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MARKET AND NON-MARKET MECHANISMS FOR PROCURING HUMAN AND CADAVERIC ORGANS: WHEN THE PRICE IS RIGHT

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ABSTRACT

In the United States, as well as throughout the world, current demands for organ transplants far exceed the actual supply. Nonconsensual human donations, taken from minors, incompetents and prisoners are regulated carefully by the courts. The Uniform Anatomical Gift Act and the National Organ Transplant Act serve also as statutory frameworks for organ retrievals and allocations and place various restrictions upon each. Altruistically motivated donations at death continue to be an inadequate mechanism for meeting the growing demands of the market. Included among the various approaches to resolving the critical shortage of human organs for transplantation are post mortem harvesting, escheatage, prospective contingent sales and standard death benefit payments—with the latter being perhaps the most attractive in the United States. While ethical and moral principles can help develop a construct for resolving harvesting and transplantation conflicts, they must be tempered—in the final analysis—by a standard of practical need that recognizes unnecessary suffering and premature death from diseased and replaceable organs as undesirable.

MARKET DEMANDS FOR ORGANS

Introduction

While the approximate total number of people waiting lists for organs or tissue transplantation is 100,000¹ the number of organ donors has, from 1989-1991, stayed at approximately 4,000 in the United States.² Another study delineates the needs of Americans as follows: 15,000 could benefit from a heart transplant, 22,500 from a kidney transplant and 5,000 each from a liver or pancreas transplant.³ Interestingly, the most ready market source for harvesting, and thus meeting these needs in the United States, is to be seen in the automobile accident pool that yields approximately 60,000 cadavers each year with some 12,000 to 27,000 of them maintained sufficiently long enough after the accidents to die in hospitals.⁴ At a minimum, these statistics suggest something along the lines of 12,000 hearts and livers and 24,000 kidneys are a potential market source for transplantation.⁵

Whatever statistical profile is used, it can be seen easily that the demand for transplant organs clearly exceeds the supply.⁶ The market base for obtaining organs becomes even more fragile and volatile when it is realized that the shortage of cadaveric organs is tied to the very suitability of the cadavers themselves. Thus, to be a suitable cadaveric candidate, the cadaver must have died as a result of either a cerebral haemorrhage or injury to the head and be maintained with respirator and ventilator assistance before its relatively healthy major organs are harvested.⁷ The central task, then, is to design a scheme or develop a market mechanism that promotes greater opportunities for obtaining transplantable organs yet – at the same time – is not antithetical to present ethical values.⁸

Surely, as a society, Americans need to enter into a full dialogue regarding all approaches to saving lives and not dismiss out-and-out any viable suggestion before it is debated fully (and even tested). This essay will seek to initiate such a dialogue and demonstrate that, as things stand at present, altruistically induced organ donations at death are not as comprehensive a mechanism for providing a supply of transplantable organs as the demands of modern society require. New market strategies will have to be examined and eventually utilized if a premium is to continue to be placed on restoring health and sustaining life. At this stage in the development of an agenda for a national debate, the payment of a standard death benefit as an inducement for organ donations appears to be the most attractive market mechanism to develop.

American Responses and Fears

A 1985 Gallup Poll found seventy-five percent of all Americans approved of organ donation and transplantation, yet only twenty-seven percent expressed a willingness to donate their own organs in the event of their death, and of that percentage only seventeen percent indicated they had signed organ donor cards to effect this commitment.⁹ These figures take on a greater relevance as market indicators of future organ sources when it is realized that approximately eighty percent of all Americans die without a will and thereby lose their opportunity to become donors.¹⁰

For those queried regarding their reluctance to become organ donors, three common reasons are given for this position: a central unwillingness to consider personal mortality;¹¹ aesthetic fears or religious beliefs forbidding dismemberment;¹² and an abiding fear that death will be hastened if previous consent to organ donation is given.¹³ Meeting, and thereby seeking to resolve, these fears will take time and years of education. Even then it will be extremely difficult to allay the fears that form the basis of these reasons for inaction.

