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## A Small Price to Pay: Incentivizing Cadaveric Organ Donation with Posthumous Payments

Stephanie Zwerner

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# A Small Price to Pay: Incentivizing Cadaveric Organ Donation with Posthumous Payments

Stephanie Zwerner, JD MBA\*

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## I. INTRODUCTION

I walked out of class and received one of the most terrifying phone calls of my life. My mother, a strong, beautiful, selfless woman, had collapsed on the floor of the hospital, requiring her fourth blood transfusion in a matter of months in an attempt to sustain her failing liver. She had been waiting

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for an organ donation and transplant for many years; one that would never come.

The next day, a young and healthy college student dies tragically in a car accident. As an adult, he had told his family members that he wanted to be an organ donor. The day of his untimely death, the same day his intended organ donation must be effectuated,<sup>1</sup> his grieving parents cannot stomach the thought of organs being removed from their son's lifeless body. Despite the multiple lives his donation could save,<sup>2</sup> the hospital acquiesces to the family's emotion-ridden objection.<sup>3</sup> As a result, the gracious young man's organs die along with him, his directives regarding his own body are not followed, and thousands of people, including my mother, continue to wait.

At the same time, in the slums of an impoverished country, the leader of a criminal cartel recognizes that unsatisfied demand can bring exorbitant prices, especially when the buyer's life is on the line. He concocts a highly profitable, yet unimaginably ruthless new business plan and begins illegally obtaining and selling organs on the aptly named "red market."<sup>4</sup> An affluent patient recognizes this precious opportunity to escape the endless waiting list, and drains his savings account to purchase an organ, trying hard to forget the horror and immorality that surround the transaction.<sup>5</sup>

These nightmares are a reality for the hundreds of thousands of people affected by one of the worst sociomedical

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1. LOUIS A. GAMINO & R. HAL RITTER, JR., *ETHICAL PRACTICE IN GRIEF COUNSELING* 152 (2009) ("In cases of donation after cardiac death, recovery of donated organs begins immediately following a waiting period of 2–5 minutes after life support has been withdrawn . . . Immediacy of organ recovery for transplant is necessary because vital organs deteriorate so quickly after loss of blood supply and oxygen.").

2. See *About Transplantation*, U.S. DEP'T OF HEALTH & HUM. SERVS., <http://optn.transplant.hrsa.gov/learn/about-transplantation/> (last visited Sept. 7, 2016) (stating one cadaveric organ donation can save eight lives); see also Leonard H. Bucklin, *Woe unto Those Who Request Consent: Ethical and Legal Considerations in Rejecting a Deceased's Anatomical Gift Because There Is No Consent by the Survivors*, 78 N.D. L. REV. 323, 324 (2002) (illustrating that, on average, between three and four organs are recovered from each cadaveric donor).

3. See *infra* Part II.C.

4. See *infra* Part III.B.

5. See Erica D. Roberts, *When the Storehouse Is Empty, Unconscionable Contracts Abound: Why Transplant Tourism Should Not Be Ignored*, 52 HOW. L.J. 747, 765–68 (2009) (explaining how this activity, dubbed "transplant tourism," is an increasingly common and troublesome issue).

dilemmas of the century. The numeric figures are nothing short of shocking. This crisis kills 30 Americans every day.<sup>6</sup> It devastates the quality of life for over 100,000 more.<sup>7</sup> It costs the national economy tens of billions of dollars annually,<sup>8</sup> supports international organized crime, and motivates human trafficking and murder.<sup>9</sup> This crisis is the national organ shortage.

The demand for donated organs absolutely dwarfs the supply.<sup>10</sup> In 2012, slightly more than 14,000 people donated organs while 117,000 continued to suffer on the transplant waiting list.<sup>11</sup> As of September 2016, the waiting list has grown to over 120,000.<sup>12</sup> Sadly, approximately 8,000 of those waiting will die this year.<sup>13</sup>

An incredibly complicated problem, the organ shortage has several causes, including: Americans' unwillingness to register as organ donors,<sup>14</sup> objections by family members that contravene the intended donor's wishes, and hospital procedures and customs that allow the family's objection to stop an intended donation.<sup>15</sup>

This Note advocates a controversial, yet straightforward and effective solution to the national organ crisis— incentivizing cadaveric organ donation with monetary compensation. A new national donor registry would enhance

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6. Keith Humphreys, *An Organ Shortage Kills 30 Americans Every Day. Is It Time to Pay Donors?*, WASH. POST (Oct. 20, 2014), <http://www.washingtonpost.com/blogs/wonkblog/wp/2014/10/20/an-organ-shortage-kills-30-americans-every-day-is-it-time-to-pay-donors/>.

7. *Id.* at 762 n.107.

8. *Id.* at 766–67.

9. *Mexican Cartel Member Busted for Child Organ Trafficking*, N.Y. POST (Mar. 18, 2014, 12:41 PM), <http://nypost.com/2014/03/18/mexican-cartel-member-busted-for-child-organ-trafficking/>.

10. *See generally* UNITED NETWORK FOR ORGAN SHARING, 2012 ANNUAL REPORT (2013), <http://www.unos.org/docs/AnnualReport2012.pdf>.

11. *Id.* at 2.

12. *Organ Procurement and Transplantation Network*, U.S. DEP'T OF HEALTH & HUM. SERVS., <http://optn.transplant.hrsa.gov/> (last visited Nov. 25, 2016) (reporting data from 2003-2015).

13. *Id.* (“On average, 22 people die each day while waiting for a transplant.”).

14. *See* Tara Parker-Pope, *The Reluctant Organ Donor*, N.Y. TIMES: WELL (Apr. 16, 2009, 11:20 AM), <http://well.blogs.nytimes.com/2009/04/16/the-reluctant-organ-donor/> (reporting that only 38% of licensed drivers are registered organ donors).

15. *See infra* Part II.C.

the integrity and efficiency of the current donation system.<sup>16</sup> Donors and their families would be motivated and rewarded by a moderate payment to the decedent's estate after a donation occurs.<sup>17</sup> The proposed financial incentive would increase donations, familiar consent, and the transplantable organ supply.<sup>18</sup> In turn, a greater amount of donated organs would decrease deaths and suffering of those waiting for an organ, reduce violations of the donors' wishes, and fight the horrific illegal trade of organs.<sup>19</sup>

Part II provides the legal background on this topic, including state law, federal law, hospital custom, and human rights implications. Part III begins by outlining the details of the proposed national donor registry and incentivization system. Part III.B discusses how the proposal would alleviate several problems caused by the organ shortage, including increasing the organ supply, respecting donors' wishes, curbing national healthcare costs, and reducing the red market and related crime. Part III.C analyzes the proposal's limitations and offers additional recommendations. The Note concludes by imploring national legislative action to implement this proposal.

## II. BACKGROUND

The organ donation system is regulated by state laws, federal statutes, government agencies, and hospital customs and procedures.<sup>20</sup> States regulate organ donation and maintain donor registries.<sup>21</sup> Under federal authority,<sup>22</sup> the Organ Procurement and Transplantation Network (OPTN) matches donated organs with transplant recipients.<sup>23</sup> The donation and procurement (removing transplantable organs from the donor's

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16. *Infra* Part III.A.1.

17. *Infra* Part III.A.2.

18. *Infra* Part III.B.1–2.

19. *Infra* Part III.B.3–4.

20. *See, e.g.*, *Flynn v. Holder*, 684 F.3d 852, 862 (9th Cir. 2012) (illustrating this relationship through the court's legal analysis of an issue involving bone marrow transplants).

21. *See* J.D. Punch et al., *Organ Donation and Utilization in the United States, 1996-2005*, 7 AM. J. TRANSPLANTATION 1327, 1333–35 (2007).

22. *See* National Organ Transplant Act of 1984, 42 U.S.C. § 274 (2012).

23. *See generally* *Organ Procurement and Transplantation Network*, *supra* note 12.

body) process is also heavily influenced by hospital policies.<sup>24</sup> Even with express donative intent, the hospital will often seek and defer to the family's wishes instead of the decedent's.<sup>25</sup> This practice conflicts the rights of several parties and has produced a significant organ shortage.<sup>26</sup> The following section describes the relevant state laws, federal statutes, hospital custom, and natural human rights that create the framework of organ donation law.

#### A. STATE LAW

Soon after organ transplantation became a viable medical procedure in the 1960s, states began enacting legislation regarding the donation and procurement of organs.<sup>27</sup> In order to promote uniformity amongst the states and facilitate effective regulation, the National Conference of Commissioners on Uniform State Laws promulgated the Uniform Anatomical Gift Act (UAGA) in 1968.<sup>28</sup> The UAGA allows adults of sound mind to donate all or any part of their body at death.<sup>29</sup> The intent to donate must be expressed in writing and signed by the declarant and two witnesses.<sup>30</sup> The true decision-maker, however, was the decedent's next of kin: if the surviving spouse, or any child of an unmarried donor, opposed the donation, it was no longer authorized.<sup>31</sup> Every state adopted the original version of the UAGA.<sup>32</sup>

Over the past fifty years, advancements in medicine, law, and ethics have introduced new challenges and issues not addressed by the UAGA. The drafters of the uniform law published revised versions in 1987 and 2006.<sup>33</sup> The 1987

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24. See Punch et al., *supra* note 21, at 1332.

25. See *infra* Part II.C.

26. See Humphreys, *supra* note 6.

27. See Daniel T. Stimson, *Private Solicitation of Organ Donors: A Threat to the Fairness of the U.S. Organ Transplant System, or a Solution to the National Organ Shortage?*, 10 MICH. ST. U. J. MED. & L. 349, 351–52 (2006).

28. UNIFORM ANATOMICAL GIFT ACT prefatory note (UNIF. LAW COMM'N 1968).

29. *Id.* § 2(a).

30. *Id.* § 4(b).

31. *Id.* § 2(c).

