1987

Some Moral Connections Between Organ Procurement and Organ Distribution

James F. Childress

Follow this and additional works at: http://scholarship.law.edu/jchlp

Recommended Citation
Available at: http://scholarship.law.edu/jchlp/vol3/iss1/10
SOME MORAL CONNECTIONS BETWEEN ORGAN PROCUREMENT AND ORGAN DISTRIBUTION

James F. Childress*

Because of major developments in recent years — particularly in immunosuppressive therapies — organ transplantation has entered a new era. That new era has been marked by increased expectations about the quantity and quality of life after organ transplantation, and those expectations have fueled a dramatic increase in the number of transplants, particularly of hearts and livers. In 1980, there were thirty-six heart and fifteen liver transplants; by 1984 there were 346 heart and 308 liver transplants, and these numbers doubled again in 1985. Kidney transplants increased from 4,697 in 1980 to 6,968 in 1984 and then to 7,695 in 1985.¹

This new era continues to be marked by scarcity — scarcity of organs and scarcity of funds for transplantation. Several policies have been proposed and developed to increase the supply of organs, to distribute organs fairly and equitably, and to provide funds for patients in need of transplants. Actions have occurred on several levels. The National Organ Transplant Act,² which was signed into law in October, 1984, addressed several areas, including the prohibition of the sale of organs. In addition, it established a Task

---

¹ These statistics were developed by the Office of Organ Transplantation from several sources. See OFFICE OF ORGAN TRANSPLANTATION, ORGAN TRANSPLANTATION BACKGROUND INFORMATION (Feb. 1985). The figures for 1985 were obtained from a telephone conversation with the Office of Organ Transplantation, 5600 Fishers Lane, Rockville, MD 20857 (Jan. 1986).

Force on Organ Transplantation to conduct a comprehensive review of medical, legal, ethical, social and economic issues in transplantation. The Public Health Service ("PHS") of the Department of Health and Human Services ("HHS") established an Office of Organ Transplantation. And HHS has announced funding of some heart and liver transplants. Public Law 99-509,\(^3\) approved by Congress and signed by President Reagan in October 1986, authorizes coverage of immunosuppressive medications for outpatients for one year after the transplant and supports hospital policies of routine inquiry. In addition to federal action, several states have conducted major studies of organ transplantation,\(^4\) and by October 1986 at least twenty-five states had mandated policies of routine inquiry in hospitals.\(^5\)

This article examines some moral connections between policies of organ procurement and policies of organ distribution. There are important moral connections between these policies, largely because parts of human beings are transferred from a cadaver to a patient in need.\(^6\) This feature, perhaps more than any other, has given organ transplantation its prominence in the media and in the moral imagination, often out of proportion to its overall importance in health care.

In reflecting on these policies, this article considers ethical acceptability, ethical preferability and political feasibility. There is, I believe, a wide range of ethically acceptable policies, at least in principle; which policies should have priority will depend on considerations of ethical preferability and political feasibility. Excluding policies that would seriously violate fundamental ethical principles, society still has to choose policies that best express the whole constellation of ethical principles, including ideals, and that can actually be implemented.

Several ethical principles are relevant to these choices.\(^7\) They are supported by various ethical theories, whether religious or secular, and they are embedded in many of our practices and policies in organ transplantation, as well as other areas of health care. However, agreement about the relevance

---

4. See, e.g., REPORT OF THE MASSACHUSETTS TASK FORCE ON ORGAN TRANSPLANTATION (Oct. 1984) [hereinafter REPORT].
5. AMERICAN COUNCIL ON TRANSPLANTATION, TRANSPLANT ACTION (1986).
7. For an explication and defense of these principles, see T.L. BEAUCHAMP & J.F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS (2d ed. 1983).
and importance of these ethical principles will not resolve all disputes. In addition to disputes about their grounds and foundations, that is, why these principles should be affirmed, there are major disputes about their implications for particular policies, especially when they appear to come into conflict. These ethical principles include, first, respect for persons, including both their autonomous wishes and their bodies. As will be seen, there may be debates about whether the wishes of the decedent or of the family should have priority in cases of conflict. Another principle is benefitting patients (beneficence), while another is not harming them (nonmaleficence). Because it may be impossible to produce only benefits and avoid all harms, a principle of utility or proportionality is necessary; it requires that we produce a net balance of good effects over bad effects, including harms, burdens, and costs. However, the mere balance of good and bad effects is not sufficient, for a fair distribution of benefits and harms, burdens, and costs is required by the principle of justice. Other ethical considerations, which may derive from these principles, are also relevant, including truthfulness, fidelity, privacy and confidentiality. These principles both point directions for policies and set limits on those policies. For example, in view of the great need for organs to save and improve the quality of life, it may be tempting to evaluate actual and proposed policies of organ procurement only according to their effectiveness and efficiency in obtaining organs. But such an evaluation would be shortsighted; even though effectiveness and efficiency, as expressions of beneficence and utility, are important, they are not sufficient. Failure to express these other principles, including respect for persons, would be ethically unacceptable, and it would probably also be counterproductive in the long-run. The moral connections between procurement and distribution emerge from the special features of organ transplantation in the context of these several ethical principles.

Policies of Organ Procurement

Approximately 20,000 people die each year under circumstances where their organs could be salvaged to benefit others.8 The gap between the number of salvageable organs and the number actually salvaged is much greater than the number of kidney transplants might suggest. There were 7,695 kidney transplants in 1985, but 1,876 of those kidneys were donated by living donors, and most cadavers provide two kidneys. Thus, it is necessary to subtract the number of living donors from the total figure and then divide the remainder by two. When allowance is made for the wastage of organs

(perhaps twenty percent in 1985 for an estimate of 1,000) and for the 200-250 kidneys shipped abroad, it is reasonable to suppose that there were approximately 3,500 donations of cadaver kidneys in 1985. The active waiting list for kidney transplants is estimated to be 9,000-10,000, and it is likely that many more of the approximately 75,000 patients on kidney dialysis would be good candidates for, and would like to have a kidney transplant if more kidneys were available.

The legal framework for organ procurement in all fifty states and the District of Columbia is provided by the Uniform Anatomical Gift Act ("UAGA"), which was rapidly adopted with some modifications in the late 1960's and early 1970's. Within this legal framework, individuals may determine what will be done with their organs after their deaths, or, in the absence of a valid expression of the decedent's wishes, the family may decide what to do with the organs. In order to eliminate confusion about the disposition of bodily parts, the UAGA clearly established the decedent's wishes as determinative while recognizing a role for familial wishes when the decedent's wishes were not known or validly expressed. Indeed, some ethicists thought that there was a close moral call between the UAGA and presumed consent, which had also been proposed, precisely because the UAGA's emphasis on the individual's autonomy threatened the tradition of the family's "quasi-property" right in the corpse.

