys would increase the number of

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468. GOODWIN, *supra* note 4, at 97–98. The UNOS ranking system at one time gave points equally to patients for “time waiting, antigen matching, antibody analyses, medical urgency, and logistic practicality.” However, the UNOS Board “subordinated all other factors of kidney allocation (including credit for time waiting) to HLA matching.” *Id.* at 98 (quoting Thomas E. Starzl & John J. Fung, *The Politics of Grafting Cadaver Kidneys*, 348 LANCET 454, 454–55 (1996)).

469. Goodwin, *supra* note 6, at 352.

470. Gaston et al., *supra* note 53, at 313. Nationally, African Americans represent 34% of patients with ESRD, but only 12% of the general population. In Alabama, African Americans represent 65% of patients on the waitlist for a kidney transplant, but only 24% of the general population. *Id.*

471. GOODWIN, *supra* note 4, at 105.

472. *See id.* at 198 (revealing that biological materials benefiting all ethnic groups are sold throughout the United States everyday).

473. *Id.* at 199.

poor-quality organs by attracting unhealthy donors.<sup>474</sup> Critics argue that “persons who do not now choose to donate their organs but who would respond to financial incentives to sell those organs would, on average, have organs of lower quality than those now donated.”<sup>475</sup>

This contention remains highly questionable. Living-donor transplant kidneys already must be screened because even charitable donors might carry unhealthy kidneys and disease, and cadaveric kidneys are donated by virtually anonymous donors.<sup>476</sup> Moreover, even if the concern proved valid, the economic incentive would likely improve screening. Blood screening was less stringent when blood banks sought to avoid paying blood donors,<sup>477</sup> and fertility clinics test the sperm and ova they buy—in part out of a fear of legal liability.<sup>478</sup>

Moreover, because compensating donors would increase the number of kidneys available for transplants, this could actually *improve* the average quality of transplants.<sup>479</sup> As a result of the enormity of the waitlist today, UNOS greatly relaxed the standards for qualifying kidneys. With a greater supply, UNOS could discard the suboptimal kidneys that it currently accepts for transplantation.

6. *The Concern that Legalizing the Sale of Kidneys Will Result in Excessive Risk to Kidney Sellers.* Some express a concern that kidney sellers expose themselves to inordinate risk.<sup>480</sup> However, it is inconsistent to oppose offering donors

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474. Weisman, *supra* note 386, at 616.

475. Robinson, *supra* note 71, at 1043 (quoting Gregory S. Crespi, *Overcoming the Legal Obstacles to the Creation of a Futures Market in Bodily Organs*, 55 OHIO ST. L.J. 1, 21 (1994)).

476. See Beard & Kaserman, *supra* note 3, at 838 (noting that transplant centers test and examine organs to assess organ quality before transplanting the organ into a patient); Weisman, *supra* note 386, at 617 (“[T]he risk involved in people selling unhealthy body parts can be contained by means of thorough medical examination of the ‘donors.’”).

477. See Ronald E. Doman, *Paid-Versus-Volunteer Blood Donation in the United States: A Historical Review*, 9 TRANSFUSION MED. REVS. 53, 55–56 (1995) (noting increased screening of paid donors and that blood from some paid-donor banks was of higher quality than that from full-volunteer donor banks).

478. See U.S. CONGRESS SPECIAL REPORT, *supra* note 175, at 77 (“Insemination with sperm containing a genetic defect could . . . result in substantial liability.”).

479. Andrew H. Barnett et al., *Improving Organ Donation: Compensation Versus Markets*, in THE ETHICS OF ORGAN TRANSPLANTS: THE CURRENT DEBATE, *supra* note 53, at 208, 215; see also *supra* text accompanying note 161 (noting that the shortage of kidneys has resulted in doctors accepting “marginal” kidneys).