32. REVISED UNIFORM ANATOMICAL GIFT ACT prefatory note (UNIF. LAW COMM'N 2006).

33. Compare REVISED UNIFORM ANATOMICAL GIFT ACT (2006), with REVISED UNIFORM ANATOMICAL GIFT ACT (UNIF. LAW COMM'N 1987).

version lifted two significant restrictions: witnesses are no longer required on the donative document, and the donor's next of kin are no longer required to consent to the donation.<sup>34</sup> Recognizing the value of donor autonomy and the ever-growing organ shortage problem, the most recent version of the UAGA further broadens the scope of permissible organ donation.<sup>35</sup> Donative intent can be communicated orally or symbolically;<sup>36</sup> an individual who is old enough to apply for a driver's license is old enough to decide to donate;<sup>37</sup> and individuals other than the decedent can donate his body unless the decedent expressly refused during his lifetime.<sup>38</sup>

Almost all of the states have adopted the 2006 UAGA,<sup>39</sup> but many have supplemented or otherwise modified the uniform law.<sup>40</sup> As a result, "[t]he law among the various states is no longer uniform and harmonious, and the diversity of law is an impediment" to the success of the organ transplantation system.<sup>41</sup> Each state maintains its own donor registry, which is often but not always linked with driver's licensing.<sup>42</sup> State laws also vary in their donation education program, if one exists at

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34. UNIFORM ANATOMICAL GIFT ACT § 2(h) (UNIF. LAW COMM'N 1987) ("An anatomical gift that is not revoked by the donor before death is irrevocable and does not require the consent or concurrence of any person after the donor's death.").

35. REVISED UNIFORM ANATOMICAL GIFT ACT prefatory note (2006).

36. *Id.* § 5.

37. *Id.* § 4(1).

38. *Id.* § 7.

39. See *Legislative Fact Sheet – Anatomical Gift Act (2006)*, UNIFORM L. COMMISSION, <http://www.uniformlaws.org/LegislativeFactSheet.aspx?title=Anatomical%20Gift%20Act%20%282006%29> (last visited Sept. 9, 2016) (listing Alabama, Alaska, Arizona, Arkansas, California, Colorado, Connecticut, District of Columbia, Georgia, Hawaii, Idaho, Illinois, Indiana, Iowa, Kansas, Kentucky, Louisiana, Maine, Maryland, Massachusetts, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Jersey, New Mexico, North Carolina, North Dakota, Ohio, Oklahoma, Oregon, Rhode Island, South Carolina, South Dakota, Tennessee, Texas, U.S. Virgin Islands, Utah, Vermont, Virginia, Washington, West Virginia, Wisconsin, and Wyoming).

40. See, e.g., Emily Denham Morris, *The Organ Trail: Express Versus Presumed Consent as Paths to Blaze in Solving a Critical Shortage*, 90 KY. L.J. 1125, 1131–32 (2002).

41. REVISED UNIFORM ANATOMICAL GIFT ACT prefatory note (UNIF. LAW COMM'N 2006).

42. See, e.g., *State Organ Donation Legislation*, U.S. DEPT. OF HEALTH & HUM. SERVS., [http://www.organdonor.gov/legislation\\_micro/](http://www.organdonor.gov/legislation_micro/) (last visited Sept. 9, 2016).

all,<sup>43</sup> and the specifics of what qualifies as legal consent for donation.<sup>44</sup> Despite these differences, all states must comply with federal law.<sup>45</sup> The following section examines the main federal statute pertaining to organ donation: the National Organ Transplant Act of 1984.<sup>46</sup>

## B. FEDERAL LAW

Problems with the promising and quickly growing organ transplantation industry drew Congressional attention in the early 1980s.<sup>47</sup> Continuous medical advancements, which increased the demand for donated organs, coupled with hospital custom issues, discussed *infra*, created a nationwide shortage.<sup>48</sup> This shortage of life-saving organs provoked questionable commercial endeavors<sup>49</sup> and national security concerns.<sup>50</sup> In response, Congress passed the National Organ Transplant Act of 1984.<sup>51</sup> The National Organ Transplant Act changed the legal landscape of organ donation in two ways: it established the OPTN and outlawed the sale of human organs.<sup>52</sup>

The OPTN is tasked with (1) maintaining the organ transplant waiting list, (2) matching donated organs with an appropriate recipient, (3) amassing, analyzing, and distributing data on organ transplantation, and (4) “work[ing] actively to increase the supply of donated organs,”<sup>53</sup> all on a national scale.<sup>54</sup> The OPTN is currently managed under contract by the United Network for Organ Sharing, a private nonprofit entity, and is overseen by the federal Department of Health and

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43. *See id.* (showing that fewer than half of states have organ donation education programs).

44. *See id.*

45. The Supremacy Clause of the U.S. Constitution states that Federal law generally takes precedence over state law. *See* U.S. CONST. art. VI, § 2.

46. 42 U.S.C. § 274 (2012).

47. Stimson, *supra* note 27, at 353.

48. *See* Punch et al., *supra* note 21, at 1336–37; *see also* Humphreys, *supra* note 6.

49. Stimson, *supra* note 27, at 353–54.

50. *See infra* Part III.B.4.

51. 42 U.S.C. § 274.

52. *Id.* § 274.

53. *Id.* § 274(b)(2)(K).

54. *See* Stimson, *supra* note 27, at 355.



Human Services.<sup>55</sup> The effectiveness of the OPTN is ensured by the power of the purse; hospitals are ineligible for Medicare payments if they fail to comply with OPTN rules and requirements.<sup>56</sup>

The National Organ Transplant Act also filled a gap in state law regarding the sale of organs<sup>57</sup> by prohibiting the acquisition, receipt, or “transfer [of] any human organ for valuable consideration for use in human transplantation.”<sup>58</sup> Only paired donation arrangements and reasonable payments for removing, preserving, and implanting the organ are permitted.<sup>59</sup> Violation of this law is a felony punishable by up to five years in prison and a \$50,000 fine.<sup>60</sup>

Since the landmark National Organ Transplant Act, federal legislation in the area of organ donation and transplantation has been sparse.<sup>61</sup> The Organ Donation and Recovery Improvement Act of 2004 focused on public awareness, education, and research grants.<sup>62</sup> In 2009, Congress considered a proposed Organ Trafficking Prohibition Act, which would allow noncash benefits for organ donation, including payment of burial expenses, insurance, and tax credits.<sup>63</sup> Despite support from the American Medical Association, the bill did not pass.<sup>64</sup>

While federal and state legislatures and courts remain relatively quiet, internal hospital protocol dictates the true

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55. 42 U.S.C. § 274(b)(1)(A); *see also* Stimson, *supra* note 27, at 355.

56. *See* Omnibus Budget Reconciliation Act of 1986, 42 U.S.C. § 1320b-8(a)(1)(B) (2012).

57. *See* Patrick D. Carlson, *The 2004 Organ Donation Recovery and Improvement Act: How Congress Missed an Opportunity to Say “Yes” to Financial Incentives for Organ Donation*, 23 J. CONTEMP. HEALTH L. & POL’Y 136, 141 (2006) (explaining how the Uniform Anatomical Gift Act failed to mention explicitly the sale of organs).

58. 42 U.S.C. § 274e(a) (2012).

59. 42 U.S.C. § 274e(c)(2).

60. 42 U.S.C. § 274e(b).

61. *See generally* *Selected Statutory and Regulatory History of Organ Transplantation*, U.S. DEPT. OF HEALTH & HUM. SERVS., [http://www.organdonor.gov/about\\_dot/laws/history.html](http://www.organdonor.gov/about_dot/laws/history.html) (last visited Sept. 24, 2016).

62. *See* Organ Donation and Recovery Improvement Act, Pub. L. No. 108-216, 118 Stat. 584 (2004) (codified in scattered sections of 42 U.S.C.).

63. Cody Corley, *Money as a Motivator: The Cure to Our Nation’s Organ Shortage*, 11 HOUS. J. HEALTH L. & POL’Y 93, 100 (2011).

64. *Id.* at 100–01.

framework of organ donation.<sup>65</sup> This “custom of consent” directly contradicts and limits the efficacy of statutes and programs designed to support donor autonomy and increase organ donation.<sup>66</sup>

### C. HOSPITAL CUSTOM

The law is clear: “a person other than the donor is barred from . . . revoking an anatomical gift of a donor’s body or part.”<sup>67</sup> Reality, however, is much different. “In reality, even if the decedent has signed a document of gift, and such document is on his person at the time of death, hospitals and organ procurement organizations will *almost never* retrieve organs without the [family’s] consent . . .”<sup>68</sup> Even silence (failure to locate the decedent’s next of kin quickly enough) can cause failure to procure donated organs.<sup>69</sup> Routinely, “most physicians follow the wishes of the deceased’s family,” which are often in direct conflict with the deceased’s express desire to donate.<sup>70</sup>

This issue is extremely complicated, long-standing, and has huge implications on the supply of donated organs. In 1990, an article in the Harvard Law Review identified several reasons why hospitals and their agents defer to familial

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65. See Morris, *supra* note 40, at 1131.

66. *Id.*

67. REVISED UNIFORM ANATOMICAL GIFT ACT § 8(a) (UNIF. LAW COMM’N 2006); see *Anatomical Gift Act (2006) Summary*, UNIF. LAW. COMM’N., [http://www.uniformlaws.org/ActSummary.aspx?title=Anatomical%20Gift%20Act%20\(2006\)](http://www.uniformlaws.org/ActSummary.aspx?title=Anatomical%20Gift%20Act%20(2006)) (last visited Sept. 25, 2016) (“[U]nder Section 8 of the 2006 UAGA, . . . there is no reason to seek consent from the donor’s family because the family has no legal right to revoke the gift.”).

68. Alexandra K. Glazier, “*The Brain Dead Patient Was Kept Alive and Other Disturbing Misconceptions; A Call for Amendments to the Uniform Anatomical Gift Act*,” 9 KAN. J.L. & PUB. POL’Y 640, 645 (2000) (emphasis added).

69. See Bucklin, *supra* note 2, at 337 (citing Jeffrey M. Prottas, *The Rules for Asking and Answering: The Role of Law in Organ Donation*, 63 U. DET. L. REV. 183, 186 (1985)) (describing the high amount of cadaveric organs lost due to the next of kin consent procurement agencies require, despite the presence of a signed organ donor card).

70. Monique C. Gorsline & Rachelle L.K. Johnson, *The United States System of Organ Donation, the International Solution, and the Cadaveric Organ Donor Act: “And the Winner Is . . .”*, 20 J. CORP. L. 5, 32 (1994) (illustrating the practical reasons why some physicians require familial consent before harvesting an organ, despite having legal immunity when an organ donor card is present).

consent in contradiction to statutory law and the decedent's intent to donate:

[U]nwarranted fears of legal liability, a legitimate concern that negative publicity might damage further organ procurement efforts, a desire to respect the family's wishes, an unwillingness to cause the grieving family any more stress, [and] physicians' reluctance to ask something of the family when they were unable to save the patient . . . .<sup>71</sup>

Placing oneself in the physician's shoes reveals the inherent complexity of the situation when a spouse is informed that her life partner has died, and moments later is informed that the organ procurement team intends to begin retrieving his organs.<sup>72</sup> The necessary brevity between death and organ

71. *Developments in the Law: Medical Technology and the Law*, 103 HARV. L. REV. 1519, 1619 (1990) (footnotes omitted) (indicating the shortcomings of the 1968 Uniform Anatomical Gift Act).

