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The Man who Removes a Mountain Begins by Carrying Away Small Stones: *Flynn v. Holder* and a Re-Examination of The National Organ Transplantation Act of 1984

Ryan Upchurch

I. Introduction

Prior to 1900, transplants of bodily matter had already begun in the form of blood transfusions.¹ Shortly thereafter in 1905, the first cornea transplant was accomplished.² However, the first successful organ transplant is said to have taken place on December 23, 1954 in Boston, Massachusetts.³ Richard Herrick, who was only 23 at the time, received a kidney from his identical twin brother, Ronald, and went on to live for another eight years.⁴ Ever since this time, and perhaps even earlier, human beings have held potentially great value in the organs that compose their bodies. As organ transplants became more common, this value presumably rose. This would become especially true once donors outside of the patient's immediate kin were factored into the equation.

The organ commodification debate has been at the forefront of bioethical thought ever since. Naturally, there are many arguments to be made against legalizing the sale of human organs. To some the ramification from someone "purchasing life" through buying a requisite organ is morally reprehensible.⁵ Fears would abound that the poor would be taken advantage of by the rich, selling their organs in an attempt to escape their downtrodden economic situation.⁶

¹ Altman, Lawrence K., *The Ultimate Gift: 50 Years of Organ Transplants*, The New York Times, December 21, 2004.

² *Id.*

³ *Id.*

⁴ *Id.*

⁵ Steve P. Calandrillo, *Cash for Kidneys? Utilizing Incentives to End America's Organ Shortage*, 13 GEO. MASON L. REV. 69 (2004).

⁶ *Id.*

All the while, these poor donors would have little to no concept of the consequences of such a decision to sell.⁷ In fact, they may even become a drain on the U.S. healthcare system later on due to complications from such transactions.⁸

Of course, this only represents one side of the often heated debate. Thousands upon thousands of people remain on organ transplant waiting lists in the U.S. without a successful match. For instance, almost 83,000 Americans are on the national waiting list for kidneys alone and roughly 13 of them will die each day.⁹ This total has increased almost a third since just the end of 2005 when 65,000 was the estimated total.¹⁰ In effect, prohibiting compensation for organs is lessening the chances of survival for these waitlisted patients and often hastening their death by hindering supply. Nevertheless, Congress fell to the former side of this debate and subsequently enacted legislation.

Since Congress' decision, time has shown that an altruistic system for organ donation has not been successful. Change is needed before the gap between those on waiting lists and the available number of organs grows even larger than it already has. Compensation for organ donation should be legalized in the United States. Some of the deeply held fears regarding such a decision are no longer relevant. In addition, more lives will be saved with compensation increasing the supply of organs than are without.

When Congress chose to address this issue almost thirty years ago, the state of organ transplantation was markedly different. Now organ recipients live longer and quality of life post-transplant has improved. Nevertheless, the number of those in need grows larger as supply lags behind. A recent decision by the Ninth Circuit has somewhat blurred the lines further

⁷ *Id.*

⁸ *Id.*

⁹ Perry, Mark J., and Sally Satel, *Compensate Organ Donors?* The Herald Sun, March 8, 2010.

¹⁰ *Id.*

between compensating certain portions of the body and not doing so with others. It has advanced questions of fundamental fairness for those afflicted with diseases of prohibited body parts. This judicial decision reinvigorated the debate and has brought it into a more modern context.

Several elements and theories of bioethical analysis lend support to organ commodification. Some of these theories have been developed recently, well after the statutory ban on compensation. Whether individually or societal based, these theories suggest that compensation for organs is the better way to lean in this debate.

Other countries, such as Iran, have experimented far more than the United States has in the past few decades by offering various forms of compensation. In general, they have seen substantial success in increasing the available supply of organs in their countries. These policies often involve offering compensation well beyond just the cost of the particular procedure. Furthermore, these programs have had other positive by-products such as lessening transplant tourism and stemming the spread of disease.

Adopting a similar approach in the United States would provide comparable results. Supply of organs would be increased and more matches found. Analogous derivatives would be seen in curtailing transplant tourism. Not only would legalizing compensation for organs help to halt any domestic underground market, but it would also likely put a dent in the international black market where American citizens are generally thought to make up a large portion of the clientele.