The Common Law Approach

The Common Law, as interpreted in 1765 by Blackstone's Commentaries, was clear: no one could have property rights in a human corpse.¹⁴ Since the law of theft operated only to protect rights of property and ownership, a corpse was incapable of being stolen. Thus, body snatchers worked regularly to obtain cadavers for anatomists for subsequent use in medical schools. Interestingly, however, property rights could be held in coffins or shrouds and their theft was an imprisonable act.¹⁵

While stealing a corpse was a mere indecency, and not a felony, consecrated burial grounds were protected and disruption of them carried a penalty as a misdemeanour. This was used as a basis by the common law judges to eventually develop new criminal laws prohibiting the disinterment of corpses without authority. At first, these new criminal offences applied to body snatchers instead of to their customers. Executors and close family members could assert a right of burial, but could still not assert ownership of a corpse. Accordingly, in cases where cadavers were discovered being used in anatomy or surgical dissection classes, there was no clear way of forcing their surrender unless they could be first identified (which, depending upon the extent of the dissection could be difficult) and then made the subject of a legal claim by the family or the descendant's executor. The only right possessed by the family was to have the body retrieved for burial and nothing more.¹⁶

In 1828, with parliamentary study being undertaken of this area, the courts seized the initiative and expanded the criminal law of body snatchers—as applied to cemeteries—to reach to the points of common delivery: the medical school anatomy classes.¹⁷ And, in 1832, Parliament passed The Anatomy Act that destroyed the trade of body snatchers altogether by essentially introducing a strict licensing procedure upon anatomy schools as well as upon instructors and students themselves who wished to perform anatomical examinations. Government inspection, fines and imprisonment were set in place for violations of the Act.¹⁸

LEGISLATIVE INITIATIVES AND DISAPPOINTMENTS

With the promulgation of the Uniform Anatomical Gift Act (UAGA) in 1968 and its subsequent adoption in some form by the fifty states and the District of Columbia in 1973,¹⁹ a statutory right was conferred upon all individuals allowing them—prior to death—to designate either their complete bodies or organs from them for donated transplants. When a descendant's wishes are not communicated prior to death, the Act provides a right of disposition to the next of kin allowing him the right to decide whether to donate his relative's organs.²⁰ The UAGA was silent on the subject of sales.²¹ Thus the Common Law position was largely controlling

here and provided no one was acknowledged as having a definitive property interest or right in a human corpse.²² This meant no one was granted any form of authority to enter into a sale or to make a gift of a cadaver or any of its parts.²³ It is important to note that this did not mean sales or gifts of this were illegal; rather, only contracts for sale or deeds of gifts were, at law, not enforceable.²⁴

For a period of time in the late 60's and early 70's – specifically, from 1968 to 1973 – some five jurisdictions²⁵ prohibited the sale of human bodies and organs²⁶ yet permitted contingent sales to be made by decedents as well as sales by their next of kin.²⁷ With the promulgation, adoption and universal interpretation of UAGA, all state statutes permitting such sales – save one, Mississippi²⁸ – were abolished effectively.²⁹

In order to redirect national thinking from a purely voluntary behaviour basis *vis-a-vis* organ donation, UAGA was built upon a principle of 'encouraged voluntarism';³⁰ p.23). To advance this principle, the whole process of consent was simplified. This was accomplished by the introduction of donor cards designed to allow individuals, carrying them as such, to indicate their consent to donate their organs upon death.³¹ Wishing, if possible, to enhance the voluntary principle of altruism implicit in UAGA for transplantable organs, yet face the realities of the failure of UAGA's 'encouraged voluntarism' to produce enough donors,³² the United States Congress acted in 1984 by passing the National Organ Transplant Act (NOTA).³⁸ In addition to underwriting financial support for the development and maintenance of local nonprofit organ procurement organizations and additionally a National Organ Procurement and Transplantation Network to assist in matching organ donors with those needing transplants, the Act criminalizes the interstate acquisition, receipt or transfer of all transplant tissue (e.g. organs) – with the exception of blood.³⁴ Since the legislation is directed toward imposing a prohibition on sales affecting interstate commerce, some doubt has been raised about the validity of suppression of intra state organ sales.³⁵ Interestingly, NOTA has been strengthened specifically on this issue of intra state sales by the enactment of specific statutes prohibiting either the purchase or the sale of human organs.³⁶

Again, in a national effort to both educate the public to the communal values associated with organ transplantation and thereby encourage, and, hopefully, enhance opportunities for more organ harvesting, in 1986 a provision was added to the Omnibus Budget Reconciliation Act that was passed into law in 1987, mandating all medicare and medicaid affiliated hospitals to establish 'written protocols for the identification of potential organ donors'.³⁷ This means that requests be made for organs and tissues whenever a death occurs in a hospital setting. Options to donate organs are to be presented in a discreet and sensitive manner to all families of potential donors enrolled as Medicare or Medicaid patients.³⁸

Hospital compliance with required request provisions of the Federal

law or complimentary state enacted legislative schemes is very uneven: characterised in fact as poor to grudging in some states.³⁹ It is said that a number of physicians view the law here as an intrusion into their professional autonomy.⁴⁰ Still others are angered over perceived inequities in the distribution of the organs and tissues.⁴¹ These attitudes translate into a lukewarm enthusiasm, if that, as the physicians seek to comply with required request provisions⁴² by phrasing their requests for permission to harvest the organs of a family member 'in a way that encourages a positive response and does not impose distress on the survivors'.⁴³