480. See Banks, *supra* note 387, at 82–83 (“Safeguards are needed to protect vulnerable organ participants . . .”); Radcliffe-Richards et al., *supra* note 410, at 225–26 (introducing and addressing arguments made that organ sellers are exposed to excessive

payment for risking their health when the highly esteemed altruistic-donor system presents exactly the same risk.<sup>481</sup> If the risks associated with donating a kidney are so great that society believes taking the risk would make donors worse off despite receiving compensation for the risk and inconvenience, then it logically follows that the risks must also be too great for unpaid donors to accept.<sup>482</sup> Offering payment does not make the transplant any more dangerous.<sup>483</sup> Even some opponents of a kidney-sale system concede that they cannot “plausibly argue that retrieving organs from living sellers is too risky.”<sup>484</sup>

A donor’s risk of perioperative mortality is only about 0.03%,<sup>485</sup> much lower than other high-risk, but perfectly acceptable, activities for people to engage in such as “mining, construction work, or deep sea diving.”<sup>486</sup> “[R]isk-conscious insurance companies do not raise their rates for kidney donors,”<sup>487</sup> under the recognition that donating (or selling) a kidney is not considered a significant risk. The paired existence of kidneys in the donor’s body creates a reserve capacity with functioning far exceeding what the body needs to filter waste, such that removal of one kidney imposes a very low risk to the donor’s health.<sup>488</sup> In fact, the surgical procedure for removing a kidney equals roughly the same risk to the donor as any basic operation.<sup>489</sup> Two to three percent of kidney donors experience serious, but temporary, injury as a result of the nephrectomy, the most common health complications being minor wound

risks); Weisman, *supra* note 386, at 616 (arguing that a person cannot truly consent to selling a kidney for economic reasons).

481. Gill & Sade, *supra* note 4, at 21–22.

482. Beard & Kaserman, *supra* note 3, at 835.

483. Watkins, *supra* note 12, at 30–31.

484. HINKLEY, *supra* note 376, at 110.

485. TAYLOR, *supra* note 384, at 126; Anderson, *supra* note 28, at 280–81 (stating that “[a]bout twenty people are thought to have died as a direct consequence of donating a kidney”); Kunin, *supra* note 298, at 269 (noting that a kidney donation from a healthy person is “well accepted medically because it entails extremely low risk to the donor”); Levey et al., *supra* note 69, at 50 (reporting that donor death during a nephrectomy is extremely rare, occurring in just 0.03% of operations, that is, in one out of 3,200 donors); Matas et al., *supra* note 143, at 435 (identifying pulmonary embolism as the most common cause of the deaths associated with kidney donation).

486. See Watkins, *supra* note 12, at 31.

487. HINKLEY, *supra* note 376, at 110 (quoting David Rothman, *The International Organ Traffic*, N.Y. REV. BOOKS, Mar. 26, 1998, at 15).

488. Halperin, *supra* note 39, at 45; see also Kunin, *supra* note 298, at 270 (citing minimal risks of kidney removal).

489. See Halperin, *supra* note 39, at 47 (noting that the danger to donors “does not substantially exceed . . . the small risks of . . . a simple operation”); *Psst, Wanna Buy a Kidney?*, *supra* note 10, at 15 (assuring that removing a kidney is at least as safe as liposuction).

infections, pulmonary and urinary tract infections, and low-grade fever.<sup>490</sup> Donors are typically discharged from the hospital within four days after the procedure and are able to return to work within six weeks.<sup>491</sup> In addition, long-term follow-up studies contradict anecdotal reports alleging that living kidney donors experience increased rate of renal failure.<sup>492</sup> In fact, properly screened kidney donors appear to outlive the average person with two kidneys.<sup>493</sup> A large-scale study just released concludes that

the life span of kidney donors is similar to that of persons who have not donated a kidney. The risk of ESRD does not appear to be increased among donors, and their current health seems to be similar to that of the general population. These outcomes may be a direct consequence of the routine screening of donors for important health conditions related to kidney disease at the time of donation.<sup>494</sup>

Donor risks could be reduced even more if transplant centers would implement stricter donor screening guidelines and take more thorough prophylactic measures.<sup>495</sup> And the very best way to ensure donor safety is to decriminalize kidney sales so that donors and recipients no longer feel compelled to transact kidney

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490. Levey et al., *supra* note 69, at 50; Matas et al., *supra* note 143, at 435.

491. Matas et al., *supra* note 143, at 435.

492. *Id.*; see also Kunin, *supra* note 298, at 270 (noting that in a twenty-year follow-up study of kidney donors, indications of possible renal disease, including abnormal creatinine clearance, hypertension, and proteinuria, were comparable with that of donors' siblings).

