

REGULATING THE ORGAN MARKET: NORMATIVE FOUNDATIONS FOR MARKET REGULATION

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I

INTRODUCTION

In this article, the first of two I have contributed to this issue of *Law and Contemporary Problems*, I do two quite different things. First, in part II, I attempt to map normative arguments against the sale of organs onto regulatory proposals for “organ markets.”¹ Those who oppose organ sale may do so for a number of different normative reasons, independently or in conjunction, and my goal is to show whether someone who opposes the sale of organs for *X* normative reasons can nonetheless support some forms of a regulated organ market. My goal might also be put in more positive terms: to show those who are unsure about whether organ markets are a good idea what forms of

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1. By “market,” here and throughout, I mean the term in its broadest sense—that is, I envision a market at work any time an organ is provided due to the inducement of monetary or nonmonetary compensation, in whole or in part. Thus, whether one is providing one’s organ for cash, burial benefits, priority in an allocation for other organs, or so one’s relative can get an organ as part of a chain, in my nomenclature an organ market is operating. What kinds of organ exchanges are *not* markets then? Those in which the only motivation for providing the organ to another is altruism. “Altruism” is itself a somewhat problematic term, and whether, as a conceptual matter, it makes sense to draw such a sharp line between the utility from the warm glow of charitable motivation and the utility from the less warm glow of gold remains to me an open question. See, e.g., I. Glenn Cohen, Note, *The Price of Everything, the Value of Nothing: Reframing the Commodification Debate*, 117 HARV. L. REV. 689, 701 (2003) [hereinafter Cohen, *The Price of Everything*] (“One might object to this point by claiming that a gift is not a ‘something for nothing’ exchange, but rather an exchange in which the giver receives something of value in return.”); Richard A. Epstein, *Are Values Incommensurable, or Is Utility the Ruler of the World?*, 1995 UTAH L. REV. 683, 689, 695 (“We may not be able to determine or quantify the determinants that encourage the gift, but the mere fact that it is made means that there is compensation, direct or indirect, not only to the person who received it, but also to the person who made it . . . [i]t is only because the utility of the donor is increased by the enhanced wealth of the donee that the transaction makes sense from the point of view of the participants.”). Some might prefer to use the locution “exchange” instead of “markets” to describe some of what is left over in a regulated market, and for those for whom this terminological change makes a difference I invite them to read in “exchange” for “market” throughout.

regulation would make organ markets worthwhile to pursue. In part III, I add to the literature on regulated organ markets by engaging a particular type of argument related to just distributions that has been offered as a reason to be concerned about organ markets. More specifically, I press on the assumption that the distribution of organs in systems where compensation is prohibited is itself a just baseline against which to measure the distribution that results when compensation is permitted.

II

MAPPING NORMATIVE ARGUMENTS ONTO REGULATORY PROPOSALS

There is a developed literature (full disclosure, I have written in it myself) providing various arguments against organ markets and/or refuting those arguments.² There is also a developing literature on potential regulations or redesigns of the organ market that would be desirable.³ There has been less dialogue between these two literatures than one might expect, in part, I suspect, because (1) those who seek to offer arguments to ban the organ markets altogether have been less interested in helping to shore up their opponents' positions or provide mechanisms by which their concerns may be blunted, and (2) because many who are interested (or have sophisticated training) in deep normative questions of freedom, rights, and justice find themselves less interested (or have less sophisticated training) in regulatory-design questions, and vice versa.

To further that dialogue, in this part I will map normative arguments against organ markets onto proposals for regulated organ markets to examine which normative theories would lead one to oppose which forms of regulation. In so doing, I am very self-consciously suspending evaluation of both the normative arguments and the regulatory proposals presented.⁴ The goal is to generate

2. See, e.g., CÉCILE FABRE, *WHOSE BODY IS IT ANYWAY?: JUSTICE AND THE INTEGRITY OF THE PERSON* (2006); MICHELE GOODWIN, *BLACK MARKETS: THE SUPPLY AND DEMAND OF BODY PARTS* (2006); DEBRA SATZ, *WHY SOME THINGS SHOULD NOT BE FOR SALE: THE MORAL LIMITS OF MARKETS* 189–207 (2010); I. Glenn Cohen, *Transplant Tourism: The Ethics and Regulation of International Markets for Organs*, 41 J.L. MED. & ETHICS 269 (2013) [hereinafter Cohen, *Transplant Tourism*]; Gabriel M. Danovitch & Alan B. Leichtman, *Kidney Vending: The “Trojan Horse” of Organ Transplantation*, 1 CLINICAL J. AM. SOC'Y NEPHROLOGY 1133, 1133–34 (2006); Leon R. Kass, *Organs for Sale? Propriety, Property, and the Price of Progress*, PUB. INT., Spring 1992, at 65, 77; Julia D. Mahoney, *Altruism, Markets, and Organ Procurement*, 72 LAW & CONTEMP. PROBS. 17, 24–26 (Summer 2009); Nancy Scheper-Hughes, *Rotten Trade: Millennial Capitalism, Human Values and Global Justice in Organ Trafficking*, 2 J. HUM. RTS. 197 (2003).

3. E.g., F. Ambagtsheer & W. Weimar, *A Criminological Perspective: Why Prohibition of Organ Trade Is Not Effective and How the Declaration of Istanbul Can Move Forward*, 12 AM. J. TRANSPLANTATION 571, 574 (2012); Cody Corley, *Money as a Motivator: The Cure to Our Nation's Organ Shortage*, 11 HOUS. J. HEALTH L. & POL'Y 93, 114–119 (2011); Sara Naomi Rodriguez, *No Means No, But Silence Means Yes? The Policy and Constitutionality of the Recent State Proposals for Opt-Out Organ Donation Laws*, 7 FIU L. REV. 149, 177–99 (2011); Lara Rosen et al., *Addressing the Shortage of Kidneys for Transplantation: Purchase and Allocation Through Chain Auctions*, 36 J. HEALTH POL. POL'Y & L. 717, 718 (2011); Eugene Volokh, *Medical Self-Defense, Prohibited Experimental Therapies, and Payment for Organs*, 120 HARV. L. REV. 1813, 1837–40 (2007).

4. If you want to know what I think about each, see my work in Cohen, *The Price of Everything*,

hypothetical imperatives of the form “if you believe *X*, then regulatory proposal *Y* is something you should oppose” or “. . . support.” I will initially present the normative reasons one by one largely for expositional ease, but of course many individuals may subscribe to multiple normative concerns about the sale of organs, in which case we would need to trace the effect of each of those multiple concerns onto which forms of regulation to support or oppose. The table presented at the end of this part, which shows the mapping in a visual form, may make it easier to do this tracing.

Before beginning this analysis, though, it is worth noting a way in which this framing exhibits a certain amount of status quo bias. My analysis takes the current nonmarket system as given and asks what normative concerns have been expressed at moving to a market system. Because the focus of this issue is potential law reform, I think that starting point makes sense. However, it is also worthwhile to imagine the question through the looking glass as well. Imagine we were in a market system and there was a proposal to move to a nonmarket system. One could undertake a parallel analysis to the one I offer below on whether to adopt the *nonmarket* system. That analysis would involve considering both new normative concerns, such as whether we would “lose” organs from the system—a reverse of the usual crowding-out argument I discuss below—as well as some concerns that are common to both analyses but might look quite different from the other side.⁵

A. Normative Concerns

1. Corruption

The basic idea behind what I have elsewhere called the “corruption” argument is that allowing a practice to go forward will do violence to or denigrate our views of how goods are properly valued.⁶ This argument is sometimes labeled the “commodification” argument, but because that term is also used in a way that encompasses some of the other arguments I discuss below, I prefer the more specific label of “corruption.” The American Medical Association, among others, has voiced this kind of objection in the domestic

supra note 1; Cohen, *Transplant Tourism*, *supra* note 2; and my chapter on transplant tourism in I. GLENN COHEN, *PATIENTS WITH PASSPORTS: MEDICAL TOURISM, ETHICS, AND LAW* (forthcoming 2014) (on file with the author).

5. For example, one might be concerned that coercion is *more* serious a concern in a nonmarket system, where the ties of family and friendship can place significant pressure on the decisions of potential donors. Moreover, if the argument I make in part III is accepted, one might think that there are distribution concerns with moving to a nonmarket system and not merely in moving in the other direction.