With no set of rules designed to achieve this delicate balance, how can such a legal requirement as this be met?⁴⁴ As one organ transplant coordinator observed, 'the consent rate when someone asks who does not want to ask, or does not know how to ask, is zero'.⁴⁵ Thus, the reality of the situation is that unless negative incentives can be structured and then imposed on doctors or hospitals, the net enforcement effect of required request laws will be viewed as little more than excessive hortatory language⁴⁶ – typical of so many congressional enactments.⁴⁷

LIVING DONORS

Since World War II, in the United States, live donors have been used as sources for organ and tissue transplantation running the gamut from blood and bone marrow to kidneys.⁴⁸ Interestingly, while no adult can be forced – without giving a mature, informed consent – to donate any organ, a minor, mental incompetent, or prisoner has traditionally not been accorded this option.⁴⁹ The case law in the United States – although lacking in any unified rationale – does evidence three bases for testing the validity of the application for a compulsory, nonconsensual donation.⁵⁰

Under one test, the court inquires whether the donation would be in the best interests of the donor – with no relevance being given to any measure of sympathy for the proposed recipient of the family.⁵¹ The second test is one of substituted judgment, where the court speculates how the minor (if mature or competent) would decide relative to the request to donate.⁵² But, this act of speculation is not flippant or inconsequential; rather, the court seeks to make a decision utilizing the same motive and considerations as would move the incompetent himself. In this regard, then, the test of substituted judgment does not deviate from adherence to the ethical principle of respect for persons. Indeed, it has been suggested that this very principle recognizes that one's welfare – rightly understood – may well depend upon an act that helps others.⁵³ An absolutist approach to this principle of respect, however, would allow for no compromise of any nature.⁵⁴ The third test utilizes a judicial review of whatever parental decision has been made here, with the court accepting in principle the importance of the parental position yet – without accepting any correlative duty to the donor – weighing the entire

family dilemma, making an ultimate decision based on achieving a balance of family interests.⁵⁵

Some argue ethically and morally that all intrafamilial donations should be prohibited simply because of the coercive forces operating within the family unit that, hypothetically, could justify the need for requiring an incompetent healthy sibling to make a forced organ donation to a competent, unhealthy brother or sister.⁵⁶ If such a scenario were in fact to be written, no destructive harm to the particular family unit would occur. Indeed, just the opposite would happen – for the unit would be preserved and strengthened by such a donation. At a minimum, the factors that comprise a valid consent should be defined with as much precision as possible – recognizing as such that there is an enormous factual difference between a family member authorizing tissue removal from the body of a deceased relative and, on the other hand, from a living relative.⁵⁷

There are other ethical and social considerations raised regarding organ transplants from living donors. One simply finds such actions to be inherently immoral.⁵⁸ This idea builds on the belief that the general ethical principle that life should always be preserved and that one should never seek his own destruction nor endanger in any way his own life except as an expression of love for another.⁵⁹ Commerce in human body parts – it is maintained – also acts to restrict free will and individual autonomy. This, in turn, is buttressed by the view that in harming oneself by deliberately undergoing tissue removal, one may well indeed harm society by later becoming sick or enfeebled and thus a burden upon it.⁶⁰ Abstract moral principles and concerns of this nature must give way to the realities and the needs of contemporary society⁶¹ and not stand as roadblocks to the maintenance of actual life.

The counter utilitarian argument to these moral-ethical concerns states that any absolute prohibition on the use of organs from minors or incompetence is unjustified;⁶² this, in light of the simple fact that donations from such classes restore health and renew life to others – and they do this without jeopardizing or ending the lives of the donors. Where the risks from the donation to the minor, incompetent or incarcerated prisoner are minimal or even if substantial – yet much less than the harm that would occur to an individual donee deprived of the benefits of sustained living – organ transplantations should be undertaken.⁶³

OTHER SCHEMES AND PROCEDURES

Presently in the United States, the prevailing system for organ donation is one of presumed non-consent; or, in other words, one is presumed 'unwilling' to be an organ donor at death unless he or his family gives permission.⁶⁴ As noted, this scheme is failing to generate sufficient resources for transplantation; thus new approaches must be evaluated and then implemented.