493. *Psst, Wanna Buy a Kidney?*, *supra* note 10, at 15.

494. Hassan N. Ibrahim, *Long-Term Consequences of Kidney Donation*, 360 *NEW ENG. J. MED.* 459, 466-67 (2009).

Kidney transplantation, particularly from a living donor, is the treatment of choice for most patients with end-stage renal disease (ESRD). The superior results achieved with kidney transplantation from living donors have resulted in an increase in this method of transplantation.

The life expectancy of kidney donors appears to be similar to that of nondonors or perhaps even longer, as suggested by one study. However, at least two reports have described donors in the United States who were subsequently placed on the waiting list for kidney transplantation. Although the risk of ESRD among donors does not appear to be increased, and although cross-sectional studies have reported no major elevations in serum creatinine levels for up to 30 years after donation, such studies estimated the glomerular filtration rate (GFR) from the serum creatinine concentration, and the length of the follow-up period and the number of subjects studied were relatively limited. The present study ascertained vital status and the risk of ESRD in a large number of kidney donors and compared their health status with that of controls. To overcome the limitations of previous studies, kidney function was formally assessed by measurement of the GFR and urinary albumin excretion in 255 donors who had donated kidneys 3 to 45 years before the study began.

*Id.* at 460 (internal citations omitted).

495. Watkins, *supra* note 12, at 30.

transplants underground.<sup>496</sup> This would allow kidney sales to avoid the generally lower-quality medical facilities of less-developed countries, where patients are often presented with risks that they could readily avoid in American hospitals.<sup>497</sup>

#### IV. PROPOSED NATIONAL KIDNEY-SALES SYSTEM

The demand curve for kidneys is highly price-inelastic,<sup>498</sup> particularly given that: (1) patients generally have government or private insurance that substantially covers most ESRD treatment; (2) untreated ESRD is fatal; and (3) patients recognize that dialysis is not a viable long-term treatment. As a consequence, the shortage of available kidneys is supply-side. Preventing kidney sales, which effectively caps the purchase price at zero, dramatically reduces that supply.<sup>499</sup> In fact, while many people might not be motivated by payment to donate a kidney, sales from only slightly more than half of 0.1% of healthy Americans between sixteen and sixty-five would completely eliminate the waitlist.<sup>500</sup> And once the current backlog of patients needing a kidney transplant has been eliminated, only the far smaller number of new kidney-transplant patients would need to be cleared each year.<sup>501</sup>

To demonstrate this point, simply compare America's transplant kidney shortage to human egg shortages for fertility treatments in other countries. In England, for example, where statute caps donor payment for eggs at £250, recipients wait years.<sup>502</sup> In Australia, where the law prohibits paying donors for eggs, recipients wait for approximately five years.<sup>503</sup> However, in America, where women receive a market price for their eggs, which averages between \$5,000 and \$15,000, no waitlist exists at

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496. *Id.*

497. Telephone Interview with Sally Satel, *supra* note 433.

498. See Becker & Elías, *supra* note 3, at 18–19 (“[O]nce a market for organs is in place, the actual demand would surpass present demand . . .”).

499. Volokh, *supra* note 29, at 1833.

500. *Psst, Wanna Buy a Kidney?*, *supra* note 10, at 15; see also Volokh, *supra* note 29, at 1834 n.98 (“[E]ven if the prospect of payment motivates only 0.01% of adult Americans to sell an organ each year, that would still bring an extra 25,000 organs into the system every year—likely enough to clear out the waiting list.”).

501. Kaserman, *supra* note 115, at 572.

502. See Posting of Eugene Volokh to The Volokh Conspiracy, Medical Self-Defense and the Risk that Compensation for Organs Will Drive Away Volunteers, [http://volokh.com/archives/archive\\_2006\\_11\\_12-2006\\_11\\_18.shtml](http://volokh.com/archives/archive_2006_11_12-2006_11_18.shtml) (Nov. 14, 2006, 18:20 PST).

503. *Id.*

all.<sup>504</sup> Simply, price caps create supply-side shortages.<sup>505</sup> Moreover, given the presence of public and private insurance, and the gravity of the need for kidneys for ESRD patients, the shortfall of available kidneys is not typically a function of ability or willingness to pay—it is a consequence of an insufficient number of donors willing to provide kidneys without any compensation.

