ADDRESSING A DIRE SITUATION: A MULTI-FACETED APPROACH TO THE KIDNEY SHORTAGE

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1. INTRODUCTION

The world today is facing a tremendous health problem: there simply are not enough kidneys to supply those who need them. Kidneys for transplantation can be procured either through cadaveric or living donation. Cadaveric donation involves a person donating her kidneys upon her death. This type of donation is complicated, however, because the deceased donor must be brain dead. The narrow criteria for cadaveric kidney donors ensure that there will never be enough kidneys that come from deceased people. Therefore, cadaveric donation will never be able to meet the demand for kidneys. Living donation, which occurs when a person decides to donate while she is alive, could supplement the kidney supply; however, because there is little incentive, aside from altruism, to donate the organ unless the donor is a relative or close friend, the number of living donors is low.

This shortage has led to the emergence of a black market for kidneys in which people from poor countries who need money more than a second kidney are the main suppliers. In many cases, middlemen broker the kidney sales, charging the purchasers a large sum of money and giving only a small fraction of the profit to the economically disadvantaged suppliers. Additionally, many suppliers cannot afford nor have access to medical care for post-surgery examinations. Consequently, many suppliers are left

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worse off economically, physically, and mentally, than they were before selling their kidney.

In response to the shortage and the black market for kidneys, several potential proposals have been put forth: an open market, a futures market, and a procurement system based on presumed consent. While these proposals are meritorious and could increase the kidney supply, they are not feasible because there are serious ethical drawbacks to each proposal and none of the solutions would individually procure enough kidneys to meet the demand.

Kidney procurement is hard to do. It is difficult finding an ethically permissible solution that will increase the kidney supply, and no matter what system the United States utilizes there will always be a core of people who will never donate for their own personal reasons. This paper, however, argues that there is a solution that would be an effective and ethically permissible system for increasing the kidney supply through cadaveric and living donations in the United States: a three-prong combination of presumptivity, a heightened education and awareness campaign, and weak economic incentives.

Section Two of this Comment provides background on the kidney shortage and why it exists. Section Three explains the laws various countries have adopted to try to combat the sale of kidneys from living donors. Section Four discusses the emergence of the black market and the problems associated with it. Section Five explores three potential policy responses to avoid the abuses associated with the black market, evaluates and analyzes their effectiveness and ethical implications, and determines that none of the proposals, alone, are ethically permissible. Section Six, therefore, proposes another solution: a three-prong combination of presumptivity, an aggressive education and awareness campaign, and weak financial incentives.

2. THE KIDNEY SHORTAGE

Today, many people suffer from kidney disease or failure. A person suffering from kidney failure has three possible treatment options: hemodialysis, peritoneal dialysis, or a kidney transplant. A hemodialysis uses an artificial kidney, a hemodialyzer, to remove the waste and extra chemicals in the patient's blood through a

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blood vessel; peritoneal dialysis cleans the patient’s blood in her body by dialystate that enters through a catheter in the patient’s stomach.² Dialysis performs the function of the kidneys; it prevents the buildup of salt, water, and waste in the body by removing the excess, balances other chemicals in the blood, and helps control blood pressure.³ Dialysis, however, can be uncomfortable since needles are inserted into blood vessels or the stomach, and there can be adverse effects such as nausea, headaches, or cramps due to a drop in blood pressure.⁴ Dialysis treatment can also require a change in diet and can be time-consuming.⁵

Because dialysis can lead to uncomfortable side effects and require a lot of treatment time, kidney transplants offer the best chance for quality of life once the procedure is completed; however, the actual process is not an easy one. The patient can receive a kidney from either a cadaveric or living donor, which is transplanted after the patient undergoes a nephrectomy, or removal of her original kidney.⁶ A transplant is expensive, about $51,000 even after Medicare or Medicaid pays its share.⁷

³ See id. (providing the purpose of dialysis).
⁴ Id.
⁵ Id.
⁷ See eHow, How to Learn More About Kidney Transplants, http://www.ehow.com/how_10141_learn-about-kidney.html (last visited Jan. 24, 2005) (providing the basic information about kidney transplants, including costs). See also Aetna, Kidney Transplant, http://www.intelihealth.com/IH/ihtIH/WSIHW000/9339/31200.html (last visited Dec. 30, 2005) (stating that hospital costs are about $40,000 for a kidney transplant and can total more than $100,000 when doctors’ bills, medications, and follow-up care are included); HEALTH CARE FIN. ADMIN., MEDICARE COVERAGE OF KIDNEY DIALYSIS AND KIDNEY TRANSPLANT SERVICES (2001), available at http://www.medicare.gov/publications/pubs/pdf/esrdcoverage.pdf (explaining that the amount Medicare will contribute to the various costs associated with a kidney transplant depends on whether a patient has Medicare Part A and Part B coverage, or is just covered by Part A; Part A is the hospital insurance which has no premiums, while Part B is medical insurance that requires premiums, deductibles, and coinsurance); Nat’l Kidney and Urologic Diseases Info. Clearinghouse, Financial Help for Treatment of Kidney Failure (Feb. 2005), http://kidney.niddk.nih.gov/kudiseases/pubs/financialhelp/#medicare (informing that Medicaid will pay for some of the treatment costs if a patient falls below a certain income level and, in some states, could pay the 20% Medicare
figure does not include the cost of the drugs needed after the transplant. Because the body's immune system protects the body from foreign substances, such as bacteria, the patient's body may reject the kidney because it recognizes the transplanted tissue as "foreign." Therefore, immunosuppressant drugs are needed to prevent rejection; hopefully, the body adjusts to the new kidney and, eventually, the transplant will be a success.

While the entire process of kidney transplantation is arduous and expensive, the most difficult part is obtaining a kidney. In the United States, as of February 26, 2006, there were 65,541 people on the waiting list for a kidney transplant. In 2005, there was only a combined total of 12,214 cadaveric and living kidney donors. In Europe, as of June 2003, there were about 40,000 people on the waiting list for kidneys, and an estimated 15-20% would die before a kidney became available. A report published by the Conference of European Health Ministers stated that in 2003 the waiting list time for a "legally acquired organ" was three years, and that by 2010 it was expected to jump to ten years because of the shortage. Thousands of people die each year from kidney failure, and many could have lived had there been a kidney match for them.

The list of potential donors is naturally limited because of the criterion that the cadaveric donors must be brain dead. Typically, donors are usually "less than fifty-five years old and free of infection" whose "major organs other than the brain must be functioning while they are temporarily sustained on the heart-lung machine." Therefore, many of the organ donors tend to be young
adults who were in an accident that involved a serious head trauma. Even more disheartening is that "[t]he potential demand for organs is much greater than present levels may indicate." For instance, the list does not include the elderly; people over the age of eighty-five are not put on the list because physicians do not think their bodies can handle a transplant and a donor kidney should go to someone with a greater chance of survival.

Not only is there a lack of a plentiful supply of kidneys, but it is also difficult to find a donor match among those kidneys. When a kidney becomes available, the kidney is matched to a candidate with the same blood group and tissue type. Other factors include how long a candidate has been on the waiting list and her medical condition. Transplant centers also try to match a kidney locally

Markets, in THE ETHICS OF ORGAN TRANSPLANTS 208, 208 (Arthur L. Caplan & Daniel H. Coelho eds., 1998). In situations of a sudden trauma, for instance a car accident, the body can be artificially maintained on a ventilator for less than an hour in order to preserve the viability of the kidneys. See E-mail from Arthur Matas, M.D., Transplant Surgeon, Univ. of Minn. (Feb. 16, 2006, 17:11:26 CST) (on file with author). Typically, however, kidneys are removed from deceased donors under controlled conditions such as an operating room, where everything is set up in advance and then stored with preservation fluid on ice until implantation into recipients. If the kidney is deprived of circulation and, therefore, oxygen for an extended period of time, the kidneys are no longer viable. It is recommended that no more than twenty minutes elapse between when the deceased goes into cardiac arrest and when the kidneys are placed on ice, although longer periods of thirty to forty minutes do occasionally occur. The longer the time lapse, the greater likelihood the kidneys will not work well or at all. Once the kidneys are on ice, they can be stored for up to forty-eight hours before being used; however, most transplant centers aim to get the kidney transplanted within less than ten to fourteen hours. Usually, kidneys are transplanted between twelve and twenty-four hours after removal. Again, the longer the kidneys stay on ice for more than twenty-four to thirty hours, the worse the post-transplant graft outcomes. The time frame for removal and transplant also depends on the quality of the donor organ because older donor organs are more susceptible to injury while younger ones are more resistant. See E-mail from Roy Bloom, M.D., Med. Dir., Kidney/Pancreas Transplant Program, Hosp. of the Univ. of Pa. (Feb. 16, 2006, 18:04:58 EST) (on file with author).

See Andrew H. Barnett et al., supra note 13 (describing the type of patients that tend to become organ donors).


See e.g. Nat'l Kidney Found., Transplant Waiting List (May 17, 2004), http://www.kidney.org/atoz/atozitem.cfm?id=114 (providing answers to typical questions regarding the donor matching process and showing that there are a lot of considerations that go into finding a match).

Id.

Id.
or within its network and if there is no match, the transplant center will look for a candidate regionally, then nationally.\textsuperscript{19} Thus, larger pools of kidneys are needed to ensure more donor-recipient matches.

In the United States, the most widely accepted method of organ donation is cadaveric donation. The donor either personally consents to donating her organs or her family, upon her death, donates her organs. The Uniform Anatomical Gift Act ("UAGA"),\textsuperscript{20} created in 1968 and adopted by all states and the District of Columbia, established this donation process based on the idea that "a person’s organs were of no value to him after his death, and . . . were of enormous value to their potential recipients," therefore, a person "would be moved by (consequentialist) moral considerations to donate them."\textsuperscript{21} It is unlikely, however, that the express consent laws of the United States are to blame for the kidney shortage.\textsuperscript{22} Even under alternative systems of presumed consent, where the deceased’s organs are harvested unless she or her next of kin registered an objection before her death, procurement rates are low as evidenced by the European countries that utilize such a system.\textsuperscript{23}

An obvious reason for the kidney shortage in the United States is that people are not motivated or provided with any incentive to donate their kidneys. The lack of motivation "is even more acute in countries where religious or cultural considerations inhibit organ donation."\textsuperscript{24} People could also fear that if they are organ

\textsuperscript{19} Id.

\textsuperscript{20} See infra note 42 (discussing the UAGA and what the act establishes).


\textsuperscript{22} See Henry Hansmann, Markets for Human Organs, in A LEGAL FRAMEWORK FOR BIOETHICS 145, 145 (Cosimo Marco Mazzoni ed., 1998) (explaining that the U.S. system of express consent for kidney donation is not to blame for the shortage because European countries also have a shortage under their system of presumed consent).

\textsuperscript{23} See id. ("In Europe . . . most countries have adopted a rule of 'presumed consent,' under which organs are assumed available for transplant unless an objection is registered . . . [y]et none of the European countries have notably better donation rates than does the United States, apparently because even strictly construed presumed consent laws function in practice like the American regime under which explicit approval is required.").

donors, then they might be less likely to receive life-saving treatment because physicians would want to harvest their organs so as to “save a greater number of lives.” The shortage problem is further magnified because of two other factors. First, just because a person decides to donate her organs upon her death does not mean the organs will be transplanted. Because a person must only be brain dead while the rest of her organs are oxygenated, there is a limited window of opportunity to harvest the kidneys. Situations could easily arise where the willing donor cannot be identified in time to harvest her organs; for instance, she could not have her driver’s license with her, indicating her donor status, when she is brought into the hospital. And, even if the willing donor does have identification indicating she is an organ donor, her “family could still object to the retrieval of [her] organs.”

Second, there are considerable costs to both the donor’s family and the physician. Keeping a willing donor on life support in order to keep the organs oxygenated can be economically burdensome on the family, as well as psychologically taxing because the willing donor is a loved one in a physical state where she seems alive. Physicians also feel psychologically burdened

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25 TAYLOR, supra note 21.

26 See also Caplan, supra note 15, at 144 (noting that there are a variety of factors that contribute to the ineffectiveness of the current cadaveric donation system in the United States including “lack of trust on the part of physicians and hospital administrators in the legal authority of donor cards, the failure of the public to sign and carry donor cards, the failure of hospital personnel to locate donor cards, and most important, the failure of physicians and nurses to inquire about the possibility of organ donation in the absence of written directive on the part of the deceased”).

27 See TAYLOR, supra note 21 (explaining a situation where a willing donor’s kidneys would not be harvested, thus, contributing to the kidney shortage).

28 Id.

29 Also, if a person is a potential donor and is “neurologically devastated,” she is given a series of tests until her full brain death is established. This process could take up to forty-eight hours after the patient’s family is notified (although there are exceptions to the full brain death criteria for donations from those without a pulse). Sometimes, this process is too intense for a family to handle and some who initially agree to donate their loved one’s organs, eventually request that the loved one be taken off of the machine, which renders donation impossible. Other families, particularly those of young loved ones, insist on holding the loved one as her heartbeat and respirations stop after the life support is removed and “find that they cannot allow their child to be taken for procurement surgery.” Ann C. Klassen & David K. Klassen, Who are the Donors in
because they are placed in a position where they must request "organs from the relatives of a person who appears still to be sentient" and who are in a highly emotional state of mind. Because of the stress and emotions the families are under when they are asked to donate their deceased loved ones’ organs, more than fifty percent do not donate.

In addition to the kidney shortage, another problem in meeting the demand for kidneys is that the limited number of available organs might not get to the patients who “need them [the] most or to whom they are best suited.” In the United States, for example, it is common for organs to be transplanted to a patient within the same hospital that extracted the organ. It is also customary that the organs are transplanted to a patient in a hospital that is “served by the same local regional transplant center, even if there is a more suitable recipient (or a more able transplant team) located elsewhere . . . because the hospital that extracts [the organ] . . . [has] little incentive to do otherwise.” Therefore, the kidneys appear to be going to those in closest proximity to the organs and not to those who need them the most.

For a variety of reasons, there is a shortage of kidneys in the United States, which isn’t meeting the demand, and the list of people who need kidneys grows by the day. If receiving a kidney is a matter of life or death, what is a patient to do?

Organ Donation? The Family’s Perspective in Mandated Choice, in THE ETHICS OF ORGAN TRANSPLANTS, supra note 13, at 156 (explaining why having a loved one on life support and being confronted with whether to donate her organs, is psychologically burdensome on families).

TAYLOR, supra note 21, at 6.

“Because most organ donors are young people who die unexpectedly, the family is often devastated and in shock. Under these circumstances, clear thinking may be impossible.” Aaron Spital, Mandated Choice for Organ Donation: Time to Give It a Try, in THE ETHICS OF ORGAN TRANSPLANTS, supra note 13, at 148. For this reason, families may feel a lot of stress if they are approached by a physician asking them for the organs of their recently deceased. It is also stressful for the medical personnel involved because they do not want to add to the families’ stress.

See id. (stating that more than 50% of families refuse to donate their deceased loved ones’ organs and reasoning that this rate is because of the emotional state the families are in and stress they are under).

Hansmann, supra note 22.

See id. at 145-46 (explaining how the hospitals are involved in the organ transplantation process and that they work together with local regional transplant centers, which does not always benefit someone who needs a kidney in another location).

Id.
3. LIVING KIDNEY DONATION LAWS

Because of the shortage of cadaveric organ donation, those who need a kidney often seek a living donor, usually either a family member or friend with the same blood type. Since having two kidneys is not essential in that a person could still lead a good life with only one kidney, it would seem that living donors would provide kidneys. Living donors, however, are not always easy to find because there is little incentive to offer for their kidneys, other than the satisfaction that comes with saving or improving the life of a family member or friend.

As a result of a higher demand for kidneys than the supply from cadaveric or living kidney donors provides, patients needing a kidney may turn to desperate measures such as buying a kidney from a living person. Paying for a kidney, however, raises a host of legal and ethical concerns and is frowned upon by the international community. Recognizing that the sale of kidneys occurs, several international organizations have issued position statements concerning the practice. In 2004, the World Health Assembly, at the urging of the World Health Organization, advocated that member states “take measures to protect the poorest and vulnerable groups from ‘transplant tourism’ and the sale of tissues and organs, including attention to the wider problem of international trafficking in human tissues and organs.”

