

SIX DECADES OF ORGAN DONATION AND THE CHALLENGES THAT SHIFTING THE UNITED STATES TO A MARKET SYSTEM WOULD CREATE AROUND THE WORLD

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I

INTRODUCTION

Since the beginning of human kidney transplantation six decades ago,¹ and especially since the first heart transplant and the creation of deceased-donation programs forty-five years ago in the United States, the Western model for organ donation has been one of unpaid giving. Such a donation typically occurs for what are termed “altruistic” reasons, meaning that the organ donor is not acting for material gain. As transplantation has spread around the world, the model of unpaid donation has not uniformly followed it into settings that are socially, medically, and legally very different. Nonetheless, over the past twenty-five years, the principled stand of intergovernmental and professional organizations has come much closer to making noncommercial organ donation truly the universal ethical norm. But its hold remains tenuous, and hence the gains made in protecting vulnerable, desperate organ sellers against exploitation could be easily lost.

In this article I examine the reasons why unpaid organ donation came to be

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1. Physician–investigators tried to use transplantation of human and animal organs for patients with acute and chronic kidney failure more than one-hundred years ago but were thwarted by the immune-rejection process that they recognized but did not understand. Only in the 1940s did physicians begin to have several small successes when the kidneys of patients with acute disease were able to become operative again. For example, in 1950, in what is sometimes termed the first successful transplant, a kidney from a deceased patient was transplanted into Ruth Tucker in Chicago. It was well-enough matched to work for five months before being rejected; this “bridge” allowed one of her own kidneys to resume functioning, and she lived another five years. DAVID PETECHUK, *ORGAN TRANSPLANTATION* 10–11 (2006).

the prevailing global standard—albeit an incompletely achieved one—with local differences and complications. I then explore the costs and benefits that might arise from moving to a system in which the transfer of organs is induced by material rewards that aim to increase the supply of organs for transplantation, as urged by several participants in this symposium.² Finally, I ask whether an ethical reckoning of the costs and benefits of moving to such a system in the United States—usually described as some sort of “market in organs”—ought to include the effects that such a change would have on the ongoing efforts in other countries to establish or extend prohibitions on organ sales; I conclude with an affirmative answer to that question.

II

THE FOUNDATIONS OF HUMAN ORGAN TRANSPLANTATION AS A SOCIAL PRACTICE

Kidney transplantation was born amid controversy because it involved—and continues to involve—a surgeon carrying out a very un-Hippocratic act that potentially endangers a person’s life and leaves him or her somewhat less healthy than had the surgeon not acted. When the first successful “permanent” human-to-human kidney transplant was performed in 1954 at Peter Bent Brigham Hospital in Boston between the Herrick twins, the surgeons were willing to wheel the donor twin, Ronald, into an operating room and remove one of his healthy organs because doing so enabled Ronald to become a donor and attempt to rescue his ailing brother, a courageous feat that Ronald could not have accomplished without the doctors’ involvement.³ In the end, the success of that heroic act quieted the criticism voiced within the medical community that physicians should not depart from the historic tenet of *primum non nocere*—above all, do no harm—even for a laudable goal.

During the following decades, such brave and loving acts were repeated as gifts, first by other identical twins and then by a wider range of donors, such as siblings and other close blood relatives, as physicians gained greater knowledge about tissue typing for transplant antigens and then as immunosuppressive drugs overcame the need for a close tissue match to avoid organ rejection.⁴ A

2. See, e.g., T. Randolph Beard & Jim Leitzel, *Designing a Compensated–Kidney Donation System*, 77 LAW & CONTEMP. PROBS., no. 3, 2014, at 253; Stephen J. Choi, Mitu Gulati, & Eric A. Posner, *Altruism Exchanges and the Kidney Shortage*, 77 LAW & CONTEMP. PROBS., no. 3, 2014, at 289; Kimberly D. Krawiec & Michael A. Rees, *Reverse Transplant Tourism*, 77 LAW & CONTEMP. PROBS., no. 3, 2014, at 145; Sally Satel, Joshua C. Morrison, & Rick K. Jones, 77 LAW & CONTEMP. PROBS., no. 3, 2014, at 217.

3. Brian Marquand, *Pioneer Organ Donor Dies*, BOS. GLOBE, Dec. 20, 2010, at B1. The Herrick brothers also saw the operation in this way. On the night before the surgery, Ronald got a note from a very sick Richard, who was in another room at the Peter Bent Brigham Hospital in Boston, telling Ronald to leave the hospital and go home. Ronald sent a note back saying, “I’m here, and I’m going to stay, and that’s it.” Richard lived for eight years after receiving a kidney from his brother who lived fifty-six years after giving it. *Id.*

4. JAY KATZ & ALEXANDER MORGAN CAPRON, CATASTROPHIC DISEASES: WHO DECIDES WHAT? 43–46 (1975).

well-managed kidney donation with good medical follow-up creates only a very small chance of serious harm to the donor, but physicians remained uncomfortable with the procedure, especially when the donor was unrelated to the recipient. One 1971 survey of transplant doctors found that half of the fifty-four respondents disapproved of using unrelated living kidney donors and that only twenty percent had used such donors themselves in transplants they had performed.⁵ Part of this came about because the physicians believed that the results for recipients using a living donor are no better than for those using a cadaver donor, which built on the long-standing principled concern over departing from the ethics of the profession by risking a healthy person's well being. But the study also revealed "much evidence of distrust and suspicion towards the donors and definite repugnance concerning their use."⁶ The physicians believed they were very likely to cause harm to the donor's personality and felt like accomplices of a person wishing to risk his or her own life.⁷ In short, the core objection seems to have been the psychological verdict that unrelated donors are "crazy."

Although the road to success initially depended on well-matched living donors, surgeons soon turned to cadaver sources, which could be utilized with the permission of next of kin without putting a living donor at risk. The shift to cadaver donors was driven not only by physicians' discomfort with unrelated living kidney donors but also by the availability of deceased donors, who were needed for transplanting a whole liver or a heart, where the first successes came in 1963 and 1967, respectively. Cadavers became the preferred source for all organs once brain-based determinations of death in ventilator-supported patients came to be widely used beginning in the late 1960s.

The promulgation of the Uniform Anatomical Gift Act (UAGA) by the National Conference of Commissioners of Uniform State Laws (NCCUSL) in 1968 facilitated the growing reliance on deceased persons as organ sources by authorizing people to execute simple "donor cards" to allow use of their bodies (or particular parts thereof) after death for transplantation, as well as for research or teaching.⁸ When a deceased person has failed to express his or her wishes regarding donation, the UAGA permits specified next of kin to make the decision to donate.⁹ The statute—which quickly became the most widely and uniformly adopted model law in the history of the NCCUSL—continued to treat organs as "gifts" but broadened the scope of beneficiaries of this

5. H. Harrison Sadler et al., *The Living, Genetically Unrelated, Kidney Donor*, 3 SEMINARS IN PSYCHIATRY 86, 95 (1971).

6. *Id.* at 96. On the practical side, the respondents worried that living donors would return to harass the recipient or the hospital.

7. Carl H. Fellner & Shalom H. Schwartz, *Altruism In Disrepute*, 11 NEW ENG. J. MED. 582, 582 (1971) (quoting Dr. Jean Hamburger as stating that "the major problem is the question as to how far the physician has the right to become *the accomplice* of a person who wishes to take a risk with his or her own life").

8. UNIF. ANATOMICAL GIFT ACT § 4, 8A U.L.A. 15 (1968).

9. *Id.* § 2.

generosity from identified individuals to the community at large, as represented by the hospital where the donor died, which serves as the trustee of the donated human remains. The UAGA not only made obtaining organs from deceased persons much simpler but also served to underline society's commitment to organ donation as an appropriate manifestation of solidarity as well as individual generosity.

Two subsequent manifestations of that commitment did at least as much to increase the rate of organ transplantation. First, the Social Security Amendments passed by Congress in October 1972 extended Medicare coverage to people with end-stage renal disease (ESRD) and gave federal administrators the authority to contract with regional "coordinating councils" of medical, nursing, and social-work specialists in renal care, hospitals, other facilities, and organ-donation organizations to facilitate care.¹⁰ The guarantee of Medicare funding prompted the creation of adequate hemodialysis capacity, so all kidney patients in need could access treatment. This was important in maintaining kidney patients while they waited for a suitable donor to be identified and in increasing the pool of potential transplant recipients.¹¹

The second instance of legislative support for the system of treating organs as unpaid gifts came in response to a Virginia physician's 1983 proposal to overcome the shortage of kidneys by bringing people from abroad to serve as paid kidney donors. Dr. H. Barry Jacobs, whose license had been revoked for Medicare fraud, proposed to establish an organization that would be known as

10. Social Security Amendments of 1972, Pub. L. No. 92-603, 86 Stat. 1329 (1972) (codified as amended in scattered sections of the U.S. Code). Under the 1976 regulations, thirty-two ESRD networks were established; this number was reduced to eighteen in 1987.

11. In 1972, out of the estimated 55,000 persons with chronic kidney disease (CKD), of whom 20,000–25,000 were candidates for dialysis, 10,000 were receiving hemodialysis and more than 2,000 patients received kidney transplants. Richard A. Rettig, *Origins of the Medicare Kidney Disease Entitlement: The Social Security Amendments of 1972*, in *BIOMEDICAL POLITICS* 176, 182, & 196 (Kathi E. Hanna, ed., 1991). In 2012, 17,287 kidney transplants were performed in the United States. Health Resources and Services Administration, UNITED STATES ORGAN TRANSPLANTATION OPTN/SRTR 2010 ANNUAL DATA REPORT 9 (2014), http://srtr.transplant.hrsa.gov/annual_reports/2012/pdf/00_intro_13.pdf. The incidence of end-stage renal disease (ESRD), which is the diagnosis that qualifies people for Medicare coverage, more than quadrupled between 1980 and 2001, but then leveled off at about 350 persons per million. National Kidney and Urologic Diseases Information Clearinghouse, *Kidney Disease Statistics for the United States* 3 (2012), <http://kidney.niddk.nih.gov>. Since dialysis and transplantation prolong the lives of ESRD patients (producing five-year survival rates of 35.8% and 85.%, respectively, as of 2009), *id.* at 10, the prevalence of ESRD increase from 290 to 1738 per million between 1980 and 2009. *Id.* at 4. As of the end of 2011, 185,626 ESRD patients were living with a kidney transplant, while 430,273 were on dialysis, an ESRD prevalence of 1901 cases per million population, 52% larger than in 2000. The marked increase in ESRD is also attributable to the rise in the number of older Americans, among whom the prevalence of ESRD per million persons reached 6307 for those age 65–74 and 6007 for those age 75 years and older in 2011. United States Renal Data System, *Annual Data Report 2013, Volume Two: Atlas of End-Stage Renal Disease in the United States*, at 223 (2014). That increase in turn reflects the rapid increase in the occurrence and detection of CKD among older persons in recent years; for example, between 2000 and 2008, the incidence of recognized CKD in persons aged 65 and older more than doubled, to 4.4%, and the 2001–2008 National Health and Nutrition Examination Study revealed that 26% of people aged 60 or more have Stage 3 CKD. *Kidney Disease Statistics, supra*, at 2.

the International Kidney Exchange, Ltd.¹² He argued that, for a large number of people in Central and South America, even a relatively modest payment would be sufficient inducement to part with a kidney.¹³ The response from Congress was immediate and bipartisan. The National Organ Transplant Act (NOTA)¹⁴ made it unlawful “for any person to knowingly acquire, receive, or otherwise transfer any human organ for valuable consideration” (excluding the costs of procurement).¹⁵ Rather than by providing payment to donors, it addressed the organ shortage by authorizing a public–private partnership in the form of the Organ Procurement and Transplantation Network (OPTN) to stimulate the process of obtaining organs and to make their distribution as fair, transparent, and efficient as possible.¹⁶

The principle that organs for transplantation are gifts to the community rather than market commodities influenced other countries as they established their own programs and laws.¹⁷ The U.S. approach was fully accepted in Western Europe, where it had been practiced from the beginning of kidney transplantation; policies in Europe were grounded in the human-rights principles that underlie bioethics legislation and in the need for cooperation across national borders.¹⁸ Elsewhere, however, in countries where the rule of

12. Walter Sullivan, *Buying of Kidneys of Poor Attacked*, N.Y. TIMES, Sept. 24, 1983, at 9.

13. *National Organ Transplant Act: Hearing on H.R. 4080 Before the Subcomm. on Health & the Env't of the H. Comm. on Energy & Commerce*, 98th Cong. 224 (1983) [hereinafter *Hearing on H.R. 4080 Before the Subcomm. on Health & Env't*] (statement of Dr. H. Barry Jacobs).

14. Pub. L. No. 98-507, 98 Stat. 2339 (1984) (codified as amended at 42 U.S.C. §§ 274–274e (2006 & Supp. IV 2011)).

15. *Id.* § 274e.

16. *Id.* § 274. The United Network for Organ Sharing of Richmond, Virginia, was awarded the initial OPTN contract on September 30, 1986; its contract has been periodically renewed. Its policy-setting is subject to public review and coordinated with the federal government.

First a UNOS committee develops policy proposals. Then the committee writes and disseminates an initial brief explaining the need for the proposed policy changes. Next the committee asks for public comments on the policy proposals. The committee then responds to the comments by the public and submits a final proposal to the Board of Directors. The Board votes on the proposal, and if the Board approves the proposal it becomes UNOS/OPTN rule. The Board can also submit an approved proposal to the Secretary of HHS, and if the Secretary approves the policy it is incorporated into official regulation.

Sam Crow & Eric Cohen, *Organ Donation Policy* [Sec. I.d.] (President's Council on Bioethics, Staff Discussion Paper: Organ Transplantation Policies and Policy Reforms (Sept. 2006)), https://bioethicsarchive.georgetown.edu/pcbe/background/organ_donation.html#part1.

17. For example, in the United Kingdom, see the Human Organ Transplants Act, 1989, c. 31, §1 (Eng.).

18. See, e.g., Convention for the Protection of Human Rights and Dignity of the Human Being with regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine, April 4, 1997, E.T.S. 164 [hereinafter *Oviedo Convention*]. Article 19(1) obligates signatories to ensure that under their country's laws organs and tissues will be removed from a living person for transplantation purposes “solely for the therapeutic benefit of the recipient and where there is no suitable organ or tissue available from a deceased person and no other alternative therapeutic method of comparable effectiveness.” *Id.* at art. 19(1). Article 21 obligates signatories to forbid payments for organs under their national laws (“The human body and its parts shall not, as such, give rise to financial gain.”) *Id.* at art. 21. This provision is further elaborated by an additional protocol passed on January 24, 2004, under which countries must also outlaw advertising to offer or solicit

law was less strong, where human rights were not enforced, where economic inequality was more pronounced, and where health-care systems were not set up to support deceased donation, transplantation depended on living donors, particularly poor and marginalized persons, whose agreement to “donate” could be bought or coerced.¹⁹ By the mid-1980s, reports began emerging, principally from Asia and Latin America, of surgeons providing wealthy patients (both indigenous and foreign) with transplanted kidneys that had been purchased from impoverished people.²⁰ In 1987, at the urging of several member states, the Fortieth World Health Assembly took note of the problem and requested the Director-General of the World Health Organization (WHO) “to study, in collaboration with other organizations concerned, the possibility of developing appropriate guiding principles for human organ transplants.”²¹ The

organs or tissues in exchanging for money “or comparable advantage,” but may permit payments to cover a donor’s lost wages and medical expenses or the costs of preparing, transporting, and transplanting an organ. *Additional Protocol to the Convention on Human Rights and Biomedicine Concerning Transplantation of Organs and Tissues of Human Origin*, art. 21, Jan. 24, 2002, E.T.S. 186. Article 22 requires that national laws prohibit “organ and tissue trafficking,” the first mention of this activity in an international legal document. *Id.* at art. 22. The *Oviedo Convention* had sufficient signatories to come into effect on January 12, 1999; at last count, it has been ratified by twenty-nine countries. Chart of Signatories to the *Oviedo Convention*, COUNCIL EUR., <http://conventions.coe.int/Treaty/Commun/ChercheSig.asp?NT=164&CM=8&DF=28/03/2013&CL=ENG> (last visited March 28, 2013). Its additional protocol on transplantation has been ratified by 12 countries. Chart of Signatories to the *Additional Protocol to the Convention on Human Rights and Biomedicine concerning Transplantation of Organs and Tissues of Human Origin*, COUNCIL EUR., <http://conventions.coe.int/Treaty/Commun/ChercheSig.asp?NT=186&CM=8&DF=28/03/2013&CL=ENG> (last visited March 28, 2013). On July 9, 2014, the Committee of Ministers adopted the *Council of Europe Convention against Trafficking in Human Organs*, which will be opened for signatures on March 25, 2015, in Santiago de Compostela, Spain. http://www.conventions.coe.int/?pg=/Treaty/projects/Projets_en.asp (last visited Oct. 18, 2014). The new convention complements existing law on human trafficking by not requiring proof of coercion or exploitation of vulnerability of organ sellers and by encompassing acts that support commercial organ donation, including knowing use of a vendored organ by transplant physicians. See Marta López-Fraga et al., *A Needed Convention Against Trafficking in Human Organs*, 383 LANCET 2187 (2014).