Iran has legalized the sale of kidneys,<sup>506</sup> making it the only country in which the opportunity to receive a kidney transplant is open to all patients, regardless of their economic status or educational background.<sup>507</sup> The waitlist there for kidneys has been completely eliminated,<sup>508</sup> which is especially significant because the Iranian theocratic government, perhaps ironically, has outlawed cadaveric kidney donations.<sup>509</sup> Between 1988 and 2000, the Iranian government procured more than 8,400 organs from living, nonrelated donors.<sup>510</sup> This model is a state-sponsored transplantation program<sup>511</sup> through which transactions are supervised by an officially approved patients' organization.<sup>512</sup> There are no middlemen and the transaction is transparent.<sup>513</sup> Donors receive between \$2,000 and \$4,000 for each kidney.<sup>514</sup> Whereas Iranian transplant surgeons were shunned by the international medical community just a few years ago, now they receive invitations to major conferences around the world and publish their findings in peer-reviewed journals.<sup>515</sup>

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504. *Id.*

505. See Abecassis et al., *supra* note 359, at 2925 (noting that the reason for considering monetary payment for live organ donations would be to increase supply); Rohter, *supra* note 9 (stating that some "transplant surgeons . . . believe that a good way to remedy the shortage of organs would be to offer payments"); see also Friedman & Friedman, *supra* note 5, at 961 (reporting that some transplant surgeons believe that a regulated system of selling kidneys would prevent as many as 100,000 deaths each year).

506. *Psst, Wanna Buy a Kidney?*, *supra* note 10, at 15.

507. Daar, *supra* note 9, at 600.

508. Daar, *supra* note 9, at 600; *Psst, Wanna Buy a Kidney?*, *supra* note 10, at 15. This is true despite the insistence by Muslim authorities that cadaveric organs may be used for transplants only if the deceased agreed in advance to the donation. Chris Hedges, *Egyptian Doctors Limit Kidney Transplants*, N.Y. TIMES, Jan. 23, 1992, at A5.

509. Becker & Elías, *supra* note 3, at 12 (stating that the Iranian government outlawed cadaveric kidney donations because they say the Koran does not permit it).

510. TAYLOR, *supra* note 384, at 176.

511. Daar, *supra* note 9, at 600 ("The Iranian model [implements a] state-sponsored, transparent, noncommercial, middleman-free kidney transplantation, whereby donors are paid by a government-sponsored agency . . .").

512. *Psst, Wanna Buy a Kidney?*, *supra* note 10, at 15.

513. Daar, *supra* note 9, at 600.

514. *Psst, Wanna Buy a Kidney?*, *supra* note 10, at 15.

515. Daar, *supra* note 9, at 600.

Iran is not the only example. Israel is currently considering whether to compensate people for donating their organs.<sup>516</sup> A bill before the Knesset—the Israeli parliament—proposes allowing organ donors to receive payment in exchange for providing a kidney for a lifesaving transplant.<sup>517</sup> The protocol would order the Israeli National Transplant Center, rather than the recipient, to pay the donor so that individuals of all economic backgrounds have an equal opportunity to receive unrelated donor kidneys.<sup>518</sup> Israeli national health insurance already pays the cost for foreign transplants—which often includes payment for organ donations.<sup>519</sup>

Based on this economic analysis and with these examples as a reference point, I propose a UNOS-controlled kidney-procurement compensation system (the “UNOS-Procurement System”).<sup>520</sup> Specifically, the UNOS-Procurement System contains the following features:

1. Empower UNOS—and only UNOS—to purchase kidneys from donors at a market price above a statutorily set minimum.
2. Restrict directed donations to related donors and those with an existing relationship to the recipient.
3. Provide payment over several years.
4. Provide donors lifetime government-funded supplemental health insurance.
5. Impose a minimum waiting period that a potential donor would have to wait before selling kidney.
6. Permit sellers to rescind the agreement at any time before surgery.
7. Require sellers to be a minimum age.
8. Require medical screening and independent oversight.

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516. *Id.* at 600–01.

