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

By: Jennifer L. Hurley[1]

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INTRODUCTION

In a landmark operation on December 23, 1954, surgeon Joseph Murray demonstrated that organ transplantation was possible.[2] Murray removed one of Ronald Herrick's two kidneys, and placed it in Richard Herrick, his identical twin brother dying of kidney failure.[3] Richard's immune system did not identify his brother's tissue as foreign because they were identical twins.[4] Initially, rejection of transplanted organs threatened organ transplantation.[5] In

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

2. Thomas S. Bodenheimer & Kevin Grumbach, UNDERSTANDING HEALTH POLICY: A CLINICAL APPROACH 148-49 (Lange Medical Books ed. McGraw Hill (1998). Authors discuss the history of organ transplantation as both a medical miracle and ethical watershed.

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

4. *Id.*

5. *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, 252 (1995).

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

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

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

7. Julian S. Moore, *The Gift of Life: New Laws, Old Dilemmas, and the Future of Organ Procurement*, 21 AKRON L. REV. 443, 455 (1988).

8. *See* Chad D. Naylor, The Role of the Family in Cadaveric Organ Procurement, 65 IND. L. J. 167, 167 (1989).

9. *Id.*

10. Dulcinea A. Grantham, *Transforming Transplantation: The Effect of the Health and Human Services Final Rule on the Organ Allocation System*, 35 U.S.F.L. REV. 751, 751 (2001).

11. *See* United Network for Organ Sharing, U.S. Facts About Transplantation http://www.unos.org/Newsroom/critdata_main.htm. (*visited November 30, 2003)*

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

13. *See* Shelby E. Robinson, *Organs for Sale*? *An Analysis of Proposed Systems for Compensating Organ Providers*, 70 U. COLO. L. REV. 1019, 1022 (1999).

14. *Id.*

15. *Id.*

16. *See id*.

17. *See* David E. Jeffries, *The Body as Commodity: The Use of Markets to Cure*

for transplantable organs greatly exceeds the present supply.[18] Experts have noted that they anticipate the number of available organs to remain constant, while the demand will continue to increase consistent with longer survival rates, thus creating a striking deficit between supply and demand.[19] Potentially, each donor can help as many as fifty recipients.[20]

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

Organ Donation Laws

the Organ Deficit, 5 IND. J. GLOBAL LEGAL STUD. 621, 624 (1998); *See also,* Traci J. Hoffman, *Organ Donation Laws in the U.S. and the U.K: The Need for Reform and the Promise of Xenotransplantation,* 10 IND. INT'L & COMP. L. REV. 339, 349 (2000).

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

19. *See* MONT. CODE ANN. §72-17-102 (2002), *supra* note 18.

20. *See* Deirdre Kelly & A.D. Mayer, *Pediatric Transplantation Comes of Age: The Main Problem Now is Shortage of Donors*, BRIT. MED. J., Oct. 3, 1998, at 897. The organs that can be taken from a single donor include the heart, lungs, kidneys, liver, pancreas, corneas and small intestine; *see also* Hoffman *supra* Note 17 at 345.

One donor can:
donate kidneys;
donate their heart, liver, lung or pancreas;
donate their corneas;
donate bone or bone marrow;
donate skin;
provide healthy heart valves.

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

Many states began to enact statutes that regulated the donor process by establishing guidelines for whom may become a donor.[24]

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

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

23. *See* Jeffrey A. McDaniel, *A Decent Proposal? Fundamental Fairness in an Un-Commercial Organ System,* 19 J.L & COM. 327, 330 (2000) (Addressing the history of organ transplantation in the United States and the attempts of federal lawmakers to protect the interests of transplant patients).

24. *See* Fred H. Cate, *Human Organ Transplantation: The Role of Law,* 20 IOWA J. CORP. L. 69, 83 (1994). The first state to enact a statute permitting an individual to donate his organs was New York. Today, New York and a number of other states continue to have laws targeted at specifying limitations on organ transplantation, including limitations on those persons who may become donees and the purposes for which anatomical gifts may be made. *See also,* R.I. GEN. LAWS §42-11-13 (2002) Rhode Island Organ Transplant Fund; R.I. GEN. LAWS §40-8-2 (2002) Human Services; Medical Assistance; N.Y. [Organ Tissue and Body Parts Procurement and Storage] Law §4362 (2002); MONT. CODE ANN. §72-17-202 (2002) (Persons who may become donees and the purposes for which anatomical gifts may be made); Mont. Code Ann. §17-17-103 (2002); MONT. CODE ANN. §17-17-102 (2002); MO. REV. STAT. §172.875 (2002); MASS. GEN. LAWS ch. 113 §8 (2002) (Gifts of human bodies, organ and tissues; persons authorized to make; rights created:
A person of sound mind and who is 18 years of age or older may make a gift of all or any part of his body for any purposes specified in section nine, said gift to take effect upon his death or in the case of a living donor at such time prior to his death as he may specify in accordance with the requirements of subsection (b) of section ten, son long as such donation does not jeopardize in any way the life and health of the donor
MASS. GEN. LAWS ch §6E (2002)(Organ Transplant Fund; Voluntary Contributions; Annual Report of Commissioner); 20 Ill. Comp. Stat. 3935/4 (2002) (Determination of an individual transplant candidate's eligibility); FLA. STAT. ch. 381 §381.0602 (2002) (Organ transplant advisory council; membership