19. See COUNCIL OF EUR. & UNITED NATIONS, TRAFFICKING IN ORGANS, TISSUES AND CELLS AND TRAFFICKING IN HUMAN BEINGS FOR THE PURPOSE OF THE REMOVAL OF ORGANS 18 (2009); Nancy Scheper-Hughes, *Keeping an Eye on the Global Traffic in Human Organs*, 361 LANCET 1645, 1647 (2011) [hereinafter Scheper-Hughes, *Keeping an Eye*]; Larry Rohter, *Tracking the Sale of a Kidney On a Path of Poverty and Hope*, N.Y. TIMES, May 23, 2004, at N1; see also Henri Decoeur, *A Special Tribunal to Prosecute Individuals Involved in Organ Trafficking in Kosovo: Born to Fail?*, CAMBRIDGE J. INT’L & COMP. L. (Apr. 5, 2014), <http://cjl.org.uk/2014/04/05/special-tribunal-prosecute-individuals-involved-organ-trafficking-kosovo-born-fail/>.

20. Nancy Scheper-Hughes, *The Global Traffic in Human Organs*, 41 CURRENT ANTHROPOLOGY 191, 207–08 (2000) [hereinafter Scheper-Hughes, *The Global Traffic in Human Organs*].

21. W.H.A. Res. 40.13, W.H.O. Doc. A40/1987/REC/1 (May 13, 1987). Following the adoption of a second resolution entitled Preventing the Purchase and Sale of Human Organs, W.H.A. Res. 42.5, W.H.O. Doc. A42/1989/REC/1 (May 15, 1989), the WHO secretariat began several initiatives, which included establishing an internal working group and convening an informal, multidisciplinary international consultation of experts in organ transplantation, medical ethics, and health policy and law, and representatives of intergovernmental and nongovernmental organizations, in Geneva in May 1990, which found that developing the guiding principles called for in WHA Resolution 40.13 was feasible and reviewed an initial draft of a set of such principles, which were then amended and widely distributed to other experts on medical, legal, ethical, cultural, religious, and health-policy aspects of organ transplantation as well as to all six WHO regional offices for their comments. A second draft was

Guiding Principles on Human Organ Transplantation (Guiding Principles), which were approved by the Forty-Fourth World Health Assembly in May 1991, established a preference for deceased over living donors and, among living donors, a preference for related over unrelated donors, and proclaimed globally the model of voluntary, unpaid donation of organs from living and deceased donors that had provided the ethical foundation for transplantation in the United States for the previous four decades.²²

A dozen years later, WHO commenced a process of reexamining the *Guiding Principles*. Several factors lay behind the request from member states for the review: first, the increasing portion of kidney transplants involving living donors—both related and unrelated—in many nations; second, the growth in “transplant tourism” in developing countries, spurred by Internet advertising geared towards reaching patients in wealthier countries who need kidney transplants; third, the need to consider the relationship between the growing commerce in processed tissues and cells and the principle of noncommercialism at the heart of the *Guiding Principles*, which had been framed in the context of solid organs;²³ and fourth, criticisms by certain Western philosophers and transplant physicians who favored allowing markets as a means of increasing the availability of organs for transplantation.²⁴ The revised WHO *Guiding Principles*, which emerged from an extensive, seven-year process of consultation with governments and experts globally, were approved by the Sixty-Third World Health Assembly in May 2010.²⁵ The new version strengthens the anticommmercialism position of the 1991 document and adds two further provisions calling for national transplant programs to provide greater transparency in their activities and heightened attention to the safety and traceability of organs, especially when sent to other countries.²⁶

reviewed at a smaller consultation in Geneva in October 1990. Following that meeting the secretariat prepared further drafts and a final version was submitted to the WHO governing bodies in 1991. World Health Organization, *Human Organ Transplantation: A Report on Developments Under the Auspices of WHO (1987–1991)* 42 INT’L DIGEST HEALTH LEGIS. 389 (1991).

22. W.H.A. Res. 44.25, W.H.O. Doc. A44/1991/REC/1 (May 13, 1991). The *Guiding Principles* also set forth other protections, such as avoiding conflicts of interest for the physician who declares a potential donor dead.

23. See World Health Org. Secretariat, *Human Organ and Tissue Transplantation: Rep. by the Secretariat*, W.H.O. Doc. A62/15 (Mar. 26, 2009).

24. See, e.g., Charles A. Erin & John Harris, *An Ethical Market in Human Organs*, 29 J. MED. ETHICS 137 (2003); J. Radcliffe Richards, *Commentary. An Ethical Market in Human Organs*, 29 J. MED. ETHICS 139 (2003) [hereinafter Richards, *Commentary*].

25. W.H.A. Res. 63.22, W.H.O. Doc. A63/2010/REC/1 (May 21, 2010).

26. World Health Org. Secretariat, *supra* note 23, at 2–3. (Guiding Principle 5 prohibits the sale of cells, tissues and organs, World Health Org. Secretariat, *supra* note 23, at 9, while the added Guiding Principles 10 and 11 call for safety and traceability, and transparency, respectively, World Health Org. Secretariat, *supra* note 23, at 12–13.)

III

MAKING (PRECARIOUS) PROGRESS

A. Global Patterns in Organ Transplantation

Organ transplantation is now undertaken at medical facilities in more than 100 countries around the world, but the rate at which it occurs varies enormously, as do the circumstances under which it is carried out. In 2011, 112,631 transplants were reported globally, an increase of 11.6% since 2008, when the *Declaration of Istanbul on Organ Trafficking and Transplant Tourism* (*Declaration of Istanbul*) was adopted.²⁷ With more than 5.5% annual growth during this period, deceased donation—which WHO Guiding Principle 3 states “should be developed to its maximum therapeutic potential” in preference to the use of living donors (who “should be genetically, legally or emotionally related to their recipients” to avoid commercial relationships)—grew even more rapidly, with a cumulative increase of approximately 17.4% between 2008 and 2011.²⁸ Overall, about 37,233 kidney transplants involved deceased donors in 2008; this number increased to just over 43,714 in 2011, and the increase in several regions was even more impressive: nearly 50% in WHO’s Eastern Mediterranean Region and almost 33% in its Western Pacific Region.²⁹

27. Steering Committee of the Istanbul Summit, *Organ Trafficking and Transplant Tourism and Commercialism: The Declaration of Istanbul*, 372 LANCET 5 (2008). The full declaration was printed in several medical journals. See, e.g., Participants in the International Summit on Transplant Tourism and Organ Trafficking convened by the Transplantation Society and the International Society of Nephrology in Istanbul, Turkey, 30 April to 2 May 2008, *The Declaration of Istanbul on Organ Trafficking and Transplant Tourism*, 23 NEPHROLOGY DIALYSIS TRANSPLANTATION 3375 (2008).

28. Compare GLOBAL OBSERVATORY ON DONATION & TRANSPLANTATION, ACTIVITY DATA 2008, at 3 (2008) [hereinafter GLOBAL OBSERVATORY ON DONATION & TRANSPLANTATION, 2008 DATA], available at <http://issuu.com/o-n-t/docs/2008?e=4461754/2882493>, with GLOBAL OBSERVATORY ON DONATION & TRANSPLANTATION, ORGAN DONATION AND TRANSPLANTATION ACTIVITIES 2011, at 5 (2011) [hereinafter GLOBAL OBSERVATORY ON DONATION & TRANSPLANTATION, 2011 DATA], available at <http://issuu.com/o-n-t/docs/2011adg?e=4461754/3988136.pdf>. These figures were calculated by applying the percentage of deceased donations in each of WHO’s regions to the total number of donations in those regions for both of the years at issue, and then by comparing the yearly figures. According to the Global Observatory on Donation and Transplantation, the percentage of organs from deceased donors grew in all regions during those years, and the absolute numbers increased in all regions except Sub-Saharan Africa. *Id.* (indicating, through the figures necessary for the calculation just mentioned, that Sub-Saharan deceased donations fell in absolute terms from 160 to about 154). The lack of an increase in Sub-Saharan Africa is probably explained by the closing of a program in South Africa that transplanted vended kidneys from living donors into foreign patients. Michael Smith, *Organ Gangs Force Poor to Sell Kidneys for Desperate Israelis*, BLOOMBERG (Nov. 11, 2011, 6:00 PM), <http://www.bloomberg.com/news/2011-11-01/organ-gangs-force-poor-to-sell-kidneys-for-desperate-israelis.html>.

29. Compare GLOBAL OBSERVATORY ON DONATION & TRANSPLANTATION, 2008 DATA, *supra* note 28, with GLOBAL OBSERVATORY ON DONATION & TRANSPLANTATION, 2011 DATA, *supra* note 28. The transplant activities included in the 2011 report actually reflect 2011 data from 94 countries along with 2010 data from four countries (including China), 2009 data for two countries, and 2008 data for three countries. *Id.* at 3, 18. The Global Observatory on Donation and Transplantation describes these numbers as “provisional estimates” that are subject to revision. *Id.* at 18. In particular, the data from China, India and South Africa are “best estimates from official sources” because these countries

Despite efforts by WHO and professional bodies to increase the technical capacity of medical facilities around the world to carry out advanced surgical procedures including transplantation and to develop the medical and governmental infrastructure to support organ donation from deceased persons, living donation is the norm in many parts of the world, with the result that the overall rate and pattern of transplantation vary widely. WHO reports data on the number of transplants broken down by organ and by its six regional groupings of countries.³⁰

Table: Kidney and Liver Transplants in 2009

WHO Region	Kidney Transplants	Liver Transplants
Sub-Saharan Africa	463 (0.56)	42 (0.05)
Americas	27728 (29.96)	8741 (9.4)
Eastern Mediterranean	5582 (9.4)	415 (0.70)
Europe	21713 (24.2)	7577 (8.45)
Southeast Asia	5801 (3.25)	508 (0.28)
Western Pacific	10131 (5.64)	3744 (2.08)

Legend: Number (rate per million population (pmp))

Note: Totals include both living and deceased donors. Bold indicates regions with highest and lowest population rates.

Source: GLOBAL OBSERVATORY ON DONATION & TRANSPLANTATION, ORGAN DONATION AND TRANSPLANTATION ACTIVITIES 2009, at 4 (2009), available at <http://issuu.com/o-n-t/docs/2009?e=4461754/2879005>.

The data in the table show the absolute numbers and the rate per million population for kidney and liver transplants (which together constitute nearly 90% of all transplants) in 2009, the year before the World Health Assembly adopted the revised WHO *Guiding Principles*. The difference between the average population rates at which transplantation occurs in the highest-ranking region (the Americas) and the lowest-ranking region (Sub-Saharan Africa) is more than 50 fold for kidney transplants and 188 fold for liver transplants.

These data are useful in gaining a general understanding of regional patterns, but further illumination depends on looking at specific countries and their organ sources. The jurisdictions with the highest rates for transplantation of all organs (greater than or equal to 75 per million population) are the United States and many Western European countries; the group with the next highest rate (from 50 to 74.9 per million population) consists of the rest of Western Europe, Turkey, Canada, Australia, and South Korea. Not surprisingly, all of

do not yet have comprehensive registries on organ transplantation. *Id.*

30. *Id.*

these countries score “very high” on the Human Development Index (HDI),³¹ save Turkey, which scores “high.”³² Moreover, the data reported by the Global Observatory on Donation and Transplantation show that of the countries with kidney-transplant rates above 40 per million population, all 14 are at the “very high” level on the HDI, and even expanding the range to 20 per million population adds 20 more “very high” HDI countries, along with nine more in the “medium” to “high” range on the HDI.³³

In some ways, however, any rates that combine data on organs obtained from living and deceased donors are not the most revealing, at least not as to the issues of transplant tourism and payments for kidneys, which—outside of China—have principally involved unrelated living donors.³⁴ Among the countries that are near the top in the rate at which kidneys are obtained from either living or deceased donors per million population, only the United States (second overall) ranks high in its rate of both deceased donation (eighth) and living donation (ninth) in the 2011 report. Most of the leading countries on one list do not rank high on the other. Other than the United States, among the countries that are in the global top ten in the rate of deceased kidney donors, only Norway (at twenty-second) appears among the top thirty-three countries ranked by the rate of living kidney donation. Most countries rely on one mode of donation or the other; even the Netherlands, which has about an equal number of living and deceased donors and ranks fifth globally in its combined rate of kidney transplantation, comes in fourth in living donation but twenty-first in deceased donation, far behind most of its neighbors in Europe.

Although many of the countries that have long had reputations as being “hotspots” for transplant tourism—such as Egypt, Turkey, Costa Rica, and Mexico³⁵—appear near the top of the list of countries with high rates of living kidney donors per million population, many other places where purchases of kidneys from living persons have been prevalent—such as India, Pakistan and

31. UNITED NATIONS DEVELOPMENT PROGRAMME, HUMAN DEVELOPMENT REPORT 2014, at 160 tbl.1 (2014), available at <http://hdr.undp.org/sites/default/files/hdr14-report-en-1.pdf>.

32. *Id.*

33. GLOBAL OBSERVATORY ON DONATION & TRANSPLANTATION, 2011 DATA, *supra* note 28, at 17.

34. Living donors are obviously not relevant for most nonrenal organs, although the donation by living donors of a portion of the liver does make up a small percentage of all liver transplants in many countries and a majority of liver transplants in several countries in the Middle and Far East such as Algeria, Egypt, Jordan and Mongolia (in all of which virtually no deceased donors were being used in liver transplantation as of 2011) and Saudi Arabia, Turkey, Japan, and South Korea (where the number of living donors far exceeds the number of deceased liver donors). GLOBAL OBSERVATORY ON DONATION & TRANSPLANTATION, 2011 DATA, *supra* note 28, at 13.

35. Gabriel M. Danovitch et al., *Organ Trafficking and Transplant Tourism: The Role of Global Professional Ethical Standards—The 2008 Declaration of Istanbul*, 95 TRANSPLANTATION 1306, 1307 (2013) [hereinafter Danovitch et al., *Global Standards*]; see Jose Melendez, *How Costa Rica Became the Center of Global Human-Organ Trafficking Ring*, EL PAIS (Mar. 17, 2014, 9:05 PM), http://elpais.com/elpais/2014/03/17/inenglish/1395085976_320480.html; Andrew O'Reilly, *Organ Trafficking on the Rise*, FOX NEWS LATINO (Aug. 16, 2012), <http://latino.foxnews.com/latino/news/2012/08/16/organ-trafficking-on-rise-in-united-states/>.

the Philippines³⁶—do not. This is because significant portions of the transplants that occur in the latter countries are performed on foreigners. Lacking a comprehensive program of organ replacement for their domestic populations, these countries' low kidney-transplant rates reflect the relatively modest total number of procedures done for wealthy or well-insured foreign and domestic patients divided by the countries' large populations.

Most significantly, the global data collected by WHO do not differentiate between related and unrelated living donation. Until recently, most of the problematic cases of commercial donation have been in the latter category. When, for example, the Indian parliament responded to the 1991 WHO *Guiding Principles* by enacting the Transplantation of Human Organs Act 1994,³⁷ the number of kidney sales in India initially fell drastically³⁸—and then rose quickly and markedly elsewhere, particularly in Pakistan and the Philippines.³⁹

B. Global Efforts to Strengthen Ethical and Legal Norms

India was one of about fifty countries that undertook to reform their practices following the approval of WHO's original *Guiding Principles*. These countries adopted laws in the early 1990s to institute the anticommercial system recommended by WHO. Similarly, a number of countries—including several that were centers for organ sales, such as Pakistan and the Philippines, and other countries, such as Israel, that had sent large numbers of “transplant tourists” abroad to receive vended kidneys⁴⁰—have adopted laws and regulations in the past few years that aim to put the 2010 WHO *Guiding*

36. Danovitch et al., *Global Standards*, *supra* note 35, at 1308–09. For data on transplant rates in all these countries, see GLOBAL OBSERVATORY ON DONATION & TRANSPLANTATION, 2011 DATA, *supra* note 28.

37. No. 42, Acts of Parliament, 1994 (India); see LILY SRIYASTAVA, LAW & MEDICINE 103 (2010).

38. The rate then crept back up over the following fifteen years due to loopholes in the statute and its 1995 implementing regulations. The Transplantation of Human Organs Rules, 1995, 51(E) Gen. S. R. & O. Section 9(3) of Chapter II of the 1994 Act allowed donations by unrelated persons acting out of “affection and attachment” for a recipient, and under the regulations the state-appointed Authorization Committees were permitted to approve unrelated transplants on grounds of “affection or attachments or . . . any special reasons.” *Id.* It has been reported that this provision was widely abused by the committees, which, either out of pity for potential recipients or because they were bribed, approved “many poor, illiterate, out of work strangers [who had] developed enough affection for rich recipients from far off places whom they ha[d] either never met or just seen a couple of times” to serve as donors to those recipients. Vivek Jha, *Paid Transplants in India: The Grim Reality*, 3 NEPHROLOGY DIALYSIS TRANSPLANTATION 541, 542 (2004). “The majority of applications to the [Authorizing Committee (AC)] are usually accepted. Most unrelated donations occur when the donor expresses their true affection for the recipient in front of the AC. Between 1995 and 2002, there were about 5,000 cases interviewed by the AC in Tamil Nadu with a rejection rate of less than 5%.” Sunil Shroff, *Legal and ethical aspects of organ donation and transplantation*, 25 INDIAN J. UROLOGY 348, 352 (2009).

39. Yosuke Shimazono, *The State of the International Organ Trade: A Provisional Picture Based on Integration of Available Information*, 85 BULL. WORLD HEALTH ORG. 955, 957 (2007).

