COMMENTARY

Using Reciprocity To Motivate Organ Donations

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New drugs and techniques have been steadily increasing the number of patients able to benefit from organ transplants,[1] but the supply of organs has not kept pace with demand. While about 39,000 candidates join waiting lists for organs in the United States every year,[2] only about 14,000 deaths occur in a manner leaving organs usable for transplants[3] and only

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1. *See* David Hamilton, *Kidney Transplantation: A History*, *in* KIDNEY TRANSPLANTATION: PRINCIPLES AND PRACTICE 1 (Peter J. Morris ed., 5th ed. 2001); United Network for Organ Sharing (UNOS), Timeline of Key Events in U.S. Transplantation and UNOS History, *at* http://www.unos.org/inTheNews/factSheets.asp (last visited Nov. 04, 2004).

2. Organ Procurement & Transplant Network, Waiting List Additions, *at* http://www.optn.org/latestData/rptData.asp (last visited Nov. 04, 2004).

3. *See* OFFICE OF INSPECTOR GEN., U.S. DEP'T OF HEALTH & HUMAN SERVS., VARIATION IN ORGAN DONATION AMONG TRANSPLANT CENTERS 1 (2003) (estimating 12,000 to 15,000 potential donors annually for August 2001 to November 2002), http://oig.hhs.gov/oei/reports/oei-01-02-00210.pdf [hereinafter 2003 HHS OIG REP.]; Ellen Sheehy et al., *Estimating the Number of Potential Organ Donors in the United States*, 349 NEW ENG. J MED. 667, 671 (2003) (estimating 13,300-13,800 annually for 1997-1999). This number may increase, however, because thirty-one states have repealed their laws requiring motorcyclists to wear

about half of those organs, approximately three per cadaver, are actually donated.[4] Lack of permission to use the remaining suitable organs leads to about sixteen deaths daily in the United States[5] and is why over 85,000 candidates remain on transplant waiting lists.[6] The majority are waiting for kidneys,[7] resulting in increased use of dialysis, which is not only burdensome for patients but also costs taxpayers tens of millions of dollars per year.[8] This Commentary contends that a reciprocity policy could dramatically increase donations and thereby decrease associated deaths. Under the policy, those who committed to donate organs would be granted a preference in the event that they later required a transplant.

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helmets, many recently. Matthew L. Wald, *As Risks Make a Helmut More Vital, Fewer Motorcyclists Wear One,* N.Y. TIMES, June 14, 2004, at A13.

4. *See* 2003 HHS OIG REP., *supra* note 3, at 4 (fifty-one percent donation rate at sample of transplant hospitals, forty-seven percent at other hospitals for August 2001 to November 2002 data); Sheehy, *supra* note 3, at 671 (forty-two percent for 1997-1999 data).

5. *See* United Network for Organ Sharing, *at* http://www.unos.org (last visited Nov. 4, 2004). This count ignores those removed from the waiting list before they die due to their health and others who are never added for health or financial reasons. *See* Teri Randall, *Too Few Human Organs for Transplantation, Too Many in Need . . . and the Gap Widens,* 265 JAMA 1223, 1223 (1991); Jonathan D. Sackner-Bernstein & Seth Godin, *Increasing Organ Transplantation–Fairly,* 77 TRANSPLANTATION 157, 157 (2004); *see also Assessing Initiatives to Increase Organ Donations: Hearing Before the House Subcomm. on Oversight & Investigations of the House Comm. on Energy & Commerce,* 108th Cong. 37 (2003) [hereinafter *2003 House Hearing*] (almost sixty percent of those on the waiting list today will die before receiving a transplant). Still, some of these deaths are due to unrelated conditions and many would still die even if all suitable donors donated their organs. *See* Anthony J. Langone & J. Harold Helderman, *Disparity Between Solid-Organ Supply and Demand,* 349 NEW ENG. J. MED. 704 (2003).

6. *See* United Network for Organ Sharing, *at* http://www.unos.org (87,271 candidates waiting as of November 4, 2004). Moreover, many patients needing organ transplants are not listed due to financial constraints, *see* Randall, *supra* note 5, at 1223, or screening standards, *see* Sackner-Bernstein & Godin, *supra* note 5, at 157 (suggesting that ten times as many listed are excluded); *see also* DAVID L. KASERMAN & A.H. BARNETT, THE U.S. ORGAN PROCUREMENT SYSTEM: A PRESCRIPTION FOR REFORM 26 (2002).

7. *See* Nat'l Kidney Found., Transplant Waiting List, *at* http://www.kidney.org/atoz/atozItem.cfm?id=114 (last updated May 17, 2004).

8. *See* KASERMAN & BARNETT, *supra* note 6, at 64-68 (estimating the social welfare cost of the present system at one billion dollars per year); *see also* Leonard H. Bucklin, *Woe Unto Those Who Request Consent: Ethical and Legal Considerations in Rejecting a Deceased's Anatomical Gift Because There is No Consent by the Survivors,* 78 N.D. L. REV. 323, 343 (2002) (estimating taxpayer savings of $500 million over twenty years if transplants replaced dialysis in one thousand cases).

Before discussing the proposal, Part I identifies the two main reasons that so many suitable organs are not donated. Part II then reviews efforts intended to address these issues, including those currently in place in the United States and the two major proposals—presumed consent and financial incentives—now receiving the most attention. Finally, Part III describes the reciprocity proposal advocated here: III.A explains how it works, III.B. describes some of its likely effects, and III.C responds to the major criticisms of the proposal.

I. TWO MAIN PROBLEMS

It has long been argued that organ donation should be motivated solely by altruism, but relying only on such generosity leaves half of the suitable organs in cadavers unused. Sadly, approximately 6000 deaths occur annually due to lack of an organ.[9] There are two main reasons why suitable organs are not transplanted. First and foremost, most people are not sufficiently motivated to commit to donate. Although more than two-thirds of Americans express a willingness to donate their own organs,[10] less than half of the public has formally committed to do so.[11] Many are

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9. *See supra* note 5 and accompanying text.

10. *See* THE GALLUP ORG., THE AMERICAN PUBLIC'S ATTITUDES TOWARD ORGAN DONATION AND TRANSPLANTATION 15 (1993) [hereinafter GALLUP POLL], http://www.transweb.org/reference/articles/gallup_survey/gallup_index.html (reporting that fifty-five percent were willing to donate their organs); Princeton Survey Res. Assocs., Organ Donation Survey (May 1999) [hereinafter 1999 Princeton Survey], http://www.pollingreport.com/health2.htm#organ (reporting that forty-two percent of respondents "very likely" to want to donate and twenty-five percent "somewhat likely"). *But see* Laura A. Siminoff et al., *Public Policy Governing Organ and Tissue Procurement in the United States*, 123 ANNALS INTERNAL MED. 10, 15 (1995) (suggesting that such figures probably reflect bias due to the high social desirability of the answer).

11. *See* Cindy Bryce et al., Do Incentives Matter? Providing Benefits to Families of Organ Donors (2004) (unpublished manuscript, on file with authors) (finding that, in a survey of residents of Pennsylvania, forty-five percent reported that they had committed to donate on a drivers' license or donor card); GALLUP POLL, *supra* note 10, at 15 (only twenty-eight percent of those surveyed said they had formally committed to donate); 1999 Princeton survey, *supra* note 10 (reporting that forty-two percent had committed to donate on a drivers' license or donor card); *see also* Laura A. Siminoff, *American Beliefs and Attitudes About Death*, *in* THE DEFINITION OF DEATH: CONTEMPORARY CONTROVERSIES 183, 189 (Stuart J. Youngner et al. eds., 1999) (finding data on drivers' license requests consistent with 1993 poll); *cf.* ENVIRONICS RESEARCH GROUP, ORGAN AND TISSUE DONATIONS: PUBLIC AWARENESS, KNOWLEDGE AND ADVERTISING RECALL 11 (2002) [hereinafter 2002 CANADIAN SURVEY] (prepared for Health Canada) (finding that about forty percent of Canadians reported

apathetic or reluctant to contemplate their own mortality.[12] They may prefer to avoid the stress[13] or even the physical effort required to sign up.[14] Many, at least partially influenced by film and television fiction, fear that their organs will be removed prematurely,[15] i.e., that some in the medical community will view them merely as potential suppliers of organs.[16] Others perceive favoritism in the allocation of organs to celebrities.[17] Still others

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having signed a donor card or registering with an organ registry).

12. *See* GALLUP POLL, *supra* note 10, at 13 (reporting that thirty-six percent of the public found it uncomfortable to think about their own death); *see also* Lloyd R. Cohen, *Increasing the Supply of Transplant Organs: The Virtues of a Futures Market,* 58 GEO. WASH. L. REV. 4, 10, 13 (1989); Jesse Dukeminier, *Supplying Organs for Transplantation,* 68 MICH. L. REV. 811, 829-30 (1970) (predicting, therefore, disappointing results for organ donations).

13. *See* Mary Frances Luce, *Choosing to Avoid: Coping with Negatively Emotion-Laden Consumer Decisions,* 24 J. CONSUMER RES. 409 (1998).

14. *See* William Samuelson & Richard Zeckhauser, *Status Quo Bias in Decision Making,* 1 J. RISK & UNCERTAINTY 7 (1988).

15. *See* GALLUP POLL, *supra* note 10, at 33 (finding that six percent of respondents feared premature removal of organs); 2002 CANADIAN SURVEY, *supra* note 11, at 45 (nineteen percent feared being declared dead prematurely); Laura A. Siminoff & Kata Chillig, *The Fallacy of the "Gift of Life,"* HASTINGS CENTER REP., Nov.-Dec. 1999, at 34, 36; John F. Neylan, *Transplant Dramas on the Critical List,* TV GUIDE, Apr. 25, 1998, at 50; Mike Holloway, The Campaign Against Organ Donation (Winter 1996-1997), *at* http://www.transweb.org/class/holloway.htm. For a recent example, see *Colo. Dispute over Organ Donor Brain Death, All Things Considered* (Nat'l Pub. Radio broadcast, Oct. 8, 2004) (reporting that a Colorado coroner ruled that organs were removed from a man for donation before medical personnel proved he was brain dead, although donor officials and the medical community counter that standard guidelines for recognizing brain death were used in the case), *available at* http://www.npr.org/templates/story/story.php?storyId=4077549. *See also* RONALD MUNSON, RAISING THE DEAD: ORGAN TRANSPLANTS, ETHICS, AND SOCIETY 173-76 (2002). *But see* Cohen, *supra* note 12, at 9. This situation also arises outside the United States and Canada. *See* Catalina Conesa et al., *Psychosocial Profile in Favor of Organ Donation,* 35 TRANSPLANTATION PROC. 1276, 1279-80 (2003).

16. *See* A. BRUCE BOWDEN & ALAN R. HULL, CONTROVERSIES IN ORGAN DONATION: A SUMMARY REPORT 23, 95-96, 98 (1993) (report for the National Kidney Foundation); Deborah L. Seltzer et al., *Are Non-Heart-Beat Cadaver Donors Acceptable to the Public?,* 11 J. CLINICAL ETHICS 347, 354 (2000) (reporting that between eighteen percent and forty-four percent of respondents worry that if doctors know they are donors the doctors may do less to save their lives); Laura A. Siminoff & Mary Beth Mercer, *Public Policy, Public Opinion, and Consent for Organ Donations,* 10 CAMBRIDGE Q. HEALTH & ETHICS 377, 384 (2001) (finding that while only twenty-one percent of whites were concerned that doctors would do less to save their lives if they knew their patient was an organ donor, fifty-two percent of non-whites felt that way).

