

MEADOR LECTURE SERIES 2007–2008: EMPIRE

EMPIRES OF THE FLESH: TISSUE AND ORGAN TABOOS

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*In each individual the spirit is made flesh, in each one the whole
of creation suffers, in each one a Savior is crucified.*

—Hermann Hesse (1723–1790)

And your very flesh shall be a great poem . . .

—Walt Whitman (1819–1892)

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On March 18, 2008, the mafia saw one of its own fall in a New York court. No, it wasn't a Gambino, or anyone tied to one of the old mob families. But the indictment, plea agreement, and court order deserve serious attention—it could be a matter of life or death. Michael Mastromarino, a celebrated dental surgeon, will now serve possibly five decades in prison for conspiracy, desecrating human bodies, and larceny among other charges.¹ Mastromarino's crime: stealing from the dead—quite literally. Mastromarino and his colleagues operated a human chop-shop through funeral homes—paying a thousand dollars per pillaged corpse, and later reselling the tissues, bones, and skin for at least \$13,000 per body. His scheme is believed to have generated more than four million dollars.² The Mastromarino conviction is the latest horrific episode in the ongoing tissue transplant industry saga that exposes the gaps in federal law, state enforcement, and the overwhelming social demand for human body parts.

Mastromarino pleaded guilty to pillaging 1,800 bodies for bones, ligaments, heart valves, organs, and other valuable tissues. After excavating the bodies, the defendants stuffed the corpses with plastic tubing and plumbing piping to deceive the decedents' relatives.³ The furtive scheme was unmasked by investigators, but only after thousands of body parts, some from diseased corpses ravaged by AIDS, cancer, hepatitis, and other communicable illnesses, were sold for transplantation to hospitals, doctors, and patients throughout the United States.⁴ Among the more illustrious to have been ransacked by Mastromarino was long time Masterpiece Theater host, Alistair Cooke. Yet, after discovering the horrific black market in body parts, prosecutors were left wondering what exactly to do. It is illegal for an individual to sell her own body parts. But is it illegal for a third party or stranger to do so? That is to say, who owns the human body?

What we have learned from sporadic case law and legislative gaps is that researchers can patent and profit from human tissue, and tissue banks can sell human bodies for up to \$250,000 in profits, but individuals lack the legal authority to enter the marketplace with their own organs and tissues. This Essay critiques those inconsistencies and argues that incentives are the best solution for increasing the supply of human tissues and organs

1. See Alan Feuer, *Dentist Pleads Guilty To Stealing and Selling Body Parts*, N.Y. TIMES, Mar. 19, 2008, at B6, available at <http://www.nytimes.com/2008/03/19/nyregion/thecity/19bones.html?ref=nyregion> (citation omitted).

2. See *id.* Mastromarino agreed to pay restitution of \$4.6 million dollars to the families of those who were mutilated. *Id.*

3. See, e.g., Kerry Howley, *Who Owns Your Body Parts? Everyone's Making Money in the Market for Body Tissue—Except the Donors*, REASON, Mar. 2007, at 20, 20; Dan P. Lee, *Body Snatchers*, PHILA. MAG., Apr. 2008, http://www.phillymag.com/articles/body_snatchers/.

4. Tissue, similar to blood transfusions, can transmit hepatitis, HIV, mad cow disease, bacteria, and various other communicable diseases to the unsuspecting transplant recipient. Recipients of "bad" tissue have died in other tissue-banking scandals.

and decreasing black markets and exploitation. By allowing a market, we remove the incentive to exploit because tissues can be obtained legally for a fee. The suggestion here is not to do away with altruism but rather to advocate for a new brand of legal realism, one that acknowledges that with a million allograft surgeries taking place each year in the United States, Mastromarino is not a big fish, but rather a small one in an ocean.

The challenge in parsing out the trade in body parts is that it is wedged between two legal processes, altruistic organ donation and legalized tissue implantation. In between is the black market industry that practically receives bodies and parts for the tiniest fraction of their profit and exploits that advantage through huge mark-ups to doctors and hospitals. Estimates range, but prosecutors speculate that 10,000 people throughout the United States and abroad received tissue from Mastromarino's dealings.⁵

To address the supply and demand problem in organ transplantation, scholars (including behavioral economists or those with such leanings) are weighing in, such as Cass Sunstein,⁶ Lior Strahilevitz, and sociologists like Eric Johnson and Daniel Goldstein.⁷ Among their proposals is one to allow default rules to govern organ supply. Essentially, they express the urgency in creating meaningful transplant legislation and believe that most individuals probably want to be donors. Therefore, the state should be able to conscript organs so long as individuals have not articulated opposition. Their proposals advocate systems of presumed consent whereby all citizens are presumptively donors unless they affirmatively *opt-out*.

This Essay argues against tissue and organ (T&O) default rules like presumed consent and offers a departure from the conventional scholarship addressing T&O supply and demand. It makes three distinct normative evaluations. First, it proposes compensating relatives for providing human tissue and bone for transplantation and medical research. It argues for the disentanglement of tissue procurement problems from that of organs. The two must necessarily be treated as distinct inquiries because organ harvesting for kidneys and lobes of livers can take place during life, and yet tissue harvesting especially for corneas, skin, heart valves, and bones is by necessity better served at death. Thus, the Essay highlights the neglected distinction between organs and tissues, less as a scientific matter, but instead to demonstrate that markets should treat the time of acquisition differently in these spheres.

Second, it proposes using incentives to promote living organ donation. It argues that *ex ante* compensation models will generally result in better

5. See Feuer, *supra* note 1.

6. See, e.g., RICHARD H. THALER & CASS R. SUNSTEIN, *NUDGE: IMPROVING DECISIONS ABOUT HEALTH, WEALTH, AND HAPPINESS* (2008).

7. See, e.g., Eric J. Johnson & Daniel G. Goldstein, *Defaults and Donation Decisions*, 78 *TRANSPLANTATION* 1713 (2004).

outcomes for donors because of better information-sharing and the costs and burdens associated with participation in organ procurement will be better understood. By contrast, the Essay argues that default compulsory or *compulsory-like* consent rules (including opt-out measures) are far more problematic, as information may be faulty and the means to opt out elusive. The Essay demonstrates why associating incentives with living donations might help to resolve the organ supply problem in the United States. This represents a departure from prior scholarship in this domain, including my own. Incentives for cadaveric donations are also emphasized in this Essay, as on a spectrum, the value of such a model should be emphasized over presumed consent, and as complementary to altruistic organ procurement.

Third, the Essay considers how we might begin to create frameworks that move the discussion of incentives for human biological materials beyond hypothetical treatments in the literature to actually testing them at the state level. To this end, the Essay stresses the importance of considering federalism to overcome resistance to markets.

Part I briefly addresses the empirical dimensions of T&O supply and demand in the United States. Part II considers default consent rules, particularly presumed consent. It identifies two spheres of concern with this procurement approach. First, presumed consent raises pragmatic concerns, including information problems and opt-out constraints. Second, presumed consent may be more prone to fraud, corruption, and abuse than other procurement strategies. Part III discusses what incentive approaches to T&O procurement might look like. It evaluates objections to payments for T&O, including fears about denigrating personhood, speculations about the exploitation of ethnic minorities, and general concerns about abuse and coercion of the poor. The Essay concludes by suggesting that states experiment with procurement protocols by seeking exemptions to the National Organ Transplant Act, the federal law that governs organ supply.

I. EMPIRICAL OVERVIEW

Sadly, New York's grave robbing scandal is nothing new. For over a decade, tissue banks have operated in very clandestine ways, surreptitiously obtaining human tissues, corneas, eyes, bones, and organs through brokers who solicit from crematoriums, funeral homes, dental offices, hospitals, morgues, medical schools, and coroners' offices.⁸ Annually, about 1.3 million Americans have surgery involving soft-tissues, skin, bones, and tendons taken from cadavers. Parts from cadavers serve a range of pur-

8. See Ralph Frammolino, *Harvest of Corneas at Morgue Questioned*, L.A. TIMES, Nov. 2, 1997, at A1 (investigating over 570 cases of nonconsensual cornea harvesting during a twelve-month period and explaining that families "were shocked that they had not been asked or told").

poses, from dental surgery to hip and knee replacements.⁹ In addition, human tissues are increasingly used in the booming plastic surgery industry, for uses ranging from genital enhancements and thickening lips to the development of pharmaceuticals. Because of the tremendous demand for elective surgeries, including plastic and cosmetic surgeries and knee operations involving cadaveric body parts, the tissue transplant industry generates billions of dollars in the United States.¹⁰

Human tissues and organs serve very different purposes; tissues, such as corneas and tendons, enhance life but cannot be used to save life. This is a minor point for purposes of discussion in this Essay. But, perhaps for this reason, scholars have avoided or neglected considering tissue supply dynamics alongside that of organs. Organs, by contrast are necessities; without them we die. Nonetheless, there are key features shared between T&O that justify or at least provide some rational basis for considering them side by side. Both T&O pertain to the human body and policies crafted for one domain will likely spill over to the other.

Subpart A briefly analyzes the procurement challenges associated with organ and tissue supply, which is unrelieved by altruistic donations. Subpart B discusses some of the empirical features of current organ demand. Subpart C studies tissue demand and provides a pragmatic overview of that industry. Subpart D briefly discusses the National Organ Transplant Act (NOTA), which governs the acquisition of human organs and tissue.

A. Bi-Coastal Problem

From California to New York, procurement specialists, coroners, and body-part brokers have been linked to the robust black market in body parts. In California, the Los Angeles coroner's office was caught in 1997 selling the corneas of Black and Latino homicide victims for about \$340 per pair. The corneas were later resold by the Doheny Eye and Tissue Bank for more than \$3,400 per pair.¹¹ In 2004, the University of California–Los Angeles Medical School was embroiled in a scandal wherein mid-

9. In the past few years, the number of Americans utilizing human allografts has nearly doubled. Compare Andrew Bridges, *FDA Shuts Raleigh Company*, NEWS & OBSERVER, Aug. 19, 2006, at A16 (“More than 1.3 million Americans each year have operations or procedures that use bone, skin, corneas or other types of tissue from donated cadavers. These range from dental implants using ground bone to knee ligament and spine repairs.”), and Renie Schapiro, *Banking on the Gift of Tissue*, MILWAUKEE J. SENTINEL, May 2, 2005, at G1, with DEP’T OF HEALTH AND HUMAN SERVS., OFFICE OF INSPECTOR GEN., OVERSIGHT OF TISSUE BANKING, at i (2001), available at <http://www.fda.gov/cber/tissue/ovrst0101.pdf> (“It is estimated that tissue banks distributed more than 750,000 [cadaveric] allografts for transplantation in 1999.”).