40. See, e.g., Benita Padilla et al., *Impact of Legal Measures Prevent Transplant Tourism: The Interrelated Experience of the Philippines and Israel*, 16 MED. HEALTH CARE & PHIL. 915, 915–16 (2013).

Principles into effect.⁴¹ These changes have been strongly supported by other intergovernmental bodies such as the United Nations,⁴² the Council of Europe,⁴³ and the UN Office on Drugs and Crime,⁴⁴ all of which have addressed the phenomena of organ trafficking⁴⁵ and of people being trafficked for the removal of the organs.⁴⁶

Equally significant in driving ethical and legal reforms have been the advocacy efforts of leaders in transplantation medicine. For example, the Transplantation Society (TTS) and the International Society of Nephrology organized a global summit on organ trafficking and transplant tourism in Istanbul in late April 2008, where a statement of professional opposition to organ markets, the *Declaration of Istanbul*, was adopted.⁴⁷ The *Declaration of Istanbul* has since been endorsed by more than 120 medical organizations and governmental agencies.⁴⁸ Realizing that the declaration would not be self-implementing, its creators formed the Declaration of Istanbul Custodian Group (DICG) in 2010 to encourage adherence to its principles and proposals.⁴⁹ The DICG and TTS have produced some notable results by calling on government officials to adopt and enforce prohibitions, and by making clear to them the harm done to the standing of medical professionals who work in locales where organ sales are widespread.⁵⁰ Furthermore, the DICG's direct interventions to

41. *Id.* at 916–17.

42. *See, e.g.*, United Nations Global Plan of Action to Combat Trafficking in Persons, G.A. Res. 64/293, U.N. Doc. A/RES/64/293 (August 12, 2010); Preventing, Combating and Punishing Trafficking in Human Organs, G.A. Res. 59/156, U.N. Doc. A/RES/59/156 (December 20, 2004).

43. Marta López-Fraga et al., *supra* note 18, at 2187–88.

44. *See* GLOBAL PROGRAMME AGAINST TRAFFICKING IN HUMAN BEINGS, U.N. OFFICE ON DRUGS & CRIME, TOOLKIT TO COMBAT TRAFFICKING IN PERSONS 494–500 (2008), available at http://www.unodc.org/documents/human-trafficking/HT_Toolkit08_English.pdf.

45. Alireza Bagheri & Francis L. Delmonico, *Global Initiatives to Tackle Organ Trafficking and Transplant Tourism*, 16 MED. HEALTH CARE & PHIL. 887, 892–93 (2013).

46. The focus of this analysis is on programs, operated by hospitals or others, in which living donors or the family of deceased donors are given money or something else of material value to agree to organ donation, rather than on the variety of human trafficking and other criminal activities that have arisen on the periphery of organ transplantation and that have, arguably been facilitated by the existence of commercial organ donation. For more on those peripheral activities, see, for example, Frederike Ambagtsheer, Damian Zaitch & Willem Weimar, *The Battle for Human Organs: Organ Trafficking and Transplant Tourism in a Global Context*, 14 GLOBAL CRIME 1 (2013).

47. *See supra* note 27 and sources cited therein.

48. *See Endorsing Organizations, DECLARATION OF ISTANBUL*, http://www.declarationofistanbul.org/index.php?option=com_content&view=article&id=74&Itemid=56 (last visited May 8, 2013).

49. *See Declaration of Istanbul Custodian Group, DECLARATION OF ISTANBUL*, http://www.declarationofistanbul.org/index.php?option=com_content&view=article&id=73&Itemid=59 (last visited Jun. 14, 2014).

50. Danovitch et al., *Global Standards*, *supra* note 35, at 1308 (citing, for example, Spain's acknowledgement of the *Declaration of Istanbul* when it modified its penal code to provide penalties for trafficking in organs and trafficking in people for organ removal); Francis Delmonico et al., *Open Letter to Xi Jinping, President of the People's Republic of China: China's Fight Against Corruption in Organ Transplantation*, 97 TRANSPLANTATION 795, 796 (2014) [hereinafter Delmonico et al., *Open Letter*] (urging the government to adhere to its 2007 organ-transplant regulations and 2013 *Hangzhou Resolution*, both adopted with aid and encouragement of the international organizations).

change professional practices have been even more successful.⁵¹ For instance, academic recognition has been withheld from physicians who have carried out transplants with organs from executed prisoners by barring the physicians' abstracts from inclusion in international medical congresses.⁵² Many medical journals have announced that they expect adherence to the *Declaration of Istanbul* by their authors, just as they have long insisted that research conducted with human beings must adhere to the *Declaration of Helsinki*, first promulgated by the World Medical Association in 1964.⁵³ In at least one instance, several articles were retracted from an academic journal when it was discovered that the work discussed involved living donors who had been paid to supply a kidney.⁵⁴

C. Recent National Changes in Response to Global Norms

Bringing about thoroughgoing changes in transplant practices requires more than academic and professional sanctions; governments must also adopt and enforce bans on organ purchases and transplant tourism. The latter has proven particularly difficult, not the least because of the built-in opposition of the people who have profited from catering to transplant tourists. Accordingly, the hard-won gains in this regard that have been achieved in the past five years are all the more remarkable.

Some local proponents of organ-trade prohibitions have successfully used global standards in their transformative efforts. This is illustrated by the experiences of Pakistan where the Transplantation of Human Organs and Tissues Ordinance was adopted by presidential decree in 2007 before becoming a parliamentary act in 2010.⁵⁵ Before the ordinance, an estimated 1500 patients from other countries—principally in the Middle East—as well as about 500 wealthy Pakistanis received vended kidneys each year, mainly in private hospitals and clinics in Lahore and other Punjab cities.⁵⁶ The efforts to bring that practice to an end were led by the professionals associated with the Sindh Institute of Urology and Transplantation (SIUT), a medical center in Karachi that provides donation-driven kidney dialysis and transplantation to all patients without charge. SIUT supplied the “moral entrepreneurs: groups and

51. Danovitch et al., *Global Standards*, *supra* note 35, at 1308.

52. Gabriel Danovitch, Michael Shapiro & Jacob Lavee, *The Use of Executed Prisoners as a Source of Organs Must Stop*, 11 AM. J. TRANSPLANTATION 426, 427 (2011); Delmonico et al., *Open Letter*, *supra* note 50, at 795 (describing the reasons for this “academic embargo”).

53. Letter from Exec. Comm., Declaration of Istanbul Custodian Grp., to Nuffield Council on Bioethics (July 2010), available at <http://www.nuffieldbioethics.org/sites/default/files/files/Declaration%20of%20Istanbul%20Custodian%20Group.pdf>.

54. Adam Marcus, *Transplant Journal Retracts Three Papers over Possible Organ Trafficking*, RETRACTION WATCH (Feb. 12, 2013, 9:30 AM), <http://retractionwatch.wordpress.com/2013/02/12/transplant-journal-retracts-three-papers-over-possible-organ-trafficking/>.

55. K.M. Bile et al., *Human Organ and Tissue Transplantation in Pakistan: When a Regulation Makes a Difference*, 16 E. MEDITERRANEAN HEALTH J. S159, S161 (2010).

56. S.A.H. Rizvi et al., *Pakistan Abolishes Kidney Market and Ushers in a New Era of Ethical Transplantation*, 1 INT. J. ORGAN TRANSPLANTATION MED. 193, 194–95 (2010).

individuals in civil society who are committed to the elimination of trade they consider harmful and repugnant,”⁵⁷ who mobilized public opposition to commercial organ donation. They urged the government to adopt the new law. Descriptions written by SIUT physicians of the socioeconomic realities of the organ trade⁵⁸ and of the resulting hazards to both donors and recipients⁵⁹ led to critical reporting of the practice in newspapers and on television.⁶⁰

The media coverage took specific aim at the role of the government, whose failed poverty-alleviation programs left individuals no choice but to sell their kidneys, and whose failure to enact a transplant law and later to enforce it allowed the organ trade to thrive. It was also noted that reports of Pakistan’s “flourishing kidney market” had appeared in the international press, tarnishing the country’s reputation.⁶¹

The owners of the private hospitals who profited greatly from transplant commercialism and who had strong connections to high-level officials mounted fierce opposition to the transplant bill and sought to water down its prohibitions on unrelated living donation.⁶² On the other side, SIUT’s founder and director, Professor Adib Rizvi, used his strong connections with international medical groups, particularly his membership in the DICG, to counteract these powerful opponents.⁶³ Prominent transplant surgeons among the DICG leadership came to Pakistan to convince government officials that organ sales were a matter of international concern and needed to be curbed to rehabilitate the reputation of Pakistani physicians.⁶⁴ As Professor Asif Esrat concludes, “For government officials, the desire to conform to widely held international norms and redeem the national reputation served as a motivation for action.”⁶⁵ When the law was contested in a federal Shariat court as an interference with the Islamic duty to save life, the existence of the international standards, as embodied in the WHO *Guiding Principles* (which Pakistan had joined in endorsing at the World Health Assembly), weighed heavily enough that the court rejected the challenge.⁶⁶

57. Asif Efrat, *The Politics of Combating the Organ Trade: Lessons from the Israeli and Pakistani Experience*, 13 AM. J. TRANSPLANTATION 1650, 1651 (2013).

58. See, e.g., Farhat Moazam et al., *Conversations with Kidney Vendors in Pakistan: An Ethnographic Study*, HASTINGS CENTER REP., May–June 2009, at 29–44.

59. See, e.g., S.A.A. Naqvi et al., *Health Status and Renal Function Evaluation of Kidney Vendors: A Report from Pakistan*, 8 AM. J. TRANSPLANTATION 1444, 1445–49 (2008).

60. Efrat, *supra* note 57, at 1652.

61. *Id.*

62. Bile et al., *supra* note 55.

63. See S.A.H. Rizvi et al., *A Renal Transplantation Model for Developing Countries*, 11 AM. J. TRANSPLANTATION 2302 (2011). The support of WHO came both from its headquarters in Geneva and from Dr. Khalif Bile Mohamud, the WHO representative in Pakistan. See, e.g., Bile, *supra* note 55; Letter from Dr. Khalif Bile Mohamud, WHO Representative in Pak., to Major Gen. R. Muhammad Aslam, Dir. of Gen. Health, Ministry of Health, Gov’t of Pak. (Feb. 13, 2004) (on file with *Law and Contemporary Problems*).

64. Efrat, *supra* note 57, at 1652.

65. *Id.*

66. Farhat Moazam, *Sharia Law and Organ Transplantation: Through the Lens of Muslim Jurists*, 3 ASIAN BIOETHICS REV. 316, 328–29 (2011).

When several transplant programs continued to carry out commercial transplants, including on patients from abroad, Dr. Rizvi and his colleagues reported these violations to the authorities and prosecutions were brought against the surgeons and hospitals that had attempted to profit by breaking the law.⁶⁷

The current situation in the Philippines resembles that in Pakistan in some ways but differs in significant respects. The country has been a well-known locale for organ purchases for the past several decades; indeed, it was one of the first places where the anthropologists of Organs Watch, an independent research and medical-human-rights project at the University of California, Berkeley, began their examination of the “new body trade” in which “the circulation of kidneys follows established routes of capital from South to North, from East to West, from poorer to more affluent bodies, from black and brown bodies to white ones, and from female to male or from poor, low status men to more affluent men.”⁶⁸

Although Internet sites have made the Philippines another important locus for the global organ trade, the initial pattern of using vended kidneys there differed from what had occurred in Pakistan because the recipients were mainly wealthy Filipinos, not foreigners. 358 of the 468 kidney transplants recorded in 2003 by the Renal Disease Control Program of the Department of Health in the Philippines involved domestic patients (though the possibility of incomplete reporting by private hospitals cannot be totally discounted).⁶⁹ It was thus not surprising that elite groups at that time supported a proposal under consideration by the government to institutionalize paid kidney donation as well as to formally accept transplantation for foreign patients.⁷⁰ As appealing as this idea may have seemed to someone viewing it “from a private hospital room in Quezon City,” it was much less so for human-rights advocates trying to protect potential organ sellers in “a sewage-infested banguay (slum) in Manila.”⁷¹ These advocates used the attention that the World Health Organization was bringing to the issue at that time to halt the movement toward legalizing compensation.

Over the following five years, international pressure on the government intensified, not only from intergovernmental and medical bodies⁷² but from the Catholic hierarchy, particularly in light of press coverage about unscrupulous organ brokers trolling in the slums for donors to meet the ever-increasing

67. S.A.H. Rizvi et al., *A Renal Transplantation Model for Developing Countries*, 11 AM. J. TRANSPLANTATION 2302, 2305 (2011).

68. Scheper-Hughes, *Keeping an Eye*, *supra* note 19, at 1645.

69. Shimazono, *supra* note 39.

70. *Id.* at 956 (citing Fumiko Endo, *Organ Plan Poses Ethical Issues; New RP Scheme to Allow Kidney Trading Aims to Close Black Market*, DAILY YOMIURI, Feb. 3, 2007, at 3 (Japan)).

71. Scheper-Hughes, *Keeping an Eye*, *supra* note 19, at 1645.

72. See, e.g., Leonardo D. de Castro, *The Declaration of Istanbul in the Philippines: Success with Foreigners but a Continuing Challenge for Local Transplant Tourism*, 16 MED. HEALTH CARE & PHIL. 929, 930–31 (2013).

demand for kidneys coming from Manila's transplant tourists.⁷³ On April 30, 2008, a ministerial directive barred foreign recipients from getting kidneys from Filipino living donors.⁷⁴ The next year, the Inter-Agency Council Against Trafficking followed the international trend and used the organ trafficking provisions of the Philippines' Anti-Human Trafficking Law as the basis for supplemental regulations outlawing all organ purchases, as well as other means of trafficking persons for organ removal, including the use of force, fraud, and taking advantage of vulnerability.⁷⁵

The fragility of these legal changes in the face of the determined opposition is indicated by the next swing of the Filipino organ-policy pendulum. When Benigno Aquino III assumed office as President in June 2010, he nominated as secretary of health Dr. Enrique T. Ona, a transplant surgeon who had previously expressed his opposition to the ban on organ sales.⁷⁶ The nomination was held up, however, when Ona announced his intention to allow organ donors to be compensated by a \$3200 "gratuity package"⁷⁷ and joined several American regulated-market advocates in sponsoring an international forum on "Incentives for Donation" in Manila that November.⁷⁸ He was confirmed as health minister, however, after providing assurances that he would not institute financial "gratuities," but he did sign the proposal for incentives that emerged from the international forum.⁷⁹ In effect, the pendulum has swung back, as the number of foreign transplant recipients, which had risen to 531 by 2007 before the ban, fell to two by 2011, even as a threefold increase occurred in deceased-donor transplants for Filipinos.⁸⁰ Movement in the opposite direction remains possible, however, as organ purchases by wealthy Filipinos have not completely disappeared, with brokers helping potential kidney recipients persuade review committees to allow as "emotionally related" donations what are in fact commercial transactions.⁸¹

Another variation on the theme of transplant tourism has taken place in Colombia, which "was a major provider of deceased-donor organs for wealthy

73. Carlos H. Conde, *The Philippines: No More Kidneys for Foreigners, Government Decrees*, N.Y. TIMES, Apr. 30, 2008, at A11.

74. *Id.*

75. INTER-AGENCY COUNCIL AGAINST TRAFFICKING, RULES AND REGULATIONS IMPLEMENTING SECTION 4(G) OF REPUBLIC ACT NO. 9208, OTHERWISE KNOWN AS THE ANTI-TRAFFICKING IN PERSONS ACT OF 2003, IN RELATION TO SECTION 3(A) OF THE SAME ACT, ON THE TRAFFICKING OF PERSONS FOR THE PURPOSE OF REMOVAL OR SALE OF ORGANS (June 2009), available at <http://www.transplant-observatory.org/SiteCollectionDocuments/wprlegethphl6.pdf>.

76. David Dizon, *DOH To Lift Ban on Organ Donations for Foreigners*, ABS CBN NEWS.COM (Jul. 2, 2010, 6:55 PM), <http://www.abs-cbnnews.com/nation/07/02/10/doh-lift-ban-organ-donations-foreigners>.

77. *Id.*

78. Working Group on Incentives for Living Donation, *Incentives for Organ Donation: Proposed Standard for an Internationally Acceptable System*, 12 AM. J. TRANSPLANTATION 306, 311 (2012).

