Rethinking the National Organ Transplant Program: When Push Comes to Shove

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I. Introduction

Human organ transplantation is no longer considered experimental medicine. An individual's chance of surviving with a transplanted organ is greater than ever before; "[t]ransplant patients not only survive, but also return to their families and communities to lead active, productive lives." More than 36,000 people are currently waiting for an organ transplant in the United States, and each day at least six more of them die before an organ becomes available. Of those presently waiting for major organ transplants such as a liver or a heart, one third will die before receiving the needed transplant. Even more alarming, "[t]he shortage of pediatric organ donors is so severe that 30% to 50% of children younger than the age of 2 who are registered for transplantation will die while..."
Tragically, the shortfalls are not the result of an inadequate supply of available organs. Indeed, if more efficiently utilized, the available organ donor pool may adequately meet current transplant needs. However, traditional methods of accessing the potential donor pool have proven ineffective as the annual number of organ donors remains at approximately 4,000 in the United States. In light of this unmet demand, the failure of traditional methods of organ procurement requires an examination of nontraditional means of increasing the potential-to-actual donor ratio and the development of alternative sources of possible transplant organs.

Proposed methods for increasing the potential-to-actual organ procurement ratio include routine request laws, presumed consent, a national

7. Evans, supra note 4, at 239. "[A]t a minimum something on the order of 12,000 hearts and livers and 24,000 kidneys are potentially available for transplantation." Lloyd Cohen, Increasing the Supply of Transplant Organs, 58 GEO. WASH. L. REV. 1, 5 (1989).
8. Evans, supra note 4, at 245. It is estimated that 34,000 potentially available kidneys, and 17,000 potentially available hearts, livers, lungs and pancreata are lost each year. Matten, supra note 2, at 155.
9. Traditional organs for transplant are procured from a “brain dead” individual after the “death” of the individual has occurred. Younger & Arnold, supra note 5, at 2769.
10. Evans, supra note 4, at 239. The actual donor supply has remained virtually unchanged except for an increase of 9.1% in 1990. Id. The efficiency of current organ procurement stands between 37% to 59%. Id. However, the actual organs available for transplant may dip even with an increase in efficiency because, by some estimates, the potential pool of donors is shrinking. Younger & Arnold, supra note 5, at 2769.
12. See George Kolata, Panel Ponders Organ Procurement Problem, 250 JAMA 455, 455 (1983); Smith, supra note 11, at 18; see also Controversial Solutions to Organ Donation Crisis to be Addressed at Regional Forum, PR NEWSWIRE, Mar. 18, 1992, available in LEXIS, Nexis Library, Omni File (reporting an upcoming meeting of healthcare professionals to discuss alternative methods of organ procurement and the increase of interest in the area of alternative solutions).
13. See Younger & Arnold, supra note 5, at 2769 (discussing the growing interest in turning to alternative sources for organ procurement as a result of frustration with current approaches).
14. Matten, supra note 2, at 156. The effectiveness of routine request laws has been the subject of debate. Compare Dr. James Prottas, Shifting Responsibilities in Organ Procurement: A Plan for Routine Referral, 260 JAMA 832 (1988) (arguing for the implementation of routine request protocols) with Robert Falcone et al., Organ Procurement, 261 JAMA 380, 380-81 (1989) (despite their full scale implementation of routine request protocols, the authors “have not seen the optimistic family response quoted by [Dr. Prottas] in consenting to the harvest of vital organs”).

organ draft, and financial incentives. Alternative transplant organ sources include animal organs, living donor transplants, partial transplants in the case of livers and lungs, retrieval from anencephalic infants, and "non-heart-beating" cadaver donors. Unfortunately for those who could benefit from the potential increase via utilization of the nontraditional approaches, the organ transplant process is one of the "most morally-tinged area[s] of health care," causing even the mere consideration of these nontraditional methods and sources to be controversial. Nevertheless, the possibility of reducing the number of needless deaths that result from the organ shortage compels the examination of nontraditional sources.

Of particular controversy are proposals which use economic mechanisms as a means to encourage organ donation. Federal law currently prohibits financial gain on the part of the organ donor. The primary concern is that such programs would turn the human body into a commodity and lead to the inequitable distribution of transplant organs—a result deemed unsatisfactory by most. But mandating reliance upon

18. Younger & Arnold, supra note 5, at 2769.
19. Id. See also Smith, supra note 11, at 21 (stating that living donors have been used in organ transplantation since World War II).
20. Younger & Arnold, supra note 5, at 2769.
21. Kathleen Nolan, Anencephalic Infants: A Source of Controversy, Oct.-Nov. 1988, HASTINGS CTR. REP., at 5. This is one of the most important sources to receive current attention because of the extreme lack of transplant organs available to infants. See Morris, supra note 6, at 412. This source, however, is also one of the most resisted. Cf. Norman Fost, Organs From Anencephalic Infants: An Idea Whose Time Has Not Yet Come, Oct.-Nov. 1988, HASTINGS CTR. REP., at 15.
22. Younger & Arnold, supra note 5, at 2769. Non-heart beating donors are not commonly used because of fears of organ quality degradation. Id.
23. Colburn, supra note 1, at Z10; see Evans, supra note 4, at 239; Younger & Arnold, supra note 5, at 2771; Stuart Younger et al., Psychosocial and Ethical Implications of Organ Retrieval, 313 NEW ENG. J. MED. 321, 321 (1985).
25. RENEE.C. FOX & JUDITH P. SWAZEY, SPARE PARTS 207 (1992); Kittur et al., supra note 15, at 1442.
28. Bioethicists warn that the poor will be coerced financially to donate organs for the
traditional methods of organ procurement as a means to ensure the equitable allocation of available transplant organs already ignores the experience of many individuals within the present organ transplant system. For instance, to be placed on a waiting list for an organ, a person must be able to pay the cost of the transplant procedure, which can approach $250,000. Indeed, the current inequality of transplant opportunities between the poor and the rich is extensive, particularly with respect to members of minority groups. Minorities are less likely than whites to donate organs and to receive organ transplants. Minorities also have more difficulty finding an organ match than other groups and are 10% to 20% more likely to experience organ rejection as a result of being forced to rely on organs that do not provide a close antigen match.