One such approach was first proposed in 1968 and simply calls for compulsory post mortem examinations to determine the salvageability of cadaveric organs.⁶⁵ As such, autopsies would be done routinely and not, as now, used only when requested by the decedent's family or as a consequence of violent death under suspicious circumstances. The post mortem examinations and autopsies would be carried out in all cases so long as they did not interfere with homicide investigations; and the dying person or his next of kin would be allowed to object to such procedures and give contra instructions thereby opting out.⁶⁶

A more contemporaneous suggestion has been to design and implement a system wherein persons who object to forced donations of this type could refuse to participate in a manner wholly consistent with individual patient and/or family sensitivities, yet is both efficient and cost-effective and also meets the plethora of religious, ethical and legal requirements of informed consent.⁶⁷ This suggestion, as engrafted on to the basic approach, is very sensitive and seeks to balance personal attitudes with the demands of a market society. Perhaps, in fact, the suggestion is too broad in its focus and seeks too wide an accommodation of personal interests. In any event, considerable more research must be undertaken in order to test its practical feasibility.⁶⁸

A more expanded version of the compulsory post mortem examination and autopsy retrieval approach is seen in escheatage.⁶⁹ Although viewed as immoral by some authorities in the United States,⁷⁰ as a system promoting recognition of the state's inherent right of ownership in the bodies of all its citizens unless otherwise specified by the citizen or its family, escheatage is being utilized by some fourteen European countries as a means of combatting the shortage of donor organs.⁷¹ In practice, the state simply delegates its ownership rights to licensed physicians who are thereby authorized to harvest and allocate salvageable organs to compatible donees.⁷² Here is an example of utilitarianism at its highest order. Yet, the practice has been analogized to both slavery and totalitarianism!⁷³

The social policy against escheatage in America is found rather simply in a recognition of the sacredness of the body in life and death and not regarding it as a form of collective personal property disposable at will by the state upon death. But, as dead bodies are recognized more and more as valuable sources of life, through the harvesting of their organs for the living, perhaps – with time – a definition of their status as property will of necessity be forced upon all sophisticated societies in the world community.⁷⁴ Yet, even in countries where escheatage is in place, there is a natural reluctance among medical personnel to dismember their former patients' bodies whom they heretofore have worked to sustain life without an actual consent from next of kin; this, even though the state, through escheatage, has adopted a policy of presumed consent.⁷⁵ This attitude then, together with the high level of emotionalism, rather than rationalism, being exhibited on this issue in the United States means that it is doubtful whether the system would have a real potential for successful adoption.

ADDITIONAL MECHANISMS

Two other mechanisms are also available for consideration: the development of a futures market;⁷⁶ and a standard death benefit payment.⁷⁷ The two central obstacles to implementation of these mechanisms are the need to either repeal or amend present state and federal legislation that prohibits the sale or purchase of human organs,⁷⁸ and to overcome the pervasive reluctance among physicians to seize the initiative at the appropriate moment and make timely inquiries regarding consent to undertake harvesting.⁷⁹ To resolve this second obstacle, it has been suggested that tort law be re-shaped in such a way as to acknowledge a new standard of care with regards to a patient's body. Accordingly, should physicians fail to determine whether a patient has signed an organ sales contract, to preserve a cadaver for subsequent harvesting, or to inform the proper organ procurement agency of its status, liability would be imposed upon the physicians to the estate of the deceased for the value of his organs.⁸⁰

Under a futures market, an individual would enter into a prospective contingent sale – before death – of his own organs.⁸¹ Proposed as such, a futures market would be only a small modification of the current system of contingent organ donation. Accordingly, individuals could be presented with an opportunity to execute a contract for the sale of their organs when they either received a driver's license, bought insurance, answered a specific solicitation for organ donation through the mail or – for that matter – stood on a street corner.⁸² The main difference with this proposal from the present system would be that the seller–donor would be promised remuneration – primarily at death. Functioning along the lines of the National Organ Procurement and Transplantation Network, pertinent donor information, including any limitations imposed on which organs were harvestable, would be fed into a computer and accessed by telephone.⁸³

While payment at death for these organs harvested successfully would be the most efficient, two other payment systems would be available: under one, at the time of execution of the organ sales contract, a vendor could be paid a fee for all of his organs made available at death; or under another scheme, an executory contract could be entered into by both parties – vendor and vendee – specifying that the vendor's estate or designated person would be paid a set fee for the cadaver whether or not upon examination at death the organs were determined harvestable.⁸⁴ Of central concern regarding the second scheme – payment at the time of contracting – would be the necessity to develop a monitoring system whereby individual sellers were not able to enter into multiple contracts for the sale of their body parts.⁸⁵ It has been suggested that the donor fee could be set at \$5,000.00 for each major organ (e.g., liver, kidney, heart), with lower amounts for blood, skin bone marrow, corneas and pituitary glands.⁸⁶ If – for example – married male donors could be educated to the fact that the contract for the sale of their organs at death had the effect of being a form of supplemental life insurance policy with a

payoff as high as \$30,000.00, it is thought many such men would sign on as donors.⁸⁷