II. Statutory and Judicial Responses to the Organ Commodification Debate

A. National Organ Transplantation Act of 1984 (“NOTA”)

In 1984, Congress enacted the National Organ Transplantation Act (“NOTA”).¹¹ NOTA itself explicitly prohibited the sale/purchase of human organs. The statute defined “human organ” as any 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.¹² This issue was addressed statutorily in 1984 specifically for several reasons.

NOTA began with the intentions that life-saving organs should never have to be purchased and they should be a “gift” to the recipient.¹³ Other reasons for addressing the issue then included increased media attention of individuals’ plights to obtain organ transplants, which they were having great difficulty achieving.¹⁴ Moreover, improvements in surgical techniques and the development of immunosuppressant drugs led to the statute’s enactment.¹⁵ From the Senate report, it is clear that Congress was perhaps most concerned with the distributive justice element of organ transplants. This was demonstrated in the plain text when it stated, “The Committee believes that individual pleas through television and newspaper articles, while commendable in bringing to public attention the urgent circumstance of one person’s need, may be counterproductive to the needs of many others requiring organ transplantation.”¹⁶ Congress felt that allocation would be fairer through donor registries and waiting lists.

As Representative Waxman stated during the time of enactment, “If [people are allowed to sell their kidneys], I believe our efforts to promote voluntary organ donations would collapse, and health risks to transplant patients would greatly increase. Human organs should not be

¹¹ 42 U.S.C. §274(e) (1984).

¹² 42 U.S.C. §274(e) (1984).

¹³ Calandrillo, at 99.

¹⁴ S. Rep. No. 98-382, at 13 (1984), 1984 U.S.C.C.A.N. 3975 at 3979.

¹⁵ *Id.*

¹⁶ *Id.*, at 14.

treated like fenders in an auto junkyard.”¹⁷ Waxman’s statement made the assumption that voluntary organ donations would suffice to combat the problem of insufficient supply.

Unfortunately, this was not proven true as the problem has only increased over time, in spite of increased surgical technology. This debate was recently brought to the forefront once more within the specific context of bone marrow transplants.

B. *Flynn v. Holder* and the Legalization of Certain Bone Marrow Transplants

1. The Difficulty in Matching Bone Marrow

In April 2010, Kumud Majumder lost his son and only child, Arya, to leukemia.¹⁸ Arya, whom Kumud described as “an angel who transformed my life” was only eleven years old when he passed.¹⁹ His death was in part hastened by the inability to find a bone marrow match for transplant. Unfortunately, stories resembling Kumud’s are far too commonplace. In excess of 100,000 Americans are diagnosed annually with serious blood and bone marrow disorders.²⁰ Many of these individuals require a transplant of bone marrow cells to combat their particular malady.

Finding matches for bone marrow recipients is an often difficult proposition because there are various types of proteins present on bone marrow stem cells. Family members generally offer the best probability for a match, but even then the estimated success rate of 30% is paltry at best.²¹ The difficulty in matching blood stem cells has led to striking statistics for those in need. Of those 100,000 Americans, roughly 40,500 are adults who will be diagnosed

¹⁷ *National Organ Transplant Act: Hearing on H.R. 4080 Before the Subcomm. on Health of the H. Comm. on Ways & Means*, 98th Cong., 2d Sess. 26 (1984).

¹⁸ *Let's Compensate Bone Marrow Donors*, USA Today Forum (March 3, 2012, 3:00 PM), http://www.usatoday.com/news/opinion/forum/2011-02-09-majumder11_st_N.htm

¹⁹ *Id.*

²⁰ Rowes, Jeff, and John Wagner, *Give These Donors a Bone*, The New York Times, January 8, 2010.