72. An educational commentary published by the American Medical Association describes the typical reaction when a wife is informed that her donor husband is brain dead. Frustratingly, brain dead patients can be an extremely valuable source of donated organs, especially the heart and lungs.

"What do you mean, he's dead?" she asked. "He's breathing. He's not cold or even pale. He's not dead."

"His brain is not functioning, Mrs. Polaski," Dr. Nichols stepped in to explain. [ ] "He can't breathe or do anything else on his own."

"Well, fine. Just leave him on that machine. He's not dead. I can see he's not dead. He doesn't look like dead people look. Don't touch him."

Dr. Nichols tried a couple more times to explain, but Mrs. Polaski said, "Even if he really *does* die, that doesn't mean you can cut him open and take his organs. I'm his wife. You have to give his body to me, and I don't want it all cut up and mutilated. I won't let you do it."

Dr. Nichols discovered that he was saying the same thing over and over—"your husband is dead and he wanted to help another person live by donating his organs." He *could not bring himself to say*, "We don't need your permission to take your husband's organs. We can take them on the basis of the signed intent to be an organ donor on his license."

John C. Moskop, *Organ Donation: When Consent Confronts Refusal*, VIRTUAL MENTOR (Feb. 2003), <http://virtualmentor.ama-assn.org/2003/02/ccas2-0302.html> (second emphasis added). The article inquires: What should Dr. Nichols do? *Id.* Tellingly, even the American Medical Association does not have a clear answer. *Id.* The commentary instructs that instead of the attending physician, a representative from the organ procurement organization (OPO) should discuss the decedent's intended donation with his widow, and that this delicate conversation must be handled with extreme care. *Id.* When the spouse continues to object and the decedent is a registered donor, should organ procurement occur?

The decision to procure an organ is a responsibility of the OPO. A survey of the 61 US OPOs published in 2001 reveals widespread diversity in consent practices for cadaveric organ donation. Despite

procurement complicates the emotional nature of cadaveric organ donation.<sup>73</sup> “As a practical matter, discussions about futility of medical treatment, withdrawing care, and potential organ donation often occur in the same time frame, if not within the same conversation.”<sup>74</sup> From this viewpoint, it is easier to understand how families may object to organ procurement, and how the hospital may allow their wishes to trump an intended organ donation.

Unfortunately, this scenario happens frequently and is a significant contribution to the organ shortage crisis—reports indicate that familial objection may stop up to *half* of cadaveric organ donations.<sup>75</sup> “[I]t [is] apparent that the organ shortage is not due to public refusal or objection to organ donation, but rather to a system that has failed to carry out the wishes of the decedent donor.”<sup>76</sup> An article in the *Yale Journal of Health Policy, Law & Ethics* co-authored by an attorney and a medical doctor states a poignant statistic: “Lack of permission [from the decedent or his family] to use . . . suitable organs leads to about sixteen deaths daily in the United States and is why over 85,000 candidates remain on transplant waiting lists.”<sup>77</sup>

Rectifying the discrepancy between law and custom is a difficult puzzle, but one that must be solved. Further complicating the problem are the inherent human rights of the donor, his family, and the potential recipient.

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this diversity, however, only 5 OPOs (8 percent) reported that they were likely to procure organs based on a person’s wishes as indicated on a driver’s license, if the next of kin objected to donation.

*Id.* (internal citation omitted).

73. See GAMINO & RITTER, *supra* note 1, at 152 (organ procurement must begin almost immediately after cardiac death).

74. *Id.* (internal citation omitted).

75. See Carlson, *supra* note 57, at 138 (citing Francis L. Delmonico et al., *Organ Donation and Utilization in the United States, 2004*, 5 AM. J. OF TRANSPLANTATION 862, 865–66 (2005)) (noting that although 10,500–13,800 people are eligible to become donors each year, a much smaller number actually become donors).

76. See Lisa E. Douglass, *Organ Donation, Procurement and Transplantation: The Process, the Problems, the Law*, 65 UMKC L. REV. 201, 202 (1996) (“[A]most 70% of Americans polled said they were willing to donate all or parts of their bodies. On the other hand, when Americans were asked about donating a family member’s organs, only 36% responded affirmatively.”)

77. Mark S. Nadel & Carolina A. Nadel, *Using Reciprocity to Motivate Organ Donation*, 5 YALE J. HEALTH POL’Y, L. & ETHICS 293, 294 (2005).

#### D. HUMAN RIGHTS

The law surrounding organ donation and transplantation implicates several fundamental human rights.<sup>78</sup> First, and arguably paramount, is the prospective donor's right to autonomy over his own body.<sup>79</sup> The Supreme Court has long recognized a constitutional right for individuals to unilaterally make decisions regarding their healthcare: "No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person."<sup>80</sup> Scholars in philosophy, medicine, and the law agree that personal autonomy, especially in the healthcare context, "is widely understood to be of enormous value and benefit to individuals" and society as a whole.<sup>81</sup> Does the nearly absolute right to autonomy over one's healthcare decisions<sup>82</sup> extend to a right to decide whether to donate one's organs after death?<sup>83</sup>

After death, does one retain any rights at all? Legal rules and cultural norms have established respect for posthumous wishes, especially in the area of probate law.<sup>84</sup> A decedent's expressed intent regarding the distribution and use of his

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78. See *infra* note 80 and accompanying text.

79. See Douglass, *supra* note 76, at 213 (footnote omitted) (internal quotation marks omitted) ("[A] person is allowed to donate all or part of their body to hospitals, surgeons, physicians, or bank or storage facilities . . . or to any specified individual for therapy or transplantation.").

80. See *Union Pac. Ry. Co. v. Botsford*, 141 U.S. 250, 251 (1891) (refusing to force the plaintiff to submit to a surgical examination); see also *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261, 278 (1990) ("The principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment may be inferred from our prior decisions."). See generally *Roe v. Wade*, 410 U.S. 113 (1973) (establishing a constitutional right to decide whether or not to bear a child); *Eisenhardt v. Baird*, 405 U.S. 438 (1972) (confirming a constitutional right to obtain and use contraceptives).

81. Kimberly M. Mutcherson, *Whose Body Is It Anyway? An Updated Model of Healthcare Decision-Making Rights for Adolescents*, 14 CORNELL J.L. & PUB. POL'Y 251, 273 (2005).

82. The government can limit an individual's right to autonomy over healthcare decisions only if the state proves a "compelling state interest," and the limitation is "narrowly drawn to express only the legitimate state interests at stake." *Roe*, 410 U.S. at 155.

83. Statutory law would say yes, but the current practice of forging procurement of organs without the donor's family's consent indicates no. See discussion *supra* Part II.C.

84. See Kirsten Rabe Smolensky, *Rights of the Dead*, 37 HOFSTRA L. REV. 763, 764 (2009).

personal and real property can be enforced for hundreds of years.<sup>85</sup> However, death does kill most rights.<sup>86</sup> The right to dictate disposal of one's body falls in a grey area between the two extremes. States generally recognize a common law right to a decent burial and to choose the location and manner of disposal of one's body.<sup>87</sup> At the same time, the next of kin are also granted a "quasi-property" right to receive the decedent's body and arrange for its burial.<sup>88</sup> The current conundrum of organ donation rights is a perfect example of this tension: statutory law affords autonomy over the decision to donate, but hospital custom allows the next of kin to contravene the decedent's wishes.<sup>89</sup>

Aside from the donor and his family, other persons' human rights are affected by this plight. Tens of thousands of Americans suffer a lower quality of life every day they spend waiting on an organ transplant list.<sup>90</sup> Many more have died waiting.<sup>91</sup> The organ shortage crisis also jeopardizes the economy and national security by funding an illegal black market for human organs.<sup>92</sup> These problems—and a proposed solution—are discussed further in the following section.

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85. For example, conservation easements are even exempt from the Rule Against Perpetuities. *See generally* Nancy A. McLaughlin & Jeff Pidot, *Conservation Easement Enabling Statutes: Perspectives on Reform*, 2013 UTAH L. REV. 811 (2013).

86. *See* Smolensky, *supra* note 84, at 763 (noting that the dead no longer have a right to maintain privacy, marry, divorce, vote, or sue for certain claims).

87. *See, e.g.*, Kimberly E. Naguit, *Letting the Dead Bury the Dead: Missouri's Right of Sepulcher Addresses the Modern Decedent's Wishes*, 75 MO. L. REV. 249, 251 n.20 (2010); John A. Gebauer, *Duty of Burial or Cremation*, 18 N.Y. JUR. 2D CEMETERIES AND DEAD BODIES § 75 (2016).

88. Naguit, *supra* note 87, at 251.

89. *See* Glazier, *supra* note 68 (stating that a doctor will almost never take an organ from a prospective donor without the consent of that donor's next of kin).

90. *See* UNITED NETWORK FOR ORGAN SHARING, 2012 REPORT *supra* note 10, at 2.

91. *See* John A. Sten, *Rethinking the National Organ Transplant Program: When Push Comes to Shove*, 11 J. CONTEMP. HEALTH L. & POL'Y 197, 197 (1994) ("[E]ach day at least six . . . die before an organ becomes available.").

92. *See* T. Randolph Beard & David L. Kaserman, *On the Ethics of Paying Organ Donors: An Economics Perspective*, 55 DEPAUL L. REV. 827, 834–35 (2006) (describing the problems created by the black market).

### III. ANALYSIS

To remedy the organ shortage crisis, cadaveric organ donation should be incentivized with monetary compensation. In addition, a consolidated national donor registry would improve and synchronize the process of expressing one's intent to donate. These proposals are discussed in detail in Part III.A. Part III.B explores the many benefits of this proposal: (1) increased organ donation, (2) decreased familiar objections, (3) fewer deaths, less suffering, and a more cost-efficient healthcare system, and (4) less organized crime related to the illegal trade of organs on the red market. Lastly, Part III.C considers limitations of the proposal and additional recommendations.