In 2000 the World Health Association noted that “[p]ayment for organs and tissues for donation and transplantation should be prohibited” because “[a] financial incentive compromises the voluntariness of the choice and the altruistic basis for organ and tissue donation” and violates “the principles of justice.”

Consistent with these views, the United States and other countries have banned the sale of organs from living donors, with the exception of Iran and Pakistan, where the sale of kidneys is


37 World Med. Ass’n, World Medical Association Statement on Human Organ & Tissue Donation and Transplantation (Oct. 2000), http://www.wma.net/e/ policy/wma.htm. Additionally, the Bellagio Task Force on Transplantation, Bodily Integrity, and the International Traffic in Organs was established to examine the social, political, ethical, and medical ramifications of the kidney shortage and kidneys for sale. See Rothmann, supra note 24 (stating the purpose of the Bellagio Task Force and its goals).
In the United States, courts have recognized a limited property right in body parts. Blood, semen, and other self-replicating body fluids can be sold. It is, however, illegal to sell your body parts for transplantation. Congress, in 1968, adopted the UAGA, which prescribed guidelines that limited the decision to donate organs upon the death of an individual to the deceased or her next of kin. The revised version of the law passed in 1987 explicitly banned the sale of organs, imposed penalties, and specified that a deceased's wishes could not be overridden by her next of kin.

A few years before Congress revised the UAGA, it also passed an act complementary to the UAGA, the National Organ

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38 See Sheera Frenkel, Organ-trafficking Laws in Key Countries, THE CHRISTIAN SCIENCE MONITOR (June 9, 2004), available at http://www.csmonitor.com/2004/0609/p12s02-wogi.html (listing various countries and the status of their organ sale laws). On the other end of the spectrum, Iran does allow kidney sales, and the transactions are controlled by two nongovernmental organizations; however, the organizations do have government endorsement.

39 See Moore v. Regents of the Univ. of Cal., 793 P.2d 479, 479-523 (Cal. 1990) (holding that the plaintiff did not state a conversion claim by alleging that the defendants used his cells for medical research without his consent because the plaintiff did not retain an ownership interest in his cells after they left his body; however, the plaintiff did state a claim for breach of a physician's duty to disclose and get the plaintiff's informed consent).

40 See Stephen A. Mortinger, Comment, Spleen for Sale: Moore v. Regents of the University of California and the Right to Sell Parts of Your Body, 51 OHIO ST. L.J. 504-06 (1990) (discussing the holding in Moore v. Regents of the University of California and other cases used to determine what aspects of the body can be put up for sale).

41 See id. at 506-08 (noting federal law banning the sale of organs discussed infra note 44); see also Arthur Caplan, Organs.com: New Commercially Brokered Organ Transfers Raise Questions, 34 HASTINGS CTR. REP. 8 (2004) (exploring the online organ trade based on the story of Robert Smith, who was jailed for online organ sales). Although federal statute bans the sale of organ, it does allow a commercial broker to charge a price for brokering a donation. A transplant surgery that occurred on October 20, 2004 in Colorado was the first one that was arranged through a commercial company serving as a middleman. Robert Smitty donated a kidney to Robert Hickey. Although Hickey did not pay Smitty, he did pay a website, MatchingDonors.com, a monthly fee of $295 to advertise his need for a kidney. Unfortunately, Smitty was arrested on failure to pay child support although his arrest raised suspicion that he actually sold his kidney to Hickey. Id.

42 Marjorie A. Shields, Annotation, Validity and Application of Uniform Anatomical Gift Act, 6 A.L.R. 6th 365 (2005). The original UAGA did not explicitly address the sale of organs although the ban on the practice was implied.

Transplant Act ("NOTA"). This Act states: "It shall be unlawful for any person to knowingly acquire, receive, or otherwise transfer any human organ for valuable consideration for use in human transplantation if the transfer affects interstate commerce." A "body part" is defined as, "[T]he human (including fetal) kidney, liver, heart, lung, pancreas, bone marrow, cornea, eye, bone, and skin or any subpart thereof and any other human organ (or any subpart thereof, including that derived from a fetus) specified by the Secretary of Health and Human Services by regulation." The United States is not the only country that has adopted laws banning the sale of organs such as kidneys. In 2004, the Council of Europe, of which there are forty-six member states including Austria, Belgium, Finland, France, Germany, Greece, Italy, Netherlands, Poland, Portugal, Spain, Sweden, Switzerland, Turkey, and the United Kingdom, recommended to member states

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45 The National Organ Transplant Act states as follows:

Prohibition of organ purchases:

(a) Prohibition: It shall be unlawful for any person to knowingly acquire, receive, or otherwise transfer any human organ for valuable consideration for use in human transplantation if the transfer affects interstate commerce.

(b) Penalties: Any person who violates subsection (a) of this section shall be fined not more than $50,000 or imprisoned not more than five years, or both.

(c) Definitions: For purposes of subsection (a): (1) The term "human organ" means the human (including fetal) kidney, liver, heart, lung, pancreas, bone marrow, cornea, eye, bone, and skin or any subpart thereof and any other human organ (or any subpart thereof, including that derived from a fetus) specified by the Secretary of Health and Human Services by regulation. (2) The term "valuable consideration" does not include the reasonable payments associated with the removal, transportation, implantation, processing, preservation, quality control, and storage of a human organ or the expenses of travel, housing, and lost wages incurred by the donor of a human organ in connection with the donation of the organ. (3) The term "interstate commerce" has the meaning prescribed for it by section 201(b) of the Federal Food, Drug and Cosmetic Act.

Id. at § 274(e) (2005).

46 Id.

that organ and tissue trafficking be prohibited.48 The United Kingdom passed the Human Organ Transplants Act of 1989, which prohibits the commercial sale of organs that are to be used for transplantation.49 Belgium requires that the removal of any organ from a cadaveric or living donor be done in collaboration with an approved transplantation center in the country.50 Germany, Japan, Switzerland, and France have clear laws against the sale of organs.51 The Israeli Ministry of Health allows the removal of organs from cadavers if the family permits it. If an individual decides to be a living donor, she must get the permission of the Ministry only after a hospital committee and social worker meet with her.52

Not all attempts to criminalize the sale of kidneys are successful, which creates certain hot spots for kidney black markets.53 India tried to outlaw sales in 1994 with its


51 See generally id. (summarizing the transplantation laws of Germany, Japan, Switzerland, France, and others).

52 Michael M. Friedlaender, The Right to Sell or Buy a Kidney: Are We Failing Our Patients?, 359 LANCET 971, 971 (2002) (explaining the Israeli laws governing kidney procurement and transfers). Israel has also banned the sale of kidneys along with Brazil and South Africa. See, e.g. Frenkel, supra note 38 (summarizing the ban on the sale of organs in various countries).

53 Other countries that have ineffective laws banning the sale of organs include Brazil and South Africa. See Frenkel, supra note 38 (discussing the laws in Brazil and South Africa). For example, in 2003, a Brazilian living donor sold his kidney to a Brooklyn, NY woman through Israeli middlemen. Both the donor and the receiver flew to South Africa where the operation took place. The donor was paid $6,000, which was used to pay off debts, while the receiver was paid $65,000. The donor was only monitored for about three days and put up in a safe house whereas the receiver was lodged in a beach house and kept under intense medical watch. The middlemen have since been arrested and jailed on organ trafficking charges. See Larry Rohter, Tracking the Sale of a Kidney on a Path of Poverty and Hope, N.Y. TIMES, May 23, 2004, at A1, A8; Nancy Schepet-Hughes, Black Market Organs: Inside the Trans-Atlantic Transplant Tourism Trade, LIF MAGAZINE, June 3,
Transplantation of Human Organs Act, but allowed for "unrelated kidney sales." The Philippines enacted an administrative order, which explicitly stated that the "sale and purchase of kidney organs by kidney vendors is prohibited" and that any medical professional or facility that permitted the trade would be penalized. Despite the law, selling kidneys is still commonplace and sometimes even the doctor is involved in brokering the transaction. And, although it is illegal in China to sell or purchase organs, the Chinese government passed a law in 1984 that allows organs to be procured if they come from the bodies of executed prisoners whose families do not claim them right away.

Cadaveric and living kidney donations do not meet the demand for kidneys, which has led those in desperate need for kidneys to resort to other methods of obtaining the organs. The combination of the United States' laws and other countries' laws banning the sale of kidneys has helped fuel the black market for the organs.

4. THE BLACK MARKET

Despite the fact that it is prohibited by law in most countries to buy or sell a kidney, a black market for kidneys has emerged because of the kidney shortage. "In general the flow of organs... follows the modern routes of capital from south to north, from..."
third to first world, from poor to rich, from black and brown to white and from female to male bodies.”

The kidneys come from people who live in the poorer countries or areas, such as India, South America, and Eastern Europe, and go to people who need them in the richer countries, such as those in the United States or Western Europe. Purchasers and suppliers are typically brought together through a middleman and the transplant occurs at designated centers in countries where there is little to no regulation. The black market for kidneys is troublesome because it exploits the poor and is unregulated, which negatively effects the participants mentally, physically, and financially.

4.1. Purchasers of Kidneys

The motivating factors for purchasers of illegal kidneys appear to be the shortage and quality of available organs. In the United States, the average waiting time for a kidney transplant at an institution such as the University of Pennsylvania transplant center is about two and a half to three years. The waiting list in Europe for a legal transplant averages six years. Thus, faced with a long wait on the recipient list as a patient’s health deteriorates, and uncertainty as to whether a matching kidney will become available, a patient desperate for a kidney resorts to purchasing the organ on the black market despite the high costs, monetarily and physically, for the transaction.

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60 See Robert Grossman, Waiting Time (March 2004), available at http://www.pennhealth.com/transplant/kidney/waiting.html (noting the average wait time at the Penn Transplant Center); see also Susan Smith, Organ Allocation at the Crossroads (Apr. 26, 2002), available at http://www.chfpatients.com/tx/txrules.htm (claiming that the average waiting time for a kidney is almost three years, and if the waiting list continues to grow at twenty percent annually while the number of donors remains below 10,000, the average wait will increase to ten years by 2010).

61 Berthillier, supra note 59. This number will likely increase, given that the number of people requiring dialysis treatment increases every year; in France, for instance, the number has increased at a rate of five percent. Id.

62 See, e.g. Rohter, supra note 53 (sharing the story of a poor kidney donor).
Even were there not a shortage of cadaveric donors, patients who can afford to buy a kidney on the black market might still choose to purchase a kidney illegally from a living donor because they like the idea that a live kidney might be in better condition than one that comes from a cadaver. Kidneys that come from cadavers often raise questions. Where did the cadaver come from? What is the state of the kidney based on the deceased's lifestyle choices (such as drinking)? What is the quality of the kidney based on the age of the deceased? Nancy Scheper-Hughes, an anthropologist at the University of California-Berkley, conducted an interview in 2000 with a former lawyer who opted to have an illegal transplant. For the lawyer, the most important factor in choosing to obtain a kidney illegally appeared to be his preference to buy a kidney from a young adult who needed money. He was able to thus learn the health and personal history of his donor, while providing the donor with economic aid.

The black market offers kidney purchasers the opportunity to circumvent the waiting list and allows the purchasers to identify the kidney's source. Thus, in order to eliminate the black market, there is a need for both cadaveric and living donors, to address not only the shortage, but also recipient preferences to know whether the kidney comes from a healthy donor.

4.2. Suppliers of Kidneys

The black market could not thrive without willing sellers, whose crucial motivating factor is money. This motivation is evidenced by the fact that the majority of kidney donors come from poorer countries such as India and Brazil. An entirely new supply source emerged with the fall of the Soviet Union. White western Europeans used to travel great distances to the Far East, South America, or even South Africa to find a potential seller, but the fall of the Soviet Union created new supply sources on the same continent. Because purchasers are concerned with the

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63 See Berthillier, supra note 59, at 162 (describing the study Nancy Scheper-Hughes conducted about illegal transplants).

64 Id.

65 Id.

66 See generally id. at 161-63 (describing the new European network for organs in addition to India and South America); see also Rohter, supra note 53 (detailing the path a kidney takes from a poor donor to a rich recipient).

67 See Berthillier, supra note 59, at 163 (explaining the emergence of a new European network for illegal kidneys after the fall of the former Soviet Union and
quality of these kidneys, many European purchasers view these new supply sources as "white, sturdy, in relatively good health and have not had to endure the famine and endemic diseases of certain countries in the Third World." Poor Eastern European suppliers who need money, therefore, transact with buyers who prefer kidneys to come from countries where there have been more sanitary health conditions.

It is easy for an indigent person to rationalize selling a kidney. A body can function with one kidney; therefore, if someone needs money, why not sell a kidney? The black market is troubling because it provides a marketplace for indigent suppliers to sell their kidneys and creates a situation where the poor are exploited. In 2001, a group of medical researchers conducted a study in Chennai (formerly called Madras), India. They sought to quantify the "economic and health consequences of selling a kidney." The study participants overwhelmingly reported that the reason they sold their kidney was to help pay off debts. The money the participants received for their kidney went to their debts or the purchase of food and clothing.

Financially, however, the sellers do not receive the full amount of money paid by the buyers. Typically, sellers in Eastern European countries receive $2,500 to $3,000 U.S. dollars for their kidneys; however, the buyer is charged up to ten times that amount because of price and convenience, buyers want to undergo the transplant operation close to home, explaining why Northern Americans tend to buy kidneys in Latin America and Europeans use the "European network"). For example, CBS broadcasting produced an episode of "48 Hours," which explored a kidney transplant where the buyer was a wealthy American who bought a kidney from a Peruvian woman for the price of $18,000. See also 48 Hours: Your Money or Your Life: The Kidney Trade (CBS television broadcast July 31, 2002), available at http://www.cbsnews.com/stories/2002/02/11/48hours/main328962.shtml (documenting an investigation conducted by "48 Hours" of an illegal kidney transplantation).

68 Berthillier, supra note 59.

69 See generally id. (describing the attitude of kidney purchasers).

70 See generally Madhav Goyal et al., Economic and Health Consequences of Selling a Kidney in India, 288 J. AM. MED. ASS'N 1589 (2002) (reporting the results of a cross-sectional survey of people who sold their kidneys in India and drawing conclusions from the results).

71 Id.

72 See id. (documenting the reasons why the study’s participants sold their kidneys).

73 See id. at 1591 (noting how the study’s participants recalled spending the money they received from selling their kidneys).
amount, with the difference going to the middleman. Participants in the India study were promised, on average, $1,410, but actually received, on average, $1,070. The middleman promised, on average, about one-third more than what was actually paid.