10. See also Schapiro, *supra* note 9, at G1. Increasingly, burn banks claim that they now lack the resources to compete against cosmetic and pharmaceutical companies for human tissues. During the period in which this Essay was prepared, the author was phoned by a National Public Radio affiliate investigating the competition for human tissue and how commercial tissue banks are winning.

11. Frammolino, *supra* note 8, at A1.

dleman Ernest Nelson chopped up bodies donated to the medical school and sold them to tissue banks and parent companies like Johnson & Johnson.¹² Lawsuits are currently being settled regarding that and other medical school body-part-selling scandals.

One significant problem is that body-part scandals are treated as episodic rather than systemic of a renegade, unregulated industry. Tissue banks trade on the global stock exchanges. Their websites boast that one cadaver reaps over \$200,000 in profit.¹³ Yet, buying and selling body parts is illegal according to the 1984 National Organ Transplant Act (NOTA).¹⁴ Despite this federal statute, which imposes a \$50,000 fine and five years imprisonment,¹⁵ law enforcement has been lax at best.

Tissue¹⁶ and organ scandals¹⁷ expose the fault lines in human biological supply and demand in the United States. Insufficient supply is a persistent problem in both spheres. For this reason, scholars are wise to consider whether government intervention should occur to alleviate the tremendous demand, and if so, what that intervention should look like. Is altruism enough? Clearly it is not. But other potential solutions to our biological supply problem, including payments and presumed consent, are not without controversy. This Essay, in part, addresses what those obstacles look like for T&O procurement and, in the case of payments, offers how objections might be overcome.

As of March 22, 2008, 98,531 people waited for organs in the U.S.¹⁸ More than 7,000 of those patients died within the year and those deaths did not include patients removed from transplant waitlists because they

12. See Michele Goodwin, Editorial, *Commerce in Cadavers is an Open Secret*, L.A. TIMES, Mar. 11, 2004, at B15, available at <http://articles.latimes.com/2004/mar/11/opinion/oe-goodwin11> (discussing the reach of body-part scandals, including that involving Ernest Nelson and Henry Reid at the University of California); Charles Ornstein & Monte Morin, *UC Got Body Parts Warning a Year Ago*, L.A. TIMES, Mar. 16, 2004, at A1 (describing the black market sales of donated cadavers by UCLA employees).

13. See, e.g., Kirston Fortune, *The Park Ridge Center for Health, Faith, and Ethics: News & Notes*, <http://www.parkridgecenter.org/Page538.html> (last visited June 3, 2009).

14. National Organ Transplant Act, Pub. L. No. 98-507, 98 Stat. 2239 (1984) (codified as amended at 42 U.S.C. §§ 273-274e (2006)).

15. 42 U.S.C. § 274e(b) (2006).

16. See Goodwin, *supra* note 12, at B15; Ornstein & Morin, *supra* note 12, at A1. One of the seminal cases regarding pecuniary gain from material otherwise considered to be medical waste occurred in 1990. See *Moore v. Regents of the Univ. of Cal.*, 793 P.2d 479 (Cal. 1990). A leukemia patient underwent treatment at UCLA's Medical Center. After removing the patient's spleen as part of his treatment, one of the doctors who treated the patient used his cells to develop and patent a profitable cell line. *Id.* at 481-82.

17. *Colavito v. N.Y. Organ Donor Network, Inc.*, 486 F.3d 78, 81 (2d Cir. 2007) (holding that decedent had no cause of action under conversion or New York law where donated kidney went to another recipient); *OPO Official Addresses the Alleged Premature Organ Retrieval Actions of a Transplant Physician*, KIDNEY TIMES, Aug. 2007, <http://www.kidneytimes.com/article.php?id=20070820204155>.

18. See United Network for Organ Sharing: Organ Donation and Transplantation, <http://www.unos.org/> (last visited June 3, 2009). This number is updated on the web site periodically—at the time of printing, it stands at 102,010.

became too old or too sick. Only twenty percent were transplanted and 90,000 patients rolled over to the 2009 waitlist. Most scholars treat this tension as a question for altruism to answer.¹⁹ The limited scholarship that develops an incentive approach is mostly limited to cadaveric procurement.²⁰

B. Organs

Over 102,000 people in the United States nervously wait for a call from a transplant center.²¹ Like the lottery, they hope that their blood type and HLA factors will match some stranger's and they might become the winner of an organ. Organ transplantation represents their last hope and the U.S. transplant system is usually either the last step before giving up to death or the first step before heading to the black market for an organ.²² Some try to cheat death by undergoing dialysis treatments several days per week. These treatments can last several hours and leave the already weary patients exhausted and nauseous. But dialysis is only a temporary treatment and not a solution. Without an organ transplant, death is imminent after dialysis begins.

Transplant registrants know all too well that fewer than ten percent will receive an organ this year.²³ More than six thousand patients on the organ waitlists will die before the year's end.²⁴ The rationing process is robust, creating high bars for entry and expedient exits; thousands will be kicked off the waitlist due to weakened medical conditions. In essence, because patients waiting for organs become *too* sick, they are removed

19. See, e.g., ARTHUR L. CAPLAN, *AM I MY BROTHERS KEEPER?: THE ETHICAL FRONTIERS OF BIOMEDICINE* (1997); NANCY SCHEPER-HUGHES, *A WORLD CUT IN TWO: THE GLOBAL TRAFFIC IN ORGANS* (forthcoming 2009); RICHARD M. TITMUS, *THE GIFT RELATIONSHIP: FROM HUMAN BLOOD TO SOCIAL POLICY* 70–71 (1971). See generally Douglas W. Hanto, *Ethical Challenges Posed by the Solicitation of Deceased and Living Organ Donors*, 356 *NEW ENG. J. MED.* 1062 (2007).

20. See generally MICHELE GOODWIN, *BLACK MARKETS: THE SUPPLY AND DEMAND OF BODY PARTS* (2006); Lloyd R. Cohen, *Directions for the Disposition of My Vital Organs*, 55 *DEPAUL L. REV.* 805 (2006); Richard A. Epstein, *Organ Transplants: Is Relying on Altruism Costing Lives?*, *THE AM. ENTERPRISE*, Nov.–Dec. 1993, at 50. But see Richard Epstein, Keynote Address at the University of Chicago Law School Contested Commodities Conference: In Cautious Praise of the Commodification of Genetic Materials (Apr. 4, 2008), available at <http://www.law.uchicago.edu/Lawecon/events/commodities/av.html>.

21. See *supra* note 18 and accompanying text.

22. *Organs for Sale: China's Growing Trade and Ultimate Violation of Prisoners' Rights: Hearing Before the Subcomm. on Int'l Oper. and Human Rights of the H. Comm. on Int'l Relations*, 107th Cong. 24, 28 (2001) (testimony of Professor Nancy Scheper-Hughes) (testifying that "the traffic in human organs, tissues, and body parts" is extensive, occurring in China, India, Brazil, and other countries).

23. See NICHOLAS L. TILNEY, *TRANSPLANT: FROM MYTH TO REALITY* 259 (2003) ("Although 50–60 percent of patients with renal failure have been estimated to benefit from a kidney graft, only about 10 percent currently receive an organ each year.").

24. See Steve P. Calandrillo, *Cash for Kidneys? Utilizing Incentives to End America's Organ Shortage*, 13 *GEO. MASON L. REV.* 69, 72 (2004).

from waiting lists.²⁵ Current transplant policies permit the removal from waitlists based on health status, which includes medical conditions such as cancer, diabetes, infections, or age. Patients exit the system because they become *too* old.²⁶

However, as thousands exit from the demand side, thousands more are added to the transplant waitlists.²⁷ As of October 25, 2007, 97,946 patients waited for organs on the U.S. transplant lists.²⁸ That figure represented an increase of nearly one thousand patients added to the list in the period between July and October of 2007.²⁹ Between October 2007 and March 2008, over six hundred persons were added to the organ transplant waitlist. Dr. Benjamin Hippen estimates that by 2010, the waiting time for an organ transplant will be nearly ten years.³⁰

As demand increases so has the supply of organs, but not as we would suspect. In 1996, there were 9,214 organ donors and in 2006, there were 14,751.³¹ However, these increases can largely be attributed to the increase in living donors joining the organ supply pool in the past seven years. Consider for example that from 1999 to 2004, living donors either surpassed or very closely kept pace with cadaveric donors.

25. See Rob Stein, *A Third of Patients on Transplant List Are Not Eligible*, WASH. POST, Mar. 22, 2008, at A1 (noting the connection between ineligibility as a subtle form of rationing given the tremendous demand for organs and the terribly low volume).

26. Calandrillo, *supra* note 24, at 84 (observing that “patients who are on the waiting list but become too sick to undergo transplant surgery are taken off the list and their eventual deaths are not recorded in official figures”).

27. Cf. United Network for Organ Sharing, *supra* note 18.

28. *Id.* (the information on the website is updated periodically).

29. *Id.* (the information on the website is updated periodically).

30. Sally Satel & Benjamin Hippen, *Code Red: The Organ Shortage is Not Something to Play Down*, NAT’L REV. ONLINE, Apr. 14, 2008, <http://article.nationalreview.com/?q=MWY3YjBiODI2ZDJIzGZhmWU3ZTgxNTFhYzFlODQ5YzM=>.

31. National Data, Organ Procurement and Transplantation Network, <http://optn.transplant.hrsa.gov/latestData/step2.asp>? (last visited June 3, 2009) (select “Donor” as category and “Kidney” as organ on main search page).