#### A. PROPOSAL

This Note's proposal is two-fold. First, the current state-by-state system for registering as an organ donor should be consolidated into a single national registry.<sup>93</sup> This will eliminate interstate discrepancies and inefficiencies.<sup>94</sup> It will also strengthen the validity of a prospective donor's donative intent.<sup>95</sup> Second, to incentivize registration and donation, a monetary payment should be given in exchange for each cadaveric organ donation.<sup>96</sup>

##### 1. National Donor Registry

A single national organ donor registry would significantly improve the United States' organ donation system. Currently, each state maintains its own unique registry and donative consent laws.<sup>97</sup> This disjointed system results in legal inconsistencies, difficulty in locating and maintaining records,

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93. See generally Sten, *supra* note 91, at 197–203.

94. See *id.* at 212–13.

95. See *supra* notes 67–70 and accompanying text (illustrating the restrictive qualities of the current laws and standards with regard to donative intent).

96. See Beard & Kaserman, *supra* note 92, at 849–50 (“By continuing to forestall the adoption . . . of this most promising solution to the organ shortage, the opponents of financial incentives are effectively condemning thousands more patients to death each year.”).

97. See *supra* notes 40–44 and accompanying text.

and systematic inefficiency.<sup>98</sup> A donor may register in one state, pass away in another state, and his family may be accustomed to the laws of a third state.<sup>99</sup> Finding the decedent's expression of donative intent is unduly cumbersome with dozens of potential state registries.<sup>100</sup> This is especially problematic because a decision regarding procurement usually must be made within hours of death.<sup>101</sup> A unified federal registry would simplify, expedite, and harmonize the process of determining the decedent's wishes.

The new registry could be consolidated with the preexisting OPTN, the federally-funded program that maintains the transplant waiting list and matches donated organs with an appropriate recipient.<sup>102</sup> The organization that administers the OPTN has extensive experience and expertise in managing a nationwide medical registry.<sup>103</sup> This organization, the United Network for Organ Sharing, has fulfilled the role of administering the OPTN since 1986.<sup>104</sup> The United Network for Organ Sharing could certainly operate an organ donor registry more efficiently and effectively than fifty separate state systems. The OPTN could be easily expanded to include a donor registry list in addition to the current transplant waiting list.<sup>105</sup> An amendment to the federal statute that mandates the OPTN<sup>106</sup> and a justifiable amount of additional funding<sup>107</sup> would achieve this change.

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98. See, e.g., REVISED UNIFORM ANATOMICAL GIFT ACT prefatory note (UNIF. LAW COMM'N 2006) ("The law among the various states is no longer uniform and harmonious, and the diversity of law is an impediment to transplantation.").

99. See *id.*; cf. *supra* notes 40–44 and accompanying text.

100. REVISED UNIFORM ANATOMICAL GIFT ACT prefatory note (2006).

101. See GAMINO & RITTER, *supra* note 1, at 152.

102. See *supra* notes 54–56 and accompanying text.

103. See Stimson, *supra* note 27, at 355.

104. *Timeline of Historical Events Significant Milestones in Organ Donation and Transplantation*, U.S. DEP'T OF HEALTH & HUM. SERVS., <http://www.organdonor.gov/legislation/timeline.html> (last visited Sept. 21, 2016) (listing the history of significant events in organ donation and transplantation).

105. See Sten, *supra* note 91, at 217 (advocating that expanding the role of the OPTN would be the best option for administering the author's proposed "death benefit program").

106. E.g., National Organ Transplant Act of 1984, 42 U.S.C. § 274 (2012).

107. The economic burden of maintaining an organ donation registry would be transferred from state governments to the federal government. This change



Medical record-keeping throughout the United States is developing from an inefficient and outdated segregated structure to a consolidated and electronic nationwide network.<sup>108</sup> Efforts to nationalize healthcare records have been successful at “dramatically reducing costs and improving the quality of care.”<sup>109</sup> Cadaveric organ donor registration should follow this trend to achieve these important improvements. A federal registry is already used for bone marrow donation and transplantation.<sup>110</sup> The program has operated for almost thirty years, and is one of the best in the world.<sup>111</sup>

A national donor registry would also improve the validity and increase the legitimacy of expressions of donative intent.<sup>112</sup> In the status quo, almost all states integrate organ donor registration with driver’s licensing.<sup>113</sup> There are several downsides to this combination.<sup>114</sup> First, the donor is asked to check the box if you want to be an organ donor when applying for a driver’s license or permit at fifteen or sixteen years old.<sup>115</sup>

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would result in a net economic benefit to society because a single federal system is more efficient than dozens of separate state systems. *See generally* Nadel & Nadel, *supra* note 77. The cost of maintaining a national registry would be “minimal.” *Id.* at 324. Further, the federal government already contributes funding to the majority of states’ organ donation registration programs. *See State Organ Donation Legislation, supra* note 42.

108. *See, e.g.,* Deth Sao, Amar Gupta & David A. Gantz, *Interoperable Electronic Health Care Record: A Case for Adoption of a National Standard to Stem the Ongoing Health Care Crisis*, 34 J. LEGAL MED. 55, 55 (2013) (“Plagued by ‘a tarnished reputation of bureaucracy, inefficiency, and mediocre care,’ the [Department of Veterans Affairs] sought to reinvent itself by implementing structural, organizational, and technological changes.”).

109. *See, e.g., id.* at 57–58 (relating the Department of Veterans Affairs’ crisis to the broader U.S. healthcare records crisis and stating that the quality of care has been drastically improved).

110. *See* Brian London, *Should Bone Marrow Donors Be Paid to Save Lives? An Assessment of the Legal Ban on Donor Compensation and Other Obstacles Facing Domestic and International Bone Marrow Registries*, 24 TEMP. INT’L & COMP. L.J. 477, 484–86 (2010) (explaining that Be The Match, the federal registry for bone marrow transplantation, was created “to facilitate recruitment of unrelated bone marrow donors” and “increase the potential for more transplants with unrelated bone marrow”).

111. *See id.* at 485 (“Be The Match is the largest and most comprehensive registry of potential stem cell transplant donors in the world.”).

112. *See supra* notes 67–70 and accompanying text.

113. *See State Organ Donation Legislation, supra* note 42.

114. *See* Douglass, *supra* note 76, at 213–14 (describing numerous flaws with Missouri’s donor registration through driver’s licensing program).

115. *See* Nadel & Nadel, *supra* note 77, at 304–05.

The decision is often made with minimal forethought, education, or information, and before the age of legal majority.<sup>116</sup> Second, family members and hospital personnel may be reluctant to accept a spur-of-the-moment checkmark several decades ago as genuine donative intent.<sup>117</sup> Finally, the decedent's driver's license may not be easily located. If it cannot be found immediately, the family may err on the side of caution and deny the donation without a clear indication of the decedent's consent.<sup>118</sup>

All of these issues would be remedied by a national registry. The prospective donor would express their intention to donate by affirmatively registering as a donor.<sup>119</sup> The donor would have access to comprehensive information on the donation and transplantation process.<sup>120</sup> Instead of the current all-or-nothing regime, the donor could choose full donation or specify the particular organs they would like to donate.<sup>121</sup> Their precise wishes would be clearly and permanently recorded, and their decision would be made with full consideration and as an adult.<sup>122</sup> Their directives would be more clear, thorough, informed, and legitimate.<sup>123</sup> Finally, the hospital and family would be more willing to respect their intent to donate if it is expressed through a trustworthy national database rather than a box on their driver's license.<sup>124</sup>

There is one significant benefit to registering as an organ donor through the state driver's licensing system: almost

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116. *Id.* at 318–19 (explaining that most people's decision to become a donor is part of a "quid pro quo agreement").

117. *Id.*

118. *See* Douglass, *supra* note 76, at 215 ("[I]f no clear intent of the decedent's wishes exists, the decedent's next of kin make the ultimate determination.").

119. *See id.* at 202.

120. *Id.*

121. The registry should also allow for citizens to register as non-donors if they are not interested in being a cadaveric organ donor. The program could also be expanded to allow for recordation of end-of-life medical care directives (resuscitation, medical ventilation, tube feeding, dialysis, etc.) like a living will.

122. *See, e.g.,* Douglass, *supra* note 76, at 213–14 (showing the ineffectiveness of the driver's license provision and indicating the need for a more uniform system to assure the prompt harvest of organs from prospective donors).

123. *Id.*

124. *Id.*

everyone is given an automatic opportunity to identify themselves as a donor when they apply for a driver's license. The national registry could achieve this exposure by suggesting donor registration whenever a citizen signs up for health insurance, registers to vote, applies to marry, or pays income taxes.<sup>125</sup> To further incentivize registering as an organ donor, the federal government should establish a program that provides monetary compensation for cadaveric organ donation.

## 2. Monetary Payment

Financial compensation in exchange for organ donation is certainly a controversial topic.<sup>126</sup> On the one hand, it is definitively illegal under federal statute.<sup>127</sup> Opponents of the idea argue that compensating organ donation is the "commodification of human body parts" and "an intrinsic evil."<sup>128</sup> They warn of negative consequences such as "decreased emotional gain for the donor family, decreased respect for life and the sanctity of the human body, and a loss of the personal link that currently exists in the donation process."<sup>129</sup> There is also an argument that compensating organ donation will lead to exploitation of people in dire economic circumstances, who will be coerced into donating when they otherwise would not due to the financial reward.<sup>130</sup> Others object based on religious

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125. Congress has already authorized organ donation information to be mailed with federal income tax refunds. See *Timeline of Historical Events Significant Milestones in Organ Donation and Transplantation*, *supra* note 104.

126. See generally H. Tristram Engelhardt, Jr., *Giving, Selling, and Having Taken: Conflicting Views of Organ Transfer*, 1 IND. HEALTH L. REV. 29, 35 (2004) (discussing conflicting moral views of organ sales).

127. See National Organ Transplant Act of 1984, 42 U.S.C. § 274e(a) (2012) ("It shall be unlawful for any person to knowingly acquire, receive, or otherwise transfer any human organ for valuable consideration for use in human transplantation . . .").

128. Engelhardt, *supra* note 126, at 35.

129. EDWARD W. NELSON ET AL., U.S. DEP'T OF HEALTH & HUM. SERVS., FINANCIAL INCENTIVES FOR ORGAN DONATION (1993), <http://optn.transplant.hrsa.gov> [<https://web.archive.org/web/20160106205231/http://optn.transplant.hrsa.gov/resources/ethics/financial-incentives-for-organ-donation>].