Unfortunately, for those donors whose sole motivating factor is economic gain, the end result is not always what they imagined. In most cases, the donors are actually worse off than they were before selling their kidney. The India study participants noted that their economic status actually declined after selling their kidney. At the time of the nephrectomy, the average family income was $660, and after the nephrectomy, at the time of the survey, it was $420. Additionally, "the percentage of participants below the poverty line increased from 54% to 71%." Further, suppliers do not usually anticipate the psychological repercussions that selling a kidney may have on them. "Organs Watch" is an organization that studies the social and economic effects of organ transplantation with a focus on the sale of organs. One aspect of the organization’s purpose is to monitor the mental and physical effects of selling a kidney. According to Scheper-Hughes, with the exception of a few villages in India, sellers throughout the world regretted selling their kidneys. One of the reasons given for sellers’ regret was "they had not imagined the

75 See Goyal, supra note 70, at 1591 (providing the average amount the study participants were promised, ranging from $450-$6,280, for selling their kidney versus the average amount they actually received, ranging from $450-$2,660).
76 See id. (citing the middleman as the one who promised the sellers more than they actually received).
77 See, e.g., id. (using the study participants’ responses as evidence that the donors are not financially better off after the sale of their kidneys).
78 Id.
79 See id. (detailing the change in economic status of the study participants based on income level).
80 Id.
81 “Organs Watch” is a project that brings together anthropologists, human rights activities, physicians, and social medicine specialists to study organ transplantation, procurement, the illegal sale of organs, and track any developments relating to the area. It was started by Nancy Scheper-Hughes and Lawrence Cohen. See generally Organs Watch, http://sunsite3.berkeley.edu/biotech/organswatch/pages/about.html (last visited Feb. 18, 2005).
82 See Organs for Sale, supra note 58, at 41; see also Berthillier, supra note 59, at 166 (revealing that most sellers regret selling their kidneys).
ordeal of the operation, the length of convalescence and the shame they felt." 83 A donor from Lima, Peru told news investigators that she felt, "forgotten." 84 The Indian sellers, in the end, realized that the problem that prompted them to sell their kidneys was not solved by the sale and concluded that they would be unlikely to recommend for others to sell their kidney. 85

Physically, there are still questions as to whether there are long-term health consequences to kidney removal. While there has been limited scientific study in this area, the participants in the India study did note some physical effects. 86 Only thirteen percent of the participants noted no decline in health while eighty-six percent reported some level of decline. 87 Additionally, "of all participants, 50% complained of persistent pain at the nephrectomy site and 33% complained of long-term back pain." 88 Although the study's participants may have overestimated their state of health prior to the nephrectomy, 89 they still experienced some level of notable pain after their kidney was removed. It is also particularly troubling that sellers cannot afford a doctor. 90 Therefore, if health problems associated with kidney removal develop, the sellers would not know because of their lack of access to doctors. 91

Lastly, many of the sellers from indigent countries are women

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83 Berthillier, supra note 59, at 166.
84 48 Hours, supra note 67; But see Rohter, supra note 53 (disclosing that the Brazilian donor did receive a note from the woman who purchased his kidney thanking him).
85 See Goyal et al., supra note 70, at 1591 (summarizing that seventy-nine percent of the 264 participants in the study who were asked whether they would recommend selling a kidney would not recommend it).
86 For a discussion about some of the adverse effects the Indians who sold their kidneys experienced, see id. But see Berthillier, supra note 59, at 166 (noting that no scientific study has looked at whether someone from a "disadvantaged living environment" who sells a kidney has the same life expectancy as someone in the same community who does not).
87 See Goyal et al., supra note 70 (reporting that many of the study's participants experienced a decline in health after selling their kidney).
88 Id.
89 See id. at 1592 (considering the possible limitation that the decline in health results could be from the participants overestimating their health status prior to the nephrectomy).
90 Berthillier, supra note 59, at 166.
91 See id. at 165 (describing how the kidney sellers become an "invisible population" and the lack of medical care they receive).
who may be forced to sell their kidney against their will. In the India study, of the 305 participants, seventy-one percent were women. Of those women, sixty percent were street vendors or laborers, and of the 221 married participants, 159 were female. When the women were asked why they sold their kidneys rather than their husbands: thirty percent said their husbands were the breadwinners, twenty-eight percent said their husbands were ill, and two participants said their husbands forced them to sell. While only two women said their husbands forced them to sell, the researchers noted that other women participants “may have been reluctant to mention being forced to donate” because other family members were around when the interviews were conducted. These survey numbers suggest that not only are suppliers being taken advantage of based on financial status, but also sex. This is exacerbated when suppliers live in patriarchal societies such as India.

The main suppliers in the black market are indigent people desperate for money. Because the market is unregulated, these people are typically exploited and left no better, or even worse-off, mentally, physically, and economically, than they were before selling their kidney. In order to eliminate this black market, more kidneys must be made available. An effective solution must ethically increase the kidney supply in order to decrease the need to buy kidneys illegally from people in poorer countries.

4.3. The Middleman

The black market is mainly controlled by a middleman, the person who brings the buyer and seller together. In the India study, seventy percent of the participants sold their kidneys

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92 See Goyal et al., supra note 70, at 1590 (stating how many of the study participants were women).
93 Id.
94 See id. (describing the types of jobs that women who participated in the study held).
95 See id. at 1591 (stating how many of the participants were married women).
96 See id. (providing data on why married women sold their kidneys).
97 Id. at 1592.
98 Vineet Chander, “It’s (Still) A Boy. . . .”: Making the Pre-Natal Diagnostic Techniques Act an Effective Weapon in India’s Struggle to Stamp Out Female Feticide, 36 GEO. WASH. INT’L L. REV. 453, 455 (2004) (“India has traditionally been a patriarchal society, a concept embedded in many of its historical, cultural practices.”).
through a middleman. Rarely do the buyer and seller come in contact; rather, a small group of individuals known as the "organ mafia" facilitate the transactions. The "organ mafia" uses people to find patients and donors, linking people on one continent to another. The "brokers," those who find the patients, are contacted by patients via Internet or classified ads. In Eastern Europe, organized crime plays the role of the middleman that connects buyers to sellers.

Sometimes, a doctor will advertise directly and serve as the middleman. Dr. Bolivar Escobedo, a Peruvian doctor, solicits kidney transactions through his own website and even took out an ad in USA Today. Financially, the middlemen are the ones who benefit the most. In one transaction brokered by two Israeli middlemen, the buyer paid $65,000 while the seller only received $6,000. Although some of the money the buyer spent covered her lodging and medical care, the middlemen pocketed a substantial amount of money.

Additionally, although laws in the United States prohibit the buying, selling, and transferring of kidneys, there appears to be a lack of enforcement. As of July 31, 2002, no one in the United States had been prosecuted for buying or selling a kidney. While

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99 See Goyal et al., supra note 70, at 1590 (showing participant characteristics).
100 See Berthillier, supra note 59, at 163-164 (explaining the role of the "organ mafia").
101 See, e.g., Rohter, supra note 53 (detailing how a Brooklyn, New York woman bought a kidney from a Brazilian man through Israeli middlemen).
102 See Berthillier, supra note 59, at 164 (explaining how buyers get in touch with the kidney brokers). A middleman can also be a commercial website. An individual in need of a kidney can pay a monthly fee to the website to post an advertisement, which a potential donor can answer. Soliciting donors through the Internet is problematic, because of the potential for deception and the practice is unregulated. Additionally, there are no protocols that govern the interaction between the donor and recipient such as the amount of contact the parties should have, the role a doctor should play, what happens if one party changes its mind at the last minute, or who bears the financial burden if the donor dies or is injured.
103 See Goyal et al., supra note 70 (discussing the role of the mafia in the illegal kidney trade). See also Organs for Sale, supra note 58 (reporting that a Japanese gang, known as a yakuza, used connections and operated through a medical center in Boston).
104 See 48 Hours, supra note 67 (noting how a Peruvian doctor solicits business in the illegal kidney trade).
105 See Rohter, supra note 53 (documenting the transaction between a Brooklyn, NY woman and a Brazilian seller).
106 Id.
107 See 48 Hours, supra note 67 (commenting how no one had been prosecuted
hospitals and physicians are prohibited from transferring an illegal organ, they are not required under NOTA to disclose whether a patient had an illegal transplantation. Therefore, many hospitals in the United States invoke a "don't ask, don't tell" policy when they see a patient who has come back from an illegal operation in another country. Two possible reasons for physician silence are that doctors may sympathize with patients because of the kidney shortage, and that it would be almost impossible to track down the seller. Additionally, doctors may realize that the patients who are paying for their kidneys would probably rather pay the monetary penalty, or even serve jail time, than die.

Doctors are the ones who see the patients, and likely the only people (besides the patients' families) who would be privy to knowledge of an illegal transplantation. Therefore, if the black market is to be eradicated, this country also needs to address how to regulate illegal kidney purchases. Without disclosure of patients who have obtained kidneys illegally or effective sanctions as a deterrent, a continued shortage of kidneys will ensure the continued existence of the black market.

5. PROPOSALS TO ELIMINATE THE BLACK MARKET

The United States and the international community have acknowledged the need to take proactive steps to eliminate the kidney black market. In Europe, during the Conference of European Health Ministers, the participant countries recognized that medical treatment is a basic human right and "called for steps to ease inequalities in access to health care both within and between different countries in Europe." At best, however, these

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108 See National Organ Transplant Act, supra note 44, (a) (prohibiting any person from knowingly acquiring, receiving, or transferring any human organ for valuable consideration for transplant purposes if the transplant affects interstate commerce). For purposes of this Act, interstate commerce is defined broadly by 21 U.S.C. § 321(b) to include foreign commerce. See 21 U.S.C. § 321(b) (2000) (defining interstate commerce as any "commerce between any State or Territory and any place outside thereof"). See also United States v. Themy-Kotronakis, 140 F.3d 858, 863 (10th Cir. 1998) (finding that the Food and Drug Administration definition of interstate commerce includes foreign commerce).

109 See e.g. 48 Hours, supra note 67 (expressing the reaction of American hospital workers to patients who have undergone an illegal kidney transplant).

110 See id. (providing explanations for why doctors do not reveal patients who obtained illegal kidney transplants to authorities).

111 Supra note 11.
steps have merely heightened awareness of the legal consequences. Because the penalties are rarely imposed, the laws are not an effective deterrent to trading kidneys on the black market. For example, in 1997, Brazil criminalized organ sales, but the trade continues to exist.\footnote{See Frenkel, supra note 38 (discussing Brazil's prohibition on organ sales); see also Rohter, supra note 53.}

Because laws against kidney sales have proved ineffective, scholars have advanced other proposals to eliminate the black market on kidneys. The potential proposals each have their advantages and disadvantages. In evaluating these suggestions, attention must be given to the ethical implications of each proposal. How is the autonomy of the donor affected? What, if any, third-party influences may arise? Is government involvement necessary and, if so, how much involvement should it have?

Addressing these ethical and legal concerns, among others, is important if we are to protect the interests of the parties involved. Upon close examination of the leading proposals, each raises ethical concerns that outweigh any potential benefits the current proposals offer. None of the proposals, alone, would effectively and ethically increase the kidney supply. The proposals that have drawn the most attention are: an open market, a futures market, and presumed consent for cadaveric organ donation.

\subsection*{5.1. Open Market}

An open market raises ethical concerns centering around the exploitation of the poor, kidney pricing and quality, notions of altruism, third-party influences, physician participation, and cultural and religious considerations. The open market proposal places a price tag on the kidney and allows people to buy and sell the organ freely. Since kidneys are already sold on the black market, an open market seems to be a logical extension. There is a supply and demand for the organs, so the transactions should be legalized. The free market for kidneys would determine the price, "so that the quantity demanded is approximately equal to the quantity supplied."\footnote{Barnett et al., supra note 13, at 211. (showing the greater the need for the kidney, the higher the price). This is because of scarcity. The higher price would then incentivize people to supply kidneys. See id. (explaining the open market system for kidneys in general terms).} This would help eliminate the kidney shortage.
Open markets for kidneys are very controversial because they raise serious ethical issues and

[1]t is generally believed by persons of all political and theoretical stripes that markets in human organs are likely to compromise the autonomy and well-being of those who participate in them as vendors, that they are likely to undermine the well-being of those who receive the body parts thus procured, that they commodify what should not be commodified, that they are demeaning to vendors and, most simply, that such markets are simply viscerally repugnant.\textsuperscript{114}

One may argue that since people are already buying and selling kidneys, if the government legalized the transactions, then the government could better regulate them and protect the participants.\textsuperscript{115} The kidney supply would increase and everyone would benefit.\textsuperscript{116}

These benefits, although legitimate, are not enough to outweigh the consequences. While any type of open market would eliminate the black market because the commodification of kidneys would then be legal, any of the open markets are wrought with moral issues and, as a matter of public policy, cannot be allowed. Simply, “the commodification of the human body is an affront to human dignity” because it “would erode respect for persons, and so would eventually lead to them being seen as nor no more than bundles of spare parts.”\textsuperscript{117}

An open market for kidneys can be structured in three ways.\textsuperscript{118}

\textsuperscript{114} Taylor, supra note 21, at 2.
\textsuperscript{115} Arthur J. Matas, The Case for Living Kidney Sales: Rationale, Objections and Concerns, 4 AM. J. TRANSPLANTATION 2007, 2007 (2004) (promoting a regulated vendor system in the Western world because it would be reasonably easy to implement, increase the kidney supply, and would be morally permissible). But see Arthur L. Caplan, Transplantation at Any Price?, 4 AM. J. OF TRANSPLANTATION 1933, 1933 (2004) (opining that Matas and other proponents of an open market do not make a convincing case because of ample evidence that markets have failed, and explaining his belief that an open market is morally impermissible because it results in the exploitation of the poor, the ethical violation of medicine, and religious opposition).
\textsuperscript{116} See generally Matas, supra note 115 (arguing that kidney sale could have certain benefits if legalized).
\textsuperscript{117} Taylor, supra note 21, at 16.
\textsuperscript{118} See Erwin Bernat, Marketing of Human Organs?, in A LEGAL FRAMEWORK FOR BIOETHICS 162 (Cosimo Marco Mazzoni ed., 1998) (stating the three types of open markets).
First, a deceased's relatives could sell the kidney to a recipient either in advance of or upon the deceased's death. Second, a prospective donor could sell her own kidney, to be transferred to the recipient upon the donor's death. Third, the donor could choose to sell her kidney and undergo the nephrectomy while the donor is still alive. Each of these approaches believes that an open market is a logical solution to the kidney shortage and black market, because people are willing to buy and sell kidneys.

An open market for relatives to sell their relative-donor's kidneys, while the relative-donor is still alive, to someone upon the relative-donor's death, "clearly violates bonos mores" or good morals because the relative-donor's kidneys are not the property of the relatives. Therefore, the relatives have no right to sell the kidneys. The United States' culture and laws are rooted in the principle of autonomy; unless a countervailing state interest exists, the law respects an individual's right to choose what to do to her body. Allowing a relative to sell their relative-donor's kidney, then, is in direct conflict with these notions of autonomy.

The same violation occurs with a living donor signing a contract for the sale of his kidney upon his death. Although the actual nephrectomy does not occur until the donor's death, the moment she contracts to sell her kidney, the donation occurs. These contracts "lead to an impermissible limitation of personal freedom because they infringe on freedom of choice in highly personal matters." For instance, if a donor contracted with the hospital, her decisions concerning medical treatment may be affected by the terms of the contract. While a donor could breach the contract if it became too burdensome, the option to enter into the contract should not exist because of the restrictive nature of

119 Id.
120 Id.
121 Id.
122 Id.
123 See, e.g., Planned Parenthood of Se. Pa. v. Casey, 505 U.S. 833 (1992) (holding that an undue burden cannot be placed on a woman seeking an abortion); Washington v. Glucksberg, 521 U.S. 707 (1997) (determining that while an individual has a right to commit suicide, an individual does not have a right to have assistance to commit suicide); Cruzan v. Dir., Mo. Dep't. of Health, 497 U.S. 261 (1990) (holding that a patient has a right to refuse life-sustaining treatment, but her family members do not have the right to withdraw her life-support).

124 See generally Bernat, supra note 118, at 165 (discussing the ethical implications of a living person contracting to sell his kidney upon his death).

125 Id.
such a contract.

A currently living donor selling her kidney for a profit is considered the most controversial issue of the three types of open market for kidneys because of its ethical implications: exploitation of the poor, kidney pricing and quality, notions of altruism, third-party influences, physician participation, and cultural and religious considerations. An open market for kidneys is impermissible because the ethical concerns associated with it outweigh its potential of elimination of the black market.

5.1.1. Exploitation of the poor

A potential proposal should seek to eliminate the abuses of a black market, such as exploitation of the poor. Under an open market system, however, there is legitimate fear that exploitation of the indigent or the "socially underprivileged" would continue to persist and the poor would suffer from a loss of autonomy.

First:

[a] living provider organ market system may result in a disproportionate number of poor people selling their nonviable organs, such as kidneys, to benefit a disproportionate number of rich organ purchasers. This could result in a greater number of poor people living in diminished physical states due solely to their economic misfortune.\(^\text{127}\)

In an open market, it is unlikely that a poor person would be able to afford a kidney. Even if insurance were to cover kidney costs, the poor people would be responsible for the remainder of the procedure costs, medications, and follow-up medical care. Commodification would thus exploit the poor and yield inequitable access and distribution of kidneys.

Theoretically, in our current health care system, everyone has access to medical care; the differences lie in the quality of care. If kidneys were commodified, they would be valued differently depending on a variety of factors—much like the value of a house. Those in need of an organ would only be able to afford a kidney within their price range, which could mean that the quality of

\(^{126}\) Id. at 169.

kidneys the poor would have access to would not be as high as a kidney a rich person could afford. Thus, the "poor people would be priced out of access to organs in [such] compensation systems. Alternatively, assuming the poor did have equal access to organs, the organs to which they would have access might be of lesser quality." 128 Access to necessary organs, such as kidneys, should not depend on a person's financial ability to obtain one.