6. See, e.g., MICHAEL SANDEL, *WHAT MONEY CAN'T BUY: THE MORAL LIMITS OF MARKETS* 111 (2012); Cohen, *The Price of Everything*, *supra* note 1, at 691–92; cf. Margaret Jane Radin, *What, if Anything, Is Wrong with Baby Selling?*, Address at McGeorge School of Law (March 4, 1994), in 26 PAC. L.J. 135, 143–45 (1995) (discussing similar arguments in the context of reproduction). In her article in this issue, Sally Satel takes aim at these kinds of corruption arguments. Sally Satel et al., *State Organ Donation Incentives Under the National Organ Transplant Act*, 77 LAW & CONTEMP. PROBS., no. 3, 2014 at 217.

organ-sale context, suggesting paying kidney donors would “dehumanize society by viewing human beings and their parts as mere commodities.”⁷

We can distinguish two subcategories of this objection, which I have elsewhere called “consequentialist corruption” and “intrinsic corruption.” “Consequentialist corruption” justifies intervention to prevent changes to our attitudes or sensibilities that will occur if the practice is allowed⁸—for example, that we will “regard each other as objects with prices rather than as persons.”⁹ This concern is contingent and to be successful must rely on empirical evidence, in that it depends on whether attitudes *actually* change. By contrast, “intrinsic corruption” is an objection that focuses on the “inherent incompatibility between an object and a mode of valuation.”¹⁰ The wrongfulness of the action is completed at the moment of purchase irrespective of what follows; the intrinsic version of the objection obtains even if the act remains secret or has zero effect on anyone’s attitudes.¹¹

2. Crowding Out

This claim has its roots in behavioral economic work on motivational crowding out, suggesting that, contrary to the classical economic model, allowing payment for goods may change its social meaning in a way that discourages altruistic giving.¹² The crowding-out objection posits that permitting the sale of organs will decrease the supply of organs in some way. There are actually four somewhat distinct variants of the argument. One focuses on crowding out of donated organs and claims that the number of organs donated *altruistically* will decrease if compensation for organs is permitted. A stronger claim is that sale will lead to “crowding out of overall organs,” such that the *total* number of organs, whether procured through altruistic donation or compensated donation, will go down—that is, the decrease in altruistic donations due to permitting a market will not be outweighed by an increase in purchased organs. Third, and perhaps closer to the central thrust of Richard Titmuss’s oft-cited work on blood supply is the crowding out of quality organs, when even if supply remains constant or increases, the new organs that become available will be of inferior quality, that is, diseased or unusable, as compared to those that are available in a market where compensation is prohibited.¹³ This

7. Council on Ethical and Judicial Affairs of the Am. Med. Ass’n, *Financial Incentives for Organ Procurement: Ethical Aspects of Future Contracts for Cadaveric Donors*, 155 ARCHIVES INTERNAL MED. 581, 581 (1995).

8. Scott Altman, *(Com)modifying Experience*, 65 S. CAL. L. REV. 293, 294–97 (1991); Cohen, *The Price of Everything*, *supra* note 1, at 692 n.13.

9. Altman, *supra* note 8, at 296.

10. Cohen, *The Price of Everything*, *supra* note 1, at 692 n.13.

11. *Id.*; see ELIZABETH ANDERSON, VALUE IN ETHICS AND ECONOMICS 144, 172 (1993) (offering what I think of as this kind of corruption argument).

12. *E.g.*, BRUNO S. FREY, NOT JUST FOR THE MONEY: AN ECONOMIC THEORY OF PERSONAL MOTIVATION (1997).

13. See RICHARD M. TITMUSS, THE GIFT RELATIONSHIP: FROM HUMAN BLOOD TO SOCIAL POLICY (1970).

objection might also hinge on the claim that methods of detecting poorer quality organs are unavailable, or if available are infeasible for financial or other reasons.¹⁴ Such an argument might also point to the crowding out of one source of organs for another less good source, for example, crowding out living organ donation in favor of deceased organ donations.¹⁵ A final variant of the argument is less concerned about the effects on supply as such, but more about a kind of coarsening of sensibilities or “crowding out of opportunities for altruism or altruistic feelings” more generally. Of course, this depends on a prior view that we care about motivation independent of its effects on supply, and also that that “altruistic” motivation is one we want to valorize. A skeptic might think that “altruistic” organ donation is itself problematic, either because unpaid organ providers, unlike their paid counterparts, are unable to self-insure against future health problems, or because unpaid providers face more pressure from friends and family to donate, making their choice less autonomous. In any event, I think this version of the crowding-out concern is better thought of as a subset of the consequentialist-corruption argument mentioned above, so, in what follows, I will not treat it as a separate normative concern.

3. Coercion, Exploitation, Undue Inducement, and Justified Paternalism

This is a family of arguments concerned with the harming or the wronging of the organ seller. Although there is some loose family resemblance between these four types of concerns, they are, as I have argued elsewhere, often improperly run together and are quite distinct.¹⁶

“Coercion” is the claim that poor sellers are improperly forced into selling their organs by brokers or recipients who have no right to propose this, because the sellers have no reasonable economic alternative.¹⁷ The easiest example of coercion in a potential organ market would be when someone is literally forced, by threat of violence to themselves or a loved one, to donate. But many who

14. As Goodwin makes clear, Titmuss’s claim about the blood supply was premised on a lack of technology to appropriately determine whether blood provided by individuals was diseased or not, but we now have the requisite technology for blood and certainly for organs. GOODWIN, *supra* note 2. Further, Titmuss seemed to assume that it was commercially supplied blood but not altruistically donated blood that provided the contamination risk; in fact, as Goodwin suggests, a good deal of the blood contamination of the 1980s was due to altruistic donation by gay men in an era before the HIV virus was widely known to be transmitted through blood transfusion. *Id.* Satel makes a similar point and also discusses empirical evidence on whether crowding out is likely in her article in this symposium. Satel, *supra* note 6. Michael Volk discusses the effect of low-quality organs on ameliorating the organ shortage in his article in this issue. Michael L. Volk, *Organ Quality as a Complicating Factor in Proposed Systems of Inducements for Organ Donation*, 77 LAW & CONTEMP. PROBS., no. 3, 2014 at 337.

15. Cf. Lainie Friedman Ross, *Potential Inefficiency of a Proposed Efficiency Model for Kidney Allocation*, 51 AM. J. KIDNEY DISEASES 545, 546 (2008) (providing data that the allocation systems favoring younger kidney recipients on the waiting list had the effect of decreasing the number of living organ donors to those children). Randy Beard and Jim Letizel discuss similar data regarding this possibility in their article for this issue. T. Randolph Beard & Jim Letizel, *Designing a Compensated Kidney Donation System*, 77 LAW & CONTEMP. PROBS., no. 3, 2014 at 253.

16. Cohen, *Transplant Tourism*, *supra* note 2, at 273–79.

17. See *id.*

are concerned with coercion have in mind something much more subtle. In what is probably the leading bioethical account of the idea, Alan Wertheimer suggests that (to use a stylized framing) we imagine *A* proposing to *B*,¹⁸

1. If you do *X*, I will bring about or allow to happen *S*.
2. If you do not do *X*, I will bring about or allow to happen another state of affairs, *T*.¹⁹

Has *A* then coerced *B*? Wertheimer provides a two-pronged test for whether a proposal constitutes a coercive threat. The first part, which Wertheimer names the “choice prong,” determines whether “*A*’s proposal creates a choice situation for *B* such that *B* has no reasonable alternative but to do *X*.”²⁰ Importantly, this prong does not ask whether *B* has *some* alternative to doing *X*, but rather whether the alternatives available to *B* are *acceptable* ones.²¹ Indeed, even in the mugger’s demand “your money or your life” the victim has *some* choice, he can choose to surrender the money. Instead, the problem is that surrendering one’s life is not an acceptable alternative to turning over one’s money; it is too costly an alternative to complying with *A*’s demand.²² Rather than calling for an empirical determination that *B* has “no choice” but to do what *A* proposes, the choice prong requires a judgment as to whether the costs to *B* of not doing what *A* proposes are too high.²³ What qualifies as an acceptable choice is an inherently normative determination. In the case of organ markets, it might be argued that the very poor have no acceptable choice but to sell their organs in order to support their family, better their life, or, in the case of organ markets in Bangladesh or Pakistan, get out of bonded labor.²⁴ Whether the same lack of acceptable choice would persist in a regulated organ market in the United States would, of course, depend on how the sellers are screened and who comes forward to sell.

Finding that the person receiving the proposal has no acceptable choice is a *necessary* but not *sufficient* condition for finding coercion. Wertheimer gives the example of a surgeon who refuses to amputate a patient’s leg for a fair price, but although the patient had no acceptable choice, we do not think the act morally problematic nor would we allow the patient to renege on the contractual obligation.²⁵ This points us to the need for a second prong to find

18. See ALAN WERTHEIMER, COERCION 204 (1987); see also JOEL FEINBERG, HARM TO SELF 222 (1986); Mitchell N. Berman, *The Normative Functions of Coercion Claims*, 8 LEGAL THEORY 45, 56 (2002).

19. See WERTHEIMER, *supra* note 18, at 204.

20. *Id.* at 172.

21. *Id.* at 267; see also *id.* at 272–74.

22. See, e.g., Benjamin I. Sachs, *Unions, Corporations, and Political Opt-Out Rights After Citizens United*, 112 COLUM. L. REV. 800, 831 n.162 (2012).

23. *Id.*

24. For a discussion of the relevant data and evaluation of this argument see generally Cohen, *Transplant Tourism*, *supra* note 2.

25. Alan Wertheimer, *Exploitation in Clinical Research*, in EXPLOITATION AND DEVELOPING COUNTRIES: THE ETHICS OF CLINICAL RESEARCH 63, 71 (Jennifer S. Hawkins & Ezekiel J. Emanuel eds., 2008); see also WERTHEIMER, *supra* note 18, at 192–201.

coercion, what Wertheimer calls the “proposal prong,” which asks whether the proposal is one that A has or does not have a right to make.²⁶ To illustrate, Wertheimer offers the following paired cases:

The Private Physician Case. B asks A, a private physician, to treat his illness. A says that he will treat B’s illness if and only if B gives him \$100 (a fair price).

The Public Physician Case. B asks A, a physician, to treat his illness. A is employed by the National Health Plan, and is legally required to treat all patients without cost. A says that he will treat B’s illness if and only if B gives him \$100.²⁷

Although in both cases *B* has no acceptable alternative but to pursue treatment from the surgeon, the first case, unlike the second, seems unproblematic at least insofar as the coercion concern; only in the second case does *A* make a proposal he does not have *the right* to make.²⁸ Therefore, only the second case is coercive on Wertheimer’s framework.