17. *See* MUNSON, *supra* note 15, at 36-37; Siminoff & Mercer, *supra* note 16, at 384

prefer to be buried intact for personal or religious reasons[18] (although all major religions permit, if not encourage, life-enhancing donations[19]). Some fear making death or funerals more difficult for their families, among other reasons.[20]

Second, hospitals and doctors also often fail to honor a deceased's directions to donate. In some cases they may lack easy access to a patient's driver's license or organ donor card and a relevant organ donor registry may not exist.[21] Yet, even when a deceased's wishes are clear, medical personnel routinely seek out surviving family members and defer to their decision, even if it overrides the deceased's directive.[22] Healthcare

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(reporting that more than sixty-seven percent of donors and seventy-five percent of non-donors believe that rich or famous people have an advantage in obtaining a needed organ); *Liver Allocation and Organ Donation: Public Hearing Before the Dep't of Health & Human Servs* 87 (Dec. 10-12, 1996) [hereinafter *1996 HHS Hearings*] (testimony of Dr. Sollinger on December 10) (noting that following Mickey Mantle's liver transplant, and the controversy over favoritism, relatives were eight times more likely to refuse to donate organs).

18. *See* GALLUP POLL, *supra* note 10, at 5, 31, 37 (finding that seventeen percent of respondents found it important for a person's body to be intact when buried and five percent believed their religion required this).

19. *See* ORGAN AND TISSUE DONATION: A REFERENCE GUIDE FOR CLERGY, at V-2 to V-5 (M. Lisa Cooper Hammon & Gloria J. Taylor eds., 4th ed. 2000), http://www.redcross.org/donate/tissue/relgstmt.html; John Gillman, *Religious Perspectives on Organ Donation*, CRITICAL CARE NURSING Q., Nov. 1999, at 19. Religious leaders of some denominations oppose donations primarily because they reject the concept that a person can be "brain dead" even though their heart can continue to beat. *See, e.g.*, Debra Nussbaum Cohen, *New Front in Fight over Organ Donation*, JEWISH WEEK, May 14, 2004, at 1.

20. *See* ENVIRONICS RESEARCH GROUP, ORGAN AND TISSUE DONATIONS: CANADIAN PUBLIC AWARENESS, KNOWLEDGE AND ATTITUDES 25-26 (2001) [hereinafter 2001 CANADIAN SURVEY] (prepared for Health Canada) (finding twenty-percent and sixteen percent consider it important that donation would make death or funeral arrangements more difficult). In addition, twenty-two percent considered it important that recipients may not deserve an organ transplant, *see id.* at 25, and some may unintentionally prevent donations by executing an advanced directive explicitly demanding the withholding of life support. *See* Eric F. Galen, *Organ Transplantation at the Millennium: Regulatory Framework, Allocation Prerogatives, and Political Interest*, 9 S. CAL. INTERDISC. L.J. 335, 346-47 (1999); Dave Wendler & Neal Dickert, *The Consent Process for Cadaveric Organ Procurement*, 285 JAMA 329, 333 (2001).

21. Organ donor registries are discussed *infra* notes 62-63 and accompanying text.

22. *See* Laura A. Siminoff & Renee H. Lawrence, *Knowing Patients Preferences about Organ Donation: Does It Make a Difference?*, 53 J. TRAUMA 754, 756 (2002) (finding that ten percent of families who knew the deceased had chosen to donate still overrode that choice); Wendler & Dickert, *supra* note 20, at 331; GALLUP POLL, *supra* note 10, at 26 (twenty-four

professionals may fear upsetting families,[23] possibly leading to harmful publicity or litigation.[24] This is so even though legal penalties are highly unlikely due to statutory immunity provisions,[25] and laws may even prohibit overriding the decedent's intent.[26] Unfortunately, many believe the often publicized myth that family consent is legally required irrespective of the donor's wishes.[27]

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percent of those who would not donate themselves would also overrule a family member's known preference to donate); *see also* Kathryn Schroeter & Gloria J. Taylor, *Ethical Considerations in Organ Donation for Critical Care Nurses,* 19 CRITICAL CARE NURSE 60, 64 (1999); Siminoff et al., *supra* note 10, at 16; Donna H. Wright, Advance Directives and Donor Card Effectiveness Survey Report (1998) (prepared for UNOS).

23. *See* Jeffrey M. Prottas, *The Rules for Asking and Answering: The Rule of Law in Organ Donation,* 63 U. DET. L. REV. 183, 186 & n.11 (1985). Also, hospital chaplains seem to define success in dealing with organ donation in terms of whether the family was able to grieve successfully, regardless of whether a decision to donate organs was made. *See* Ann Mongoven, *Giving in Grief: Perspectives of Hospital Chaplains on Organ Donation, in* CARING WELL: RELIGION, NARRATIVES AND HEALTH CARE ETHICS 170, 183-84 (David H. Smith ed., 2000).

24. *See* Ann C. Klassen & David K. Klassen, *Who Are the Donors in Organ Donation? The Family's Perspective in Mandated Choice,* 125 ANNALS INTERNAL MED. 70, 71-72 (1996); Wendler & Dickert, *supra* note 20, at 332; Wright, *supra* note 22. *But see* Bucklin, *supra* note 8, at 339-40 (observing that honoring a donor's intent to improve another's life would seem more likely to generate good, rather than bad, publicity); Schroeter & Taylor, *supra* note 22, at 67 (same).

25. *See infra* note 44 and accompanying text. The immunity provision encourages judges to block suits on "summary judgments" without trials, and this shield has not been pierced. *See* Bucklin, *supra* note 8, at 334-36; Prottas, *supra* note 23, at 190. Still, the medical community greatly fears litigation for overriding the wishes of the deceased's family, *id.* at 190-91; Bucklin, *supra* note 8, at 339 n.145, and recent data support that, *see* Wright, *supra* note 22, at 8 (reporting survey finding that five of forty-one organ procurement organizations, or OPOs, had been sued for organ removals).

26. Some states have adopted laws to this effect. *See, e.g.,* VA. CODE ANN. § 54.1-2984 (Michie 2004) ("In no case shall the agent refuse or fail to honor the declarant's wishes in relation to anatomical gifts or organ, tissue or eye donation."); *see also* Bucklin, *supra* note 8, at 339 n.148, 343-48; Daniel Jardine, Comment, *Liability Issues Arising Out of Hospitals' Organ Procurement Organizations: Rejection of Valid Anatomical Gifts: The Truth and Consequences,* 1990 WIS. L. REV. 1655.

27. The myth that family consent is legally required has even been spread by those seeking to increase donations. *See* Robert E. Sullivan, *The Uniform Anatomical Gift Act, in* ORGANS AND TISSUE DONATION: ETHICAL, LEGAL, AND POLICY ISSUES 19, 30-31 (Bethany Spielman ed., 1996) [hereinafter ORGANS AND TISSUE DONATION]. For example, a senior organ donation administrator, writing a column titled "Legally Speaking," in the nationally respected publication *RN,* advised nurses in 1987: "[A]ny family has the legal right to say

Where there is no formal directive, families, who often have not discussed the issue with the deceased,[28] are forced to make quick decisions in moments of grief and anguish. About half of families asked to donate refused.[29] In addition to the reasons noted above, some families are unwilling to delay funerals, and many act out of concern that the deceased "has already suffered enough."[30] Others fear disfiguring the bodies of loved ones.[31] Many likely view the deceased's donation directive as a nonbinding charitable impulse.

II. EFFORTS TO ADDRESS THE PROBLEMS

A. The Current System

To better understand policies for increasing organ donations, it is useful to consider the current organ allocation system. Those requiring an organ from a cadaveric donor must be listed on the United Network for Organ Sharing (UNOS) waiting list.[32] This generally requires that they meet the medical suitability standards of a transplant center and demonstrate their ability to finance the transplant.[33] Medicare generally

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'No' [to donation] even though the patient was carrying a donor card permitting the retrieval of his organs for use in transplants." John Kiernan, *If You Have to Ask for an Organ Donation*, RN, Oct. 1987, at 112, 114. Assertions that "family consent is required" have also been made by UNOS, *see* Jardine, *supra* note 26, at 1658 n.17, and by the U.S General Accounting Office, *see* U.S. GEN. ACCOUNTING OFFICE, ORGAN TRANSPLANTS: INCREASED EFFORT NEEDED TO BOOST SUPPLY AND ENSURE EQUITABLE DISTRIBUTION OF ORGANS 17 (1993) [hereinafter 1993 GAO REPORT]. *See also* Bucklin, *supra* note 8, at 328-34 (discussing legislative efforts to clarify that family consent was not required where an individual had previously stated his or her desire to donate his or her organs). *But see infra* note 49.

28. *See* GALLUP POLL, *supra* note 10, at 19-20 (finding that about fifty percent of respondents had not discussed their preferences regarding donations with their family).

29. *See* Sheehy, *supra* note 3, at 671; Siminoff et al., *supra* note 10, at 14.

30. *See* Siminoff & Chillig, *supra* note 15, at 36; Siminoff & Lawrence, *supra* note 22, at 756.

31. *See* GALLUP POLL, *supra* note 10, at 38 (reporting that nineteen percent of respondents feared disfigurement from a donation).

32. Patients can avoid the UNOS waiting list process by receiving a "directed donation" from a willing and compatible donor. Such directed donations to named individuals are legal throughout the United States. *See* 1987 UAGA, § 6(a); 1993 GAO Report, *supra* note 27, at 63-64; *see also* ROBERT M. VEATCH, TRANSPLANTATION ETHICS 303-04, 388-411 (2000).

33. *See* WILLIAM J. CURRAN ET AL., HEALTH CARE LAW AND ETHICS 768 (1998); MUNSON, *supra* note 15, at 51-52.

covers the bulk of the costs of kidney transplants for its beneficiaries, and Medicaid may cover some transplants for the poor in some states.[34] Some patients, however, are forced to pursue loans, grants, or donations,[35] and many, like Denzel Washington's character's son in the 2002 film *John Q*, fall short and are thus excluded by this so called "green screen."[36]

The allocation of organs among those on the UNOS waiting is based, to a large degree, on compatibility.[37] For example, for kidneys, a standardized formula awards points to potential recipients based on factors like tissue type, immune status, time on the waiting list, and distance from the donor.[38] For most organs, consideration is first given to recipients located within the same donation service area (DSA) as the donor. Nationwide, there are fifty eight DSAs, which are regional combinations of organ procurement organizations (or OPOs) and their transplant center networks. The organ is given to the person in the DSA with the highest UNOS score.[39] If there are no suitable recipients in the donor's DSA, the organ is offered next to the candidates in the donor's OPO region (there are eleven OPO regions nationwide), again, based on their scores. If there are no suitable recipients in that region, then the organ is offered nationwide based on those UNOS scores.[40] This "local first" policy has been

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34. *See* UNOS, Financing a Transplant, http://www.transplantliving.org/beforethetransplant/finance/funding.aspx#medicare (last visited Nov. 17, 2004).

35. *Id.*

36. *See* TOM KOCH, SCARCE GOODS: JUSTICE, FAIRNESS, AND ORGAN TRANSPLANTATION 131-50, 175-98 (2002); Clive O. Callendar et al., *Blacks and Whites and Kidney Transplantation: A Disparity! But Why Won't It Go Away?*, 16 TRANSPLANTATION REV. 163, 171 (2002) (discussing the "green screen").

37. *See* MUNSON, *supra* note 15, at 47-51. OPOs, however, cannot consider an organ seeker's ethnicity, gender, or religion, and some OPOs also have policies against discrimination against prison inmates. *See, e.g.*, James Sterngold, *Inmate's Transplant Prompts Questions of Costs and Ethics*, N.Y. TIMES, Jan. 31, 2002 at A18.

38. UNOS Organ Distribution Policies § 3.5-3.9 (July 2004) (rules for kidneys, livers, and hearts), http://www.unos.org/policiesandbylaws/policies.asp?resources=true; *see also* Marlies Ahlert et al., *Kidney Allocation in Eurotransplant*, 23 ANALYSE & KRITIK 156 (2001); Johan De Meesters et al., *The New Eurotransplant Kidney Allocation System*, 66 TRANSPLANTATION 1154 (1998).

39. With some exceptions (e.g., special priority is given to O-type recipients, *see* Galen, *supra* note 20, at 357-58), the organ is offered first to the transplant team of the person on the top of the list from the DSA. Meanwhile, doctors of the patients scoring highest will decline an organ when their patient is not willing and healthy enough to undergo major surgery immediately or insufficiently compatible with the donor.