The "donor card," available in many states with the driver's license, was envisioned as the main mechanism for the individual to express his wishes. However, in practice, the decedent's signed donor card plays only a modest role in organ donation and procurement, and the family of the decedent plays the major role. Few people sign donor cards; such cards are rarely available when the decision must be made, and procurement teams generally will not remove an organ without the family's consent even when there is a signed donor card. In practice then the family is the major source of authorization for the removal of organs. Furthermore, the term "donor" is ambiguous because it may refer to (a) the source of the decision to donate, or to (b) the source of the organs, even if the decedent has not expressed his or her wishes.

12. Task Force on Organ Transplantation, supra note 6, at 29.
There are sound arguments for ensuring that the individual's valid donation is implemented, regardless of the family's wishes. The principle of respect for persons, or autonomy, backed by the UAGA, supports the view that persons have the right to dispose of their bodies after their deaths and that this right is not subject to family veto. Since the UAGA grants agents who act in good faith immunity from liability for damages in any civil action and from prosecution in any criminal proceeding, procurement teams appear to have unreasonable worries about threats of legal action. Nevertheless, because they depend on the good will of the community, procurement teams have several reasons for not acting against the family's wishes even when there is a signed donor card. These reasons include not offending the family and not jeopardizing the community's good will, which is essential for organ donations over time. Because of the principle of respect for persons, state statutes should be modified to provide sanctions against procurement teams that deliberately fail to implement the decedent's wishes when his organs are potentially useful. Even though such a modification would ensure respect for the decedent's wishes in cases where family members are opposed to donation, it would make little difference in the number of organ donations because few people actually sign donor cards, and, where there is a signed donor card, the family will usually act on the decedent's expressed wishes.

Educational policies have been largely directed at individuals as potential signers of donor cards. A Gallup poll taken in 1968, just a few weeks after the first heart transplant, provided a basis for the belief that donor cards would be effective: seventy percent of those polled indicated that they would be willing to donate their organs for transplantation. However, in 1985 only forty-five percent indicated that they were very or somewhat likely to donate their organs. There are several reasons for the reluctance to donate one's own organs where such donation requires signing a donor card. The main objection is to putting oneself on record as a potential source of organs. While respondents gave such reasons as a dislike of "thinking about dying" and a dislike of "the idea of somebody cutting me up after I die," they most frequently listed two reasons as "very important": "They might do something to me before I am really dead" (twenty-three percent); and "I'm afraid the doctors might hasten my death if they needed my organs" (twenty-one percent). These reasons reflect the public's distrust of medical institutions and professionals. Furthermore, the willingness to donate organs is even

lower among Blacks and other groups who view themselves on the margins of society and who are even more likely to view its institutions and professionals as un trustworthy. Several factors could be identified as probable causes of this distrust, including the same factors that have contributed to the increasingly adversarial relations between patients and physicians during the 1970’s, as reflected in the tremendous rise in malpractice suits. Because it stems in part from such broader socio-cultural factors, this attitude of distrust may not be very amenable to educational efforts.

Perhaps “brain death” is one area where educational efforts could make a major difference. Yet caution is even required at this point. Long ago Paul Ramsey argued that it is important, as most recognized, to have a practical separation between the determination of brain death and determination of the need for organs by differentiating roles: the physician involved in the transplant should not determine whether the potential source of the organs is dead. However, in contrast to many others, Ramsey also insisted on a differentiation at the intellectual level between updating the criteria for determining death and the need for organs for transplantation. He held that the criteria for determining death should be updated as a part of the care of dying patients, not as a way to increase the supply of organs, which proponents of brain death tended to emphasize. It is important to avoid two concepts of death, one for potential sources of organs and the other for everyone else. Even though the concept of death and the criteria for determining death involve such fundamental socio-cultural perspectives, efforts to educate the public — and professionals — about brain death may reduce distrust.

Another possibility is to change the aim of educational programs to increase organ donations. Such programs have usually been directed at individuals as potential signers of donor cards. However, in view of individuals’ reluctance to put themselves on record as organ donors, based largely on distrust, it would probably be more effective to target individuals as members of family units involved in the process of organ donation. Thus, society should encourage individuals to discuss their wishes with their family members and to donate the organs of a dead or dying relative. Again, the 1985 poll suggests the plausibility of such an approach. In contrast to the forty-

17. P. RAMSEY, supra note 11.
five percent who said that they were very or somewhat likely to donate their own organs, eighty-five percent indicated that they were very or somewhat likely to donate the organs of a relative, and sixty-five percent indicated that they were very or somewhat likely to donate the organs of their children. A cynical reader of this poll could point to the discrepancy between the willingness to donate one's own organs and the willingness to donate the organs of others, but such an interpretation would miss the point about distrust. In this context, individuals are in control as family members in deciding to donate the organs of a relative, but they fear that neither they nor their family would be in control if they signed a donor card. They view the signed donor card as putting them at the mercy of an untrustworthy system. This interpretation is further supported by the fact that sixty-three percent approved of the following statement: "Even if I have never given anyone permission, I wouldn't mind if my organs were donated upon my death." This approval presupposes, as will be clear later, that family members are making the decision. Donor cards could remain important, not only for individuals to sign if they choose, but especially for individuals to use as an occasion for discussion with family members, both to indicate their wishes to their family members and to learn about their family members' own wishes. I have argued that signed donor cards should be respected, but the goal of educational efforts should not be to get individuals to sign donor cards. The goal should rather be to facilitate communication among family members regarding organ donation.