130. See *id.* ("Great concern has also been expressed regarding a potential rich versus poor phenomena and the fact that financial need should not be linked in a coercive way to giving consent for organ procurement.").

beliefs,<sup>131</sup> although scholars have had difficulty finding support for this position in any dominant religious teachings.<sup>132</sup>

On the other hand, there are countless supporters of creating a system that compensates organ donation.<sup>133</sup> Proponents abound in the fields of medicine, law, and economics.<sup>134</sup> The American Medical Association supports researching financial compensation as a way to increase cadaveric organ donation.<sup>135</sup> Nobel Prize-winning economist Gary Becker “do[es] not find compelling the arguments against allowing the sale of organs, especially when weighed against the number of lives that would be saved by the increased supply stimulated by financial incentives.”<sup>136</sup> State governments have toyed with the idea;<sup>137</sup> seventeen states provide an income tax deduction of up to \$10,000 for living organ donation.<sup>138</sup> Lastly, a recent public opinion poll found that sixty percent of Americans support a financial incentive for organ donation.<sup>139</sup>

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131. See Engelhardt, *supra* note 126, at 43–47 (“Many of the strong institutions against a market in organs derive from a secular displacement of prior religious views.”).

132. See Nadel & Nadel, *supra* note 77, at 297 (“[A]ll major religions permit, if not encourage, life-enhancing donations.”).

133. See *id.* at 310–11.

134. See, e.g., Gorsline & Johnson, *supra* note 70, at 28–29; Curtis E. Harris & Stephen P. Alcorn, *To Solve a Deadly Shortage: Economic Incentives for Human Organ Donation*, 16 ISSUES L. & MED. 213, 232 (2001).

135. AM. MED. ASS’N CODE OF ETHICS ch. 6.1.3 (2016), <https://www.ama-assn.org/sites/default/files/media-browser/code-of-medical-ethics-chapter-6.pdf>.

136. Steven E. Levingston with Gary S. Becker, *In Praise of Human Organ Sales*, WASH. POST (Oct. 22, 2009, 5:30 AM), [http://voices.washingtonpost.com/shortstack/2009/10/nobel\\_prize-winning\\_economist.html](http://voices.washingtonpost.com/shortstack/2009/10/nobel_prize-winning_economist.html).

137. Pennsylvania passed legislation in 1994 whereby “family members of deceased donors would be reimbursed for funeral expenses to encourage cadaveric organ donation.” Carlson, *supra* note 57, at 146. The bill “received significant support in the organ transplantation community,” and was supported by “ethicists, organ procurement organization executives, physicians, and surgeons.” *Id.* at 148–49. Unfortunately, the program was discontinued several years later after the Department of Health “concluded that the funeral benefit ‘strayed too close’ to violating federal law” prohibiting valuable consideration for organs. *Id.* at 146.

138. Richard Knox, *Tax Breaks for Organ Donors Aren’t Boosting Transplant Supply*, NPR (Aug. 31, 2012, 8:46 AM), <http://www.npr.org/blogs/health/2012/08/30/160338259/tax-breaks-for-organ-donors-arent-boosting-transplant-supply>.

139. Scott Hensley, *Poll: Americans Show Support for Compensation of Organ Donors*, NPR (May 15, 2012, 3:00 AM), <http://www.npr.org/sections>

Distinguished scholars, state governments, and the general public agree that the benefits of financial incentives for organ donation clearly outweigh any perceived risks.<sup>140</sup> Proposals vary regarding the type, amount, and timing of compensation for donation.<sup>141</sup> This Note proposes (1) a single lump sum payment (2) to the donor's estate (3) financed by the transplant recipient's health insurance provider (4) upon the event of an executed cadaveric organ donation.

A monetary payment will provide additional motivation to register as a cadaveric organ donor.<sup>142</sup> In the status quo, organ donation is purely altruistic; it is described as a "selfless gift to others without expectation of remuneration."<sup>143</sup> However, the devastating organ shortage crisis proves that altruism is simply not sufficient to create a supply that meets the current demand for donated organs.<sup>144</sup> When the only impetus is altruism, "most people are not sufficiently motivated to commit to donate. Although more than two-thirds of Americans express a willingness to donate their own organs, less than half of the public has formally committed to do so," and even fewer actually donate.<sup>145</sup> A secondary motivation is needed to solve this problem.<sup>146</sup>

The promise of financial compensation will provide an additional incentive for organ donation.<sup>147</sup> More people will register as donors, and families will be less likely to object to an

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/health-shots/2012/05/16/152498553/poll-americans-show-support-for-compensation-of-organ-donors.

140. See *supra* notes 134–39 and accompanying text.

141. See, e.g., Sten, *supra* note 91, at 213–15 (discussing general financial incentive proposals and the death benefit pilot program); Alexander Tabarrok, *Life-Saving Incentives: Consequences, Costs and Solutions to the Organ Shortage*, LIBR. OF ECON. & LIBERTY (Aug. 3, 2009), <http://www.econlib.org/library/Columns/y2009/TabarrokLifesaving.html> (outlining various proposals for financial incentives).

142. See generally Harris & Alcorn, *supra* note 134, at 230.

143. Greg Moorlock, Jonathan Ives & Heather Draper, *Altruism in Organ Donation: An Unnecessary Requirement?*, 40 J. MED. ETHICS 134, 134 (2013).

144. See *supra* notes 11–13 and accompanying text; see also Harris & Alcorn, *supra* note 134, at 227–30.

145. Nadel & Nadel, *supra* note 77, at 295 (footnotes omitted).

146. See Harris & Alcorn, *supra* note 134, at 227 ("The United States has always relied upon altruism for organ procurement. While this system leaves the decision to the individual and preserves personal autonomy, it does so at the expense of effective organ procurement.").

147. See *id.* at 230 ("[M]ore donors would step forward if given a certain kind of nudge: that is, an economic incentive.").

intended donation.<sup>148</sup> In modern Western culture, money is indisputably one of the strongest influences of human behavior.<sup>149</sup> Money is the main reason why most people spend forty or more hours each week working; money is a dominant factor in a boundless array of decisions; “money is a motivator.”<sup>150</sup> Money could also be used to incentivize cadaveric organ donation.<sup>151</sup>

A lump sum payment is a simple and effective way to accomplish this objective.<sup>152</sup> The choice to donate one’s organs, and whether to donate all viable organs or only certain ones, should be at the sole discretion of the individual.<sup>153</sup> A reasonable monetary payment would provide incentive to do so.<sup>154</sup> To maximize the efficiency of the program, the amount of financial compensation should vary based on the extent of the decedent’s donation.<sup>155</sup> The payment should be around \$5,000 for each donated organ.<sup>156</sup> For full donors, the payment would usually amount to \$15,000 or \$20,000.<sup>157</sup> This would encourage people to register as donors, and to choose full instead of partial donation.

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148. Levingston with Becker, *supra* note 136 (“[T]he promise of financial gain would increase the pool of available organs.”); *see also supra* Part III.B.1–2.

149. *See* GARY S. BECKER, *THE ECONOMIC APPROACH TO HUMAN BEHAVIOR* 5–6 (1976).

150. *See* Thomas Li-Ping Tang, *The Meaning of Money Revisited*, 13 J. ORGANIZATIONAL BEHAV. 197, 197 (1992).

151. *See* Levingston with Becker, *supra* note 136 (“To [a Nobel Prize-winning] economist, it is clear that the major reason for the imbalance between demand and supply of organs is that the United States . . . forbid[s] the purchase and sale of organs.”).

152. *See* Corley, *supra* note 63, at 116 (“[M]oney would almost certainly yield the greatest increase in usable organs . . .”).

153. *See* Morris, *supra* note 40, at 1126 (“[I]n the United States the ultimate decision about whether to become an organ and tissue donor still rests with the individual . . .”).

154. *See* Harris & Alcorn, *supra* note 134, at 230.

155. A varying payment structure is more cost-efficient because it would compensate full donors more than partial donors. Less compensation for partial donors would save money and incentivize full donation.

156. Further research and analysis beyond the scope of this Note would be necessary to ascertain the most efficient amount of financial incentive.

157. On average, cadaveric organ donors provide three or four transplantable organs. *See About Transplantation, supra* note 2 (stating that one organ donor can save eight lives).

The payment should be given to the donor's estate. This would provide the donor with autonomy over how the money is spent: through his will, he could bequeath it to a family member, donate it to a favored charity, or allocate it to satisfy a debt.<sup>158</sup> The payment could be used to fund the decedent's funeral or pay his final medical expenses.<sup>159</sup> If the donor or his family is opposed to the idea of financial compensation, the money could be donated to charity, perhaps for medical research to cure the disease that caused the donor's death.<sup>160</sup> By executing the payment upon donation rather than registration, the issues of exploitation<sup>161</sup> and coercion are mostly avoided.<sup>162</sup> The money would never be in possession of the donor, so consenting to donation would not provide him with any immediate funds.<sup>163</sup> Rather, it would add a modest

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158. See Corley, *supra* note 63, at 104–05.

159. A scholarly article advocating for an open spot market for organs tells the story of cadaveric organ donor Susan Sutton.

Her bones were used for reconstructive surgery, her skin helped burn victims, her liver saved a life, and her corneas went to eye transplants. With the exception of Susan's estate, every party involved in the collection and redistribution of Susan's gifts reaped a financial reward. [Because of limited financial resources,] Susan's parents were forced to bury Susan in a pine box without a chapel service and with no grave marker.

Corley, *supra* note 63, at 102 (footnotes omitted). Financial compensation for organ donation would help solve this problem.

160. The Ad Hoc Committee to End the Intractable Shortage of Human Organs suggests the following approach and language to maintain respect for purely altruistic donations:

Dear Mr. Smith/Ms. Jones, as you may know, it is our standard policy to offer a gift of \$5,000 to the estate of the deceased, as a way of saying "Thank you for giving the gift of life." The money can be used to help offset funeral or hospital expenses, to donate to your loved one's favorite charity, or simply to remain with the estate, to be used in any manner the heirs see fit. No price can be placed upon the many lives that can be saved by your gift. Our donation in return is merely society's way of honoring the sacrifice you are being asked to make, and is a token of our deep and sincere appreciation for your generosity at this most difficult time.

Tabarrok, *supra* note 141.

161. See *supra* note 156. From this viewpoint, it seems more exploitative to *not* pay people for donating their organs.

162. See, e.g., Sten, *supra* note 91, at 217–18 (stating that a modest posthumous payment in consideration of an organ donation "although tempting, would not be coercive in nature," in part because cadaveric organ donation is a "one time event, not a habitual income-producing situation" (internal quotation omitted)).