Of course, what kind of proposals one does or does not have the right to make is itself an inherently normative inquiry. Wertheimer would incorporate a “moral” test to distinguish the two types of proposals,²⁹ whereas legal scholars have suggested the existing law could also define what we do and do not have the right to propose.³⁰

As Wertheimer emphasizes in discussing the private physician case, in determining whether the proposal prong is met one must “distinguish between B’s rights against other *individuals* and B’s rights against the *society* or the *state*.”³¹ If one subscribes to a political theory in which everyone has a right to health, “B’s moral baseline with respect to the *society* includes his right to medical care, but his moral baseline with respect to a *private physician* does not,” such that a physician who says he will treat the patient only if paid is not engaging in coercion.³² Similarly, we need to distinguish rights claims an organ seller might have (on some political theories) against his or her *nation state* to end bonded labor, to provide food, employment, health care, and so on, from rights claims as against the *organ recipient or broker*. Moreover, Wertheimer notes his approach leaves open the possibility of distinguishing “between B’s background conditions for which A is not responsible and rights-violating threats to B’s welfare which are specifically attributable to A.”³³ This tracks, for example, the difference between demanding a “rescue fee” from a drowning person you stumble upon versus one you yourself pushed in the water.³⁴

26. See, e.g., WERTHEIMER, *supra* 18, at 172.

27. *Id.* at 207–08.

28. See *id.* at 208.

29. *Id.* at 207.

30. Mitchell N. Berman, *Coercion Without Baselines: Unconstitutional Conditions in Three Dimensions*, 90 GEO. L.J. 1, 16 (2001).

31. WERTHEIMER, *supra* note 18, at 218.

32. *Id.*

33. *Id.* at 219.

34. See, e.g., I. Glenn Cohen, *Conscientious Objection, Coercion, the Affordable Care Act, and U.S. States*, 20 ETHICAL PERSP. 163, 176 (2013) (discussing the importance of distinguishing cases of “taking advantage of someone’s existing condition versus putting a person in a condition which you then

In sum, as applied to organ markets, the coercion argument requires showing that the organ seller has no acceptable choice but to comply with the buyer or broker's offer to purchase the organ, and that the offer of organ sale is an offer the buyer or broker does not have a right to make to the seller.

Someone can be exploited if not coerced and coerced if not exploited. The concept of "exploitation" comes in several varieties, but the most prominent philosophical account distinguishes harmful from mutually advantageous exploitation—a distinction that turns on whether "both parties (the alleged exploiter and the alleged exploitee) reasonably expect to gain from the transaction as contrasted with the pre-transaction status quo"—and consensual versus nonconsensual exploitation.³⁵

To determine that *A* has wrongfully exploited *B*, philosophers usually stipulate that two requirements must be met: (1) *A* benefits from the transaction, (2) the outcome of the transaction is harmful (harmful exploitation) or at least unfair (mutually advantageous exploitation) to *B*, and *A* is able to induce *B* to agree to the transaction by taking advantage of a feature of *B* or his situation without which *B* would not ordinarily be willing to agree.³⁶ Those opposing organ markets will often suggest that even if consensual, organ sales can wrongfully exploit the organ seller either because (1) the seller is ultimately harmed (harmful exploitation) by the transaction as compared to the pretransaction baseline, or more commonly (2) because the buyer induced the seller to sell at a given price by taking unfair advantage of the seller's poverty or other need, without which the seller would not have sold the organ.

Although often labeled as "exploitation," "undue inducement" is in fact a separate, and in some respects, opposite concern about organ sale. In the case of exploitation, the claim is that the seller is getting offered too little, a "raw deal," whereas undue inducement is the claim that they are being paid *too much*, the "offer too good to refuse," such that their autonomy is in some sense overwhelmed by the price offered and the decision is (again in some sense) less than voluntary.³⁷

All three of these concerns are to be contrasted with opposition to organ sale as a form of "justified paternalism."³⁸ Such arguments seek to protect organ

exploit." (emphasis omitted)).

35. See Wertheimer, *supra* note 25, at 67–68. In her article in this issue, Satel takes aim at these kinds of exploitation arguments. Satel, *supra* note 6.

36. E.g., FABRE, *supra* note 2, at 142. Fabre breaks the second condition into two, yielding three conditions total, *id.*, but I find it more useful to treat the second condition as one.

37. E.g., Cohen, *Transplant Tourism*, *supra* note 2, at 276. Once again, by listing this argument I do not mean to endorse it. In fact, as my struggling to formulate this particular argument suggests, I am especially skeptical of it. I think the strongest formulation would be that the offer of money induces a level of bounded rationality in the decision making of the organ seller.

38. Although I find it helpful to sever exploitation and justified paternalism in this way, there is a relationship between the conditions for justified paternalism and the distinction between consensual and nonconsensual exploitation. However, that latter distinction presumes that there is exploitation afoot, whereas those making arguments about justified paternalism may be concerned that the transaction not go forward even if the seller is *not* being exploited.

sellers from making the “wrong” decision. Typically, these arguments look to see whether purported consent to sell the organ is really consensual in a more robust sense of the term. That is, they think whatever formal consent the seller gives, be it contractual or otherwise, falls short because it is involuntary, uninformed, or otherwise invalid because the seller lacks competence or capacity to sell the kidney. These arguments would forbid what appears to be a voluntary transaction by pointing to at least one of these defects in the consent process and by the presence of anticipated harm to the seller.³⁹

4. Unfair Organ Distribution

A final set of arguments concerns “unfair organ distribution” to those who would have received an organ in the status quo state of the world where sales are not permitted. There is some relationship between this and the crowding-out arguments discussed above, but the two are independent in that the *supply* of organs could *increase* due to permitting sale and yet the *distribution* of organs could change in a way that makes the distribution *less just* (I will have more to say in Part III about under what conditions such changes in distribution are in fact less just). This is, in a sense, the difference between Kaldor–Hicks and Pareto conceptions of efficiency. The distribution of organs that results from permitting a market (as compared to the distribution where markets are forbidden) would be superior from a Kaldor–Hicks perspective—there are winners, those who get organs because they can purchase them, and losers, those who would have received them in the no-compensation mode, and the gains to the winners are larger than the losses to the losers such that in theory the winners could compensate the losers and still remain ahead. By contrast, the new distribution is not Pareto superior, which would require that no one be made worse off and at least one person made better off. Those who would have received the organ if the system did not permit compensated sale have been made worse off, even if many more now receive organs because of the system change that permits compensation. I will have a bit more to say about the normative assumptions of this argument in Part III, but for now I merely want to get the argument on the table.

Although perhaps not quite exhaustive,⁴⁰ this is a fairly good list of the arguments offered against organ sale. It is also worth emphasizing that the listed arguments are representative of those typically offered for blocked exchanges more generally—selling surrogacy services, gametes, sex, and so on. Many of the potential regulations discussed below might also be used as potential

39. In my own work I have suggested that justified paternalism, though seldom trumpeted, provides one of the strongest arguments against allowing organ sale, although that is in part a relative comparison based on my conclusion that the other arguments are more problematic than they might at first appear. COHEN, *supra* note 4; Cohen, *Transplant Tourism*, *supra* note 2, at 273–79.

40. For example, Debra Satz’s chief concern with such markets relating to “equal status considerations” and antihierarchy principles, *see* SATZ, *supra* note 2, at 197–99, might be thought to be a separate objection or instead a combination of the exploitation, consequentialist, and intrinsic-corruption objections.

regulations for these other markets. Thus, although my focus here is on mapping the normative and regulatory dimensions of *organ* markets, the work I do is, I hope, of more general purchase as well.

B. Regulatory Options

A series of regulatory interventions have been discussed in the literature. Again, my focus here is not on evaluation but merely to provide a thorough listing. Again, although I will list these potential interventions one by one for expository simplicity, many serious regulatory proposals will combine more than one of these options.

1. Price Controls

The state or another body could control the price of organs. This could be done by establishing a set price per organ, or establishing price floors or price ceilings.

2. Restrict the Form(s) Compensation Can Take

Instead of limiting the amount payable for organs, we can instead limit the forms that compensation might take, restricting it to nonmonetary forms of compensation. In a recent challenge to the U.S. National Organ Transplant Act (NOTA), the challengers proposed to recompense bone marrow donors with noncash compensation: “MoreMarrowDonors.org, a California nonprofit corporation[, claimed it] wanted to offer \$3,000 awards in the form of scholarships, housing allowances, or gifts to charities selected by donors, initially to minority and mixed-race donors of bone marrow cells.”⁴¹ As Sally Satel details in her article for this issue, Pennsylvania also passed a law that would have given modest reimbursement of hospital or burial expenses of a deceased donor, but the plan was ultimately never implemented due to concern it would have violated NOTA.⁴²

Some forms of nonmonetary compensation, such as offering someone a house or a car in return for their organs, might be thought to be so similar to cash payments as to be indistinguishable from the moral point of view.⁴³ A more promising response to the normative concerns is programs that *limit organ sale to compensation in kind*. In some variants the trade is an organ for an organ. The simpler version is simultaneous paired kidney exchange. As Healey and Krawiec describe it,

41. I. Glenn Cohen, *Selling Bone Marrow—Flynn v. Holder*, 366 NEW ENG. J. MED. 296, 296 (2012).

42. Satel, *supra* note 6.

43. See Cohen, *The Price of Everything*, *supra* note 1, at 696 (“To divide all goods into two spheres, one of money goods and one of non-money goods—to focus only on blocking sales and not barter—is to fetishize money. Money is merely a more convenient way of accomplishing barter in the absence of a double coincidence of wants; there is no reason to think that trading your child for a Volkswagen is any less problematic than trading the child for money. The anticommmodificationist thus has no principled reason to block sales and not barter.” (footnote omitted)).