40. *See* 1993 GAO REPORT, *supra* note 27, at 18-19.

widely criticized.[41]

B. Policies Already in Place To Increase Organ Donations

The problem of enforcing a deceased's express wish to donate was first addressed by the model 1968 Uniform Anatomical Gift Act (UAGA), which all states adopted.[42] It makes such decisions irrevocable after a donor's death[43] and grants immunity from liability to those who act in good faith to honor those wishes.[44] When, despite this, few OPOs were willing to take organs based solely on a deceased's written directive, a 1987 revision was offered.[45] Its more explicit language states that: "An anatomical gift that is not revoked by the donor before death is irrevocable and does not require

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41. The justification given for the "local first" policy is that organs deteriorate rapidly and that the policy encourages local donors. Livers, however, are generally offered to the medically suitable patient with the most urgent need nationwide, rather than local, subject to travel time constraints. *See infra* notes 139-142 and accompanying text.

42. *See* UNIF. ANATOMICAL GIFT ACT (UAGA) prefatory note (1987), 8A U.L.A. 4 (2003) [hereinafter 1987 UAGA].

43. The 1968 UAGA § 2(e) stated that: "The rights of the donee [OPO] created by the gift are paramount to the rights of others except as provided in Section 7(d)," where 7(d) states that the UAGA is subject to state laws regarding autopsies. UNIF. ANATOMICAL GIFT ACT (UAGA) §§ 2(e), 7(d) (1968), 8A U.L.A. 116, 146 (2003) [hereinafter 1968 UAGA]. In addition, the official comment to the subsection explained "Subsection (e) recognizes and gives legal effect to the right of the individual to dispose of his own body without subsequent veto by others." *Id.* § 2(e) cmt.

44. 1968 UAGA § 7(c), 8A U.L.A. 146 (2003). That provision was slightly clarified in the 1987 UAGA § 11(c), 8A U.L.A. 64 (2003), and now reads: "A hospital, physician, . . . or other person, who acts in accordance with this Act . . . or attempts in good faith to do so is not liable for that act in a civil action or criminal proceeding." And, absent a factual dispute about whether consent was given, such immunity has been upheld by courts on summary judgment. *See, e.g.*, Lyon v. U.S., 843 F. Supp. 531 (D. Minn. 1994); Nicoletta v. Rochester Eye & Human Parts Bank, 529 N.Y.S.2d 928 (N.Y. Sup. Ct., 1978); Carey v. New England Organ Bank, 17 Mass. L. Rptr. 582, 2004 WL 875623, at *9 (Mass. Super. 2004).

45. 1987 UAGA § 2(h) was an attempt to respond to the medical community's failure to take advantage of the 1968 UAGA. *See* Thomas D. Overcast et al., *Problems in the Identification of Potential Organ Donors: Misconceptions and Fallacies Associated with Donor Cards,* 251 JAMA 1559, 1561-62 (1984) ("The evidence suggests . . . that . . . family consent is still required in [all states except California, Colorado, Florida, and Wyoming]. . . . In the majority of instances, this policy is based on fear of prosecution. The medical community does not think that the provisions of the UAGA provide sufficient protection."); *see also supra* note 25; *infra* note 49.

the consent or concurrence of any person after the donor's death."[46] Although only thirty-four states have adopted that revision,[47] the effort to pass legislation which can overcome the resistance of transplant professionals[48] is now gaining greater attention under an initiative entitled "donor designation."[49]

The U.S. Department of Health & Human Services (HHS) is focusing its efforts on helping hospitals to improve their ability to convince the families of dead or dying patients to donate. HHS created a "Gift of Life Initiative," which includes an "Organ Donation Breakthrough Collaborative" to identify and promote the best practices for requesting donations from family members.[50] It builds on experiences, particularly

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46. 1987 UAGA § 2(h).

47. *See* Advisory Committee on Organ Transplantation (ACOT), U.S. Dep't of Health & Human Servs., Recommendations to the Secretary app.6 (2003), http://organdonor.gov/acotapp6.html. States have opposed the revised UAGA for various reasons. *See* Ann McIntosh, Comment, *Regulating the Gift of Life*, 65 WASH. L. REV. 171, 176 (1990).

48. *See supra* text accompanying notes 23-26.

49. The AOPO, UNOS, and HHS ACOT have all endorsed implementing the 1987 UAGA provision, i.e., the "donor designation" policy, in all states. *See* U.S. Dep't of Health & Human Servs. Advisory Comm. on Organ Transplantation (ACOT), Summary Notes from Meeting, Wash. DC 4, 9-10, 11-13 (May 22-23, 2003), *available at* http://www.organdonor.gov/acot5-03.html [hereinafter ACOT May 2003 Notes]. This has been the rule in four states since 1985. *See* Overcast et al., *supra* note 45, at 1562; *see also* David A. Peters, *A Unified Approach to Organ Donor Recruitment, Organ Procurement, and Distribution*, 3 J.L. & HEALTH 157, 185-87 (1988) (noting that families "should be considerately informed that retrieval procedures will be implemented in deference to their loved one's prior decision."). OPOs that fail to abide by donor directives could even be penalized with a temporary suspension of federal funds or of accreditation by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). This option was pointed out to the authors by Peter Cohen. *See* E-mail from Peter Cohen to the author (Nov. 21, 2003) (on file with authors). Moreover, this would appear practical to enforce where there was a disgruntled family member, angry that the rest of the family had overridden the deceased's wishes.

50. *See* U.S. DEP'T OF HEALTH & HUMAN SERVS. & SERVS. ADMIN., OFFICE OF SPECIAL PROGRAMS, DIV. OF TRANSPLANT, THE ORGAN DONOR BREAKTHROUGH COLLABORATIVE: BEST PRACTICES FINAL REPORT (2003), http://www.organdonor.gov/bestpractice.htm (identifying seven overarching principles and fifteen specific practices for increasing organ donations); U.S. Dep't of Health & Human Servs. Advisory Comm. on Organ Transplantation (ACOT), Summary Notes from Meeting, D.C., May 6-7, 2004, http://www.organdonor.gov/acot5-04.htm [hereinafter ACOT May 2004 Notes]; *2003 House Hearing*, *supra* note 5, at 36, 41-42 (testimony of Michelle Snyder, Dir. Office of Special Programs, HRSA, discussing HHS's Gift of Life Initiative); Laura Siminoff et al., *Factors Influencing Families' Consent for Donation*

with the Spanish Model—whereby a specially trained team, separate from the medical/transplant teams, is responsible for increasing organ donations[51]—and also with the "Donor Action" diagnostic review protocols.[52] It seeks to raise the average donation rate to the seventy-five percent level now achieved by the most successful hospitals.[53]

Efforts to increase donor consent rates have also long included attempts to educate the public, and over the last decade public service announcements promoting organ donation in the United States have used about half a billion dollars in free television time.[54] In addition, special organ donation programs have been initiated by the American Medical Association (AMA), HHS, the American Society of Transplant Surgeons (ASTS), and UNOS.[55] HHS, for example, is promoting major public

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of Solid Organs for Transplantation, 286 JAMA 71 (2001).

51. *See* Blanca Miranda et al., *Optimizing Cadaveric Organ Procurement: The Catalan and Spanish Experience,* 3 AM. J. TRANSPLANTATION 1189 (2003). *But see* George E. Chang et al., *Expanding the Donor Pool: Can the Spanish Model Work in the United States,* 3 AM. J. TRANSPLANTATION 1259 (2003) (suggesting that the protocol may primarily represent a higher utilization of marginal donors).

52. *See* Leo Roels & Celia Wight, *Non-Exploited Potential for Organ Donation: Aggregated Data from the Donor Action Database,* 2 AM. J. TRANSPLANTATION 375 (Apr. supp. 2002); Leo Roels & Celia Wight, *Donor Action: An International Initiative to Alleviate Organ Shortage,* 11 PROGRESS TRANSPLANTATION 90 (2001).

53. *See* Press Release, Sec'ys Donation Initiative, U.S. Dep't of Health & Human Servs., HHS Expands Organ and Tissue Donation Initiative, Promotes Living Donation Safety and Awareness (June 3, 2003), http://www.organdonor.gov/secgrndbrk.htm.

54. Telephone conversation with Melissa Devanny, Assistant Director, Coalition on Donation (Oct. 1, 2003); *see also* Thomas J. Cossé & Terry M. Weisenberger, *Words Versus Actions About Organ Donation: A Four-Year Tracking Study of Attitudes and Self-Reported Behavior,* 50 J. BUS. RES. 297 (2000).

55. *See* Am. Med. Ass'n, D-370.992, *at* http://www.ama-assn.org/apps/pf_new/pf_online?f_n=browse&doc=policyfiles/DIR/D-370.992.HTM; Tommy Thompson, U.S. Dep't of Health & Human Servs., Organ Donation, http://www.organdonor.gov/workplace.htm (describing the Workplace Partnership for Life); First Family Pledge, What's New at First Family Pledge, *at* http://familypledge.org/WhatsNew.asp. Other successful efforts include the National Minority Organ Tissue Transplant Education Program (MOTTEP). *See* LISA GILMORE ET AL., U.S. DEP'T OF HEALTH & HUMAN SERVS., STATE STRATEGIES FOR ORGAN AND TISSUE DONATION: A RESOURCE GUIDE FOR PUBLIC OFFICIALS 53-77 (2001); Clive O. Callender & Patrice. V. Miles, *Obstacles to Organ Donation in Ethnic Minorities,* 5 PEDIATRIC TRANSPLANTATION 383 (2001) (addressing the particular difficulty recruiting minorities); *see also* Amitai Etzioni, *Organ Donation: A Communitarian Approach,* 13 KENNEDY INST. ETHICS J. 1, 5-7 (2003).

education initiatives.[56] Unfortunately, evidence from the substantial national educational campaigns in the United States, Canada, Sweden, the Netherlands, Australia, and England indicates that none have significantly increased organ donation rates.[57] Then again, it could be that the primary impact of such programs is offsetting the negative impact of the chilling, fictional media broadcasts noted above.[58]

Another related set of efforts include "mandated choice," requiring individuals to decide in advance whether they will donate;[59] "required request" laws, which command hospitals to ask patients or their families

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56. The HHS organ donation website, Organ Donation, *at* http://organdonor.gov, is being redesigned and will feature HHS's educational initiatives prominently, according to ACOT's recommendation #11. *See 2003 House Hearing, supra* note 5, at 36-37, 80.

57. *See* 2002 CANADIAN SURVEY, *supra* note 11 (finding little change in Canadian attitudes after a 2001 to 2002 media campaign); Cossé & Weisenberger, *supra* note 54; Mehmet C. Oz et al., *How To Improve Organ Donation: Results of the ISHLT/FACT Poll*, 22 J. HEART & LUNG TRANSPLANT 389, 393 (2003) (noting the 1998 Netherlands campaign); *see also* B. Cuzin & J. M. Dubernard, *The Media and Organ Shortage, in* ORGAN SHORTAGE: THE SOLUTIONS 287, 288-89 (J.L. Touraine et al. eds., 1994) (reporting on a campaign in Australia); BILL NEW ET AL., KINGS FUND INST., A QUESTION OF GIVE AND TAKE: IMPROVING THE SUPPLY OF DONOR ORGANS FOR TRANSPLANTATION (1994); Margaret S. Verble & Judy Worth, *The Case Against More Public Education to Promote Organ Donation*, 6 J. TRANSPLANT COORDINATION 200 (1996). *But see* Ian Kennedy et al., *The Case for "Presumed Consent" in Organ Donation*, 351 THE LANCET 1650, 1650 & 1652 nn.6-8 (1998) ("Supply can be increased by energetic educational campaigns . . . ."); Cuzin & Dubernard, *supra*, at 289-90 (reporting on some success in Saudi Arabia). There is some evidence that direct personal contacts, such as speaking at drivers' education classes and church functions, is most effective. *See* Cuzin & Dubernard, *supra*, at 292-93; Ellen G. Lanser, *Sharing the Gift of Life: Your Role in Raising Organ Donor Awareness*, HEALTHCARE EXEC., Nov./Dec. 2001, at 20, 23-25.

58. *See supra* note 15 and accompanying text.