Second, indigents would "compromise their autonomy" if poverty coerced them into selling their kidneys. 129 However, an individual's decision to sell her kidney could be a rational, informed choice to make herself financially better off. The government allows, and society accepts, a number of market transactions people engage in because they are poor and have no other choice such as "work[ing] in coal mines, neglect[ing] their children while working two jobs, join[ing] the military, drop[ping] out of school, [and] sell[ing] family heirlooms" to name a few. 130 Prohibiting the underprivileged from participating because of their economic or social situation is leaving them "worse-off in their own lights." 131 Therefore, someone should be able to participate in the transaction if she values the price of her kidney more than the slightly better chance she has of avoiding death or illness because she has two, instead of one, kidneys. It is unclear where the line should be drawn between what market transactions are acceptable and what are not. 132

Although the seller may make a "rational" choice, this is not the issue. The concern is the "absence of real alternatives... choice is imperiled by high compensation, not because the sellers are rendered irrational by the prospect of money, but for those in need of money certain offers, no matter how degrading, are irresistible." 133 Thus, their choice to sell the organ is not really a

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129 TAYLOR, supra note 21, at 14.
130 See Barnett et al., supra note 13, at 213.
131 See Hansmann, supra note 22, at 153.
132 Id.
133 Caplan, supra note 115, at 1933. For example, someone who needs money could rationally decide to sell her baby, yet we prohibit this practice because it is a "gross exploitation of the poor if they have no options but to resort to child sales." Id. While a person may be autonomous in deciding to sell her kidney, having the option to sell it is an "autonomy-impairing constraining option" because having the option "will likely lead to the future diminution of either the vendor's own autonomy, or the autonomy of other persons who are economically
choice, but the result of a lack of alternatives. There are sound reasons why governments should act paternalistically. Our government prohibits certain livelihoods, such as prostitution, because they are against public policy. Selling a kidney differs from selling labor. Someone can always quit her job and resume it if she finds nothing better. For example, while a fashion model may commodify her beauty and use her physical assets to make a living, she can always stop modeling.

Additionally, selling a kidney is an irreversible, one-time decision. "[T]hose individuals who would sell a kidney for commercial motives would . . . contain a disproportionate number of individuals who had acted improvidently—whether from lack of education or intellect or because circumstances made them temporarily and irrationally desperate—and who will come to regret their act." We all make mistakes in life that we cannot reverse and some of those mistakes we come to regret; however, selling a kidney is parting with a physical piece of yourself that cannot be regained and, therefore, the risk of mistake and regret is greater because peoples' lives could be at issue. For instance, if a person sold her kidney and a few years later a relative suffered from kidney failure and needed a transplant, she would be unable to provide the relative with her other kidney.

Although paternalism could be preserved in an open market through government regulation (i.e., who can sell kidneys, who can buy them, at what price they could be sold, and when the transaction could occur), it is unclear whether these regulations would help. In many instances, if someone desperately needs a kidney and someone desperately needs money and is willing to

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134 Prostitution is illegal in most of the U.S.

[T]he giving of sexual intercourse in exchange for something of value is one of public morality regarding the nature and uses of sex, viz. that intimate, sexual relations, even in private between consenting adults, are not to be a matter of commerce because their purpose is to express love and to beget children within marriage. To allow the sale of sexual intercourse is to undermine marital fidelity and to cheapen sexuality.


135 See generally Barnett et al., supra note 13, at 213 (discussing why selling a kidney is different than taking on an exploitative job).

136 See Hansmann, supra note 22, at 153.
sell a kidney, the two will find a way to transact, even if regulations won't allow it. Thus, the seller and buyer will have circumvented the open market and transacted in a black market. This double market system would detrimentally affect the group of poor people who decided to transact in the legalized market because the price they could obtain for their kidneys on the open market would be devalued by the existence of the black market. While there would be potential buyers who would prefer to pay for a kidney in a regulated, open market, there will always be buyers who are looking for a cheaper deal because all they want is a kidney. Therefore, it seems that it does not matter whether the commodification of kidneys is legalized on a regulated, open market because although some people, like the rich, would transact in it, the poor still would not reap many of the benefits.

Third, an open market raises concerns about how informed a seller is in making her decision regarding a variety of issues such as health consequences, psychological affects, or financial implications. Donors are not necessarily provided with adequate information concerning these issues and do not always receive the proper medical treatment post-nephrectomy. In many cases, donors do not understand the financial issues and are left no better off than they were before the sale. While legalization could result in the institution of laws in the United States requiring criteria of informed decision-making to be met before selling an organ or making medical care for the sellers pre- and post-operation mandatory, such standards would be hard to regulate if the seller comes from a foreign country.

While an open market may increase the supply of kidneys, it does not do away with the exploitation of the poor, which is one of the main abuses of a black market. Further, it is unclear whether an open market would even eliminate the black market because those priced out of the system might still find a way to transact. Thus, in order to effectively and ethically increase the kidney supply without the existence of a black market, a proposal must equitably treat and provide options for both the rich and poor.

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137 See Berthillier, supra notes 59, at 165-66 (discussing the lack of medical attention donors received).

138 As discussed in Section 4.2, the suppliers of kidneys are typically indigent people who cannot afford medical care and are not economically better-off after the sale of their kidneys.
5.1.2. Kidney pricing and quality

An open market does not ensure the fair value of a kidney. Currently, in the United States, there is no price for a kidney per se; rather, the money kidney recipients pay to the regional nonprofit organ procurement agencies are for the physicians’ services, other personnel, and medical equipment used to harvest, transport, and transplant the kidneys. The prices the agencies charge usually just cover their own costs.

In an open market, the kidney price could be set by the government or by market forces. The government, though, does not typically become involved in the pricing of goods available on the open market; however, because of the ethical issues that surround selling a kidney and the potential to exploit the poor, the government should step-in to help prevent corruption and abuse of the market and its participants. If the government sets the price, this could ensure fair value for all parties involved, and if people believe they are selling and buying a kidney at a fair price, it could deter them, from transacting in a black market.

Prices set by market forces could be determined based on supply and demand. The scarcer a resource, such as a kidney, the higher the price; a higher price leads to more incentive to supply the kidney. The more kidneys exist in the market, the less valuable the organ becomes, and the price naturally lowers. Besides the natural forces of supply and demand, an item’s price in an open market can also be set by a product’s manufacturer who sets the price to cover the production costs and make some profit. Kidneys, though, are not manufactured in a warehouse; there is no production cost associated with it to serve as a baseline for its price.

Regardless of whether the market or the government sets the price, there is question concerning how a kidney would be valued. Although a market will value the kidney automatically, it seems inevitable that there will be debate about how to set the values, even if the government were to set the price. It seems there could also be price differences based on the quality of a kidney. Although the kidney itself is standard in that every person has

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139 See Hansmann, supra note 22, at 149 (discussing what the price people pay for kidney transplants entails).
140 Id.
141 See Barnett et al., supra note 13, at 210-211 (explaining, generally, how an open market would work and how it would affect the price of a kidney).
two, kidneys serve the same functions, and the general size and shape is the same, the quality of a kidney could greatly vary. For instance, a person can buy an ordinary baseball in a sports store for a certain price. But, the person will pay a higher price for a baseball with a Babe Ruth signature on it because it is rarer.

Like baseballs, some kidneys are ordinary and some are rare. A kidney needs to be matched by blood type in order to ensure that the recipient’s body will not reject it, which would render the transplant unsuccessful.\textsuperscript{142} Certain blood types are rarer than others. Should those rarer kidneys be valued more, like the baseball with the Babe Ruth signature? Further, a kidney from a man who is in his sixties and had a habit of drinking a lot in his younger years would seem to be less valuable than a kidney from a man who is in his twenties with no health problems. And, if a wealthy person would sell his kidney, how would a kidney from Bill Gates, for instance, be valued compared to a kidney from someone in prison? Before establishing an open market, criteria would need to be established to determine the fair value of the varying types of kidneys to prevent market abuses, make sure sellers’ are not taken advantage of, and that buyers’ expectations are protected.

In addition to problems pricing kidneys, there is concern about the quality of kidneys; those likely to sell a kidney because of the financial incentive might be those whose kidneys would be of lesser quality because of lifestyle choices such as drinking or drugs.\textsuperscript{143} Furthermore, a worrisome issue is that people desperate for money and looking to sell their kidneys could lie about their health problems, which would otherwise impede them from being a kidney donor. Additionally, medical tests cannot pick up all diseases, so we cannot rely on them to catch the health issues people may have lied about in order to donate and collect the money. Therefore, without some type of supplemental enforcement or screening criteria that does not simply rely on people’s disclosure and medical testing, it would be difficult to ensure that people do not falsify their health status and put the kidney recipients’ health in jeopardy.


\textsuperscript{143} See Robinson, \textit{supra} note 128, at 1044–50 (addressing the criticisms and concerns of establishing an open market for kidneys).
An open market aims to protect the interests of the parties involved by regulating the price of kidneys. However, because of the potential differences in kidney quality, it is unclear whether an open market could meet its goal. Commodifying the kidney does not solve the abuses of a black market, such as inequitable pricing and quality; therefore, a solution is needed that focuses on increasing the kidney supply by targeting potential cadaveric and living donors without directly offering them cash for their kidneys.

5.1.3. Altruism and the slippery slope

The United States' system for kidney procurement is currently based on altruism; however, commodifying the kidney in an open market would mean the elimination of voluntarily donations of kidneys while an individual is alive or upon the individual's death. While there would still be altruistic people, the majority would be tempted by monetary gain and sell, rather than donate, their kidney. If person A plans on donating her kidney when she dies, she might as well make some profit for herself or her family while she is alive.

A slippery slope also develops with the commodification of kidneys. "[O]nce organ sales are permitted as a matter of principle, the moral high ground will be lost and it will be difficult or impossible to withstand market forces that seek to promote increasing commercialization of the body and further erosion of the inherent rights of personhood." 144 Allowing a kidney to have a price would make it hard to draw the line in determining what other organs could have a price tag. Commodification of the kidney opens the door to putting a price tag on someone's liver or heart, which is troublesome because a person only has one of either organ. Thus, if the price is high enough and a person's family desperately needed money, a person could sell that organ and effectively kill herself. Or, someone who is contemplating suicide could use the extraction of her heart or kidney as a means to end her life while leaving her loved ones some money.

It would seem for public policy reasons that the government would not want to encourage suicide by offering what people could view as a financial benefit. Additionally, this country does not allow physician assisted-suicide. 145 Allowing the sale of a heart

144 Gregory S. Crespi, Overcoming the Legal Obstacles to the Creation of a Futures Market in Bodily Organs, 55 OHIO ST. L.J. 1, 23 (1994).
145 In Washington v. Glucksburg, the Supreme Court of the United States held
or lung would require a physician to remove the organ, thereby killing the patient. Not only is this against current law because it could be viewed as assisted-suicide, but it is against the medical ethics requirement to "do no harm." Further, as science and technology develop, we may be able to price other bodily components such as a person's DNA, which is worrisome because a person's DNA is the core and foundation of their physical identity. For public policy reasons, society should not place a monetary value on a person because we are all unique human beings.

An open market reduces the likelihood of altruistic organ donation, which undermines the policies United States laws are based. It also creates a slippery slope of what other body parts could be commodified. These results of an open market are ethically troubling and a proposal is needed that will respect our notions of altruism in kidney donation and protect the invaluableness of our organs.

5.1.4. Third-Party influences

An open market for kidneys raises ethical implications because of the potential family conflict it could promote. A family member who is financially strapped might be tempted to sell a deceased relative's kidney or, worse yet, "pull the plug" earlier on a relative if she knows that she would be compensated for her relative's kidney. In the most extreme circumstance, if an individual knows her family faces financial difficulties, she might commit suicide in order to provide them with her organs for them to sell.

Allowing a living person to sell her kidney could also create a

that a state statute banning assisted-suicide was constitutional because it was rationally related to a government interest. The Court recognized that the history, legal traditions, and practice support criminalizing assisted suicide and that the government's interest in preserving human life and upholding the ethics of the medical profession was a legitimate interest. See generally Washington v. Glucksberg, 521 U.S. 707 (1997) (determining that while an individual has a right to commit suicide, an individual does not have a right to have assistance to commit suicide).

146 The Hippocratic Oath that physicians take requires them to "do no harm" to their patients. Removing a vital organ such as a heart or lung from a healthy, living patient would violate this principle.

147 See Robinson, supra note 128, at 1042 (expressing why there is concern over what family members might do in tough situations if they need money and could receive a monetary gain from selling a relative's kidney).

148 Id.
situation where a third party, such as a person to whom the potential seller owes a debt, may exert pressure on the potential seller to engage in the transaction. Or, a family member could be in a dire financial situation and ask the potential seller to sell her kidney. The potential seller could feel compelled to sell her kidney because of family dynamics and pressure. Thus, the potential seller does not seem to make the choice to sell if she is forced or coerced into the sale because of a third-party influence. The potential seller would be stuck in between the proverbial "rock and a hard place" because she would lack any real alternatives; the choices are either suffering the consequences of owing the third-party debt, and have something happen to her family member, or earning money by selling a part of her body. If the consequences of the potential seller not selling her kidney are drastic to her, she would have no choice but to sell her kidney in order to avoid the alternative consequences.

There are scenarios, however, where selling a kidney might be acceptable such as someone selling her kidney to pay for her sick child's medical expenses. While these types of scenarios present a compelling reason to allow for the sale of kidneys, people should not have the option to sell their kidney because the potential situations where a person is coerced into selling her kidney because of a lack of alternatives are more ethically troublesome. An ethically effective proposal, thus, should recognize the pressure third-party influences can exert and limit strong financial incentives, such as commodifying a kidney, to protect the potential donor's autonomy.

5.1.5. Physician participation

An open market requires physician participation in the sale of kidneys, which violates a central tenet of the medical profession: "do no harm." The principle of "do no harm," also known as non-malfeasance, holds that medical intervention should be beneficial. Unless the living person is having her kidney

149 See Caplan, supra note 115, at 1934 (commenting that a key moral problem with markets in kidneys and other body parts is what it does to the ethics of the medical profession). See also Ludwig Edelsten, The Hippocratic Oath: Text, Translation, and Interpretation (Ludwig Edelstein trans., 1943) (explaining the various principles that doctors agree to abide by when they take the oath).

removed and undergoing harm solely to help another living person, taking organs from a living person seeking to make a profit seems to directly violate this principle.\textsuperscript{151}

Even if the buyer and the seller are both the physician’s patients, and causing harm to one patient is for the benefit of another, a doctor’s obligations lie individually with each patient; just because the buyer may benefit does not negate the harm to the seller. While a patient’s autonomy is respected, and is considered by the physician when making treatment decisions, the principle of “do no harm” must be given weight. Situations could arise where a patient is seemingly making an autonomous decision to have her kidney removed; however, she could be forced or coerced into selling to make money. In these cases, the principle does trump a patient’s autonomy because it is the physician’s ethical obligation to consider the total moral permissibility of the procedure. Even though there is little data on physicians’ opinions concerning markets, the data that does exist indicates that healthcare providers oppose the idea of a market system for kidneys.\textsuperscript{152}

An open market could force a physician to disregard medical ethics by creating a situation where a patient’s autonomy always trumps the basic tenet of “do no harm,” even if the physician believes the procedure is ethically impermissible. Similar situations, of course, occur in medicine every day, but a system should not be created that actually constructs these scenarios. A permissible proposal should encourage physicians to openly discuss kidney donation with their patients rather than potentially violating an ethical tenet of their profession.

5.1.6. Cultural and religious considerations

An open market could potentially alienate cultural groups. Certain cultures, like the Japanese who view every part of the

\textsuperscript{151} See Caplan, supra note 115, at 1934 (distinguishing an altruistic donor from one that is selling her kidney, and arguing that creating a market would place doctors in a position where they are harming someone only interested in gaining compensation, and that doctors’ roles are to help people get better and alleviate their pain, not to aid them in making a profit through permanent and significant harm).