Within each patient–donor dyad, the donor’s kidney is incompatible with the patient’s immune system—yet it is suitable for the patient in the other pair. There are thus two donor–patient pairs, each incompatible internally but compatible with their counterparts. The obvious solution is a straightforward, simultaneous swap of kidneys between the two dyads. With the right combination of compatibilities across dyads, simultaneous swaps of three or four or even more pairs are possible in principle. In swaps of this sort, parties to the exchange cannot back out in the middle of things—either everything happens at once, or nothing does. Although multi-way pairings are possible in principle, they are rare in practice because the logistical demands of organizing simultaneous swaps grow rapidly as the number of pairs increases. Each individual in the swap requires her own surgical theater and team, either to remove the donor kidney or to transplant it into a recipient. Doing all of this at once is very difficult. As a result, simultaneous kidney exchanges typically involve only a limited number of swaps.⁴⁴

A more recent innovation is nonsimultaneous, extended, altruistic donor (NEAD) chain. In NEAD chains “an altruistic donor freely gives a kidney to a patient, initiating a chain of transplants among a series of donor–patient pairs” but because “[e]ach donor has a kidney that is incompatible with ‘her’ patient, . . . each donates her kidney to the compatible patient of another donor–patient pair, forming the next link in the chain.”⁴⁵ NEAD chains require both altruism and trust, in that to initiate a NEAD chain one needs “an altruistic donor, who gives a kidney without having a particular recipient in mind” and this “extra” kidney means “the transplants do not need to take place all at once,” rather a “patient can have her donor pay it forward later—say, when another suitable patient–donor pair is found.”⁴⁶ Trust is necessary because there are, at present, no enforceable contracts between donors in the NEAD chain, and the literature “contains several accounts of bridge donors who failed to perform on their promise to pay a kidney forward.”⁴⁷

A different form of in-kind compensation involves *giving organ donors priority* for future organ distributions. For example (to simplify somewhat), some have proposed that “those who committed to donate would receive a significant advantage in the organ allocation process, if they later needed a transplant,” enabling them, “like military veterans seeking a government job, to be placed ahead of non-donors of slightly superior qualifications on the waiting list.”⁴⁸ Israel has, indeed, recently adopted a system of this sort as described in-depth in Jacob Lavee and Avraham Stoler’s article in this issue.⁴⁹ While the public U.S. system does not incorporate this form of compensation, it has somewhat been accomplished here by a voluntary system called “Lifesharers”

44. Kieran Healy & Kimberly D. Krawiec, *Custom, Contract, and Kidney Exchange*, 62 DUKE L.J. 645, 651 (2012).

45. *Id.* at 647.

46. *Id.* at 652 (emphasis omitted).

47. *Id.* at 657.

48. Mark S. Nadel & Carolina A. Nadel, Commentary, *Using Reciprocity to Motivate Organ Donations*, 5 YALE J. HEALTH POL’Y L. & ETHICS 293, 314 (2005).

49. 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.

in which “organ donors join by designating that, in the case of their deaths, their organs should first go to other members of the LifeSharers network” and “[o]rgans may only be shared with those outside the network when there is no matching recipient within the network.”⁵⁰ In their article for this issue, Stephen Choi, Mitu Gulati, and Eric Posner discuss other types of nonmonetary compensation, some of which come very close to monetary compensation while staying within the bounds of U.S. law.⁵¹

3. Restrict Who Can Buy or Sell Organs

The state can establish that only authorized persons or entities can buy organs. This might take the form of outlawing brokerages or at least referral fees. It might also take the form of establishing a monopsonistic government buyer while outlawing private sale. The Iranian organ system in theory (at least) works in this way, with government being the only lawful buyer of organs and then distributing the organs it acquires according to criteria that are not based on willingness to pay.⁵² Randy Beard and Jim Leitzel recommend such a monopsonistic governmental agency in the model they set out in their article in this issue.⁵³

A separate set of proposals would “prequalify” sellers. This might include excluding poor sellers altogether by requiring that a seller have a gross taxable income above a certain threshold or, perhaps more sophisticatedly, a measure of wealth and need, not simply income. It might also involve psychological or medical screening of sellers to indicate low likelihoods of adverse events due to the surgery or being without the organ in question following the donation. One could also imagine legal prescreening of donors and sellers, in analogous to some of the devices used for surrogacy agreements. For example, the state of New Hampshire

statutorily requires judicial pre-clearance for a surrogacy agreement to be enforced and demands that the intended parents must be examined and a licensed child placement agency or the Department of Health and Human Services must perform a home study to verify that the intended couple can provide the child with food, clothing, shelter, medical care, and other basic necessities.⁵⁴

50. Christopher Tarver Robertson, *From Free Riders to Fairness: A Cooperative System for Organ Transplantation*, 48 JURIMETRICS J. 1, 12 (2007).

51. Stephen J. Choi, Mitu Gulati & Eric A. Posner, *Altruism Exchanges and the Kidney Shortage*, 77 LAW & CONTEMP. PROBS., no. 3, 2014 at 289.

52. As one set of Iranian scholars relatively recently described it, Iran has robust regulation of kidney selling—all renal-transplantation teams belong to universities and the costs of the transplant are paid by the government with no incentives allowed to transplant teams. Sellers are provided health insurance and an award from the government, and most are also provided a “rewarding gift” arranged before the agreement from the recipient or a charitable organization. The Iranian Society for Organ Transplantation carefully monitors all transplants for ethical violations. See generally Ahad J. Ghods & Shekoufeh Savaj, *Iranian Model of Paid and Regulated Living-Unrelated Kidney Donation*, 1 CLINICAL J. AM. SOC’Y NEPHROLOGY 1136 (2006). As with most things pertaining to Iran, it is quite difficult to get a good sense of how the system *actually* operates in practice.

53. Beard & Leitzel, *supra* note 15.

54. I. Glenn Cohen, *Regulating Reproduction: The Problem with Best Interests*, 96 MINN. L. REV. 423, 469–70 (2011) (citing N.H. REV. STAT. ANN. §168-B:16 to 18 (LexisNexis 2010)) [hereinafter

One could imagine a similar, court-supervised process in which contracts paying for organs are rendered enforceable after (1) the court inquires about whether buyer and seller are (a) adequately represented by counsel, (b) of sound mind, and (c) not coerced in the basest sense, and (2) the money is put in escrow pending performance. Such prescreening could also involve “cooling off” or “waiting periods,” as Beard and Leitzel note in their paper.⁵⁵

4. Restrict What Kinds of Organs Can Be Sold or For What Purposes

A final category of regulations involves determining which organs can be sold. One simple division is to permit the sale only of *cadaveric* but not *live* organs. In addition or separately, the system might permit the sale of only certain *kinds* of organs. The National Organ Transplant Act’s prohibition on sale, for example, only prohibits the sale of a “‘human organ,’ defined as ‘human (including fetal) kidney, liver, heart, lung, pancreas, bone marrow, cornea, eye, bone and skin or any subpart thereof and any other human organ (or any subpart thereof, including that derived from a fetus) specified by the Secretary of Health and Human Services by regulation’” and therefore does not cover “all animal organs, . . . blood, ova and sperm.”⁵⁶ Another form of division would be between renewable and nonrenewable organs (or bodily substances). These distinctions can be drawn even more finely, and recently a panel of the U.S. Court of Appeals for the Ninth Circuit held that the National Organ Transplant Act’s prohibition on selling organs did not apply to “peripheral blood stem cells” obtained through apheresis, although it did prohibit the sale of the same stem cells derived when derived through aspiration.⁵⁷

A different variant of this approach is to *limit the uses to which organs may be put*. The National Organ Transplantation Act does this by not prohibiting sale of organs when used for research and other nontransplantation activities.⁵⁸ Similarly, “as of 2007, [thirteen U.S.] states independently banned either the sale of human embryos for research purposes and/or the sale of human ova to produce embryos for research purposes, while New York, on the other hand, has now explicitly allowed it.”⁵⁹

5. Other Measures

Finally, there is a more heterogeneous set of limitations one might impose on an organ market while leaving the sale intact. The first is to permit the

Cohen, *Regulating Reproduction*].

55. Beard & Leitzel, *supra* note 15.

56. I. Glenn Cohen, *Can the Government Ban Organ Sale? Recent Court Challenges and the Future of U.S. Law on Selling Human Organs and Other Tissue*, 12 AM. J. TRANSPLANTATION 1983, 1984 (2012) (quoting 42 U.S.C. § 274e (2006)) [hereinafter Cohen, *Can the Government Ban Organ Sale?*].

57. Flynn v. Holder, No. 10-55643, slip op. at 10, 15, 18 (9th Cir. Dec. 1, 2011), *opinion amended and superseded on denial of reh’g en banc*, 684 F.3d 852 (9th Cir. 2012); see Cohen, *Can the Government Ban Organ Sale?*, *supra* note 56, at 1983.