59. *See* Klassen & Klassen, *supra* note 24, at 72 (critiquing mandated choice and noting that when the Virginia DMV began using mandatory choice forty-five percent of subjects registered as nondonors and twenty-four percent as undecided); Siminoff & Mercer, *supra* note 16, at 380 (noting that when Texas attempted mandated choice in the early 1990s there was an eighty percent refusal rate and the Texas legislature repealed the law); Aaron Spital, *Mandated Choice for Organ Donation: Time To Give It a Try*, 125 ANNALS INTERNAL MED. 66 (1996); Monique C. Gorsline & Rachelle L.K. Johnson, Note, *The United States System of Organ Donation, the International Solution, and the Cadaver Organ Donor Act: "And the Winner is . . .,"* 20 J. CORP. L. 5, 38-48 (1994). At least five states ask their residents whether they are willing to be organ donors. *See* GILMORE ET AL., *supra* note 55, at 43; Andrew C. MacDonald, *Organ Donation: The Time Has Come to Refocus the Ethical Spotlight*, 8 STAN. L. & POL'Y REV. 177, 183 (1997) (interpreting Colorado's Department of Motor Vehicles (DMV) preference request to be an example of mandated choice).

about donating;[60] as well as driver's license applications that invite drivers to check off a box to donate.[61] At least thirty states have created donor registries,[62] which facilitate hospital access to patient choices, and Congressional bills have proposed a national registry.[63]

The introduction of live donors for kidneys, as well as for liver or lung parts, has reduced the organ shortage.[64] In addition, transplants of organs

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60. Such laws were federalized in 1986. Pub. L. No. 99-509, § 9318(a), 100 Stat. 2009 (1986) (codified as amended at 42 U.S.C. § 1320b-8(a)(1)(A) (2000)). The statute conditions eligibility for Medicare and Medicaid hospitals on employment of some form of required request. Federal regulations require hospitals to notify an OPO of all imminent or recent deaths and ensure that families of potential donors are asked to donate by a specially trained representative. 42 C.F.R. § 482.45(a)(3) (2003). In addition, by 1992, almost all states had enacted some form of 1987 UAGA § 5, which requires that potential donors be asked about donation. Fred H. Cate, *Human Organ Transplantation: The Role of Law,* 20 J. CORP. L. 69, 73 & n.48 (1994).

61. *See* Overcast et al., *supra* note 45; Editorial, *The Virginia DMV's Noble New Cause,* ROANOKE TIMES & WORLD NEWS, May 20, 1999, at A20 (noting a jump from 16,000 to 64,000 registering to donate organs in March 1999 after the Virginia DMV began orally asking customers to do so).

62. *See* Ass'n for Organ Procurement Orgs., Donor Registry Information by State (Dec. 2003) (on file with authors); *see also* UNOS, Donor Designation (First Person Consent) Status by State (May 2004), *at* http://www.unos.org/Resources/factsheets.asp?fs=6. *See generally* LEWIN GROUP, GUIDELINES FOR DONOR REGISTRY DEVELOPMENT CONFERENCE, FINAL REPORT app. B (2d rev. 2002) (prepared for the Div. Transplantation, U.S. Dep't of Health & Human Servs.), http://www.organdonor.gov/nfdrguidelines.html; OFFICE OF INSPECTOR GEN., U.S. DEP'T OF HEALTH & HUMAN SERVS., ORGAN DONOR REGISTRIES: A USEFUL, BUT LIMITED TOOL (2002), http://oig.hhs.gov/oei/reports/oei-01-01-00350.pdf.

63. *See, e.g.,* Motor Donor Act, S.788, 107th Cong. (2001); Motor Donor Act, H.R. 2645, 107th Cong. (2001); Donate Act, S.1062, 107th Cong. (2001); Organ Donor Enhancement Act H.R. 955, 107th Cong. (2001). There are also registries like Living Bank, *at* http://www.livingbank.org. Belgium has had a national registry since 1986, and Austria and Sweden established them in 1996. *See* Paul Michielsen, *Informed or Presumed Consent Legislative Models, in* ORGAN AND TISSUE DONATION FOR TRANSPLANTATION 344, 345 (Jeremy Chapman et al. eds., 1997) [hereinafter CHAPMAN].

64. In fact, in 2001 and 2002 there were more live kidney donors than cadaver donors, although more organs came from the latter. *See* Alvin E. Roth et al., *Kidney Exchange,* 119 Q. J. ECON. 457, 458 (2004); *see also* Denise Grady, *Transplant Frontiers: A Special Report; Healthy Give Organs to Dying Raising Issue of Risk and Ethics,* N.Y. TIMES, June 24, 2001, § 1, at 1. Moreover, kidneys from live donors appear to produce significantly better results. *See* Sundaram Hariharan et al., *Improved Graft Survival After Renal Transplantation in the United States,* 342 NEW ENG. J. MED. 605 (2000). This is leading to increased focus on "paired exchanges." *See* Francis L. Delmonico, *Exchanging Kidneys—Advances in Living-Donor Transplantation,* 350 NEW ENG. J. MED. 1812 (2004); Roth, *supra.* Yet, the better results for

that were previously considered unusable are now possible because of new drugs, technologies, and methods.[65] Research continues on more controversial options like using animal organs, known as xenotransplantation, and cloning.[66]

Despite all of these current efforts, however, half of the usable organs in cadavers continue to go undonated, leading to thousands of unnecessary deaths annually.[67] While some current initiatives—such as the HHS Breakthrough Collaborative—are certainly promising,[68] it seems worthwhile to also consider other options.[69]

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recipients of organs from live donors may actually be due to the better health of such recipients. They tend to be younger and have spent less time on waiting lists than those receiving cadaveric donations. *See* Alex Tabarrok, *Life-Saving Incentives: Consequences, Costs and Solutions to the Organ Shortage*, LIBR. ECON. & LIBERTY, Apr. 5, 2004, at n.3, *at* http://www.econlib.org/library/Columns/y2004/Tabarrokorgans.html. Also researchers have estimated that one in three liver donors suffers a medical complication and half of those are serious. *See* Laura Meckler, *Living Organ Donors Often Oblivious to Risks They Run*, L.A. TIMES, Aug. 10, 2003, at A1. *See generally* David Steinberg, *An "Opting In" Paradigm for Kidney Transplantation*, AM. J. BIOETHICS, Dec. 2004, at 1, 1-5 (discussing the drawbacks of live donation).

65. *See* Robert J. Stratta, *Expanded Criteria Donors in Kidney Transplantation: A Treadmill or Bandwagon Effect?*, MEDSCAPE TRANSPLANTATION, Sept. 16, 2004, http://www.medscape.com/viewarticle/488926. *But see* B. K. Rayburn et al., *Are Efforts at Expanding the Donor Pool Misdirected?*, 17 J. HEART & LUNG TRANSPLANTATION 998 (1998).

66. *See* JOINT COMM. ON ACCREDITATION OF HEALTHCARE ORGS., HEALTH CARE AT THE CROSSROADS: STRATEGIES FOR NARROWING THE ORGAN DONATION GAP AND PROTECTING PATIENTS 35 (2004) [hereinafter 2004 JCAHO REPORT], *available at* http://www.jcaho.org/news+room/press+kits/organ+donation+white+paper/organ+donation+white+paper.pdf; MUNSON, *supra* note 15, at 220-64. The use of organ donations from condemned prison inmates, however, appears to be beyond the pale. *See* Phyllis Coleman, *"Brother, Can You Spare A Liver?," Five Ways To Increase Organ Donation*, 31 VAL. U. L. REV. 1, 26-34 (1996). *But see* Craig S. Smith, *On Death Row, China's Source of Transplants*, N.Y. TIMES, Oct. 18, 2001, at A1.

67. *See supra* note 4-5 and accompanying text.

68. *See* ACOT May 2004 Notes, *supra* note 50, at 24-26 (reporting promising preliminary results from the Collaborative Breakthrough).

69. One option that is beyond the scope of this analysis is the one voiced by Tom Koch, among others, that organ transplantation should be suspended in the nation until the fundamental social and geographical inequalities of the current system are remedied. *See* KOCH, *supra* note 36.

C. Other Proposed Policies: Presumed Consent & Financial Incentives

At least nineteen nations have legislated a policy of "presumed consent."[70] Under that policy, an individual is treated as having consented to donate organs absent express instructions to the contrary.[71] It appears to be the preferred approach of many, if not most, transplant professionals,[72] and the HHS Advisory Committee on Organ Transplantation (ACOT) is considering whether to recommend the policy to HHS.[73] Not only have data indicated that a presumed consent default could save lives by increasing actual donations by sixteen percent or more,[74] but the policy also relieves many grieving relatives of the burden of deciding whether or not to donate a loved one's organs.

On the other hand, many medical professionals are concerned that strictly enforcing presumed consent tramples the autonomy, if not civil liberties, of individuals who prefer not to donate but fail to formally opt

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70. *See* Ronald W. Gimbel et al., *Presumed Consent and Other Predictors of Cadaveric Organ Donation in Europe*, 13 PROGRESS TRANSPLANTATION 17, 19 (2003) (listing eighteen nations). Singapore is another example. *See infra* note 97.

71. *See* Carl Cohen, *The Case for Presumed Consent To Transplant Human Organs After Death*, 24 TRANSPLANT PROC. 2168 (1992); Jesse Dukeminier & David Sanders, *Organ Transplantation: Proposal for Routine Salvaging of Cadaver Organs*, 279 NEW ENG. J. MED. 413 (1968); William N. Gerson, Note, *Refining the Law of Organ Donation: Lessons from the French Law of Presumed Consent*, 19 N.Y.U. J. INT'L L. & POL. 1013 (1987); Kennedy et al., *supra* note 57; Oz et al., *supra* note 57; *infra* note 78. A version whereby consent is presumed absent informed rejection by donor or family has also been suggested. Arthur J. Matas et al., *A Proposal for Cadaver Organ Procurement: Routine Removal with Right of Informed Refusal*, 10 J. HEALTH POL. POL'Y & L. 231 (1985). As of 1995, twenty-one states applied presumed consent to corneal tissue. *See* Cate, *supra* note 60, at 84 & nn.115-16. *See generally* The Presumed Consent Foundation, *at* http://www.presumedconsent.org (last visited Nov. 11, 2004).

72. *See* Oz et al., *supra* note 57, at 391. *But see* J.D. Jasper et al., *Altrusism, Incentives, and Organ Donation: Attitudes of the Transplant Community*, 42 MED. CARE 378, 383 (2004) (finding support for presumed consent/ mandatory donation from only nineteen percent of surgeons, seven percent of transplant center coordinators, and five percent of nurses).

73. *See* ACOT May 2003 Notes, *supra* note 49, at 5-9. *But see infra* note 78.

74. *See* ALBERTO ABADIE & SEBASTIEN GAY, THE IMPACT OF PRESUMED CONSENT LEGISLATION ON CADAVERIC ORGAN DONATION: A CROSS COUNTRY STUDY (Harvard Univ. John F. Kennedy Sch. of Gov't, Working Paper No. RWP04-024, 2004), http://ssrn.com/abstract=562841 (finding a twenty-five to thirty percent increase for a survey of twenty-two nations over ten years); Gimbel et al., *supra* note 70 (finding more than a fifty percent increase for a broad survey of European nations); Eric J. Johnson & Daniel Goldstein, *Do Defaults Save Lives?*, 302 SCIENCE 1338, 1339 (2003).

out.[75] In fact, personal autonomy is valued so highly that no nation has been willing to override it, even to save lives, as by requiring that all usable organs of the dead be made available for transplants.[76] Accordingly, in France, Greece, Hungary, and Italy, among other nations with presumed consent laws, medical professionals often enforce a de facto "informed consent" policy, deferring to families to determine whether the deceased had preferred not to donate even where no formal record suggests this.[77] Furthermore, in the United States, there is both significant public opposition to presumed consent[78] and good reason to question whether it would be effective.[79]

A second, controversial proposal for increasing organ donations is the

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75. *See* Robert M. Veatch & Jonathan B. Pitt, *The Myth of Presumed Consent: Ethical Problems in New Organ Procurement Strategies*, 27 TRANSPLANTATION PROC. 1888 (1995) (expressing particular concern about the impact of presumed consent on the uneducated). Some doctors find it awkward, if not immoral, to take organs absent express permission of the deceased or next of kin. *See* Cohen, *supra* note 12, at 19-20; James F. Childress, *Ethical Criteria for Procuring and Distributing Organs for Transplantation*, 14 J. HEALTH POL. POL'Y & L. 87, 95-98 (1989). This led many nations to shift to an opt-in approach. *See* Troy R. Jensen, Comment, *Organ Procurement: Various Legal Systems and Their Effectiveness*, 22 HOUS. J. INT'L L. 555, 558-67 (2000).