²¹ *Id.*

specifically with leukemia.²² In addition, another 3,500 children will share the same fate.²³

Between 2,000 and 3,000 Americans die every year from a failure to achieve a suitable bone marrow match for their blood-based illness.²⁴

Statistics also illustrate varying success rates for people of different racial groups. Those of mixed-race parentage and African-American descent tend to possess a mix of African, Caucasian, and Native American genes, making matches even rarer.²⁵ Consequently, Caucasian patients are successfully matched roughly 70% of the time.²⁶ Meanwhile, this number drops to only about 40% for those Americans of African descent.²⁷ The numbers inarguably point to a decreased chance of finding a match for African-Americans and those individuals of mixed-race parentage. A potentially effective means of combating these numbers is to increase the potential number of donors by offering some form of compensation. However, until the *Flynn v. Holder* decision came down, compensation for all forms of bone marrow transplant were thought to be prohibited by NOTA.²⁸

2. Compensation is Legal under the Apheresis Method

On December 1, 2011, the Court of Appeals for the Ninth Circuit handed down its decision in *Flynn v. Holder* that compensation for bone marrow stem cells derived from the “peripheral blood stem cell apheresis method” (“apheresis”) was legal.²⁹ Additionally, the Court

²² Will, George F., *The 9th Circuit’s Proper Call on Bone Marrow Donations*, The Washington Post, December 28, 2011.

²³ *Id.*

²⁴ Satel, Sally, *A Lifesaving Legal Ruling on Organ Donation*, The Wall Street Journal, December 6, 2011.

²⁵ *Id.*

²⁶ Rows, *Give These Donors a Bone*.

²⁷ *Id.*

²⁸ 42 U.S.C. §274(e) (1984) (Bone marrow is included under the statutory definition of “human organ”).

²⁹ *Flynn v. Holder*, 665 F.3d 1048 (9th Cir. 2011).

held that compensation was still prohibited for donation of bone marrow through the more antiquated method of aspiration.³⁰

The two methods of donation contain substantial differences and these contained the distinctions the Court used in arriving at its ruling. The Court described aspiration as a “painful, unpleasant procedure” in which thick needles were inserted into the cavities of the anesthetized donor’s bones in order to extract the soft, fatty substance from within commonly known as bone marrow.³¹ This was the procedure for bone marrow donation in place when Congress enacted the National Organ Transplant Act (NOTA).³² However, the newer method of apheresis has been developed since. Under the apheresis method, the donor is first injected for five days with “granulocyte colony-stimulating factor” medication prior to the actual procedure, which increases the amount of blood stem cells that exit from the marrow and enter into the bloodstream.³³ Afterwards, a needle for collection is placed into the donor’s vein.³⁴ The donor’s blood is subsequently run through an apheresis machine. The machine separates out the blood stem cells. The remaining blood is then injected back into the donor. The stem cells taken from the donor will be replaced naturally by his/her body within three to six weeks.³⁵ The apheresis method of extraction is more common presently, being used in about two-thirds of all donations (the remaining third still coming through the aspiration method).³⁶

On its face, NOTA prohibits any compensation for bone marrow.³⁷ However, the Ninth Circuit did not believe that the statute was applicable to the apheresis method of bone marrow

³⁰ *Id.*, at 1057.

³¹ *Id.*

³² *Id.*

³³ *Id.*, at 1052.

³⁴ *Id.*

³⁵ *Id.*

³⁶ *Id.*, at 1051.

³⁷ 42 U.S.C. §274(e) (1984).

donation because the Court likened the apheresis method to an ordinary blood donation.³⁸ Blood and its derivatives were specifically intended not to fall under NOTA's scope.³⁹ As the Court pointed out, the only difference between an ordinary blood donation and a donor undergoing the apheresis method is that the latter involves the donor sitting for longer as well as the apheresis machine separating stem cells from the blood.⁴⁰ When the apheresis machine is used to sort and collect plasma or platelets the procedure is referred to as a "blood donation" or a "blood plasma donation."⁴¹ When it is used to separate out blood stem cells, it is commonly known as a "bone marrow donation."⁴²

3. The Court's Distinction

The question then remained whether commonly referring to a procedure as a "bone marrow donation" actually entailed that bone marrow itself was involved. Under the apheresis method, none of the soft, fatty substance that is extracted through aspiration is present.⁴³ Rather, the apheresis machine merely separates *blood stem cells* from the *blood* that is extracted.⁴⁴ For the Court, the critical components were the actual material separated out and the location from which the material came. The donor would be providing his/her blood stem cells, not their bone marrow. Furthermore, these blood stem cells would come from the bloodstream, not from within the cavities of the donor's bones. If compensating donors for their stem cells through this method was banned, the Court reasoned then that all compensated blood donations must be

³⁸ *Flynn v. Holder*, 665 F.3d 1048 (2011).