The final economic mechanism for obtaining organs for transplantation has been a standard death benefit payment of \$1,000.00.⁸⁸ This would be paid by presently operating organ procurement organizations to the families of the organ donors and ideally would not be viewed as coercive in any way – but rather only motivational.⁸⁹ The amount and the source of the benefit would be controlled strictly by law thereby hopefully continuing the prohibition on bartering for organs.⁹⁰ Under this proposal, any organ obtained – regardless of whether the donor family accepted the death benefit payment – would enter the national organ allocation system where all donee-recipients are registered and treated alike and where allocations are made, in turn, on matching medical need and period of time waiting.⁹¹

Of course for this proposal to be adopted without any real or implied complications – as with the futures market itself – the illegality of such payments presently set forth in the National Organ Transplant Act and the Uniform Anatomical Gift Act of 1987 would have to be amended to allow administration of this one-time death benefit to a donor family.⁹² Since these present laws allow reasonable payments to be made to those who participate in the actual harvesting of the human organs for transplantation (e.g., surgeons, hospital staff involved in donor care) why, it may be asked, should not a similar reasonable payment be allowed to the family members of the donor – who, next to the donor himself are the most important participants in the process of harvesting and transplantation?⁹³

ETHICAL, MORAL AND RELIGIOUS CONCERNS

As might be expected, various ethical, moral and religious concerns have been raised to these market mechanisms designed to increase the supply of harvestable organs for purposes of transplantation.⁹⁴ Chief and foremost has been the financial vulnerability of the poor to being pressured into becoming ‘forced’ donors; forced as such by their own circumstances and coerced by enticement of affluent buyers.⁹⁵ Other concerns are whether a commercial market would enhance opportunities for suicides and murders⁹⁶ and promote harvesting of the organs of anencephalic infants before actual death.⁹⁷ Those religious views and traditions that regard the body as a gift of God and man’s rights in it as merely those of a steward with no correlative rights of ownership would include a prohibition on the sale of body parts and would thus be in direct conflict with these market mechanisms.⁹⁸

These fears of the slippery slope are understandable. Yet, while it is recognized that commercial profit making with non-related donors may have a tendency to promote an exploitation of those who are financially vulnerable, and may lead to progressive abuses and self-degradations, it is

argued here that death payments benefits cannot be properly viewed as morally objectionable. This is simply because the verifiable benefits of sustained life that accrue to participating donees of non-commercial organ sales outweigh the moral fears or costs of using this mechanism as an inducement for stimulating the market for transplantable organs.⁹⁹

Utilitarian v Egalitarian Allocative Standards

The search for rational and principled standards of apportionment of scarce resources is and will remain a vexatious problem for decades to come. Informal 'rules of thumb' cannot be countenanced. Of course, one way to avoid totally the problem of distribution is to avoid using the scarce medical resource altogether. But, here, this would mean certain death to the countless thousands of transplant hopefuls.

Both in the formation of the transplantation waiting list and the actual distribution of donated organs, there is however, a consensus that the primary criterion operable at both stages should be medical: that is, medical need and probability of success. Intense debate focuses rather upon whether these medical criteria should be defined broadly or narrowly (i.e., the relevance of factors such as age, life-style and probability of success measured by a qualitative survival).¹⁰⁰ Rehabilitation or salvageability – consistent with basic principles of *triage* – is also of relevance.¹⁰¹

Since the law provides at present no uniformly agreed-upon principles that may be applied in order to regulate the allocation of scarce medical resources (e.g., cadaveric and human organs), current medical practice draws upon a structure for decision-making evolved as such from a number of philosophical and ethical constructs. There are five utilitarian principles of application that are operative in the hierarchy of *triage*: the principles of medical success, immediate usefulness, conservation, parental role, and general social value.¹⁰²

Translated as such into decisional operatives, there emerges a recognition that priority of selection for use of a scarce medical resource should be accorded to those for whom treatment has the highest probability of medical success or would be most useful under the immediate circumstances; to those candidates for use who require proportionally smaller amounts of the particular resource or to those having the largest responsibilities to dependents or to those believed to have the greater actual or potential general social worth. The utilitarian goal is, simply stated, to achieve the highest possible amount of some good or resource. Thus, utilitarian principles are also commonly referred to as 'good maximizing strategies'.¹⁰³

Egalitarian alternatives, on the contrary, seek either a basic maintenance or a restoration of equality for persons in need of a particular scarce resource. There are five basic principles utilized here: (1) the principle

of saving no one; thus priority is given to no one because, simply, none should be saved if not all can be saved; (2) the principle of medical neediness under which priority is accorded to those determined to be the medically neediest; (3) the principle of general neediness which allows priority to be given to the most helpless or generally neediest; (4) the principle of queuing, where priority is given to those individuals who arrive first; and, lastly, (5) the principles of random selection, where priority of selection is given to those selected by pure chance.¹⁰⁴