Initially, many states enacted statutes and regulations pertaining to organ transplantation that were ambiguous and irreconcilable to one another.[25] In order to promote an analogous and extensive system of regulation, the National Conference of Commissioners on Uniform State Laws (NCCUSL) met in 1968 and drafted the Uniform Anatomical Gift Act (UAGA).[26] In 1984, UAGA was supplemented by the National Organ Transplant Act (NOTA).[27] As recently as 1998, these regulations were improved upon by the enactment of the Organ Procurement and Transplantation Network (OPTN).[28]

THE UNIFORM ANATOMICAL GIFT ACT

In enacting the UAGA, the NCCUSL was cognizant of the many competing interests influencing organ transplantation.[29] In promulgating the Act, the UAGA addressed these concerns by posing twelve questions.[30] As many scholars note and as is evidenced by the

respobsibilities); CONN. GEN. STAT. §17b-288 (2001) (Organ transplant account)

25. *See* Sipes, *supra* note 21 (discussing promulgation of Uniform Anatomical Gift Act.)

26. *See id*. The UAGA was drafted by the NCCUSL and was presented by Congress in an effort to achieve uniformity among state laws pertaining to organ donation.

27. *See id.*

28. *See* 42 C.F.R. §§121.1-121.12 (2000); *see also,* 63 Fed. Reg. 16296 (April 2, 1998) (setting forth the final rule governing the Organ Procurement and Transplantation Network, which performs a variety of functions related to organ transplantation under contract with HHS.) *id.* In combination with a new National Organ and Tissue Donation Initiative, this rule is intended to improve the effectiveness and fairness of the Nation's transplantation system and to further the purposes of the National Organ Transplant Act of 1984, as amended. *See id.* These objectives include: encouraging organ donation; developing an organ allocation system that functions as much as technologically feasible on a nationwide basis; providing the basis for effective Federal oversight of the OPTN, as well as for implementing related provisions in the Social Security Act; and providing better information about transplantation to patients families and health care providers. *See id.*

29. *See* Moore, *supra* note 7. Among the interests that the drafters sought to address included protecting the expectations of the potential donor and his or her family, while drafting organ donation regulations to satisfy the increasing demand for donations.

30. Uniform Anatomical Gift Act, reprinted in Statutory Regulation of Organ Donation in the United States (R. Hunter Manson ed., 2d ed. 1986). The twelve questions include:

Who may during his/her lifetime make a legally effective gift of his body or a part thereof?

What is the right of the next-of-kin, either to set aside the decedent's expressed wishes, or themselves to make the anatomical gifts from the dead body?

Who may legally become donees of the anatomical gift?

For what purposes may such gifts be made?

How may gifts be made, such as by will, by writing, by a card carried on the

subsequent regulations designed to enhance the UAGA, this particular regulation should be understood to require regular modifications and amendments to address society's evolving needs and concerns.[31]

The UAGA successfully achieved its stated purpose of achieving uniformity among state laws pertaining to organ donation.[32] Four years after its inception, every state and the District of Columbia had adopted some version of the 1968 UAGA.[33]

The provisions of the UAGA provide that any eighteen-year-old has the legal right to decide whether to donate all or part of their bodies after their death.[34] The decision to donate their organs is shared by the donor and his or her immediate relatives or other person standing in a fiduciary capacity.[35] The donor may bequeath a post mortem donation through any written document to any one particular person or group of people.[36] At any time before the donor's

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

31. Wayne L. Anderson & Janolyn D. Copeland, *Legal Intricacies of Organ Transplantation: Regulations and Liability*, 50 J. MO. B. 139, 140 (1994); *see also,* Hoffman, *supra* note 17 at 355.

32. *See* Cate, *supra* note 24. The UAGA has undergone minor modifications in some states. *Id.* Presently, the most apparent modifications relate to defining death, outlining procurement protocol and prohibiting the sale of organs. *Id.*

33. *See id.*

34. *See* Uniform Anatomical Gift Act §2(a), reprinted in Statutory Regulation of Organ Donation in the United States, 4 (R.Hunter Manson ed., 2d ed. 1986).

35. *See* Uniform Anatomical Gift Act. §2(b), at 4. The people who may make the decision on behalf of the donor are listed in order of priority: "the spouse, an adult son or daughter, either parent, either parent, an adult brother or sister, guardian of the person of the decedent at the time of his death or any other person authorized or under obligation to dispose of the body." *Id.*

36. *See* Uniform Anatomical Gift Act §4(a-b), at 5.
If the donor designates the disposition of his organs by will, the gift becomes effective at the death of the donor without having to go through probate. If the will is not probated or, if the will fails for any reason, the bequest of his organs is still valid if is was made in good faith. If the donor expresses his desire to donate through other documents, the document must be signed by the donor in the

death, he or she may amend or revoke the document purporting to express his or her desire to donate.[37]

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

presence of two witnesses who must sign the document is his presence. Today, the two witness requirement is no longer necessary unless the donor expresses his intent to donate verbally. *Id.*