79. *Id.*

80. Danovitch et al., *Global Standards*, *supra* note 35, at 1309.

81. See de Castro, *supra* note 72, at 931.

foreigners” during the first decade of this century,⁸² mainly for liver transplantation.⁸³ With strong international and regional backing, local medical leaders succeeded in redirecting organs to recipients from Colombia and neighboring countries. The annual rate of transplantation to foreigners, which stood at 200 in 2005 (16.5% of the national total), was reduced to 10 by 2011 (0.9% of the total, down from 1.45% the prior year).⁸⁴

The situation in Colombia is indicative of the progress that has been made across Latin America with the adoption by the Ibero-American Council of a set of principles and objectives in a regional parallel to the *Declaration of Istanbul*, the *Document of Aguascalientes*,⁸⁵ which was encouraged through a strong alliance with the Spanish transplant program. The *Document of Aguascalientes* has provided legal and ethical as well as technical guidance for countries across that region as they have created or strengthened their own systems for organ donation, allocation, and transplantation that seek the support of the public and medical professionals and that aim to meet the transplant needs of the domestic population and achieve “self-sufficiency” nationally or through regional cooperation.⁸⁶

Over the past five years, the most impressive examples of countries that have responded to stronger global norms regarding the opposite side of “self-sufficiency”—namely, not sending transplant tourists abroad as the means to meet domestic demand for organs—are in the Middle East. Israel’s enactment in 2008 of legislation halting insurance coverage for commercial transplants that violate local laws ended its reliance on Turkey, South Africa, China, and the Philippines, among other countries, as sites where Israeli patients could go to obtain vended kidneys.⁸⁷ The law also stimulated the development of a robust system of deceased and living-related donation, which has been widely praised.⁸⁸

82. Danovitch et al., *Global Standards*, *supra* note 35, at 1309.

83. Francis L. Delmonico, *The Implications of Istanbul Declaration on Organ Trafficking and Transplant Tourism*, 14 CURRENT OPINION IN ORGAN TRANSPLANTATION 116, 117 (2009).

84. INSTITUTO NACIONAL DE SALUD, INFORME ANUAL RED DONACIÓN Y TRASPLANTES [DONATION AND TRANSPLANT NETWORK ANNUAL REPORT] 26 (2012).

85. See Ashley Baquero & Josefina Alberú, *Ethical Challenges in Transplant Practice in Latin America: The Aguascalientes Document*, 31 NEFROLOGIA 275, 275 (2011) (Spain).

86. See, e.g., *The Madrid Resolution on Organ Donation and Transplantation: National Responsibility in Meeting the Needs of Patients, Guided by the WHO Principles*, 91 TRANSPLANTATION (SUPPLEMENT 11S) S29 (2011); see also F. Delmonico, M. Dominguez-Gil, R. Matesanz & L. Noel, *A Call for Government Accountability to Achieve National Self-Sufficiency in Organ Donation and Transplantation*, 378 LANCET 1414 (2011) (articulating the rationale for a new paradigm of self-sufficiency in which each country or region would strive to provide a sufficient number of organs from within its own population).

87. Gabriel M. Danovitch, *The High Cost of Organ Transplant Commercialism*, 85 KIDNEY INT’L 248, 250 (2014).

88. See, e.g. Danovitch et al., *Global Standards*, *supra* note 35, at 1309–10; Efrat, *supra* note 57, at 1652–53; Padilla, *supra* note 40, at 918–19. Drs. Jacob Lavee and Avraham Stoler provide a comprehensive analysis of the Israeli donation program in their contribution to this issue of *Law and Contemporary Problems*. See Jacob Lavee & Avraham Stoler, *Reciprocal Altruism: The Impact of Resurrecting an Old Moral Imperative on the National Organ Donation Rate in Israel*, 77 LAW & CONTEMP. PROBS., no. 3, 2014, at 323.

A number of Arab countries have taken steps—thus far less sweeping in scope or impact than the Israeli program but still effective—to treat patients at home rather than sending them abroad. The evolution of policy in Qatar provides a vivid example of the competing forces at work: expediency, self-interest, generosity, and concern about adhering to international norms. The local provider of transplant services, the Hamad Medical Corporation (HMC), has concluded that it needs to go beyond the existing Qatari program for honoring donors if it is to achieve self-sufficiency in organ transplantation.⁸⁹ Consequently, the HMC increased outreach within the expatriate community in Qatar (more than 85% of residents) to ensure that they too have access to transplantation services.⁹⁰ Additionally, the HMC has substantially increased deceased donation by publicizing that “brain death” is acceptable under Islam⁹¹ and by having prominent persons, such as members of the royal family, not only recognize the generosity of living donors and the families of deceased donors but also enroll in the organ-donor registry.⁹²

A central component of the new Qatari program is the Doha Donation Accord,⁹³ which was formulated in November 2009 with assistance from the leaders of the DICG and the International Society for Organ Transplantation, and which came into effect in 2010 following approval by the country’s Supreme Council of Health. The accord aimed to combat organ commercialism, to create a deceased-donor program in which everyone—whether citizen or foreign worker—would participate as both a potential donor and potential recipient, and to provide a path to self-sufficiency in organ transplantation.⁹⁴ The original accord departed from practices elsewhere in the region by not offering any financial payment to the families of donors,⁹⁵ but several of its promises—in

89. Donate Life, *International Organ Donation News—Doha, UAE, Aims To Promote Organ Donation*, ORGAN & TISSUE DONATION BLOG (Nov. 20, 2009), <http://donatelife-organodonation.blogspot.com/2009/11/international-organ-donation-news-doha.html> (last visited July 18, 2013) (quoting HMC Managing Director Dr. Hanan Al Kuwari as stating that “since our first renal transplant in 1986, HMC has struggled to acquire the appropriate number of donors to develop our organ transplant programme[;] despite our frequent campaigns to promote a culture of donation, the gap between the available organs and our waiting list has pushed many of our patients to go abroad for organ transplants,” and noting that Dr. Al Kuwari stressed the need for Qatar to meet the organ requirements of its citizens from within its own population).

90. See SUPREME COUNCIL OF HEALTH, SCH ANNUAL REPORT 2012, at 41 (2013) (Qatar), available at <http://www.nhsq.info/app/media/540>; Supreme Council of Health, *Putting Ethics Into Practice*, QATAR HEALTH, Jan. 1, 2014, at 10, 12 [hereinafter Supreme Council of Health, *Putting Ethics Into Practice*], available at <http://www.nhsq.info/app/media/1196>.

91. Supreme Council of Health, *Putting Ethics Into Practice*, *supra* note 90, at 14.

92. Press Release, Hamad Med. Corp., Huge Surge of Support for Organ Donation as People of All Nationalities Follow Her Highness Sheikha Moza Bint Nasser’s Lead (Sept. 2, 2012), available at http://www.hmc.org.qa/en/hcp/news_and_features/news/september_2012/press_release_02_09_12.aspx.

93. HAMAD MED. CORP., DOHA DONATION ACCORD (2010), available at http://organdonation.hamad.qa/en/images/Doha_Donation_Accord.pdf.

94. Hanan Alkuwari, et al., *The Doha Donation Accord Aligned With the Declaration of Istanbul: Implementations to Develop Deceased Organ Donation and Combat Commercialism*, 97 TRANSPLANTATION 3, 4 (2014).

95. Some form of family support is available, from a government foundation, in the case of all

particular, that a their family member would be offered a free airplane ticket to accompany the deceased's body from Qatar "at the time of donation"—do not align with Guiding Principle 5 of the WHO *Guiding Principles*, which states that "[c]ells, tissues and organs should only be donated freely, without any monetary payment or other reward of monetary value."⁹⁶ To the accord's framers, it would have been inconsistent with cultural norms of reciprocal gift-giving not to provide something of value to those who agree to donate organs for transplantation. To outsiders, however, such a provision seemed to exploit the vulnerable situation of the families of Qatar's manual laborers and domestic workers from India, Nepal, the Philippines, and other developing countries, who would otherwise find it difficult to repatriate their loved one's remains.⁹⁷

At a meeting in Doha in April 2013, held to mark the fifth anniversary of the *Declaration of Istanbul*, the leaders of the HMC transplant program acknowledged the remaining shortcomings in the Doha Donation Accord and pledged to make revisions satisfactory to the DICG.⁹⁸ In particular, they pledged to ensure that any benefits provided to donors' families would be offered to the families of all potential donors, irrespective of whether they agree to donate their deceased relative's organs for transplantation; further,

[A] social welfare program at HMC, in association with Qatar charities, provides assistance where required to patients and their families. This assists in securing long-term medical care, supply of medications, and financial support during residency in Qatar and sometimes following the return home of expatriates. For example, following a formal socioeconomic evaluation, social services provide support to eligible families of all patients who die within HMC hospitals, including families resident abroad. [W]hile the team at the Organ Donation Centre may directly refer families of critically ill patients to welfare services for assistance as part of their routine care, such referrals and provision of welfare benefits are unrelated to donation decisions—a point that is made clear to families.⁹⁹

deaths in Qatar, and "[i]n the course of their engagement with potential donor families, donor coordinators may also facilitate referral to social support services where needed, irrespective of whether consent is provided for donation." *Id.* at 4.

96. World Health Org. Secretariat, *supra* note 23, at 9. The commentary on Guiding Principle 5 notes that the principle "allows for circumstances where it is customary to provide donors with tokens of gratitude that cannot be assigned a value in monetary terms. National law should ensure that any gifts or rewards are not, in fact, disguised forms of payment for donated cells, tissues or organs." *Id.* The commentary goes on to observe that "[w]hile the worst abuses involve living donors, dangers also arise when payments . . . are made to next of kin of deceased persons." *Id.* Guiding Principle 5 is not violated by the practice of transferring the coffin to the deceased's homeland because, as the Doha Donation Accord notes, this is done irrespective of organ donor status, pursuant to Qatari law applicable to the death of all foreign workers. See Law No. 4 of 2009 Regarding Regulation of the Expatriates Entry, Departure, Residence and Sponsorship, art. 4, available at <http://www.almeezan.qa/LawPage.aspx?id=2611&language=en>.

97. Owen Gibson, *More Than 500 Indian Workers Have Died in Qatar Since 2012, Figures Show*, GUARDIAN (Feb. 18, 2014, 12:33 AM), <http://www.theguardian.com/world/2014/feb/18/qatar-world-cup-india-migrant-worker-deaths>.

98. Danovitch et al., *Global Standards*, *supra* note 35, at 1310.

99. Dominique Martin & Riadh A.S. Fadhil, *The Doha Model of Organ Donation and Transplantation: Thinking Beyond Citizenship* 2 GRIFFITH J. L. & HUM. DIGNITY 293, 300–01 (2014). The provision of welfare benefits does not appear to be essential for a decision to donate. Between January 2011 and May 2014, only four of the eighteen families who gave consent to donation (out of 98

The forces at play in the movement of Qatar toward a more self-sufficient program of organ transplantation are the same as those that have operated in the other countries described. In the countries that have provided transplants to large numbers of transplant tourists, the forces favoring payments to living donors have largely been controlled by those who directly profit from this business. But in Qatar, as in other countries that have sent most of their potential kidney and liver recipients abroad for transplantation, those who had supported transplant tourism shifted toward favoring payments to donors in Qatar, because they do not believe a domestic transplant program can be built without such financial rewards.¹⁰⁰ In a setting like Qatar where the population is sharply divided in both socioeconomic and ethnic terms, as well as by residents' degree of integration in, and identification with, the country and its institutions, it is particularly easy to understand the view that those who are disadvantaged and disenfranchised will only respond to a request for assistance—in the form of a life-saving organ—when it is accompanied by an offer to improve their condition materially. Nevertheless, the forces on the other side have been successful—as they have been in Pakistan and the Philippines—in finding ways of overcoming the barriers to voluntary donation that do not link benefits to an agreement to donate.¹⁰¹

In all these settings, the local medical and human rights advocates opposed to giving material rewards for organ donation have been inspired by professional and intergovernmental statements of principle and have derived strength from the medical leaders and WHO officials who have assisted them in persuading their governments to align national laws and practices with international norms.

families who were contacted by the donation team because of a “brain dead” family member in the HMC intensive care unit) had been granted benefits; seven other families that required financial support did not give permission for organ donation. *Id.* at 301.

100. In 2006, the Mobile Donor Action Team in the Riyadh region of the Kingdom of Saudi Arabia (Qatar's neighbor) adopted an “Incentive-Based Payment System” to overcome a low rate of consent by the families of potential organ donors. This team's success in increasing the rate of donation appears to have had several causes but some observers attribute it to the financial incentives paid to donor families and believe “[o]ther Middle Eastern countries may have a similar outcome.” Mohammed I. Sebayel, *Donor Organ Shortage Crisis: A Case Study Review of an Economic-Incentive System* 52 (June 2010) (unpublished M.P.H. Dissertation, University of of Liverpool), *available at* www.palts.org/Sebayel_MPH_thesis.pdf.

101. The results in Qatar have been dramatic: The establishment of a registry for deceased donation has helped increase the level of deceased donation threefold between 2011 and 2013, and Qataris have started becoming living donors for family members (with seventeen related persons being prepared to donate a kidney in December 2013, a large number given that there are fewer than 300,000 Qatari citizens—equivalent to 59 donors per million population, well above the highest rate of living-kidney donor rate of almost 30 per million population in the two developed nations with the highest rates, Japan and the Netherlands). The increased opportunities for transplants within Qatar have resulted in a ninety-percent reduction in the rate at which patients travel abroad for transplants. Supreme Council of Health, *Putting Ethics Into Practice*, *supra* note 90, at 12–14.

IV BENEFITS, COSTS, AND INTERCONNECTIONS

National patterns of organ donation can be expected to be less diverse in the future, thanks to changes of the sort detailed above, as countries move away from their former roles as buyers or sellers in what has been called “the global traffic in human organs.”¹⁰² But progress toward a world in which all countries where organ transplants are performed¹⁰³ rely on deceased and living-related donors, rather than paying living donors and the families of cadaver donors, has been halting, and the outcome is far from assured. To a large extent, the changes that have occurred have been heavily influenced by the WHO *Guiding Principles* and the *Declaration of Istanbul*, which, in turn, rest on the consistent practice of noncommercial organ donation in the United States, Canada, and Western Europe for more than four decades. The hands-on advocacy of WHO and DICG leaders has conveyed this vision to the responsible authorities in countries that have previously relied on paid organ vendors, and it has reinforced the efforts of local medical leaders to reform national laws and practices.

But if systems that have so long embodied the ideal of voluntary, altruistic solidarity as their basis for organ donation and that have thereby attained the highest rates of donation were to move to a “regulated market” with financial inducements for donation, the progress achieved in countries that have only recently come into line with, or that have been moving in the direction of, the WHO *Guiding Principles* and the *Declaration of Istanbul* would reverse course in short order. The proponents of paying for organs in those countries—whether they be surgeons and brokers who stand to profit from transplant tourists or those who believe it is necessary to offer material expressions of gratitude in order to build a functioning organ-transplant system¹⁰⁴—would seize upon the change of policy in the West and say, “Clearly, no principle is offended by the sale and purchase of organs, for these enlightened countries allow it; and if these countries, which are rich and medically well equipped, find payment necessary to generate an adequate supply of organs, how can we

102. Scheper-Hughes, *The Global Traffic in Human Organs*, *supra* note 20, at 191.

103. For many low-resource countries that struggle to provide basic primary health care to their whole population, it would seem difficult to justify the creation of an organ-donation and transplant program. Where such programs exist in low-resource countries, two rationales are most commonly offered. First, once a country offers dialysis services, it is much more cost-effective to transplant kidneys and move patients off dialysis; second, the development of a transplant program (a process that is often assisted by medical experts and organizations from developed countries) can help improve the quality of surgical care generally and serve to keep qualified surgeons from emigrating to countries with better-equipped health-care facilities. See *The Madrid Resolution on Organ Donation and Transplantation*, *supra* note 86, at S29–S30.

104. See, e.g., Anne Griffin, *Kidneys on Demand*, 334 BRIT. MED. J. 502, 505 (2007) (quoting Dr. Behrooz Broumand, a past president of the Iranian Society of Nephrology, as stating that although paid living unrelated donation may be a “temporary” but “not a long term” solution for developing countries, it allowed Iran to increase facilities and manpower and develop a base on which the technical capacity for cadaveric transplants could be expanded).

succeed in any way other than by following their example?”

Two questions are thus presented. First, are there good reasons to believe that all countries would be better off with some form of a “regulated market” in organs? Second, when policymakers in North America and Western Europe consider whether to adopt such a system, should they take into account the effect that such a change in their laws would have on the remaining countries, many of which are only now overcoming histories of organ vending that even advocates for regulated organ markets admit were rife with abuses?¹⁰⁵

A. A Market in Organs: Practical Challenges

The first question needs to be tackled in two steps: How might organ markets operate, and would they be better than current norms against paying for organs? At the threshold, some proponents of using “inducements” to increase organ donation object to the description of the resulting situation as a “market.” Some inducements (which may either involve providing a benefit or withholding a negative consequence) might not create what would normally be called a market.¹⁰⁶ An action can be induced by the desire to receive public recognition or praise without creating a market governed by particular “praise prices.” Likewise, people who fear that donating one kidney might someday leave them needing a replacement, should their remaining kidney fail, could be induced to donate by the assurance that should the need arise, they would be placed at the head of the queue for a transplant. But when inducements involve cash (paid directly to the donor or to a donor’s chosen beneficiary) or something else of material value (health or life insurance, contributions to fund college tuition or retirement, and the like), the result is a market.

Of course, proponents of organ markets recognize the risks—amply manifested in countries where organ sales have existed for years¹⁰⁷—and insist that what is needed is a “regulated market.”¹⁰⁸ Market regulation comes in

105. See, e.g., James Stacey Taylor & Mary C. Simmerling, *Donor Compensation without Exploitation*, in *WHEN ALTRUISM ISN'T ENOUGH: THE CASE FOR COMPENSATING KIDNEY DONORS* 50, 51 (Sally Satel ed., 2008) (arguing that “a regulated and transparent regime” would provide a remedy for “the corrupt and unregulated system” in which “disadvantaged members [of society] feel unduly pressured by financial necessity to give up parts of their bodies to the advantaged who can afford them”).