\textsuperscript{152} See J.D. Jasper et al., Altruism, Incentives and Organ Donation: Attitudes of the Transplant Community, 42 MED. CARE 378, 380-81 (2004) (revealing that the physicians who participated in the study did not find a $1500 cash incentive or health insurance rebate to be “morally appropriate”).
deceased's body as part of the deceased's body and soul,\(^{153}\) would likely find the concept of an open market repugnant. Even within the United States, it is likely that groups may not favor an open market for body parts based on historical experiences regarding slavery or their notions of distrust of the medical profession.\(^{154}\)

Establishing an open market for kidneys could also offend the tenets of some of the world's major religions.\(^{155}\) Pope John Paul II made the Catholic Church's position against a market for kidneys no secret.\(^{156}\) In the Church's view, an individual does not own her body; rather it is a gift from God and she is merely the steward.\(^{157}\) Thus, because it is a gift, she should not harm or mutilate it unless the goal truly is to assist someone else.\(^{158}\) Because Catholics account for one-third of the organs donated, creating a market for kidneys may alienate many potential donors, which would have a negative impact on the supply of kidneys.\(^{159}\) While Catholics could

\(^{153}\) Although the Japanese have accepted the effects of modern medicine and while many do equate brain death as equivalent to human death, the Japanese view of the human body is different than a Western view, which could be a reason why people do not wish to donate their organs. See Masahiro Morioka, *Bioethics and Japanese Culture: Brain Death, Patients' Rights, and Cultural Factors*, 5 EUBIOS J. OF ASIAN AND INT'L BIOETHICS 87, 87-90 (1995) (illustrating how the Japanese have responded to newly imported bioethical ideas by examining their discourse on brain death and patient's rights).

\(^{154}\) See W.J. Minniefield et al., *Differences in Attitudes Toward Organ Donation Among African Americans and Whites in the United States*, 93 J. NAT'L MED. ASS'N 372-379 (2001) (noting possible reasons why African Americans may have negative attitudes towards organ donation). See also Caplan et al., *infra* note 157, at 221 (recognizing that slaves were often used by physicians for experimentation without their consent, and "for autopsy and teaching purposes" after they died).

\(^{155}\) See Caplan, *supra* note 115, at 1934 (claiming that major world religions would not support creating an open market, which could have a detrimental impact on the number of organ donors).

\(^{156}\) See id. ("The Pope, for example, has made himself quite clear about the Catholic church's aversion to markets in organs.").

\(^{157}\) Arthur L. Caplan, Emmanuel and Robert Hart Professor of Bioethics, Dir., Ctr. for Bioethics, Univ. of Pa., Speech at the University of Pennsylvania Forum: What is Wrong with Markets Using Living Persons to Increase the Supply of Organs? (Dec. 6, 2005); see also Arthur L. Caplan et al., *Financial Compensation for Cadaver Organ Donation: Good Idea or Anathema?*, in THE ETHICS OF ORGAN TRANSPLANTS, *infra* note 13, at 222 (recognizing that major religions are hesitant about organ procurement and only allow it for the narrow purpose of helping another human being, and that many of these religions oppose commodification because it would view the body as property of the individual rather than as a gift from God).

\(^{158}\) Id. (describing religious endorsement of the use of organs from cadavers only under certain limited circumstances).

\(^{159}\) See also Caplan, *supra* note 115, at 1934 (hypothesizing the potential effect
still donate an organ, they might find an open market appalling enough to decline to participate at all.

It is likely that the Muslim faith would also be opposed to an open market. For Muslims, while "the general population tends to feel positively toward donation, guidelines set limits, including that: transplants occur only when no other treatment is available, that the procedure has a good chance of success, that voluntary consent is obtained from either the donor or the next of kin to procure the organs, and that death has accurately been pronounced." Like Catholics, Muslims believe in the sacredness of the human body and allow organ donation because of a responsibility to help others as long as no harm is inflicted upon the donor herself. Thus, it seems that Islam would oppose an open market because it would take away from the altruistic nature of kidney donation.

An open market would offend the basic tenets of some of the world’s most practiced religions. We cannot afford to alienate these groups from donating. Therefore, a proposal is needed that respects the religious and cultural ideas that may inhibit kidney donation through education and open discussion about the kidney shortage and procurement procedure.

5.2. Futures Market

Another form of commodifying kidneys is a futures market, or "posthumous organ market," for kidneys. A futures market involves purchasing "the right to harvest a person's organs upon his death . . . from him far in advance, while he is alive and well." A future donor can either contractually create an irrevocable transfer of the right to the kidney, (which would be an open market for the future right to the kidney), or it could create a temporary right (for example, a right for one year renewable annually). Similar to an open market, ethical concerns center on a potential donor's autonomy and third-party influence in a futures market. While these concerns are not as troubling as in an open market would have on donors who have religious affiliations).

160 ROBERT M. VEATCH, TRANSPLANTATION ETHICS 9 (2000).
161 See id. at 17 (citing the Islamic Code of Medical Ethics, which states "the individual patient is the collective responsibility of the Society, that has to ensure his health needs by any means inflicting no harm on others.
162 Crespi, supra note 144, at 24.
163 Hansmann, supra note 22, at 147.

http://scholarship.law.upenn.edu/jil/vol27/iss1/5
market because there is no direct payment, the kidneys are still commodified and there is still the potential to exploit the poor. Additionally, a futures market alone cannot solve the kidney shortage because of the limited number of cadavers that could be used for kidney procurement. Thus, an effective proposal could draw on some of the components of a futures market, but would simultaneously need to focus on increasing living donation.

5.2.1. Futures market involving health insurance

Several scholars have put forth various proposals for futures markets. One such proposal comes from Henry Hansmann, who proposes a futures market where the health insurance companies, through their agents, would purchase the future rights to a policyholder’s kidneys when the policyholder signs up for a policy period.164 Purchasing the future rights to policyholders’ kidneys, however, does not need to be limited to health insurance companies. Other insurance agencies that sell life, automobile, or property insurance could enter similar agreements with the policyholder.165

Integrating the right to purchase organs with the sale of insurance seems natural since “these companies are already involved in the types of actuarial calculations and financial transactions that would be involved.”166 An individual would simply check-off a box on her annual premium statement, which would signify that if she died within the time period of the insurance coverage, the insurance company would have the right to harvest the organs that were transplantable.167 In return, the individual would receive a deduction on the insurance premium she paid for that term.168 The individual would also be free to change the agreement every time her policy came up for renewal.169 The insurance company would then send the individual’s name to a national registry that a hospital would

165 See Hansmann, supra note 22, at 148 (describing other options for futures markets).
166 Id.
167 See id. (explaining how the health insurance futures market would work).
168 Id.
169 Id.
check each time someone died.170 If the registry listed the name, the hospital would enter data about the transplantable organs, and a suitable recipient would be found through a national matching network linked to the registry.171 Finally, the recipient would “pay the deceased's insurance company, or their assignee, the latter's specified price for an organ upon accepting it for transplant.”172

Setting the price, or premium reduction, an insurance company would pay for the future right to the organ would depend on the price they could receive for the organ at the time of removal. The insurance industry is competitive and, therefore, the “companies would be able to take only a market rate of return for their efforts as intermediaries in such transactions; the rest of the (expected) price received by the insurance companies for the harvested organs would be passed through to their policyholders in the premium reductions offered them.”173 One way to determine the price of the harvested kidney would be to let the natural market forces of supply and demand set the price. The government could also establish the price. It is important to remember, however, that this type of futures market system only works if the price of the organ is “high enough to make the value of the future rights in the policyholder’s organs large enough to cover the costs to the insurers of administering the system”174 with enough remaining to offer a premium reduction large enough to induce the policyholder's agreement.

A futures market involving health insurance companies might be one way to increase the supply of available kidneys. Most individuals are not morally opposed to donating; most just do not donate because of “inertia, mild doubts about their preferences, a slight distaste for considering the subject, or the inconvenience in completing or carrying a donor card.”175 Insurance premium reductions would draw attention to donating because there would be some incentive involved.176 Additionally, because health insurance companies also have an interest in getting donations,
their solicitation of individuals would heighten awareness about donating kidneys.\textsuperscript{177}

5.2.2. \textit{Futures market with benefits to the deceased's estate}

Lloyd Cohen argues that, "a system which binds the organ provider during life is unnecessary and undesirable" because of the loss of individual autonomy; however, he also suggests that "a system of renewable, annual organ procurement contracts should be used" because it "would authorize the creation of contingent or option contracts which only become effective upon the death of the organ provider, at which time the remuneration would be paid to the decedent's estate."\textsuperscript{178} Cohen's proposal is similar to Hansmann's health insurance proposal, except that in the former the decedent could designate a beneficiary who would receive the funds for the sale of her kidney upon the decedent's death.\textsuperscript{179} The price for the kidneys would be set either by the market or the government.\textsuperscript{180}

In order to ensure that the hospital maintains the kidney in harvestable condition until the transportation arrangements are made, the parties could bring a negligence cause of action against the hospital and "the hospital would be liable for the value of any resulting loss should it fail to exercise reasonable care in its notification and organ preservation efforts."\textsuperscript{181} Lastly, Cohen would allow for parents to consent to organ donation for their children as long as they would donate their organs on the same terms.\textsuperscript{182}

A futures market could help enhance the supply of kidneys while avoiding the "entire parade of horribles regularly invoked by opponents of commercialization."\textsuperscript{183} Gregory Crespi believes that a futures market wherein the procurement contracts could be

\textsuperscript{177} \textit{Id.}

\textsuperscript{178} \textit{Banks, supra} note 127, at 76.


\textsuperscript{180} \textit{See id.} (discussing the question of who would set the price for kidneys).

\textsuperscript{181} \textit{Id.}

\textsuperscript{182} \textit{See id.} (describing the conditions under which parents can consent to their child donating a kidney).

\textsuperscript{183} Crespi, \textit{supra} note 142, at 6-7 (discussing a futures market designed so that someone who is in desperate need of money won't feel compelled to sell an organ).
renewed annually, "would reduce the likelihood of potential abuses against the poor and other vulnerable groups because the sale of human organs would be effective only upon the death of the decedent, and the decedent’s surviving relatives would be prohibited from selling the decedent’s organs."\textsuperscript{184} A futures market system would provide a sufficient financial incentive to clear out any opposition, such as a family’s hesitation to allow the dissection of a loved one for her organs.\textsuperscript{185}

A futures market where an individual can renew her decision to donate a kidney upon her death seems to allay concerns about the loss of individual autonomy resulting from a person’s decision to contract away her right to her body. The individual would have the right to terminate her decision whenever she renews her policy. Additionally, the decision to donate is actually made by the individual when she is alive and healthy, and has time to discuss her decision with family and friends.\textsuperscript{186} In contrast, many of the other kidney donation proposals involve putting pressure on the family to make a decision about the individual’s organs immediately following her death. This places a lot of psychological pressure on the family during an emotional time.\textsuperscript{187} However, although a futures market takes the decisionmaking power away from the next of kin, an individual may be hesitant to participate in a futures market because her next of kin may not be comfortable with the idea of having her body cut up and parts removed upon her death.\textsuperscript{188}

Because the kidney is still commodified in a futures market, there would be similar issues raised involving the pricing and quality of kidneys that an open market would encounter. Additionally, a futures market that provides financial compensation to a decedent’s estate upon her death, even if renewed annually, does not eliminate the ethical concern of third-party influences. If a family is in desperate need of money, it is

\textsuperscript{184} Banks, supra note 127, at 76.
\textsuperscript{185} See Cohen, supra note 179, at 34-35 (describing a futures market as the solution to flushing out the blockage to procuring organs).
\textsuperscript{186} See Hansmann, supra note 22, at 151 (explaining that one benefit of the futures market is that individuals can make a decision when they are alive and healthy).
\textsuperscript{187} See id. (describing the psychological pressure a family may feel when faced with a relative’s death and the potential decision to sell her organs).
\textsuperscript{188} See, e.g., Caplan, supra note 157, at 221 ("In practice, families often do not donate because they do not want their relative to undergo further ‘suffering.’").
plausible that they would end a loved one’s life support earlier than necessary to collect the money for remuneration. It is also unclear whether a futures market would eliminate the exploitation of the poor in terms of opportunity and access. It seems that the poor may be shut out of this system because they are less likely to have insurance; thus, they would lack a benefit that the rich would have.

On the surface, it appears a futures market would discourage volunteerism because of the financial incentive involved.189 While money adds an incentive for potential cadaveric donors, however, one’s perception of altruism depends on how the option is phrased.190 For instance, people are typically asked, “would you sell your right to your kidney for $40 a year?” But, what if the question were phrased as, “are you willing to pay an extra $40 a year in health insurance premiums for the privilege of refusing to make your organs available to several other people when you die?”191 When phrased the latter way, if a person chooses not to donate, he will appear selfish, which would increase “altruistically motivated donations.”192

While a futures market is not as ethically troubling as an open market, it still raises concerns about autonomy and third-party influences if money is given to a potential donor’s family upon her death. It is also important to remember that there will never be enough cadaveric donors to ensure an adequate supply of kidneys because the donors must be brain dead, and there are a limited number of deaths that meet this qualification. Therefore, a futures market alone will not cure the problem of a black market.

5.3. Presumed Consent for Cadaveric Organ Donation

Another possible solution to the kidney shortage and black market is to have presumed consent for cadaveric kidney donation in the United States;193 however, this system would be hard to

189 See generally Hansmann, supra note 22, at 150 (explaining a concern that futures markets will decrease altruism and proponents’ response and solution to that the counter argument).
190 Id.
191 Id.
192 Id. (providing an example of how a question’s wording can affect the mindset of the listener).
implement because of this country's notions of autonomy. Currently, the United States does not have this system in place because of its long-standing belief in individual and property rights. Presumed consent has been successful in other countries such as Italy, Sweden, Spain, France, Austria, and Belgium, countries that tend to have a "history of high level state intervention and/or authoritarian rule." Conclusions that presumed consent systems generate a higher rate of kidney procurement, however, are arguable. If the United States were to adopt such a system, it should draw on foreign countries as examples and would need to work with the medical profession to

194 See id. (explaining one reason the United States does not support presumed consent). Additionally, Germany, Japan, and the Netherlands do not have a system of presumed consent. See WHO, supra note 50 (discussing Germany's donation law, which declares that any person may have an organ donor card stating whether she is a donor, not a donor, or she can delegate the decision to her next of kin. The Act even has age minima for making the decisions. Further, the Act discusses when the removal of organs of a dead person is permissible and in cases where the person does not have a donor card indicating her preferences, the physician is to ask her next-of-kin based on a relationship as defined by the Act); MACHADO, supra note 193, at 44 (noting that the Netherlands does not have presumed consent).

195 See Decree of 8 April 2000, Gazz. Uff. No. 89 (Italy) (declaring that citizens shall receive a memo asking them to declare whether they agree to donate their organs upon their death or wish to opt out. If a citizen does not return the memo within 90 days, and their organ donation wishes are unknown, then it will be presumed that they consented to donate. Further, if a citizen does not get a memo in the mail, she can go to a hospital or sanitary unit to declare her choice. For citizens who wish to opt out, their intentions must be entered into a national registry. If a citizen's wishes are unknown, her next-of-kin can show a signed proof of her intent, even if she originally said "yes," but the next-of-kin has proof that she changed her mind to "no," and vice versa. Lastly, a citizen has the right to change her mind at any time). See also MACHADO, supra note 193, at 46 (providing examples of countries with presumed consent); R.M. Veatch & J.B. Pitt, The Myth of Presumed Consent: Ethical Problems in New Organ Procurement Strategies, in THE ETHICS OF ORGAN TRANSPLANTS, supra note 13, at 175 (affirming that Austria, Belgium, Italy, and Spain have presumed consent laws in addition to Finland, Norway, and Switzerland as well as other countries).

196 MACHADO, supra note 193, at 45.

197 See e.g. DAVID PRICE, LEGAL AND ETHICAL ASPECTS OF ORGAN TRANSPLANTATION 1, 87-92 (2000) (explaining that proponents of a presumed consent system tout it as the most effective system for procuring kidneys, but the conclusions of analysts differ. The author looks at Austria, Belgium, and Singapore and notes that while these countries have high procurement rates, it is unclear whether it is because of their presumed consent laws or because of other factors). But see Christian Williams, Combating the Problems of Human Rights Abuses and Inadequate Organ Supply Through Presumed Donative Consent, 26 CASE W. RES. J. INT'L L. 315, 340 (1994) ("Presumed consent, when strictly followed by the state, has proven to be the best practiced method of maximizing organ procurement.").
modify views of autonomy as they relate to organ donation. They would do so in hope that the public will accept government intervention to procure organs so that presumed consent would be accepted and successful in the United States.