To the utilitarian, maximizing utility, and hence what is diffusely referred to as the 'general welfare', are both the primary ground and subject of all judgments. That which is required in order to maximize utility overall may thus infringe upon an individual's own entitlement of rights to particular goods. Accordingly, moral rights are either rejected generally, or recognized as certainly not absolute.¹⁰⁵

Philosophy and religion may well provide us all with the necessary balance and direction for life and allow us to develop an ethic for daily living and a faith as to the future. The basic challenge of modern medicine should be, simply, to seek, promote, and maintain a level of real – and, when the case may indicate, potential – achievement for its user-patients which allows for full and purposeful living. Indeed, man himself should seek to pursue decision-making responsibilities and exercise autonomy in a rational manner and guided by a spirit of humanism. He should seek, further, to minimize human suffering and maximize the social good. Defining the extent and application of the social good will obviously vary with a situation of each case.¹⁰⁶

CONCLUSIONS

Thus far, it has been seen that voluntary donations of cadaveric organs have been an ineffective means of tackling the crisis in organ transplantation and the same is true of the required request provisions of the federal legislation in 1987. Under current federal and state legislative directives, sale of human organs is prohibited. Compulsory post mortem examinations and retrievals bear a close resemblance to recognizing a new collective property right by the government, through escheatage, in all the dead bodies of its citizens. Strong anti-government sentiments against intrusiveness into issues of privacy and autonomy – when combined with equally strong moral, religious and ethical attitudes about the sacredness of the body – will preclude these two mechanisms from ever being adopted successfully in America.

The development of a futures market, although fraught with two major obstacles as observed, nonetheless bears future study and testing. Perhaps the most attractive of all the suggested mechanisms is the standard death benefit – this simply because of its non-commercial focus. But – as with the

future market option – present laws in the United States would surely have to be re-written or amended regarding present prohibitions against the sale of organs to make certain such one-time death benefit payments would be allowed. As well, harvesting physicians will have to be educated to the needs (or, legal ‘rights’) of their living patients to ‘prosper’ from dead ones. Education on a massive scale in both public and private sectors is called for here.

Instead of trying to develop new and innovative approaches to organ retrieval, it has been suggested that more emphasis be placed on promoting voluntary, altruistic donations and ensuring the access to transplants is fair and the process for assisting transplant recipients to pay for their new organs is equitable. Indeed, the suggestion is even carried further urging public funding of transplants for the poor as well as establishing specific reimbursements policies for not only the costs of pre-transplant evaluation, food, baby-sitters, travel and housing for prospective patients but all economic assistance for those who are unable to work post-transplant.¹⁰⁷

These are noble sentiments and set a broadly defined philosophical goal to total equality of opportunity. Yet, these concerns are but one facet of the most central problem here: namely, developing a reliable (market) mechanism for assuring a ready supply of cadaveric organs for ready transplantation. Once this mechanism is set, remedial problems can be tackled. Some type of informed consensus must soon be reached in any event that develops a new mechanism for retrieving organs if, that is, the preservation of human life is to be advanced and not paralyzed by social taboos. Stated otherwise, ‘If human lives are to be saved, the agony of hard choices cannot be avoided.’¹⁰⁸ In the final analysis, then, a price – economic, social, legal, ethical, moral or religious – *must* be set in determining the allocative process for organ retrieval and transplantation; and market mechanisms would appear to be the most functional and objective tool for achieving this. Forced altruism, nurtured as such through the pursuit of lofty educational goals, does not have a practical history for dealing with the problems of the day. Perhaps the words from the book of Deuteronomy provide both a contemporary and useful ethic to utilize here: ‘I have set before you life and death, blessing and curse; therefore choose life, that you and your descendants may live’.¹⁰⁹