163. See *supra* notes 158–62 and accompanying text.

amount to the donor's estate for him to gift to his family or favorite charity after he dies.<sup>164</sup>

The transplant recipient's health insurance policy<sup>165</sup> should fund the payment to the organ donor's estate. The organ recipient receives the most benefit from the transaction, so he should be responsible for the cost.<sup>166</sup> By structuring the compensation per organ, the expense would likely be spread amongst several payers.<sup>167</sup> Although health insurance providers may balk at an additional \$5,000 expense for an organ transplant, it would only increase the cost of a transplant by less than two percent.<sup>168</sup> Further, this proposal will save money in the long run.<sup>169</sup> A kidney recipient will no longer need dialysis; a heart or lung recipient will soon leave the intensive care unit; a burn trauma victim will recover much more quickly.<sup>170</sup> Not only will the recipient's length and quality of life be greatly improved after a successful transplant, but they will incur significantly fewer medical expenses.<sup>171</sup> Federal and state governments could also contribute to the financial incentive program, either through direct funding or by excluding the payment from taxable income.<sup>172</sup>

Finally, the payment should be made only if donation actually takes place. This will lower the total cost of the

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164. See Corley, *supra* note 63, at 104–05.

165. Most health insurance policies, including Medicare and Medicaid, cover organ transplantation for patients with end-stage kidney failure. *Organ Transplantation: The Process*, U.S. DEPT OF HEALTH & HUM. SERVS., <http://www.organdonor.gov/about/transplantationprocess.html> (last visited Sept. 17, 2016).

166. While the organ donor and his or her family may feel altruistic or morally right in making the donation, the recipient undoubtedly receives a more tangible benefit – the gift of life. See Moorlock, Ives & Draper, *supra* note 143, at 134–35.

167. See *About Transplantation*, *supra* note 2 (stating one organ donor can save eight lives). Under the proposed system, those eight people would pay for the organs, thus spreading the expense amongst multiple parties.

168. The average cost of transplantation in 2011 ranged from \$262,900 for a single kidney to over \$1,200,000 for a heart-lung transplant. UNITED NETWORK FOR ORGAN SHARING, WHAT EVERY PATIENT NEEDS TO KNOW 30 (2013), <https://www.unos.org/wp-content/uploads/unos/WEPNTK.pdf>.

169. See discussion *infra* Part III.B.3.

170. See discussion *infra* Part III.B.3.

171. See discussion *infra* Part III.B.3.

172. The Author advocates that the payment should be tax-exempt.



program without decreasing its incentivization value.<sup>173</sup> People will be incentivized to consent to liberal donation in the hope that their organs will be useful for transplantation when they die.<sup>174</sup> Their families will be incentivized to respect the decedent's intent to donate; if they object and stop the donation, the decedent's estate will no longer receive the payment.<sup>175</sup> This policy will also encourage prospective donors to view the compensation as a bonus, rather than rely on it as a source of income for their estate.<sup>176</sup> By varying the amount of payment based on the number of organs actually donated, the compensation is more aligned with its objectives.<sup>177</sup>

This financial incentive program, coupled with a national donor registry, will bring substantial improvements to the American organ donation system.<sup>178</sup> The main benefits, including increased donations and organ supply, more respect for healthcare decision autonomy, reduced costs and suffering from the organ shortage, and improved national security, are discussed next.

## B. BENEFITS

Encouraging cadaveric organ donation with financial incentives and improving the efficiency and legitimacy of donative consent with a national registry will bring numerous benefits to the healthcare system, economy, and national security.<sup>179</sup> First, citizens will be more likely to register as donors.<sup>180</sup> Second, families will be less likely to object to an

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173. Restricting payments to organs that are actually donated cuts out the inefficiencies of systems where simply registering to donate elicits payment, because donors in such a system can renege or fail to follow through, thus earning payment without actually donating. *Cf. Corley, supra* note 63, at 116.

174. Donating more organs will necessarily mean the possibility of more compensation for the donor's family. *See supra* notes 155–57 and accompanying text.

175. *See supra* notes 155–57 and accompanying text.

176. For example, a prospective donor's will may read: I wish to donate any and all of my organs upon my death. Accordingly, I have registered with the National Donor Registry. Should my organs be able to be donated, I bequeath the financial compensation therefrom to my next of kin.

177. *See supra* note 155.

178. *See infra* Part III.B.

179. *See generally* David E. Harrington & Edward A. Sayre, *Paying for Bodies, but Not for Organs*, REG., Winter 2006–2007, at 18–19.

180. *See id.* at 19 (describing how modest payments may be able to “coax families to donate organs, tissues, and other body parts”).

intended donation.<sup>181</sup> Third, increasing donations and decreasing familial objections will help to alleviate the national organ shortage.<sup>182</sup> This will relieve people on the transplant waiting list from years of suffering,<sup>183</sup> and save the healthcare system billions of dollars.<sup>184</sup> Lastly, rectifying the organ shortage will reduce the black market for organs and weaken the financial strength of the criminal cartels that profit from it.<sup>185</sup>

### 1. Increase Donations

The most significant benefit of a financial incentive for cadaveric organ donation is that it would increase the number of donations and therefore increase the supply of donated organs.<sup>186</sup> The organ shortage crisis is not an obscure, distant theory; it is the harsh reality for 125,000 Americans and their families, employers, and loved ones.<sup>187</sup> The consequences of this crisis are exorbitant: individuals on the transplant waiting list suffer a shorter and lower quality of life, incur expensive ongoing medical costs, and are often unable to work or care for themselves.<sup>188</sup> “There is a strong public policy towards encouraging . . . donations,” but the current system has failed.<sup>189</sup> The figure below shows that over the past decade, the

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181. *See id.* at 18–19 (“[F]inancial considerations are an important component of the donation decision, not a negligible factor in an essentially altruistic decision.”).

182. *See id.* at 19 (explaining how a “lack of market incentives” leads to the shortage of transplantable organs).

183. *See Beard & Kaserman, supra* note 92, at 840–41 (noting that patients waiting for donations require continuous treatment).

184. *Id.* (indicating that the ban on donor compensation indicates “losses of billions of dollars each year”).

185. *See, e.g., Corley, supra* note 63, at 99–100 (noting that “organ trafficking and illegal payments will continue as long as the demand exceeds the supply”).

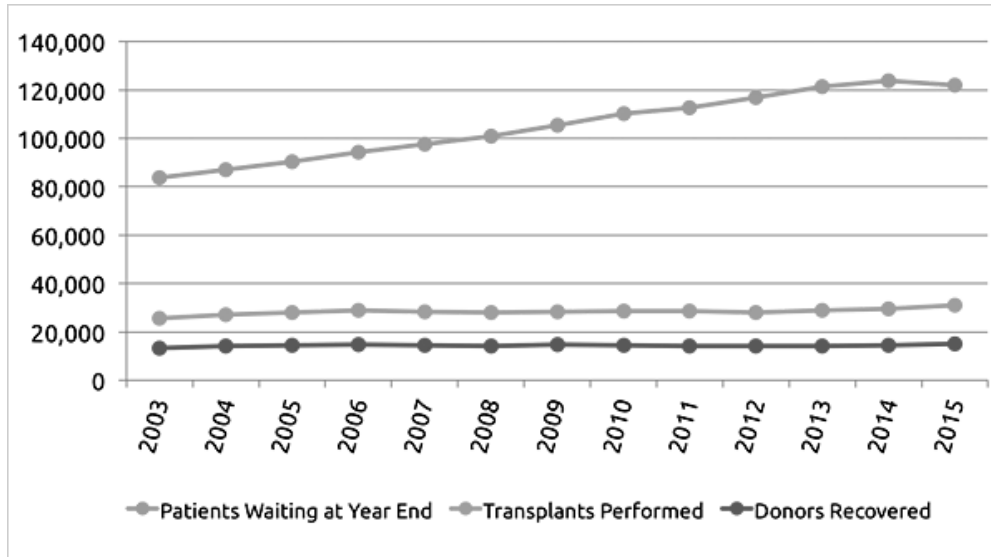
186. *See* sources cited *infra* note 198.

187. *See* Humphreys, *supra* note 6.

188. T. RANDOLPH BEARD, DAVID L. KASERMAN & RIGMAR OSTERKAMP, *THE GLOBAL ORGAN SHORTAGE: ECONOMIC CAUSES, HUMAN CONSEQUENCES, POLICY RESPONSES* 72–74 (2013).

189. Morris, *supra* note 40, at 1126–27.

waiting list has grown steadily, but the number of donations and transplants has hardly increased at all.<sup>190</sup>



The gap between supply and demand for donated organs must be closed, and a financial incentive is the most effective way to do so.<sup>191</sup> Objective research indicates that this proposal will work.<sup>192</sup> A recent scientific study found that states with more regulated, and therefore more expensive, funerals have higher rates of whole body cadaveric donation (where the recipient, usually a medical school, pays for the funeral and related expenses).<sup>193</sup>

[R]esidents in states with more stringent funeral regulations donate 4.9 more bodies per thousand deaths than those in unregulated states. This difference is statistically significant and economically meaningful. It indicates that financial considerations are an

190. *Organ Procurement and Transplantation Network*, *supra* note 12. OPTN requires the following disclaimer in connection with the use of this figure in reprint:

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See also Carlson, *supra* note 57, at 166 (“[T]he waiting list [is] growing longer at twice the rate of the number of transplants . . .”).

191. See generally Carlson, *supra* note 57, at 155.

192. See generally Harrington & Sayre, *supra* note 179.

193. See *id.* at 16–19.

important component of the donation decision, not a negligible factor in an essentially altruistic decision.<sup>194</sup>

The authors conclude that this research indicates that financial incentives for organ donation would increase donations and likely eliminate the organ shortage.<sup>195</sup> The country of Iran provides additional evidence that financial incentives can solve an organ shortage: Iran “has legalized financial payments to kidney donors,” and is now the “only . . . country in the world [that] has eliminated the shortage of transplant kidneys[.]”<sup>196</sup>

People are unquestionably motivated by money.<sup>197</sup> The possibility of receiving several thousand dollars to bequeath to their family or favorite charity will encourage people to donate their organs and formally memorialize their intent to do so by registering. Numerous scholars, supported by well-reasoned theory and objective data, agree that financial incentives will significantly increase organ donation.<sup>198</sup> More donations means more organs available for transplantation, which will reduce the organ shortage crisis and the numerous problems it causes.