³⁹ S. Rep. No. 98-382, at 16-17 (1984) (prohibition was not "meant to include blood and blood derivatives"); H.R. Rep. No. 98-1127, at 16 (1984) (Conf. Rep.) ("the term 'human organ' is not intended to include replenishable tissues such as blood or sperm").

⁴⁰ *Flynn*, at 1058.

⁴¹ *Id.*

⁴² *Id.*

⁴³ *Id.*

⁴⁴ *Id.*

outlawed as well. Yet, the Senate Report had plainly excluded blood from the language of the statute.⁴⁵

NOTA provides that the term “human organ” means the human (including fetal) kidney, liver, heart, bone marrow...etc. (or any subpart thereof).⁴⁶ As a result, the government raised the issue as to whether the blood stem cells fell under the statutory language of “or any subpart thereof” in reference to not just organs in their entirety but any subpart of them as well.⁴⁷ These blood stem cells do after all originate within the bone marrow before naturally moving into the bloodstream. The Court did not find merit in this argument because the theoretical distance between actual bone marrow and the bloodstream was simply too great.⁴⁸ Further buttressing the Court’s reasoning, the drafters of NOTA could not have had the apheresis in mind because it had not yet been developed.⁴⁹

Since the decision in December, the Court of Appeals for the Ninth Circuit has declined the Obama Administration’s request to reconsider its ruling.⁵⁰ Consequently, the Administration had 90 days from that time to consider petitioning the Supreme Court of the United States.⁵¹ Regardless, this is a ruling that should remain and one which the other circuit courts would be wise to follow. The 9th Circuit’s analogy of peripheral blood stem cell apheresis to other blood donations appears strong. Since apheresis does not fall under the scope of NOTA, there is nothing to prevent payment for such donations. It is almost guaranteed that the donor pool for

⁴⁵ S. Rep. No. 98-382, at 16-17 (1984), 1984 U.S.C.C.A.N. 3975 at 3982.

⁴⁶ 42 U.S.C. §274(e) (1984).

⁴⁷ *Flynn*, at 1057.

⁴⁸ *Id.*

⁴⁹ *Id.*

⁵⁰ Associated Press, *Court won’t Reconsider Bone Marrow Payments Ruling*, Fox News, http://www.foxnews.com/health/2012/03/28/court-wont-reconsider-bone-marrow-payments-ruling/?cmpid=cmt_y_7BlinkBack%7D_Court_won't_reconsider_bone_marrow_payments_ruling (March 28, 2012).

⁵¹ *Id.*

this method of bone marrow donation will increase and thereby lives will be saved by matches that would not have occurred beforehand.

4. Questions Raised by the Court's Holding

The initial question following the *Flynn* ruling was what does this mean for those patients with afflictions of other organs? Does this holding offer them any renewed hope of seeing their particular donor pools increase? The short answer is no. Since the Ninth Circuit found that apheresis does not fall under NOTA, the statute was not affected in any manner. The holding was therefore limited strictly to this particular form of bone marrow stem cell donation for transplant.

Flynn does raise an interesting hypothetical, which concerns fundamental questions of fairness involving compensation for organs. Recipients of any organ transplant currently require immunosuppressant medications to prevent their body from attacking the new organ. However, a highly successful, albeit admittedly small Stanford University study, recently challenged this prevailing knowledge with kidney recipients.⁵² Patients in the study subsequently received a bone marrow transplant from the same donor as their kidney, using the apheresis method.⁵³ They were able to then be removed from these expensive and potentially dangerous immunosuppressant medications.⁵⁴ In fact, eight of the twelve patients have been off the medications completely since, while the others showed substantial progress.⁵⁵ According to *Flynn*, compensation for the donors' peripheral blood stem cells would be legal while compensation for their kidneys would still be prohibited by NOTA. The question that then arises is why a donor would be allowed to be compensated for one part of an overall process, but

⁵² Frodsham, George, *Stem Cell Therapy Hope for Kidney Transplant Patients*, BioNews, (October 10, 2011).