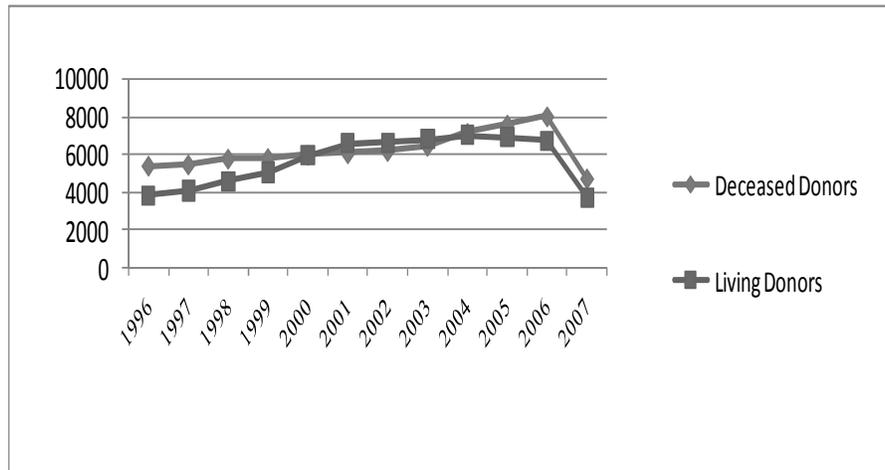


Figure 1:
Donors Recovered in the U.S. by Donor Type, 1996–2007

Much can be gleaned from the increase in living donations. First, doctors increasingly urge that the healthiest of organs, especially kidneys, come from living donors.³² Second, with the advent of minimally invasive techniques, including laparoscopic nephrectomy, a technique to remove whole kidneys with narrow incisions, health risks are minimized, which may assuage donors' fears about recovery time and pain.³³ Third, we know from this data that altruistic organ donation has hit a plateau. Without the participation of living donors, only 5,418 donors would have been available in 1996 and ten years later, only 8,019 in 2006.³⁴ Most striking is the near doubling of living organ donor participation in the past ten years. In 1995, there were 3,495 living donors, and by 2005, there were 6,902 participating in the transplantation process.³⁵

Identical patterns emerge in the kidney transplant realm. Living kidney donors represent the most significant increase of all "donor types," which includes all organs. Between 2000 and 2004, living kidney donations surpassed cadaveric donations.³⁶ In 2000, for example, cadaver and living kidney donations ran constant at 5,499 kidneys from living donors and

32. See Arthur Matas, *Risks of Kidney Transplantation to a Living Donor*, in *WHEN ALTRUISM ISN'T ENOUGH: THE CASE FOR COMPETING KIDNEY DONORS* 10, 10–18 (Sally Satel ed., 2009).

33. *Id.*

34. See National Data, *supra* note 31.

35. *Id.*

36. *Id.*

5,489 from cadavers.³⁷ By 2003, over 700 more kidneys were made available from living donors than cadaveric.³⁸

What does this empirical data tell us? In part, it points to something that policy analysts, law scholars, and economists overlooked. More organs were viable from living donors than cadaveric donors. For each deceased donor in a given year, there would have been two kidneys to come available. So long as the number of donors ran constant, this should have represented nearly a 2-to-1 ratio of cadaveric kidneys to those from living donors. However, it is important to remember that not all kidneys from brain-dead donors are viable and healthy. At least 11% are nonviable,³⁹ and others are severely compromised.⁴⁰ For this reason, those who support presumed consent as a default rule miscalculate the viability and impact of that policy. An increase in the supply of cadaver organs does not necessarily translate to an increase in transplantable organs. Thus, proposals to remedy organ supply must necessarily consider viability at the time of harvest.

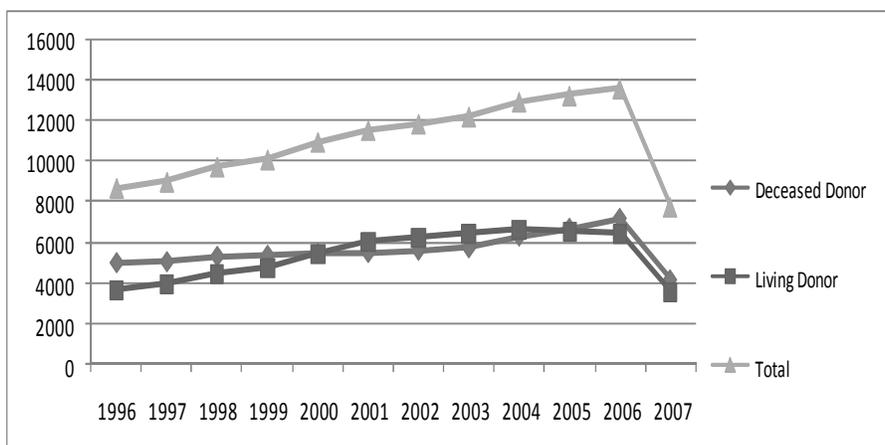


Figure 2:
Kidney Donors Recovered in the U.S. by Donor Type, 1996–2007

Of the patients in line for organs, most need kidneys.⁴¹ Despite the rise in both living and cadaveric kidney donations, those numbers pale in comparison to the dramatic growth in the patient pool. Currently, there are

37. *Id.*

38. *Id.*

39. See United Network for Organ Sharing, *supra* note 18.

40. See Ellen Sheehy et al., *Estimating the Number of Potential Organ Donors in the United States*, 349 NEW ENG. J. MED. 667 (2003).

41. See National Data, *supra* note 31 (select “Waiting list” as category, “Registrations” as count, and link to “Overall by organ”).

approximately 84,000 registrants waiting for kidneys.⁴² This number masks, however, the actual number of individuals needing a kidney transplant as it fails to account for patients on dialysis or those who are registered on internet websites like *matchingdonor.com*.⁴³ The kidney wait process provides the most compelling narrative for purposes of critiquing supply, demand, and the human costs associated with failed procurement proposals. Race and class animate the debate on organ procurement; among kidney patients, one-third are described as African-American.⁴⁴ They wait longer for kidneys than other ethnic populations and experience the highest rates of death.⁴⁵

The kidney waitlist more than doubled over the past ten years⁴⁶ and nearly tripled in the last thirteen years. In 1994, 25,827 persons were waiting for kidneys; by the close of 2003, that number had doubled to 54,231.⁴⁷ The median number of waiting days also increased substantially.⁴⁸ In 1994, the wait for a kidney was 836 days. By 2001–2002, it increased nearly fifty percent to 1,288 days for whites and, unexplainably, to 1,861 days (nearly two years longer) for African-Americans.⁴⁹ Nearing the end of the 1990s, so few kidney transplantations had occurred compared to need that the Organ Procurement Transplantation Network (OPTN)—which coordinates and collects data on organ transplants for the federal government—found it “‘impossible . . . to calculate an overall median waiting time for 1996 and 1997 registrants’” in its 1998 report.⁵⁰

42. *Id.*

43. See Michele Goodwin, *The Body Market: Race Politics & Private Ordering*, 49 ARIZ. L. REV. 599, 626–28 (2007).

44. *Id.* at 600; see also LAURIE KAYE ABRAHAM, MAMA MIGHT BE BETTER OFF DEAD: THE FAILURE OF HEALTH CARE IN URBAN AMERICA 179–97 (1993) (chronicling African-American man’s struggle to obtain kidney transplant); Barbara A. Noah, *Racial Disparities in the Delivery of Health Care*, 35 SAN DIEGO L. REV. 135, 137, 143 (1998) (“The role that conscious or unconscious racial bias may play in the health care context has, by comparison, attracted comparatively little public attention.”).

45. See National Data, *supra* note 31 (select “Median Waiting Time” as category, “Kidney” as organ, and link to “Waiting Time by Ethnicity”). See generally ORGAN PROCUREMENT & TRANSPLANTATION NETWORK & SCIENTIFIC REGISTRY OF TRANSPLANT RECIPIENTS, OPTN/SRTR ANNUAL REPORT (2004), available at <http://optn.transplant.hrsa.gov/data/annualReport.asp> (Chapter VI) [hereinafter OPTN].

46. See National Data, *supra* note 31 (select “Waiting List Additions” as category, “Kidney” as organ, and link to “Waiting List Additions by Age”).

47. OPTN, *supra* note 45, tbl. 5.1. The number of women on the waitlist went from 11,021 to 23,035 during the period discussed. *Id.* For men also, the waitlist increased dramatically. Note that in 1994, there were 14,806 men on the waitlist, making up 57.3% of those on the list. *Id.* While the male to female ratio remained constant, the overall number of men on the waitlist increased to 31,196. *Id.*

48. See *id.* at tbl. 1.5.

49. Cf. *id.*; see also *Putting Patients First: Resolving Allocation of Transplant Organs: Hearings Before the H. Commerce Comm., Subcomm. on Health and the Env’t and the S. Labor and Human Res. Comm.*, 105th Cong. 215 (1998) (testimony of Clive O. Callender) (testifying before a congressional subcommittee about institutionalized racism in healthcare and, in particular, organ allocation).

50. GOODWIN, *supra* note 20, at 44 (quoting ORGAN PROCUREMENT & TRANSPLANTATION NETWORK & SCIENTIFIC REGISTRY OF TRANSPLANT RECIPIENTS, OPTN/SRTR ANNUAL REPORT (2003)).