This educational effort is essential to any program to increase the supply of organs for transplantation. However, it is not likely to be sufficient because there are bottlenecks other than individual or familial reluctance to donate organs. In the absence of explicit authorization from the decedent, it is often necessary for someone to ask the family members about the decedent's willingness and/or their own willingness to donate the decedent's organs. Faced with a tragic set of circumstances, the family may not initiate a donation, whether the decedent had expressed his wishes. Hence, as a mode of respect for the decedent's wishes, which are unlikely to have been expressed in a donor card, and as a mode of respect for familial wishes, it is important that the family be asked about organ donation. Such an inquiry has a twofold object: first, to determine the decedent's wishes and to give the family an opportunity to act on those wishes, and, second, in the absence of familial knowledge about the decedent's wishes, to determine the family's own wishes. In short, such an inquiry is appropriate to inform family members about and to effectuate the decedent's and the family's legal rights. It is also appropriate, if handled properly and sensitively, as an effort to increase the supply of organs.
Human generosity, whether expressed by the decedent or by the family, may not be sufficient to initiate donation in these circumstances. The decedent may have feared the consequences of signing a donor card, while the family may not think about donation in the face of its tragedy. An affirmative response to an inquiry displays generosity as much as initiation of donation. Thus, a familial donation may itself respect the decedent's wish to donate or, in the absence of knowledge of the decedent's wishes, express the family's own generosity.

A policy of "routine inquiry," "routine notification," or "required request" — first proposed in 1984 by Arthur Caplan — is currently gaining momentum, having been voluntarily adopted by several hospitals, having been passed by at least twenty-five state legislatures, having been supported by the federal Task Force on Organ Transplantation, and now having been connected with hospital eligibility for Medicare and Medicaid reimbursement by Public Law 99-509. The language of "routine inquiry" is preferable, because it focuses on the goal of routine inquiry about the decedent's and/or the family's wishes. However, this goal may best be realized by requiring hospitals to adopt policies of routinely notifying families about the decedent's rights as well as their own, and of inquiring about the decedent's and their own wishes. The most defensible legislation does not require the attending physician or some other identified professionals to undertake the inquiry; instead, it requires hospitals to adopt a policy of routine inquiry, allowing them latitude in developing the most appropriate policy for their own context. Pilot studies indicate that a policy of routine inquiry is both feasible and effective; in addition, it is consistent with the constellation of values identified earlier.

Proponents of individual autonomy are likely to emphasize another version of "routine inquiry" or "required request," one that focuses on the individual while alive rather than on the family after his death. Thus, the individual might be asked to make a decision about whether to donate his organs, perhaps in the context of obtaining a driver's license or filling out a state income tax form. Defenders of this version note that families may not act on the decedent's expressed wishes (expressed in ways other than donor cards). One problem is how to interpret the widespread failure to sign donor cards. As I interpreted the evidence above, it seems to reflect less an unwill-


21. In one major medical center which had averaged six organ donors per year, a policy of required request increased the number of organ donations to twenty in only nine months. Oh & Uniewski, Enhancing Organ Recovery by Initiation of Required Request Within a Major Medical Center, Transplant Proceedings (unpublished law review article).
ingness to donate than an unwillingness to put oneself on record as an organ donor out of fear that the record will lead to one's abuse in a situation of extreme vulnerability. However, it may be appropriate and important to develop a way to record the decedent's wish not to donate as well as his wish to donate. This too is required by the principle of respect for persons, which allows individuals to thwart as well as to permit donation by others or to donate organs through their own advance directive.

A policy of required request of individuals that forces individuals to indicate "yes" or "no" would probably reduce rather than increase the supply of organs for transplantation. In view of the reasons people give for their reluctance to make an advance decision to donate and to record it on donor cards — in particular their distrust — it is probable that many individuals would say "no." Their negative decision would preclude familial donation after their deaths and would reduce the number of organ donations. But, as I have argued, the current failure to sign a donor card often reflects distrust of the system of organ procurement rather than a wish not to donate. Two additional changes would be important in a policy of required request of individuals. First, individuals should be given several options, such as "yes," "no," and "undecided." Second, individuals should be asked if they would like to designate a decision-maker regarding donation, just as several Natural Death Acts allow individuals to designate a decision-maker. Such an approach would be reassuring because the individual could establish a buffer or barrier between himself and the system of organ procurement, and the designated decision-maker could presumably reflect the decedent's values in the situation.

Two other policies have received serious attention, but, even if they are not ethically unacceptable in the abstract, they are not as ethically preferable as the policies already discussed and they are not politically feasible. First is the policy of presumed consent, which has been adopted for corneas in at least twelve states and for other organs in such countries as Denmark, France, Israel, Norway, Spain, Sweden and Switzerland. Having adopted a policy of "opting out" rather than "opting in," these countries "seem to come closer to meeting their needs for transplant kidneys" than the United States. But, whatever the differences in legal framework, the actual practices appear to be much the same. For example, although France's policy

of presumed consent does not require familial approval or ratification, health professionals still seek familial consent. In such a practice, the decedent's presumed consent may be used as a basis for approaching the family, i.e., for a ritual of inquiry.

A major reason offered for the ethical preferability of a policy of opting in is the promotion of altruism. However, a policy of presumed consent builds on passive altruism — a presumption that a person's failure to dissent from organ removal constitutes tacit consent to removal — and such a policy does not preclude active altruism. Furthermore, it does not presuppose that bodily parts belong to the state. The individual and/or family still controls the disposition of those bodily parts; the only difference is the shift in presumption about the individual's wishes. Even this shift may not be too significant, for our current practice of familial donation could be construed as (a) based on the family's presumption of the decedent's consent, or (b) based on the family's "quasi-property" right in the corpse.

A policy of presumed consent thus shifts the presumption about a person's wishes apart from his explicit statement of those wishes. Whether it is morally acceptable in practice depends on the background conditions that determine the validity of any consent: understanding and voluntariness. For presumed — or, perhaps better, tacit — consent to be valid, the agent must understand what is involved, including that a failure to dissent will be construed as consent, and must voluntarily give his tacit consent. Such conditions are morally exacting, and they would require widespread, vigorous educational efforts.

Finally, whatever might have been the case fifteen or twenty years ago, a policy of presumed consent does not appear to be politically feasible in the United States now. The prevalence of distrust prevents such a policy from being a viable alternative. When the 1985 Gallup poll asked, "Do you feel that doctors should have the power to remove organs from people who have died recently but have not signed an organ donor card without consulting the next of kin," 86.5% said "no." Indeed, instituting a policy of presumed consent in these circumstances would probably be counterproductive; because of their distrust many individuals would explicitly dissent.