106. Some of the strategies that have been used successfully—and some particularly ingenious ones suggested by authors in this issue of *Law and Contemporary Problems* (see, for example, Kimberly D. Krawiec & Michael A. Rees, *Reverse Transplant Tourism*, 77 *LAW & CONTEMP. PROBS.*, no. 3, 2014, at 145)—involve nonfinancial inducements, which are not the object of this article’s critique of markets.

107. See Scheper-Hughes, *The Global Traffic in Human Organs*, *supra* note 20, at 195.

108. Advocates sometimes speak of “markets” and sometimes use the less descriptive term “systems.” See David C. Cronin II and Julio J. Elias, *Operational Organization of a System for Compensated Living Organ Providers*, in *WHEN ALTRUISM ISN'T ENOUGH: THE CASE FOR COMPENSATING KIDNEY DONORS*, *supra* note 105, at 34, 35, 37 (comparing a “regulated, centralized system” with an “unregulated market for kidneys”); Elbert Huang, Nidhi Thakur & David O. Meltzer, *The Cost-Effectiveness of Renal Transplantation*, in *WHEN ALTRUISM ISN'T ENOUGH: THE CASE FOR COMPENSATING KIDNEY DONORS*, *supra* note 105, at 19, 32 (contrasting the value of a kidney on the “black market” and on a “regulated, legal market”); Sally Satel, *Introduction* to *WHEN ALTRUISM*

several forms. The first involves price regulation, namely fixing the type and amount of the incentive provided, which is the approach taken by the working group that ran the meeting on incentives in Manila in November 2010.¹⁰⁹ Fixed prices are attractive to those who favor organ sales for several reasons: First, when prices are fixed, the resulting transactions can appear to be less market-like because prices are not generated by the interplay of supply and demand as they are in a commodity exchange or by call and response as they are at an auction; second, a price can be fixed that is neither so low as to seem exploitative of certain sellers' financial desperation, nor so high as to risk overwhelming rational, self-protective judgment.

How, then, are prices set in regulated markets? One familiar tradition involves regulated utilities, where an administrative body fixes the prices to be charged by the utility so as to provide the utility with a reasonable rate of return on capital. Figuring out how to use this approach for organs would be challenging—what is a “reasonable rate of return” for a kidney? Another tradition, seen in wartime wage and price controls,¹¹⁰ is to regulate prices based upon achieving another goal, such as preventing inflation. But such controls provide, at best, a temporary solution because the forces the regulators try to affect cannot be so easily tamed, and actors in the regulated market simply find other ways to express those forces. Indeed, we owe our system of employer-funded health insurance in large part to World War II wage controls, which employers responded to by using “benefits” (which were not restricted) as a means of luring the workers they needed, because they were prohibited from competing on wages.¹¹¹ Today, in settings where excessive demand for health-care services cannot be released through higher prices because prices and supply are inflexible, consumers (patients) try to get the care they want through side payments to providers. This phenomenon also occurs in Iran, the only country with a regulated market in organs from living donors, where side payments from prospective recipients to potential donors are a standard part of the transaction.¹¹²

The well-recognized problem with using any form of price regulation is that

ISN'T ENOUGH: THE CASE FOR COMPENSATING KIDNEY DONORS, *supra* note 105, at 1, 9 (advocating a “regulated compensation-based system with strong donor protections”).

109. Working Group on Incentives for Living Donation, *supra* note 78, at 309–11 (“[T]here should be a fixed ‘incentive’ to the donor so that all donors in any one country receive equal payment.”).

110. Hugh Rockoff, *Price Controls*, in THE CONCISE ENCYCLOPEDIA OF ECONOMICS (David R. Henderson ed., 2008), <http://www.econlib.org/library/Enc/PriceControls.html> (last visited Nov. 2, 2014).

111. Thomas C. Buchmueller & Alan C. Monheit, *Employer-Sponsored Health Insurance and the Promise of Health Insurance Reform 3* (Nat'l Bureau of Econ. Research, Working Paper No. 14839).

112. Anne Griffin, *supra* note 104, at 502. In addition to a modest fixed payment from the government (\$1200), donors and recipients negotiate private side payments. *Id.* The transplant foundation neither brokers the arrangement (though it facilitates it by providing a private space on-site where the parties can agree on a price if they have not already) nor keeps records of the amount of money exchanged. *Id.* at 504. To keep transplant tourists from taking advantage of the system, the law requires that donor–recipient pairs must be the same nationality, so non-Iranians are not supposed to be able to obtain an organ from Iranian donors. *Id.* at 502.

it leads to market inefficiencies. For example, a price that is set at an arbitrarily high level (for the reasons already mentioned) means that many sellers are paid much more than required to induce them to exchange the item in question; in a regulated organ market, this would result either in not having enough funds to obtain all the organs needed for potential recipients on the waiting list or in spending a larger amount than needed, leaving less for other pressing needs in health care or otherwise. The inefficiency problem is exacerbated here because it is so difficult to know where the price ought to be set. In markets, prices ordinarily result from the intersection of supply and demand. If the government not only set the price for kidneys but were also the sole purchasing agent, so as to preserve the allocation system now used to assign organs from deceased donors, then there would be no demand curve because the different values that individuals would place on receiving a kidney transplant would not be visible.

Yet no single, objective measure is available for use by a central price setter when calculating the value of an organ to the hypothetical average recipient or to any particular recipients who may vary from the average but who are not able to express how much they would pay for an organ because the price is being set centrally rather than by individual choices. If a transplanted organ saves a life, does it have (near) infinite value? If it extends and improves the quality of life, should it have a price that reflects the subjective value of such extension to each recipient? Or should the price be derived from an objective “value of a human life,” such as the number used to evaluate the benefits provided by safety regulations,¹¹³ which reflects the average life expectancy for the group in question and their average projected annual earnings? If so, should that amount be adjusted to reflect the expected length of remaining life for the particular recipient being transplanted with a particular organ, given the substantial variations in predicted survival associated with certain characteristics of the organ and the recipient? For example, should a kidney from a deceased donor be judged less valuable than one from a living donor, given the better survival of the latter? What about downgrading the price that Medicare should be willing to pay for organs that are intended for transplantation into patients whose expected survival is substantially below average, due to their age or the presence of comorbid conditions such as cardiovascular disease or diabetes?¹¹⁴ Either of these adjustments makes sense in terms of the underlying model: The price of the organ should reflect the value that it produces in enhancing and extending a recipient’s life. Yet adjusting what would be paid for an organ because of the recipient’s characteristics would likely seem more problematic than adjusting because of the organ’s characteristics.

113. K. Robin Yabroff, *Estimates and Projections of Value of Life Lost From Cancer Deaths in the United States*, 100 J. NAT’L CANCER INST. 1755, 1755–62 (2008).

114. John Vella, Daniel C. Brennan & Alice M. Sheridan, *Patient Survival after Renal Transplantation*, UPTODATE, <http://www.uptodate.com/contents/patient-survival-after-renal-transplantation> (last updated Nov. 21, 2013).

Any of these means of putting a value on a transplantable organ could yield a huge price; one study, using a modest figure of \$50,000 per quality-adjusted life year (QALY) gained from transplantation estimated that a kidney from a living unrelated donor would remain cost-effective up to a price of \$306,403.¹¹⁵ Such a figure would almost certainly exceed the willingness of public- or private-insurance plans to pay, yet anything less might seem to underpay sellers for their contribution to the “miracle of organ transplantation.”¹¹⁶ Would a substantial price seem more justifiable if viewed from the perspective of not exceeding the cost of the alternative treatment, namely, dialysis? Yet if so, would that price be zero for patients who are transplanted preemptively, that is, before they are so sick that they require dialysis? If not, should the amount saved be based on the cost of dialysis for the average patient?¹¹⁷ If so, should Medicare adjust how much it is willing to pay for a kidney for any particular recipient in light of that patient’s expected survival on dialysis (for example, a lower amount when the potential kidney recipient is expected to die in a few months from another condition, such as cancer)? Further, should the prospective value of a transplant be reduced by deducting from the average cost of dialysis the amount already spent providing dialysis to a particular patient? And how would the “cost savings” method of price setting be employed when setting the price of organs for transplantation to treat conditions in which organ failure is usually followed by rapid decline and death because no effective treatment, such as an artificial organ, is available to sustain patients waiting for a transplant? In other words, would the organs used in transplantation in such cases be deemed to have little if any value?

On the opposite side, the first difficulty with presuming the flat supply curve that results from setting a single, fixed price has already been mentioned—it can produce either too few organs or too much spending. Another difficulty, described below, arises from the need to determine who makes up the group of potential suppliers. Finally, if political pressures were to lead to setting a low price for organs—either to hold down total spending or to avoid the risk that a high amount might seem to be aimed at persuading people to act against their better judgment—and the program failed to clear the organ waiting lists, the pressure to raise the level of payment would be great, though finding the right level could remain an awkward process of trial and error.

The alternative—which true believers in inducements should embrace—would be a genuine market with prices set by the forces of supply and demand

115. Huang, Thakur & Meltzer, *supra* note 108, at 31 (extrapolating from the results reported in Arthur J. Matas & Mark A. Schnitzler, *Payment for Living Donor (Vendor) Kidneys: A Cost-Effectiveness Analysis*, 4 AM. J. TRANSPLANTATION 216 (2003)).

116. See Scheper-Hughes, *Keeping an Eye*, *supra* note 19, at 1647 (“[I]f regulation . . . is to be the norm, how can a government set a fair price on the body parts of its poorest citizens without compromising national pride, democratic values, or ethical principles?”).

117. This figure has been calculated to be \$102,000, taking account only of the savings from transplanting a kidney rather than performing dialysis, without considering the gain in QALYs. Huang, Thakur & Meltzer, *supra* note 108, at 31.

that reflect the point at which individual sellers would part with an organ and individual buyers would part with their money to obtain one. The market would qualify as “regulated” because of other non-price-based rules aimed at protecting donors against abuses, such as requirements regarding postoperative care of organ donors. On the demand side, reliance on a true market would effectively upend the present allocation system, because successful buyers would be those who not only place a higher value on receiving an organ transplant but also have a greater ability to pay (whether from their own wealth or generous medical-insurance coverage). The result would be differentiation not only among the purchasers, with willingness to pay determining one’s place in line, but also among the sellers, with the most desirable organs commanding a higher price. Although some market proponents might not be bothered by this outcome, others have suggested that it should be avoided by keeping organ donors and recipients anonymous to each other and by having the latter pay into the fund that supports the organ-procurement system rather than directly to their donor.¹¹⁸ Yet such a system would produce both market inefficiencies and strategies to get around them, of the sort previously described.¹¹⁹

On the supply side of a true market in organs, one must begin with the question of whether, in this era of trade liberalization, there would be any ground for restricting donation to domestic sellers. The aversion in certain circles to letting people from other countries come to the United States to work really has no relevance to organ sales, because the persons involved would be coming into the country solely as the delivery vehicles for their kidneys (or liver lobes), and would return to their country of origin once their cargo had been unloaded. This was indeed the vision of Dr. Jacobs, whose projected International Kidney Exchange, Ltd. was intended to be a setting where U.S.

118. See, e.g., Working Group on Incentives for Living Donation, *supra* note 78, at 309.

119. The guideline that “the donation should be anonymous and nondirected” is intended by the Working Group on Incentives for Living Donation as a means of avoiding the stratagem often used by buyers when prices are set—to make side payments, as now occurs in the Iranian organ-procurement system. *Id.* It is difficult to believe that prosecutors would prioritize pursuing violators of such a rule (for example, those who arrange a transplant using a kidney from a donor whose “emotional connection” to the recipient—a common ground for allowing directed donation from an unrelated altruistic donor today—actually reflects a side payment, beyond or in place of what the donor would receive through the organ allocation system). Once it is no longer objectionable to pay organ donors, an arrangement in which a willing seller and a willing buyer agree to pay above a set price is the very model of a “victimless crime.” When something is defined as not being a marketable commodity, then it makes sense to prosecute those who violate the prohibition, as occurs if parents are paid for transferring custody of their child. But if baby-selling took place in a “regulated market” (in which parents could reap a financial reward for supplying an adopting couple with a much-wanted child), how tolerable would it be to say that adopting couples must pay a fixed price into a state agency’s fund and then take whichever child the agency chose to assign them, rather than being free to find an available child and arrange payment directly with the child’s parents? Whether from the outset or once faced with the side arrangements that will soon arise, policymakers, like prosecutors, who are willing to allow payments for organs on the grounds advanced today by philosophers and economists that doing so produces a win-win result (money for sellers and more organs for buyers) will soon be faced with the inevitable conclusion from such liberty-based arguments, that, provided force and fraud are prevented, the only defensible course is to allow those who wish to enter into such transactions to do so under the conditions that meet their mutual needs.

patients could exchange their funds for the kidneys of willing donors from Latin America.¹²⁰ But why should such an institution not have a more global reach than that, when it is already apparent that thousands of Pakistanis, Indians, Filipinos, and other impoverished “would be vendors” of the world, when allowed “to decide for themselves about their own best interests,”¹²¹ are willing to exchange a kidney for a relatively modest sum of money?

The argument for allowing payments for organs rests on the principle of utility (that the greatest good consists in saving or, in the case of kidney transplants, extending and improving, human life) and the principle of liberty (that freedom of contract must be protected). Yet these principles provide no grounds for erecting impediments to patients, physicians, or indeed health systems seeking potential organ sellers anywhere in the world. As philosopher Janet Radcliffe Richards argues, “If it is presumptively bad to prevent sales altogether, because lives will be lost and adults deprived of an option some would choose if they could, it is for the same reason presumptively bad *to restrict* the selling of organs.”¹²² Thus, if restrictions are to be placed on markets, principles other than utility and liberty must justify them. Such justification can be found in the three basic principles of medical ethics: justice, beneficence, and autonomy.¹²³

B. Ethical Challenges to a Market in Organs

Here the stories recounted earlier again become relevant. They are relevant not for the reason they were initially recited—to show that the countries whence potential transplant tourists came or whither they went to buy organs are moving, however tentatively, toward enforcing international norms regarding organs sales and transplant tourism. Rather, they are relevant because they demonstrate the costs for buyers as well as sellers generated by organ markets. Part of the cost is the injustice of a system in which the sellers are the poorest in society,¹²⁴ whose attempts to escape debt and poverty by

120. *Hearing on H.R. 4080 Before the Subcomm. on Health & Env't, supra* note 13.

121. Richards, *Commentary, supra* note 24, at 140.

122. *Id.* Additionally, Richards continues her critique of the controlled system of organ sales proposed in Erin & Harris, *supra* note 24, under which each organ market would be kept within a “self governing geopolitical area,” by arguing,

Of course there is something undesirable about a one way international traffic from poor to rich; but that is not enough to settle the all-things-considered question of whether it should be allowed. Much international trade is currently objectionable on the same grounds, but simply stopping it would be worse for the poor countries. It is much better, for them, to improve the conditions of trade than to prevent it altogether. Is the case different with organs?

Richards, *Commentary, supra* note 24, at 140.

123. NAT'L COMM'N FOR THE PROT. OF HUMAN SUBJECTS OF BIOMEDICAL & BEHAVIORAL RESEARCH, U.S. DEP'T OF HEALTH, EDUC. & WELFARE, DHEW PUB. NO. (OS) 78-0012, THE BELMONT REPORT: ETHICAL PRINCIPLES AND GUIDELINES FOR THE PROTECTION OF HUMAN SUBJECTS OF RESEARCH 4-9 (1978) (placing “autonomy” within the principle of “respect for persons”).

124. Reports collected by Combatting Trafficking in Persons for the Purpose of Organ Removal (known as the HOTT Project) from Bangladesh, Colombia, Egypt, India, Moldova, Pakistan, and the

selling a kidney almost universally leave them worse off than they were before. As Dr. Francis Delmonico, President of the Transplantation Society, has remarked, “[T]he experience in Iran and elsewhere is that the poor remain poor following a vendor sale and then with one less kidney.”¹²⁵ Given the difficulties that many organ vendors face with continuing to do manual labor,¹²⁶ especially when experiencing medical complications,¹²⁷ it is not surprising that among the 100 Iranian donors interviewed in one study, virtually none would donate if they had known then what they knew when interviewed (six months to eleven years after donating).¹²⁸ Indeed, 39% said they would prefer to beg and 60% would prefer to get a loan instead of selling a kidney. More than three-quarters of the interviewees thought kidney sales should be banned.¹²⁹

The injustice in taking kidneys from the global poor is certainly made worse when, as is frequently true, they are not paid even the small amount they were promised for their kidney.¹³⁰ But the indisputable decline in the economic

Philippines recount that most unrelated kidney donors come from the ranks of the unemployed, marginalized, and semi- or completely illiterate. HOTT PROJECT, *TRAFFICKING IN HUMAN BEINGS FOR THE PURPOSE OF ORGAN REMOVAL* 35 (2013), available at <http://hottproject.com/userfiles/HOTTProject-TraffickinginHumanBeingsforthePurposeofOrganRemoval-AComprehensiveLiteratureReview-OnlinePublication.pdf>. Even in Iran, one unpublished study of 300 living kidney donors conducted by the Transplantation and Special Disease Centre found that 79% of donors were uninsured, only 30% were employed full time, and just 6% were either at university or had a degree. Griffin, *supra* note 104, at 504. The claim that brokers do not operate in Iran has been disputed. “One of our Organs Watch researchers has reported directly from Iran that kidney sellers there are recruited from the slums by wealthy kidney activists.” Scheper-Hughes, *Keeping an Eye*, *supra* note 19, at 1646.