As shown in figure three, the gap between organ demand and supply is persistent. The gap between the number of transplants performed and the number of patients registered to receive organs expands yearly. Despite creative procurement campaigns framing organ donation as the best gift one can offer, too few people are motivated, committed to altruism, or convinced to sign on.⁵¹

But perhaps more importantly, the framers of transplant policies neglected to consider the true nature of human biological exchanges. For example, Laura Siminoff and Kata Chillag argue quite persuasively that the gift-of-life language applied to organ transplantation deserves serious scrutiny and perhaps they are right.⁵² Organ gifting, according to the authors' study on donor perceptions, is more like creating fettered "creditor-debtor" relationships with the inability of donors or recipients, particularly children, to ever fully come to closure with the transactions.⁵³ Their study confirms prior research, which reveals that transplant recipients may later feel unworthy or guilty about receiving the organs.⁵⁴

The donors too, according to a research study conducted by psychologists at the University of California San Francisco and the Pacific Graduate School of Psychology, experience significant angst. Wendy Packman and Mary Crittenden, the lead authors of that study, assert that siblings who make up three-quarters of the donors in pediatric bone marrow transplant cases often suffer anxiety and seem to feel worse about themselves than non-donor siblings.⁵⁵

Packman's research reveals that organ donation remains a complex, nuanced consideration for many people.

However, a few scholars have come to articulate a different perspective, one that suggests that government intervention is necessary and, ultimately, would not be so objectionable. To them, the public's failure to

51. See, e.g., Calandrillo, *supra* note 24, at 73; Gabriella Boston, *Emory Addresses Reluctance of Black Organ Donors*, ATLANTA J.-CONST., May 6, 1999, at JA9 (speculating why blacks are more reluctant to donate, including distrust of the medical community and racism).

52. See Laura A. Siminoff & Kata Chillag, *The Fallacy of the "Gift of Life,"* 29 HASTINGS CENTER REP. 34, 34 (1999) ("Education campaigns identifying organ donation as the gift of life were designed to make the public aware of the good that comes from transplantation and to encourage people to become donors.").

53. *Id.* at 36 (quoting RENEE C. FOX & JUDITH P. SWAZEY, SPARE PARTS: ORGAN REPLACEMENT IN AMERICAN SOCIETY 40 (1992)).

54. See, e.g., Philip Cohen, *Donors' Dread: Why Do Children Who Help a Sick Sibling End up Depressed?*, NEW SCIENTIST, Aug. 23, 1997, at 20; Deane L. Wolcott et al., *Psychological Adjustment of Adult Bone Marrow Transplant Donors Whose Recipient Survives*, 41 TRANSPLANTATION 484, 484 (1986).

55. Michele Goodwin, *My Sister's Keeper? Law, Children, and Compelled Donation*, 29 W. NEW ENG. L. REV. 357, 364 (2007) (internal quotation marks omitted).

respond more enthusiastically about organ donation amounts to little more than lethargy and that if forced to make a choice whether or not to donate, most would choose to be organ donors.⁵⁶ But such an analysis ignores important cultural, racial, and religious norms.⁵⁷ Negative perceptions about organ donations can be overcome, but first they must be acknowledged and evaluated.⁵⁸

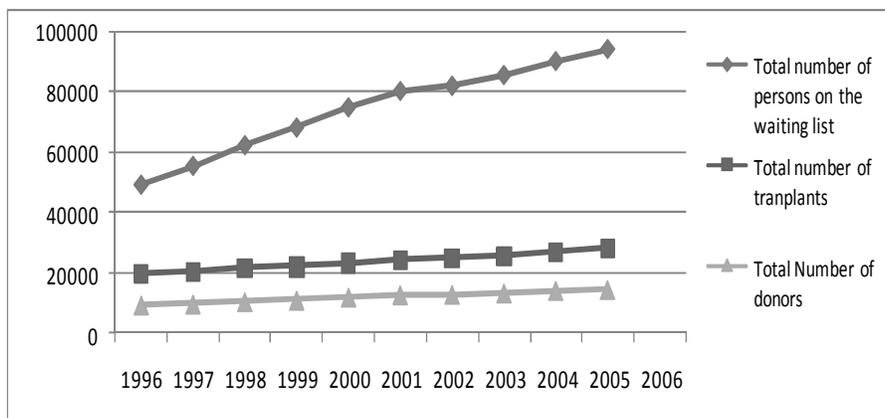


Figure 3:
Organ Demand and Supply, 1996–2005

C. Tissues

In some ways, a discussion about human tissue supply and demand is far more complicated than an analysis of organ shortfall. In part, the demand for human tissues is a broader phenomenon, spread among very different constituencies including doctors,⁵⁹ patients,⁶⁰ researchers,⁶¹ dent-

56. Johnson & Goldstein, *supra* note 7, at 1713.

57. See GOODWIN, *supra* note 20, at 21 n.119 (citing Elliot Pinsley, *Routine Donation of Organs Pushed; Ethics Group Seeks Presumed Consent*, THE RECORD, Dec. 22, 1992, at A1 (observing that presumed consent measures could be problematic among those of Jewish faith and “that a government bureaucracy cannot be trusted to maintain proper records”)); James Lindemann Nelson, *Transplantation Through A Glass Darkly*, 22 HASTINGS CENTER REP. 6 (1992); Mackenzie Carpenter, “*Presumed Donor Bill Aired*,” PITTSBURGH POST-GAZETTE, July 14, 1993, at A10 (raising concerns about the constitutionality of a proposed presumed consent measure because “[f]or Native Americans, Orthodox Jews and most Asian religions, disemboweling the body is a sacrilege”).

58. A few scholars have taken on the task to disentangle and pick apart the considerations that motivate, but also dissuade, organ donation. See, e.g., CAPLAN, *supra* note 19; FOX & SWAZEY, *supra* note 53; KIERAN HEALY, *LAST BEST GIFTS: ALTRUISM AND THE MARKET FOR HUMAN BLOOD AND ORGANS* (2006); STUART J. YOUNGNER ET AL., *ORGAN TRANSPLANTATION: MEANINGS AND REALITIES* (1996).

59. See, e.g., Moore v. Regents of Univ. of Cal., 793 P.2d 479, 485 (Cal. 1990) (discussed *supra* note 16, recognizing potential claim against physician for breaching fiduciary duties to his patient,

ists,⁶² pharmacologists,⁶³ the cosmetic industry,⁶⁴ and even artists.⁶⁵ As well, the information problems are considerable. Unlike the easily accessible organ data collected and distributed by the Organ Procurement Transplantation Network (OPTN), tissue acquisition and transplantation is far more elusive. For example, there is no central data source that provides information about the frequency or volume of human cadaver supply in cosmetics, dentistry, or pharmacology. Ironically, even the Food and Drug Administration (FDA) and the Department of Health and Human Services are deficient data sources on these issues, as these agencies do not collect empirical data on these issues.

Industries enter and exit tissue banking without good data sharing. Because of deaths associated with patients receiving infected tissues and general lack of oversight, the FDA has in the past few years taken some strides toward registering and visiting tissue banks—a process that was not in place in 2002 when a college student died from a routine knee operation. In that case, Bryan Lykins purchased a knee implant infected with clostridium, a bowel bacteria later traced to the cadaver from which it was extracted.⁶⁶ That seventy-year-old cadaver was purchased and processed by a tissue bank, although it had not been refrigerated for nearly twenty hours.

where physician fraudulently induced the patient to provide tissue, blood, and sperm samples under false pretenses); *Bauer v. N. Fulton Med. Ctr., Inc.*, 527 S.E.2d 240, 244 (Ga. Ct. App. 1999) (concluding that a widow could not maintain a claim for conversion based on the unauthorized removal of her husband's eye tissue).

60. See, e.g., *Cryolife, Inc. v. Super. Ct.*, 2 Cal. Rptr. 3d 396, 401 (Cal. Ct. App. 2003) (denying strict liability recovery for plaintiff who purchased contaminated body part from Cryolife tissue bank).

61. See, e.g., *Greenberg v. Miami Children's Hosp. Research Inst., Inc.*, 264 F. Supp. 2d 1064, 1072 (S.D. Fla. 2003) (denying relief for families whose donated cell lines and fluids to a researcher were later patented by the researcher and Miami Children's Hospital).

62. See, e.g., *The European Market for Dental Bone Graft Substitutes*, 12 *IMPLANT DENTISTRY* 3–5 (Mar. 2003).

63. See, e.g., Human Genome Project, *Pharmacogenomics: Medicine and the New Genetics*, http://www.ornl.gov/sci/techresources/Human_Genome/medicine/pharma.shtml (last visited June 3, 2009).

64. Human collagen is widely used in plastic surgery and for lip and reproductive organ enhancements. See Ian Cobain & Adam Luck, *Special Report: The Beauty Products From the Skin of Executed Chinese Prisoners: Cosmetics Firm Targets UK Market: Lack of Regulation Puts Users at Risk*, *THE GUARDIAN*, Sept. 13, 2005, at 3.

65. See Alexis Madrigal, *Bioartists Create Sculptures From Living Human Tissue*, *WIRED SCIENCE*, Dec. 13, 2007, <http://blog.wired.com/wiredscience/2007/12/bioartists-crea.html>. See also *Fusion: Art, Science and Technology*, *VELOCITY*, Sept. 2007, <http://velocity.ansto.gov.au/velocity/ans0019/article6.asp> (describing the embrace of human or “bio-art” in Australia, where young artists use viruses, tissues, blood, and other biological matter to create works of art).

66. See Robert Pear, *F.D.A. Delays Regulation of Tissue Transplants*, *N.Y. TIMES*, May 14, 2003, at A18; see also Amanda Gardner, *U.S. Strengthens Rules Governing Tissue, Organ Transplants*, *HEALTHDAY NEWS*, Nov. 19, 2004, <http://domains.e-healthsource.com/?p=news1&id=522463> (describing Brian Lykins's surgery as “routine”).

Demand for these tissues is not confined to patients. For example, biomedical researchers at universities, as well as pharmacologists in the private sector, need human tissues to study the effects of diseases in human beings and develop tests for genetic diseases and cancer. The BRCA1 gene (commonly referred to as the “breast cancer gene”) was discovered through the study of human tissues and genes.⁶⁷ Equally, patents have been derived from the study of human tissues. That nearly twenty percent of the human genome has been patented is a reflection of the demand for human tissues for medical and scientific research and in part exposes one sphere of the demand conundrum.⁶⁸

Allograft surgeries in the United States have surpassed the annual one million mark. The number of new surgeries is a three-fold increase in ten years.⁶⁹ Some of the demand can be directly attributed to advancements in technology that allow for reduced recovery periods and outpatient surgeries, as well as the availability and low cost of some reconstructive surgeries.