## 2. Decrease Familial Objections

The financial payment and improved national registry will also discourage family members from overriding the decedent’s

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194. *Id.* at 17–18.

195. *Id.* at 19 (“[T]he shortage could be eliminated by offering modest payments for families to donate the organs of their deceased relatives.”).

196. Tabarrok, *supra* note 141. “In the Iranian system organs are not bought and sold at the bazaar. Instead a non-profit, volunteer-run Dialysis and Transplant Patients Association (DATPA) mediates between recipients and donors.” *Id.* The United States’ OPTN could suitably provide this service. *See supra* notes 102–07 and accompanying text. “The [Iranian] government pays donors \$1,200 plus limited health insurance coverage. In addition, charitable organizations also provide remuneration to impoverished donors and recipients may also contribute to donor remuneration.” Tabarrok, *supra* note 141.

197. *See supra* notes 148–50 and accompanying text.

198. *See, e.g.,* Carlson, *supra* note 57, at 155 (reasoning that financial incentives would “encourag[e] organ donation from individuals who are not inclined to donate within the current framework of pure altruism”); Corley, *supra* note 63, at 104 (“Money is a method of financial compensation that would likely yield the highest increase in usable organs.”); Gorsline & Johnson, *supra* note 70, at 28 (“[S]ome individuals who are unwilling to donate their organs may wish to sell them.”).

wishes and stopping an intended donation from taking place.<sup>199</sup> Statutory law,<sup>200</sup> as well as fundamental human rights,<sup>201</sup> dictates that an individual should have complete autonomy over the decision to donate his organs. Unfortunately, organ procurement procedures customarily allow the family's objection to trump the decedent's wishes.<sup>202</sup> "[T]he major reason why people [planning to donate] do not become organ donors after death [is] the refusal of family members to give consent to donation."<sup>203</sup> This is a significant cause of the national organ shortage because it terminates up to half of all intended cadaveric organ donations.<sup>204</sup>

A posthumous payment to the donor's estate would provide a monetary incentive for families to consent to donation, especially if the donor has bequeathed the money to his family.<sup>205</sup> The prospective donor's estate or designated charity will not receive the money if the family objects and quashes the donation.<sup>206</sup> "In this case, the shortage could be eliminated by offering modest payments for families to donate the organs of their deceased relatives."<sup>207</sup> The payment will incentivize families to respect the decedent's wishes and consent to the donation.<sup>208</sup> Further, family members will be less likely to

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199. See generally Laura A. Siminoff et al., *Factors Influencing Families' Consent for Donation of Solid Organs for Transplantation*, 286 J. AM. MED. ASS'N 71, 71 (2001) ("The major factor limiting the number of organ donors is the low percentage of families who consent to donation.").

200. See *supra* notes 34–38 and accompanying text.

201. See *supra* notes 80–83 and accompanying text.

202. See Glazier, *supra* note 68, at 645. See also discussion *supra* Part II.C.

203. See David Orentlicher, *Presumed Consent to Organ Donation: Its Rise and Fall in the United States*, 61 RUTGERS L. REV. 295, 295 (2009) (explaining that presumed consent to donation, an alternative proposal to solve the organ shortage crisis, failed because it did not overcome the critical barrier of familiar objection).

204. See *id.* at 298 & n.7.

205. See *supra* notes 174–75 and accompanying text.

206. This result is another reason why the payment should be made to the donor's estate upon a donation as opposed to the donor himself upon registration. See Corley, *supra* note 63.

207. Harrington & Sayre, *supra* note 179, at 19.

208. *Id.* ("[F]amilies are proud of [whole body donations for which they receive compensation], often highlighting them in obituaries . . . . We think that families will feel similarly about donating organs under a system where procurement agencies help with funeral expenses.").

attempt to revoke a donor's "quid pro quo agreement" than a "unilateral charitable impulse."<sup>209</sup>

More importantly, the upgraded national registry will improve the validity of the donor's express intent.<sup>210</sup> His desire to donate will be memorialized in an accessible database, when he is an adult, after informed consideration, and with clear and specific directives.<sup>211</sup> Families will certainly consider this type of expression more persuasive and legitimate than the current driver's license system,<sup>212</sup> and will be less likely to ignore and contravene it.<sup>213</sup>

The two proposed changes to the organ donation system will result in fewer families objecting to organ procurement.<sup>214</sup> This is highly beneficial in two ways. First, it will increase the supply of donated organs and therefore help alleviate the organ shortage.<sup>215</sup> Not only that, but it will also result in more adherence to the decedent's wishes.<sup>216</sup> Some may argue that the inherent right to autonomy over healthcare decisions ends at death.<sup>217</sup> Many, however, believe that an individual's decisions about his body, including the choice to donate his organs posthumously, should be respected even after he passes away.<sup>218</sup> Selflessly saving several strangers' lives through

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209. Nadel & Nadel, *supra* note 77, at 318–19.

210. *Id.*

211. *See generally* the discussion *supra* Part II.B.1.

212. *See generally* the discussion *supra* Part II.B.1.

213. A study published in the *Journal of the American Medical Association* revealed that the family's knowledge of the decedent's intent to donate was positively correlated to giving consent. *See* Siminoff et al., *supra* note 199.

214. *Cf. id.* *See generally supra* notes 174–75 and accompanying text.

215. Sten, *supra* note 91, at 219 ("Compensating families for their donation of cadaveric organs could produce more organs.")

216. *E.g.*, Gorsline & Johnson, *supra* note 70, at 31–32 (pointing to the practice that physicians in the United States will defer to the families wishes about organ donation over the deceased).

217. *See, e.g.*, Smolensky, *supra* note 84, at 763 (noting that most rights for individuals end at death); Naguit, *supra* note 87, at 251 (noting that the United States recognizes a "quasi-property right" in the body of the deceased for family members).

218. *See, e.g.*, Bucklin, *supra* note 2 (making numerous legal and ethical arguments why familiar objection should never impede an intended donation).

There is a moral imperative to accept the valid organ gift by a decedent. An OPO [organ procurement organization] should take a decedent donor's organ gift even if the next of kin objects. An OPO that seeks the consent of next of kin, when there is a known donation

cadaveric organ donation is a noble election that should never be circumvented by a family member.

An improved donor registration system and modest financial incentive will help stop this tragedy from happening and help solve the national organ shortage crisis.<sup>219</sup> Remediating the organ shortage will reduce the suffering and healthcare costs caused by long waits for an organ, and fight the illegal trade of organs.<sup>220</sup>

### 3. Reduce Deaths, Suffering, and Healthcare Costs

Financial compensation for organ donation will remedy the national organ shortage crisis.<sup>221</sup> Eliminating the organ shortage will save<sup>222</sup> and improve the lives of millions of transplant recipients.<sup>223</sup> “Organ transplantation is often the only treatment for end state organ failure, such as liver and heart failure.”<sup>224</sup> Waiting for a donated organ means suffering through the pain, expense, and “slow, horrible” death caused by diseases such as coronary heart disease, cystic fibrosis,

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by the decedent, violates the ethical principles of justice, utility, and autonomy.

*Id.* at 354.

219. For a review of the benefits of financial incentives, see the discussion *supra* Part III.B.1.

220. I will discuss these points in the following subsections: Part III.B.3 *infra* (suffering and healthcare costs); Part III.B.4 *infra* (fighting the illegal organ trade).

221. “Indeed, every economist who has written on this subject has reached precisely the same conclusion—the organ shortage is caused by the legal ban on donor payments and can be resolved successfully by eliminating that ban.” Beard & Kaserman, *supra* note 92, at 828. Fundamental economic theory explains that “shortages are caused by prices held artificially below their equilibrium, or market-clearing levels. As a result, shortages can generally be resolved in a straightforward manner simply by allowing price to rise to its market-determined value.” *Id.*

222. *Organ Procurement and Transplantation Network*, *supra* note 12 (“On average, 22 people die each day while waiting for a transplant.”). Over 100,000 people have died because they did not receive a donated organ. Corley, *supra* note 63, at 97.

223. Over 120,000 people are currently on the OPTN waiting list for a full organ, and a new person joins every ten minutes. *Organ Procurement and Transplantation Network*, *supra* note 12. Further, more than one million people each year could benefit from donated tissues, such as bone and skin. *Organ Donation Facts*, LIVEONNY, <http://www.donatelifeny.org/about-donation/quick-facts-about-donation/> (last visited Sept. 7, 2016).

224. *Human Organ Transplantation*, WORLD HEALTH ORG., <http://www.who.int/transplantation/organ/en/> (last visited Sept. 7, 2016).

hepatitis, and other forms of severe organ failure.<sup>225</sup> The devastating physical, emotional, and financial costs associated with these maladies would predominately be avoided by a sufficient supply of donated organs.<sup>226</sup>

Modern medicine has improved so much that almost all transplants are successful.<sup>227</sup> After a successful transplant, whether a skin graft or new heart, recipients are in substantially better health.<sup>228</sup> Many recover fully from their end-stage organ failure, which allows them to return to living at home, caring for themselves, working, and enjoying life.<sup>229</sup> “Transplant patients not only survive, but also return to their families and communities to lead active, productive lives.”<sup>230</sup>

Without a transplant, the repercussions of end-stage organ failure on an individual and his family are devastating; even worse is the fact that those hardships could be cured if a donated organ was available.<sup>231</sup> Even worse still is the aggregate effect on national healthcare costs and the economy. One “very conservative estimate[ ]” of the “probable costs of the current ban on donor compensation” and resultant organ shortage “indicate[s] losses of *billions of dollars each year*.”<sup>232</sup>

Although the proposed national registry and financial incentive program will create additional costs, there is overwhelming support that the overall economic effect of such a

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225. Corley, *supra* note 63, at 119; see *Organ Transplantation: The Process*, *supra* note 165.

226. Remedying the organ shortage would alleviate the “continuous and costly treatment” of waiting for a transplant and the “deaths of patients who cannot obtain transplants.” Beard & Kaserman, *supra* note 92, at 840–41.

227. The current success rate is between eighty and ninety percent. *Organ Donation Facts*, *supra* note 223.

228. See *After the Transplant*, TRANSPLANT LIVING, <https://transplantliving.org/after-the-transplant/staying-healthy/health-concerns/> (last visited Sept. 27, 2016) (“Most patients recover fully, return to work and resume a normal, active life after receiving a new organ.”).

229. See *id.* For individual stories of life after an organ transplant, see *Organ Donation and Organ Transplant Stories*, FINGER LAKES DONOR RECOVERY NETWORK, <http://www.donorrecovery.org/stories/> (last visited Sept. 7, 2016).