76. *See, e.g.*, John Harris, *In Praise of Unprincipled Ethics*, 29 J. MED. ETHICS 303, 304-05 (2003). Many advocates of drafting organs from dead bodies note that nations are willing to force the young to risk their lives in war. *See, e.g.*, Theodore Silver, *The Case for a Post-Mortem Organ Draft and a Proposed Model Organ Draft Act*, 68 B.U. L. REV. 681 (1988). Still, nations generally permit conscientious objectors. On the paramount status of autonomy see Raanan Gillon, *Ethics Needs Principles – Four Can Encompass the Rest – and Respect for Autonomy Should Be "First Among Equals,"* 29 J. MED. ETHICS 307, 310-11 (2003).

77. *See, e.g.*, Gerson, *supra* note 71, at 1024; Gimbel et al., *supra* note 70, at 19 (listing France, Greece, Hungary, Italy, Luxemburg, Norway, and Slovenia in this group); Michielsen, *supra* note 63. Also, in presumed consent nations many may register as non-donors in panic. *See* Jensen, *supra* note 75, at 572-73; Siminoff et al., *supra* note 10, at 16.

78. *See* VEATCH, *supra* note 32, at 170 (concluding that from the empirical evidence of limited public support for actually donating their organs, "there can be no basis for presuming consent"); TASK FORCE ON ORGAN TRANSPLANTATION, U.S. DEP'T OF HEALTH & HUMAN SERVS., ORGAN TRANSPLANTATION: ISSUES AND RECOMMENDATIONS 30-31 (1986) [hereinafter 1986 HHS TASK FORCE] (rejecting presumed consent due to polling data); Seltzer et al., *supra* note 16, at 354 (reporting that only fourteen to thirty-six percent of respondents supported presumed consent); Siminoff & Mercer, *supra* note 16, at 380 (reporting that only twenty-three percent of respondents supported presumed consent). *But see* 2001 CANADIAN SURVEY, *supra* note 20, at 45 (half support presumed consent).

79. *See* CURRAN ET AL., *supra* note 33, at 751 (noting that in the first year after medical examiners were given presumed consent authority in Texas, it was only used twice).

use of financial incentives. There have long been strong objections to using monetary incentives to procure organs, even to pay for funeral expenses.[80] Many worry that this would lead to exploitation of the poor.[81] An aversion to treating body parts as commodities sold for profit led the 1984 National Organ Transplant Act (NOTA) to prohibit donors from being offered any "valuable consideration,"[82] and many states followed suit.[83] A U.S. Congressional hearing on this issue in June 2003 confirmed strong ongoing and widespread opposition to direct financial incentives.[84]

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80. For a general review of the issue of monetary compensation for organs, see Donald Joralemon, *Shifting Ethics: Debating the Incentive Question in Organ Transplantation,* 27 J. MED. ETHICS 30 (2001); Abdullah S. Daar, *Paid Organ Donation: Towards an Understanding of the Issues in* CHAPMAN, *supra* note 63, at 46; and Abdullah S. Daar, *Rewarded Gifting,* 24 TRANSPLANTATION PROC. 2207 (1992).

81. *See* MUNSON, *supra* note 15, at 116-19; Madhav Goyal et al., *Economic and Health Consequences of Selling a Kidney in India,* 288 JAMA 1589 (2002); Nancy Scheper-Hughes, *Keeping an Eye on the Global Traffic in Human Organs,* 361 THE LANCET 1645 (2003).

82. 42 U.S.C. § 274e (2000) (making it illegal "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"). The provision appears to have been a reaction to a Virginia physician's efforts to address the organ shortage by brokering living donors' kidneys in a manner designed to earn a profit. *See* Cate, *supra* note 60, at 80. Instead of specific justifications, the reports of the House, Senate, and the task force they established to inquire further into these policy matters all offer only conclusory condemnations of organ sales. *See, e.g.,* S. REP. No. 98-382 (1984), at 16, *reprinted in* 1984 U.S.C.C.A.N. 3975, 3982; H.R. CONF. REP. No. 98-1127 (1984), at 16, *reprinted in* 1984 U.S.C.C.A.N, at 3989, 3992; 1986 HHS TASK FORCE, *supra* note 78, at 96. The 1968 UAGA had intentionally left open the issue of payment. *See* E. Blythe Stason, *The Uniform Anatomical Gift Act,* 23 BUS. L. 919, 927-28 (1968).

83. The 1987 UAGA § 10, 8A U.L.A. 29, 64 (2003), adopted by many states, prohibits the sale of organs. *See* Radhika Rao, *Property, Privacy, and the Human Body,* 80 B.U. L. REV. 359, 376 n.58 (2000).

84. *See 2003 House Hearing, supra* note 5, at 5, 21, 64-67; *see also* Arnold et al., *supra* note 88 (position of ASTS); *id.* at 1362-63 (position of Pope John Paul II); Thomas J. Cossé & Terry M. Weisenberger, *Encouraging Human Organ Donation: Altruism Versus Financial Incentives,* J. NON-PROFIT & PUB. SECTOR MARKETING, Sept. 1999, at 77; Francis L. Delmonico et al., *Ethical Incentives – Not Payment – For Organ Donors,* 346 NEW ENG. J. MED. 2002 (2002); Jasper, *supra* note 6, at 384 (reporting that a $1500 cash payment was only supported by only sixteen percent of surgeons, seven percent of transplant center coordinators, and nine percent of nurses); J.D. Jasper et al., *The Public's Attitudes Toward Incentives for Organ Donation,* 31 TRANSPLANTATION PROC. 2181, 2183 (1999) (reporting that forty-three percent of respondents found a direct payment of $1500 to be morally inappropriate while only thirty percent found it morally appropriate); Oz et al., *supra* note 57, at 391, 393 (finding that sixty-six percent of those surveyed opposed direct compensation for organs); *see also*

Although the sale of human organs for transplants is also illegal in almost all nations (with the apparent exceptions of Iran, Kuwait, and the Philippines), such sales have been tolerated with little secrecy in Israel, India, China, and Russia, where there may be little or no penalties for violating the law[85] (although, that may be changing[86]).

Motivated by the desire to save some of the thousands of lives lost annually under current policies, proposals for limited financial incentives or even restricted markets have been made in books and scholarly journals,[87] as well as legislative bills.[88] All recognize the need to address the

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KASERMAN & BARNETT, *supra* note 6, at 89-99 (finding that the medical community has a financial incentive to maintain the current rules). *But see* Bryce, *supra* note 11, tbl.3 (fifty-three percent support direct payment).

85. *See* Goyal et al., *supra* note 81, at 1590; Nancy Scheper-Hughes, *The Global Traffic in Human Organs*, 41 CURRENT ANTHROPOLOGY 191 (2000); Michael Finkel, *This Little Kidney Went to Market*, N.Y. TIMES, May 27, 2001, § 6, at 28; Abraham McLaughlin et al., *What is a Kidney Worth?*, CHRISTIAN SCI. MONITOR, Jun. 9, 2004, at 1; Larry Rohter, *Tracking the Sale of a Kidney on a Path of Poverty and Hope*, N.Y. TIMES, May 23, 2004, § 1, at 1; David J. Rothman & Shelia M. Rothman, *The Organ Market*, N.Y. REV. BOOKS, Oct. 23, 2003, at 49; Furthermore, convictions for organ trafficking appear nonexistent. Scheper-Hughes, *supra* note 81, at 1646.

86. *See* McLaughlin et al., *supra* note 85; Rohter, *supra* note 85; Rothman & Rothman, *supra* note 85 (reporting on the scandal at Bangkok's Vachiraprakarn General Hospital; Michael Wines, *14 Arrested in the Sale of Organs for Transplant*, N.Y. TIMES, Dec. 8, 2003, at A6.

87. *See* KASERMAN & BARNETT, *supra* note 6, at 69-88; GREGORY E. PENCE, RE-CREATING MEDICINE: ETHICAL ISSUES AT THE FRONTIER OF MEDICINE 33-62 (2000); William Barnett II & Michael Saliba, *A Free Market for Kidneys: Options, Futures, Forward & Spot*, 30 MANAGERIAL FIN. 38 (2004); Janet Radcliffe-Richards et al., *The Case for Allowing Kidney Sales*, 351 THE LANCET 1950 (1998). The first major proposals appear to have been Marvin Brams, *Transplantable Human Organs: Should Their Sale Be Authorized by State Statute?*, 3 AM. J.L. & MED. 183 (1977); and Richard Schwindt & Aidan R. Vining, *Proposal for a Future Delivery Market for Transplant Organs*, 11 J. HEALTH POL. POL'Y & L. 483 (1986). *See also* Gregory S. Crespi, *Overcoming the Legal Obstacles to the Creation of a Futures Market in Bodily Organs*, 55 OHIO ST. L.J. 1 (1994) (comparing four proposals).

88. *See, e.g.*, Gift of Life Tax Credit Act of 2001, H.R. 1872, 107th Cong. (2001) (granting a $10,000 tax credit for donated organs); *Putting Patients First: Increasing Organ Supply for Transplantation: Hearing Before the House Subcomm. on Health & Environment, House Comm. on Commerce*, 106th Cong. 87-126 (1999) [hereinafter *1999 House Hearing*] (describing $10,000 insurance policy for donors known as Project Donor); H.R. 540, 98th Cong. (1983) (allowing organ donors to deduct $25,000 per organ from their estate). Pennsylvania enacted a statute creating a special state fund that could provide donors and donors' families up to $3000 to pay for reasonable hospital, medical, and funeral expenses incurred in connection with organ donation. 20 PA. CONS. STAT. § 8622(b)(1) (2003), *discussed in* Robert M. Arnold et al., *Financial Incentives for Cadaver Organ Donation: An Ethical*

ethical dangers such incentives produce; suggested strategies have included providing appropriate, continuing medical aftercare to living donors and preventing sales that would merely enable creditors to squeeze a bit more out of debtors.[89] Assuming that this could be done, many have noted that permitting sales might actually aid the disadvantaged by allowing them to avoid even less attractive options, like taking a life-threatening job or being forced to watch a child die for lack of funds for medical care.[90] Thus, the AMA, ASTS, and UNOS/OPTN (Organ Procurement Transplant Network)[91] all now support the *study* of financial options.[92] Since 1994, Georgia has reduced its drivers' license fees for those who agree to donate their organs.[93]

Reappraisal, 73 TRANSPLANTATION 1361, 1366 (2002). Fearing that a $3000 payment could be coercive, the designated organ donor committee recommended payments of $300. Due to state officials' concern that this statute may violate federal law, however, funds collected for this program are, instead, being used to offset travel and lodging expenses of live donors. *See* Christopher Snowbeck, *Organ Donor Funeral Aid Scrapped*, PITTSBURGH POST-GAZETTE, Feb. 1, 2002, at B1.

89. *See, e.g.*, 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, 83-107 (1995).

90. *See* Rohter, *supra* note 85 (quoting Orley de Santana, a twenty-six-year-old Brazilian laborer, who stated "in order not to have to steal or kill, I thought it better to sell my kidney" for $6,000); *cf.* Nicholas D. Kristof, *Inviting All Democrats*, N.Y. TIMES, Jan. 14, 2004, at A19 (describing the dangerous, uncomfortable, and very low-paying work that many Cambodians engage in because they have no better options, possibly because some better options had been prohibited by well meaning, but naïve, social liberals). In fact, a 2001 study found that about sixty-four percent of non-whites supported direct payments to families who agreed to donate a kin's organ. *See* Bryce, *supra* note 11, tbl. 3.