But the focus and interests that once defined the tissue banking industry has also shifted. Thirty years ago, the industry was focused primarily on serving burn victims. Now, plastic and other allograft surgeries, including reproductive resurfacing surgeries and even lip enhancements that use human tissue, generate greater profitability for tissue banks. In some instances, tissues for use in reconstructive surgeries for burn victims are less available than for plastic surgeries. This reflects allocation choice on the part of the tissue industry, but it does not bode well for burn units and other industries that treat individuals with life-threatening conditions. Tissues go where profit is to be made.

And not all human tissues will be allocated to the wealthy seeking plastic surgeries. Tissues are also harvested, processed, and sold for use in surgeries that will restore vision, revive arthritic joints, restore knees, and very likely promise to improve the quality of life of thousands of patients.

Yet, the gross number of tissue transplant surgeries obscures the complicated supply problem by masking the supply shortfalls with tissues obtained illegally. For example, consider a new computer store in your neighborhood with a large inventory of laptop computers packaged with the company logo. It would appear that a laptop is ready for your purchase anytime you wish to pay for it. There are certain assumptions and warranties that you—the consumer—will make simply by the packaging, perhaps, and the fact that you bought this product at a store rather than on a street

67. On the discovery of the BRCA1 gene, see generally Richard Li-dar Wang, *Biomedical Upstream Patenting and Scientific Research: The Case for Compulsory Licenses Bearing Reach-Through Royalties*, 10 YALE J.L. & TECH. 251, 295–97 (2008).

68. See, e.g., *id.*; see also Wash. Univ. v. Catalona, 490 F.3d 667 (8th Cir. 2007).

69. Schapiro, *supra* note 9, at G1.

corner. You might assume, for example, that the laptop was legally obtained and, for that matter, built with legally acquired parts. You might assume that the laptop will function properly, that you hold title to the computer, and that no one else holds a claim to it. But you would be mistaken if that logic were applied to human tissues.

Now imagine that most of the inventory is stolen or acquired through fraudulent means. Tissue banking is complicated. The National Organ Transplant Act (NOTA) prohibits the buying and selling of body parts, including human tissue.⁷⁰ Nevertheless, a robust industry has emerged, which passes off payments as processing fees and transportation costs (for moving the tissue from one place to another). NOTA makes clear that providing “consideration” for any body part is a felony, punishable by a fine of \$50,000 and/or five years incarceration.⁷¹ However, enforcement is lacking, thereby impliedly creating a default rule that organ buying and selling may be illegal but not punishable.

Section 301 of NOTA, entitled “Prohibition of organ purchases,” threatens imposing stiff penalties on anyone who “knowingly acquire[s], receive[s], or otherwise transfer[s] any human organ for valuable consideration for use in human transplantation if the transfer affects interstate commerce.”⁷² But here, enforcement is far more illusory than real.

So how are human tissues obtained? Hospitals,⁷³ organ procurement organizations,⁷⁴ medical schools,⁷⁵ funeral homes,⁷⁶ coroners,⁷⁷ and crema-

70. 42 U.S.C. § 274e (2006).

71. *Id.* § 274e(b).

72. *Id.* § 274e(a).

73. See Press Release, Senator Charles E. Schumer, In Wake Of National Body Part Transplant Scandal, Schumer To Unveil Critical Legislation To Regulate Tissue Transplants (Jan. 23, 2006), available at http://schumer.senate.gov/new_website/record.cfm?id=259357 (discussing New York Senator’s call for increased regulation of the tissue transplant industry); see also Jeff Sturgeon, *Possibly Stolen Body Parts Find Way to Carilion*, ROANOKE TIMES, Jan. 7, 2006, at A1 (investigating the possible link between stolen tissues and bones in New York and those purchased by Carilion). Reporter Jeff Sturgeon noted that there were safety concerns as well:

Carilion buys from one affected company, LifeCell Corp., a manufacturer of reconstructive, urogynecologic and orthopedic surgical products, and had received merchandise from a lot of goods deemed suspect because the lot was manufactured or might have been manufactured using raw material from Biomedical Tissue Services.

Id.

74. See Michelle Oberman, *When the Truth is Not Enough: Tissue Donation, Altruism, and the Market*, 55 DEPAUL L. REV. 903, 908–09 (2006) (describing how organ procurement organizations will often sell donated human tissue).

75. See Stuart Silverstein, *Figure in UCLA Cadaver Case Agrees to Plea Deal*, L.A. TIMES, July 11, 2007, at B5.

76. Feuer, *supra* note 1, at B6 (highlighting Mastromarino’s plea after an admission to conspiracy for stealing body parts from funeral homes); Paul Harris, *Raising the Dead*, THE OBSERVER, Apr. 2, 2006, at 20, available at <http://www.guardian.co.uk/world/2006/apr/02/usa.features>; Jeff Nesmith, *Funeral Home Thefts: Body Parts May Be Tainted: Patients Tested as ‘Ripple of Fear’ Reaches Atlanta*, ATLANTA J.-CONST., Apr. 23, 2006, at A1; see also Amended Complaint, Jackson v. Biomed. Tissue Servs., Ltd., No. 2:06-CV-01323 (D.N.J. Mar. 28, 2006) (plaintiff alleging that hepatitis was contracted through purloined body parts sold in the donor market); Kitty Caparella, *Co-Defendant Sparring Likely at Body-Parts Trial*, PHILA. DAILY NEWS, Oct. 25, 2007, at 11.

toriums⁷⁸ are all sources of human tissue trade. As mentioned earlier, the consent processes involved with these tissue donations are frequently illusive. Hospitals, for example, may condition treatment on a patient waiving her right to recover or destroy her tissue, including placentas.

What is to be done? The majority in *Moore v. Regents of the University of California*⁷⁹ assessed the problem in the following way: two decades ago, human tissues left behind at hospitals were simply incinerated; tissues and bones were considered waste. Now, the human body is the most profitable commodity per square inch, more profitable than nearly any other “property” in the United States. We should not be stuck on whether to commodify; market realities oblige our recognition that industries are beyond that consideration. If that is correct, the relevant questions address how much commodification we should tolerate, and how such markets might operate.

The temptation when assessing tissue supply and demand might be to leave it alone because it seems that patients’ needs are being met, albeit through a system that raises ethical and legal questions about the source of the products. Ironically, to fix the problem, by introducing more transparency and establishing equitable consent frameworks, might result in a crowding out effect or reduce the supply of human tissues.

II. DEFAULT CONSENT RULES AND PRESUMED CONSENT

In the past ten years, more than 70,000 people in the United States died while waiting for a suitable organ.⁸⁰ The organ shortage is extensively documented.⁸¹ It would seem that Americans are disinterested in participating in the current altruistically based procurement regime.

77. See Frammolino, *supra* note 8 (investigating over 570 cases of nonconsensual cornea harvesting during a twelve-month period and explaining that families “were shocked that they had not been asked or told”); see also Newman v. Sathyavaglswaran, 287 F.3d 786, 789–90 (9th Cir. 2002) (holding that the coroner’s removal of body parts from the decedents without prior consent and against the wishes of their family was a violation of fundamental human dignity and constitutional law); Brother-ton v. Cleveland, 923 F.2d 477, 482 (6th Cir. 1991) (referring to the presumed consent law in Ohio that allowed a coroner to conscript human tissue as “an egregious abuse of governmental power” (quoting Vinson v. Campbell County Fiscal Ct., 820 F.2d 194, 199 (6th Cir. 1987))).

78. Scott Farwell, Michael Fisher & Sandy Stokes, *Big Money in Body Parts: Relatives Are Devastated When They Find Remains Have Been Cut up For Sale*, PRESS-ENTERPRISE, Feb. 26, 2002, at A1 (describing how hundreds of Californians may have been effected by a crematorium carving up and selling their relatives’ body parts).

79. 793 P.2d 479, 491 (Cal. 1990) (discussed *supra* notes 16, 59).

80. New York Donor Network, Why Should You Be a Donor?, <http://www.donatelifeny.org/organ/why.html> (last visited June 3, 2009).

81. See, e.g., Richard A. Epstein, *The Human and Economic Dimensions of Altruism: The Case of Organ Transplantation*, 37 J. LEGAL STUD. 459 (2008); Michele Goodwin, *Altruism’s Limits: Law, Capacity, and Organ Commodification*, 56 RUTGERS L. REV. 305 (2004); Benjamin E. Hippen, *Organ Sales and Moral Travails: Lessons from the Living Kidney Vendor Program in Iran*, CATO INST. POL’Y ANALYSIS, Mar. 20, 2008, available at <http://www.cato.org/pubs/pas/pa-614.pdf>.

However, some scholars suggest that signals and assumptions about organ donation are being misread. They suggest that the discussion about organ donation can be enhanced by a constructive critique of preference approaches. Quite correctly, they argue that donation decisions are often “constructed in response to the question,”⁸² or framing.⁸³ Indeed, even altruistic procurement is the byproduct of organizational and institutional framing. Altruistic T&O procurement is “structured, promoted, and made logistically possible by organizations and institutions with a strong interest in producing it.”⁸⁴

Johnson and Goldstein, for example, argue that studies addressing *preference to become a donor* are not well developed.⁸⁵ In sum, their research suggests that with a change in default consent rules or how we frame consent opportunities, different results will emerge. Thus, by reducing the opportunities for a potential donor to be a passive bystander by mandating that individuals opt-in or -out, or simply by making the default rule that everyone will donate T&O, states will likely experience a surge in available T&O. Their proposal has certain upsides at a glance. First, their framing analysis is tied to presumed consent, which as discussed *infra*, is an “opt-out” measure that grants the state an opportunity to consent for its citizens who fail to “opt-in” or “opt-out.”