230. Sten, *supra* note 91, at 197.

231. See Corley, *supra* note 63, at 93 (stating that 7000 people died in 2010 while on the organ transplant waitlist despite the fact that 12,000 individuals die every year who are eligible donors).

232. Beard & Kaserman, *supra* note 92, at 841 (emphasis added).



program will reduce total healthcare costs.<sup>233</sup> Put simply, an extra \$5,000 payment to the donor's estate is miniscule compared to the cost of continued treatment for end-stage organ failure, which is usually between \$500,000 and \$1,000,000.<sup>234</sup> A simulation analysis revealed that in a single year, compensation for kidney donation would save the healthcare system \$1,342,190,000.<sup>235</sup> This figure is for one year, for one type of organ, and "undoubtedly understate[d]."<sup>236</sup>

Organ donation and transplantation saves lives and money. Incentivizing donation with monetary compensation will efficaciously and cost-effectively resolve the organ shortage crisis.<sup>237</sup> In addition, remedying the shortage will help stop the illegal sale of organs on the international black market.<sup>238</sup>

#### 4. Combat Red Market Crime

When demand exceeds supply, especially in the case of live-saving transplantable organs, people may resort to desperate measures. Although the United States and almost every other country ban the sale of human organs,<sup>239</sup> an illegal underground market has been flourishing for several years.<sup>240</sup> According to the World Health Organization, one in ten transplanted organs are illegally purchased on this "red market."<sup>241</sup> Americans are one of the worst offenders, engaging in "transplant tourism" (traveling abroad to receive dangerous and illegal organ transplants) at alarming rates.<sup>242</sup>

The red market allows "criminals to reap outlandish profits buying and selling human flesh" at the expense of

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233. "Numerous studies of healthcare costs for . . . transplant patients have found substantial savings associated with transplants." *Id.* at 847.

234. *Id.* at 847–48; see also Donald A. Brand et al., *Waiting for a Liver—Hidden Costs of the Organ Shortage*, 10 LIVER TRANSPLANTATION 1001, 1005–07 (2004) (reaching a similar conclusion after analyzing the financial implications of liver transplants).

235. Beard & Kaserman, *supra* note 92, at 848 ("[E]ach additional cadaveric donation saves about \$576,000 for kidneys alone.").

236. *Id.*

237. See sources cited *supra* note 198.

238. Beard & Kaserman, note 92, at 84–85.

239. Tabarrok, *supra* note 141.

240. Scott Carney, *The Rise of the Red Market*, FOREIGN POL'Y (May 30, 2011), <http://foreignpolicy.com/2011/05/30/the-rise-of-the-red-market/>.

241. *Id.*

242. Roberts, *supra* note 5, at 768–69.

impoverished, kidnapped, or executed victims.<sup>243</sup> The volume of red market trade is estimated at several billion dollars per year.<sup>244</sup> Frighteningly, the newest organizations to join the illegal organ trade are the Mexican drug cartels, and their practice of “kidnapping children to harvest their organs” is particularly gruesome.<sup>245</sup> The Mexican drug cartels represent a “clear and present danger to the . . . national security” of the United States.<sup>246</sup> As the cartels continue to profit from involvement in illegal organ trafficking and the red market, the danger they pose to the United States continues to grow.<sup>247</sup>

Eliminating the organ shortage with financial compensation for organ donation would eliminate the red market.<sup>248</sup> Criminal organizations involved in the red market, including the too-close-for-comfort Mexican cartels, would be financially weakened.<sup>249</sup> Fewer Americans would travel abroad to obtain dangerous illegal transplants, fewer people would be exploited, kidnapped, or killed for their organs, and less money would be collected by one of the biggest threats to our national security.

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243. Carney, *supra* note 240.

In Romania, Moldova, Turkey, and Egypt, brokers can easily acquire kidneys for \$3,000 and sell them for \$50,000 or more. In 2008, an Indian broker was arrested for kidnapping people from New Delhi slums and literally stealing their kidneys to sell to foreign transplant patients. In China, selling the organs of executed prisoners continues to be an official state policy.

*Id.*

244. SCOTT CARNEY, *THE RED MARKET* 3 (2011).

245. Olga R. Rodriguez, *Police Nab Cartel Member in Organ Trafficking Case*, DALL. MORNING NEWS (Mar. 18, 2014), <http://www.dallasnews.com/news/local-news/20140317-police-nab-cartel-member-in-organ-trafficking-case.ece>.

246. Arthur Rizer, *Hannibal at the Gate: Border Kids, Drugs, and Guns – and the Mexican Cartel War Goes On*, 27 ST. THOMAS L. REV. 48, 94 (2015).

247. *See generally id.*

248. “[B]lack market activity is the direct consequence of shortages . . .” When the “shortage[]—and concomitantly, the profitability of black market activity—disappear[s],” the black market disappears. Beard & Kaserman, *supra* note 92, at 834–35.

249. An expert in national security law has made the argument that decriminalizing or legalizing marijuana will reduce the Mexican cartels’ revenue, profit, and power by shrinking the black market for drugs. Rizer, *supra* note 246, at 47. Shrinking the red market by legalizing financial compensation for organ donations would similarly reduce the cartels’ revenue, profit, and power. *Id.*

## C. LIMITATIONS AND RECOMMENDATIONS

Despite the numerous benefits of increasing the donated organ supply with financial incentives and an improved national registry, some limitations must be observed. Although several scholars advocate for financial compensation for living donors,<sup>250</sup> this presents issues of exploitation, irresponsibility, and health complications for the donor.<sup>251</sup> Only compensating for cadaveric donations avoids these problems.<sup>252</sup>

Cadaveric organ donation of children is another tricky issue. Under the current legal framework, the parents or legal guardians of a minor child are unilaterally authorized to donate their child's organs posthumously.<sup>253</sup> This may be the best option because children generally cannot give legal consent,<sup>254</sup> but further analysis is necessary regarding the interplay of this rule and financial incentives.

In addition to the proposed financial incentive program and national donor registry, other recommendations would improve the efficiency and public opinion of the organ donation and procurement process. First, hospitals and organ procurement organizations should adhere to federal law and never permit familial objection to stop an intended donation.<sup>255</sup> Second, hospitals should always treat a donor's body with utmost respect, preserve the option of an open casket funeral, ensure that the body is timely available for burial, and observe any relevant religious considerations.<sup>256</sup> Third, hospitals and

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

251. See Kelly Lobas, *Living Organ Donations: How Can Society Ethically Increase the Supply of Organs?*, 30 SETON HALL LEGIS. J. 475, 488–96 (2006).

252. See *id.* at 488 (“[L]iving organ donations raise concerns not present with cadaver donations.”).

253. Nicole Hebert, *Creating a Life to Save a Life: An Issue Inadequately Addressed by the Current Legal Framework Under Which Minors Are Permitted to Donate Tissue and Organs*, 17 S. CAL. INTERDISC. L.J. 337, 353–54, 367 (2008).

254. *Id.* at 353, 367.

255. See Bucklin, *supra* note 2, at 337 (explaining how organ procurement organizations typically do not accept a decedent's organ donation without ratification from the decedent's next of kin).

256. See *Funeral Traditions of Different Religions*, EVERPLANS, <https://www.everplans.com/articles/funeral-traditions-of-different-religions> (last visited Sept. 7, 2016). For example, the Muslim faith dictates the body “should be buried as soon as possible after death.” *Muslim Funeral Traditions*,

medical researchers should seek to more fully utilize each cadaveric donor.<sup>257</sup> Finally, additional resources should be spent on education regarding organ donation, especially if changes such as financial incentives or a national registry take place.<sup>258</sup> National advertising campaigns have resulted in some success at increasing donations.<sup>259</sup>

#### IV. CONCLUSION

The combination of federal laws that prohibit valuable consideration for organ donation and hospital customs that prioritize family objections over the decedent's express intent has caused a devastating organ shortage crisis. This crisis jeopardizes national security and the American way of life in several ways. Hundreds of thousands of people suffer and die waiting for an organ transplant because there is a shortage of donated organs.<sup>260</sup> This increases national healthcare costs and creates an illegal black market for organs, which criminal organizations such as the Mexican drug cartels benefit and profit from.<sup>261</sup>

The national organ shortage could be cured by introducing a system of monetary compensation for cadaveric organ donation. This Note advocates that a payment of approximately \$5,000 should be paid to the donor's estate by the transplant recipient's health insurance policy when an organ is posthumously donated.<sup>262</sup> Further, an improved national registry would improve the validity of donative intent.<sup>263</sup>

These programs would generate multiple benefits. People would be incentivized by the possibility of additional money for

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EVERPLANS, <https://www.everplans.com/articles/muslim-funeral-traditions> (last visited Sept. 7, 2016).

257. See Bucklin, *supra* note 2 (illustrating that only an average of 3.37 organs are currently recovered from cadaveric donors); Orentlicher, *supra* note 203, at n.7 (“[O]rgan transplants could more than quintuple if all usable organs were transplanted.”).

258. See *State Organ Donation Legislation*, *supra* note 42.

259. Nadel & Nadel, *supra* note 77, at 302–04.

260. Corley, *supra* note 63, at 97 (“From 1995-2010, approximately 105,000 individuals in the United States have died while waiting on an organ to become available.”).

261. See *Mexican Cartel Member Busted for Child Organ Trafficking*, *supra* note 9; Beard & Kaserman, *supra* note 92, at 834–35, 847.

262. See *supra* note 156.

263. See *generally* Nadel & Nadel, *supra* note 77.

their estate, so organ donations would increase.<sup>264</sup> Also, families would be less likely to override an intended donation when they stand to benefit financially from consent and the donor's intent is more legitimate.<sup>265</sup> More donations and fewer objections will increase the supply of donated organs and remedy the organ shortage crisis.<sup>266</sup> This will reduce deaths, suffering, and healthcare costs of those waiting for an organ, and reduce the financial strength of the criminals who profit off the red market.<sup>267</sup>

The federal government should immediately begin implementing a financial incentivization program and national donor registry. The additional cost is a small price to pay to save lives, money, and the integrity of our national security.

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264. *E.g.*, Harris & Alcorn, *supra* note 134; Corley, *supra* note 63.

265. *See generally supra* notes 155–57.

266. *See, e.g., supra* Part III.B.2.

267. *See, e.g., supra* note 184 and accompanying text; Rizer, *supra* note 246.