37. *See id*., §6(a).
The donor may amend or revoke the written document at any time before his death, even if the document has already been delivered to the individual so designated to be the recipient of the donor's organs. If the donor has designated a specific recipient and has delivered the document to the donee, he may revoke the gift by (1) delivering to the donee a signed statement, (2) making an oral statement in the presence of two witnesses that is communicated to the donee, (3) making a statement to any attending physician during a time of terminal illness or injury that is communicated to the donee, or (4) signing a card or other document that can be found on his person or in his effects. If the document has not been delivered to the donee, the donor may do any of these four steps or cancel the gift by destruction, cancellation, or mutilation of the document and any existing copies. *See id*. §6(b). If the donor made the gift by will, he may amend or revoke the gift using any of the four steps outlined above, or by doing so as provided in the laws regulating the amendment and revocation of a will. *See id*. *See also*, Hoffman, *supra* note 17 at 356.

38. *See* Uniform Anatomical Gift Act at §7.

39. *See* Uniform Anatomical Gift Act §7. The UAGA states in section 7(c): A person who acts in good faith in accord with the terms of this Act or with the anatomical gift laws of another state [or foreign country] is not liable for damages in any civil action or subject to prosecution in any criminal proceeding for his act." Some states have expressly adopted the UAGA, while others have substantially adopted it: Alabama (ALA. CODE §22-19-47(c)(1984)); Alaska (ALASKA STAT. §13.50.060(c)(1976)); California (CAL. HEALTH AND SAFETY CODE §7155.5(d-e)(1984) (Supp.1986)))[California omits reference to liability for acting in accord with gift laws of other states or foreign countries and makes reference to gifts on drivers' licenses]; Colorado (COLO. REV. STAT. §12-34-108(3) (1985)); Connecticut (CONN. GEN. STAT. ANN. §19a-278(c)(1986))[Connecticut makes no reference to acting under the gifts laws of another state or foreign nation]; Delaware (DEL. CODE ANN. tit.24 §1786 (c) (1981)); District of Columbia (D.C. CODE ANN. §2-1507(c) (1981))[D.C. omits reference to acting under the laws of a foreign nation]; Florida (FLA. STAT. ANN. §732.917(3) (1976 & Supp. 1984)[Florida adds a provision to its statute that says that a person who acts without negligence in accord with UAGA is not civilly or criminally liable]; Georgia (GA. CODE ANN. §44-5-148(c) (1982))[Georgia omits reference to acting under other state or foreign laws]; Hawaii (HAWAII REV. STAT. §327-7(c) (1976 & Supp. 1984)); Idaho (IDAHO CODE §39-3407(3) (1977); Illinois (ILL. ANN. STAT. ch. 110 ½ §308 (c) (Smith-Hurd 1978 & Supp. 1984)); Indiana (IND. CODE ANN. §29-2-16-4(g) (Michie Supp. 1986))[Indiana requires that the doctors act without actual notice of revocation and limits protection to civil liability]; Iowa (IOWA CODE ANN. §142A.7(3)(1972 & Supp. 1984)[Iowa omits reference to acting under laws of a foreign nation]; Kansas (KAN. STAT. ANN. §65-3215(c) (1980)); Kentucky (KY. REV. STAT. ANN. §311.225(3) (Bobbs-Merrill 1983))[Kentucky

Despite the general success of the UAGA, the Act has been criticized on three major grounds.[40] The first criticism principally relates to the ineffectiveness of the organ donor card system.[41] The