Generally, presumed consent means that individuals are presumed to donate their organs upon their death unless they indicate otherwise; thus, the burden is on the individual to “opt out.” Presumed consent systems fall into two categories: pure/strong presumed consent or weak presumed consent. Presumed consent regimes differ in whether they consider solely an individual’s decision to opt out or if they will defer to the decision of the family or next-of-kin if the desires of the deceased are unknown. In Austria, for instance, the country follows a “pure informed consent system,” which procures the decedent’s organs, unless the decedent filed objection while she was alive, and the system does not consider the decedent’s next-of-kin’s wishes. A weak presumed consent system, such as in France, seeks the approval of the deceased’s next-of-kin before removing the organs. Belgium also utilizes a weak presumed consent system where its citizens register whether they will donate their organs in a computerized national registry, which only the transplant centers have access to. The physician, then, has the freedom and

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198 The presumed consent system is based on the notion that “people would consent if asked... to a policy of taking organs without explicit permission.” The reasoning behind the policy is that it is permissible to take organs from people upon their death because, if they were asked whether they would donate when they were alive and competent, they would have agreed. See Veatch, supra note 195, at 176 (explaining the premise of presumed consent).

199 See MACHADO, supra note 193, at 45 (commenting on presumed consent systems).

200 See Sean R. Fitzgibbons, Cadaveric Organ Donation and Consent: A Comparative Analysis of the United States, Japan, Singapore, and China, 6 ILSA J. INT'L & COMP L. 73, 97 (1999) (offering alternative explanations for Austria’s high rate of organ procurement). Austria, thus, has procured sixty kidneys for every million people. While this rate may still seem low, it is double that of the United States and most other European countries. Even those European countries with a lower procurement rate than Austria still have a higher rate than the United States, which might be why seventy-eight percent of physicians in the United States favor presumed consent. See Williams, supra note 197, at 340-41 (explaining the rate of organ procurement).

201 See MACHADO, supra note 193, at 46 (describing a weak presumed consent system and noting that most legislation does not include a provision about asking the next-of-kin even though that is what is practiced).

202 Laurie G. Futterman, Presumed Consent: The Solution to the Critical Donor Shortage?, in THE ETHICS OF ORGAN TRANSPLANTS, supra note 13, at 167 (explaining Belgium’s system of organ donation as an example of presumed consent).
discretion to act according to her own ethics "within the limits of the recorded decision of the donor and the right of the family to object," which is one reason the Belgium system is so successful in procuring organs.203

The presumed consent option has its ethical drawbacks, however, which make it an unacceptable proposal. First, there is a loss of autonomy in making personal choices about one's body.204 The state should not have the right to make such personal choices and place the burden on the individual to object. A further problem is that people might not be educated about presumed consent, what it means, and their right to opt out. "[P]reserved consent will 'lead to a situation where the poor, the uneducated, and the legally disenfranchised might bear a disadvantageous burden, and only the more advantaged groups would exercise autonomy,' since only the more advantaged groups would be aware of their right to opt out."205 Thus, it is problematic that individuals suffer a loss of autonomy not only because of a presumed consent system, but also because they do not have a full understanding of their rights, which is necessary to make an informed decision.

Additionally, allowing family members to determine what their relative would have wanted to do with her own corpse raises further concerns over individual autonomy. There is no guarantee that the family members' decision would reflect what the individual would have wanted;206 however, even if we were to determine that an individual loses her right to autonomy upon her death, presumed consent still poses a problem for determining whether the deceased's family or the state has the right to choose what to do with the kidney. It would appear that under a strong presumed consent regime, the state infringes on the family's right to choose as the deceased's next of kin. In the United States, the government does recognize the rights of a deceased's next of kin. For example, many states allow a deceased's estate to pass to her next of kin if there is no will; it would be logical, then, that a family

203 Id.
204 See generally Veatch & Pitt, supra note 195, at 177 (explaining that there is a difference between "giving" and "taking," and in Western societies, the individual is given the right to determine what is done to her body).
205 Williams, supra note 197, at 343 (quoting David Lamb, ORGAN TRANSPLANTS AND ETHICS 135, 142 (1996)).
206 See id. (explaining why presumed consent systems that ask for the deceased donor's preferences before procuring her organs are problematic).
should retain the right to determine what happens to its loved one’s body after her death.

Lastly, presumed consent takes away from the altruism in actively donating an organ. Rather than voluntarily donating a kidney for a good cause, the donors are in the system because they have to be. Although the need for kidneys is great, the United States’ policy on organ donation is rooted in notions of altruism. To take such an extreme step from a purely voluntary system to one of presumed consent would be a huge shock to the public, which could mean more resistance than if the public were eased into a weak version of the system through education and advertising campaigns.

Presumed consent can also be taken to the extreme: consider, for example, China. It is common practice for the Chinese government to execute its criminals as one way to procure organs to meet demand. In China, about 100,000 kidneys are needed for transplantation each year and, clearly, these are not going to come from voluntary donors. Therefore, the Chinese government has warped presumed consent to mean that if you commit a crime, you give your organs to the government, which is problematic because the punishment should fit the crime. The crime should not be the vehicle for kidney procurement; this is a gross violation of human rights. China thus supports the inhumane practice of killing its prisoners to harvest their organs.

In 1997, China executed 4,367 of its citizens who supposedly committed one of the sixty-eight crimes punishable by death and, of those executed, ninety percent of them had their organs harvested. Chinese officials deny the practice and claim that they only procure the organs of deceased prisoners if the prisoner’s body is not claimed, the prisoner donated her body for medical

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207 Id.

208 See Organs Watch, Hot Spots, at http://sunsite3.berkeley.edu/biotech/organismswatch/pages/china.html (last visited Feb 18, 2006) (stating that China executes its prisoners to harvest and sell organs); Fitzgibbons, supra note 200, at 100-04 (discussing China’s “disturbing practice” of harvesting organs from executed prisoners).

209 See id.

210 See id. at 102 (providing statistics concerning the percentage of Chinese prisoners executed for organs); see also Illegal Human Organ Trade from Executed Prisoners in China, supra note 57 (listing examples of petty crimes criminals are put to death for in China).

211 However, because of China’s large size, a deceased’s family may not be able to get to the deceased’s body within the time frame required by the
use, or the prisoner’s family consents.\textsuperscript{212}

The Chinese practice of harvesting the organs of executed prisoners could seem acceptable. After all, they are going to die, so some benefit should be derived from their deaths.\textsuperscript{213} This practice is unacceptable, however, because even though these are criminals, they are still humans who maintain their right to humane treatment and integrity. To presume their consent through execution is a gross violation of human rights.\textsuperscript{214}

Presumed consent raises serious ethical concerns because of our notions of autonomy. The system, however, has had success in other countries; therefore, a proposal that can incorporate certain aspects of presumption, without fully becoming a strong, or even weak, presumed consent system, combined with education and discussion about kidney procurement and individual rights, could be ethically acceptable and successful in increasing the supply of kidneys.

6. A PROPOSAL

According to public opinion surveys, a majority of the United States population is not opposed to donating an organ such as a kidney.\textsuperscript{215} There is still, however, a shortage of kidneys, which

\textsuperscript{212} See Illegal Human Organ Trade from Executed Prisoners in China, supra note 57 (noting the Chinese government’s responses to claims that it is violating human rights). Physicians who participate in this program are also silent about it. See Scheper-Hughes, supra note 150 (relating a story about China’s well-known practice of executing prisoners to harvest their organs). Stories of these prisoner executions have come to light through organizations like Amnesty International and OrgansWatch. For instance, Mr. Lin of San Francisco, California related a story to OrgansWatch of a visit to a friend who was in a medical center in Shanghai. A patient in the bed next to his friend was a “wealthy, and politically well-situated professional man” who told Mr. Lin he was waiting for a kidney that was coming from an executed prisoner the next morning. The man said that as soon as the prisoner was shot in the head, doctors would immediately remove his kidneys and rush them to the medical center for the transplant teams to transplant.

\textsuperscript{213} Rothman, supra note 24 (criticizing and expressing worry about the organ procurement process in China).

\textsuperscript{214} Further, the Chinese process is “hidden and, therefore, subject to gross abuse.” Id. Additionally, the covert nature of the practice seems to contradict the claims that voluntary consent is obtained and that by using doctors in the process, the ethical integrity of the profession is protected. See id.

\textsuperscript{215} Of the 20,000 people that die each year in the United States under circumstances that would allow their organs to be transplanted, only 15% actually
seems to indicate that although people are not opposed to donating, they are not taking sufficient affirmative steps to donate their kidneys. This gap could be attributed to laziness, apathy, or lack of knowledge about how to donate. Therefore, it is of crucial importance to find a way to close this gap. After reviewing and analyzing the proposals to increase the supply of kidneys for transplants, because of its effectiveness and ethical permissibility, the most viable option for increasing the kidney supply would be a hybrid of presumptivity, an improved publicity and education campaign, and a weak form of monetary incentives. In this way, our notions of autonomy and altruism are not fully abandoned, and weak economic incentives are used to help supplement the campaign to increase kidney donors.\textsuperscript{216}

The number of kidneys that come from cadavers is always going to be limited because the kidneys must come from brain dead cadavers. Therefore, this proposal seeks to increase the number of cadaveric as well as living donors. First, presumptivity and an improved publicity and education campaign would increase awareness of the kidney shortage and of steps people can take while still alive, which would aid in boosting the number of cadaveric as well as living donors. Second, weak incentives like tax deductions for expenses related to kidney donation combined with a weak futures market would help maximize the number of kidneys that come from cadaveric and living donors. Lastly, this proposal’s programs should be re-evaluated every five years to assess their effectiveness and to implement any necessary changes, especially as scientific advances lead to new medical developments. No proposal will ever be without some flaws, and there is always going to be a group of people who just will not donate their kidneys, but this proposal is the best chance for the

\begin{footnote}
Concern has been raised that “[a] policy that resorts to monetary inducements, that replaces altruism by selfish self-interest and that manipulates consent by monetary incentives, has too many ethical liabilities to be acceptable either as a policy or as an experiment.” Edmund D. Pellegrino, \textit{Families’ Self-Interest and the Cadaver’s Organs: What Price Consent?}, in \textsc{The Ethics of Organ Transplants}, supra note 13, at 206. This proposal recognizes these concerns and attempts to allay them by focusing on both education and incentives.
\end{footnote}

\textsuperscript{216} See Hansmann, \textit{supra} note 22 (noting United States kidney donation statistics). In a poll taken in 1993, Gallup reported that 55% of Americans said they would be willing to donate their organs; however, only 28% had a signed organ donor card or indicated that they were donors on their driver’s licenses. Gallup Poll, \textit{The American Public’s Attitudes Toward Organ Donation and Transplantation} (Feb. 1993), at, http://www.transweb.org/reference/articles/gallup-survey/gallupindex.html.
United States to increase its kidney supply.

6.1. Presumptivity

The first aspect of the proposal involves the concept of presumptivity, which could certainly aid in increasing the number of cadaveric kidney donations, but would also help the number of living kidney donations by raising awareness. Presumed consent for kidney procurement has been successful in some European countries and based on public opinion in the United States, it appears that a majority of people are not averse to donating their organs. Therefore, it would seem that presumed consent would help increase the kidney supply; however, because the United States is rooted in its commitment to the values of autonomy and liberty, a strong or weak presumed consent system would conflict with these core beliefs.

Presumptivity is a very weak form of presumed consent. The system does not assume that a person will donate her kidney upon her death; rather, it simply seeks to adjust our frame of mind when considering whether to donate. For instance, volunteers for the National Kidney Foundation, Red Cross, or similar organizations could cold call people and discuss organ donation. Physicians and insurance agents could also ask their patients and policyholders about organ donation (as discussed in the second-prong of the proposal). Instead of asking, “Would you like to donate your kidney?” these groups of people should reframe the question to something like, “You’d like to donate your kidney, as most people wish to do, right?” In this way, we presume the potential donor will donate and the onus is placed on the potential donor to opt out of donating while she is still alive.

This subtle reframing of the question is similar to when a physician needs a patient to come back to the office for more tests. Typically, a doctor will say, “We need you to come back in a few days to run some tests” rather than asking “Will you come back in a few days so we can run some tests?” The doctor’s office presumes that patients will want to do what is in the best interest of their health and, thus, will come back for the tests. If the patient doesn’t want to go back, or can’t make it back on the day the office wants her to come, then it is up to the patient to make those intentions known.

217 Gallup poll, supra note 215.
Presumptivity does not run into the same moral or legal problems of autonomy that arise under a system of either strong or weak presumed consent. People still maintain their autonomy through opting out of donating, yet presumptivity retains some of the characteristics of a presumed consent system that have proven successful and capitalizes on people's lack of opposition to donating.

6.2. Publicity and Education Campaign

The second aspect of my proposal involves a more aggressive publicity campaign to help transform the way we conceptualize kidney donation. Like presumptivity, this aspect could have an impact on the number of cadaveric and living kidney donations in this country.

The educational campaign's aim would be to heighten awareness of the kidney shortage, present people with the ways they can help, and alert them of the options available. Better publicity and education seek to complement presumptivity by providing people with knowledge; therefore, if someone wishes to opt out of donating when someone asks them, they know they can. But, more importantly, if people have a better understanding of the shortage and dire need, there is a greater chance that people will not opt out, or better yet, they will commit to a living donation. Improved communication about living and cadaveric donation is necessary to "increase public trust and awareness." 218

6.2.1. Different slogan for advertising

Currently, the advertisement campaign used for kidney donation involves billboards or late-night/early-morning television commercials echoing slogans such as "Be a Hero" or "Make a Gift of Life." These slogans are meant to appeal to our altruistic side; however, given the kidney shortage, they appear to be somewhat ineffective. The need for more mainstream advertising and public awareness campaigns has not gone unnoticed. Recently, the Bush Administration promulgated the Organ Donation and Recovery Improvement Act, 219 which provided $15 million annually for fiscal year 2005 and as much as

218 Sheldon Zink et al., Living Donation: Focus on Public Concerns, 19 CLINICAL TRANSPLANTATION 581, 583 (2005).

necessary for fiscal years 2006 to 2009 to increase public awareness.\textsuperscript{220}

To achieve the goals of this Act, the government should modify its advertising campaign through the use of a different slogan. Perhaps, instead of promoting altruism, campaigns could promote a sense of duty in people through slogans such as “Do the Right Thing: Donate a Kidney” or “Someone Out There Needs You: Donate a Kidney.” To be effective, however, the slogans must reach many people, perhaps through urban billboards, television, or radio. Flyers could be mailed out to households, and both kidney donation organizations and the federal government could take out newspaper or magazine advertisements. The government publishes a brochure about Medicare to help educate people about the program; it should be able to put together something similar for kidney donation that could be placed in physicians’ offices. Perhaps television and broadcasting stations and newspaper and magazine publishers could give the government these slots or ad space for free, or for a slight tax break. The government, or the FCC, could also consider requiring certain advertisers whose products could affect kidney health, such as alcoholic beverage companies, or drug manufacturers who have kidney-related drugs in their pipeline, to sponsor five minutes of kidney advertisement during primetime for every thirty minutes they spend on advertising their own products. Additionally, stories of people who altruistically donate should be highlighted by the media.\textsuperscript{221}

Another consideration for an improved advertisement campaign would be to solicit celebrities who had kidney problems and transplants to be spokespeople.\textsuperscript{222} Celebrities are a good way to heighten awareness because people feel as if they can identify


\textsuperscript{221} See, e.g., Ian Parker, \textit{The Gift: Zell Kravinsky Gave Away Millions But Somehow It Wasn’t Enough}, \textit{New Yorker}, Aug. 2, 2004, at 54, 54-63 (discussing Zell Kravinsky, a wealthy man who donated a substantial amount of his money to various organizations and decided to give someone his kidney because he determined that organ donation was the ultimate gift).