91. UNOS is the contractor that HHS selected to administer the Organ Procurement and Transplantation Network.

92. *See* AM. MED. ASS'N., CODE OF ETHICS § E-2.15 (Aug. 7, 2002), http://www.ama-assn.org/ama/pub/category/8445.html (Financial Incentives for Organ Donation); Francis L. Delmonico & James A. Schulak, Letter to the Editor, WASH. POST, May 12, 2002, at B06 (position of the ASTS); Press Release, UNOS, OPTN/UNOS Board Endorses Studies of Incentives to Increase Donation (June 28, 2002), http://www.unos.org/news/newsDetail.asp?id=1.

93. *See* GA. CODE ANN. § 40-5-25(d)(2) (2003), adopted in 1994 Ga. Laws 1200. The maximum $8 fee for donors (versus $15 for others) was upheld as constitutional in *Barnhill v. State*, 575 S.E.2d 460 (Ga. 2003). Nevertheless, the Georgia governor proposed repealing the discount, claiming that it had little impact: although it raised donation rates by thirty-three percent. *See* Brian Basinger, *Organ Donor Discount Could End*, SAVANNAH MORNING NEWS, Feb. 6, 2003, http://www.savannahnow.com/stories/020603/LOCXGRDonor

In summary, current efforts leave half of all usable organs from cadavers unused, and proposals for presumed consent and markets in organs face stiff political opposition. Against this background it is useful to consider a less controversial option—a reciprocity policy—which is also compatible with both presumed consent and financial incentives.[94]

III. A RECIPROCITY PROPOSAL

Fortunately, a relatively simple adjustment to the organ donation rules would likely alleviate the two central problems with the current system by inducing many more commitments to donate and deterring families from challenging those wishes. Instead of asking individuals to act purely altruistically, UNOS/OPTN[95] should formally recognize those who commit to donate organs at death by significantly increasing such individuals' chances of receiving an organ should they later need one.

Variations of this idea have been proposed periodically over the last twenty years, apparently beginning with Jonathan Kaufelt's 1986 letter in the *Wall Street Journal*.[96] One version of this proposal was adopted by

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Discounts.shtml. In addition, the firm Administrative Resource Options (ARO) has a program to reimburse every one of its employees for the cost of their drivers' licenses if they sign up to be an organ donor. Memorandum from Jenn Hirjak, Donate for Life Benefit Program (July 8, 2004) (on file with authors). *See also Marketing Organ Donations: Give Speeders a Break?*, ASSOCIATED PRESS (June 28, 2004), http://www.wcpo.com/wcpo/localshows/healthyliving/3aa3fad8.html (describing a billboard in Cleveland, which calls out "Hey policeman," with an arrow pointing to a donor insignia on a young man's license, "give this guy a break").

94. In fact, one commenter supports a reciprocity policy as a useful adjunct to presumed consent. *See* Stephanie Eaton, *The Subtle Politics of Organ Donation: A Proposal*, 24 J. MED. ETHICS 166 (1998); *see also infra* note 97 (discussing Singapore law).

95. UNOS identifies criteria that may be used for allocating organs. *See* 1993 GAO REPORT, *supra* note 27, at 18; *see also* 42 U.S.C. § 273(b)(3)(E)(2002); Jeffrey Prottas, *Rationing Human Organs for Transplant*, *in* TRANSPARENCY IN PUBLIC POLICY: GREAT BRITAIN AND THE UNITED STATES 70, 76-77 (Neal D. Finkelstein ed., 2000). In contrast, in England, individual surgeons set their own allocation criteria. *Id.* at 82-83.

96. *See* Jonathan D. Kaufelt, Letter to the Editor, *Meeting the Need for Human Organs*, WALL ST. J., May 15, 1986, at 29; Peters, *supra* note 49, at 177-82; Irwin Kleinman & Frederick H. Lowy, *Cadaveric Organ Donation: Ethical Considerations for a New Approach*, 141 CANADIAN MED. ASS'N. J. 107, 109-10 (1989); James Muyskens, *Procurement and Allocation Policies: Should Receiving Depend on Willingness To Give?*, 56 MT. SINAI J. MED. 202 (1989); Irwin Kleinman & Frederick H. Lowy, *Ethical Considerations in Living Organ Donation and a New Approach: An Advance-Directive Organ Registry*, 152 ARCHIVES INTERNAL MED. 1484, 1486-87 (1992); James Muyskens, *Should Receiving Depend upon Willingness To Give?*, 24

Singapore in 1987.[97] Although a 1993 UNOS Committee Report recommended wider discussion of a priority program,[98] it has generally been overlooked by policymakers. The idea was never raised during either the 1999 or 2003 hearings in the House of Representatives on increasing organ donations,[99] nor was it identified in either the 1993 General Accounting Office (GAO) review of alternatives for achieving this goal[100] or

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TRANSPLANTATION PROC. 2181 (1992); Rupert Jarvis, *Join the Club: A Modest Proposal To Increase Availability of Donor Organs,* 21 J. MED. ETHICS 199, 202-03 (1995); Richard Schwindt & Aidan Vining, *Proposal for a Mutual Insurance Pool for Transplant Organs,* 23 J. HEALTH POL. POL'Y & L. 725 (1998); Gundolf Gubernatis & Hartmut Kliemt, *A Superior Approach to Organ Allocation and Donation,* 70 TRANSPLANTATION 699 (2000); Alexander Tabarrok, *The Organ Shortage: A Tragedy of the Commons, in* ENTREPRENEURIAL ECONOMICS: BRIGHT IDEAS FROM THE DISMAL SCIENCE 107, 109-10 (Alexander Tabarrok ed., 2002); Adam J. Kolber, *A Matter of Priority: Transplanting Organs Preferentially to Registered Donors,* 55 RUTGERS L. REV. 671 (2003); Sackner-Bernstein & Godin, *supra* note 5; Steinberg, *supra* note 64; Michael J. Booker, Justice and the Macroallocation of Human Donor Organs 146-54 (1990) (unpublished Ph.D. dissertation ,University of Tennessee) (on file with authors); *see also* Dukeminier, *supra* note 12, at 848 (priority for family if they agree to donate). In addition, a 1993 survey found that seventy percent of those eighteen to twenty-four were either very or somewhat interested in using a form of preference. *See* BOWDEN & HULL, *supra* note 16, at 117. *But see* Marlies Ahlert et al., *Common Sense in Organ Allocation,* 23 ANALYSE & KRITIK 221, 226-27 (2001) (finding that a majority of German students in one study oppose such a preference); Jasper, *supra* note 72, at 384 (reporting that a priority policy was supported by only forty-five percent of surgeons, thirty-four percent of transplant coordinators, and forty percent of nurses); Siminoff & Mercer, *supra* note 16, at 380 (reporting that only twenty-five percent of respondents believed that people who have signed organ donor cards should get a preference).

97. Singapore's Human Organ Transplant Act, adopted July 16, 1987, establishes both a system of presumed consent, 131A C.A.P. §§ 5, 9-11 (Sing.), http://statutes.agc.gov.sg, and priority in receipt of organs for those who have not opted out., *id.* § 12. Despite the latter and financial incentives, by 1997 only three percent of Muslims—exempt from the presumed consent provision—had registered to donate. *See* Volker H. Schmidt & Lim Chee Han, Organ Transplantation in Singapore: History, Problems, and Policies 6-7 (Aug. 2003) (unpublished manuscript, on file with authors). Still, the priority policy is probably not publicized widely in Singapore, given that most of the population is subject to presumed consent. Thus, most Muslims may be unaware of the policy, and it seems unlikely that any significant efforts were made to inform Muslims and encourage individuals to register.

98. *See* JAMES F. BURDICK ET AL., PREFERRED STATUS FOR ORGAN DONORS: A REPORT OF THE UNITED NETWORK FOR ORGAN SHARING ETHICS COMMITTEE (1993), http://www.unos.org/resources/bioethics.asp?index=5 (concluding that the idea required further discussion). Such efforts, however, appear to have been neglected in favor of other priorities.

99. *See 1999 House Hearing, supra* note 88; *2003 House Hearing, supra* note 5.

100. *See* 1993 GAO REPORT, *supra* note 27, at 61-65.

the June 2004 Joint Committee on Accreditation of Healthcare Organizations (JCAHO) report entitled *Strategies for Narrowing the Organ Donation Gap and Protecting Patients.*[101]

While almost all of the suggestions for this approach have been offered in general, conceptual terms, this Commentary attempts to offer a detailed proposal that can be tested. This Commentary also offers specific reasons why this approach should be effective and attempts to respond comprehensively to potential counter-arguments.

A. How the Proposal Would Work

Under the reciprocity policy proposed here, those who committed to donate would receive a significant advantage in the organ allocation process, if they later needed a transplant. This would enable them, like military veterans seeking a government job, to be placed ahead of non-donors of slightly superior qualifications on the waiting list. For kidneys, where potential organ recipient scores are in the range of about ten to twenty-five, and former live kidney donors receive four extra points,[102] committed donors might receive up to two points on their kidney score.[103] The bonus would be phased in, based on how long a patient had been registered as willing to donate (similar to the "time on waiting list" criteria now used).[104] Individuals, including young adults who had been registered

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101. *See* 2004 JCAHO REPORT, *supra* note 66.

102. The point system for kidney allocation is based on time on the waiting list (1 point for each year and up to 1 point on each list), quality of "antigen" match (2, 1, or 0 points), the presence of reactive antibodies (4 points), and age (4 points if 3-11 years old, 3 if 11-18). Former donors receive 4 extra points and medical urgency is considered. *See* UNOS Organ Distribution Rules, *supra* note 38, § 3.5.11.6 (Point System for Kidney Allocation).

103. Selecting an appropriate size preference is important, *see* BURDICK ET AL., *supra* note 98, and, given the time and data, one might seek the pareto optimal level that maximizes the number of lives saved while not leaving any non-donor worse off, *see* Kolber, *supra* note 96, at 704-14, or simply maximizes the number of lives saved. Two points is suggested here as a reasonable estimate of the optimal value, which would appear to be between four points and zero.

104. *See* Hartmut Kliemt, Clubs and Reciprocity in Organ Transplantation 9-10 (2003), http://www.indiana.edu/~workshop/colloquia/papers/kliemt_paper.pdf; *see also supra* note 102. The full bonus might be reached ten years after one had committed to donate. Alternatively, there could be a waiting period before the bonus took effect or those who had not committed to donate before they needed an organ could be denied any bonus at all. Some such policy is needed to encourage healthy people to commit to donate. Singapore uses a two year waiting period, 131A C.A.P. § 12(1)(b) (Sing.), as does Peters, *supra* note 49, at 180.

by their parents, would be permitted to change their minds, but anyone who removed themselves from the committed-to-donate list would lose credit for the time they had already been listed, even if they later re-registered.[105] For livers and hearts, committed donors might be granted first priority within their "status" group (i.e., 1A, 1, 2, etc.) and ranked within the group based on how long they had been on the committed-to-donate list.[106]

To motivate those who expect to be denied access to a transplant due to the green screen, the preference could also include a chance to benefit from funds set aside to cover at least one "free" organ transplant annually.[107] These patients would be given a contingent status on the waiting list—only considered for a transplant if funds were available at the time an organ was available.

Individuals would continue to record their commitments in a manner similar to the way they currently do—through license renewals at offices of state DMVs or by filling out organ donor forms made available elsewhere, including health care facilities, voter registration offices, or other social service agencies. For individuals to receive preferences, their commitments would have to be recorded in registries—databases maintained by individual states for their residents[108] or in a national database for residents of states without their own databases, which would also linked to existing state registries.[109]

The status of those whose medical condition, e.g., those with HIV or

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105. Babies could be enrolled by parents. *See* Coleman, *supra* note 66, at 40-41; Raanan Gillon, *On Giving Preference to Prior Volunteers When Allocating Organs for Transplantation*, 21 J. MED. ETHICS 195, 195 (1995); Aidan R. Vining & Richard Schwindt, *Have a Heart: Increasing the Supply of Transplant Organs for Infants and Children*, 7 J. POL'Y ANALYSIS & MGMT 706, 708 (1988). Given the burden of reconsidering the decision to donate, *see* Johnson & Goldstein, *supra* note 74, it would seem unlikely that many would change their minds. On the other hand, the proposal would subject any person who attempted to gain the preference for registering while using some other legal device to nullify that commitment in the case that they died, to a significant fine for fraud. Furthermore, it would impose criminal penalties on anyone who conspired to organize multiple frauds of this kind.