omits reference to acting under the laws of a foreign nation]; Louisiana (LA. REV. STAT. ANN. §17:2357 (c) (West 1982))[Louisiana protects persons from both civil and criminal liability if they act in good faith and without actual knowledge of revocation and in accord with the Louisiana UAGA or the laws of the state in which the state in which the gift document was executed]; Maine (ME. REV. STAT. ANN. tit. 22 §2907(3)(1980)); Maryland (MD. EST. & TRUSTS CODE ANN. §4-508(b)(1974)); Massachusetts (MASS. GEN. LAWS ANN. ch. 113, § 13(c) (West 1983); Michigan (MICH. COMP. LAWS ANN. §333.10108(3) (West 1980)); Minnesota (MINN. STAT. ANN. §525.927(3) (West 1975) [Minnesota adds that a person must also comply with the drivers' license gift laws in order to escape liability]; Mississippi (MISS. CODE ANN. §41-39-45 (1981))[Mississippi makes no mention of acting in accordance with the laws of another state or foreign nation and protects the actor only from liability for civil damages]; Missouri (MO. ANN. STAT. §194.270 (3) (Vernon's 1983)); [Missouri only requires that a person act without negligence in order to escape liability] Montana [Montana makes no provision for non-liability]; Nebraska (NEB. REV. STAT. §71-4807(3) (1981)[Nebraska does not mention acting in accord with the laws of a foreign country]; New Jersey (N.J. STAT. ANN. §26:6-63(c) (West. Supp. 1984)); New Mexico (N.M. STAT. ANN. 24-6-7(c)(1981))[New Mexico does not make any reference to the gift laws of a foreign country]; New York (N.Y. PUB. HEALTH LAW §4306(3) (McKinney 1985))[New York omits reference to acting under the laws of a foreign country]; Nevada (NEV. REV. STAT. §451.580(3) (1985))[Nevada substitutes "the state of Nevada for "another state or foreign country."]; North Carolina (N.C. GEN. STAT. §130A-409(c) (Supp. 1983)); Ohio (OHIO REV. CODE ANN. §2108.08 (Page 1976) [Ohio omits reference to acting under the laws of a foreign country]; Oklahoma (OKLA. STAT. ANN. tit. 63, §2208(c) (West 1984)); Oregon (OR. REV. STAT. §97.290(3) (1983)) [Oregon substitutes acting "with probable cause" for "acting in good faith."]; Pennsylvania (20 PA. CONS. STAT. ANN. §8607(c) (Purdon 1975)); Rhode Island (R.I. GEN. LAWS §23-18.5-7(c) (1985)); South Carolina (S.C. CODE ANN. §44-43-380 (c) (Law. Co-op. 1985))[South Carolina omits reference to a foreign country and provides that civil immunity shall not extend to cases of "provable malpractice"]; South Dakota (S.D. CODIFIED LAWS ANN. §34-26-39 (1977); Tennessee (TENN. CODE ANN. §68-30-108 (c) (1983)); Texas (TEX. STAT. ANN. art. 4590-2 §8 (c) (Vernon 1976))[Texas protects individuals acting under the Texas UAGA if the prerequisites for an anatomical gift have been met under the laws in effect when the gift was made]; Utah (UTAH CODE ANN. §26-28-5 (1984))[Utah requires that doctors have actual notice of revocation in order to be held liable and specifies only that such doctors shall not be liable in damages]; Vermont (VT. STAT. ANN. tit. 18, §5237(c) (Supp. 1984)); Virginia (VA. CODE §32.1-295 (D) (1985)); Washington (WASH. REV. CODE ANN. §68.08.560(3) (Supp. 1984-5)); West Virginia (W. VA. CODE §16-19-7(c) (1979)); Wisconsin (WIS. STAT. ANN. §155.06(7)(c) (West 1974 & Supp. 1984)); and Wyoming (WYO. STAT. §35-5-107(c) (1977)). All of these statutes are reprinted in Statutory Regulation of Organ Donation in the United States (R. Hunter Manson ed., 2d ed. 1986)

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

41. *See* Cate, *supra* note 24. Generally the American public approves of organ donor cards yet most do not carry them. *Id.* Furthermore, even in the presence of a signed donor card, removal of organs usually does not occur without the consent of

second criticism relates to the failure to sufficiently define the time of death of a patient for purposes of organ retrieval.[42] The third criticism of the UAGA is its inability to effectively increase the number of available organs.[43] These inadequacies contributed to the drafting of a new UAGA, which was adopted by the NCCUSL in 1987, and by the American Bar Association in 1988.[44]

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

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

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the family. *Id.*. Doctors are reluctant to become the target of family opposition to the removal of organs and consequently abide by their wishes despite the provisions of the UAGA releasing the physician from liability. *See* Uniform National Gift Act §7, reprinted in Statutory Regulation of Organ Donation in the United States 4 (R. Hunter Manson ed., 2d ed. 1986).). *See also,* Hoffman, *supra* note 17 at 356-358.

42. *See* Uniform Anatomical Gift Act §7(b), reprinted in Statutory Regulation of Organ Donation in the United States 4 (R. Hunter Manson ed., 2d ed. 1986). Section 7(b) of the UAGA states only that death shall be determined by the attending physician. To alleviate fears that a physician will have conflicting interests in helping his patient survive and in procuring organs for transplant, the UAGA provides that the attending physician shall have no part in obtaining the organs.). *See also,* Hoffman, *supra* note 17 at 356-358.

43. *See* Moore *supra* note 7.

44. *See* Cate *supra* note 24. *See* Hoffman, *supra* note 17 at 358.

45. *See id.*

46. *See id.*

47. *See* Uniform Anatomical Gift Act (1987), §5(c), 8A U.L.A. 19, 47 (1993); *see also,* Hoffman, *supra* note 17.

48. *See id.*

49. *Id.* §10 (a), at 58.

50. *Id.* §10 (b) at 58.

THE NATIONAL ORGAN TRANSPLANT ACT

The National Organ Transplant Act (NOTA) was effectuated to regulate organ transplantation on the federal level.[51] In 1984, Congress promulgated the Act to establish federal guidelines to the organ transplantation process.[52] The primary purpose behind NOTA was to ensure an equitable nationwide system for the distribution of organs.[53]

NOTA is founded on six basic objectives.[54] The first objective established a task force on organ procurement and transplantation that is comprised of twenty-five members who study a broad range of medical, legal, ethical, economic and social issues related to organ procurement and transplantation.[55] The second purpose compels the Secretary of Health and Human Services to convene a conference relating to the potential for establishing a national registry of voluntary bone marrow donors.[56] The third purpose created the division of Organ Transplantation.[57] The fourth goal empowers the Secretary to make grants for the planning, creation, initial operation and expansion of organ procurement organizations.[58] The fifth objective obligates the Secretary to contract for an Organ Procurement and Transplantation network and a Scientific Registry.[59] The sixth objective forbids the purchase and sale of human organs for valuable consideration.[60]