517. *Id.*; see also Grazi & Wolowelsky, *supra* note 168, at 185 (stating that for the first time, the Israel Health Ministry is preparing legislation that would allow payment to be given to kidney donors).

518. Grazi & Wolowelsky, *supra* note 168, at 187.

519. Andrew Batson & Shai Oster, *Change of Heart: China Reconsiders Fairness of Transplant Tourism*, WALL ST. J., Apr. 6, 2007, at A1.

520. Of course, my proposal employs elements from many other proposals. See, e.g., Banks, *supra* note 387, at 86 (arguing for a twenty-four hour waiting period for organ donations); Finkel, *supra* note 3, at 52 (discussing foreign countries, in particular Iraq, with successful organ sale markets); Posting of Gary Becker, *supra* note 162 (calling for a market-determined organ price system).

9. Prohibit creditors from considering the value of debtors' kidneys—essentially a “homestead exemption” for kidneys.
10. Exempt the potential value of kidneys from government evaluation of applicants' qualification for welfare and similar programs.

A. *Empower UNOS—and Only UNOS—to Purchase Kidneys*

Arguments opposing a market system for selling transplant kidneys commonly employ the invalid assumption that if donors can sell kidneys, then potential recipients can buy kidneys directly from them.<sup>521</sup> This need not be the case. For example, in the existing system for supplying blood products, donors sell blood products to blood banks, but recipients do not buy blood products directly from donors. Of course, since we generally do not have a shortage of blood products—*because* we supplement the altruistic system with a compensation regime—individuals generally do not even seek to buy blood products privately.

Under the UNOS-Procurement System, kidneys would be traded in a regulated market—like blood products—where, even though kidney donors are paid, recipients could *not* buy kidneys from donors. Since ESRD patients would not face shortages in a kidney-sale regime given that the market would clear any shortages, patients would have no need or motive to purchase kidneys outside the regulated system. The problem of allocating organs according to the relative economic ability of the patient simply would no longer present an issue in a regulated market wherein an agency acquires transplant kidneys and allocates them according to patient need.<sup>522</sup>

Under the UNOS-Procurement System, live-donor kidneys would be allocated no differently than cadaveric organs—UNOS would distribute them by the quality of the donor-patient match and the immediacy of the patient's need.<sup>523</sup> As a consequence,

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521. See Gill & Sade, *supra* note 4, at 19 (proposing that federal agencies, rather than individual recipients, could be responsible for paying kidney donors).

522. See Volokh, *supra* note 29, at 1840 (“Such a system would actually *decrease* the advantages rich patients have.”).

523. Gill & Sade, *supra* note 4, at 19 (observing that the system for allocating blood products is similar; a donor may receive compensation for helping to provide blood products, but the recipient is chosen regardless of his or her economic status); see also Finkel, *supra* note 3, at 31 (relating the relative ease of successfully matching kidneys). Even without a waitlist, UNOS would likely need several weeks to coordinate non-emergent transfers. Some patients will inevitably present the need for an emergency transplant. In these circumstances, under the UNOS-Procurement System, UNOS would “fast track” these patients.

“[n]ot only will donors, many of whom are poor, be paid, but recipients will face a much larger number of organs available for transplantation, thereby eliminating incentives for discrimination that currently exists in the allocation process.”<sup>524</sup> Under the UNOS-Procurement System, instead of maintaining a list of dying patients—only some of whom will be saved—UNOS would maintain a list of contracted donors, and UNOS would contact them upon an expressed need from a transplant hospital.<sup>525</sup>

Further, like the current U.S. blood-collection system, under the UNOS-Procurement System, the donor and patient remain total strangers. Recipients often highly value anonymity, as it removes the sense of enormous personal and ongoing obligation that many recipients feel towards revealed living donors.<sup>526</sup> Equally, recipients can expand the pool of potential donors beyond the one that they currently aspire, often in vain, to get.<sup>527</sup> This allows for quality selectivity as well.