58. Cohen, *Can the Government Ban Organ Sale?*, *supra* note 56, at 1984.

59. *Id.* at 1984 (citations omitted); see *Feminists Choosing Life of N.Y., Inc. v. Empire State Stem Cell Bd.*, 926 N.Y.S.2d 671, 678 (App. Div. 2011) (permitting sale).

market but prohibit advertising.⁶⁰ Another possibility would be to permit sale, but forbid contractual enforcement of the promised exchange, such that an individual who contracted to supply a kidney would not be able to enforce that agreement in court. As we saw, the possibility that one party might defect is already a cause for concern in NEAD chains. More subtle versions of this approach make the contract enforceable but permit only damages rather than specific performance, or make the contract voidable but not void such that the seller of the organ can go through with the contract or void it at her election but the same is not true of the buyer.

C. Mapping Normative Concerns onto Regulatory Options

Now that we have a full, though admittedly not completely exhaustive, account of the normative concerns with and the regulatory options for organ markets, we can start connecting them.

If one's concern with organ markets is *consequentialist corruption*, it is an empirical question as to whether any of the regulations discussed will blunt the attitude-modifying effects about the status of the body or human beings that represents the chief concern with authorizing organ markets. As such, one cannot definitively endorse or reject any of the regulations until we run appropriate experiments with the various regulations and develop appropriate measures of attitude modification. Of course, doing either, and certainly doing both, of those things would be extremely difficult—one of the reasons why I think this argument may be rhetorically persuasive, but in practice not particularly grounded in evidence—so perhaps the best we can make are “guesses” about the effects of various regulations on these attitudes, with the proviso that armchair empiricism is no substitute for the real thing.

Limiting the form that compensation might take to, for example, MoreMarrowDonors.org-type scholarship funding, or organs received from the in-kind trading of organs that occurs in NEAD chains or simultaneous paired kidney exchanges discussed above, seems most likely to blunt the effect of consequentialist corruption. If one is convinced that these alternative benefits are part of the same or a closely allied “sphere” or “modes” of valuation as organs,⁶¹ then these kinds of exchanges may have fewer attitude-altering effects than do exchanges for money. Similarly, making government the monopsonistic buyer of organs may cause us to regard organs as a special good and not a pure market or use good. It might also, though, have the opposite effect, and government participation in purchases might be seen as legitimating the

60. Cf. MARGARET JANE RADIN, *CONTESTED COMMODITIES* 136 (1996) (arguing for a ban on advertising for prostitution as a way of trying to fight complete commodification by “failing to legitimate the sales we allow” and as a way of adding information costs to potential buyers to discourage them).

61. E.g., Cohen, *The Price of Everything*, *supra* note 1, at 692; ANDERSON, *supra* note 11, at 144. Indeed, there is a sense in which the “stranger” and more limited the kinds of goods for which organ exchange is permitted, the less likely it is that the public will come itself to think of organs as pure market or use goods.

economic way of valuing organs. Limitations on the use to which organs may be put after purchase might also help forestall attitude modification, especially if the uses are thought of as noble or of collective instead of individual benefit—such as restricting the use of organs to scientific purposes. To the extent that the attitude changes about the body and human beings that we want to avoid are keyed to *living* bodies rather than the dead, and/or there is more of a tendency of corrupted attitudes towards organs to become corrupted attitudes about the value of human beings when the human beings from whom the organs come are alive, then limiting sale of organs to cadaveric organs may be desirable on this view. To the extent that advertising augments the attitude-modifying nature of commodified exchanges, a ban on advertising might mitigate this normative concern. And to the extent that state participation, even in the seemingly neutral form of contract enforcement, is thought to have an expressive effect, endorsing the attitude that the organ is a market good, forbidding contractual enforcement may be viewed as desirable as well. By contrast, it may be counterproductive to limit enforcement to the damages rather than specific performance if the damages remedy is thought to further express an attitude of commodification towards the good.

Might setting price controls also assist in avoiding the attitude-modifying effects of organ sale? Elsewhere I have argued for adopting a “Formula from the Nature of the Transaction,” which “does not focus on the nature of the goods, but rather on the nature of the transaction.”⁶² With roots in Kant’s work, I have suggested that part of what makes gifts of organs and other “sacred” goods permissible and not corrupting is that giving—in contrast to sale—does not express a notion of “value equilibrium.” With sale, however, “the transaction is thought to have no ‘value remainder’ because the two sides receive things of equal value” or at least equal value *to them*.⁶³ Price ceilings or fixed prices may also have the effect of expressing a certain amount of value remainder in the transaction: Although the parties would ordinarily ask for more in terms of price, the state prevents that by fixing a price or prohibiting its sale above a certain amount, such that the transaction does not suggest that the price actually paid represents the full value of the organ being sold, and hence the value remainder. On the other hand, an intervention that fixes the price paid for organs may express a certain interchangeability—all organs are equal—that makes the organs seem more like widgets and less like something with special nonmarket value—such as art—making matters worse not better in terms of attitude modification.

Intrinsic corruption is focused not on changes of attitudes towards the good, but instead on the more metaphysical concern that the value of the good is denigrated by the mere incompatibility of the modes of valuation, such that wrongfulness of the action is completed at the moment of purchase irrespective of what follows, even if no attitudes change. As I have explained in more detail

62. Cohen, *The Price of Everything*, *supra* note 1, at 703.

63. *Id.* at 705.

in other work (albeit with some skepticism), on some views, “[e]ven if one concedes that good X (your child, your vote) is denigrated when treated as equivalent to money, the questions remain whether there are other goods that you can exchange X for that will not denigrate it, and how many types of such goods there are.”⁶⁴ That is, “if the problem is the exchange of things that have radically different spheres of valuation, then the philosophical battleground will be in defining how wide the various spheres are and the extent to which they overlap.”⁶⁵ There are many ways of formulating the different “widths” of spheres of valuation, but let me highlight two that are particularly relevant for our purposes. First, one that I associate with Michael Sandel suggests a tripartite division between market goods, civic goods, and sacred goods, wherein exchanges across categories are problematic but exchanges *within* a category are not problematic (or at least less so).⁶⁶

On this view NEAD chains and simultaneous paired kidney donations, although still market exchanges, are not (or are at least less) problematic because they exchange one “sacred” good (a body part) for another. Lifesharers and other organ-priority enhancers for donors are similar in that the goods exchanged both come from the “sacred” good sphere of “organs.” Indeed, a version of Lifesharers, or priority, where the benefit to donation was related to health or the body but not organs per se—for example, priority in influenza-vaccine inoculation, ICU-bed access, compensated elder care—might also be unproblematic on this logic.

A second theory of sphere width, which I have discussed elsewhere, restricts noncorrupting exchanges to those where the good is “of the same ‘type,’ as that term is used narrowly in ordinary language, has its own sphere (for example, trading one cat for another cat is an exchange of two goods within the same type, whereas trading a cat for a vehicle is not).”⁶⁷ On this theory, NEAD chains or simultaneous kidney exchanges are permissible, because they are a trade of “my” organ for “your” organ, but attempts to use organ donation as the basis for priority as to other health benefits, such as vaccines, are problematically corrupting.

As with consequentialist corruption, restricting sale to cadaveric organs might also satisfy those concerned with intrinsic corruption, but here the question is *not* whether individuals *perceive* or *react to* the severing for compensatory-seeking purposes of parts from dead bodies differently from living ones, but whether, at a metaphysical level, living bodies and dead bodies are to be differently valued, such that market exchange does violence to the way we think the latter but not the former is to be valued. Some of the forms of regulation I suggested might be endorsed by those concerned about

64. *Id.* at 696.

65. *Id.* at 696–97.

66. *Id.* at 697 (citing Michael Sandel, *What Money Can't Buy: The Moral Limits of Markets*, in 21 THE TANNER LECTURES ON HUMAN VALUES 89, 94, 112 (Grethe B. Peterson ed., 2000)).

67. *Id.* at 697.

consequentialist corruption—price controls that force a certain amount of value remainder in the transaction, making government the monopsonistic buyer, limiting the uses to which organs might be put, and so on—might also be endorsed by those concerned with intrinsic corruption to the extent these limitations reduce the *actual* denigration of the good, metaphysically speaking, and not merely our reactions to the exchange. By contrast, other regulations endorsed to fight consequentialist corruption, such as bans on advertising and perhaps state enforcement of contracts, are more focused on the communication of corrupting messages and less germane when the concern is intrinsic corruption.

For the crowding-out concern, in any of its forms, once again we face an empirical question, and one for which existing studies are not at all supportive that the crowding-out effect is a real one.⁶⁸ Assume, though, for the sake of argument, that the introduction of a market in organs did substantially crowd out supply. What might counteract the effect? It is unclear whether something like a fixed price or a price ceiling is likely to help maintain the existing level of altruistic donation—if it keeps the organ valued at a low level, perhaps individuals will not think of themselves as “chumps” if they give the organ away—or whether it will actually make supply worse than allowing the market to set the price—for it may be that both fewer individuals will donate *and* that the regulator’s price does not incentivize enough compensated donation. One can also imagine the practice of monopsonistic government purchase of organs as in theory being better than an unregulated market in terms of crowding out, because of the identification of the seller with civic mindedness in participation with a government program; or worse, if an act of charity now feels more like paying one’s taxes or other types of interactions with the government. The introduction of opportunities to participate in NEAD chains, simultaneous paired donation, or priority programs might also plausibly, from the armchair, push in either direction, giving a “boost” or “thank you” for altruism or, instead, changing the act into one that looks more like a market exchange, and make those who donate outright feel like “chumps.” The same is true for bans on advertising. Limiting the compensation for organ provision to cadaveric donations and/or based on what uses the organs purchased can be put to, might cause potential donors to better segment domains in which they see markets (cadaveric, scientific use) from those where they see charity (live, health-care uses). Alternatively, these limitations might have no effect, or even a perverse effect.