Many transplant professionals and bioethicists insist that the traditional methods of organ procurement are altruistic in nature, and that economic considerations would be inconsistent with such an organ transplant system. Yet every party involved in the organ procurement and transplant process, except for the donor, receives financial compensation. Moreover, transplant hospitals routinely bill transplant patients more than

benefit of the rich and that people may even be murdered for their organs and tissues. See, e.g., Smith, supra note 11, at 25 (questioning "whether a commercial market would enhance opportunities for suicides and murders and promote harvesting of the organs of anencephalic infants before actual death").

29. There may be as many as 75,000 additional people needing transplants who do not have the money necessary to get on the organ transplant waiting list. Scott Shepard, Diamond Aims to Spark National Debate on Organ-Procurement Issue, 15 MEMPHIS BUS. J. 14 (1993).

30. Ricks, supra note 24, at A1; see generally Roger W. Evans, Money Matters, 21 TRANSPLANT PROCEEDINGS 3419 (1989) (discussing whether the ability to afford transplantation should ever be a factor in allocation).


32. Marcia Dunn, Doctors Work to Overcome Reluctance Among Blacks to Donate Organs, L.A. TIMES, June 14, 1987, at 21. In Washington D.C., more than 60% of the kidney dialysis patients are black. Id. Sixty percent of the people who receive transplants there are white, making the rate of organ transplants for whites there nearly double the rate for blacks. Id.

33. See id.; see also Evans, supra note 4, at 245 (discussing the problems associated with immunologic considerations and donor selection criteria).

34. See, e.g., Edmund Pellegrino, Families' Self-interest and the Cadaver's Organ, 265 JAMA 1305 (1991); Fox & Swazey, supra note 25, at 207; Smith, supra note 11, at 25 ("religious views and traditions . . . 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"); Kittur et al., supra note 15, at 1442.

twice the hospital's organ acquisition cost\textsuperscript{36} without being perceived as acting in conflict with the spirit of altruism.\textsuperscript{37}

It must also be recognized that lack of compensation to the donor for his or her "gift of life" does not reduce transplantation costs for the donee.\textsuperscript{38} Instead, the donor's gift provides a financial incentive to organ procurement organizations (OPO) to acquire more organs.\textsuperscript{39} It is a successful incentive. Regional OPOs are now beginning to compete with one another for individual organ acquisitions in order to realize greater economies of scale\textsuperscript{40} and to develop marketing techniques to sell "brotherhood like soap" in an effort to increase their proportional share of available organs.\textsuperscript{41}

In response to this reality, many medical and legal professionals advocate revision of the existing organ donation system and its statutory underpinnings to allow the impact of financial incentives on the supply of transplant organs to be studied.\textsuperscript{42} For example, a panel of the National Kidney Foundation recently announced that ethical and legal considera-

\textsuperscript{36} Roger W. Evans, \textit{Organ Procurement Expenditures and the Role of Financial Incentives}, 269 JAMA 3113, 3115 (1993). This figure is in addition to the hospital, surgical, and other fees. \textit{Id.} "Viewed generously, organ recipients and payers on their behalf are being asked to cross-subsidize [through the markup] other worthy causes in which transplant hospitals engage." Frank Sloan, \textit{Organ Procurement: Expenditures and Financial Incentives}, 269 JAMA 3155, 3155 (1993).

\textsuperscript{37} Sloan, supra note 36, at 3155; Evans, supra note 36, at 3113; see also Roger D. Blair & David L. Kasserman, \textit{Cadaveric Organ Procurement Policies}, 8 \textit{YALE J. ON REG.} 403, 412 (1991) (believing that the current problem is primarily an economic one).

\textsuperscript{38} Evans, supra note 36, at 3117. Whatever savings result from the donor's charitable "gift of life" is absorbed by the OPO in its organ acquisition cost markup. \textit{Id.}

\textsuperscript{39} \textit{Id.} at 3116. "A single multiorgan donor can save multiple lives and generate considerable revenue [for the OPO] as each recipient is separately billed for each donor organ." \textit{Id.}

\textsuperscript{40} Bill Lumbricoid, \textit{Battle is Shaping Up in Congress Over Organ Procurement Rules}, St. Louis Post-Dispatch, June 24, 1993, at 8A. This occurs when an OPO sets up a procurement relationship with a hospital in another OPO's region. \textit{Id.}

\textsuperscript{41} Raymond L. Horton, \textit{Marketing the Concept of Becoming a Potential Organ Donor}, 11 J. Health Care MkTG. 36, 40 (Sept. 1991). When you talk somebody into buying your brand of soap, in the end he has a bar of soap. With public service, in the end, he has only the psychic reward. \textit{Id.} This sells a humanitarian act like a traditional product defined by the frequently used slogan, "the gift of life." \textit{Id. But cf.} Pellegrino, supra note 34, at 1305 ("Altruism is not a value [that can be] imposed on donor families. No one can be coerced into altruism because altruism requires a free and conscious recognition of other persons in the way we conduct ourselves.").

\textsuperscript{42} \textit{Be Open to New Ways to Spur Organ Donations}, USA Today, Sept. 24, 1991, at 10A; Dr. Thomas G. Peters, \textit{Life or Death: The Issue of Payment in Cadaveric Organ Donation}, 265 JAMA 1302, 1302-03 (1991); Evans, supra note 4, at 239; see also Bailey, supra note 35, at 365 (proposing solutions including payment to families of deceased donors).
tions should not necessarily preclude consideration of financial compensation as a method to increase consent to organ donation. Nor is the bulk of public opinion adverse to the idea of compensating an organ donor in order to increase donation rates. According to Dr. Wesley Alexander, chairman of the United Network of Organ Sharing donations committee, "[W]hen push comes to shove, the public has to make a decision as to whether they would rather see people die on dialysis while leading a fairly dissatisfying life . . . or to allow the buying and selling of human organs."