*B. Restrict Directed Donations to Related Donors and Those with an Existing Relationship to the Recipient*

The current kidney-collection and distribution system is in jeopardy of becoming irrelevant, if not worse.<sup>528</sup> Living-donor transplants already roughly mirror cadaveric transplants,<sup>529</sup> with living donors completely bypassing the need criteria of UNOS. Donors determine who receives their kidneys, not UNOS. Supporters of the status quo suggest that these altruistic donors would not otherwise donate, and therefore the inequity of a distribution scheme that bypasses the UNOS criteria does not harm those remaining on the waitlist.<sup>530</sup>

However, as services such as matchingdonor.com serve to increase the number of unconnected living donations, this argument loses force.<sup>531</sup> If these donors are unconnected to the

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524. Kaserman, *supra* note 115, at 577.

525. See *supra* note 129 and accompanying text.

526. Telephone Interview with Sally Satel, *supra* note 433.

527. Telephone Interview with Jim Cohan, *supra* note 91.

528. See *supra* notes 193–207 and accompanying text (discussing objections to the current UNOS system that discourages solicitation of stranger donors).

529. See GOODWIN, *supra* note 4, at 41 (noting that living kidney donation surpassed cadaveric kidney donations in 2001).

530. Alexandra K. Glazier & Scott Sasjack, *Should It Be Illicit to Solicit? A Legal Analysis of Policy Options to Regulate Solicitation of Organs for Transplant*, 17 HEALTH MATRIX 63, 68 (2007).

531. See *supra* notes 195–202 and accompanying text (discussing the concerns associated with donor–recipient Internet solicitation).

recipient, then their motivations to donate are truly altruistic—and that should survive even if UNOS became the collector of their charity on behalf of those most in need.<sup>532</sup>

Moreover, if any of these matching services results in undisclosed payments to donors, then an underground market already exists without any of the protections of the UNOS-Procurement System. By restricting directed donations to donors and recipients in close relationships, the UNOS-Procurement System will redirect the truly altruistic donors to those who most need kidneys, thereby meeting the needs of all future recipients in a short time, and restoring the fairness otherwise lost in our current bifurcated system.

Indeed, the current system embodies an even more insidious inequity. Patients who can afford an overseas transplant need only prepay \$90,000 for a kidney transplant, and within several weeks they will be on their way to a foreign transplant facility.<sup>533</sup> This payment includes all charges—even the cost of flying and housing a companion with the patient.<sup>534</sup> While these black market transactions potentially free up cadaveric kidneys for those whose economic status forces them to remain on the UNOS waitlist, the ability of the well-off to pursue these foreign transplants likely reduces the political pressure for change from the status quo from the patients with the loudest voices (as measured by wealth). As such, the wishes and needs of the disenfranchised will remain unmet—while the needs of the empowered will remain satisfied through international, extrajudicial means.

### C. Price Floor

The UNOS-Procurement System requires a minimum price for a kidney. This mimics a minimum wage and presents the attendant debate as to whether restricting the ability of workers to contract at any wage ultimately helps or harms them.<sup>535</sup> While a price floor for a kidney could be set via various methods,<sup>536</sup> I

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532. See Glazier & Sasjack, *supra* note 530, at 63 (pointing out that people in need of organs have been appealing to the public “as far back as the early 1980s” and citing examples of public appeals).

533. Telephone Interview with Jim Cohan, *supra* note 91.

534. *Id.*

535. The debate is whether the paternalism of a minimum wage assists workers by transferring to workers the economic surplus that labor purchasers enjoy as a result of market inefficiencies, or whether a minimum wage forecloses employment options from those who need it the most. Cf. RICHARD POSNER, *ECONOMIC ANALYSIS OF LAW* 342–44 (7th ed. 2007) (discussing the effects of unionization on prices, wages, and output).

536. See Dickens, *supra* note 444, at 130–31 (proposing that a provincial health plan

recommend using an economic projection of a kidney's value that considers the costs and risks of the surgery and the average utility of income. Individual sellers willing to take a price below that minimum *might* reflect inefficiencies in the market or inappropriate factors affecting the sellers' price calculus. The price floor will ensure that those sellers are not undervalued. Of course, price floors have a cost, i.e., the possibility that the minimum price results in a continued shortage. This will depend on whether the economic model sets a price below or above the market price. While I believe that it will be the former—therefore, avoiding any shortage—should the latter occur, the value of the floor would have to be balanced against its benefits.