The second policy — allowing or encouraging the sale of organs — is also politically infeasible. Public Law 98-507 prohibits the interstate transfer of organs for valuable consideration, and several states have also prohibited the sale of organs. A market in organs is not politically feasible in part because of the strong moral opposition to treating human bodies as property
and commodities. On the one hand, it has been claimed that a market could alleviate the shortage of organs and tissues and thus save lives and improve their quality. Respondents to this claim note that there are more effective, safer, and ethically preferable ways to increase the supply of organs. On the other hand, it has been argued that a market would respect the freedom of individuals to do what they want to do with their lives as long as they do not harm others. Respondents to this argument contend that individuals are being exploited rather than acting freely when they sell bodily parts, and, often drawing an analogy with prostitution, they insist that a commercial market is abhorrent to our system of values.27

In conclusion, both ethical and political arguments support educational efforts within the structure of UAGA, but also a redirection of those efforts. Instead of encouraging individuals to sign donor cards, educational efforts should encourage them to communicate their wishes to family members and to ascertain family members' wishes regarding organ donation. An application of several ethical principles suggests this redirection along with other changes, including a policy of routine inquiry aimed at family members in order to determine the decedent's wishes and/or the family's wishes in the absence of knowledge of the decedent's wishes.

THE DISTRIBUTION OF DONATED ORGANS

Who controls the distribution of donated organs and by what standards should donated organs be distributed? Living donors may, of course, designate the recipient of a kidney, and they usually give to a family member. Recently there has been some debate about whether any living donors should be used, and especially about whether living, genetically unrelated donors, such as spouses or friends, should be accepted.28 In an effort to increase organ donations, the President and other public officials, as well as the media, have made specific, ad hoc appeals on behalf of particular needy recipients, usually a child. Questions have been raised about the morality of such appeals, in part because of inequality of access to public officials and the media. In response, it has been argued that such appeals increase the overall supply of organs and thus redound to the benefit of all recipients. When cadaver organs have been donated for an identified recipient, they


have sometimes been inappropriate for that recipient and, with the family’s permission, have been used for other needy persons.

It is difficult to criticize the parents who donated their son’s heart to his sick girlfriend after his sudden, unexpected death, because he had indicated that she should receive his heart if he should die. Nevertheless, the morality of accepting designated organs has been debated. Here again there may be a tension among the principles of respect for persons, beneficence—especially utility—and justice. The most effective and efficient way to design and implement a system of organ procurement is to engender altruism toward unidentified strangers, even if the system needs an occasional stimulus by appeals for identified recipients. However, even in such a system, the question will arise about whether to accept an organ that has been donated for a particular recipient or group of recipients by the decedent and/or the family. Most donor restrictions specify a group or groups which should receive or should be denied the gift. For example, donors may request that the organ be used or not be used for members of certain racial, religious, or other groups. According to the UAGA’s list of people who may become donees, it is possible to designate “any specified individual for therapy or transplantation needed by him,” as well as various professionals and institutions.29 On the one hand, there may be good reasons to respect the donor’s wishes and to avoid wasting the gift. On the other hand, there may be good reasons for physicians and other professionals to refuse to be instruments of donor’s wishes when those wishes are contrary to medical judgment and standards of justice affirmed by the system of procurement and distribution, such as avoidance of racial discrimination. However, the legal situation is not totally clear.

Most donations of organs are made without specification of the recipient, and the organ procurement team controls the distribution of such organs. As the donee under the UAGA, the organ procurement team may accept or reject the gift. But there may be debate about the organ procurement team’s legal responsibility under such circumstances. For example, would the team be subject to legal liability for failing to accept the gift if it became known that another patient’s life could probably have been extended or quality of life improved with that organ? There may also be uncertainty about the legal responsibility of the procurement team for the use of an organ that has been donated without restriction, as long as it is not transferred for “valuable consideration” in violation of federal and state statutes that prohibit the sale of organs.

Whatever the legal picture, it can be argued morally that donated organs

belong to the community. This fundamental conviction undergirded the Task Force’s deliberations and recommendations regarding equitable access to organ transplantation in response to its mandate in the National Organ Transplant Act to make “recommendations for assuring equitable access by patients to organ transplantation and for assuring the equitable allocation of donated organs among transplant centers and among patients medically qualified for an organ transplant.” According to the Task Force, donated organs should be viewed as scarce public resources to be used for the welfare of the community.

Within this conception, organ procurement and transplant teams receive donated organs as trustees and stewards for the community, and they should determine who will receive available organs according to public criteria that have been developed with public input and reflect principles of justice as well as medical standards. In general, the evidence received by the Task Force indicates that organ procurement and transplant teams make responsible decisions. However, because of some widely publicized exceptions, particularly involving nonimmigrant aliens, there is increasing demand that the public participate in formulating the criteria for patient selection in order to ensure that they are fair. This demand stems from the nature of the organ procurement system, which depends on voluntary gifts to strangers.

Policies of organ procurement and distribution interact. The success of policies of organ procurement may reduce scarcity and some of the difficulties of patient selection. But the scarcity of organs for transplantation will probably remain a problem for the indefinite future, and the demand may always exceed the supply. Under these circumstances, difficult questions will remain about the process and criteria of patient selection. If policies of distribution are perceived by the public to be unfair, then it is likely that public distrust — already a major factor in the reluctance to donate organs — may reduce the effectiveness of policies of organ procurement. While strongly recommending some criteria and rejecting other criteria such as bribery, favoritism, sex and race discrimination, the Task Force concluded that several disputed criteria should be subject to ongoing public debate, and that the Organ Procurement and Transplantation Network should involve significant public representation, particularly participation in the examination of current and proposed criteria for patient selection. Just procedures for developing and applying criteria for patient selection are important for maintaining the trust essential to successful organ procurement.

Most conceptions of justice permit rationing or triage under conditions of

31. TASK FORCE ON ORGAN TRANSPLANTATION, supra note 6.
scarcity, but they rule out selection criteria that reflect morally irrelevant characteristics, such as race or sex. Thus the major debates focus on which characteristics are morally relevant and which are morally irrelevant in the two stages of selecting patients for organ transplants — formation of an active waiting list for transplantation, and distribution of donated organs. There is general agreement that at both stages the primary criteria should be medical: medical need and probability of success. However, there is debate about whether these medical criteria should be defined broadly or narrowly, about how to specify them, about the relevance of such factors as age, and about whether need or probability of success should have priority in cases of conflict.