There are many unanswered questions here in need of empirical investigation. The regulation that seems to have the most surefire effect on dealing with the subset of crowding-out concerns relating to the quality of organs is the ability to screen sellers for physical and psychological health. It is

68. See COHEN, *supra* note 4 (reviewing existing evidence); Julia D. Mahoney, *Altruism, Markets, and Organ Procurement*, *supra* note 2.

less clear whether price floors would help address this concern as well. On the one hand, the population interested in for-profit sale of organs is likely to expand beyond the poor and destitute, which may mean more high-quality organs; on the other hand, there may also be more incentive to misrepresent one's health state to have one's organ purchased at the high price.

When the concern is *coercion*, the most useful regulatory interventions will be legal and psychological prescreening of the donors as well as waiting periods—to help guard against the buyer threatening the seller or otherwise putting pressure on him besides for the price term offered—and potentially making the government the monopsonistic buyer of organs.⁶⁹ I say “potentially” because although, on the one hand, one would expect the government to be less likely than private individuals to threaten an unwilling provider of organs to induce him or her to sell, on the other hand, should one face a government with this kind of orientation (perhaps this is particularly easy to imagine in other countries, or perhaps that is merely a case of wishful thinking) the power of the government to coerce is much stronger than that of private individuals. Limiting the sale of organs to only cadaveric organs might also be thought to serve as a bulwark against coercion, though it is also possible that individuals will be more susceptible to being coerced *while alive* to sell *while dead* than they would be to sell *while alive*, since they internalize fewer of the negative consequences. That may mean individuals are more subject to coercion but the coercion has fewer negative effects when it does occur. The prohibition of contractual enforcement or making the contract voidable but not void by the seller might, on the one hand, ameliorate coercion—the coercive buyer cannot rely on the state to enforce the bargain that was the product of coercion—but, on the other hand, may be worse for the seller since the buyer will now rely on self-help remedies to ensure that the seller complies, which at least in theory may be *more* coercive.

When *exploitation* is the concern, price floors or high fixed prices are one very pertinent regulatory intervention. This is a remedy that is often overlooked by those who claim that exploitation is the chief evil with organ markets. If, in a hypothetical transaction for the sale of the kidney (or any good for that matter) at *X* price, one claims that the seller has been exploited, there ordinarily exists a hypothetical value for *X* where the claim is false. As I suggested above, one necessary element to claim that a transaction is exploitative is that the outcome of the transaction is harmful (harmful exploitation) or at least unfair (mutually advantageous exploitation) to the seller on the basis of the terms being offered. In this way, exploitation mirrors to some extent the doctrine of substantive unconscionability in contract law, which in the words of one classic case looks at whether the “contract terms . . . are unreasonably favorable to” one party over

69. Of course there are plenty of forms of nonmarket coercion. This is true not just in terms of physical threats, but also the much more subtle and yet powerful types of pressures that family or friends can place on a potential donor in the altruistic-donation context.

the other.⁷⁰ For every substantively unconscionable set of contract terms, one could imagine a hypothetical rewriting of the contract's terms that would *not* be substantively unconscionable. Similarly, for every sale of organs on terms that seem exploitative, one could imagine a set of terms that would not be harmful or unfair to the seller, such that they would not be exploitative. A change in the price term is one very powerful way of turning an exploitative transaction into a nonexploitative one. If the problem is that the seller of a kidney is being exploited by being offered the opportunity to sell at a given price, there likely exists a hypothetical higher price at which he will not be exploited.

Should that last sentence read “likely” or “necessarily”? That depends, to some extent, on whether one believes that money can always compensate for other potential losses and change a harmful or unfair transaction into a nonharmful or fair one. For those who believe that money can compensate for any losses, there will always exist a price at which an organ sale does not exploit a given seller. For those who do not believe that money can compensate, one may also have to consider alterations to nonprice terms. Even for the latter group, though, a substantial price floor or fixed price will help *reduce* the unfairness or harm of the transaction for the seller and thus make it less *exploitative*.

Will a limitation to in-kind compensation also reduce the likelihood of exploitation? I think not, and in fact the opposite may be true, because it may be more likely that provider of the organ will be harmed or treated unfairly. In the NEAD-chain example, it is possible that somewhere along the line one of the kidney providers will defect (in the game-theoretical sense of the term), and a person who provides a kidney in a transaction for the purpose of getting a kidney for someone else will end up getting nothing in return. Let us put the problem of defection aside, however, and suppose we had an organ-priority system whereby the priority is guaranteed by law and we are completely confident it will be enforced. It is more likely that a transaction in which one's kidney is “sold” for priority in other organs may be exploitative as compared to a case where one's kidney is “sold” for money. How would one know whether one is getting “fair-market value” for the kidney in the priority case? The value of the priority is conditional on needing an organ oneself in the future, the expected value of which is difficult to anticipate *ex ante*. Further, the value of that priority is a function of how many other people also get priority and how many organs are available—if there is a surplus of organs such that everyone who wants one gets one, the priority would be useless, and it might be better from the point of view of a particular seller to free ride. Thus, it will actually be more difficult to know—both from an outside regulatory observer and for the person deciding whether or not to “sell” their kidney—whether the value of the priority is fair or unfair, as compared to a cash benefit.

If one believes that brokerages are more likely to offer transactions that are

70. *Williams v. Walker-Thomas Furniture Co.*, 350 F.2d 445, 449 (D.C. Cir. 1965).

exploitative, outlawing brokerages will reduce exploitation. It is harder to know whether monopsonistic government purchase will help prevent exploitation or not. Much would depend on whether one thought governments were likely to set a fair and nonexploitative price for organs, or whether the lack of competition from other buyers was likely to lead to lower prices that were unfair.

Recall that one of the elements necessary for a transaction to be exploitative is that the buyer is able to induce the seller to agree to the transaction by unfairly taking advantage of a feature of the seller or his situation without which the seller would not ordinarily be willing to agree. The poverty of the seller is one such feature of the situation. Therefore, a restriction that prohibited poor sellers from selling organs would reduce the chances that this element of exploitation would obtain in the organ-sale context.⁷¹ Waiting periods and psychological and legal prescreening may also reduce the pressure on sellers that is a hallmark of exploitation. It is less clear whether prohibitions on advertising are a good idea—on the one hand such advertising may prey on the poor and downplay risks, but on the other hand advertising may inform prospective sellers on what the “going rate” is and facilitate price competition among buyers to the sellers’ benefit.

Limiting organ sales to cadaveric organs rather than live ones might be thought to reduce the chance of exploitation by reducing the chance that the practice will prove harmful to the seller, although that may in turn depend on the question of whether one thinks one can be harmed (or at least exploited) after one is dead;⁷² it may also be possible to be exploited while alive based on what will happen to one’s body after one is dead. Limitations of organ sale to only certain types of organs may also help ameliorate exploitation concerns by making it less likely the seller will be harmed.

If the concern is *undue inducement*, the main desirable intervention is the setting of a price ceiling or a low fixed price, because lower sums are less likely to have this undue inducement effect. Limitations on who may provide organs that exclude the poor may also be justified for this set of concerns on the theory that a given offer is less likely to be an undue-inducement if one’s preoffer holdings make one wealthy and thus less in need of the money. Monopsonistic government purchase, to the extent it results in a lower price being offered, may also be endorsed on this argument as an intervention, as may some forms of limiting the form compensation may take, such as priority based limits.

Where *justified paternalism* is the main motive for intervention, psychological screening and legal prescreening of potential organ providers, as

71. That said, as I have discussed elsewhere, we run into the potential “hypocrisy” problem with such an intervention, in that we both block an exchange for poor sellers and do not compensate them for the lost opportunity to improve their lot in life, thus causing them to *remain* poor. See COHEN, *supra* note 4.

72. I have discussed the question of posthumous harms elsewhere, see I. Glenn Cohen, *The Right Not to Be a Genetic Parent?*, 81 S. CAL. L. REV. 1115, 1139 & n.64 (2008).

well as mandatory waiting periods, may be called for as a way of trying to improve the quality of the consent process. Some limits on the form of compensation might, in theory, serve a similar function. They may give organ providers more opportunity to be reflective about their decisions and/or to improve consideration because the payoff is by necessity delayed. Because the harms of cadaveric organ provision, if they exist, are largely psychological, restricting organ markets to those kinds of organs would also be justified on this view. Similarly, restricting organ markets to renewable organs, or those organs the removal of which from the provider have fewer negative health ramifications on the provider, could also be justified. Monopsonistic government purchase of organs might also be called for on this view, if one trusts the government to effectively pair informational and libertarian paternalist-type interventions, sometimes called “choice architecture,” to help counter poor decision making by potential organ providers in the way it structures its organ procurement programming. That may be a big “if” for some who view government as the problem, not the solution.

Finally, if the concern is an *unfair organ distribution* to the ultimate recipients, there are a few regulations that might be justified. First, price ceilings or low fixed prices for organs may increase the share of the market of purchasers who can afford them. Second, monopsonistic government purchase can uncouple sale and purchase. Sale becomes legal, but only to the government, but purchase becomes illegal and a willingness-to-pay distribution system can be replaced with our existing organ distribution system, that is, United Network for Organ Sharing (UNOS), or another form of rationing. In the next part, I have a bit more to say about this justification for regulating the organ market.