This Comment examines the ethical guidelines and state model codes regarding the organ procurement process including: The Unified Anatomical Gift Act (1968) and its 1987 revision; The National Organ Transplant Act of 1984; and the proposed Organ Transplant Program Reauthorization Act of 1993. Based upon ethical, legal, and financial considerations, this Comment recommends amending The National Organ Transplant Act to authorize the United States Department of Health and Human Services to sponsor a series of pilot programs, through the United Network of Organ Sharing (UNOS), which would employ limited financial incentives for organ donations as part of the present national organ allocation program. This Comment argues that such a series of programs, if conducted in the recommended manner, would be consistent with both the letter and the spirit of the current national organ transplant program.

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43. James Warren, A Literal Gift of Life, L.A. TIMES, Oct. 18, 1992, (Special Section) at 14. See also Smith, supra note 11, at 26 ("[T]he 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.").

44. Warren, supra note 43, at 14. Only 22% of those polled opposed compensation. Five percent thought it would cause abuse within the system, while two percent feared it would create a black market. Physicians, when polled, were found to be firmly opposed to the idea by as much as 80% of those surveyed. "[A] telephone survey of 1,000 Americans taken for Time magazine in June [1991] suggests that health professionals and ethicists may be out of touch with the public's attitude on the matter." Id. at 15; see also Smith, supra note 11, at 28 ("Forced altruism . . . does not have a practical history for dealing with the problems of the day.").


50. See infra notes 165-66 and accompanying text.
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II. CONSIDERATIONS

A. Ethical Considerations Regarding Organ Procurement and Allocation

Two rules are generally accepted as fundamental to an ethical organ procurement process. First, "vital organs should only be taken from dead patients, and, correlatively, living patients must not be killed by organ retrieval." Second, "the care of living patients must never be compromised in favor of potential organ recipients." In order to resolve the health care practitioner's possible conflict of interest between the potential donor and the potential recipient, a strict separation must always be maintained between the medical staff responsible for the transplantation process and those caring for the dying patient. If an increase in transplantable organs can be obtained in accordance with these rules, then attaining that increase should be the goal of public policy.

In addition, transplant organs, as a scarce medical resource, should be allocated in an effective, efficient, and equitable manner. This is best accomplished when organ donation is prioritized through a combination of egalitarian and utilitarian principles that balance the length of time a person has been waiting for a needed organ and the urgency of that need against the probability of success for the transplant procedure.

51. Younger & Arnold, supra note 5, at 2771.
52. Id. This is known as the "dead donor rule." Id.
53. Id.
54. Id.
55. Id.
57. Smith, supra note 11, at 26; see Evans, supra note 4, at 245 (describing the problems faced by immunologic incompatibility).
59. Egalitarian theory seeks to maintain or restore the equality of those in need. Smith, supra note 11, at 26.
60. Id. This is an example of utilitarianism, which attempts to achieve the maximum efficiency available from a scarce resource.
B. State Considerations Regarding Organ Procurement and Allocation

1. The Uniform Anatomical Gift Act of 1968

In 1968, the National Conference of Commissioners on Uniform State Laws61 (NCCUSL) drafted the Uniform Anatomical Gift Act of 1968 (UAGA of 1968) to serve as a guideline to state governments of principles and procedures for the donation and receipt of transplant organs.62 Under the UAGA of 1968, any competent adult has the choice to permit, specify, or forbid the use of his body and organs for transplantation, research, or educational purposes after his death.63 Consent to organ donation is accomplished by a testamentary instrument, such as a will, or a nontestamentary writing, such as a donor card.64 In the absence of memorialized intent, a decedent's next of kin can make the final determination of donation consent.65 Any such person acting in good faith in accordance with the UAGA of 1968's guidelines for granting third-party consent is immune from civil liability or criminal prosecution.66 In addition, the decedent may specify a particular use for his organs or identify a specific donee.67

The UAGA of 196868 intentionally omitted all reference to the role of financial incentives in the organ procurement process.69 The NCCUSL's drafters believed that until the impact of incentives to donate were felt "the matter should be left to the decency of intelligent human beings."70 This omission regarding financial incentives made the UAGA of 1968 less controversial and, therefore, more likely to be adopted by the states.71

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61. "The National Conference of Commissioners on Uniform State Laws (NCCUSL) was organized in 1892 to promote uniformity of state law." Ann McIntosh, Comment, Regulating the Gift of Life, 65 Wash. L. Rev. 171, 171 n.8 (1990).
63. UNIF. ANATOMICAL GIFT ACT (1968) § 2.
64. Id. § 4. However, "even if the decedent has a signed donor card on his person at the time of death, physicians will almost never retrieve organs without the permission of the next of kin." Developments in the Law: Medical Technology and the Law, 103 Harv. L. Rev. 1519, 1619 (1990).
65. UNIF. ANATOMICAL GIFT ACT (1968) § 2.
66. Id. § 7.
67. Id. § 4; Developments in the Law, supra note 64, at 1617 n.16; see also Note, supra note 62, at 1016-17.
68. UNIF. ANATOMICAL GIFT ACT (1968) §§ 1-7.
69. Note, supra note 62, at 1017.
70. Id. (footnote omitted).
71. See McIntosh, supra note 61, at 176. In contrast, the 1987 UAGA was the subject of controversy, particularly regarding its required request provisions, and has not been
By 1973, all fifty states and the District of Columbia enacted the UAGA of 1968. However, the organ deficit continued despite this unanimous endorsement.

2. The Uniform Anatomical Gift Act of 1987

The ineffectiveness of the UAGA of 1968 in alleviating the transplant organ shortage prompted the drafting of a new Uniform Anatomical Gift Act in 1987 (UAGA of 1987). The UAGA of 1987 expressly awarded priority to the donors over objections from the donors' next of kin, simplified the requirements for creation of a valid donor card, and banned commercial transactions involving cadaverous organ acquisition. The UAGA of 1987 also required medical personnel to request consent for organ donation from all suitable patients or their next of kin if the patient has not made this decision.