The determination of the floor is not a theoretical curiosity. Gary Becker, a Nobel Prize-winning economist from the University of Chicago, and his colleague, Julio Elias, recommended a price of \$45,000 for a living donor kidney.<sup>537</sup> This calculation was based on the following assumptions:

1. A mean American salary of \$40,000 per year.
2. An average life value of \$3 million.
3. A nephrectomy mortality rate of one percent, which is much higher than it actually is.
4. A reduction in the quality of the donor's life by five percent—also an overestimate.
5. A loss of \$7,000 in income due to the donor from the surgery.<sup>538</sup>

Substituting the nephrectomy death risk at one in three hundred, which is still over ten times the actual risk, reduces the kidney purchase price to \$20,000,<sup>539</sup> which is where I would set the price minimum. To be clear, the market could—and I believe likely would—set a price far above this. But under the UNOS-Procurement System, UNOS could not provide less than this price.

Once the price is set, implementation proves simple—given that the UNOS-Procurement System maps onto the existing UNOS structure. As such, under the UNOS-Procurement System, the Department of Health and Human Services covers administrative costs, and the recipient's insurance company and Medicare's ESRD Program cover donor incentive payments—

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calculate the reward to donors by evaluating the costs associated with dialysis treatment and subtracting the savings associated with an earlier transplantation).

537. Friedman & Friedman, *supra* note 5, at 961.

538. *Id.*

539. *Id.*

much like they currently do for ESRD treatment.<sup>540</sup> UNOS would charge the kidneys to the transplant hospitals, which would then bill the recipient's insurance company or Medicare's ESRD program. While these programs already cover most ESRD payments, savings from avoiding extended costs associated with dialysis would easily fund any currently uncovered costs and, likely, any remaining uncovered patients, as well.<sup>541</sup> One analysis shows that, were each dialysis patient currently on the national waitlist to receive a kidney transplant from a paid donor, "society could break even while *paying* \$90,000 [to every] kidney vendor."<sup>542</sup> Another study asserts even greater savings.<sup>543</sup>

*D. Provide Payment over Several Years; Lifetime Government-Funded Supplemental Health Insurance; Minimum Waiting Period; and Seller's Right to Rescind the Agreement*

The annuity and lifetime supplemental health insurance<sup>544</sup> essentially determine how the donor spends her compensation.<sup>545</sup> This apparent paternalism directly responds to the concerns, described above, that donors essentially cannot be trusted to make sound decisions in spending their compensation and in deciding whether to sell a kidney. In a free society and free market system such an approach raises suspicion, but rebuttably so.

The supplemental health insurance would only cover what the donor does not already receive from private insurance or Medicare. Thus, the overall cost would not reach the cost of fully insuring all donors, and would not dramatically impact the cash remuneration that donors would receive.<sup>546</sup> Moreover, the uninsured and underinsured impose significant externalities on

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540. Arthurs, *supra* note 8, at 1122–24.

541. See *supra* notes 50–57 and accompanying text (discussing the costs associated with dialysis).

542. Arthurs, *supra* note 8, at 1119 (emphasis added) (quoting Arthur J. Matas & Mark Schnitzler, *Payment for Living Donor (Vendor) Kidneys: A Cost-Effectiveness Analysis*, 4 AM. J. TRANSPLANTATION 216, 216 (2004)).

543. Calandrillo, *supra* note 82, at 118 (showing that studies indicate insurance savings would be between \$200,000 and \$400,000 in insurance costs).

544. See *supra* notes 440–43 and accompanying text (setting forth certain procedures that could eliminate the problem of people spending money received from kidney donations unwisely).

545. Telephone Interview with Sally Satel, *supra* note 433.

546. A current debate exists over whether government-provided health insurance will "squeeze out" private health insurance—at the expense of taxpayers. See Maxwell J. Mehlman, "Medicover": A Proposal for National Health Insurance, 17 HEALTH MATRIX 1, 12 (2007) (discussing the adverse effects of voluntary public health programs). The small scale of the proposal in this Article will have no significant squeeze-out effect.

the insured and taxpayers in our highly regulated system. As a consequence, fee shifting no longer constitutes outright paternalism, but rather imposes an equitable redistribution of expenditures onto those actually incurring costs.