\textsuperscript{222} See \textit{All American Talent and Celebrity Network}, http://www.allamericanspeakers.com (last visited Feb. 18, 2006) (offering the agency’s services to help companies and organizations find celebrity spokespeople).
with a celebrity.\textsuperscript{223} Organizations and fundraisers see a definite increase in donations and awareness when a celebrity is associated with their cause.\textsuperscript{224} For instance, in February 2005, Alonzo

\textsuperscript{223} After her husband passed away from colon cancer, Katie Couric became a very vocal spokeswoman to help educate the public. She not only appeared on news shows, but hosted a special five-part series on \textit{Today}, discussed her struggle with losing a loved one in magazines, spoke before Congress, and even co-founded the National Colorectal Cancer Research Alliance, which has broad celebrity support. \textit{See}, e.g., Katie Couric, \textit{Katie Couric: I Must Share This Vital Information} (Mar. 31, 2004), http://www.msnbc.msn.com/id/4602812/ (writing about why it was important to her to be a co-anchor on a special five-part series about colon cancer on the \textit{Today} show); Joanna Powell, \textit{Katie Couric's Story: Life After Loss, GOOD HOUSEKEEPING} (Oct. 1998) at 124 (interviewing Katie Couric about how she dealt with the loss of her husband to colon cancer and that she is going to increase awareness); National Colorectal Cancer Research Alliance, at http://www.eifoundation.org/national/nccra/splash/ (last visited Dec. 20, 2005) (providing a variety of information about colon cancer, getting tested, donating, and using celebrities to support the cause).


\textsuperscript{224} In 1996, for instance, Lance Armstrong was diagnosed with advanced stage testicular cancer and the cancer spread to his brain and lungs. After surgery to remove his right testicle, two brain legions, and chemotherapy, Armstrong recovered and went on to win seven consecutive Tour de France titles. In 1997, Armstrong founded the Lance Armstrong Foundation to raise money, and support and inspire people with cancer to "live strong" through educational programs, advocacy, and research programs. One fundraising initiative was a yellow wristband with the words "Live Strong" on it. In conjunction with Nike, the foundation began selling the wristbands in early summer 2004, with an initial goal of raising $5 million. The wristbands sell in packets of 10, 100, and 1200, and cost $1 for one wristband. As of May 2005, the foundation had sold over 50 million wristbands. In 2003, the foundation received $4,782,488 in cash or cash-equivalent donations; in 2004, it received $19,843,725. The foundation's total assets increased from $15,870,877 in 2003 to $44,441,804 in 2004. \textit{See generally About Lance, at http://www.lancearmstrong.com} (last visited Jan. 6, 2005) (summarizing Lance Armstrong's life and career) Lance Armstrong Foundation, 2004 and 2003 Combined Audited Financial Statements (Feb. 14, 2005), http://www.livestrong.org/atf/cf/[FB6F8D43-0E4C-4414-8B370D001EFBDC49]/
Mourning\textsuperscript{225} worked with American Greeting cards to come up with a series of four inspirational cards, "Words of Strength," for African Americans and Hispanics who are faced with kidney disease.\textsuperscript{226} The online greeting cards were offered free of charge and sponsored by Ortho Biotech Products.\textsuperscript{227} Mourning also committed to visiting clinics throughout the United States to discuss chronic kidney disease and its signs and symptoms.\textsuperscript{228}

Mourning's support and activities are a great step in the right direction in terms of bringing kidney disease into the spotlight. The federal and state governments, medical industry, and various organizations should continue to encourage celebrity activism such as Mourning's, which has helped raise awareness about the importance of early detection and treatment of chronic kidney disease.
as Mourning's. Living donation could be highlighted through "donor days" where celebrities speak out about the need for living donors and the altruistic nature of the act. The kidney shortage and steps people can take to help, both while living and after they pass on, should also be highlighted in celebrity advertisements—posters, television ads, radio spots, magazine articles—and public speeches to increase awareness.

An aggressive advertising campaign would heighten the public's awareness of the kidney shortage and what they can do to help. The more people know about the subject, the more open discussion can occur, which could aid in increasing the kidney supply.

6.2.2. Education

The federal government should mandate that organ donation, specifically kidney donation, be discussed in high school classrooms. "Making good decisions about complicated issues requires careful consideration." Therefore, the health education classes of schools should cover and facilitate discussion about kidney donation; not only would the students gain more awareness, but their education would facilitate discussions with their family members and friends. Schools teach teenagers sexual education in health class; there is no reason the health classes could not teach students about the kidney shortage, kidney donation, the different ethical considerations, and the necessity of talking with their family about donating. The federal government should consider enacting a statute that would provide high schools with grant money to implement an organ donation program. Part of the budget from the Organ Donation and Recovery Improvement Act could be earmarked for this. This education

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229 These donor days could be similar to blood drives or bone marrow drives such as those Nelly promoted for Jes Us 4 Jackie. See supra note 222.

230 Spital, supra note 31, at 149.

231 See id. (explaining that education about organ donation is preferable to "the question of organ donation [being] sprung upon people at motor vehicle bureaus" because "[t]his issue should be considered in a setting that provides ample opportunity for reflection and discussion with family and friends, and these deliberations should take place before a decision is made").

should be considered particularly important and necessary since it seems that young people are too often the ones who tragically find themselves in life-threatening situations while their next of kin often are unaware of their wishes.\footnote{Trauma from car accidents is one of the leading causes of death for young adults, and they constitute a higher percentage of organ donors. See e.g., Ellen Sheehy et al., Estimating the Number of Potential Organ Donors in the United States, 349 NEW ENG. J. MED. 667, 670 (2003) (stating that of the study participants, approximately nineteen percent of their cadaveric donors were eighteen or younger while only seven percent were above the age of sixty-five, and that about forty-four percent of the donors died from trauma). In 2005, of the 5,714 cadaveric donors, 1,869 were between the ages of eleven to thirty-four and 1,525 between ages thirty-five to forty-nine. There were 1,151 donors who died from a motor vehicle accident in 2005, which accounted for about one-third of the donors. Head trauma was the cause of death in 2,212 donors, which accounted for about half of the donors. See also The Organ Procurement and Transplantation Network, Deceased Donors Recovered in the U.S. by Circumstance of Death (Dec. 30, 2005), http://www.optn.org/latestData/rptData.asp (reporting the number of deceased donors by circumstance of death); The Organ Procurement and Transplantation Network, Deceased Donors Recovered in the U.S. by Cause of Death (Dec. 30, 2005), http://www.optn.org/latestData/rptData.asp (reporting the number of deceased donors by cause of death).}

A potential roadblock for this education program could be other interest groups who want access or the same class time for their causes. For instance, interest groups representing organizations concerning heart disease might clamor for equal time in the classroom. While these diseases and the issues they raise are important and people should be aware of them, there is a pressing need for kidney donation education because broad public participation is the only way to solve the dire shortage of kidneys. Discussion about kidney disease and transplantation could also be covered during class lessons about diets and eating habits since heart disease is contributes to kidney failure. The government could reassess the effectiveness of the organ education programs and grants after a set period of time and if the results are positive, or the goals are met, then the program could continue since schools have new students each year; if the program results are negative, however, then the program could be scaled back.

Additionally, high school health education classes could talk about the need for young people to have living wills or advanced directives since it is the “young people who die unexpectedly.”\footnote{Spital, supra note 31.} Health education classes could encourage the students to consider executing these living wills or advanced directives and as part of those documents, they could state their preference for kidney
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donation. Further, lawyers, when discussing these documents, or even when counseling clients on estate planning, should include kidney donation as part of the conversation.\textsuperscript{235}

The medical community could also participate in the education process by speaking to the public about the donation process. Hospitals could make public information regarding the general health outcomes of donor and recipients such as the percentage of successful versus unsuccessful transplants or the percentage of patients who suffered from adverse side effects and which ones, encouraging donors to speak to the media about their story, help clarify any confusion regarding medical reimbursement for cadaveric versus living donation, or ask physicians and transplant teams speak to the media to facilitate more openness and transparency to the process.\textsuperscript{236}

Physicians could also have more open discussions about laparoscopic surgery, so individuals who are not aware of it would understand the benefits such as reduced recovery time, which would mean less burden financially, socially, and mentally for a living kidney donor.\textsuperscript{237} The medical profession is in a unique position because they possess the medical knowledge regarding kidney transplants, have a solid understanding of the kidney shortage, and interact with the patients. Physicians, therefore, could exert some pressure on politicians to include not only themselves in the policy process or public forums such as hearings about kidney procurement, but also donors and recipients of both living and cadaveric transplants. Ultimately, the donors and recipients are the ones who understand best what a patient goes through.\textsuperscript{238} Physicians could also pressure the government to increase funding for research and data collection.\textsuperscript{239}

Lastly, the failure to obtain permission from potential donors

\textsuperscript{235} See Rudy Serra & Annette E. Skinner, Feature: Counseling the Gay, Lesbian, Bisexual, or Transgender Client, 80 Mich. B.J. 52, 54 (2001) (suggesting that it is important for a client to provide a power of attorney for health care decisions, which is a "logical document to use to authorize organ and tissue donation and the ability to make burial decisions").

\textsuperscript{236} See Zink supra note 218, at 584 (suggesting ways the medical community could use the media to inform the public about organ donation).

\textsuperscript{237} See Stephen T. Bartlett, Laparoscopic Living Donor Nephrectomy for Kidney Transplantation, 28 Dialysis & Transplantation 318, 331 (1999) (detailing some of the benefits of laparoscopic surgery such as shorter hospital stays and less scarring).

\textsuperscript{238} Id.

\textsuperscript{239} Id.
or their families also contributes to the lack of donors.\textsuperscript{240} Several studies have shown that a significant number of health care professionals do not know their own health care institution’s brain-death and organ donation policies or what the institution’s medical criteria is for those situations.\textsuperscript{241} Therefore, the medical institutions should also establish in-house education programs for their own medical professionals and staff in order to ensure that everyone knows and understands what the hospital’s transplant policies are, thereby enabling the institutions’ professionals and staff to better serve their patients and the transplant process.

Better education would complement an aggressive advertising campaign by improving public awareness about the kidney shortage and available treatment options. Again, the more people know about the situation and what they can do to help, the more informed they will be in making an autonomous decision.

6.2.3. Other avenues to sign up donors

Our system for kidney donation currently relies heavily on the driver’s licensing system to get people to sign up to donate kidneys by soliciting an agreement about willingness to donate on licensing applications. The shortage of kidneys suggest that this system has not been especially successful, perhaps because it depends on a state employee and a licensing clerk to ask an individual about whether she would like to donate. And, even if the employee does ask, it is uncertain whether the employee would be able to appropriately answer questions concerning kidney transplants and the procurement process.

Therefore, the federal government must consider other avenues to reach people about kidney donation. One possible solution is blood drives. It seems likely that people who donate blood would also be inclined to donate kidneys because of their altruistic nature, and for those people who have not affirmatively made a decision to donate, a blood drive would be a great and convenient opportunity. The federal government should ask the organizations sponsoring the blood drives, such as the Red Cross, to advertise

\textsuperscript{240} See Futterman, supra note 202, at 164 (arguing that the disparity between supply and demand of organs could be considered a result of failure to get permission to procure the organs from potential donors).

\textsuperscript{241} See id. at 164 (citing several studies that demonstrate that a significant number of healthcare professionals lack the relevant knowledge concerning their institution’s brain-death and organ donation policies).
that people can also sign up for kidney donation at the same time the organizations promote their blood drives.

Churches and other houses of worship would also serve as good institutions to educate people about the kidney shortage and need for kidneys. Houses of worship could be particularly important in encouraging living organ donation since several major world religions favor kidney donation in order to help another human being.242 The message of altruism would be especially effective. Churches could also play a crucial role in increasing the number of African American donors. African Americans suffer from kidney failure more than people of other races.243 They also spend a longer time on the waiting list for a kidney244 because there is a shortage of kidneys from African Americans245 and they have lower rates of cadaveric donation compared to other races.246

242 See Caplan & Veatch, supra note 157 (discussing the permissibility of organ donation in the eyes of those religions when it is to help another human being); Veatch, supra note 158, at 9 (discussing religious traditions related to the handling of the body and their implications relevant to organ procurement).

243 In 2003, about 900 out of 1,000,000 African Americans, aged fifty to fifty-nine, had end stage renal disease compared to 200 out of 1,000,000 Caucasians of the same age cohort. For African Americans, aged 30 to 39, nearly 100 out of 1,000,000 had end stage renal disease compared to about 30 out of 1,000,000 Caucasians of the same age range. United States Renal Data System, Incidence and Prevalence of ESRD (2005), available at http://www.usrds.org/atlas.htm. Two of the leading causes for kidney failure include diabetes and high blood pressure, which occur in higher rates of African Americans than Caucasians. See, e.g., Lynt B. Johnson, Some of the Challenges of Encouraging Organ Donation Among Minority Populations, 65 N.C. MED. J. 35, 35 (Jan./Feb. 2004) (claiming that hypertension occurs at a rate of thirty percent versus twenty percent in other populations and that African Americans with diabetes are three times more likely at risk for end stage renal disease).

244 See, e.g., Johnson, supra note 243, at 36 (noting that in 1997, African Americans waited, on average, two and a half years longer for a kidney than Caucasians).

245 African Americans need kidneys from other African Americans because of tissue matching. See Northwest Kidney Centers, African Americans and the Need for Organ Donation, http://www.nwkidney.org/yourhealth/organdonor/african_need.html (listing some facts about why African Americans are in need of kidneys). See also Johnson, supra note 243, at 36 (stating that in a study of the state of Maryland, sixty-five percent of Caucasians self-identified as organ donors on their driver’s licenses while only nineteen percent of African American men did so, and while sixty percent of Caucasian families would permit a cadaveric donation of a loved one, only twenty-five percent of African American families would).

246 This distrust could stem from several reasons, but centers around a general distrust of the medical establishment and fear that if an African American decides to be a cadaveric donor, the physicians will not do everything to help her
Therefore, increased education and communication about the shortage and need for kidneys in a community environment like a church, or at an event that already involves altruistically inclined people such as a blood drive, might help improve rates of cadaveric and living kidney donation.

6.2.4. Centralized database

Currently, there is no effective database that lists willing kidney donors. NOTA created the Organ Procurement and Transplantation Network ("OPTN"), a non-profit, federally funded organization, to systemize organ donation and devise standards for the process. OPTN then contracted with the United Network for Organ Sharing ("UNOS"), "a non-profit, scientific and educational organization that administers the nation's only [OPTN]."248

While UNOS provides comprehensive data on the number of donors needed per organ, the number of living donors, and the number of deceased donors, it does not track those who are willing to donate.249 Therefore, the federal government should consider creating a centralized database, a national donor registry, so that hospitals can easily determine whether there is a match for a kidney transplant.250 Kidney donor information should be collected routinely, just as a person's social security number is.

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247 See 42 U.S.C.S. § 274(b)(2)(A)(i)-(ii) (LEXIS, 2005) (listing the functions of the Organ Procurement and Transplantation Network ("OPTN")). OPTN was supposed to have a dual computer system, one that listed people who needed kidneys and one that listed those who were willing to donate.

248 The United Network for Organ Sharing ("UNOS") was awarded the initial OPTN contract in 1986 and has had the contract since. Through OPTN, UNOS collects and manages the transplant data, facilitates the organ matching and placement process, and helps develop organ transplantation policy. See United Network for Organ Sharing, Who We Are, http://www.unos.org/whoWeAre/ (last visited Feb 18, 2006) (describing the purpose and role of UNOS).

249 See generally, United Network for Organ Sharing, Data, http://www.unos.org/data/about/viewDataReports.asp (last visited Feb 18, 2006) (providing a variety of data reports concerning organ need and organ donors).

250 See World Med. Ass'n, supra note 37 (noting that doctors are in a prime position to help increase organ donation and that a national registry linking together patients and willing donors would be an effective solution).
For instance, when people go to visit any type of physician, they are normally required to fill out paperwork. The federal government could encourage physicians, if not mandate them, to have a section within that patient information questionnaire that relates to kidney donation: whether the patient has ever consulted with a doctor about the process, whether the patient is a donor, whether the patient would like to be a cadaveric donor, whether the patient would consider being a living donor. It seems unlikely that there would be any reason a patient would feel forced to answer "yes" to any of those questions. The questions do not ask the patient to commit to any course of action; they simply are a means of gathering information about the patient. If the patient had any questions relating to it, she could ask the physician during her appointment, and after each patient appointment, the physician would enter in the information into the national registry.  

Physicians may argue that because of the demands placed on them by insurance companies, they do not have time to have a conversation with each and every patient they see. Thus, perhaps there should be some financial incentive for these doctors to talk with their patients. This incentive could come from the money health insurance companies save on patients who either have laparoscopic surgery or transplants, which cost less overall than a patient on life-long dialysis. Physicians could attach these claims along with the patient’s other insurance claims.