The UAGA of 1987 has not replaced the UAGA of 1968 in many states primarily because states object to the priority of donor consent. Therefore, at present most state laws do not prohibit transplant organ sales. Moreover, prior to adopting the UAGA of 1968, several of the state laws banning organ sales were repealed with the adoption of the UAGA of 1968, which did not itself address organ commerce.


72. Cohen, supra note 7, at 6.

73. Developments in the Law, supra note 64, at 1617 (discussing how the UAGA of 1968 standardized the organ procurement process but did not increase the organ supply).


75. Id. § 2(h).

76. Id. § 5. Even though a signed donor card is usually legally binding transplants still normally do not occur without the surviving family's consent, even in states that have adopted the UAGA of 1987. Id.

77. Id. § 10.

78. Id. § 5.


80. McIntosh, supra note 61, at 176. Resistance to the UAGA of 1987 is also due to controversy surrounding both the routine request provisions and the prohibition on organ sales. Id.


82. Note, supra note 62, at 1023.
C. Federal Considerations Regarding Organ Procurement and Allocation

1. The National Organ Transplant Act of 1984

In 1984, Congress enacted the National Organ Transplant Act83 (NOTA of 1984) to alleviate the scarcity of transplant organs and to improve donor-recipient matching through a national system of organ procurement and distribution.84 Congress attributed the low rate of organ donation and inefficient organ allocation to poor organization and lack of a national transplant organ system,85 and sought a solution through improvements in organ donation, procurement, and distribution.86 The NOTA of 1984 was intended to “strengthen the ability of the nation’s health care system to provide organ transplants”87 by developing procedures for the establishment of a nationwide organ network capable of responding to and quickly implementing future considerations of organ procurement and allocation policy.88 To aid in that objective, the NOTA of 1984 directed the Secretary of the Department of Health and Human Services (HHS) to establish a nationwide Organ Procurement and Transplantation Network89 (OPTN). The objective of the OPTN was to provide a central computer registry of potential transplant recipients to facilitate the distribution of organs among regional organ procurement organizations (OPOs) throughout the country.90 The United Network for Organ Sharing (UNOS), a transplant organ registry that predated the

85. See H.R. REP. No. 575, supra note 84, at 7. The Senate Conference Committee Report stated that the small number of medical centers able to perform organ transplants is a limiting factor of efforts to boost transplant rates. S. REP. No. 382, supra note 84, at 2, reprinted in 1984 U.S.C.C.A.N. at 3976.
86. H.R. REP. No. 575, supra note 84, at 8.
87. Id. at 6.
88. Id. at 6-7.
89. 42 U.S.C. § 274(a) (Supp. IV 1992). Even though established by Congress and reliant upon Congressional funding for continued operation, the OPTN was intended to be established in the private, not public, sector. S. REP. No. 382, supra note 84, at 15, reprinted in 1984 U.S.C.C.A.N. at 3981.
90. 42 U.S.C. § 274(b)(2). The OPTN was also intended to educate physicians regarding organ donations and to act as an informational center for organ transplants and donations within the United States. Id.
NOTA of 1984, was chosen to administer the OPTN. In addition, the NOTA of 1984 authorized HHS to establish a national system of regional OPOs and financially assist them in matching donated transplant organs with suitable recipients. The NOTA of 1984 also directed HHS to establish the Task Force on Organ Procurement (Task Force). The Task Force was directed to aid HHS by “conduct[ing] comprehensive examinations of the medical, legal, ethical, economic, and social issues presented by human organ procurement and transplantation” in an effort to develop new methods of improving the national organ procurement and allocation system.

With one exception, the NOTA of 1984 did not regulate the national organ system. Organ transplant centers were not required to participate in the national organ transplant system through the OPTN which, while central in nature, served only to coordinate the decentralized organ procurement and distribution system. “To the extent that other avenues of donation and procurement were available and more attractive, transplant centers and their patients were free to utilize those other sources and resources as well.”

92. 42 U.S.C. § 273(a) (Supp. IV 1992). To qualify as an OPO, an agency must, among other things, (1) be non-profit; (2) be qualified to receive Medicare reimbursement for kidney transplants; (3) serve a geographic area large enough to include at least 50 organ transplant donors a year; (4) have agreements with most of the medical facilities in its area capable of performing transplant procedures; (5) participate in the Organ Procurement Transplant Network and act in concert with its standards; and (6) comply with the statutorily required public and professional representations of its board of directors. 42 U.S.C. § 273(b); see also Blumstein, supra note 91, at 463.
94. 42 U.S.C. § 273. The Task Force was comprised of 25 members: 9 physicians or scientists who specialize in human organ transplantation, 3 non-physician organ transplant specialists, 4 experts in law, theology, ethics, or health care financing, 3 members of the general public, and 2 medical insurance specialists, the Surgeon General of the United States, the Director of the National Institutes of Health, the Commissioner of the Food and Drug Administration, and the Administrator of the Health Care Financing Administration. 42 U.S.C. § 273.
95. Id. The Task Force was required to submit its findings and recommendations to HHS in a final report which HHS was compelled by statute to consider. Id.
96. See 42 U.S.C § 274e (1988) (prohibiting the sale of human organs); see also Blumstein, supra note 91, at 465 (commenting on the dynamics of the federal ban).
97. See 42 U.S.C § 274e.
The one formal regulation under the NOTA of 1984 was a prohibition of commercial transactions involving human organs. Under 42 U.S.C. § 274e it is currently illegal to "knowingly acquire, receive, or otherwise transfer any human organ for valuable consideration for use in human transplantation." "[H]uman organ’ means the human (including fetal) kidney, liver, heart, lung, pancreas, bone marrow, cornea, eye bone, and skin, [or any other organ] specified by the Secretary of Health and Human Services by regulation." Violation of this law constitutes a felony punishable by a fine of $50,000 and/or five years imprisonment. This prohibition, however, “does not include the reasonable payments associated with the removal, transportation, implantation, processing, preservation, quality control, and storage of a human organ or the expenses of travel, housing and lost wages incurred by the donor of a human organ in connection with donation of the organ.” Thus, hospitals in which organs are procured and as well as the physicians who perform the surgical transplant procedures will receive financial compensation for their services.