Both medical need and probability of success reflect medical utility, which requires the maximization of the welfare of patients suffering from end-stage organ failure. Medical utility should be distinguished from social utility. While social utility might include the value of salvageable patients to society, medical utility requires that organs be used as effectively and as efficiently as possible to benefit as many patients as possible. For example, if there is no reasonable chance that an organ will benefit a particular patient, it would be unethical stewardship of the donated organ to implant it in that patient. If donated organs are viewed as scarce community resources, it might appear that social utility rather than medical utility should be adopted by trustees of donated organs. In such a setting, some would argue, it is appropriate to consider "the likely pattern of future services to be rendered by the patient (adequate recovery assumed)."32 Proponents of social utility do not deny medical utility, but they want to add social utility whenever possible. However, in addition to the difficulty of formulating and adopting standards of social utility, there are strong arguments for viewing the distribution of medical care and especially organs as exempt from this broader version of social utility.33 In particular, the policies of procurement described and proposed earlier would be unfair and also ineffective if organs were distributed on the basis of social utility as well as medical utility.

Because judgments about medical need and probability of success are value-laden, they will need constant medical and public scrutiny. For instance, there is debate about what will count as success — e.g., length of graft survival, length of patient survival, quality of life, and rehabilitation — and about the factors that influence the probability of success. Some contraindications are well established, such as mismatched blood group or positive

donor-recipient cross-match. On the basis of current evidence, the Task Force held that, according to both medical utility and justice, a recipient with a perfect match or zero antigen mismatch for Human Leukocyte Antigen ("HLA") A, B, and DR antigens should be offered that organ first and that O blood-group organs should always be offered first to suitable "O" recipients. (Since O blood-group organs can be used for patients with all blood types, but not vice versa, "A" patients have received transplants sooner, and "O" patients have spent more time on the waiting list.) Apart from these special circumstances, there are other difficult questions about mandated organ sharing that will be addressed below.

Not only do values enter judgments about medical need and probability of success, but they also affect judgments about priority in cases of conflict. For example, sometimes there is a tension between urgency of need and probability of success. The patient with urgent medical need may not be able to survive until another organ becomes available, but that patient's overall condition may greatly reduce the probability of a successful transplant and thus increase the chances that the organ will be "wasted." The Task Force notes:

A decision on how to apply the criterion of urgency must be developed by a thoughtful and broadly representative group, which must struggle with the concept of [the] best use of organs in the context of compassion and humanitarianism. Because donated organs are a scarce resource, policies to resolve conflicts between equity and efficiency that arise in the distribution of organs should be determined by a broadly representative group that includes patient, community, and ethical perspectives, as well as those of the medical professionals involved. In addition, it is important to make sure that the category of urgent medical need or emergency is strictly applied so that some patients do not gain unfair advantage over others by an inappropriate use of this classification. It can also be argued that medical urgency should include not only the immediate threat of death but also the likelihood of not receiving another organ because of presensitization. However, even though sensitized patients now form the hard core of the waiting lists for kidney transplants and wait longer for transplants, their success rates are also lower than those of unsensitized patients. Again, there may be a tension between medical need and probability of success.

Medical need and probability of success, however defined and however ranked, are not always sufficient to determine who should receive particular

34. Task Force on Organ Transplantation, supra note 6, at 74.
35. Id. at 88-89.
donated organs. If, according to these medical criteria based on medical utility, two or more patients are equally good candidates for an organ, then the fairest way to make the final selection is to consider their time on the waiting list. There are two different approaches to the use of this criterion. The Massachusetts Task Force recommended its use after determining the waiting list and prior to determining the medical need and probability of success. Thus, according to this approach, the “highest ranking candidate [rank is determined by time on the waiting list] who ‘matches’ [the] first available donor organ gets it, unless [the] lower ranking candidate is in immediate danger of death and [the] first candidate has a reasonable chance of surviving to receive the next available donor organ.” Breaking the queue in such cases “must be approved by a system-wide selection committee with public representation.”

According to the federal Task Force, time on the waiting list should be invoked only if medical need and probability of success are roughly equal. In part, the question concerns the moral weight of queuing in relation to efficiency in the use of organs. The federal Task Force put primary weight on medical utility, including both medical need and probability of success, and held that probability of success as determined in part by a good HLA match should be considered prior to time on the waiting list. Nevertheless, the criterion of time on the waiting list will be used frequently, because many organs will need to be allocated by criteria other than HLA match and sensitization; this criterion will often give priority to highly sensitized patients over nonsensitized patients who are equivalent matches for particular organs because the highly sensitized patients are likely to have spent more time waiting for an organ.

Several other criteria have been proposed or adopted, and it is important to examine them carefully in order to make sure that they reflect medical utility rather than social utility and that they are not otherwise unfair. For example, former Health and Human Services (“HHS”) Secretary Patricia Harris withdrew the earlier tentative authorization for Medicare to cover some heart transplants in part because of her concern that some criteria of patient selection were more social than medical. Among the other criteria that require constant examination by the Organ Procurement and Transplantation Network, and other publicly accountable bodies, are age, lifestyles, social network of support, number of previous transplantations, geography, and ability to pay. The first three — age, lifestyles, and social network of support — are especially complicated because they may reflect

---

36. REPORT, supra note 4.
37. TASK FORCE ON ORGAN TRANSPLANTATION, supra note 6, at 89.
either judgments about medical acceptability and priority, particularly the probability of success, or judgments about social acceptability and priority, particularly the value of some people and the disvalue of others to the society. A publicly accountable body should examine such criteria very carefully in order to ensure that they are really medically relevant and, if they are medically relevant, that they are properly applied. For example, age may be a rough indicator of the probability of survival of a major operation and may thus be medically relevant, and the probability of success may also focus on the length of time that the recipient of an organ may be expected to survive. However, since the major medical concern is physiological age rather than chronological age, each case must be assessed individually.

Lifestyle is another controversial criterion in patient selection. It has been argued that it is not unjust to assign low priority to transplant candidates whose lifestyles, in contrast to the natural or social lottery, contributed significantly to their end-stage organ failure. An example is end-stage liver failure as a result of alcohol and drug abuse. Even if it is not unjust to consider such factors in ranking potential recipients, it would be difficult both morally and politically to apply such a criterion, especially because of social compassion for patients in need, regardless of the origin of that need, and because of uncertainty about the connection between many lifestyles and diseases and about the voluntariness of the individual’s choice of a risky lifestyle. Nevertheless, lifestyle itself may be medically relevant in predicting the probability of a successful transplantation, if success includes more than graft survival for a short period. For example, a patient’s continued heavy use of alcohol and drugs may greatly reduce the probability that a transplant will be successful, and neither medical utility nor justice requires that this patient receive a particular organ under conditions of scarcity.