106. Those on the UNOS heart and liver waiting lists are given a status, e.g., 2, 1, 1A, depending on their condition. If the medical community believed that giving committed donors first priority in their status group was too great a bonus, it could subdivide the status group or award a set number of relevant points.

107. These funds might come from private donations or NIH; alternatively, UNOS could add a $500 charge for each organ transplanted.

108. *Cf. supra* note 62.

109. *Cf. supra* note 63.

Hepatitis C, makes them unacceptable donors raises a difficult question. This proposal would permit such individuals to get equal credit for agreeing to donate their body for medical research on transplantation. Other options might be to permit those unable or unwilling to donate their organs to make alternative efforts to increase the supply of organs, as by helping to educate the public at health fairs; however, this would raise many administrative questions about precise standards.[110]

Donors' commitments would effectively represent organ insurance,[111] not unlike the former "family credit" blood donor systems, under which a blood donor's contribution served to cover his or her family's annual blood needs.[112] The proposal advocated here would operate somewhat differently than "club" systems,[113] like Singapore's,[114] or "LifeSharers," the provocative directed donation entity.[115] Rather than offering only a limited preference for committed donors,[116] club proposals favor a minimally medically compatible club member over non-members who are much

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110. Individuals currently HIV positive or with Hepatitis C might be asked to provide similar service and this might also be offered to those with other objections. *See* Abdullah S. Daar, *Altruism and Reciprocity in Organ Donation: Compatible or Not?*, 70 TRANSPLANTATION 704, 704-05 (2000); Peters, *supra* note 49, at 180-82. Then again, Illinois recently recognized that HIV positive patients may donate to other HIV positive patients. 2004 Ill. Legis. Serv. 93-737 (West) (codified at ILL. COMP. STAT. 20 § 2310-330(c-5)).

111. *See* PAUL RAMSEY & MARGARET A. FARLEY, THE PATIENT AS PERSON: EXPLORATIONS IN MEDICAL ETHICS 212 (2d ed. 2002) ("This practice [of rewarding blood donors with insurance against their future needs] of giving and receiving, not buying and selling, is the one that should be extended to other tissue."); Muyskens, *supra* note 96, at 2182; Schwindt & Vining, *supra* note 96; Tabarrok, *supra* note 96, at 109;.

112. *See* DOUGLAS STARR, BLOOD: AN EPIC HISTORY OF MEDICINE AND COMMERCE 190, 250-56 (1998); RICHARD M. TITMUSS, THE GIFT RELATIONSHIP: FROM HUMAN BLOOD TO SOCIAL POLICY 82 (1971).

113. *See* Jarvis, *supra* note 96.

114. *See supra* note 97.

115. Open to all willing donors, this program requires members to agree to donate their organs (upon death) to another member of the club if a member is a medically acceptable recipient. *See* LifeShares, How LifeSharers Works, *at* http://www.lifesharers.com/howitworks.htm (last visited Nov. 18, 2004); *see also* Chris Fusco, *An Organ Transplant is a Mouse Click Away*, CHI. SUN-TIMES, Nov. 23, 2002, at 3 . LifeSharers members make directed donations, which appear to be legal. *See supra* note 32. However, this has been subject to criticism. *See* Sheldon Zink et al., Examining the Potential Exploitation of UNOS Policies (Sept. 2004) (unpublished manuscript, on file with authors) (criticizing the fairness of directed donations other than those to family members).

116. Organ seekers receiving small preferences may still face long waits. *See* Delmonico et al., *supra* note 84, at 2004.

better matches,[117] in the same manner as the current "local first" preference rules favor local recipients over better-matched recipients outside the local area.[118] There would certainly be a greater incentive for people to register under a club system rather than a bonus system, yet it is not clear that the incremental benefit from a marginally increased incentive justifies the cost of favoring a barely compatible recipient over one who was an excellent match.

B. Likely Effects of the Proposal

There are good reasons to believe that, by making it in a person's self interest to commit to organ donation, a priority policy would produce significantly more donations. In fact, the policy would respond to both current problems deterring donations: It should convince more people to sign up to donate and make it more likely that those wishes will be honored, even if the donors' families would prefer to override them.

First, the policy would appear to significantly increase the likelihood that individuals would sign up to donate when they were seeking a driver's license renewal or during a visit to their doctor. With respect to the former, it is reasonable to assume that a significant number of individuals who presently decline to check the box for organ donor on their driver's license renewal are neutral or only slightly predisposed against signing up. Some may have slight concerns that registering as donors would lead doctors to work less hard to save their lives, but even a small doubt might be enough to outweigh an even smaller expected benefit from acting altruistically. For many of such current borderline non-donors, a small, but significant health benefit should lead them to choose to donate.

This effort might also be aided by a new marketing approach. While the most effective publicity in the past has involved celebrity athletes[119] or poignant stories about children,[120] a different tactic might well better motivate visitors to the DMV. Instead of relying solely on the positive

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117. *See* Timothy F. Murphy & Robert M. Veatch, Members First: The Ethics of Donating Organs and Tissues to Groups (2004) (unpublished manuscript, on file with authors).

118. *See* Schwindt & Vining, *supra* note 96, at 736; *infra* notes 139-142 and accompanying text.

119. For example, the NBA star Alonzo Mourning has brought considerable attention to the topic of organ donation. *See* Chris Broussard, *Dozens Offer a Kidney to Mourning*, N.Y. TIMES, Nov. 26, 2003, at D1; Maureen Dowd, *Give Thanks and Life*, N.Y. TIMES, Nov. 27, 2003, at A39.

120. *See, e.g.*, REG GREEN, THE NICHOLAS EFFECT (1999), http://www.nicholasgreen.org/contents.html.

feelings people should get from donating, which might be too weak to trigger registration, instructions about registering to donate on driver's license forms could highlight how non-donors could lose out. For example, instructions might note that "failure to agree to donate could permit those who have committed to donate to move ahead of you on the organ wait list if you later need an organ." Studies have shown that individuals are much more likely to act to avoid a bad outcome ("loss aversion") than to obtain a comparable good result.[121]

The health benefit from committing to donate should also make it more likely that doctors and nurses would place donor registration forms in their waiting rooms and, if there was time at the end of check-ups, recommend donation, possibly right after they typically now suggest how patients might improve their diets and exercise regimes. While patients concerned about their health—particularly those whose test results served as a wake-up call of potential danger—may find it difficult to maintain their good intentions regarding diet and exercise for a few weeks or even days, registering to donate would require no ongoing motivation; a simple recommendation to act should often be enough to trigger a registration.

Also, since those entitled to this preference would be less likely to die for lack of an organ, life insurance companies might well offer them a discount.[122] Some individuals who noticed this when purchasing life insurance or comparing policy prices might find it sufficient motivation to register to donate.

A priority policy should also help to address the second problem with donation: enforcing a donor's wishes against family opposition. Today, family members may well regard a donor's decision to donate as a unilateral charitable impulse, whose revocability should continue after their death, even though the law is otherwise. Once a transplant specialist had politely informed them about the basic concept of a priority policy, however, most family members would likely recognize that the donor's decision to donate was part of a quid pro quo agreement. Most would probably understand that it would be wrong for them to try to renege on the donor's death-triggered promise. Thus, one would expect fewer families to attempt to override a donor directive, and it should be easier

121. This psychological phenomenon is called "anticipatory regret," which appears to be the same as "loss aversion," discussed in Alexander J. Rothman et al., *The Systematic Influence of Gain- and Loss-Framed Messages on Interest in and Use of Different Types of Health Behavior*, 25 PERSONALITY & SOC. PSYCHOL. BULL. 1355 (1999).

122. Given how long it took life insurance companies to give non-smokers a discount, however, this would likely be a long time in coming.

for transplant specialists to overcome any resistance offered.

Finally, although non-donors on the waiting list would sometimes be bypassed by a patient with a bonus, a substantial increase in the total supply of organs triggered by this policy should more than offset that loss, actually increasing even non-donors' chances to receive an organ. Of course, one's chances would still be better if one committed to donate.

C. Responses to Main Criticisms

The reciprocity policy has been subject to a number of criticisms, but none appear to be very persuasive.

The most significant charge is that the policy would not produce more donations. Although there is good reason to believe that the proposal would increase the supply of transplantable organs,[123] it would certainly be sensible to test it—in a state with an existing database of committed donors[124]—before adopting it more widely. At least four types of effects would deserve to be evaluated. First, it would be useful to review DMV records to measure the effect of a short statement on drivers' license forms that explained the benefit of a preference and how those who did not sign up could be bypassed on the waiting list by others who had signed up. Second, it would be important to survey primary care physicians to determine whether a reciprocity policy led any of them to make a greater effort to encourage their patients to sign up, such as providing forms in their waiting rooms and encouraging patients to fill them out. Third, it would be relevant to see whether the policy led a smaller percentage of families to seek to override a donor's directive after being informed of the quid pro quo nature of the priority policy. Fourth, it would be useful to try to determine whether the type of people who were spurred to register to donate by this policy were demographically similar to current donors or whether they were more (or less) likely die in a manner that led them to be suitable donors.

A second complaint about a reciprocity policy is that it would threaten the purity of altruistic efforts. Thus, an UNOS Committee evaluating the reciprocity concept in a 1993 report found "the most important negative aspect of the idea" is that, like "all other forms of inducement, [a preferred status priority system] is likely to be seen by some as inherently compromising the altruism" of the current voluntary system.[125] Yet public

123. *See supra* Subsection III.B.

124. *See* UNOS, *supra* note 62.

125. *See* Burdick et al., *supra* note 98.

health is rooted in enlightened self-interest, i.e. utilitarian principles;[126] society does not expect transplant or other healthcare professionals to be motivated solely by altruism. Moreover, a priority policy would actually represent a form of "reciprocal altruism."[127] Granting an optional preference to committed organ donors seems no more morally harmful than making charitable contributions tax deductible. Furthermore, like the latter, it should increase, not decrease the incentive to donate.[128] Finally, an excellent, detailed examination of the significance of altruism in the context of organ donations exposed the inconsistencies in the arguments that incentives, like a priority system, are detrimental to altruism or contribute to inhumane "commoditization" of the human body.[129]

A third concern may be that a preference might be considered "valuable consideration" for an organ donation, which arguably would violate the current law,[130] but that seems very unlikely for two reasons. First, as a technical matter, there would be no actual exchange of organ for value. The deceased parties who actually donated their organs would not receive any compensation and those who benefited from the preference would not have donated their organs.[131] Second, prosecutors and legal counsel for UNOS already seem to recognize that the ban on compensation for organ donors does not apply to the current UNOS policy of rewarding live kidney donors (or paired partners) with a preference,[132] and both should regard this policy the same way.[133] Still, to

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126. *See* A.H.M. Kerkhoff, *Origin of Public Health and Preventative Medicine, in* ETHICAL DILEMMAS IN HEALTH PROMOTION 35 (Spyros Doxiadis ed., 1987).

127. *See* Robert Trivers, *The Evolution of Reciprocal Altruism,* 46 Q. REV. BIOLOGY 35-57 (1972); *cf.* Ernst Fehr & Simon Gächter, *Fairness and Retaliation: The Economics of Reciprocity,* 14 J. ECON. PERSP. 159 (2000).

128. The even more provocative policy of financial incentives would seem to produce an even greater net gain. *See, e.g.,* Bryce, *supra* note 11, tbls. 2, 4 (indicating that seventeen percent are more willing to donate; less the eight percent who are less willing to donate will yield a nine percent net gain); GALLUP POLL, *supra* note 10, at 43 (demonstrating a net gain of seven percent).