The scant legislative history of section 274e reveals that its enactment was intended to avoid the “destructive impact” that the proposed market schemes, featuring private auction markets with transplant organs sold to the highest bidder, would have had upon the voluntary donation system. Congress feared that a for-profit system would prey upon the indigent members of our society or the Third World as a source for or-
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Section 274e, as enacted, therefore reflects the intent to prevent the human body from being treated as a commodity.

2. The Task Force on Organ Transplantation

In 1986, the Task Force issued its report in which it recommended the immediate establishment of a national network to regulate, rather than merely coordinate, organ acquisition and distribution in order to increase organ acquisition and to improve the equity of allocation. The report advocated increasing public education and outreach through the intense advertisement of the humanitarian value of organ donation. The report recommended that hospitals establish a procedure of routinely asking the immediate family of the dying individual to consider allowing organ donation. In addition, the 1986 Task Force report indicated that organ allocation must be based on objective medical criteria, such as the patient’s need for the transplant, the probability of transplant success, and, in cases where the candidate patient is otherwise equally medically qualified to receive a transplant, by their length of time on the waiting list. To facilitate meeting these criteria, the Task Force recommended expanding private and public health benefit programs to include heart and liver transplant procedures, as well as requiring Medicare and Medicaid to cover the cost of outpatient drug therapy for organ recipients.

3. The Omnibus Budget Reconciliation Act of 1986

Responding to the 1986 Task Force report, Congress included within

111. Id. at 68.
112. Id. at xxi.
113. Id. at 4.
114. Id. at 3. “The ostensible rationale is that families, who have legal authority to donate organs of their next-of-kin, should be given the opportunity to do a good deed for society and to feel good about themselves by donating their dying relative’s organs to the common weal.” See Blumstein, supra note 91, at 467 (citations omitted).
116. Robert Pear, Federal Payment for Transplants for Poor Studied, N.Y. Times, May 18, 1986, at A1. This extended coverage was estimated to cost between $42 and $70 million each year. Id.
the Omnibus Budget Reconciliation Act of 1986\textsuperscript{117} (OBRA of 1986) a mandate that all facilities engaging in organ procurement or transplant procedures (participating institutions) become members of the nationwide organ procurement and transplant network (OPTN) instituted under UNOS by the NOTA of 1984, or forfeit their eligibility to participate in all Medicaid and Medicare programs.\textsuperscript{118} This altered the role of UNOS. Instead of merely acting as the coordinator of the Organ Procurement and Transplantation Network, UNOS became the regulator of the OPOs and transplant hospitals.\textsuperscript{119} With qualification for membership in UNOS as a prerequisite for continued transplant facility operation in the United States, UNOS was able to adopt and maintain strict standards and practices for membership.\textsuperscript{120} No transplant hospital would risk disbarment of the entire hospital from Medicare or Medicaid participation by failing to comply with UNOS's policies.\textsuperscript{121}

The OBRA of 1986\textsuperscript{122} also added requirements for all participating transplant hospitals to establish written protocols for identifying potential organ donors,\textsuperscript{123} notifying their regional OPO of the potential donor's presence,\textsuperscript{124} and requiring that the families of identified potential donors be informed by the participating institution of their option to consent or decline performance of the donation procedure.\textsuperscript{125}

4. Senate Bill 1597: The Organ Transplant Program Reauthorization Act of 1993

On October 27, 1993, Senator Edward M. Kennedy of Massachusetts\textsuperscript{126} introduced Senate Bill 1597: The Organ Transplant Program Reauthor-

\begin{thebibliography}{99}
\bibitem{119} 53 Fed. Reg. 6525, 6528 (1988) (detailing HHS's vision of UNOS as the organ program watchdog).
\bibitem{120} 42 U.S.C. § 1320b-8; UNOS guidelines include strict personnel qualifications, certain minimum survival rates and stringent facility requirements. UNOS, BY-LAWS, app. B (June 1993).
\bibitem{121} UNOS, supra note 120, at IV-1. UNOS requires that all transplant hospitals come into full compliance with its standards, and if, after a short grace period, UNOS approval is not secured, the hospital must not perform any further transplant procedures until it has established itself as fully complying to UNOS's satisfaction. \textit{Id}.
\bibitem{122} 42 U.S.C. § 1320b-8.
\bibitem{123} \textit{Id}.
\bibitem{124} \textit{Id}.
\bibitem{125} \textit{See id.; see also} Matten, supra note 2, at 156 (discussing nurses' unique access to patients and their families in the context of organ procurement).
\bibitem{126} S. 1597, 103d Cong., 1st Sess. (1993).
\end{thebibliography}
ization Act of 1993 (S. 1597) into the 103rd Congress to reauthorize the National Organ Transplant Act of 1984 (NOTA of 1984). In addition to reauthorizing the NOTA of 1984, S. 1597 attempts to improve organ procurement by increasing public education programs that train people in requesting donations, and providing technical assistance to organ-procuring organizations and hospitals. Senate Bill 1597 also seeks to alleviate the more severe organ shortages faced by minority and other populations by requiring that each regional OPO:

Evaluate annually, and report to the Organ Procurement and Transplantation Network . . . on the effectiveness of the organization in acquiring potentially available organs, particularly among minority populations, and the variation of procurement across hospitals within the organ procurement organization region, and identify a plan to increase procurement, particularly among minority populations and other populations for which there is a greater degree of organ shortages relative to the general population, and at hospitals with low rates of procurement.