A social network of support was used as a criterion by the Stanford heart transplant program, and it was also invoked in the initial decision to deny Baby Jesse a heart transplant at Loma Linda University.\(^3\) If the probability of a successful outcome includes more than graft survival for a short period, then such a social network of support may be important in the overall success of the transplant and thus in the effective and efficient use of the donated organ. But, as the Massachusetts Task Force on Organ Transplantation insisted, “the absence of a family or the existence of an unconventional substitute should not serve as a reason to exclude the patient from evaluation.” Instead, “society should develop mechanisms, in cooperation with the transplanting hospitals, to provide sufficient support resources for such patients during their recuperation” and should include the costs of after

\(^{39}\) T.L. Beauchamp & J.F. Childress, supra note 7, at 325-26.
care in the analysis of the cost of the transplantation itself.\textsuperscript{40} Here again medical utility and social utility must be sharply distinguished from and constrained by justice.

Similar tensions emerge when we consider how many transplants any patient should be eligible to receive, particularly in view of the scarcity of organs. Between 1977 and 1981, forty-two patients received three or more kidney transplants, 713 received two transplants, and 10,063 received one transplant.\textsuperscript{41} The fundamental question is whether equitable access should limit a patient to one transplant; if it does, then physicians and patients might hold out for the best possible chance, considering, for example, the quality of the organ as well as the closeness of the match. In addition, sensitization as a result of previous transplants may reduce the chances of a successful transplant. Even though it is not clear that limiting a patient to one transplant would constitute abandonment, judgments may differ according to whether there are back-up or alternative treatments, such as dialysis.

To what extent should “accidents of geography” be relevant in selection of patients to receive scarce organs? In 1984, approximately forty percent of the donated cadaver kidneys and many of the hearts and livers were transplanted outside the geographical areas where they were retrieved.\textsuperscript{42} I have already dealt with the question of donors’ expressed restrictions, which may include geography. Now the question is whether “accidents of geography” should be otherwise relevant in distributing organs, particularly in view of the conviction, expressed by the Task Force, that donated organs are scarce public resources. Some argue that because donated organs are public resources and belong to the community, “in principle, and to the extent technically and practically achievable, any citizen or resident of the United States in need of a transplant should be considered as a potential recipient of each retrieved organ on a basis equal to that of a patient who lives in the area where the organs or tissues are retrieved.”\textsuperscript{43} In addition to practical and technical limits, several ethical considerations may be relevant.

Technical limits involve possible damage to organs by transportation and delay in transplantation. And since cyclosporine is nephrotoxic, there may be additional reasons to use kidneys as quickly as possible, and much earlier than the seventy-two hours that many consider a maximum limit outside the body. Transportation is often less feasible for hearts, which should be used within eight hours after removal from the cadaver, and livers, which should be used within six hours. Thus, medical utility, particularly the probability

\textsuperscript{40} Report, supra note 4.  
\textsuperscript{41} Office of Organ Transplantation, supra note 1.  
\textsuperscript{42} Task Force on Organ Transplantation, supra note 6, at 65.  
\textsuperscript{43} Id. at 92 (testimony of the Council of the Society of Transplant Physicians).
of success and avoidance of wastage, may assign priority to local or regional recipients under some conditions. There are also disputes about the importance of HLA matching (apart from perfect matches or zero antigen mismatches) to increase the chances of success when cyclosporine is used.

Practical considerations include the additional incentive that local use provides to professionals involved in procurement. In addition, local use provides an occasion for public education and may increase the public's willingness to donate. Nevertheless, these practical considerations should be reduced considerably, if not totally eliminated, in a network that distributes according to objective medical criteria and time on the waiting list. Such a network, a single national system of organ procurement and distribution that is being developed under contract by United Network for Organ Sharing in Richmond, Virginia, should have a major impact on these practical considerations by ensuring equity in distribution. Such a network should offer all the advantages of reciprocity in giving and receiving. However, until other criteria are developed with public participation, the Task Force recommended a policy of mandatory sharing by centers only under the conditions identified earlier: a perfect donor-recipient match of HLA A, B, and DR antigens or zero antigen mismatch (if at least one antigen has been identified at each locus for both donor and recipient), priority to highly sensitized patients, and the use of O blood-group organs only in O blood-group recipients.

Considerations of equity are also relevant. Dr. Olga Jonasson has argued that mandated sharing on the basis of HLA match (apart from the perfect match or zero antigen mismatch) could actually be unfair to Blacks and Hispanics. Most organ donors are White (for reasons that were suggested earlier), certain HLA phenotypes are different in White, Black, and Hispanic populations, and the identification of HLA phenotypes is less complete for Blacks and Hispanics; thus, mandated sharing of retrieved organs according to HLA typing could reduce the access of Blacks and Hispanics to kidneys, even though they have a much higher rate of end-stage renal disease than Whites (perhaps four to five times the rate of Whites).44

So far in discussing the moral relevance of "accidents of geography" I have focused on distribution of organs within the United States without regard to the national origin of the recipients. However in 1985, of the cadaver kidneys retrieved in the United States, approximately 300 were transplanted into nonimmigrant aliens who had come to the United States for medical care and 200-250 were shipped abroad for use in other coun-

44. See id. at 92.
Stories in the *Pittsburgh Press* indicated that nonresident, nonimmigrant aliens sometimes receive priority over citizens of the United States for scarce organs retrieved in the United States. Hence, the question emerged about whether construing donated organs as a public or community resource meant viewing them as a scarce *national* resource or as a scarce *international* resource. The term "national" has been invoked to limit local and regional claims on organs, but it has also been invoked to limit international claims on those organs. Here again there is a connection between procurement and distribution. If the system of organ procurement is viewed as a voluntary, cooperative system, involving gifts of organs, it may be appropriate to assign priority to citizens of the United States, but it may also be appropriate and perhaps even commendable, even if not obligatory, to share some organs with people outside the national boundaries.

There are several possible policies regarding nonimmigrant aliens: (1) allow some nonimmigrant aliens on waiting lists and give them priority; (2) exclude them from receiving any cadaver organs obtained in the United States; (3) include some on waiting lists after informing them that they will not receive an organ until it has been determined that no United States citizen (or alien residing in the United States) could benefit from that organ; (4) accept a maximum number (such as five to ten percent) of nonimmigrant aliens on waiting lists and then treat them equally by using the same criteria of distribution for all people on the waiting lists; and (5) accept nonimmigrant aliens on waiting lists as candidates for organs without any numerical restrictions or priority to United States citizens.