Second, scholars assume that presumed consent minimizes costs by requiring less investment than incentive approaches. Their argument is that presumptively taking T&O is more cost-effective than incentives and more efficient than standard explicit consent rules that necessitate “opting-in.” Third, some believe that social utility will be increased by providing greater access to organs. For these reasons, scholars have suggested that presumed consent “may be an attractive way of increasing social welfare.”⁸⁶

Yet, there are risks and externalities associated with presumed consent. Let us consider what presumed consent might mean domestically. Presumed consent acknowledges that the body has value as a source of transplantable goods. However, that value is gifted to the state absent failure to notify the state that the gift is revoked.⁸⁷ State legislatures have experimented with presumed consent default rules in the past.

82. Johnson & Goldstein, *supra* note 7, at 1713.

83. Kieran Healy, *Altruism as an Organizational Problem: The Case of Organ Procurement*, 69 AM. SOC. REV. 387, 387 (2004).

84. *Id.*

85. Johnson & Goldstein, *supra* note 7, at 1713; *see also* Linda C. Fentiman, *Organ Donation As National Service: A Proposed Federal Organ Donation Law*, 27 SUFFOLK U. L. REV. 1593, 1596 (1993).

86. Johnson & Goldstein, *supra* note 7, at 1713.

87. UNIF. ANATOMICAL GIFT ACT § 4(a)(3) (amended 1987), 8A U.L.A. 38 (2003).

Medical examiner laws were ratified in over two dozen states, and most were enacted during the mid-1980s, a time marked by gang violence and death in minority-majority urban communities.⁸⁸ Some eye bank officials, including those from California and Alabama, credit presumed consent laws with an increase in corneal tissues available for transplantation in their states.⁸⁹ Indeed, data from these states indicates that corneas available for transplantation increased, particularly as more tissues were available from victims of trauma and homicides.⁹⁰ In some instances, surpluses were created which allowed tissue banks to sell “left-over” tissues to medical research laboratories, sometimes at tremendous profit.⁹¹

First enacted in Maryland,⁹² presumed consent laws operate much like substituted judgment, whereby one’s choice to pursue or not to pursue a particular course of action with her body is usurped by the state.⁹³ Pursuant to statutory authority, medical examiners, coroners, and their desig-

88. See GOODWIN, *supra* note 20, at 120 & n.28.

89. Telephone Interview with Doyce Williams, Executive Dir. of the Ala. Eye Bank (Feb. 21, 2000) [hereinafter Williams Interview I]. Mr. Williams expressed his great support for presumed consent legislation and asserted that legislative consent had a very positive influence on the number of corneas that were made available for transplantation. *Id.*; see also Frammolino, *supra* note 8.

90. Telephone Interview with Doyce Williams, Executive Dir. of the Ala. Eye Bank (Feb. 23, 2000) [hereinafter Williams Interview II].

91. See Frammolino, *supra* note 8.

92. MD. CODE ANN., EST. & TRUSTS § 4-509.1 (LexisNexis 2001), which provides:

(a) *Requirements.* – In any case where there is a need for corneal tissue for a transplant or research, the Chief Medical Examiner, the deputy chief medical examiner, or an assistant medical examiner shall provide the cornea upon the request of the Medical Eye Bank of Maryland, Incorporated, or the Lions of District 22-C Eye Bank and Research Foundation, Incorporated, subject to the provisions of subsection (b) of this section, and under the following conditions:

- (1) The medical examiner has charge of a decedent who may provide a suitable cornea for the transplant or research;
- (2) An autopsy will be required;
- (3) No objection by the next of kin is known by the medical examiner;
- (4) No religious objection made by the decedent before death is known by the medical examiner; and
- (5) Removal of the cornea for transplant will not interfere with the subsequent course of an investigation or autopsy or alter the postmortem facial appearance.

(b) *Distribution of corneal tissue.* – Corneal tissue provided under subsection (a) of this section shall be distributed as follows:

- (1) If the decedent died in Prince George’s County, Montgomery County, Charles County, Calvert County, or St. Mary’s County, the corneal tissue shall be distributed to the Lions of District 22-C Eye Bank and Research Foundation, Incorporated; or
- (2) If the decedent died in any other county or in Baltimore City, the corneal tissue shall be distributed to the Medical Eye Bank of Maryland, Incorporated.

(c) *Liability of medical examiner, Medical Eye Bank of Maryland, etc.* – The Chief Medical Examiner, the deputy chief medical examiner, an assistant medical examiner, the Medical Eye Bank of Maryland, Incorporated, or the Lions of District 22-C Eye Bank and Research Foundation, Incorporated, are not liable for civil action if the next of kin subsequently contends that authorization of that kin was required.

93. See UNIF. ANATOMICAL GIFT ACT, *supra* note 87, § 4(a) (“The [coroner] [medical examiner] may release and permit the removal of a part from a body within that official’s custody.”) (alterations in original).

nated personnel are authorized to extract corneas, whole eyes, and other tissues from cadavers without first obtaining consent from the “donor” if the donor has not declined a donation.⁹⁴ Here it is important to remember that the “donor” is likely the living relative with legal authority over the deceased body.

The presumed or statutory consent laws usually incorporate an opt-out feature. The opt-out provision, however, can veil the fact that such laws are more like conscription measures and less like an option or “choice.” Where, after all, is one to “opt-out”? We know the dead cannot opt “out,” but what about their relatives? Studies show, and several lawsuits indicate, that relatives are often in the dark; they lack the requisite knowledge to opt-out. In the United States most people, even local legislators such as aldermen and city council members, are relatively ignorant about presumed consent laws (in their own states) and have no idea of what the term means or what the law authorizes. Given the shortage of T&O, it could be argued that biotech companies and coroners might find informing relatives about presumptive transplantation to be a disincentive as it would provide a vehicle for and an opportunity to “opt-out.”

Cornea extractions were most commonly performed under presumed consent rules. Perceived as less invasive, cornea harvesting is certainly less disfiguring and thus less noticeable. Cornea extraction does not leave signs easily noticeable to lay people; there are no bruises on the face and no scratches on the eyelids.⁹⁵ Thus, if the deceased is prepared for burial, particularly with closed eyelids, family would be completely unaware of the medical intrusion.⁹⁶ For this reason, critics of presumed consent policies regard these laws as surreptitious and unethical, while proponents argue that statutory consent measures are creative, welfare-maximizing efforts to procure corneas and can have a tremendous effect in the broader T&O procurement realm.⁹⁷ Proponents also argue that compulsory donations require so little—and families are minimally harmed if at all.⁹⁸

94. ARK. CODE ANN. § 12-12-320 (1987); CAL. GOV'T CODE § 27491.46-.47 (West 2003); COLO. REV. STAT. § 30-10-621 (1986); CONN. GEN. STAT. ANN. § 19a-281 (West 1986); DEL. CODE ANN. tit. 29, § 4712 (2002 & Supp. 2008); FLA. STAT. ANN. § 732.5185 (West 2005 & Supp. 2009); HAW. REV. STAT. ANN. § 327-4 (LexisNexis 2008 & Supp. 2008); IDAHO CODE ANN. § 39-3405 (2002 & Supp. 2008); 755 ILL. COMP. STAT. ANN. 50/5-30 (West 2007 & Supp. 2008); KY. REV. STAT. ANN. § 311.187 (LexisNexis 2001); LA. REV. STAT. ANN. § 17:2354.1-3, 33:1565 (2001, 2002); MD. CODE ANN. EST. & TRUSTS § 4-509.1 (LexisNexis 2001); MICH. COMP. LAWS ANN. § 333.10202 (West 2001); MO. ANN. STAT. § 58.770 (West 2007); MONT. CODE ANN. § 72-17-215 (2008); OHIO REV. CODE ANN. § 2108.60 (West 2005); OKLA. STAT. ANN. tit. 63, § 944.1 (West 2004); UTAH CODE ANN. § 26-4-23 (2007).

95. See, e.g., Frammolino, *supra* note 8, at A1; S. Gregory Boyd, *Comment: Considering a Market in Human Organs*, 4 N.C. J.L. & TECH. 417 (2003).

96. See, e.g., Boyd, *supra* note 95, at 417; Frammolino, *supra* note 8, at A1.

97. Marie-Andrée Jacob, *On Silencing and Slicing: Presumed Consent to Post-Mortem Organ “Donation” in Diversified Societies*, 11 TULSA J. COMP. & INT'L L. 239, 254-55 (2003) (describing the criticism that presumed consent is unethical); Maryellen Liddy, Note, *The “New Body Snatchers”:* *Analyzing the Effect of Presumed Consent Organ Donation Laws on Privacy, Autonomy, and Liberty*,

The legislation authorizing this type of body part conscription currently operates pursuant to mandatory autopsy rules. Thus, the only bodies to which presumed consent applies are victims of homicide or catastrophic deaths requiring a medical investigation.

Disproportionately in some states, blacks and Latinos were the overwhelming majority of the presumed consent donors.⁹⁹ In California, prior to the legislature repealing the legislation, well over 80% of presumed consent donors were black and Latino.¹⁰⁰ In effect, the state presumes that a potential donor would in fact have wanted to donate were she still alive and able to make the choice. This Essay does not suggest that legislatures withhold information about state regulations that authorize presumed consent from the public. On the other hand, neither tissue banks, which process and sell the tissues at considerable profit, nor state governments advertise the existence of such laws. It is not surprising then that tissue banks generate considerable revenue from processing, storing, and selling cadaver tissues. The tissue banking industry, which derives its “stocks” of tissues through the most vague and clandestine means, is estimated to be worth billions.

The compulsory aspect of the regulations makes these donations problematic. Forced use of non-consenting individuals’ tissues is justifiable only if the donation is viewed as a form of civic duty or our bodies are property of the state. Donation as a civic duty is a laudable concept, though not supported by social custom or an American legal tradition. Our common law tradition rejects rescue doctrine, and more pointedly warns “rescue at your own risk.”

That our bodies belong in service to the state cannot be justified by the ways in which we organize labor, medicine, or reproduction. Consider that alongside our T&O shortage is the growing demand by infertile couples to obtain reproductive resources such as sperm, ova, wombs for rent, and adoptive embryos. Intuitively, if one were to think of T&O as state property that can be conscripted for the public good, it would be hard to say what is wrong with other possible forced enterprises, including compulsory reproduction, surrendering ova and sperm, relinquishing cryo-preserved embryos, and forced donation of extra cars, homes, books, computers, shoes, and clothes.