⁵³ *Id.*

⁵⁴ *Id.*

⁵⁵ *Id.*

prohibited for the other part. The kidney provides the patient with the chance at extended life. However, the bone marrow transplant offers the recipient the ability to forgo medications laden with severe side effects and extreme cost. Immunosuppressant medications generally run anywhere between \$2,000 and \$4,000 per month.⁵⁶

Additionally, *Flynn* raises questions about why patients with certain afflictions may benefit from a donor pool increased by compensation while others would not. If someone were unfortunately diagnosed with leukemia, they may now have a better chance of getting the bone marrow transplant they need because of compensation being legalized. On the other hand, if someone were diagnosed with kidney disease they would continue to see a largely decreasing chance of a match, in part because compensation for their afflicted organ is still banned under NOTA.⁵⁷

Twenty-eight years after the enactment of NOTA, and in light of the *Flynn* decision, it may be time to once again reassess this prohibition and decide whether it truly offers the best solution given the current technology of organ transplantation and state of waiting lists. It is important to weigh out the competing bioethical elements and theories within this context. Additionally, while the United States policy on compensation for organ transplants has been wholly stagnant for almost three decades, many other countries have been more experimental in their approaches to this problem. Although not necessarily definitive, a look at other countries' potential solutions could provide an idea of what might happen if they were effectuated here. The development of a peripheral blood stem cell market under the apheresis method will similarly provide a prototype of what a market for other organs may in fact resemble.

⁵⁶ U-M Transplant Center: Kidney Transplant, *Financial Aspects*, <http://www.michigantransplant.org/kidney/financial.htm>

⁵⁷ See, "Induced Immune Tolerance for Kidney Transplantation- Letter to the Editor," N. ENG. J. MED. 365;14 (October 6, 2011) (For an additional and much more technical report from the study's authors themselves).

Undoubtedly, a reassessment of NOTA and the prohibition on compensation is warranted given the current state of transplant waiting lists.

III. Bioethical Analysis of the Organ Commodification Debate

Several elements of bioethical analysis find themselves constantly invoked regarding the organ commodification debate. The two most important are autonomy and distributive justice. These two elements generally find themselves competing within this context. Proponents of organ compensation use autonomy to support their arguments. Conversely, opponents of compensation lean heavily upon distributive justice in order to support their claims. It should also not be understated that compensation for organ donations finds itself equally supported by both societal-based and individually-based bioethical theories. Utilitarianism has long been the bioethical theory most widely used to support organ commodification. However, newer theories of bioethical analysis have developed within the last few decades that also lend support to this concept. These theories include Narrative Bioethics and the Law and Economics theory. It is important to first observe the conflict between the two main competing elements.

A. Autonomy vs. Distributive Justice

Autonomy is one of the fundamental principles of bioethics and simply represents the concept that independent actions and choices of the individual should not be constrained by others.⁵⁸ However, distributive justice is also a fundamental bioethics element and runs contrary to autonomy. Distributive justice represents the idea that benefits and burdens ought to be distributed equitably, that resources ought to be allocated fairly, and that one ought to act in such a manner that no one person or group bears a disproportionate share of benefit or burdens.⁵⁹

⁵⁸ Furrow, Barry, Thomas Greaney, Sandra Johnson, Timothy Jost, and Robert Schwartz, *Bioethics: Health Care Law and Ethics*, 6th Ed., Thomson West, St. Paul, MN, 2008, at 4.

⁵⁹ Furrow, at 4.

When placed into the context of organ compensation, these elements clearly are in conflict.

Proponents of autonomy would argue that since organs are of one's own property people should be free to do as they please with them, including selling them. Proponents of a more distributive justice based system, as it currently exists, would claim that there needs to be a mechanism in place to promote fairness in the process of deciding who gets each available organ. Presently in the U.S., the waiting lists are maintained by the United Network of Organ Sharing ("UNOS").⁶⁰ UNOS possesses the contract to operate the Organ Procurement and Transplant Network ("OPTN").⁶¹ The average wait time for a kidney for a U.S. resident varies from anywhere between two and ten years.⁶² This all depends upon blood type, antibody level, organ availability, among other factors.⁶³ If a patient chooses to decline an available matching organ, they do not then retain their spot for the next available organ. In fact, they may endure an even further waiting time if this occurs.⁶⁴