129. Kolber, *supra* note 96, at 714-37; *see also* Henry Hansmann, *The Economics and Ethics of Market for Human Organs,* 14 J HEALTH POL. POL'Y & L. 57, 68, 74-78 (1989); Julia D. Mahoney, *The Market for Human Tissue,* 86 VA. L. REV. 163, 215-20 (2000). *But see* Arnold et al., *supra* note 88.

130. *See supra* note 82-83.

131. *See also* Kolber, *supra* note 96, at 698-700.

132. That policy is noted *supra* note 102 and *infra* note 138. The legislative history does not indicate any opposition to this practice. *See supra* note 82. Nor was there any proposal to ban it, despite clear notice, when Congress considered a revision to the definition of

avoid any confusion, laws that now ban compensation for organs should be amended to add this form of reciprocity/insurance to the list already exempted from such bans.[134]

Fourth, some argue that it is critical for organ allocations to avoid the corrupting influence of non-medical issues,[135] but there are three responses to this point. First, it is not clear what should be considered as "medical" criteria and why such criteria do not raise ethical issues. To the extent that medical criteria focus on not "wasting" a scarce organ on a likely medical failure, then a commitment to donate comes close to satisfying that criteria, by helping to reduce the waste of scarce organs. Granted, it is not a pure medical factor, but it appears much closer to one than to a subjective criteria like social worth, which requires subjective judgments and ethical questions about their relevance.

In addition, many features of the current organ allocation system are justified principally by their impact on the organ supply or on non-medical social values.[136] Some may consider "time on waiting list" as a proxy for

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"valuable consideration" in 2004. *See also* Williams Mullen, Legal Memorandum to UNOS, Intended Recipient Exchanges, Paired Exchanges and NOTA §301 (Mar. 7, 2003), http://asts.org/ezefiles/UNOSSection_301_NOTA_.pdf (explaining why 42 U.S.C. §274(e) does not apply to such exchanges).

133. *See also* Burdick et al., *supra* note 98 (citing UNOS Ethics Committee report that a trial of priority incentives "could be implemented without requiring any alteration in existing legislation, unlike other mechanisms under discussion").

134. 42 U.S.C. § 274e(c)(2) now reads: "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 an organ." S.573, 108th Cong. (2003), passed by the Senate, would have amended that provision by adding, at the end of it: "Such term does not include familial, emotional, psychological, or physical benefit to an organ donor, recipient, or any other party to an organ donation event." The version that became law, however, did not include that provision. *See* Pub. L. No. 108-216, 118 Stat. 584 (2004) (codified at 42 U.S.C. §§ 273a, 274f). State laws should also be amended. *See* ACOT May 2003 Notes, *supra* note 49, at 4.

135. *See* 42 C.F.R. § 121.8 (2003); Gillon, *supra* note 103, at 196 (contending that the Achilles heel of the club proposal is creating a slippery slope of using non-medical criteria for allocating organs); *see also* Alexander M. Capron, *More Blessed to Give Than Receive?*, 24 TRANSPLANTATION PROC. 2185 (1992).

136. *See* Stefanos A. Zenios et al., *Dynamic Allocation of Kidneys to Candidates on the Transplant Waiting List*, 48 OPERATIONS RES. 549, 564-66 (2000); Mark E. Votruba, Efficiency-Equity Tradeoffs in the Allocation of Cadaveric Kidneys 49-52 (Nov. 15, 2001 draft) (unpublished Ph.D. dissertation, Princeton University), http://www.princeton.edu/~mvotruba/KA_text.pdf. The policy of favoring those on the list longest, separate and apart

urgency, but the failure to replace it with a better metric for medical urgency is probably due to the view that it is only fair to favor those who have waited longest, even though this is a biased statistic.[137] As noted earlier, some paired partners of living kidney donors already receive priority access to an organ in consideration for their partners' contribution to the supply of organs.[138] Also, as mentioned above, while the rapid deterioration of organs justifies a preference for shorter transport times,[139] the current "local first" preference is much greater than medically justified.[140] The rationale offered is that more individuals will donate organs if they know that they will most likely be aiding someone in their

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from their medical condition, appears to be due to "fairness," *see* Childress, *supra* note 75, at 104-05, since the data do not support such a large preference for them, INSTITUTE OF MEDICINE, ORGAN PROCUREMENT AND TRANSPLANTATION: ASSESSING CURRENT POLICIES AND THE POTENTIAL IMPACT OF THE DHHS FINAL RULE 90 (1999) [hereinafter 1999 IOM REPORT]; Votruba, *supra*, at 38. Also, the list of UNOS objectives includes some non-medical goals. *See* UNOS, UNOS RATIONALE FOR OBJECTIVES OF EQUITABLE ORGAN (1994), http://www.unos.org/resources/bioethics.asp?index=8.

137. *See* Gabriel M. Danovitch et al., *Waiting Time or Wasted Time? The Case for Using Time on Dialysis To Determine Waiting Time in the Allocation of Cadaveric Kidneys*, 2 AM. J. TRANSPLANTATION 891 (2002).

138. *See* Lainie Friedman Ross & Stefanos Zenios, *Practical and Ethical Challenges to Paired Exchange Programs*, 4 AM. J. TRANSPLANTATION 1553 (2004) (noting that, in 2001, region one of UNOS developed a program, now called "list pair exchange," whereby those seeking an organ could go to the head of the recipient line if they found a live person willing to donate an organ on their behalf); David Wessel, *Easing the Kidney Shortage*, WALL ST. J., Jun. 17, 2004, at B1. HHS supports such preferences. *See* ACOT May 2003 Notes, *supra* note 49, at 2 (HHS supports ACOT recommendation #5). Furthermore, research indicates that such programs produce a net gain of organs. *See* STEFANOS ZENIOS ET AL., PRIMUM NON NOCERE: AVOIDING HARM TO VULNERABLE WAIT LIST CANDIDATES IN AN INDIRECT KIDNEY EXCHANGE (Graduate Sch. of Bus., Stanford Univ., Research Paper No. 1684, 2001), http://gobi.Stanford.edu/ResearchPapers/Library/RP1684.pdf. Careful structuring can even yield a net gain for blood type O organ recipients. *See* Lainie Friedman Ross & Stefanos Zenios, *Restricting Living-Donor-Cadaver-Donor Exchanges To Ensure that Standard Blood Type O Wait-List Candidates Benefit*, 78 TRANSPLANTATION 641 (2004).

139. The maximum allowable transport time for organs removed for transplant (also known as cold ischemic time) limits how far they can be sent to recipients. *See* Introduction to Transplants, *at* http://www.ustransplant.org/primer_intro.php (last updated July 9, 2004). There is also a cost advantage to minimizing transport time. *See* Mark A. Schnitzler et al., *The Economic Impact of Preservation Time in Cadaveric Liver Transplantation*, 1 AM. J. TRANSPLANTATION 360 (2001).

140. *See* Votruba, *supra* note 136, at 112. Thus, some suggest accounting for travel time directly. *See* Sackner-Bernstein & Godin, *supra* note 5, at 158..

own "community,"[141] but the evidence does not support this.[142]

Finally, while some might perceive a preference policy as favoring committed donors due to their moral superiority over non-donors, that is not the case: the preference is based solely on a person's willingness to participate in a reciprocal system designed to increase donor incentives and thus the supply of organs. Thus an unemployed ex-convict who committed to donate would get the preference, while a Nobel Peace Prize winner who did not commit to donate would not. It is not an inherently subjective, and thus problematic, policy; it is objective and treats all individuals on the same terms.

As a fifth matter, a reciprocity system could be seen as unfairly punishing those currently receiving the worst health care, many of whom would fail to commit to donate out of ignorance of the policy. Yet this seems no different from the impact of the current preference for those who have been on the waiting list longest. After all, those now receiving the worst health care are likely to be late in discovering their need for a transplant and thus not enroll on the UNOS list until months, if not years, after those with the identical condition who receive superior healthcare.[143] Meanwhile, unlike the current "local first" policy (which favors those who can afford to register at multiple locations[144]), a reciprocity policy would treat rich and poor equally[145] (except for those unable to finance a

141. *See* MUNSON, *supra* note 15, at 49; *1999 House Hearing, supra* note 88, at 48-52, 54-56, 72, 77; *1996 HHS Hearings, supra* note 17, at 76-77 (testimony of Dr. D'Alessandro).

142. *See* 1999 IOM REPORT, *supra* note 136, at 52-53 (1999) (reporting that both a 1998 Gallup poll and a 1995 Southeastern Inst. of Research poll found little patient preference for local recipients over more needy patients in the nation). On the other hand, a local preference probably serves to improve the morale and motivation of those involved in encouraging organ donation in each community. *See* KOCH, *supra* note 36, at 74, 97-99. This policy also reflects the efforts of smaller, local transport centers to protect themselves and their patients. *See* Jeffrey Prottas, *The Politics of Transplantation, in* ORGANS AND TISSUE DONATION, *supra* note 27, at 3, 17.

143. To avoid the bias against the disadvantaged caused by using time on wait list, UNOS should require that OPOs that desire to use such a metric to use time on dialysis instead. *See* Danovitch et al., *supra* note 137.

144. The current UNOS system permits wealthy or well-insured organ seekers to increase their chances of receiving an organ by registering at multiple transplant centers. *See* Robert M. Merion et al., *Prevalence and Outcomes of Multiple-Listing for Cadaveric Kidney and Liver Transplantation,* 4 AM. J. TRANSPLANTATION 94 (2004); Tracy E. Miller, *Multiple Listing for Organ Transplantation: Autonomy Unbounded,* 2 KENNEDY INST. ETHICS J. 43 (1992).

145. The 1993 UNOS Report found this aspect of a preference system admirable. *See* Burdick et al., *supra* note 98.

transplant operation[146]), and the system would not encourage black market donations.[147] Certainly society should work to provide the most disadvantaged with healthcare more fully and effectively, but the flaws in the current system are no more of a justification for rejecting a preference policy than they are for rejecting the use of the "time on waiting list" statistic for allocating organs.

A sixth complaint might be that the system would discriminate against those who refused to donate for religious or other reasons,[148] but this would not appear to create unfairness. Religions that forbid organ donations would seem, almost necessarily, to reject organ transplantation generally, and thus their believers would not desire organs at all, certainly not a preference over others who had chosen not to donate. It should also be noted that veterans' preferences already discriminate against pacifists, and that fifty-nine percent of transplant professionals surveyed would go so far as to refuse access to the donor pool to those who refuse to donate because of religious reasons.[149] Finally, the preferences here would not be based on an individual's minority group status, but rather, only on their actual willingness to aid the organ donor pool.[150]

CONCLUSION

The substantial health benefit of a system of reciprocal organ donation incentives and its minimal cost (for maintaining registries) should combine to lead many people—encouraged by their families, their physicians, and the media—to overcome the factors that currently inhibit organ donation. In addition, families should be less likely to attempt to override a deceased's decision to donate if they understand it as a binding portion of an "insurance" arrangement, based on reciprocity.[151] Relying purely on altruism for organ donations would certainly be ideal, but it is

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146. Still, a chance at a free transplant would begin to alleviate the inequality for those otherwise neglected by the system. *See supra* text accompanying notes 34-36.

147. *See* Finkel, *supra* note 85; Goyal et al., *supra* note 81; Rohter, *supra* note 85; Christian Williams, Note, *Combating the Problems of Human Rights Abuses and Inadequate Organ Supply Through Presumed Donative Consent*, 26 CASE W. RES. J. INT'L L. 315, 321-27 (1994); *see also* DIRTY PRETTY THINGS (Miramax 2003) (illustrating the tragedy in the black market in organ sales).

148. *See* Robert A. Sells, *Donation: Will the Principle of "Do As You Would Be Done By" Be Enough?*, 70 TRANSPLANTATION 703, 703 (2000).

149. *See* Oz et al., *supra* note 57, at 394.

150. *See* Gubernatis & Kliemt, *supra* note 96, at 700-01.

151. *See* Siminoff & Chillig, *supra* note 15, at 35.

not worth the loss of thousands of lives annually.