There is some evidence that the first policy has sometimes been adopted by some centers. For example, two cadaver kidneys became available on May 4, 1985, as the result of the death of a fifteen year old North Carolina youth. The waiting list at Presbyterian Hospital in Pittsburgh included a sixty year old woman, who was a United States citizen, who had been on the list for three years, who had almost exhausted her bodily sites for hook-up to dialysis machines, and whose organ-rejecting antibodies were at a lower level than usual and within acceptable limits for transplantation; an Egyptian physician's eleven year old son who had not yet been put on dialysis; and a Saudi Arabian who had only been in the United States seven weeks waiting

---

for a transplant. The kidneys were used for the last two candidates.\textsuperscript{47} In part, the debate about such cases has focused on the relevance of a person’s ability to pay more than the federal government pays through the End-Stage Renal Disease Program (“ESRD”). If a nonimmigrant alien receives priority because of his ability to pay more than the going rate, or even to make a substantial contribution to the institution, then the institution is selling organs that have been donated to the community. The arguments against such a practice have been identified earlier. Assignment of priority according to wealth or favoritism is unjust and it threatens the voluntary cooperation of various donors who already doubt the system’s trustworthiness. One major problem is that foreign nationals, on the average, are transplanted more quickly than United States residents, largely because fewer of them are highly sensitized. The serious threat to the system of organ procurement and donation has been emphasized in a 1986 report on The Access of Foreign Nationals to U.S. Cadaver Organs which indicated that:

Organ donation in the U.S. rests on a fragile foundation. People donate organs with the assumption that the system for distributing them will be a fair one. When they learn that foreign nationals receive organs instead of U.S. residents and that they generally do so in a shorter period of time, they begin to question the fairness of that system and may very well become less inclined to donate. Indeed, in some communities where there has been much publicity about foreign nationals receiving transplanted kidneys, there has been a subsequent reduction in donation levels.\textsuperscript{48}

The second policy — excluding nonimmigrant aliens altogether — has been opposed as uncompassionate and unfair, particularly because so many organs are wasted. However, it is possible that wastage could be reduced by increasing the number of United States citizens on waiting lists for kidney transplantation, since only 9,000-10,000 of the approximately 75,000 patients on dialysis are also on active waiting lists for transplantation. Total exclusion has also been opposed as chauvinistic and near-sighted because it neglects the international good will that American transplant programs can generate, especially if they combine transplantation of some foreign nationals with efforts to develop transplant programs in those countries. In addition, it is probable that United States citizens do not oppose transplanting some nonimmigrant aliens but only oppose giving them priority on morally irrelevant grounds.

Humanitarianism is frequently offered as a reason for rejecting the second


\textsuperscript{48} \textit{OFFICE OF ANALYSIS AND INSPECTIONS}, \textit{supra} note 9.
policy, particularly because medical humanitarianism does not recognize such criteria as sex, race, and nationality. However, in reality, even medical humanitarianism recognizes some limits and priorities when not everyone can be treated, and, in any event, the distribution of organs is not merely a matter of medical humanitarianism. Donated organs are not the property of medical professionals but of the community, and medical professionals hold them only as trustees and stewards for that community. Then the debate is whether the national community has an obligation to share its organs with citizens of other countries. Obviously there are strong moral obligations to share with other countries that participate in a system marked by reciprocity, and, even where there are no strict moral obligations of justice, it may be compassionate and generous for the national community to share, as long as the sacrifices are not excessive for its own citizens. But when it is impossible to meet the needs of everyone, it may be permissible to give priority to near neighbors (citizens) over distant neighbors.

An argument to share organs based on a duty of beneficence, not on a duty of justice or on the ideal of generosity, would also have to recognize the limits that usually mark duties of beneficence. An agent, whether an individual or a group, may be obligated to share except where that sharing would result in excessive harms, costs, or burdens to the agent. Using cadaver kidneys for foreign nationals reduces the number of kidneys available for United States residents and increases their average waiting time; in addition it costs Medicare, because for each kidney transplant performed on a Medicare beneficiary in 1985 the Medicare system saved an average of $62,000 over a five-year period. If 275 of the estimated 300 cadaver kidneys that went to foreign nationals in 1985 had gone to Medicare recipients, the system would have saved approximately $17 million over a five-year period. These arguments for some limits count against the fifth position that would accept nonimmigrant aliens without any numerical restrictions or priority for United States citizens.

Both the third and fourth positions accept some sharing for various moral and nonmoral reasons, but disagree about how organs should be distributed to nonimmigrant aliens or shipped abroad. The third position can be characterized as “Americans first,” and it would assign priority to United States residents, while accepting some nonimmigrant aliens at the bottom of the waiting list or on a separate, but unequal, waiting list. The major objection is that nonimmigrant aliens are then treated as second-class patients with little realistic chance of obtaining organs. Even if nonimmigrant aliens vol-

49. T.L. Beauchamp & J.F. Childress, supra note 7, at 148-49.
50. Office of Analysis and Inspections, supra note 9, at 10.
untarily accept their place on the waiting list in order to have a slight chance of a transplant, it is possible to argue that they are being exploited in order to avoid wastage of retrieved organs.

The fourth position would attempt to avoid such inequities by setting a limit on the number of nonimmigrant aliens on waiting lists but then granting those on waiting lists access to donated organs according to the same criteria as United States residents: medical need, probability of success, and time on waiting lists. Whether sharing is an ideal or a duty, some limits are reasonable from both moral and political standpoints. Such a policy would probably be politically feasible, because public protest appears to have been directed against giving priority to, not against any sharing with, nonimmigrant aliens. However, proponents of the third position contend that any numerical limit is arbitrary and that this policy is still unfair to U.S. citizens who should have priority over nonimmigrant aliens in the competition for scarce organs.

The fifth policy — acceptance of nonimmigrant aliens without any numerical restrictions or priorities for United States citizens — is difficult to defend in view of the shortage of organs for United States citizens who support a system of kidney retrieval and of maintenance of patients on kidney dialysis and transplantation through their tax dollars and who participate in the voluntary, cooperative system of donation. (Also see the arguments discussed under the second policy.)