While the argument for the forced supplemental insurance has an economic basis, the mandatory annuity and minimum waiting period fall squarely within paternalism. The reduction in free choice directly responds to the concerns that donors cannot be trusted to spend wisely and will be “unfairly” lured by quick compensation. The cost to freedom of such restrictions—in exchange for the elimination of deaths caused by ESRD—seems acceptable.

Finally, entitling sellers to rescind the agreement at any time before surgery offsets some of the aforementioned paternalism of the UNOS-Procurement System by removing UNOS’s and potential-recipients’ right to sue donors for breach of contract. The purpose of the restriction is to ensure that donors have full freedom to constantly reevaluate their choices without the encumbrance of a potential lawsuit by either UNOS or donors claiming rights in the purchase contracts as third party beneficiaries.

Because UNOS, not would-be recipients, will be contracting with the donors, no individual will likely be prejudiced by those who withdraw prior to consummating the transaction, because if a seller rescinded, UNOS would simply approach the next seller on its contract list that matches the recipient to complete the transaction. At worst, this restriction may result in some administrative inconvenience to UNOS. And while the anonymity of the UNOS-Procurement System makes third party beneficiary claims likely not pursuable—legally or factually—the immunity granted by this provision resolves the question completely. This reduces litigation risks and costs.

*E. Exempt Creditors and Government from Considering the Value of Debtors’ Kidneys for the Purposes of Debt Obligation and Welfare Qualification*

Donors should be free to choose whether they want to pursue welfare programs or insolvency without having to first exhaust their ability to monetize kidneys.<sup>547</sup> Given the unique nature of this transaction, it should not be forced upon anyone. However,

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547. See *supra* notes 443–45 and accompanying text (addressing the concern that creditors and the government would consider the worth of a person’s kidney part of the person’s net worth).

this concern, while valid, overstates any real problem. Currently, as discussed, individuals can sell "tissue," and I have found no cases in which debtors were required to do so as part of any insolvency proceeding, pursuant to any contract to satisfy a debt, or as a requirement to provide collateral for any transaction or meet qualifying standards for any social welfare program. Indeed, any attempt to do so would highly likely be found unenforceable as against public policy.<sup>548</sup>

*F. Require Sellers to Be a Minimum Age, Medical Screening, and Independent Oversight*

Corruption often accompanies money. A well-devised government program hopes for the best and safeguards against the worst. Undoubtedly, with a proposal to sell kidneys, the potential for abuse exists. The program would need institutional protections, such as requiring sellers to be a minimum age, medical screening, and independent oversight. These, however, do not exhaust the list of precautions. Under the UNOS-Procurement System, the Health and Human Services Administration would oversee UNOS and would be empowered to establish reasonable regulations to ensure safety and equity to patients and donors alike.

For example, the UNOS-Procurement System would prohibit children from contracting to sell one of their organs and would prohibit their parents or legal guardians from contracting on their behalf.<sup>549</sup> Such regulation would "alleviate fears of children being conceived solely for the purpose of growing organs."<sup>550</sup> The UNOS-Procurement System would also require donor medical and psychosocial examinations.<sup>551</sup> Sellers would be properly checked for disease and drug use prior to donation and would receive proper follow-up medical care after the operation.<sup>552</sup>

## V. CONCLUSION

An Orthodox rabbi once told me that, as heretical as it may be, he saw no purpose in death. While this is a topic of some

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548. See *supra* note 289–91 and accompanying text (discussing *McFall v. Shimp*, in which the court found that requiring an invasion of a person's body without his or her consent was against public policy).

549. Harris & Alcorn, *supra* note 10, at 232.

550. *Id.*

551. Friedman & Friedman, *supra* note 5, at 961.

552. *Psst, Wanna Buy a Kidney?*, *supra* note 10, at 15; see also Becker & Elias, *supra* note 3, at 21 (assuring that the kidneys of individuals "who use drugs or have AIDS, hepatitis, or other serious illnesses would be rejected").

discourse in religious studies, few if any would dispute that needless death should be avoided. This paper has presented an exegesis of the current tragedy of needless deaths resulting from the inability of our medical system to address kidney failure. The Article's proposed solution—the UNOS-Procurement System—will provide kidneys to those who need them and compensate donors for their charitable acts. Like the rabbi's statement, this proposal will undoubtedly engender significant controversy. Hopefully, it will also result in a solution that benefits everyone.