125. Griffin, *supra* note 104, at 505.

126. See, e.g., DAVID J. ROTHMAN AND SHEILA M. ROTHMAN, *TRUST IS NOT ENOUGH: BRINGING HUMAN RIGHTS TO MEDICINE* 23 (2006) (noting that Filipino kidney sellers from the slums of Manila “had typically worked at loading ships on the docks” but “were no longer physically able to do the heavy lifting required” or “had been summarily fired because their bosses thought they were no longer able”).

127. See Scheper-Hughes, *Keeping an Eye*, *supra* note 19, at 1647 (“On returning to their villages or urban shantytowns, kidney sellers are often unemployed because they are unable to sustain the demands of heavy agricultural or construction work, the only labour available to men of their skills and backgrounds.”)

128. Javaad Zargooshi, *Iranian Kidney Donors: Motivations and Relations with Recipients*, 165 *J. UROLOGY* 386, 387 (2001).

129. *Id.* A more recent study found that 91% of Iranian donors were satisfied with their donation, and 53% suggested donation to others. Malakoutian T et al., *Socioeconomic Status of Iranian Living Unrelated Kidney Donors: A Multicenter Study*, 39 *TRANSPLANTATION PROC.* 824, 825 (2007). Likewise, another study of 600 Iranian donors, found that only 1.5% regretted their decision at the time of discharge. Heidary Rouchi A. et al., *Compensated Living Kidney Donation in Iran: Donor’s Attitude and Short-term Follow-up*, 3 *IRANIAN J. KIDNEY DISEASES*, 34, 36 (2009). As Julian Koplin has pointed out, however, both studies utilize surveys completed before discharge from the hospital whereas Zargooshi’s respondents were interviewed at least six months postoperatively. Julian Koplin, *Assessing the Likely Harms to Kidney Vendors in Regulated Organ Markets*, 14 *AM. J. BIOETHICS*, 7, 12 (2014). The passage of time seems to be associated with growing regret, not only among Iranian organ vendors but also in other countries, such as India and Bangladesh. Lawrence Cohen, *Where It Hurts: Indian Material for an Ethics of Organ Transplantation*, *DAEDALUS*, Fall 1999, at 135, 141; Monir Moniruzzaman, “*Living Cadavers in Bangladesh: Bioviolence in the Human Organ Bazaar*,” 26 *MED. ANTHROPOLOG. Q.* 69, 80–81 (2012).

130. See JAMES S. TAYLOR, *STAKES AND KIDNEYS: WHY MARKETS IN HUMAN BODY PARTS ARE*

security of organ vendors in a wide range of countries following the removal of a kidney underlines that even being paid the full promised amount does little to improve vendors' long-term fiscal, much less physical, well-being.¹³¹ "For vendors, the physical effects of nephrectomy, psychological effects of depression, and social effects of stigma all undermine the ability to find and maintain employment, reversing any short-term financial gains."¹³²

An additional justice issue raised by organ markets is that they implicate the medical system in the gross social inequity that occurs when those most in need of health care or education are encouraged to jeopardize their future well-being. The tradition that once ennobled the medical profession of physicians caring for those who are unable to pay has been eroded in recent years by the increasing application of market principles to health care; it can hardly be improved by making physicians agents in the extension of market principles to the human body and its parts. No ethical physician would remove an eye or a hand to make a beggar an object of greater pity and generosity, but only a fine line separates such acts from the removal of a kidney from a poor organ vendor.

That the latter act is regarded as a mutilation by organ vendors can be seen not only in those vendors' critical views of physicians, but in the vendors' common desires to hide scars and lie about their origins.¹³³ This adversely affects the donors' health given that they are then reluctant to seek follow-up medical care, not only because doing so risks shame and ostracism, but also because it reminds them of the miserable personal situation that led them to sell their kidney in the first place and of the ongoing position of peril in which that act has placed them.¹³⁴

MORALLY IMPERATIVE 88–89 (2005); James Stacey Taylor, *Autonomy, Inducements and Organ Sales*, in PHILOSOPHICAL REFLECTIONS ON MEDICAL ETHICS 135, 151 (Nafsika Athanassoulis ed., 2010); James S. Taylor, *Why the "Black Market" Arguments Against Legalizing Organ Sales Fail*, 12 RES PUBLICA 163, 163–78 (2006).

131. Roger Lee Mendoza, *Colombia's Organ Trade: Evidence from Bogotá and Medellín*, 18 J. PUB. HEALTH 375, 380 (2010); Nancy Scheper-Hughes, *Illegal Organ Trade: Global Justice and the Traffic in Human Organs*, in LIVING DONOR ORGAN TRANSPLANTATION 106, 118 (R.W.G. Gruessner & E. Benedetti eds., 2007) (addressing vendors' postdonative health in Brazil, Moldova, and the Philippines); Sallie Yea, *Trafficking in Part(s): The Commercial Kidney Market in a Manila Slum*, 10 GLOBAL SOC. POL'Y 358, 369–70 (2010); Moniruzzaman, *supra* note 129, at 81 (addressing vendors' postdonative health in Bangladesh).

132. Koplín, *supra* note 129 (manuscript at 13).

133. See, e.g., Scheper-Hughes, *Keeping an Eye*, *supra* note 19, at 1646 (quoting a twenty-seven-year old Moldovan who reported that one individual had said of the surgeon who performed his nephrology in Turkey, "How could that man call himself a doctor? That dog left me an invalid"). Organs Watch found such "disappointment, anger, resentment and hatred for surgeons and even for the recipients of their organs" to be so prevalent that Scheper-Hughes concludes that "kidney selling is a serious social pathology." *Id.*

134. See *id.* at 1647 ("Some were ashamed to appear in a public clinic because they had tried to keep the sale (and their ruined bodies) a secret. Others were fearful of receiving a bad report because they would be unable to pay for the treatments or medications. Above all, the kidney sellers I interviewed avoided getting medical attention for fear of being seen and labeled as weak or disabled by their potential employers, their families, and their co-workers, or (for single men) by potential girl friends.").

As Richards argues,¹³⁵ it would be difficult not to regard a market in organs as a global business, with middlemen free to move organ vendors and recipients anywhere in the world that would maximize utility (the most people transplanted successfully at the least cost). This would represent a novel use of the various “modes of supply” in cross-border trade of medical and other services under the General Agreement on Trade in Services.¹³⁶ Territorial limits could be imposed on this market, as some proponents of a regulated market favor,¹³⁷ by invoking the principle of justice, but that raises the problem that the same principle would call into question the entire enterprise. Does a situation in which vendors from one group within a nation—the most economically and socially marginalized citizens of that nation—provide kidneys for another, largely separate group in that nation—patients who are well-off enough, well-enough cared for, and simply well enough to be candidates for an organ transplant—seem much more just than when the vendors come from impoverished settings on the other side of the world? The global impoverished might usually be invisible to most people in the United States, emerging into consciousness only when a factory in Dhaka, where people earn a pittance making clothes for U.S. companies, catches fire, collapses, and kills the employees therein.¹³⁸ In the context of transplantation, it would only be when members of this group arrived on our doorstep to sell their organs that they would become at all real to us. Yet how different is that from many people’s awareness of the homeless, the mentally ill, or the chronically unemployed from the rural backwaters and inner cities of their own country? Were payments to organ donors permitted, those would be the quarters to which organ brokers would repair, to seek people willing to give up one of their kidneys for a price. Although Westerners often feel they are able to take only small steps to improve the lot of the poor far away in “the global South”¹³⁹ (perhaps by buying products made in factories that have been certified as adhering to better labor and safety standards), if they were to rely an organ-procurement system built on the backs of the poor in their own country they would be exacerbating the same

135. Richards, *Commentary, supra* note 24, at 140 (“[I]f it is presumptively bad to prevent sales altogether, because lives will be lost and adults deprived of an option some would choose if they could, it is for the same reason presumptively bad to *restrict* the selling of organs”).

136. See Nancy J. King & Kishani Kalupahana, *Choosing Between Liberalization and Regulatory Autonomy Under GATS: Implications of U.S.-Gambling for Trade in Cross Border E-Services*, 40 VAND. J. TRANSAT’L L. 1189, 1208–09 (2007).

137. See, e.g., Erin & Harris, *supra* note 24, at 137; Working Group on Incentives for Living Donation, *supra* note 78, at 309 (stating that “there should be a fixed ‘incentive’ to the donor so that all donors (in any one country) receive equal value” and that “the program (donors and recipients) should be limited to citizens and legal residents”).

138. Anbarasan Ethirajan, *Dhaka Bangladesh Clothes Factory Fire Kills More Than 100*, BBC NEWS (Nov. 25, 2012, 10:54 AM), <http://www.bbc.com/news/world-asia-20482273>.

139. *Global South*, AM. UNIV. CTR. FOR GLOBAL SOUTH, <http://www1.american.edu/academic.depts/acainst/cgs/about.html> (last visited Aug. 8, 2014). Commentators have directly linked kidney sales to the exploitation of people from the global south. Vinay Lal, *Foreword* to NANCY SCHEPER-HUGHES, *THE LAST COMMODITY: POST-HUMAN ETHICS, GLOBAL (IN)JUSTICE, AND THE TRAFFIC IN ORGANS* 3, 11–12 (Vinay Lal ed., 2008).

sort of inequities closer to home. Such inequities cannot be dismissed as matters that ought to weigh solely on the consciences of surgeons and organ recipients, because these inequities—which worldwide experience has made clear are the dominant factor in determining who ends up as a paid organ donor—result from the way our society treats its own most needy and vulnerable citizens.

In addition to the challenges that organ sales would pose to the principle of justice, an organ market would also challenge the principle of beneficence. The harm done to—and resented by—organ vendors signals that nonmaleficence, the negative version of beneficence, is at risk of being violated.¹⁴⁰ As noted earlier, a potential violation of surgeons' duty of nonmaleficence is inherent in procuring organs from living donors, but, at least with unpaid related and other altruistic donors, it is counterbalanced by the reasonable view that a surgeon is acting to enable a donor to accomplish an act of great beneficence for the recipient. Moreover, the ties between related donor-recipient pairs increases the likelihood that the recipient will be concerned for the welfare of the donor after the donation, as will the medical team. Such a sense of obligation can, however, be diminished or extinguished when the gift relationship has been replaced by an exchange of money: What thought does the average person give to the welfare of a person from whom he or she has purchased something?¹⁴¹

Organ vending also ill serves the principle of beneficence as applied to recipients. Many of the factors that are relevant to accepting or rejecting a potential organ donor depend on medical and social history, rather than solely on the results of laboratory tests. A donor who is concerned with the welfare of a potential recipient (with whom the donor would have, for example, a biological or emotional connection) has every reason to cooperate fully with the transplant team by providing complete and truthful information. In contrast, a person faced with an opportunity to receive something of value for providing a kidney to a stranger might choose to withhold material information that could lead the transplant program to exclude that person as a donor. This factor may contribute to the higher rate of complications and bad outcomes experienced by patients who go abroad now to receive a transplant of a vended kidney,¹⁴² though physicians' desire to facilitate such transplants probably also contributes to inadequate screening.

The third ethical principle, respect for autonomous decision-making, comes into the discussion regarding organ markets in two ways. The first applies the arguments developed over the past forty years in the legal and philosophical

140. Rather than follow THE BELMONT REPORT, *supra* note 123, in subsuming physicians' traditional duty to "do no harm" within their duty to advance the interests and well-being of patients and research subjects, most bioethicists follow the lead of Professors Tom Beauchamp and James Childress, in regarding nonmaleficence as a duty distinct from beneficence. See generally TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS*, SEVENTH EDITION (2012).

141. See, e.g., U. Gneezy & A. Rustichini, *A Fine is a Price*, 29 J. LEGAL STUD. 1, 13–14 (2000).

142. Jacob A. Akoh, *Key Issues in Transplant Tourism*, 2 WORLD J. TRANSPLANTATION 9, 12 (2012).

realms based on assertions by, and on behalf of, patients who want to have the final say about the medical interventions used in their care, especially care at the end of life. According to the proponents of these arguments, respect for individual autonomy reflects people's sovereignty over their own bodies, based on "their capacity to make choices about how their body is to be treated by others."¹⁴³ This concept is, however, ill-suited to be transferred from the purely self-regarding and self-protecting realm of medical care—where in legal terms it is manifested in the rule that unwanted touching, even by a physician, amounts to a trespass on the person¹⁴⁴—to the context of a transaction in which part of a person's body is traded for cash or something else of value. The claim asserted in the latter case is not one of a sovereign, but of a merchant, and treating the human body as merchandise does nothing to enhance either the dignity or the bodily integrity of the person, concepts that are essential in explaining why it is important to protect medical choices in the first place.

The second way that the opponents of the present regime invoke the autonomy principle directly embraces the notion of organs as property for sale and rests on the precepts of classical liberal economics in which free markets expand people's choices. Here, autonomy is manifested as the liberty to seek whatever ends one wants and can achieve through buying and selling whatever one has. Just as the first version of autonomy regards restrictions on organ sales as paternalistic interference with an individual's sovereignty over his or her body, for the second version, these restrictions stand in the way of the welfare maximization that an unfettered market would produce. Even accepting these characterizations for the sake of argument, there are many circumstances in which choices are constrained because of their effects, either directly on particular others (the familiar harm principle of *sic utero tuo*, use your own property so as not to harm another's) or more generally on society. Other principles—such as those of beneficence, nonmaleficence, and justice, discussed previously—are not subordinate to the principle of autonomy, so the development of an ethical policy for organ donation must weigh their claims as well. As Debra Satz has argued, we cannot ignore the adverse effects markets may have on social equality nor the ways in which the unequal positions of participants in markets both negate the voluntariness of certain choices and produce unjust results.¹⁴⁵ When some market participants act out of extreme vulnerability or "weak agency" (because they either lack important information about the nature of the market or are not direct participants in it), the market not only inherits this characteristic of desperation and inequality, but

143. Gerald Dworkin, *Markets and Morals: The Case for Organ Sales*, in *MORALITY, HARM, AND THE LAW* 155, 156 (Gerald Dworkin ed., 1994).

144. *Schloendorff v. Soc'y N.Y. Hosp.*, 105 N.E. 92, 93 (N.Y. 1914) ("In the case at hand, the wrong complained of is not merely negligence. It is trespass. Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault, for which he is liable in damages.")

145. See generally DEBRA SATZ, *WHY SOME THINGS SHOULD NOT BE FOR SALE: THE LIMITS OF MARKETS* (2010).

exacerbates it.¹⁴⁶

The preceding considerations concern reasons why one might, in the name of other ethical values, place limits or prohibitions on certain transactions in which some people choose to engage. But when it comes to markets in organs, there are good reasons to think that many of the sellers are not acting voluntarily. “When people are choosing between selling their children and their kidneys to meet essential family needs or to temporarily escape crushing debt, coercion and exploitation—not autonomy—are the more apposite terms.”¹⁴⁷ It is easy to argue that there is no such thing as undue inducement. Many people would prefer to live on perpetual holiday but are “induced” to show up at work by the offer of the wages they need to support their lives. One can even suggest that such archetypes as the “offer you can’t refuse” do not negate the notion of voluntary choice. After all, individuals usually expect to part with their money only when they obtain a good or service that they want, but they are willing to hand over their wallets when faced with the choice of “your money or your life” posed by an armed robber. Yet does such a highly determined or constrained “choice” represent a level of voluntariness appropriate for the medical procedure of obtaining a kidney from a living donor?¹⁴⁸ There are good reasons why transplant programs employ very high standards—implemented through painstaking psychosocial evaluation of potential donors’ decision-making capacity and motivation—in cases of unpaid living, related donation. To set those standards aside when dealing with paid donors would afford the latter less respect and concern for their dignity and worth as human beings.

Voluntariness can be undermined not only by individual psychological forces but also by social circumstances because the existence of a market has both endogenous effects (on the item being sold) and exogenous effects (on persons beyond those who have chosen to participate in the market). Just as a market in votes would change the meaning of elections, so too would a market in organs change all kidneys for transplantation into medical commodities, like artificial hips. Moreover, the existence of the market affects all persons whose circumstances make them possible organ vendors.

For example, in the Tamil countryside where the practice of selling kidneys is widespread, the organs are viewed as loan collateral. In such circumstances, a person who does not want to sell her kidney may find it harder to obtain a loan. Many markets generate what economists call pecuniary externalities—effects of production or exchange on outside parties through prices. But although many markets have such effects, the question here is, Should a person face restricted market opportunities for not wanting to sell her kidney?¹⁴⁹

146. See Debra Satz, *The Moral Limits of Markets: The Case of Human Kidneys*, 108 PROC. ARISTOTELIAN SOC’Y 269, 282 (2008).

147. Nikola Biller-Andorno & Alexander Morgan Capron, “*Gratuities*” for Donated Organs: *Ethically Indefensible*, 377 LANCET 1390, 1390 (2011).

148. The same sorts of concerns arguably apply to obtaining permission from grieving relatives to procure the organ of a deceased donor, though the concern there is not protecting a person from undergoing surgery based on less than fully informed or voluntary consent but protecting the family from feeling exploited or taken advantage of, where the harm would be psychic rather than physical.