In these instances, the default rule might look like the following: *if an individual has more than three cars or homes, one must be surrendered for women and families transitioning from state welfare. Or, the state will*

28 FORDHAM URB. L.J. 815, 819 (2001) (describing that many supporters believe presumed consent will increase the supply of organs available for transplant).

98. See Fentiman, *supra* note 85, at 1596.

99. See GOODWIN, *supra* note 20, at 120 n.28.

100. See, e.g., Frammolino, *supra* note 8, at A1; see also GOODWIN, *supra* note 20, at 121 & n.30.

consider all embryos cryo-preserved for more than two years to be abandoned and eligible for adoption. Making the defaults easier to “opt-in” or “opt-out” somehow does not adjust or recalibrate the imbalance in power between the state and individual. Nor does it make that imbalance any less relevant or real. We have strong intuitions about the physical trappings we acquire, and it would seem that we have an even stronger intuition about why our bodies, with very narrow exception (vaccinations), cannot be compelled into service for the state.¹⁰¹

What also bothers some scholars about presumed consent laws is the arbitrary line that distinguishes who becomes a conscripted donor and who does not. Why require only those dead from homicide or catastrophic means to surrender T&O? Racial and class impacts will surely emerge, as they have in the past, through this means of T&O procurement. There are other pitfalls to skirt. Organs are far more viable from living rather than deceased donors. Presumed consent will not necessarily maximize health outcomes, even while imposing significant liberty costs.

Imagine requiring every newborn to surrender one kidney at birth. Only one kidney is needed for a full and healthy life. The burdens of this type of operation are arguably outweighed by the benefits to others, no? Harvests could be done at the time of vaccination. Doctors could monitor the healing process. Parents would be more informed participants. Relatives, in town for the birth, could provide support and comfort the mother and baby. For the baby, the scars would heal seamlessly and more importantly a life would be saved or extended, at least, for ten to fifteen years. Every child in America would be part of a plan to “gift” life to another. This would surely cure the organ shortage. But alas, Americans are not so generous; nor as a nation would we be eager to embrace this type of default rule, and for good reason.

III. INCENTIVES

How might we rethink incentives for T&O? To be clear, the goal of this Essay is not to discourage voluntary altruistic donations. Thus, a hybrid, where the two systems are able to coexist and flourish is important. Several incentive models have been introduced in the literature.¹⁰² In the past, scholars advocated an incentive approach that was triggered at

101. The case law is very compelling on this topic. *See, e.g., Newman v. Sathyavaglswaran*, 287 F.3d 786 (9th Cir. 2002); *Brotherton v. Cleveland*, 923 F.2d 477 (6th Cir. 1991). *But see* *Ga. Lions Eye Bank, Inc. v. Lavant*, 335 S.E.2d 127 (Ga. 1985); *see also* *Rivers v. Greenwood Cemetery, Inc.*, 22 S.E.2d 134, 135 (Ga. 1942) (holding “that a dead body is quasi property over which the relatives of the deceased have rights which the courts will protect”).

102. *See* Epstein, *supra* note 20, at 52–54 (1993); Gary S. Becker, *How Uncle Sam Could Ease the Organ Shortage*, *BUS. WEEK*, Jan. 20, 1997, at 18.

death.¹⁰³ The motivation there was to avoid some of the obstacles associated with payments for organs. Equally, prior proposals sought to deflect some of the criticisms that predicted abuse, objectification, coercion, and commodification of the poor in organ payment proposals.

Part III turns to incentives and considers what values must be present in a procurement system that encourages and/or promotes the use of incentives for T&O. It is also important to acknowledge that T&O might require different incentive approaches. Some approaches might warrant robust state interference or involvement and others would depend on limited state intervention.

A. *Tissues*

For example, it seems reasonable (for health and safety reasons) and necessary (to minimize the potential for corruption and coercion) to create prohibitions against doctors and researchers harvesting tissue and bones from living persons, with mild exceptions. Equally, the State should guard against “ethical ecstasy”—living persons attempting such donations—which could lead to severe externalities and public health concerns. That is to say, the State should guard against living persons donating tissues and organs that would directly result in the termination of their lives or severely compromise their quality of life.

Consider the following: while a person might express considerable desire to extract her corneas (while alive), such an action would produce undesired externalities for the State, individuals, and third parties. Voluntarily inducing blindness to enable sight to another would be chief among these concerns. Equally, the State should guard against individuals donating hearts, both kidneys, or both lungs (while alive). Again, for public policy reasons, we would want to deny those types of donations as they would amount to the State’s complicity in killing healthy persons to increase the quality of life for the sick. To be clear, these situations—involving otherwise healthy adults—are philosophically, medically, and ethically different than cases involving physician-assisted suicide and should be recognized as such.

Here, I am less concerned about exactly how much payment goes to an individual or estate for contributions into the T&O supply pools. Rather, as discussed, such issues can be negotiated by states, citizens, and local community groups to craft sustainable, meaningful models at the local level.

103. See, e.g., DAVID L. KASERMAN & A.H. BARNETT, *THE U.S. ORGAN PROCUREMENT SYSTEM: A PRESCRIPTION FOR REFORM* 50 (2002); Lloyd R. Cohen, *Increasing the Supply of Transplant Organs: The Virtues of a Futures Market*, 58 GEO. WASH. L. REV 1 (1989); Epstein, *supra* note 20; Becker, *supra* note 102, at 18.

It would be easy to imagine that compensation for tissues might be less than payments for organs. Equally, payment guidelines or schedules could be developed based on current cost indicators, which are available for organ and tissue donation. For example, some biotech companies claim that one human body can generate \$250,000 in profits for their firms. Thus, it would seem that somewhere between \$1,000 (the black market value of human tissues and bones at the funeral home level) and \$250,000, a market equilibrium could be struck.

B. Organs

So, how might this work? Gary Becker and Julio Jorge Elías provide an elegant treatment of the issue in a recent article, *Introducing Incentives in the Market for Live and Cadaveric Organ Donations*, which is worthy of borrowing here.¹⁰⁴ Keeping in mind that harvesting an organ for transplantation may affect an individual's "risk of mortality and his ability to perform market and non-market activities for some period of time after the surgery," Becker and Elías assume three components are essential to assess how much an organ is worth.¹⁰⁵ They consider the monetary compensation of the risk of a reduced quality of life, monetary compensation for the risk of health, and monetary compensation for the risk of death. Under their model, the market equilibrium price for kidneys will be determined by live donations. They estimate that under this model, compensation to the "average" donor will be \$15,200.¹⁰⁶

The Becker model would be *pareto superior* were a market to be legalized. *Pareto superior* requires that in market transactions for limited social goods, at least one person is made better off and that no one be made worse off.¹⁰⁷ The application of this principle fits neatly within the goals of this proposal—to promote social justice and the efficient procurement and distribution of organs. Individuals would be compensated for providing live donations for organs, but not tissues and bones.

Instead, this model would permit individuals to negotiate prior to death for T&O transfers upon death. Family members, the decedent's estate, or charitable organizations could be compensated for the tissues. As for organs, recent studies by Dr. Arthur Matas and others provide compelling data that the best organ transfers for recipient health come from living donors. The focus of public policy must be how best to frame incentive

104. Gary S. Becker & Julio Jorge Elías, *Introducing Incentives in the Market for Live and Cadaveric Organ Donations*, 21 J. ECON. PERSP. 3 (2007).

105. *Id.* at 9.

106. *Id.* at 11.

107. See Adam J. Kolber, *A Matter of Priority: Transplanting Organs Preferentially to Registered Donors*, 55 RUTGERS L. REV. 671, 706 (2003).

models for living donations while preserving autonomy; weeding out fraud, corruption, and coercion; and promoting good health.

Finally, oversight and information-sharing must be an essential component of a viable market model. The FDA performs a vital role in monitoring the health and safety of biological, pharmaceutical, and medical devices introduced to the market. However, that agency's demonstrated weaknesses and past reputation for political capture might indicate the need to look beyond the FDA as the ideal agency to respond or give oversight to these issues.

A better model will emerge from the development of special state offices to address organ and tissue oversight with a federal arm contracting to gather and disseminate information on T&O procurement and donation. This model would be a departure from the current system, which is replete with gaps and holes.

C. Class and Corruption

Some scholars perceive organ markets to necessarily exclude the poor. In this they are mistaken. For example, the cost of kidney dialysis averages \$66,000 per year, per individual.¹⁰⁸ This figure represents only the financial costs, as the quality of life and independence of dialysis patients are severely compromised.¹⁰⁹ The costs never recede. Over the course of seven years, an average life span of a patient on dialysis, the costs are at least \$450,000 per patient. For the economically indigent, these costs are absorbed by the state and federal governments. Compare those costs with the payment to a kidney provider at ten or fifteen thousand dollars. The estimated cost of a kidney transplant is \$90,000 and drug therapies to avoid rejection will cost nearly \$16,000.¹¹⁰ Financially, it becomes clear; providing incentives for organ donation costs far less than dialysis—the expensive, slow death alternative.¹¹¹

Let us place organ dynamics and demand in perspective. The National Kidney Foundation reports that there are 485,000 people in the United States with end-stage renal disease (ESRD). Nearly 350,000 of these

108. Michael J. Lysaght, *Maintenance Dialysis Population Dynamics: Current Trends and Long-Term Implications*, 13 J. AM. SOC'Y NEPHROLOGY S37, S38 (2002), available at http://jasn.asnjournals.org/cgi/reprint/13/suppl_1/S37.

109. See *id.* at S39 (describing patients' dislike for dialysis treatments, but noting that "[a]lmost everything that is likely to improve dialysis therapy and patient quality of life would also significantly increase its costs: longer, slower therapy, more pleasant and commodious treatment facilities, better trained and less peripatetic staff, referral to highly qualified surgeons for access placement, quits to the tawdry practice of hemodialyzer reuse, more face time with doctors, and so forth").