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14. Scott, R. (1981) *The Body as Property*, pp. 6, 7. Allen Lane; London.
15. *ibid*.
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17. *ibid* at p. 8.
18. *ibid* at pp. 11, 12.
19. Uniform Laws Annotated (1983), 8a, §§22-23 (Supp. 1991).
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23. Vestal, A., Jaber, R. and Shoemaker, W. (1954) *op cit*.
24. *ibid*.
25. Delaware, Hawaii, Oklahoma, Nevada and New York. Cohen, L.R. (1989) *op cit* p. 7.
26. Hansmann, H. (1989) *op cit* p. 59.
27. Cohen, L.R. (1989) *op cit* p. 7.
28. Mississippi still allows its citizens the right to sell their body parts to hospitals - with delivery to be effectuated after death. Mississippi. Code Annotated §41-39-9 (1972 & Supp. 1988).
29. Cohen, L.R. (1989) *op cit* p. 8.
30. Mehlman, M.J. (1991) Presumed consent to organ donation: a re-evaluation. *Health Matrix*, 1, pp. 31, 33.
31. *ibid* at p. 23.
32. *ibid*.
33. 42 United States Code §§273-274c (Supp. IV 1986).
34. See §273 note, §273(a) §274(b) (2). Violation of the Act carries with it a fine of \$50,000.00 or a five year jail sentence or both. See §274(b) (2). The sale of blood, as a bodily substance, had had a ready market by hospitals and commercial blood banks for years. In 1956, forty-two percent of the blood collected in New York City came from paid donors with the New York City Memorial Hospital obtaining sixty to seventy percent of its blood from commercial sources. Dukeminier, J. (1970) Supplying organs for transplantation. *Michigan Law Review*, 68, pp. 811, 847. Its commercial acquisition has been allowed traditionally because of the mild invasive nature by which it is obtained, the lack of risk to the donor (unlike that involved in organ donations) and its replenishable nature.
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37. United States Code, 42, §§273-274c (Supp. IV. 1986).
38. United States Code, 42, §§1320b-8(a) (1) (A), 1320b-8(a) (1) (A) (ii) (Supp. IV, 1986).
39. Caplin, A.L. and Welvang, P. (1989) Are required request laws working? altruism and the procurement of organs and tissues. *Clinical Transplantation*, 3, p. 170 (1989).
40. Caplin, A.L. and Welvang, P. (1989) *op cit* p. 174.
41. *ibid*.
42. *ibid*.
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48. Scott, R. (1981) *The Body as Property* Ch. 5. Allen Lane; London; Wadlington, Waltz, J. and Dworkin, R.B. (1980) *Cases and Materials on Law and Medicine* pp. 945-962. Foundation Press; New York.
49. Scott, R. (1981) *The Body as Property* p. 121. Allen Lane; London.
50. See *Little v Little*, 574 SW2d 493 (Ct. App. Tex. 1979); *McFall v Shimp*, (No. 78-17711, Equity), C.P. Allegheny County, Pa., July 26, 1978; *Lausier v Pescinski*, 226 NW 2d 180 (Wisc. 1975); *Hari v Brown*, 289A 2d 386 (Conn. Sup. Ct. 1972); *Strunk v Strunk*, 445 SW 2d 145 (Ky. 1969).

51. Scott, R. (1981) *The Body as Property*, *op cit* pp. 116–120.
52. Robertson, J. (1976) Organ donations by incompetents and the substituted judgment doctrine. *Columbia Law Review*, 76, p. 48.
53. *ibid* at p. 77.
54. *ibid* at p. 51.
55. Scott, R. (1981) *The Body as Property*, *op cit* pp. 120–122.
56. *ibid* at p. 122.
57. *ibid* at p. 137.
58. *ibid* at p. 183.
59. *ibid*.
60. *ibid* at p. 184.
61. Dukeminier, J. (1970) Supplying organs for transplantation. *Michigan Law Review*, 68, 857–863.
62. Robertson, J. (1976) *op cit* p. 50.
63. *ibid* at pp. 50–51.
64. Mehlman, M.J. (1991) *op cit* p. 31.
65. Sanders, D. and Dukeminier, J. (1968) A proposal for routine salvaging of cadaver organs. *New England Journal of Medicine*, 279, p. 413.
66. Dukeminier, J. (1970) *op cit* at 842 *passim*.
67. Mehlman, M.J. (1991) *op cit* at pp. 44–62, 66.
68. *ibid* at p. 66.
69. Cohen, L.R. (1989) *op cit* pp. 15–21.
70. *ibid* at p. 18. The National Organ Transplant Task Force, in particular, inveighed against the immorality of the system. *ibid*.
71. Norrie, K.M. (1985) Human tissue transplants: legal liability in different jurisdictions. *International and Comparative Law Quarterly*, 34, pp. 442, 460–461. The countries subscribing to this in 1985 were: Austria, the then Czechoslovakia, Denmark, Finland, Greece, Hungary, Italy, Norway, Poland, Spain, Sweden, Switzerland and the then West Germany. *ibid* at pp. 460–461.
72. Cohen, L.R. (1989) *op cit* p. 15.
73. *ibid* at p. 16.
74. *ibid* at p. 17.
75. Cohen, L.R. (1991) The ethical value of a futures market in cadaveric organs. In *Organ Replacement Therapy: Ethics, Justice and Commerce* (W. Land and J.B. Dossetor, eds.) p. 302. Springer-Verlag; Berlin.
76. Cohen, L.R. (1989) *op cit* p. 1; Hansman, H. (1989) *op cit*.
77. Peters, T. (1991) Life or death: the issue of payment in cadaveric organ donation. *Journal of the American Medical Association*, 265, p. 1302; Harvey, J. (1990) Paying organ donors. *Journal of Medical Ethics*, 16, p. 117. Another alternative to direct compensation for organs would be a promise of free medical care and assistance given to the organ donor for either a period of years or life for any or all subsequent diseases or disabilities arising from the removal of an organ. Dukeminier, J. (1970) *op cit* p. 848.
78. Hansmann, H. (1989) *op cit* p. 59.
79. Cohen, L.R. (1991) *op cit* pp. 308–309.
80. *ibid*.
81. Cohen, L.R. (1989) *op cit* pp. 32–33. Presently two countries—Brazil and India—tolerate markets in body parts. Caplin A.L. and Welvang, P. (1989) *op cit* p. 170.
82. Cohen, L.R. (1989) *op cit* p. 33.
83. *ibid*.
84. *ibid*.
85. *ibid*.
86. *ibid* at p. 35.
87. *ibid*.
88. Peter, T. (1991) *op cit*.