By prohibiting the sale of organs in interstate commerce, Congress effectively protected indigent and ostracized persons from becoming an exploited source of organ donations.[61] Further the task force on

51. *See* Lisa E. Douglass, *Organ Donation, Procurement and Transplantation: The Process, the Problems, the Law*, 65 UMKC. L. REV. 201, 207 (1996). Secondary federal legislation affecting organ donation in the United States includes: the Public Health Service Act (42 U.S.C. 262) (1996), The Federal Food, Drug and Cosmetic Act (21 U.S.C. 2131), and the Omnibus Budget Reconciliation Act of 1986 (Pub. L. No. 99-509, §9318, 100 Stat. 1874, 2009-2010)(amending the Social Security Act).

52. *See id*.

53. *See id*.

54. National Organ Transplantation Act of 1984, Public Law 98-507 at §101 (b)(1)(A)). *See also,* Hoffman, *supra* note 17 at 359.

55. *See id See also,* Hoffman, *supra* note 17 at 359.

56. *See id* at §410(a). *See also,* Hoffman, *supra* note 17 at 359.

57. *See id* at §375. *See also,* Hoffman, *supra* note 17 at 359.

58. National Organ Transplantation Act of 1984, Public Law 98-507 at §371. *See also,* Hoffman, *supra* note 17 at 359.

59. *See id* at §372. *See also,* Hoffman, *supra* note 17 at 359.

60. *See id* at §301. *See also,* Hoffman, *supra* note 17 at 359.

61. *See* National Organ Transplant Act of 1984 at §301. Anyone caught in the purchase or sale of organs commits a felony punishable by a fine of $50,000 and/or five years imprisonment. *Id.* Furthermore, it appears that Congress' fears were

organ transplantation created under the Act conducts comprehensive reviews of the medical, legal, ethical and social issues presented by human organ procurement.[62] Unfortunately, the lack of any real enforcement and supervision of the system has failed to lead to a significant increase in donated organs.[63]

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

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

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

justified. *Id.* Evidence of a commercial market for organs in the United States prompted Congress to pass NOTA. *See* Harris, *infra* note 106. Dr. H. Barry Jacobs attempted to merchant human kidneys from live donors. He founded an organization named the "International Kidney Exchange Ltd." with the purpose of procuring kidneys from indigent Third World residents. *See id.* The potential organ donors would establish the price for the sale of their kidneys and Jacobs would collect $2000 to $5000 for his brokerage services. *Id.*

62. *See* Robinson *supra* note 13 at 1029. NOTA has been criticized for allowing the task force too much discretion in determining issues in need of resolve and ignoring issues relating to the organ deficit. *Id.* Critics have alleged that NOTA demonstrates Congress' efforts to expand the role of the federal government in organ procurement rather than increasing the number of available organs. *Id.*

63. *See* Douglass *supra* note 51 at 211.

64. *See* Robinson *supra* note 13.

65. *See id*.

66. *See id*. *See also,* Gail L. Daubert, *Politics, Policies and Problems with Organ Donation: Government Regulation Needed to Ration Organs Equitably*, 50 Admin. L. Rev. 459 (1998). In 1998, the Department of Health and Human Services proposed regulations that would ensure that UNOS "develop an organ allocation system that functions on a national rather than a local-regional basis and gives preference to the most medically urgent patients, defined as those who are very ill, but who, according to their physician, have a reasonable likelihood of post-transplant survival."

67. *See* 42 U.S.C.A. §273 (2003).

68. *See* Robinson *supra* note 13 at 1030 (quoting Charles K. Hawley, *Antitrust Problems and Solutions to Meet the Demand for Transplantable Organs*, 1991 U. ILL. L. REV. 1101, 1103-1105 (1991).

69. *See* United Network for Organ Sharing, U.S. Facts About Transplantation < *http://www.unos.org/Newsroom/critdata_main.htm.*

upon the organ donation process in the United States and to supplement the earlier regulations so that they might reach the breadth of their purported potential, in an Act called the "Final Rule."[70] The Clinton administration ordered the organ-sharing network to construct a more effective distribution system.[71] If the organ-sharing network failed to construct a more effective system, the Secretary of Health and Human Services threatened to take the appropriate measures to amend it.[72] Consequently, as a result of the "Final Rule," officials and doctors with local organ procurement organizations have begun to pressure their state legislatures to pass laws that would keep organs within state boundaries.[73]

THE FINAL RULE

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

Under the Final Rule, "human organs donated for transplantation

70. *See* Organ Procurement and Transplantation Network, 63 Fed. Reg. 16296 (April 2, 1998).

71. *See* Sheryl G. Stolberg, *Fight Over Organs Shifts From States to Washington*, N.Y. TIMES, March 11, 1999, at C1.

72. *See id*.

73. *See id*.

74. 42 C.F.R. §§121.1-121.12 (2000) Organ Procurement and Transplantation Network. The provisions of this part apply to the operation of the Organ Procurement and Transplantation Network (OPTN) and the Scientific Registry; *See also generally*, Walter Block, et al, *Human Organ Tranplantation: Economic and Legal Issues*, 3 QUINNIPIAC HEALTH L. J. 87 (1999/2000).