149. Debra Satz, *Brother, Can You Spare a Kidney: The Real Cost of Selling Body Parts*,

In sum, all of these factors—the potential harms to organ donors and recipients, the concomitant exploitation and exacerbation of inequities within and between nations, the doubtful voluntariness of the decision to sell a kidney, and the negative effects on the social environment when kidneys become commodities with market value, making unpaid donation seem foolish and pressuring the poor to monetize their kidneys—suggest that a belief in the utility-maximizing effects of free markets and an attachment to autonomy as protection against invasions of bodily integrity and paternalistic interference in self-determination do not provide an adequate foundation for an ethically defensible policy on organ donation.

C. Is a Market Likely to Generate Net Benefit?

In resolving the policy implications of the conflict among ethical values, proponents of organ sales argue that the burden of persuasion falls on those who urge prohibitions or restrictions because markets would make more organs available and hence save more lives.¹⁵⁰ The first response to such a claim is that a society that fails to develop and utilize all forms of medical interventions to extend every life does not fail its citizens, whereas one that builds life-saving efforts on practices that are destructive of other important values—of equality, dignity, and liberty—does.¹⁵¹ The second response—which does not depend upon taking a stance on what constitutes a good society—is that good reasons exist to doubt proponents' claims that a market run according to acceptable ethical standards would, in the long run, produce a larger number of organs than can be achieved without financial inducements, much less put an end to the shortage in organs.¹⁵²

Free-market economists are quick to pronounce that the organ transplantation policies based on the noncommercial model followed by most countries over the past three decades “have failed.”¹⁵³ This seems a rather

STANFORD MAG. (Jan.–Feb. 2011), http://alumni.stanford.edu/get/page/magazine/article/?article_id=28079.

150. See JANET RADCLIFFE RICHARDS, *THE ETHICS OF TRANSPLANTS: WHY CARELESS THOUGHT COSTS LIVES* 45–48, 94–100 (2012).

151. See, e.g., Hans Jonas, *Philosophical Reflections on Experimenting with Human Subjects*, 98 *DAEDALUS* 219, 245 (1969) (“A slower progress in the conquest of disease would not threaten society, grievous as it is to those who have to deplore that their particular disease be not yet conquered, but that society would indeed be threatened by the erosion of those moral values whose loss, possibly caused by too ruthless a pursuit of scientific progress, would make its most dazzling triumphs not worth having.”).

152. The notion that the “gap” between supply and demand can ever be closed ignores the elasticity of demand. The large increase in the United States over the past twenty years in the number of people waiting for a kidney transplant reflects not only the growing incidence of kidney disease (as to which preventive efforts would be the preferable response) but also the substantial increase in the number of kidneys available for transplantation, which makes nephrologists more willing to place patients on the waiting list. Were kidneys no longer scarce, physicians would list not only those patients with less severe kidney failure but also those patients whose prospects for a good outcome are lower because of comorbidities.

153. T. RANDOLPH BEARD, DAVID L. KASERMAN & RIGMAR OSTERKAMP, *THE GLOBAL ORGAN SHORTAGE: ECONOMIC CAUSES, HUMAN CONSEQUENCES, POLICY RESPONSES* 1 (2013).

blinker assessment of a system that has extended and improved millions of lives while also providing a dramatic affirmation of human generosity and solidarity. There is no question that more organs are needed, but were all countries to adopt the “best practices” used by the organ-procurement programs with the highest rates of donation, a huge increase in transplantation would be possible without resort to paying for organs. Indeed, during the first decade of this century, a concerted effort by the Department of Health and Human Services led to an increase of more than twenty-five percent in the rate of donation in the United States.¹⁵⁴ Moreover, if only a small fraction of the amount that would need to be spent to purchase organs in a “regulated market” were instead used to improve the present system, further substantial increases in the rate of donation would be possible.

But what of the claim that it is self-evident that paying for organs would increase the net rate of donation?¹⁵⁵ The extensive literature on “crowding out” suggests that many people who are willing to donate in a voluntary, unpaid system would cease doing so once paid donation became an accepted practice.¹⁵⁶ It is not simply that one does not want to be played for a fool (by giving away what others are paid for), but that the nature of the act changes when it is not experienced by the donor, and seen immediately and universally by others, as something that is generous and ennobling. This change would be especially pronounced if, as is likely to be the case, most organ vendors were understood to be acting out of financial desperation.

Although today’s most highly motivated donors—those who are giving a kidney to a close relative—might be expected to be immune to such a change, this has been found not to be the case.

[R]ecently, when the U.S. rules for allocating deceased donor kidneys were changed to give children on the waiting list greater access to deceased adult donors’ kidneys, parental donations fell by a larger amount, so that overall fewer pediatric kidney transplants are being done while some potential adult recipients have been deprived of a kidney that went to a child instead.¹⁵⁷

Likewise, the ready availability of vended kidneys and liver lobes would leave most potential recipients disinclined to ask a relative or friend to donate. Who

154. *Donors Recovered in the U.S. by Donor Type*, U.S. DEP’T HEALTH & HUM. SERVS., <http://optn.transplant.hrsa.gov/latestData/step2.asp?> (choose “Donor” for category; choose “All” for organ; then follow “All Donors by Donor Type” hyperlink) (last updated Aug. 1, 2014).

155. See, e.g., Michael B. Gill & Robert M. Sade, *Paying for Kidneys: The Case Against Prohibition*, 12 KENNEDY INST. ETHICS J. 17 (2002).

156. Gabriel M. Danovitch & Alan B. Leichtman, *Kidney Vending: The “Trojan Horse” of Organ Transplantation*, 1 CLINICAL J. AM. SOC’Y NEPHROLOGY 1133, 1134 (2006) (“The term ‘crowding out’ describes the hypothesis that the moral commitment to do one’s duty can be weakened by financial compensation and monetary reward.”). Richard Titmuss showed that the purchase of blood for transfusions, which was allowed in the United States but forbidden in the United Kingdom, “represe[d] the expression of altruism (and) erode[d] the sense of community” and led to “a generally worsening situation” regarding blood collection in the United States. RICHARD TITMUSS, *THE GIFT RELATIONSHIP: FROM HUMAN BLOOD TO SOCIAL POLICY* 245 (Pantheon Books 1971).

157. Alexander M. Capron, Gabriel M. Danovitch & Francis L. Delmonico, *Organ Markets: Problems beyond Harm to Vendors*, 14 AM. J. BIOETHICS 23, 24 (2014).

would want to ask for such a gift from a loved one when his or her need for an organ can be met without imposing any burden on that person and without enmeshing oneself in all the psychological and moral complexities that arise in “the gift relationship”?¹⁵⁸ Summarizing observational and experimental research over many decades by economists and social psychologists, Sheila and David Rothman conclude that “although the case for the ‘hidden costs of rewards’ is certainly not indisputable, it does suggest that a market in organs might reduce altruistic donation and overall supply.”¹⁵⁹

Experience in countries around the world where recipients have paid for kidneys lend further support to the results of research on crowding out. In the countries where purchases have been the principal source of kidneys for transplantation, kidneys have not been procured at rates near those of countries that rely on unpaid donation, in part because the availability of organs purchased from the poor reduces the pressure to create a system of uncompensated deceased donation or of living-related donation.¹⁶⁰ The clearest evidence of this phenomenon is provided by Israel, which has overcome religious and cultural barriers to deceased organ donation and has rapidly built a successful program that relies on both deceased and living-related donors in place of sending its patients to China, South Africa, Turkey, and the Philippines to purchase organs.¹⁶¹ The Israeli success, as described by Jacob Lavee and Avraham Stoler,¹⁶² has depended on much more than a change in the law: It has relied on a concerted effort by the government and medical leaders to convey to the public that organs for transplantation are a resource that will be available for people in need only if the community makes them available.¹⁶³

158. See, e.g., Cohen, *supra* note 129, at 161 (indicating that when payment for kidneys was still a common practice in India, potential recipients preferred to purchase rather than ask relatives to be donors); Moniruzzaman, *supra* note 129, at 83 (“many Bangladeshi recipients who can afford to do so purchase organs from the poor, rather than seeking organ donation from their family members”).

159. S.M. Rothman & D.J. Rothman, *The Hidden Cost of Organ Sales*, 6 AM J. TRANSPLANTATION 1524, 1525 (2006).

160. A.H. Rizvi, A.S. Naqvi, N.M. Zafar & E. Ahmed, *Regulated Compensation Donation in Pakistan and Iran*, 14 CURRENT OPINION IN ORGAN TRANSPLANTATION 124, 127 (2009) (arguing that paying for kidneys has forestalled development of deceased-donor programs, which are needed for other solid organ transplant programs). The deceased donation that occurs in Iran, which is sometimes cited to show that reliance on paid donors does not depress deceased donation, actually results from the rejection of the national norm by one major center:

Shiraz Organ Transplant Centre is the largest centre [in] Iran performing liver and kidney transplant from deceased donors. They started their programme with kidney transplantation based on live altruistic donors without any monetary consideration in the name of compensation. They maintained their policy for several years and finally their credibility took them to becoming one of the largest centres of deceased liver transplantation in Middle East and today they are performing the highest number of deceased transplants.

E-mail from Dr. Anwar Naqvi, Professor & Coordinator, Centre of Biomedical Ethics & Culture, Sindh Inst. of Urology & Transplantation, to author (July 19, 2013, 5:17 AM) (on file with author).

161. Jacob Lavee et al., *Preliminary Marked Increase in the National Organ Donation Rate in Israel Following Implementation of a New Organ Transplantation Law*, 13 AM. J. TRANSPLANTATION 780, 782 (2013).

162. See Lavee & Stoler, *supra* note 88.

163. *Id.*

Some market proponents have argued that we should experiment with NOTA's prohibition on organ sales, perhaps by allowing individual states to try out various forms of compensation or financial inducement¹⁶⁴—as though the natural experiments with various forms of regulated and unregulated organ markets that have occurred around the world over the past thirty years have not already demonstrated that payments crowd out unpaid donations and prevent development and optimal use of unpaid deceased donation. Social-policy experiments undertaken by the government have indeed produced useful results in a number of fields. These experiments have involved altering government-supported benefit programs for some participants,¹⁶⁵ so the ethical issue they raise is whether some people may be treated differently than others for a period of time. In contrast, to experiment with the ban on organ purchases would require the dubious assumption that one can “experiment” with a policy that rests on moral principles without in effect abandoning those principles. Once established as a market commodity, how would kidneys go back to being something that cannot be bought and sold? As Gneezy and Rustichini found in their famous nursery study, not only did the imposition of a penalty when the parents were late picking up their children change parents' perception of what the teachers provided from “a generous, nonmarket activity” to something that could be bought, but even after the charge was eliminated, parents did not revert to the old norm: “Once a commodity, always a commodity.”¹⁶⁶

V

WORDS WILL MEAN LITTLE IF OUR ACTIONS ARE OTHERWISE

The arguments just presented provide sound reasons not to abandon NOTA's prohibition on exchanging organs for “valuable consideration,” but if more reasons are needed, the adverse effects of such a change on the newly adopted prohibitions in a number of countries constitute additional strong grounds for maintaining the present prohibitions in North America and Europe. A brief review of developments in China—where recent progress in replacing commercial organ procurement with a voluntary system that relies on uncompensated deceased and living-related donors remains precarious and very dependent on the combined efforts of many entities, from WHO to professional and other nongovernmental organizations—illustrates this point.

The omission of China from the earlier catalogue of transplant hotspots that have recently undergone reforms may have seemed puzzling given that both its number of organ “donations” and its number of transplant tourists dwarf activity in every other county.¹⁶⁷ Moreover, the manner in which almost all of

164. Laura Meckler, *Kidney Shortage Inspires a Radical Idea: Organ Sales*, WALL ST. J., Nov. 13, 2007, at A1.

165. Michele Goodwin, *The Veneer of Altruism*, 14 VIRTUAL MENTOR 256, 258 (2012).

166. Gneezy & Rustichini, *supra* note 141, at 14.

167. Mark McDonald, *Beijing Investigates Transplants for Tourists*, N.Y. TIMES, Feb. 18, 2009, at A13.

these organs have been obtained and distributed transgresses international norms even more markedly than the often-criticized methods used in other countries. Finally, the push and pull of the government's attempts to bring its practices into alignment with those norms is perhaps the most contested of any national efforts at reform.

Details about China's organ transplantation are controverted, but for nearly thirty years it has had the most unusual program for obtaining organs of any nation. For a country that is very large and diverse in territory and population and that moved rapidly up the HDI during this period,¹⁶⁸ the rate of organ transplantation in China is not high: The combined living and deceased-donation rate for all organs probably remains under twenty per million population.¹⁶⁹ But in absolute numbers (better than 10,000 transplants per year, with a very high percentage going to foreign recipients¹⁷⁰), the extent of China's program and its impact on the development of transplant programs in other countries is potentially immense.

The basis for the Chinese transplant program has been the *Temporary Rules Concerning the Utilization of Corpses or Organs from the Corpses of Executed Criminals*, secretly issued by the government in 1984.¹⁷¹ Though criticized in the past five years by Chinese officials themselves,¹⁷² the rules are still on the books and account for the huge volume of deceased-donor transplantation in China every year, which generates many millions of dollars in revenue.¹⁷³ Under these rules, organs from executed prisoners may be used for medical purposes if no one claims the body, if the prisoner slated for execution volunteers to have his corpse so used, or if the family consents after the execution.¹⁷⁴ The use of executed prisoners would raise concerns—most centrally, about validity of any consent and about conflicts of interest—even were there no reason to have doubts about the manner in which prisoners are condemned to death. But of

168. *Human Development Index Trends, 1980–2012*, U.N. DATA, <http://data.un.org/DocumentData.aspx?id=327> (last updated Mar. 27, 2013).

169. GLOBAL OBSERVATORY ON DONATION & TRANSPLANTATION, ORGAN DONATION AND TRANSPLANTATION ACTIVITIES 2012, at 6, 7, 10 (2012), available at <http://www.transplant-observatory.org/Documents/Data%20Reports/Basic%20slides%202012.pdf>.

170. Radio broadcast: Falun Gong Prisoners Targeted For Organs, reported by Jennifer Macy, Reporter, The World Today, Australian Broadcast News (Aug. 12, 2008), available at <http://mpegmedia.abc.net.au/news/audio/twt/200808/20080812twt08-chinas-organs.mp3>.

171. Joan E. Hemphill, *China's Practice of Procuring Organs from Executed Prisoners: Human Rights Groups Must Narrowly Tailor Their Criticism and Endorse the Chinese Constitution to End Abuses*, 16 PAC. RIM L. & POL'Y J. 431, 446 (2007).

172. See Jiefu Huang, Yilei Mao & J Michael Millis, *Government Policy and Organ Transplantation in China*, 372 LANCET 1937, 1937 (2008); *China Admits Death Row Organ Use*, BBC NEWS (Aug 26, 2009, 12:32 PM), <http://news.bbc.co.uk/1/hi/8222732.stm> ("In a rare admission of the extent to which this takes place, China Daily—citing unnamed experts—said on Wednesday that more than 65% of organ donations come from death row prisoners.")

173. Christopher H. Smith, *China's Illegal Organ Harvesting*, WASH. TIMES (Sept. 18, 2012), <http://www.washingtontimes.com/news/2012/sep/18/chinas-illegal-organ-harvesting/>.

174. David J. Rothman, *The Body Shop: Harvesting Organs from Executed Prisoners in China*, SCIENCES, Nov. 1997, at 17, 19.

course human-rights advocates have also raised grave doubts about the fairness of the Chinese justice system.

First, it appears that the demise of organ donors may be timed for the convenience of waiting recipients with whom each executed prisoner is well matched, thus implying that executions are being carried out solely to benefit organ recipients.¹⁷⁵ Second, allegations have been made (and denied by the government) that political, ethnic, and religious dissidents, such as ethnic Uighurs in western China and the practitioners of the outlawed Falun Gong discipline, constitute a disproportionate number of the persons targeted for execution.¹⁷⁶ The practice of taking organs from executed prisoners has been repeatedly criticized by groups such as Amnesty International and Human Rights Watch but, even after Deputy Minister of Health Huang Jiefu publicly acknowledged it in 2006 and stated that the time had come for Beijing to adopt a sustainable basis for organ donation in line with international norms, the practice continues, albeit it on a reduced scale.¹⁷⁷ In March 2013, at the start of the major People's Congress to choose new leaders for the People's Republic, Dr. Huang announced that China would completely cease the practice of using executed prisoners within two years.¹⁷⁸ At a meeting in Hangzhou in October 2013, Bin Li, chairperson (equivalent to minister) of the National Health and Family Planning Commission (NHFPC),¹⁷⁹ announced a five-point plan that committed the government and all hospitals to "open and transparent" organ procurement and allocation and other standards to replace the use of executed prisoners with living related donors and patients diagnosed dead on circulatory or neurology grounds.¹⁸⁰ This plan was then formally endorsed as the *Hangzhou*

175. See A.L. Caplan et al., *Time for a Boycott of Chinese Science and Medicine Pertaining to Organ Transplantation*, 378 LANCET 1218, 1218 (2011); A. Sharif, et al., *Organ Procurement From Executed Prisoners in China*, 14 AM. J. TRANSPLANTATION 2246, 2248 (2014).

[I]t also appears implausible that every prisoner deemed healthy enough to donate viable organs is coincidentally scheduled for execution on the exact day a matching recipient is available. This second paradox is of greatest concern, as it raises the question as to whether the organ procurement follows the execution or if the death sentence follows the demand for organs procured from a pool of prescreened prisoners.