89. *ibid.*
90. *ibid* at p. 1304.
91. *ibid* at p. 1303.
92. *ibid* at p. 1304.
93. *ibid* at p. 1304.
94. Childress, R. (1987) Some moral connections between organ procurement and organ distribution. *Journal of Contemporary Health Law and Policy*, 3, p. 85.
95. Harvey, J. (1990) *op cit* p. 117. Moralisms (or assimilated moral and political rights) often act in a way to prohibit organ selling (Radin, M. (1987) Market-Inalienability, *Harvard Law Review*, 100, pp. 1864–1865). Even though strong moral objections combined with notions of self-paternalism and true paternalism may make it inefficient to sell organs and thus classify them as inalienable entitlements, this does not mean compensation to the holder of the entitlement will be denied if this entitlement is taken from him. Thus, although society forbids the sale of organs (e.g., kidneys, lungs), it will still generally compensate the individual whose kidney or lung is destroyed in an automobile accident. Calabresi, G. and Melamed, A.D. (1972) Property rules, liability rules and inalienability: one view of the cathedral. *Harvard Law Review*, 85, p. 1089 n. 4, at pp. 1112, 1113–1115.
96. Cohen, L.R. 61989) *op cit* pp. 40–43.
97. Scott, R. (1981) *op cit*.
98. Caplin, A.L. (1991) Commentary on Cohen. *Clinical Transplantation*, 5, pp. 467, 472.
99. Harvey, J. (1990) *op cit* pp. 118. While others fear the slippery slope of commercializing organ sales will lead to personal discomfort, insult, degradation or loss of value because bodily integrity will have become a fungible object (Radin, M. (1987) *op cit* p. 1881), others are more positivistic and view the slope as leading to a totally free market economy where everything scarce and desired is ownable and salable (or commodified). (Posner, R.A. (1977). *Economic Analysis of Law* pp. 29–33, Little Brown & Co: Boston). For another view, see also Calabresi, G. and Bobbitt, P. (1978) *Tragic Choices*. Norton; New York.
100. Smith, G.P. (1989) *The New Biology: Law, Ethics and Biotechnology*. Plenum; New York.
101. Smith, G.P. (1985) Triage: endgame realities. *Journal of Contemporary Health Law and Policy*, 1, p. 143.
102. *ibid.* The three pivotal values that in focus in any decisional process involving tragic choices are efficiency, honesty and equal treatment—with most societies giving precedence to some conception of equality. Calabresi, G. and Bobbitt, P. (1978) *op cit* pp. 24–25.
103. Smith, G.P. (1989) *op cit*; Pellegrino, D.G. (1986) Rationing health care: the ethics of gatekeeping. *Journal of Contemporary Health Law and Policy*, 2, p. 23.
104. Smith, G.P. (1989) *op cit* Ch. 5.
105. *ibid.*
106. Smith, G.P. (1989) All's well that ends well: toward a policy of assisted rational suicide or merely enlightened self-determination? *University of California-Davis Law Review*, 22, 275; Smith, G.P. (1990) The Frankenstein myth and contemporary human experimentation: spectre, legacy, curse or imperative. *BioLaw*, §463.
107. Caplin, A.L. (1991) Commentary on Cohen. *Clinical Transplantation*, 5, pp. 467, 472.
108. Dukeminier, J. (1970) *op cit* pp. 811, 847.
109. *Deuteronomy*, 30:19.