75. *See* 63 Fed. Reg. 16296 (1998).

76. *See id*.

77. *See* 3 Fed. Reg. 16296 (1998);*See generally*, Block et al, *supra* note 74.

78. *See* 3 Fed. Reg. 16296 (1998).; *See generally*, Block et al, *supra* note 74.

79. *See* 63 Fed. Reg. 16296 (1998); *See generally*, Block et al, *supra* note 74.

are a public trust."[80] Consequently, the government argued that it must control the process to "ensure that donated material is equitably allocated among all patients," without regard to their economic status.[81] The preamble of the Final Rule states that, "at the national level, the current policies treat patients inequitably because they create enormous geographic disparities in waiting time."[82] The tenet that donated organs are a national resource implies that to the extent technically and practically achievable, any citizen or resident of the United States in need of a transplant should be considered as a potential recipient of an available organ regardless of geographic location.[83]

The Secretary of the Department of Health and Human Services has identified three major effects of the Rule.[84] "First, it establishes terms of public oversight and accountability for the entire organ transplantation system, and the OPTN in particular.[85] This reform creates major public benefits in the categories of 'good government' in preserving public trust and confidence in organ allocation, and assuring the rule of law."[86] The benefits of the proposed rule are substantial and its impact may be realized in future problems avoided, rather than the current dilemmas that need to be resolved.[87]

Second, this rule requires "a system of patient-oriented information on transplant program performance."[88] The Secretary maintained that the new rule would inform patients and physicians of the number of transplants, the amount of waiting time for a transplant, and the percentage of times that a transplant center denies the transplant of organs for non-traditional reasons.[89] Finally, patients, physicians and families must have access to relevant information to facilitate the comparison of actual center performance with these objectives.[90]

Third, this rule will improve equity by "creating performance goals against which the OPTN can reform current policies."[91] Benefits accrue equitably to members of society at large, to donor families, to transplant candidates, and to transplant recipients.[92] The Secretary

80. *See* 63 Fed. Reg.16298 (1998).
81. *See id.*
82. *See* Fed. Reg. 162304 (1998).
83. *Id.*
84. *See* Fed. Reg. 16324 (1998); *See generally,* Block et al, *supra* note 74.
85. *See* Fed. Reg. 16324 (1998)*; See generally,* Block et al, *supra* note 74.
86. *See* Fed. Reg. 16324 (1998)*;* Block et al, *supra* note 74.
87. *See* Fed. Reg. 16324 (1998); *See generally,* Block et al, *supra* note 74.
88. *See* Fed. Reg. 16324 (1998); *See generally,* Block et al, *supra* note 74.
89. *See* Fed. Reg. 16324 (1998).; *See generally,* Block et al, *supra* note 74.
90. *See* Fed. Reg. 16324 (1998); *See generally,* Block et al, *supra* note 74.
91. *See* Fed. Reg. 16324 (1998)*; See generally,* Block et al, *supra* note 74.
92. *See* Fed. Reg. 16324 (1998); *See generally,* Block et al, *supra* note 74.

regarded a system that allocates organs to those most in need grounded on sound medical judgment, as a reasonable and profound benefit to society.[93]

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

NEW PROPOSALS

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

93. *See* Fed. Reg. 16324 (1998); *See generally,* Block et al, *supra* note 74.
94. *See* C.F. E. §121.8(a)(3)(i) (1998).
95. *See id.*
96. *See id see also generally,* Block, et al, *supra* note 74.
97. *See* John Zen Jackson, *When it Comes to Transplant Organs, Demand Far Exceeds Supply*: *American Medical Association Renews the Debate on Financial Incentives to Obtain Organs for Transplant,* NEW JERSEY LAW JOURNAL, December 16, 2002 at 1.
98. *Id.* The AMA proposal was limited to a study of cadaveric organ donations and would not include living donors. Furthermore, it is noted that studies should only be implemented after: 1) protocols, which meet all ethical standards and scientific design requirements that are generally applied to research, have been reviewed and approved by appropriate oversight bodies, such as Institutional Review Boards, and Congress has waived legal prohibition; and 2) guidance and advice have been sought from the particular population under study to ensure that the proposed research is consistent with their needs, values and mores.
99. *Id.*
100. *Id.*
101. *Id.* Apart from the organ brokerage on the free market, additional economic incentives may include an organ futures market, tax deductions and health insurance reduction. *Id.*

unanimously to oppose any attempt to legalize financial incentives for organ donations.[102]

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

Offering valuable consideration for organ donations will inevitably lead to a host of unnecessary ethical and moral problems.[105] Consider that in 1983, a Virginia surgeon announced the formation of a company to solicit healthy individuals for the sale of a kidney and the subsequent brokering of the organ for a transplant procedure.[106] Within six months, Virginia enacted legislation prohibiting the sale of human organs.[107] In 1984, the federal government also acted by