In this part, I have mapped out the main arguments offered against organ markets and the main potential forms of regulation of organ markets, and have also tried to connect the two to show how certain normative concerns might lead one to endorse or oppose certain forms of regulation. That mapping is summarized in the table below, which covers the following two pages.

Table: Mapping Normative Arguments onto Regulatory Proposals

Corruption		Crowding Out			
<i>Consequentialist</i>	<i>Intrinsic</i>	<i>Donated organs</i>	<i>Overall organs</i>	<i>Quality Organs</i>	
-Limiting form of compensation -Gov't is exclusive purchaser -Limitations on organ use -Limitation to cadaveric organs -Ban on advertising -Ban on contractual enforcement -Price ceilings or fixed prices	-Limiting form of compensation -Limitation to cadaveric organs -Price ceilings or fixed prices -Limitations on organ use -Gov't is exclusive purchaser ^a	-Price ceilings or fixed prices -Limiting form of compensation -Ban on advertising -Limitation to cadaveric organs -Limitations on organ use -Gov't is exclusive purchaser	-Price ceilings or fixed prices -Limiting form of compensation -Ban on advertising -Limitation to cadaveric organs -Limitations on organ use -Gov't is exclusive purchaser	-Price ceilings or fixed prices -Limiting form of compensation -Ban on advertising -Limitation to cadaveric organs -Limitations on organ use -Gov't is exclusive purchaser	
				-Price ceilings or fixed prices -Limiting form of compensation -Ban on advertising -Limitation to cadaveric organs -Limitations on organ use -Gov't is exclusive purchaser -Physical and psychological prescreening -Price floors	

Table (Continued): Mapping Normative Arguments onto Regulatory Proposals

Coercion and Related Arguments				Unfair Distribution
Coercion	Exploitation	Undue Inducement	Justified Paternalism	
<ul style="list-style-type: none"> -Legal or psychological prescreening of donors -Gov't is exclusive purchaser -Limitation to cadaveric organs -Ban on contractual enforcement/allow contract to be voidable but not void 	<ul style="list-style-type: none"> -Legal or psychological prescreening of donors -Price floors or high fixed prices -Gov't is exclusive purchaser -Ban on poor sellers -Limitation to cadaveric organs -Limitation to certain types of organs 	<ul style="list-style-type: none"> -Price ceiling or low fixed price -Gov't is exclusive purchaser -Ban on poor sellers -Limiting form of compensation 	<ul style="list-style-type: none"> -Legal or psychological prescreening of donors -Limiting form of compensation -Limitation to cadaveric organs -Limitation to certain types of organs -Gov't is exclusive purchaser 	<ul style="list-style-type: none"> -Price ceilings or low fixed prices -Gov't is exclusive purchaser

One thing that should be obvious from this discussion and the Table is that not only do the normative concerns justify different forms of regulation, but in some instances they justify *conflicting* forms of regulation. For example, exploitation and undue inducement concerns generate opposite and incompatible regulation here because the former is focused on keeping prices high through price floors or high fixed prices, whereas the latter is focused on lowering prices through ceilings and low fixed prices. Thus, it is particularly important to distinguish these two arguments relating to organ markets even though many writers in the area confuse them, or at least equivocate. Likewise, to the extent the value of the monetary, or for that matter nonmonetary, compensation bears a relationship to the total number of organs that are procured to the system, and assuming larger rewards result in more organs procured,⁷³ the price ceilings or low fixed prices that the undue-inducement argument pushes for will exacerbate the crowding-out concern. There may also be conflicts between solving exploitation and consequentialist or intrinsic corruption concerns. To avoid exploitation, I have suggested regulators may want to try price floors or high fixed prices, however, to the extent that what saves some of these transactions from being corrupting is the existence of what I have termed “value remainder,” that remainder gets eaten up as the price paid for an organ is increased.

This list is not exhaustive and there are very likely other conflicts between regulatory possibilities, as well. Thus, if one is concerned by more than one of these normative issues, one may have to prioritize and make hard choices. That priority will depend not only on an assessment of which of the normative issues is more concerning for the reader, but also on an evaluation of which of the conflicting regulations is more effective in improving or exacerbating the normative concern in question. That prioritization is important for a second reason: while some forms of regulated market seems more desirable than the status quo of no-market or a completely free market, there is such a thing as death by regulation; that is, it is possible that trying to adopt *all* of these fixes (or at least all nonconflicting ones) would produce a market that is worth more than either of the two polar options. The right approach from a system design point of view is, I think, to start with the greatest concern for the policy maker, adopt the regulations best targeted at those concerns, and then move to the next concern at each point asking whether the additional regulation added improves or worsens things as against the state of play before it is added on.

73. Although such a monotonic relationship between the two variables is the easiest to imagine, it is not the only possible one. For example, it could easily be the case that low levels of compensation reduce altruistic giving because they simultaneously cause those providing transplanted organs not to feel like they are “a hero,” to use a term from Beard and Leitzel, while at the same time ensuring that donors are not getting paid nearly enough as market actors (“you want to pay me that?!”). If that were the case, it may be that no payment is better in terms of overall supply of organs than only a little payment, while a lot of payment is better than either. As with so much of this, without robust experimentation it is only possible to make guesses from the armchair about how individuals will respond to various market designs.

Others might take a different tack in figuring out which regulations to combine, but I think prioritization by level of concern will be crucial for any decision method.

III

UNFAIR ORGAN DISTRIBUTION REVISITED

Some of those opposed to organ markets are concerned about the resultant distribution of organs. As I have said in part II, there may be regulatory interventions that can mediate this concern, but for the purposes of this part, I am more interested in whether this concern is a justified one.

As I said above, one way of formulating this concern is that even if the new distribution of organs in a world where markets are permitted is Kaldor–Hicks superior, as compared to one where it is forbidden, it is not Pareto superior, because some of those who would have received the organ if the system did not permit compensated sales have been made worse off, even if many more now receive organs because of the system change that permits compensation. As a descriptive matter, that is accurate. As a normative matter, though, the change in the distribution is only significant if we think that the distribution in a world where organ markets are prohibited is more just than the distribution in which organ markets are permitted.

We should be careful to distinguish two versions of this concern. In the first, and the one I will focus on, one can imagine a system designer choosing between the two potential systems, market or nonmarket, at time zero, before either has started operating. In this set up of the problem, the complaints of those who would have received an organ in the nonmarket system but do not receive it in the market system are based on an argument that the “loser” had a superior moral claim to the organ. By contrast, in the second version one imagines transition from our existing nonmarket system to a market system in real time. Here, the same individuals who would have received an organ in the nonmarket system but would not receive it in the market system will have a complaint, but they will have an additional ground for that complaint: that is, they had a legal or moral entitlement under the old system, a sort of settled expectation from the prior system design.

I would not be inclined to give much additional weight to this extra reason. This is in part because *any* change to the regulation of the organ market will have this kind of effect on distribution and frustrate the entitlement claim of those who say they would have received an organ under the old system. After all, if UNOS today changed some aspect of its priority weighting for who gets organs that caused a change in the distribution, I do not know that the preexisting entitlement should give us much pause if we felt the new distribution was more just. Moreover, it is not just changes in the regulation of the market or allocation systems that may end up changing who receives an organ; changes in technology, such as better tissue matching, or in the manner of procurement, such as recruiting more deceased donors, or more donation

after brain death instead of donation after cardiac death, will have comparable effects, and yet we do not give the “losers” a veto over such changes.

In any event, though, one can avoid this issue entirely by imagining—as seems likely—that there will be some kind of nonretroactivity or phase-in to the system change for organ distribution. In the most extreme form one could imagine that we decree that the new organ market would only go into effect 100 years from now when all existing potential entitlement holders under the old system will be dead. Less extreme phase-ins are also possible and indeed much more likely, but I use the extreme version just to show how implementation of a change might nonetheless get us to something more like the “pure” case resembling initial choice by a system designer.

Do those who would have received organs in a market-prohibited system, but would not in a market-permitted system, have a claim of justice against our adopting the market system? I want to suggest that there are at least two complications with answering “yes” and therefore the answer may be only a qualified yes.

First of all, it will depend on *why* they got the organ in the market-prohibited system to begin with. If the organ flows to them through the UNOS priority system—which combines a first-come-first-served principle with a priority to the worst-off system that focuses on the health sphere, and a best-outcomes measure focused on antigen, antibody, and blood-type matches of the donor and recipient⁷⁴—then the question arises whether those criteria are themselves valid bases for allocating organs. That is a big question, and many fine-tuned rationing questions are quite difficult,⁷⁵ but there is good reason to think that even UNOS’s system, which may have imperfections, produces a more just organ distribution than does a complete free market where access is allocated by willingness to pay.

However, not all organs end up in the bodies of their ultimate recipient through the UNOS rationing system. Many come from directed donations from friends and families. Do the subset of individuals who would have received organs from friends and families in a market-prohibited system, but do not receive those organs in a market-permitted system—either, hypothetically, because those donations are completely crowded out or because particular individuals who would have altruistically given those organs sell them instead—have a justice-based complaint relating to the regime change which deprives them of those organs? The answer is yes only if such individuals who are now “losers” have a superior entitlement to those organs, as a matter of justice, than do those who would purchase the same organs. That raises the question of whether those who purchase organs are *more* deserving of those organs than those who receive them from altruistic giving by friends and family. I do not

74. E.g., Govind Persad et al., *Principles for Allocation of Scarce Medical Interventions*, 373 LANCET 423, 426 (2009).

75. For some of my own thoughts on many of these issues, see I. Glenn Cohen, *Rationing Legal Services*, 5 J. LEGAL ANALYSIS 221 (2013).

intend to provide a definitive answer here, but instead just want to hint why, when it is understood that *this* is the right question to ask, the matter is complicated and what many take for granted may not be correct.