Finally, S. 1597 requires the General Accounting Office and Office of Technology Assessment to study numerous issues relating to organ procurement and allocation, to evaluate the effect of the Organ Transplant Program Reauthorization Act of 1993 on improving the equitable allocation of organs nationwide, and to issue, within two years, recommendations for improving the national organ program.

127. Id. § 1 (authorizing citation of the bill as the Organ Transplant Program Reauthorization Act of 1993).
129. S. 1597 § 2(a).
130. Id. HHS would receive authorization to make grants to organ procurement organizations and other public and nonprofit institutions for the purpose of increasing organ donations. Id.
131. Id. “[T]he Secretary shall give priority to . . . minority or other populations for which there is a greater degree of organ shortages relative to the general population.” Id. § 2(b)(4)(F).
132. Programs initiated under this section of S. 1597 would receive funding priority by HHS. Id. § 2(a).
133. Id. § 2(b)(5). This includes “the number and percentage of cadaveric organ transplants for foreign nationals categorized by [OPO] and by transplant center . . . [as well as] any information on the current rate of organ donation by individuals other than United States citizens or legal residents.” Id. § 4.
134. Id.
135. Id. This evaluation would be submitted directly to Congress for their consideration. Id. Hearings, supra note 128, at 2 (testimony of Sen. Edward M. Kennedy).
However, S. 1597, in its current form, fails to address "financial incentives . . . as a method to increase organ donation and thereby improve the efficiency of organ procurement efforts" or to investigate the potential for "increasing the potential organ pool by turning to alternative sources."

III. **Analysis**

**A. Analysis of the Current State of the National Organ Transplant Program**

For all of its modifications of the NOTA of 1984, S. 1597 does no more than continue the hope that "greater public recognition of the need for these life-saving gifts" will be sufficient to end the continuing organ shortage. However, new questions are being raised as to the sufficiency of altruism as the sole motivation for organ donation. The coordinated network of organ procurement and distribution of the NOTA of 1984 has not alleviated the shortage of organs. Nor has the subsequent unification and regulation of that system, as recommended by the Task Force Report and instituted under the OBRA of 1986, provided a solution. As previously stated, organ donation rates have, for the most part, remained unchanged since 1989, while the demand for organ transplants increases daily. Consequently, the organ deficit continues to expand. There were approximately 13,000 people waiting for solid-organ transplants in 1988 compared to the more than 36,000 currently waiting.

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139. See generally S. 1597 § 2 (making no revision, in its current form, of § 274e of the NOTA of 1984).

140. See Smith, *supra* note 11, at 18; Evans, *supra* note 36, at 3114 (exploring the potential of financial incentives to increase the rate of organ procurement).


142. See *supra* notes 1-11 and accompanying text; *Hearings, supra* note 128, at 1 (testimony of Sen. Edward M. Kennedy).


The pressures of transplant organ demand have affected the distribution patterns of currently available organs and caused growing dissen- sion between local transplant facilities, the OPOs, and UNOS regarding the equitable allocation of available transplant organs. The existing scarcity has resulted in the politicization of organ distribution, creating opportunities for individuals with money and power. Indeed, a 1993 General Accounting Office report found that, in violation of federal law, present inequalities in the organ allocation system deny organs to sicker patients and to patients who have been on organ waiting lists longer than other equally medically qualified organ recipients. "The National Organ Transplant Program has resulted in a more systematic process for organ transplants, but problems still exist and improvements should be made."

B. Analysis of Proposals Involving Financial Incentives for Organ Donation

1. Market and Nonmarket Financial Incentives

Many of the early proposals suggesting or incorporating financial incentives as a means of improving the rate of organ donation promoted the establishment of organ brokerage systems that depended on market forces of supply and demand; dealing in human organs as if they were commercial property. Critics of these proposals for organ markets forecast the rise of a "black market" for organs if the proposals were

147. Lutz, supra note 136, at 32. Many OPOs set up relationships with hospitals outside the region designated to them by Congress. Id.
148. The recent controversy regarding the transplant procedure performed on Gov. Robert Casey is a case in point. See CNN Crossfire: Buying Time? (CNN television broadcast, June 17, 1993) (transcript on file at J. CONTEMP. HEALTH L. & POL'Y).
151. Hearings, supra note 128, at 1 (testimony of Sen. Edward M. Kennedy). This statement is quoted somewhat sarcastically in the belief that it will remain applicable even after S. 1597 becomes law.
implemented.\textsuperscript{153} Indeed, much of the impetus behind congressional enactment of section 274e was the fear of an unregulatable market in human organs.\textsuperscript{154}

However, current proposals involving financial incentives pursue nonmarket approaches for increasing procurement rates. Proposed incentives include coverage of funeral expenses, estate tax breaks, or college education benefits for survivors.\textsuperscript{155} It is important to note that such incentives do not permit the buying or selling of organs as property, but instead appear as alternatives to altruism in rewarding the decision to consent to organ donation.\textsuperscript{156}

2. \textit{The Death Benefit Pilot Program}

In 1991, Dr. Thomas G. Peters proposed the study of a death benefit payment to families of potential organ donors as a means of increasing actual organ donations and providing a more equitable allocation of organs.\textsuperscript{157} This “death benefit” is a $1,000 payment offered to the individual “who legally enables organ donation in any case where solid-organ recovery for transplantation is completed.”\textsuperscript{158} To prevent conflicts of interest, whether on the part of the medical center or the surviving family, no effort to obtain the organs would be made prior to the time of brain death.\textsuperscript{159} In addition, acceptance of the death benefit would be only an