Id.

176. See, e.g., DAVID MATAS & DAVID KILGOUR, BLOODY HARVEST: REVISED REPORT INTO ALLEGATIONS OF ORGAN HARVESTING OF FALUN GONG PRACTITIONERS IN CHINA 12 (2007), available at <http://organharvestinvestigation.net/report0701/report20070131-eng.pdf>; Ethan Gutmann, *The Xinjiang Procedure: Beijing's 'New Frontier' is Ground Zero for the Organ Harvesting of Political Prisoners*, WEEKLY STANDARD, Dec. 5, 2011, at 19.

177. See Haibo Wang, *New Era for Organ Donation and Transplantation in China*, 90 BULL. WORLD HEALTH ORG. 802, 802 (2012) [hereinafter Wang, *New Era*].

178. Huang Qin, *Chinese Regime's Organ Transplant Spokesperson Fired: Restructuring Leaves Deputy Minister Huang Jiefu Out of a job, Weeks after Suggesting Reform*, EPOCH TIMES (Mar. 15, 2013), <http://www.theepochtimes.com/n3/3893-chinese-regimes-organ-transplant-spokesperson-fired/>.

179. The NHFPC, one of the twenty-five ministries that make up the State Council, was created at National People's Congress in March 2013, by combining the Ministry of Health and the National Population and Family Planning Commission. *China to Merge Health Ministry, Family Planning Commission*, ENGLISH.NEWS.CN (Mar. 10, 2013), http://news.xinhuanet.com/english/china/2013-03/10/c_132221724.htm (last visited Nov. 8, 2014).

180. Jie-Fu Huang et al., *China Organ Donation and Transplantation Update: The Hangzhou*

Resolution by the Chinese Transplant Congress, which met in that city on November 1–2, 2013, at which time representatives of 38 of the nation’s leading transplant hospitals signed the resolution and pledged to comply with the interim regulations promulgated by the NHFPC in August 2013, in particular to cease using executed prisoners as organ donors.¹⁸¹ However, the government has not acted against transplant centers that continue to rely on organs from executed prisoners,¹⁸² but has instead aimed to end transplants to non-Chinese citizens (although the allowance for overseas Chinese citizens to return to China for a transplant has apparently become a loophole for medical centers that use Chinese names for their foreign patients).¹⁸³

Besides China’s singularity in terms of the scope of its commercial transplant program and the source of the organs, the struggle among various forces over the character of the new organ-transplant system that it is now constructing has enormous implications not only for China but for the whole world. On the one side are organ procurers who have linked the civilian and military prisons with the hospitals where transplants have been performed; their ability to resist change has been aided by the financial power they wield, the regional distribution of influence and power within the bureaucracy, and the difficulties facing the national health ministry in organizing an organ-procurement system to replace the one that has relied on executed prisoners. On the other side are Chinese transplant professionals, supported by the DICG and international organizations such as WHO, who urge the government to adopt reforms that will bring them into line with international ethical norms for transplantation. These outside groups have offered guidance to the government in crafting appropriate legislation to provide for the use of donors who die from loss of neurological or circulatory functions while under medical care and to condition licenses for hospitals’ transplant programs on following the new rules.¹⁸⁴

Foreign transplant professionals have also been involved in programs to train the staff of organ-procurement organizations on how to organize a fair and

Resolution, 13 HEPATOBILIARY PANCREATIC DISEASES INT’L 122, 122 (2014).

181. Editorial Office, *OTC Hangzhou Resolution*, 2 HEPATOBILIARY SURGERY & NUTRITION 317 (2013) [hereinafter Editorial Office, Hangzhou Resolution]; Huang et al., *supra* note 180, at 123–24. “More hospitals are anticipated [to sign the resolution] in the days ahead.” Huang et al., *supra* note 180, at 124. “OTC” stands for the way the body now in charge of organ transplantation, the Organ Transplantation Committee, is named in English. See Jiefu Huang et al., *The National Program for Deceased Organ Donation in China*, 96 TRANSPLANTATION 5, 5 (2013) [hereinafter *The National Program*].

182. Delmonico et al., *Open Letter*, *supra* note 50, at 795 (criticizing government’s failure to end hospitals’ continued reliance on organs from executed prisoners, in violation of NHFPC regulations, as well as corrupt practices that depart from prescribed rules for allocation of organs).

183. McDonald, *supra* note 167; Press Release, Doctors Against Forced Organ Harvesting, China’s Announcement of Phasing Out the Harvesting of Organs From Prisoners is Deceptive and Insufficient (Sept. 16, 2013), available at <http://www.dafoh.org/dafoh-statement-chinas-announcement-of-phasing-out-the-harvesting-of-organs-from-prisoners-is-deceptive-and-insufficient/>.

184. Sam D. Shemie et al., *International Guideline Development for the Determination of Death*, 40 INTENSIVE CARE MED. 788, 789 (2014).

transparent system and to work with physicians and potential donors (individuals and the families of the deceased) in implementing the regulations.¹⁸⁵ The DICG has also sought to bring negative as well as positive reinforcement to incentivize Chinese transplant professionals to adhere to international standards by encouraging academic medical journals to place “barriers to the publication of data that involve executed prisoners,” by advocating for professional societies to prevent “the presentation at their meetings of clinical research involving executed prisoners,” and by urging pharmaceutical companies to limit “clinical trials in China for the same reason.”¹⁸⁶

Even the Chinese who employ international norms to push for change within their own system do not want their country to be seen as bowing to outside pressure. They point out that Western countries built their transplant programs slowly and that a total transformation cannot reasonably be expected to occur in a large nation that is simultaneously undergoing huge technical, economic, and demographic changes, and they are reluctant to totally renounce “the executed prisoner’s right to donate organs.”¹⁸⁷ Such a concept may seem so ludicrous as to be offensive, but how much freer is the choice exercised by bonded laborers in Pakistan or slum dwellers in Delhi or Manila when they accept a small sum to become kidney donors?

Dr. Huang Jiefu, who retired from the health ministry following the changes in Communist Party leadership in the spring of 2013, was subsequently named by the new minister, Bin Li, to head the newly created committee charged to carry out the joint efforts of the NHFPC and the Red Cross Society of China (RCSC) to promote organ donation and manage the allocation of organs from deceased donors.¹⁸⁸ The NHFPC has made clear its intention to have a fair and transparent system for organ procurement and allocation, recognizing the necessity of increasing deceased donation given the promised cessation of using executed prisoners’ organs.¹⁸⁹ In 2010, an experiment began in ten localities to promote deceased donation; in five, the RCSC offered the families of potential donors financial incentives, consisting of two parts. In Zhejiang Province, for example, the deceased’s funeral expenses were paid and each consenting family was provided \$1600 for the purchase of a grave plot and \$3200 in cash as an expression of gratitude; further, the Red Cross gave families facing financial

185. Editorial Office, Hangzhou Resolution, *supra* note 181; Huang et al., *supra* note 180, at 122–23.

186. Danovitch et al., *Global Standards*, *supra* note 35, at 1309; *see also* Caplan et al., *supra* note 175, at 1218.

187. *See, e.g.*, Wang, *New Era*, *supra* note 177, at 802.

188. The new committee is known as the Organ Transplant Committee (OTC). *See The National Program*, *supra* note 181, at 5.

189. Editorial Office, Hangzhou Resolution, *supra* note 181. The NHFPC regulations provide for the mandatory use of a computer system for the allocation of organs to patients on the waiting list (the China Organ Transplant Response System), the defined responsibility and geographical service area for the organ-procurement organization, and the defined qualifications, responsibility and accreditation of the organ donation coordinator.

hardship extra compensation up to \$4800.¹⁹⁰ Such payments have been strongly criticized,¹⁹¹ but have not been finally rejected by Dr. Huang and his colleagues. They face a substantial dilemma because unlike countries where a relatively low initial rate of deceased donation occurred at a time when the national capacity to organize transplant surgeries was just beginning to be developed, China already has a large transplantation infrastructure that has been supported by the ready availability of organs from executed prisoners, so the prospect of slowly building up deceased donation seems unacceptable to many important actors in the field of transplantation.¹⁹² Although the RCSC experiment indicates that, at least in the short-run, giving cash incentives to donor families can increase number of organs available for transplantation, the experiment also shows that no current Chinese deceased-donation program can produce the volume of transplantable organs that would be necessary to fill the gap that would arise were executed prisoners to truly cease being a source of organs.

Equally important, the RCSC experiment made clear that—as is true whenever organs are exchanged for money—consent to donation comes disproportionately from the poorest segments of society. Of the 207 deceased donors obtained in the pilot program between March 2010 and March 2012,¹⁹³ 90% of the donor families faced financial difficulties that entitled them to total payments of up to \$8000 (in a country where 10% of the population lives in poverty, defined as an urban household that has annual living expenses below \$368 per capita). “This indicates that some of these families consented to donation because they were in need of financial assistance,” on account of general family poverty, the loss of the family’s principal source of income, or high medical expenses.¹⁹⁴

The risk for China of adopting a policy of paying families that give permission for organs to be removed from their deceased relative is particularly grave because the notion of deceased donation is still unfamiliar to many Chinese. Confusion and anxiety about determining death on neurological grounds typically occurs among the public, and indeed among nurses and physicians as well, in the early years of organ procurement from deceased

190. Xiaoliang Wu & Qiang Fang, *Financial Compensation for Deceased Organ Donation in China*, 39 J. MED. ETHICS 378, 378–79 (2013).

191. See, e.g., Francis L. Delmonico, *A Welcomed New Policy in China*, 96 TRANSPLANTATION 3, 3 (2013) [hereinafter Delmonico, *A Welcomed New Policy in China*] (payment undermines trust by creating doubts among donor families about the reliability of death determinations and concerns by the general public that the system will not fairly distribute organs and is corrupt; those who have paid for the organs will of course sell them).

192. As diplomatically phrased by Dr. Huang and his coauthors, it is generally recognized “that the development of a mature and ethical organ donation and transplantation system will be an arduous journey with numerous difficulties and challenges.” Huang et al., *supra* note 180, at 124.

193. The enthusiasm for financially incentivizing donations has thus far produced such modest results that the authors, in a model of understatement, describe the rate of donation in China as “significantly lower than in Spain and other Western countries.” Wu & Fang, *supra* note 190, at 378.

194. *Id.* The authors note that “as the economy develops, the existing policy will become less effective at incentivizing donation.” *Id.*

donors.¹⁹⁵ In China, a request to donate organs creates additional discomfort because of the cultural norm that dead persons should go whole into the afterlife.¹⁹⁶ Some of the payment to donor families has been framed as an expression of “thanks,” but at least half is justified as a means of relieving a burden (for example, hospital and funeral bills) from the shoulders of especially poor families.¹⁹⁷ But it is hard to see the payments as an expression of fairness or true generosity given that many families face crushing expenses and loss of their main earner but only those that agree to donate organs are given funds. The families that feel economically compelled to accept funds in exchange for their consent are seen to have done something crass, which adds to their stress.¹⁹⁸ The result is that the system of commercialized organ procurement where organs have a price continues to operate in China, the only difference being that while payments formerly went to prison officials and middlemen, they now go to the families of deceased donors and perhaps to the agents who pay them and then have organs to allocate to hospitals for a price.¹⁹⁹ Any short-term increase in the rate of deceased donation creates a tremendous risk for the long-term success of Chinese organ donation, which is now being framed as an activity that people engage in only if they are in such dire financial need that they will abandon their cultural traditions for a cash payment.

Because the Chinese transplant program is so large and the concept of voluntary, unpaid donation of organs—especially by family members of recently deceased patients—is still so unfamiliar, the choices being made by government officials, the RCSC, and leaders of transplant programs in China illustrate particularly dramatically the difficulties that come with any market in organs. The adoption of such a market represents a value choice about human relations, either viewing organ donations as acts of community solidarity and personal goodness or treating organs as market commodities and regarding all things as property suited to market transactions.

Any notion that paying families carries no harm is mistaken for at least

195. Laura A. Siminoff et al., *Death and Organ Procurement: Public Beliefs and Attitudes*, 59 SOC. SCI. & MED. 2325, 2330–32 (2004).

196. *Culturally Appropriate Geriatric Care: Delivery of Care*, STANFORD SCH. MED., http://geriatrics.stanford.edu/ethnomed/chinese/delivery/advance_directives.html (last visited Aug. 9, 2014).

197. Wu & Fang, *supra* note 190, at 378–79.

198. *Id.* at 379 (stating that families in needy circumstances “have suffered great stress, as they were thought to have sold organs of their deceased loved ones”).

199. Delmonico, *A Welcomed New Policy in China*, *supra* note 191, at 3; Yaqiu Wang, *Amid Scandals, Can China's New Organ Transplant System Work?*, TEA LEAF NATION (Sept. 19, 2013), <http://www.tealeafnation.com/2013/09/with-scandals-already-aplenty-can-the-new-organ-donation-system-work-in-china/> [hereinafter Wang, *Amid Scandals*] (reporting that a poll of more than 1000 Guangzhou residents found that 79% regard deceased donation as “noble” but 81% worry that it will lead to organ trade); *Chinese Red Cross Accused of Demanding Donations for Organs*, WANT CHINA TIMES (Oct. 7, 2013, 4:09 PM), <http://www.wantchinatimes.com/news-subclass-cnt.aspx?id=20130710000122&cid=1103> (municipal branches of RCSC, which control two-thirds of all donated organs, have been accused of “asking hospitals to make donations if they want the use of these organs”).

three reasons. First, offering money tells people that organ donation is all about financial gain, and that money ought to be the determinative factor in their thinking—not honoring the deceased, saving lives, or supporting the community.²⁰⁰ The result is to impoverish the relationship of these family donors with the community and potentially to harm them psychologically.²⁰¹ Second, payment generates distrust in the system: If the family is being offered a financial reward for providing an organ, might the physician caring for the potential donor also be swayed by a comparable reward to compromise his professional standards?²⁰² And third, a system that provides financial rewards to families that permit the removal of organs from their deceased relatives will have to pay living donors as well, because it would seem inherently unfair to reward families, who face no physical risk in agreeing to allow organ procurement, but not to provide a financial reward to living donors, who experience physical burdens and a small risk of substantial harm.²⁰³

The situation in China epitomizes the peril—in practical and ethical terms—faced by many countries transitioning toward an organ-transplant system aligned with the WHO *Guiding Principles* and the *Declaration of Istanbul* but pulled by powerful actors within their society—and even by one view of their national interest—toward what many believe is the expedient solution to the shortage of organ donors, namely providing financial rewards to donors. At the same time, the Western countries that have built programs for uncompensated donation which have successfully treated millions of patients with end-stage organ failure over the past six decades also face an important choice: Should they institute practical improvements in their programs to increase the rate of donation or yield to the siren song of those who argue that when everything is for sale everyone is better off?

The abandonment of the principle that the human body as such is not an

200. In 1994, while vacationing with their two children in Calabria, Reg and Maggie Green were the victims of a shooting that left their seven-year-old son Nicholas “brain dead.” The generous nature of their decision to donate his organs and corneas for transplantation received major coverage in the Italian media and led to a quadrupling of donation rates in Italy. See NICHOLAS GREEN FOUND., <http://www.nicholasgreen.org> (last visited Aug. 24, 2013).

201. In a setting that offers genuine choice, few people would opt to sell rather than donate an organ. See A. Rid et al., *Would You Sell a Kidney in a Regulated Market? Results of an Exploratory Study*, 35 J. MED. ETHICS 558, 560–61 (2009). Studies of public attitudes reveal an overall preference across different national and methodological settings for noncommercial forms of organ donation. See, e.g., Klaus Hoeyer, Silke Schicktanz & Ida Deleuran, *Public Attitudes to Financial Incentive Models for Organs: A Literature Review Suggests That it is Time to Shift the Focus from ‘Financial Incentives’ to ‘Reciprocity’*, 26 TRANSPLANT INT’L 350, 355 (2013).

202. Wang, *Amid Scandals*, *supra* note 199 (noting that the distrust of potential organ donors regarding the trustworthiness of the Red Cross Society of China discourages people from signing onto the registry).

203. Several recent reports suggest that the long-term risks to donors (especially those in whom kidney problems that would disqualify them as a donor have not yet emerged because they are still young) are higher than were previously believed. See A.D. Muzzale, *Risk of End-Stage Renal Disease Following Live Kidney Donation*, 311 J. AM. MED. ASSN. 579 (2014); G. Mjølven et al., *Long-term Risks for Kidney Donors*, 86 KIDNEY INT. 126–67 (2014); R.W. Steiner et al., *Estimating Risks of De Novo Kidney Diseases After Living Kidney Donation*, 14 AM. J. TRANSPLANT. 538 (2014).

item of commerce would create a truly global market in organs that “is likely to always flow in the one direction, further widening the gap between the rich and the poor, the powerful and the powerless.”²⁰⁴ It would also provide the basis needed by the brokers and surgeons working in developing countries who profit from transplanting organs from poor “donors” to recipients from wealthy nations to urge their governments to replace their nascent systems of community-supportive, unpaid donations with some version of their old market system, perhaps cosmetically enhanced to make it palatable to international ethical and human-rights critics. This consequence is predictable and should not be ignored when policymakers weigh the reasons for and against abandoning sixty years of unpaid organ donation in the United States and other Western nations.

204. *Legal and Illegal Organ Donation*, 369 LANCET 1901, 1901 (2007).