110. News Release, Univ. of Me. Med. Ctr., The "Break Even" Cost of Kidney Transplants is Shrinking (May 1999), available at <http://www.umm.edu/news/releases/kidcost.htm>.

111. Jack M. Kress, *Xenotransplantation: Ethics and Economics*, 53 FOOD & DRUG L.J. 353, 364 (1998) ("Kidney transplantation is thus far more cost-effective than long-term dialysis for patients with renal failure.").

people are on dialysis and over 85,000 will die from ESRD. Clearly, the demand for organs exceeds the number of those persons who currently wait on the transplant lists. Rationing helps to explain why only 100,000 are on the United States transplant waitlist rather than one-half million. Most sobering are the economic figures: nearly twenty-five percent of Medicare's budget is spent on ESRD and dialysis.

Who pays? Federal dollars and insurance currently take up the costs for organ transplants as well as dialysis. For this reason, benefits would accrue if the federal government moved individuals off of dialysis and transplanted them. By most studies, in two years, even with paying for the organ, the government would recoup costs and in year three begin to save millions of dollars.

D. Are We Better Off With Incentives?

Some scholars believe that *pareto superior* transactions are misleading. Accordingly, they suggest, it is impossible for one person's position to be enhanced without somehow making the other worse off (i.e., *pareto inferiority*). In this way, both sellers and purchasers are characterized as "worse off" because both parties have demeaned their personhood and degraded themselves in the process, like purchasing sex from a prostitute or selling part of one's mother.

But consider, altruism and markets coexist in the reproductive realms of ova donation and selling, as well as adoption through both state-facilitated foster care to adoption processes and private adoptions that involve lawyers, brokers, and agencies. In these scenarios as well as my proposal, altruism competes minimally with markets. Indeed, my proposal only expands the realm of permissible coexisting spheres of markets and altruism, which already consist of other essential, though non-biological "goods" and services, including food, clothing, health care, and medical insurance.

Beyond increasing the supply of organs, incentives for organ sharing will likely benefit society in several meaningful ways. First, there is an incentive to avoid buying organs on the black market. Black market organ shopping has the advantage of a reduced wait time but exposes the purchasers and sellers to numerous health and social risks. In black markets, the risks are high. Too many variables remain irresolvable; the sellers' health histories cannot be confirmed, unfavorable past social conduct (that can impact the quality of an organ) is unlikely to be disclosed, and there is no medical follow-up. Nor can the purchaser be sure that the seller is a voluntary participant in the transplant transaction. For black market sellers, the future is equally bleak. Because of their complicity in an illegal act—selling an organ—there is a disincentive to report any abuses expe-

rienced in the process. After the transaction, follow-up care is unlikely to be available.

Second, a more reliable system emerges with the use of incentives. Currently, the altruistic procurement system is mired by delays, deaths, unpredictability, and unreliability. By introducing a market-based system to coexist with altruistic donation, greater reliability is introduced to the larger complex of organ procurement and distribution. Greater reliability is likely to inspire greater confidence, trust, and respect for the organ procurement system.

Third, incentives will likely promote better health outcomes for potential sharers and recipients. Those interested in receiving a payment for sharing T&O will have an incentive to stay healthy during their lives so that their organs will be “picked” for transplantation. Likewise, because their organs have a real value, there is an incentive in maintaining their health. The benefits of healthier living are well-documented in scientific and medical literature. Beyond reducing medical costs, healthier eating and living increases life span, vitality, and productivity. Healthier people are less likely to become obese and suffer the secondary stresses of diabetes, hypertension, high blood pressure, chronic fatigue, alcoholism, and drug abuse. The benefits here inure not simply to the individual, but extend also to families’ and sharers’ communities.

Fourth, economically disadvantaged individuals might receive better screening for illnesses. Currently, participants in reproductive markets incorporate medical care, psychological evaluations, and sometimes therapy into their negotiation processes. Medical screening and support has evolved into a standard benefit associated with the adoption and surrogacy processes. Similarly, in the context of organ selling, medical screenings to determine the health and vitality of the sellers will likely be a health benefit to participants and not simply a moment of objectification.

Here, I have described how society might benefit from utilizing benefits to procure T&O. Yet to describe only the benefits disserves my interests as well as the attempt here to expand the dialogue about the incentives and pitfalls in creating a sustainable system to increase the odds of survival for patients dying from illnesses that are treated by organ transplantation.

Scholars warn that using incentives to drive T&O procurement will lead to crowding out and serious externalities. They caution that incentives may motivate some to donate but will drive others away from donating. In other words, those who would otherwise provide gratuitous tissue and organ donations might find incentives repugnant and therefore refuse or withhold their donations. Such concerns deserve serious attention. After all, they could be right; altruistic donors might possibly be driven away from human donation if incentives are introduced. And yet, they could be

wrong. To better test their assumption, we need better data and to pilot incentive programs.

The best way to approach thinking about this policy issue is to examine what is lost and what is gained under an incentive system and whether the gains will outweigh the losses. To the extent that what scholars indicate is a loss of personhood or human dignity, we should acknowledge the difficulty in quantifying that possible result. We would, however, be able to balance the perception of lost dignity against the restoration of health and the restoration of families made whole again through T&O transplantation. Organ and tissue transplantations produce third-party benefits, including restoring family relationships, allowing parents to re-engage in their children's lives, returning dialysis patients to the workforce, and bringing people who were once sick back in full health to their communities. If the concerns were reframed we might wonder whether incentive-based donations might create equilibrium between demand and supply. Thus, even if a few less altruists entered the supply pool, if more organ "sharers" willing to receive compensation emerged, then the loss of altruists might be absorbed with fewer transactional costs than imagined.

By relying exclusively on altruistic procurement, we avoid questions of property and ownership in the human body that obviously dominate discussions about markets. To this end, altruism has been the less-controversial approach to organ procurement. Introducing alternatives requires making tough choices and considering socially unattractive possibilities, including labels associated with the human body that were otherwise reserved for inanimate commercial goods. Change brings about discomfort; it challenges social, political, and economic order. Yet change is exactly what the present procurement regime deserves. Failure to effectively assess the organ procurement system's dysfunctions will only exacerbate a staggering death toll and siphon public support.

IV. CONCLUSION AND A FEW PRAGMATIC CONSIDERATIONS

This Essay, molded from my lecture at the University of Alabama as part of the Meador Lecture Series on Empire, concludes on two thoughts. The first reflects my ruminations on the series theme: empire. The second responds to the first and considers ways to move beyond empire.

I would like to suggest that the federal government operates in many ways like an "empire" with regard to T&O. In the lecture, I suggested that there are several characteristics (power, influence, monopolistic hold, veiling, a lack of accountability—or the need to be accountable—and imperviousness to human suffering and the law) that help us to determine whether an entity acts as, or could be considered as, an empire. The signs of empire are surely present within this context, although each may not

map entirely onto the federal government's position on organ transplantation.

Currently, the federal government asserts a monopolist hold on organ transplantation. State legislatures are severely limited in the ability to chart new paths, create alternative models, or pilot low-risk, benefit-oriented programs such as funeral or medical cost reimbursements or payments. This monopolistic hold derives from an unyielding power hoarded over organ transplantation. And perhaps such power and monopolistic control might avoid pushback if thousands of patients on transplant waitlists did not die each year. Rising rates of death, racial disparities, extended waits, and binding state legislatures are the well-documented consequences of the federal response to organ transplantation. It would hardly seem that such a system is fully accountable.

The debate about organ procurement style and method is only partially captured by the contest between incentives, presumed consent, and altruism. The more significant question is one about states' rights. In an elegant discussion of institutional balance and choice, Neil Komesar thoughtfully reminds us that laws and institutions have their limits.¹¹² Capacity problems relating to efficiency, effectiveness, and equitable participation arise when governments become wedded to particular institutions or approaches. Change becomes difficult not as a procedural matter but because of a false affinity to traditional—even if failed—approaches.

The objective then, at both the state and federal levels, should be moving away from empire and monopolistic control by testing pilot programs through a waiver program that keeps the NOTA intact, while granting states an exemption and authority to respond internally and/or regionally to organ procurement and allocation. These programs could be independently funded by states or contributions from Medicaid, Medicare, or the National Institute of Health.

For nearly two decades, from 1968 to 1984, the Uniform Anatomical Gift Act was the only law governing organ transplantation in the United States. It was enacted in all fifty states and the District of Columbia.¹¹³ Federal intervention occurred as a hasty response to the entrepreneurial efforts of a rogue, unlicensed doctor, H. Barry Jacobs, whose proposal to broker organs from men and women in the Caribbean incited racial animosity, provoked religious groups, and placed a spotlight on transplantation. Jacobs proposed receiving a fee for every organ harvested under his plan.¹¹⁴

In the period since the passage of the NOTA in 1984, one question prompts significant debate. What powers do local governments retain to

112. NEIL KOMESAR, *LAW'S LIMITS* (2001).

113. Uniform Anatomical Gift Act, *supra* note 87, prefatory note.

114. See Calandrillo, *supra* note 24, at 79–80.

craft organ transplantation policies that respond to local dynamics and needs? NOTA did not resolve this question, except in the negative. That is to say, it made clear that certain authority was removed from states and citizens. Specifically, it curtailed any possibility that incentives or “valuable consideration” (an ambiguous term, which broadly included anything thought to generate financial and even *emotional* value) could legally be implemented in local organ transplant policies.

NOTA proponents claimed that the law left open many possibilities for states. But their assessment is misleading. After 1984, states wishing to enact any programs that would compensate organ donors for expenses resulting from organ transplantation, recovery, and lost wages risk violation of federal law. All forms of financial exchanges, including reimbursement or attention to small, but nevertheless important priorities, including utility payments, car payments, phone bills, food for the donor’s family, rent, or mortgages were deemed illegal under NOTA.¹¹⁵

What have we learned from twenty-five years of federal organ transplant policy? To be sure, we know that altruism alone will not resolve the demand for organs. The statistics bear that out. Neither the consequences nor the prescription require translation: to be sure, without an increased supply, thousands of Americans will die each year.

115. See 42 U.S.C. § 274e(c)(2) (2006).