\begin{itemize}
\item \textsuperscript{153} Blair & Kasserman, \textit{supra} note 37, at 416. This recent study of organ procurement policies indicates that the imbalance between supply and demand encourages black market profiteers, and that if the supply of transplant organs were increased to better meet demand, black market practices would wither. \textit{Id.} A similar situation exists in the adoption field, where an excess demand for children has led, in some cases, to bribery and other forms of coercion. \textit{See generally} Elisabeth Landes & Richard A. Posner, \textit{The Economics of the Baby Shortage}, \textit{7 J.L. STUD.} 323 (1978).
\item \textsuperscript{154} \textit{See supra} notes 100-09 and accompanying text; S. \textit{REP.} NO. 382, \textit{supra} note 84, at 4, \textit{reprinted in} 1984 U.S.C.C.A.N. at 3978; \textit{see also} Blumstein, \textit{supra} note 91, at 465 (commenting on the dynamics of the federal ban).
\item \textsuperscript{155} Bailey, \textit{supra} note 35, at 366.
\item \textsuperscript{156} \textit{Id.}
\item \textsuperscript{157} Dr. Thomas G. Peters, \textit{Life or Death: The Issue of Payment in Cadaveric Organ Donation}, \textit{265 JAMA} 1302, 1302 (1991).
\item Several active organ procurement organizations should test the concept of death benefit payment in the field. If a greater number of organs are procured, a nationwide program should be adopted so that a compassionately administered, centrally controlled death benefit payment plan to families of cadaveric organ donors is operating throughout the United States. \textit{Id.} at 1302-03.
\item \textsuperscript{158} \textit{Id.} at 1304. “In general, the enabling individual is defined by law as the spouse, adult son or daughter, parent, brother or sister, or legal guardian (in that order).” \textit{Id.}
\item \textsuperscript{159} \textit{Id.} at 1303.
\end{itemize}
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option, not a requirement of organ donation. "[N]o family would be compelled to accept payment for recovered organs." Because the goal of the death benefit program would be to increase the actual number of organs donated in a cost efficient manner, there would be no payment until the actual organ recovery occurred.

However, under the state-adopted provisions of the UAGA of 1987, section 274e of the NOTA of 1984, and the current version of S. 1597, a death benefit pilot program to study the impact of financial incentives upon the transplant organ supply may be considered illegal. More important, any transplant facility attempting to conduct such a pilot program without government sanction would jeopardize its UNOS membership status, thereby endangering its participation in Medicare and Medicaid. Thus, this Comment recommends that Congress add a provision to the NOTA of 1984 authorizing HHS to confer grants upon its designated OPTN for the limited purpose of planning and conducting a death benefit pilot program. This program would further examine “organ procurement expenditures and the role of financial incentives” in encouraging organ donation. As part of this authority, HHS should create a panel, similar to the Task Force created under NOTA of 1984, to independently observe and report, either to HHS or to Congress, within a specified time period, on the rates of organ procurement under the initiated programs, and those programs’ overall cost efficiency.

IV. Implications

A. Ethical Implications of the Death Benefit Pilot Program

Ethically, institution of a death benefit pilot program would neither

160. Id.
161. Id.
162. Id. at 1304. Payments for prior consent would lead to speculation and might give rise to suspicion as to the inevitability of the donor’s death. Id.
163. Id.
164. To remain a member of UNOS a transplant hospital must strictly maintain all UNOS guidelines. The institution of the death benefit pilot program would constitute a risky deviation. See generally UNOS, supra 120, at app. B.
165. Evans, supra note 36, at 3113. However, federal authorization of the death benefit pilot program should be written so as not to prevent a state from choosing to exclude participation of its OPOs in the death benefit program, especially those states that have enacted versions of the UAGA of 1987.
166. This report provision would conceivably be analogous to the Task Force report and recommendation requirement included in the NOTA of 1984. See 42 U.S.C. § 273. Alternatively, the report can be added to the GAO and the Office of Technology Assessment reports which are already included as part of S. 1597. See S. 1597 § 4(b).
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degrade whatever altruistic spirit the current procurement system presently possesses nor alter the current means of organ allocation.167 In addition, "on ethical grounds, if everyone else involved in transplantation, the [OPO], the surgeon, the nurses, and the hospital, receive compensation, why should the donor's family be excluded?"168 Perhaps most important, "the desire to promote a particular ethical environment should not come at the expense of those awaiting transplantation."169

B. Legal Implications of the Death Benefit Pilot Program

Legally, it is indisputable that Congress intended to prevent the commercialization of the human body.170 But there is no evidence that Congress meant to prohibit all organ procurement procedures that employ financial incentives yet operate in a non-market environment.171 When Congress enacted section 274e its concerns were the effect a for-profit organ procurement system would have upon the national transplant program, which at that time was a decentralized and unsupervised system.172 Congress feared that a commercial market system of organ procurement and distribution would operate coercively, or otherwise inappropriately, in the organ procurement process.173 But with the current organ procurement and distribution program tightly controlled under UNOS,174 such fears of an unscrupulous market in transplant organs are unjustified.175

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167. Peters, supra note 42, at 1304. In addition, the National Kidney Foundation proposed that an individual who agrees to donate his or her organs at death could receive a financial award to his or her estate or to a previously designated beneficiary. Lutz, supra note 136, at 34.

168. Sloan, supra note 36, at 3155. "A single multiorgan donor can save multiple lives and generate considerable revenue as each recipient is separately billed for each donor organ." Evans, supra note 36, at 3116.

169. Developments in the Law, supra note 64, at 1624.


172. The OBRA of 1986 made membership in the OPTN mandatory, unifying the national organ program under UNOS. See supra notes 117-25 and accompanying text.

173. See S. REP. No. 382, supra note 84, at 13, reprinted in 1984 U.S.C.C.A.N. at 3979 (noting that "it is timely to direct the development of a national policy regarding the appropriate federal and private sector roles in organ transplantation").

174. See generally OBRA of 1986, Pub. L. No. 99-509 (1986); UNITED NETWORK FOR ORGAN SHARING BY-LAWS (May 1988). The scope of UNOS's authority has given rise to constitutional questions regarding the power of the federal government to delegate lawmaking or rulemaking authority to a private interest. Blumstein, supra note 91, at 476.