102. *See* Jackson *supra* note 97. It opposed even nominal payments that might indicate to people in other countries that there was support for the organ trade. *Id.* The concept of financial and other incentives for post-mortem organ donations received consideration at an international congress titled "Ethics in Organ Transplantation," which was held from December 10, 2002 through December 13th. *See* Carey Goldberg, *Fiscal Incentive Weighed to Boost U.S. Organ Supply,* Boston Globe, October 8, 2003 at A1. Dr. Francis L. Delmonico, a Massachusetts General Hospital transplant surgeon who is active in the National Kidney Foundation, said financial incentives "inevitably raise many of the same ethical problems inherent in the outright buying and selling of organs." *Id.* Delmonico states that "any attempt to assign a monetary value to the human body or its body parts, even in the hope of increasing organ supply diminishes human dignity and devaluates the very human life we seek to save." *Id.* Delmonico also warns that "payments could undermine the integrity of the donor pool and would give relatives incentives to cover up flaws in a potential donor's medical history to get the money." *See id.*

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

104. *See* Transplant Communications, *supra* note 103.

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

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

107. *See* Harris *supra note 106.*

establishing the National Organ Transplant Act.[108] The potential for exploiting this particular market will be reintroduced by repealing the current laws prohibiting offering valuable consideration for organ donations.[109]

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

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

108. *Id.*

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

110. *See generally* Jackson, *supra* note 97.

111. *See* Douglas Starr, BLOOD: AN EPIC HISTORY OF MEDICINE AND COMMERCE, (Knopf, 1998)

112. *See id.*

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

114. *Id.*

115. *Id.* This was especially true of women who had developed a sensitivity to the Rh factor, the condition in which a baby with Rh-positive blood triggers an immune reaction in its Rh-negative mother. *Id.* Two scientists had shown that an Rh-negative woman could be immunized against the disease by injecting her with Rh antibodies immediately after the birth of her first Rh positive child, and by the late 1960s this injection became economically available. *Id.* Dorothy Garber of Miami, Florida, had such a high concentration of the "Big D" antibody, that she was able to earn more than $80,000 a year. *Id.*

was that there were thousands of less fortunate sellers; the unemployed, indigent, and substance-addicted often lined up outside donation centers to sell their plasma for ten dollars a pint.[116]

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

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

Adequate consideration must also be afforded the concept: How

116. *Id.* the director of a South Carolina plasma center run by Cutter Laboratories wrote in an undated memo: "A high percentage of our donors are either illiterate or functionally illiterate. . . they have great difficulties reading words with more than two syllables and even more trouble understanding the meaning of those words I am fairly sure most of the other Plasmacenters have the same problems."*Id.*

117. Starr *supra* note 111. "Gamma globulins can be fractionated from anybody's plasma, but the best way to gather them is to find someone who has been exposed to a disease and has produced a high concentration of the antibodies in question." *Id.*

118. *Id.*

119. *Id.*

120. Starr *supra* note 111.

121. *Id.* By the mid 1960s Stough had set up centers in five prisoners in the South and was supplying the raw material for approximately 25% of the nation's hyperimmune gamma globulin.*Id.* Stough ran a careless and reckless operation, often risking the lives and health of the prisoners in exchange for access to the plasma. *Id.*

122. Starr *supra* note 111.

123. *See* Transplant Communications *supra* note 103.

124. Starr *supra* note 111.

can we sell that which we don't own?[125] One of the most well known cases that ruled on the possible property interests in human tissue is *Moore v. Regents of the University of California*.[126] Moore's doctors had taken away some of his cells during the removal of his spleen and because the cells were unique and potentially possessed scientific and commercial value, they were used to conduct research.[127] Without Moore's consent, the doctor's patented a very lucrative cell line from his cells for his own research purposes.[128] The California Supreme Court held that after removal, Moore owned neither his cells nor the cell lines produced outside of his body. [129]

Legal scholars have suggested that the right to sell organs is a constitutionally protected liberty interest.[130] However, the case of *Mansaw v. U.S. District Court* suggests otherwise.[131] In this case, a young boy sustained a gunshot wound to his head and was declared brain dead when he arrived at the hospital.[132] One of his parents signed a written consent allowing her son's organs and tissues to be harvested.[133] However, his other parent was not asked for his consent and indicated that if he were asked, he would not have signed.[134] The court found that both parents had a constitutionally protected "property interest" in a minor child's body.[135] The court emphasized that these property rights should not be considered more constitutionally "essential."[136] "When compared with the rights of privacy, of liberty, etc., property rights, particularly the minimal property right presented here may fairly be described as a low right on the constitutional totem pole."[137] Thus, the court held that any constitutionally protected liberty interest that a parent may have in a

125. *See* Jackson *supra* note 97.
126. *See generally*, Moore v. Regents of the Univ. of Cal, 51 Cal. 3d 120 (Cal. 1990)
127. *See id.*
128. *See id*.
129. *See id* at 174. Other cases, however, have declared that blood and preembyonic cells may be bought, sold, donated, and devised by will, all of which are characteristics traditionally embodied in property law.
130. *See* Jackson *supra* note 97.
131. Mansaw v. United States District Court for the Western District of Missouri, 1998 U.S. Dist. LEXIS 10307.
132. *Id.*
133. *Id.*
134. *See id* at 3. The boy's father was not married to his mother at the time of the boy's death. However they shared joint custody.
135. *See id*. *See also*, Whaley v. County of Tuscola, 58 F.3d 1111(6th Cir. 1995). *See also*, Brotherton v. Cleveland, 923 F.2d. 477 (6th Cir. 1995).
136. *See* Brotherton, *supra* note 135 at 481.
137. Mansaw *supra* note 131 (describing the state's legitimate and compelling interest to protect the rights of the living.)