One important reason that the distribution of access to a particular good, like a life-saving organ, may be unjust is because the distribution is based on a morally arbitrary factor. Ability and willingness to pay is sometimes derided as a thoroughly morally arbitrary factor, but in my view that is a bit strong. Although few who study distributive justice from a philosophical perspective would claim that those with wealth *fully deserve it free of any moral arbitrariness*, neither is it the case that *no wealth is deserved, that all wealth distributions are morally arbitrary*. For example, although I may not deserve the wealth I get when a distant and unknown relative leaves me a huge bequest, I may deserve some of the wealth I get when I invent a novel technology through risk, pluck, intelligence, and perseverance. The right question to ask is whether ability or willingness to pay is a *more morally arbitrary* method of allocating a scarce good like organs than a competitor allocation principle.

I do not believe so. Or, to put it more cautiously, it is far from clear to me that it is *more* morally arbitrary than allocation based on the availability of friends or family willing or able to donate altruistically as part of directed donation. Why should we think I am deserving for having a friend or relative who is (1) a tissue match, (2) willing to donate, and (3) fond enough of me to be motivated to do so? Of those three joint criteria, only the last seems connected at all to my dessert. It is through no doing of my own that I do or do not have relatives or friends who happen to be tissue matches. Indeed, whether I have siblings or not is a choice my parents likely made long before I needed the organ and is now likely too late to rectify!⁷⁶ Similarly, whether the friend or relative is still alive when I need a donation is beyond my control. The willingness of my relatives or friends to be organ donors is, likewise, something unconnected to my dessert and for which I do not have much control.

Only the fondness of my friends and relatives for me is something that I can perhaps say I deserve. But even here there are many factors outside of my control. For example, “I was an army brat so I kept moving high schools and thus did not form deep attachments,” or “I was born with autism making it more difficult for me to form close friendships,” or “I am a member of a disfavored minority group who has experienced significant discrimination and have found it harder to make friends.”⁷⁷ There is arbitrariness in both this and the ability or willingness-to-pay criterion, but it is not at all pellucid to me

76. One exception is the controversial so-called “savior siblings” case where children are conceived in order to be a bone or chord-blood match to an ill sibling. I have discussed these cases in I. Glenn Cohen, *Intentional Diminishment, the Non-Identity Problem, and Legal Liability*, 60 HASTINGS L.J. 347, 364 & n.53 (2008) and Cohen, *Regulating Reproduction*, *supra* note 54, at 479 n.168.

77. This last example raises the possibility that not only is a system of allocation by donation by friends or families somewhat arbitrary, but in fact it may actually be discriminatory to the extent that it may reflect existing biases as to who has friends or even family willing to donate. That said, the distribution of wealth may also reflect some of the same discriminatory biases.

whether one's ability to purchase an organ is *more* morally arbitrary than whether one has a friend or relative who is a tissue match, willing to donate, and fond enough of oneself to be motivated to do so. The question is whether one can clearly say one *deserves* tissue-matching friends and relatives willing to donate more than one *deserves* one's wealth. It is far from clear that this is the case.

Suppose one concludes that in fact the availability of friends and family to donate organs is a morally arbitrary basis for allocating those organs. The strong intervention would be to consider making that method of allocation illegal, just as willingness to pay is currently illegal in the United States, I am not arguing for that here. Doing so would require an inquiry into the proper boundaries of impartiality in making decisions that affect intimate associations. For example, on some moral-theory views there are "agent-centered prerogatives": In responding to the critique that consequentialism impermissibly alienates an agent from his own life projects—that is, requires him to pursue certain goals or projects only if they further the aim of maximizing aggregate welfare—some have urged a modification in which we recognize that, in some cases, an individual may permissibly depart from his duty to produce the best overall state of affairs in order to pursue important life projects necessary for the integrity of his person,⁷⁸ such as favoring one's loved ones in moral choices like organ donation. I would also imagine that trying to bar familial donations in this strong way would be noxious to most Communitarians.

My point here is less ambitious. I only want to make the subtler point that if the supply of organs "diverted" due to permitting a market comes from the directed donation from friends and relatives, whatever change in distribution occurs is not necessarily normatively problematic, and indeed may be an improvement in terms of distributive justice.⁷⁹ Of course, if the lion's share of

78. See SAMUEL SCHEFFLER, *THE REJECTION OF CONSEQUENTIALISM* 5–6, 20–23 (Rev. ed. 1982).

79. Another way of seeing this is by imagining ourselves behind a veil of ignorance-type device and asking ourselves, not knowing who in a given society we would be, which of the two forms of organ distribution we would choose, allowing allocation by ability to pay or by donation from matching friends and family who are willing to do so? To the extent one would choose the ability-to-pay criterion, that suggests at least that the distribution that results from allowing that system is not more unjust than that which results when friends and family can donate if they match. It may be that even this more limited argument—that if ability to pay allocation disrupts familial allocation that may not be problematic from the perspective of distributive justice—is problematic for some communitarians as well as other thinkers. In particular, it may be thought that a particular vision of family life, with particular kinds of sharing, is essential for the flourishing of human beings and disrupting familial sharing disrupts that vision. It is unclear to me that cutting off this particular margin for familial sharing is likely to have a major impact, especially since many would choose to donate to family even if there were an arm's length bidder. Even if it did have this impact, I am not sure I agree that the vision is worth promoting. Where my critic sees sharing and obligation I also see the potential for coercion through emotional pressure. I do not plan on resolving this disagreement here, but merely seek to show that it is a highly contestable argument for resisting adoption of more market-like approaches. I should also add that many are skeptical about veil of ignorance-type arguments (Rawlsian or otherwise) and think that much of those arguments' moral force depends on the thickness of the veil, for which there

the “diverted” organs comes from those who would have received them based on UNOS criteria—not directed donation—then matters look different.

Second, suppose organ sale *both* increases the number of quality organs available, that is, it is Kaldor–Hicks efficient, but also makes the distribution less just, in that those who are less deserving get an organ that would have gone to those who are more deserving. Whether this is a *problem* from the moral point of view will depend on several variables in the equation. How many more organs are gained? How unjust has the distribution become? How badly off are those who have lost out? Even many moral theories with Prioritarian components—that is, those that do “not give equal weight to equal benefits, whoever receives them,” but instead give more weight to “benefits to the worse off”⁸⁰—only discount benefits to those other than the worst off and do not fail to count them entirely. Depending on how much priority is attached to helping the worst off, the unfairness of the new distribution may in some instances be outweighed by the gain in organs available. Therefore, even for those most concerned with distributional justice, organ markets may, in some instances, be not only morally acceptable but morally desirable.

IV

CONCLUSION

One of the things that is most exciting about this issue of *Law and Contemporary Problems* is that it attempts to get beyond the typical black-and-white debate of supporting or opposing organ markets into the finer grey normative and regulatory-design questions about what kinds of market mechanisms are most appropriate. I have shown how some of the key arguments in the debate about whether to permit organ markets—relating to corruption, crowding out, coercion, exploitation, undue inducement, paternalism, unfair organ distribution—can be used to recommend or oppose particular attempts at regulating organ markets. Unfortunately, but unsurprisingly, these arguments do not push uniformly in favor of or against a particular regulatory proposal, such that we must still determine which of these normative reasons to support and how strongly in determining which regulations are most desirable. There are also formidable empirical questions about the effectiveness of various forms of regulation that I have highlighted in making such an evaluation. These are questions that will likely only be answered through some amount of policy experimentation.

I have also shown some complications in the frequent assumption made by those opposed to ability or willingness-to-pay allocation systems: At least as to cases of directed donation to family members or friends these opponents may have erroneously assumed that the distribution of organs in systems where compensation is prohibited is itself a just baseline against which to measure the

may not be right answers.

80. E.g., Derek Parfit, *Equality and Priority*, 10 *RATIO* 202, 213 (1997).

distribution that results when compensation is permitted.

This article has quite explicitly been pitched at the level of how rational analysis can help with policy choice. The emphasis has been on articulating public reasons and the regulations they can and cannot support. Of course, actual legislative choice happens in a quite different space—one featuring not only logrolls, horse trades, and special-interest lobbying, but also considerable constraint from “yuck factors” and preferences of the governed that may not meet the criteria for public reason or may not even be reflected upon. In their article in this issue, Christopher Robertson, David Yokum, and Megan Wright instead try to gauge public opinion and also what motivates it on various potential reforms.⁸¹ One cannot, however, analyze this divergence and the related question of when the political theory should bow to public opinion, unless one has already undertaken the kind of analysis I have offered here. Moreover, if one thinks that these kinds of preferences can or should be engaged and potentially altered, this roadmap will provide useful for that purpose as well.

81. Christopher T. Robertson, David V. Yokum & Megan S. Wright, *Perceptions of Efficacy, Morality, and Politics of Potential Cadaveric Organ Transplantation Reforms*, 77 LAW & CONTEMP. PROBS., no. 3, 2014 at 101.