175. In addition, the complex legal issue of the commerciality of the human body does not require resolution for the death benefit program to be enacted. It is already settled law
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Administration of the death benefit program could occur under the existing national organ network with UNOS providing oversight and enforcement.\textsuperscript{176} Payment of the death benefit to the donor family would be conducted as part of the present OPO organ procurement cost reimbursement process.\textsuperscript{177} The regional OPOs would disburse the death benefit payment to the families, acquire and transfer the organs to the recipients, and then seek reimbursement from the OPTN (i.e., UNOS) for its incurred costs.\textsuperscript{178} This procedure could become part of the present OPO organ procurement cost reimbursement process with the singular addition of payment to the donor’s family.\textsuperscript{179} The central regulation and administration of the death benefit, controlled by federal law and supervised by UNOS, would act to eliminate any undesirable commercial payment practices from the procurement process.\textsuperscript{180}

A standard payment of $1,000 through the UNOS system, although tempting, would not be coercive in nature.\textsuperscript{181} Moreover, because procured organ allocation under the death benefit program is based upon equitable principles of matching, time waiting, and need,\textsuperscript{182} the “death benefit payment to the donor family would in no way favor those who could better afford costly medical care.”\textsuperscript{183} To the contrary, one of the expected benefits of the death benefit program is an increase in the donation rate among minority populations, which are among the most underrepresented and under-served by the present transplant system.\textsuperscript{184} Finally, there is no evidence that transplant organ quality would deteriorate

\textsuperscript{176} Peters, supra note 42, at 1304.

\textsuperscript{177} Id.

\textsuperscript{178} Id.

\textsuperscript{179} OPO cost accounting “would treat the death benefit payment to the enabling family member no differently than it treats payment to the recovery surgeon, charter aircraft owner, or any other individual involved in the organ procurement and distribution process.” Id.

\textsuperscript{180} Id. Organ brokering and commercialization are the main concerns, but their viability depends upon a market system. The death benefit would not permit development of such a market system. \textit{See also} Blair & Kasserman, supra note 37, at 417 (detailing the market dynamics at work within the organ transplant system).

\textsuperscript{181} Peters, supra note 42, at 1304; Blair & Kasserman, supra note 37, at 417.

\textsuperscript{182} Peters, supra note 42, at 1304; Blair & Kasserman, supra note 37, at 417.

\textsuperscript{183} Peters, supra note 42, at 1303; Blair & Kasserman, supra note 37, at 417.

\textsuperscript{184} “The matching process involves immunologic determinations that are related, at least in part, to race.” Peters, supra note 42, at 1303.
under the death benefit payment program. The stringent medical criteria surrounding donor qualification would not be altered, and "cadaveric organ recovery is a one time event, not a habitual income-producing situation as in the skid-row blood donor."

The death benefit pilot program would also study the economic impact of the death benefit payment upon the current organ procurement system. "Whether implicit or explicit, the cost utility of financial incentives must be established before full-scale implementation." It is estimated that operation of the death benefit program would cost up to $4 million annually. However, that amount does not take into account the cost savings that may result from an increased organ supply.

If more organs were obtained through death benefit payment, the increased efficiency and use of nonexpendable resources (fixed costs) would promote an economy of scale diminishing some costs per organ recovered. Few organ procurement organizations are busy enough that they have made the best use of their fixed resources. In addition, it is clearly recognized that successful renal transplantation is far more cost-effective than continued dialysis treatment. Any pilot project to study the fiscal effects of the death benefit payment to families of organ donors should take into account the cost savings resulting from increased renal transplantation [versus] dialysis therapy.

In addition, funds that presently go to OPOs as implicit incentives for increased organ acquisitions could be set aside in order to defray the expense of a death benefit payment program, thereby further augmenting the program's cost effectiveness. Overall, the significant lifesaving benefits of the death benefit program far outweigh the slight cost increase to the current procurement system. Already, "[o]ne is struck by the

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185. Id.
186. Id. Similarly, the Mayo Clinic financially compensated approximately 60% of its blood donors between 1966 and 1970. Its patients had a remarkably low rate of "post-transfusion" hepatitis. Developments in the Law, supra note 64, at 1624.
187. Peters, supra note 42, at 1304.
188. Evans, supra note 36, at 3117.
189. Peters, supra note 42, at 1304.
190. Id. But see Evans, supra note 4, at 245 (noting the debate concerning the high expense of organ transplantation and its relative worth to society, with or without the added expense of the financial incentive).
191. Peters, supra note 42, at 1304.
192. The financial incentive to the OPOs results from the extensive markup of organ acquisition costs for reimbursement to the transplant hospitals. See Evans, supra note 36, at 3117.
193. See Developments in the Law, supra note 64, at 1629.
high level of organ procurement charges in spite of the characterization of organ procurement as altruistic." With an estimated average cost of $30,000 to $40,000 per transplant procedure, an additional $1,000 (the cost of the death benefit payment) increases the total cost per procedure by about four percent. Finally, instituting a limited death benefit pilot program would pose only a minor risk to the stability of the national organ procurement and distribution system. If the pilot program failed to conclusively demonstrate that the death benefit payment significantly increases the actual number of organs procured, the program could be ended with its participants reverting to the traditional methods of organ procurement, thereby leaving the current system undisturbed. Contrast this risk with the lives that may be saved if it works.

V. Conclusion

The death benefit proposal, if developed in the manner proposed above, can exist within the accepted legal and ethical boundaries that govern the national organ system. When push comes to shove, we as a society cannot focus our concerns on some abstract and philosophic moral imperative such as altruism while ignoring our collective responsibility to maximize lifesaving transplant organ recovery. It is recognized that organ brokerage cannot be allowed, and that the organ allocation system must be used fairly for all patients in need of a transplant. Compensating families for their donation of cadaveric organs could produce more organs. Those organs will save people who are, right now, literally dying to receive them.

John A. Sten

194. Sloan, supra note 36, at 3155.
195. Evans, supra note 36, at 3116 tbl.6. This figure does not include the potential savings from the diversion of OPO financial incentive funds to the death benefit program. See, e.g., Peters, supra note 42, at 1304.
196. Peters, supra note 42, at 1304.
197. Id. at 1302.
198. Id. at 1305.
199. Id.