minor child dies with the child.[138]

FUTURE SOURCES OF ORGAN DONATION

With over 80,000 people currently on the national UNOS waiting list, it is illogical to assume that the existing regulations are adequately promoting organ donation.[139] Under existing regulations, it is illegal to offer valuable consideration for organ donations.[140] Presumably, the law is unlikely to change until the moral and ethical objections cited are adequately considered and addressed.[141]

Within the existing regulations, there are multitudes of ways to promote organ donations.[142] One organization, Lifesharers has abided by the existing federal regulations and has still developed a mechanism to promote organ donations.[143] Lifesharers provides an incentive to donate, by directing the donation of organs and tissue first to members of the nonprofit organization.[144] Lifesharer's members join the organization for free and confer preferred access to their organs and tissue to other members.[145] Lifesharers does not purport to interfere with the UNOS list.[146] If an organ becomes

138. *Id.*
139. *See* United Network for Organ Sharing, U.S. Facts About Transplantation (visited February 16, 2003) < http://www.unos.org/Newsroom/critdata_main.htm. *See also*, Jeffrey A. McDaniel, A Decent Proposal? Fundamental Fairness in an Un-Commerical Organ System, 19 J.L. & Com. 327 (2000)
140. 42 U.S.C. 273
141. *See* Jackson *supra* note 97.
142. *See* http://lifesharers.com (last visited November 30, 2003)
143. *See id.*
144. *See id.*
145. *See id.*
146. *See id.* "If you have an organ that is failing, there may be several treatment options, including an organ transplant. If you and your doctor decide to pursue a transplant, you will have to find a transplant center that will agree to treat you. If you are accepted by a transplant center, you will become part of the nationwide organ distribution system (OPTN). It is operated by the United Network for Organ Sharing (UNOS). UNOS maintains a national waiting list of eligible transplant patients awaiting organs, and establishes policies that decide who gets offered which organs. When an organ becomes available, the local organ procurement organization (OPO) gathers relevant information about the donor and enters it into the computer program maintained by the UNOS Organ Center. This program generates a ranked list of potential recipients from the UNOS waiting list. If you are the highest ranking person on the waiting list, the OPO will contact your transplant center. Your transplant center will then decide whether to accept the organ. If they reject it, the OPO will contact the transplant center for the next-highest ranking patient on the waiting list. If you are a Lifesharers member, you go through the exact same process to get on the waiting list. You also send an email to info@lifesharers.com. When an organ becomes available, your chances of getting it depend on your ranking on the UNOS waiting list and on whether the donor is a Lifesharers member. If the organ is not from a Lifesharers member, the process of

available on the national waiting list, the Lifesharers members (if any) has preferred access to it and the Organ Procurement Organization will offer the organ to them first.[147] As Professor Richard Epstein notes, "Lifesharers is an ingenious effort to harness the collective efforts of many individuals to increase the supply of usable organs; It gives preference in case of need to those who are willing to make their organs available to others."[148] As of February 28, 2003, Lifesharers had 552 members, which was a 53% increase over January's total of 361; as of October 31, 2003, there are approximately 1743 members.[149] This organization appears to have the potential to thrive by providing the important incentive for individuals to act within their own self-interests without offering economic incentives to promote donation.[150]

CONCLUSION

Legislation should not be enacted to repeal current prohibitions against offering valuable consideration for organs and human tissue, as it will only serve to exploit those in need. By offering economic incentives to promote organ donations, we are encouraging the dangerous practice of organ brokerage. Undoubtedly we need to recognize the inherent need for incentives to donate. Offering valuable consideration appears to be an oversimplified solution to sufficiently address such a complex situation. Lifesharers.com has demonstrated that through the use of creative innovations, the organ deficit may be addressed without introducing the added conflicts presented by offering economic compensation for body parts. History has consistently shown us that those individuals who are potentially the most likely to donate will be those who cannot afford any other options. The potential exploitation of the poor and indigent cannot be overemphasized. Furthermore, to permit families to "cash in" on the organs of their deceased loved ones will inevitably lead to a host of

determining who gets it is exactly the same as above. The OPO will offer your transplant center the organ if you are the highest ranking person on the UNOS waiting list. If the organ is from an Lifesharers member, the Lifesharers members on the UNOS waiting list for that organ get preferred access to it. Note however, there is a provision in the membership agreement that specifies that donors can designate that their organs go to members of their family over other Lifesharers members." *Id.*

147. *See* http://lifesharers.com (last visited November 30, 2003).

148. *See id.*

149. *See id*. *See also,* Email from Professor Cohen to Jennifer Hurley on March 8, 2003, 18:37:04 EST (on file with author). stating that Lifesharers.com had approximately 600 members.

150. *See* http://lifesharers.com (last visited November 30, 2003).

unnecessary problems. Most importantly, there will no longer be any sense of autonomy of ones self and their bodies. Rather, individuals will be considered as mere vessels of valuable goods.

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