Another way to get kidney donation information from people would be through health or life insurance companies. When people sign up for their policies, the insurance form could have a

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251 Further research should be conducted as to how the national registry and the doctors’ involvement would conform to the Health Insurance Portability and Accountability Act ("HIPAA"), which addresses the security and privacy of patient health data. See United States Department of Health and Human Services, Office for Civil Rights - HIPAA, http://www.hhs.gov/ocr/hipaa/ (last visited Feb 18, 2006) (providing basic and comprehensive information about HIPAA and compliance).

252 See Alexander Tabarrok, Life-Saving Incentives: Consequences, Costs and Solutions to the Organ Shortage, THE LIBRARY OF ECONOMICS AND LIBERTY (Apr. 5, 2004), http://www.econlib.org/library/Columns/y2004/Tabarrokorgans.html (last visited Feb 23, 2006) ("Kidney transplants are cheaper than dialysis over prospective lifetimes and they pay for themselves within two to three years."). Additionally, most dialysis costs are covered by the government through the End Stage Renal Disease Program. Thus, money saved from this program could be used to provide some financial incentive to doctors to talk to their patients. Id. (summarizing how transplants cost less money in the long-run than dialysis).
section requiring that information and the insurance representative could be on hand to answer any questions of the policyholders. The insurance agent could then enter the data into the centralized database. If the potential policyholder had general questions about the donation process, the insurance agent could answer them and if the agent was unsure of the correct answer, the agent could direct the potential policyholder to the right source of information. For those who do not have easy or affordable access to doctors, or cannot afford insurance policies, social workers could bear the responsibility of talking about the kidney shortage and need for organs when meeting with people about welfare, jobs, housing, or any other similar issue.

An accessible, centralized system that contains donor information could make kidney procurement more effective. As long as the information is entered into the system, a centralized database could easily bring together recipients and donors.

6.2.5. Amend NOTA

In order to better regulate United States citizens from participating in the illegal kidney trade, the federal government should amend NOTA to ban physicians from treating those patients who illegally purchased a kidney and had it transplanted abroad. Currently, the Act only bans the interstate sale of kidneys, which includes foreign commerce, and does not place any sanction on physicians who know their patients have illegally obtained a kidney abroad; physicians are only prohibited from participating in the transfer of a kidney and not from any medical treatment after the kidney has been transplanted.

Additionally, the government should create a reporting system, perhaps as part of the centralized database for donors, which only the proper authorities would have access. Physicians could report patients whom they suspected obtained an illegal kidney and the proper authorities could conduct further investigation. Stricter regulations and sanctions would help limit illegal kidney transactions. The laws would deter people from participating in illegal kidney sales and transplants abroad because of fear their physicians may turn them in to the authorities when they seek medical care post-transplant.

253 See supra note 108.
6.3. Weak Economic Incentivization

The third aspect of my proposal focuses mainly on increasing the number of people who commit to donating their organs upon their death by offering some sort of a weak economic incentive, although there are a couple proposals that aim to increase living donations. Weak economic incentives would also help increase kidney donation "in populations now giving the fewest organs, needing them the most, and being underserved by the present donation system" such as African Americans.254

Although some may argue that even a weak economic incentivization takes away from the altruistic nature of donating, while it is noble for the United States to employ a kidney procurement system based on altruism, this social notion of regarding the interests of others comes from the perspective of people (such as politicians, medical professionals, or bioethicists) who have the luxury of generally being "able to manage circumstances to the benefit of ourselves and others."255 Our altruistic system removes any idea that kidneys could be procured by motivating people to donate through any other type of incentive.256 "We who have advocated 'free choice' in altruistic organ donation have fully ignored the fact that we are imposing our own values on persons who may not appreciate those values at all."257 Therefore, it is important to consider the best way to increase the kidney supply with as few ethical violations as possible. Weak economic incentives could be the "push" a potential donor, who would consider donating altruistically, needed to make her ultimate decision to donate.

The concept of weak economic incentives is not new; however, this proposal seeks to combine four types in an attempt to effectively increase the kidney supply. In a recent study, a majority of respondents favored the idea of providing donors benefits for organ donation, but the findings suggested that direct payment would receive the least amount of support.258 Therefore,

254 Id.
255 Id. at 199.
256 See generally id. (discussing why offering death benefits could help increase the organ supply).
258 See C.L. Bryce et al., Do Incentives Matter? Providing Benefits to Families of Organ Donors, 5 AM. J. OF TRANSPLANTATION 2999, 3005 (2005) (concluding that, generally, people would welcome a policy such as benefits or incentives that
this proposal offers a combination of four weak economic incentives as an alternative to direct payment.

6.3.1. Tax deductions and limited reimbursement for medical expenses

A tax break could be offered to an individual, or the individual’s family, if she decides to be a living kidney donor. Such laws have already been passed in states like Wisconsin\(^\text{259}\) and Georgia\(^\text{260}\) which provide $10,000 in tax deductions for costs associated with living donor donation such as travel expenses, lost wages, and hotel bills. Maryland has proposed and Arkansas offers living donors a tax deduction for themselves or their dependents.\(^\text{261}\) On the surface, these laws seem to provide incentives for people to do a living donation, which might exploit the poor; however, the laws are more like “reimbursements rather than incentives”\(^\text{262}\) because the living donor is refunded the money she spent in traveling expenses or lost wages. Therefore, the person is only incentivized to be a living donor because she will not lose any money; she is not incentivized by the prospect of making money on her donation.

Additionally, if a person decides to be a cadaveric donor, the


\(^{261}\) See Income Tax-Subtraction Modification for Living Organ Donors, MD General Assembly, H.R. 443 (Md. 2005) (proposing a subtraction modification for specified expenses that are attributable to organ donation to another individual under specified circumstances. The maximum tax deduction is $10,000 and only applies to one organ donation); Gift of Life, H.R. 1393, 85th Gen. Assem., Reg. Sess. (Ark. 2005) (finding that organ donating that “organ donation is courageous, admirable, and vital demonstration of one’s commitment to the value of human life and, in many instances, is necessary for the preservation of life itself” and offering tax deductions on net income for expenses related to living organ donation such as travel, medical, lodging, and lost wages). See also Wesley Brown, House Committee Endorses Tax Deduction for Organ Donors, ARKANSAS NEWS BUREAU, Feb. 9, 2005, http://www.arkansasnews.com/archive/2005/02/09/News/317001.html (reporting on the passage of the bill and summarizing its effects). As of winter 2005, Illinois, Indiana, Maryland, Massachusetts, Minnesota, Missouri, New Jersey, New Mexico, New York, Pennsylvania, Rhode Island, South Carolina, and Utah all had similar legislation pending. See Hannah Vahaba, A New Georgia Law Compensates Living Organ Donors, Transplant Chronicles (Winter 2005), available at http://www.kidney.org/transplantation/livingDonors/shareShowStory.cfm?storyID=92 (noting which states passed tax deductions for living organ donation and which states had pending legislation).

\(^{262}\) Bryce, supra note 258, at 3007.
federal government could consider providing an estate tax credit for the deceased donor's family. Because only a small number of deaths qualify for kidney donation, it would not cost much for the federal government to provide such a credit. While this weak economic incentive is admittedly unfair because it would not provide the incentive to the poor, it may increase the number of rich people who donate, which would increase the overall number of kidneys. A rich person may not be motivated by a tax reimbursement; they already have the economic means and the opportunity to be a living donor if they want to be. An estate tax, however, could be appealing because it would provide a financial break to the rich donor’s loved ones upon her death.

Lastly, the federal or state governments could provide limited reimbursement for the medical expenses associated with persistent vegetative state (PVS) care for someone donating a kidney upon her death because PVS care could be an expensive burden on the patient’s family. Currently, doctors, hospitals, and organ transplant services are the ones who benefit the most, financially, from a transplant procedure. In 1992, a review of twenty-three patients in PVS found that the hospital bills of the patients, on average, were $170,000. Limited reimbursement for those families whose loved ones decided to donate could alleviate some of the tremendous medical expense associated with end-of-life care. A weak economic incentive like limited medical care reimbursement would ease concerns that a family might "hasten" the death of a loved one for financial reasons. Direct payment could motivate families to end a loved one's life earlier than necessary, essentially profiting from the direct payment. Limited medical reimbursement, however, merely provides a reimbursement to help minimize the cost of the deceased's medical treatment and does not create a situation where a family could be left financially better off than they were before the deceased passed away.

A tax credit or limited reimbursement of medical expenses would provide compensation for donation unlike an open market, which places a direct price tag on the kidney. These weak financial incentives could be the catalyst for a potential donor yet minimize the exploitation of the poor because the incentive is not as coercive.

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as a direct payment.

6.3.2. Reimbursement of funeral expenses

Reimbursement for the donor’s funeral expenses could be offered as an in-kind reward. Pennsylvania offered such a death benefit program; it established a pilot program that contributed $300 toward the funeral expenses of each organ donor.\(^{264}\) The compensation was paid directly to the funeral home or hospital, and not the donor’s family or estate.\(^{265}\) The pilot program, however, was short-lived because of concern that it violated federal law.\(^{266}\) Such a program would require documentation of the funeral to avoid situations where a family does not have a funeral for the deceased donor in order to pocket the reimbursement.

Similar to the other weak financial incentives, just because payment is offered, the altruistic nature of the organ donation does not disappear. This type of incentive system is analogous to a church patron giving money to the church or a person donating money to a charity or school.\(^{267}\) People are motivated to do such actions not only because they are altruistic, but also for the reduced taxes\(^{268}\) or other financial benefit such as a reimbursement of funeral expenses.

Specifically, this weak financial incentive would require simultaneous education and communication with the African American community concerning kidney donation because of cultural and historical reasons. Offering reimbursement for funeral expenses could stir up memories of the last time the government offered African Americans funeral expenses, which was “when the bodies of those who died in the notorious Tuskegee Syphilis study were sought for autopsy.”\(^{269}\) Thus, in order to show

\(^{264}\) 1994 Pa. Legis. Serv. 102 (West 1994); see also Siegel, supra note 43, at 941 (detailing how Pennsylvania subsequently limited payments for funeral expenses to $300).

\(^{265}\) Siegel, supra note 43, at 941 (detailing how Pennsylvania’s Organ Donation Awareness Trust Fund works).

\(^{266}\) See generally Hope Yen, State to Give $300 to Organ Donors, PIT. POST-GAZETTE (Mar. 30, 2000) at B6 (reporting on the Pennsylvania pilot program and the reason it was halted).

\(^{267}\) See Barnett supra note 13, at 211 (providing an analogous example to show why financial incentives for organ donation should be permissible).

\(^{268}\) Id.

\(^{269}\) Caplan et al., supra note 157, at 221.
sensitivity to these past experiences, the government and medical profession would need to be open with the African American community about kidney procurement, the shortage of organs, and how this incentive aids in increasing the kidney supply and will not harm the African American community.

Similar to the tax credits and limited medical reimbursement, a reimbursement for funeral expenses would not be a direct payment for the kidney; rather, it would provide the donor’s family with some financial relief for donating.

6.3.3. Life or health insurance premium discount

This proposal incorporates Hansmann’s suggestion to use a discount on a life or health insurance policy to encourage policyholders to be cadaveric kidney donors as one of the four weak economic incentives the government should utilize to increase the kidney supply. The federal government could mandate that states determine a certain monetary discount for insurance premiums. Individuals would have the ability to change their mind each time their insurance premium is renewed; therefore, they maintain their autonomy because they are not locked into their decision. For example, if a twenty-two year-old man starts working for a corporation whose life insurance company offers a deduction for donating his kidney, he may opt to donate his kidney upon his death. Every year he is asked to renew his policy, including the provision specifying his willingness to donate. Five years later, he marries a woman who does not want him to donate a kidney for whatever reason. When his policy is up for renewal, he then may choose the option to not donate his kidney upon his death.

While people may be uncomfortable with a government statute that allows this, people should realize that although the government respects the right of individuals to choose what to do with their bodies, there are certain situations where state interests call for government intervention. For instance, while a woman may choose to become a prostitute, the government has determined, for public policy reasons, that prostitution is illegal. A dire kidney shortage, such as the one occurring today, could very well be a legitimate state interest justifying the government’s intervention in enacting proposals to increase the kidney supply.

See Gray, supra note 134 and accompanying text.
Additionally, as discussed previously, people with either health or life insurance could talk to representatives about their options. By discussing general issues with representatives and following up on the representatives’ suggestions about where to seek additional information, the individuals will be more well-informed of their options for donating. For those who do not consent and leave the decision to a family member, the insurance company could require that the donor’s family member be present during any conversation regarding the donor’s decision to be a cadaveric donor before approving the premium discount. Thus, the family member will be informed of kidney donation during a calmer time so she can absorb the information rather than being put on the spot after her relative has passed away.

Alone, this proposal would not be effective because it would not generate the kidney supply needed to meet the demand because the deceased donors must be brain dead. However, because this aspect of the proposal does not run into as many ethical concerns as an open market, it could be combined with other suggestions to effectively increase the kidney supply through cadaveric and living donations.

7. CONCLUSION

The kidney shortage requires swift action. Countries around the world have recognized both the shortage and the existence of the black market. If countries seek to eliminate the black market, they need to truly enforce the laws they already have established against the sale of kidneys. Additionally, they need to take other proactive measures to increase the supply of kidneys from cadavers, which would lessen the need of kidneys from live people. Because most people are not morally opposed to donating their kidneys, it is important to inform them about how to donate and offer incentives to motivate them to take the steps necessary to ensure donation.

Commodification of kidneys through a direct payment is ethically impermissible. An open market in which donors can presently sell their kidneys or one that allows their relatives to sell their kidney rights is unacceptable. First, the underprivileged will still be taken advantage of and have less access to the kidneys. Second, allowing family members to contract to sell relatives’ kidneys strips the donor of his autonomy. Lastly, a slippery slope would emerge over what could be commodified next.
The futures market offers an alternative similar to the open market, except that the right to the kidney is purchased for the future. While it is unethical to promote absolute contracts for the sale of one’s kidney, it is acceptable to provide people with the option to sell the future right to her kidney on a renewable basis. In this way, individuals do not lose their autonomy because they can change their decision at set periods of time. Individuals will be informed of their donating options and while their donation might not reflect pure altruism, individuals are still choosing to help others.

Presumed consent for kidneys, while successful abroad, is not an ideal proposal either. Presumed consent creates confusion, as well as loss of individual autonomy. If an individual does not remember to express her objection, she loses her right once she passes away. Additionally, if she does not object, confusion might arise if family members try to decide what the individual might have wanted. Either way, the deceased has lost her right to choose what to do with her kidneys.

No one proposal is without downsides, but the hybrid proposal of presumptivity, a more aggressive publicity and education campaign, and the use of weak incentives would maximize the benefits of the proposals and minimize the consequences. Presumptivity will aid in raising the number of cadaveric donations without stripping people of their autonomy. Through a more aggressive publicity and education campaign, individuals will become more aware of the kidney shortage, which would help

271 Additionally, in order to have an organ procurement system that is effective, we cannot simply focus on creating such a system, but must address the participants, particularly the donors, because “donor safety is paramount.” Zink, supra note 218, at 583. Donor safety can be protected through informed consent, which is absolutely essential to organ donation, living or cadaveric, and a standardized form of informed consent should be established to ensure an ethical practice of organ donation. Some additional suggestions to consider would be providing the donor with an advocate who will protect the donor’s best interests, protecting donors from extraneous costs for donation such as child care or lost wages, and implementing a long-term follow-up of the donor that includes both mental and physical evaluations. See generally id. (concluding that donor safety is important, and that studies should formulate a standardized plan for obtaining the informed consent of donors in order to protect donor interests in the long-term). Further, research should be conducted to help address the psychological issues that donors and recipients may face. Psychological screening and evaluation should be mandatory, criteria for identifying psychologically inappropriate donors and for evaluating participants’ psychological state of mind should be established, and methods to track donor’s post-transplant mental quality of health should be developed. Id.
increase the number of cadaveric and living donations. Additionally, a national donor registry would create the necessary link between those who need donors and those who are willing to supply them. Lastly, weak financial incentives or in-kind rewards will assist in increasing the number of cadaveric and living donors because they can commit an altruistic act of donation at no financial cost to themselves.

In conclusion, no solution is going to be perfect. But, as a society, we are facing a dire situation and need to take action to remedy the shortage to help save lives. Thus, this ethically acceptable solution offers the United States an optimal solution to maximize the kidney supply. Once the kidney supply levels reach a more desirable level, the system can be reevaluated.