The compromise adopted by the Task Force on Organ Transplantation endorsed the fourth position for renal organs, setting a maximum number of ten percent from any one center until reviewed by the Organ Procurement and Transplantation Network, and the third position for extrarenal organs. The fourth position, which evoked a vigorous dissent from eight members of the twenty-five member Task Force, was accepted for kidney transplants because kidneys are not as scarce as extrarenal organs and because dialysis is usually available as a backup or an alternative. However, the dissent focused on the unfairness of denying members of this donating community, including aliens living in the United States as well as American citizens, access to donated organs, and of taxpayers’ money covering the costs of kidney procurement. In addition, critics of the majority position emphasize that setting a limit of ten percent could actually have the unintended effect of “legitimizing a higher incidence of transplants for foreign nationals at centers now functioning well below the ten percent level.”

51. Task Force on Organ Transplantation, supra note 6, at 93-95.
52. Id. at 137-38.
53. Office of Analysis and Inspections, supra note 9, at ii.
The Task Force recommended the fourth position for the disposition of cadaver kidneys "until the Organ Procurement and Transplantation Network has had an opportunity to review the issue."\(^{54}\) If the premise is accepted that some sharing is defensible, even if not obligatory, it will be necessary to explore further the ethical questions raised by "accidents of geography," particularly national residence, in the context of the close moral connections between organ procurement and distribution. Public input is indispensable on grounds of fairness; it is only fair for the public to participate in the development of criteria of patient selection for scarce organs donated to the community and held by professionals as trustees. Public confidence that the criteria of distribution are morally acceptable and fairly applied is important for the maintenance of the trust that is essential to organ donation.

**PROVISION OF FUNDS FOR TRANSPLANTATION**

Ability to pay has played a major role in organ transplantation, especially, but not limited to, heart and liver transplantation. Even if it is unfair for procurement teams to sell organs to the highest bidder, to the patient who can pay more than the going rate, there may still be debate about whether it is unfair to select the recipient who can pay the going rate. The Task Force on Organ Transplantation firmly rejected the criterion of ability to pay as unjust, in part because of the moral connections between practices of organ procurement and practices of organ distribution.

Renal dialysis and transplantation have been covered by the End Stage Renal Disease program of Medicare since the early 1970's, and, even though the costs of the program are tremendous — over three billion dollars each year for approximately 75,000 patients — patients who need dialysis are able to receive it, and priority is no longer given, as it was earlier, to white, college-educated males.\(^{55}\) More equal access has resulted from this program, at least for patients needing dialysis and probably also for patients needing (and wanting) kidney transplants. Nevertheless, access to kidney transplantation has sometimes been limited by a lack of information and referral and, more recently, by a lack of funds for expensive immunosuppressive therapies, particularly cyclosporine, which costs approximately $6,000 a year for kidney transplant recipients. Thus, the Task Force recommended the establishment of a Joint HCFA-PHS program "to provide immunosuppressive medications to transplant centers for distribution to financially needy Medi-

\(^{54}\) TASK FORCE ON ORGAN TRANSPLANTATION, supra note 6, at 95.

care eligible transplant patients." Its aim was to reduce the inequities based on inability to pay for immunosuppressive medications that had emerged in a program designed to eliminate the criterion of ability to pay in the distribution of kidney dialysis and transplantation. (Public Law 99-509, approved by the U.S. Congress and signed into law by President Reagan in October 1986 with an effective date of January 1, 1987, will provide coverage of immunosuppressive medications for one year following each procedure for Medicare-covered transplant recipients.)

Even if consistency supports a federal governmental role, at least as a last resort, in the provision of funds for immunosuppressive medications for transplants that are covered by Medicare, it does not have the same weight in arguments for a federal role in the provision of funds for organ transplants that are not currently covered. Nevertheless, there are several strong arguments for a societal obligation to provide funds for expensive — heart transplants average $95,000 (range: $57,000-110,000) and liver transplants average $130,000 (range: $68,000-238,000) — but effective extrarenal transplants. In the current situation, only a few heart transplants and some liver transplants for children are now eligible for coverage by the Health Care Financing Administration, along with cornea transplants and some bone marrow transplants. While approximately eighty percent of the commercial insurers and Blue Cross and Blue Shield plans now cover both heart and liver transplants, many people — perhaps twenty-five to thirty-five million — have no insurance, and many of them could not qualify for Medicaid programs, many of which do not cover heart and liver transplants.

The first argument builds on society's obligation to meet the basic needs of its members. This obligation has already been recognized in several precedent-setting governmental programs, including the ESRD program for dialysis and kidney transplantation. According to the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, the standard of "equitable access to health care requires that all citizens be able to secure an adequate level of health care without excessive burdens." Of course, there is widespread debate about what constitutes an "adequate level of health care" and "excessive burdens," but the
Task Force contends that life-saving procedures that are comparable in both efficacy and cost to other procedures that are routinely covered should qualify. The need for heart and liver transplants is evident; many patients die in a short time without them. And heart and liver transplants result in significant increases in quantity and quality of life. Thus, there is continuity between heart and liver transplants and other forms of health care that are recognized to be part of the decent minimum or adequate level of health care that the society is obligated to provide. Concerns about the costs of health care are legitimate, but the Task Force believes that the burden of saving public health funds should be distributed equitably, rather than imposed on particular groups of patients, such as those suffering from end-stage heart or liver failure.

There is a second argument for the federal government’s role in guaranteeing equitable access to organ transplants, regardless of the patient’s ability to pay. While the first argument focuses on the continuity between extrarenal organ transplants and other forms of health care that are part of the decent minimum level, the second argument focuses on the special nature of organ transplantation, especially the social practice of organ procurement and donation. This argument connects organ procurement and distribution, and it appeals to what the society does in procuring organs rather than to what the society should do or already does in distributing other forms of health care, including renal transplants. As a matter of social practice, involving such public officials as the President and the Secretary of HHS, efforts to increase the supply of donated organs are aimed at the poor as well as at the rich. All segments of society are urged to donate organs. However, it is unfair and even exploitative for the society to ask people, rich and poor alike, to donate organs if those organs are then distributed on the basis of ability to pay, rather than medical need, probability of success, and time on the waiting list. The system fails to meet the standard of justice or fairness when it solicits organs from all people for the community at large and then excludes some people, i.e., those who cannot pay, from access to donated organs. In addition, such exclusions contribute to distrust and thus reduce the overall supply of donated organs. Therefore, the Task Force strongly recommended that the federal government, as a last resort, cover the costs of non-experimental extrarenal transplants for the financially needy who have no other sources of funds for those transplants.61

61. TASK FORCE ON ORGAN TRANSPLANTATION, supra note 6, at 99-105.