Since the enactment of NOTA, this distributive justice based model has only seen the number of patients increase while supply has lagged further behind. Although everyone may have an equal chance at receiving an organ, too many people are unnecessarily dying while waiting. If an individual has the means to acquire an available organ, they should be able to do so. Introducing compensation would only serve to increase the supply of available organs. Those patients who are better off financially would undoubtedly then have an advantage towards acquiring the requisite organ. Nevertheless, more lives would be saved in total than are

⁶⁰ Harris, Jacqueline, RN, *How the Transplant Waiting List Works*, Kidney Times, (April 2011), <http://www.kidneytimes.com/article.php?id=20110419164454>

⁶¹ *Id.*

⁶² *Id.*

⁶³ *Id.*

⁶⁴ *Id.*

currently. This objective of saving more lives as a whole leads directly into an examination of utilitarianism.

B. Utilitarianism

The most important traditional theory for compensation of organs comes in the form of utilitarianism. Utilitarianism essentially provides that the proper act is the one that maximizes the aggregate happiness of the whole society.⁶⁵ For those proponents of reform to the current U.S. organ transplantation system, utilitarianism often makes up the backbone of their arguments. Clearly, organ transplant waiting lists are only growing in size while supply is declining or stagnating. By legalizing some compensation for organs, the donor pool for each would likely grow. How substantially it might grow is debatable but statistics from other countries suggest that compensation would cause the number of donors to increase greatly.⁶⁶ The tradeoff under the utilitarian view would be those in society who would be harmed from compensation for organs being legalized. Generally, this is thought to be the exceptionally poor who would donate while not receiving adequate compensation for their efforts. Examples of this are also prevalent in other countries.

However, this focuses largely on the two extremes. It is the middle ground under which utilitarianism theory would shift the balance in favor of legalizing organ compensation. The middle ground is composed of those individuals who are not exceptionally poor and have some altruistic motivations. Nevertheless, altruism alone may not be enough by itself to inspire them to donate. The addition of compensation into the equation subsequently shifts them from not donating towards donating. This class of donors would receive their compensation while also receiving an altruistic benefit. In turn, the recipient of their organ would get the gift of extended

⁶⁵ Furrow, at 6.

⁶⁶ See *infra*, pp. 15-19.

life. In this simplistic analysis, utilitarian theory appears to show that compensation for organs would increase the aggregate happiness of the whole society in comparison to the current state of affairs.

C. More Recently Developed Theories of Bioethical Analysis

Just as the organ commodification debate is constantly evolving so too are the bioethical approaches towards such issues. Critics of more traditional principle-based ethical analyses have argued that not everything should be parsed into oft-used bioethical elements, such as autonomy, distributive justice, and beneficence.⁶⁷ Several new theories have arisen within the last decade, which offer interesting perspectives on this dilemma. A few of them are worth a cursory glance in order to get a general idea of how this debate may sit within their particular frameworks.

1. Narrative Bioethics

The first relevant new theory is that of narrative bioethics. Narrative bioethics suggests that a great deal can be learned from the stories of those involved in bioethical matters.⁶⁸ The argument is that if those involved are able to tell their personalized stories, the proper ending to those stories will become readily apparent.⁶⁹ One obvious example has already been addressed in the context of the *Flynn* case. Upon hearing Kumud Majumder's story of his only child, Arya, it would become blatantly obvious to most that something should be done. Before Arya passed that would have involved finding a match for him, even if it meant offering compensation to potential donors to increase his chances. Unlike the broad-based element approaches and such society-wide theories like utilitarianism, narrative bioethical theory offers an important individual-based approach to this and other debates. It seems clear that under narrative bioethics, organ

⁶⁷ Furrow, at 11.

⁶⁸ *Id.*

⁶⁹ *Id.*

compensation would garner great support for legalization as people's various stories of suffering without any choice in the matter were further analyzed and publicized.

2. Law and Economics Theory

Another newer theory is the law & economics theory of bioethics analysis. The law & economics theory applies traditional economics models to bioethics, generally favoring private, rather than governmental, resolution of bioethical disputes.⁷⁰ Moreover, this theory tends to be more libertarian in nature, favoring authority for competent adults to make virtually any non-coerced decisions concerning medical treatment.⁷¹ Once again, this tends to favor the concept of compensation for organ transplants. There is certainly a strong presence of individual autonomy underlying this theory. It is worth noting as well that the law and economics theory is generally skeptical about government's paternalistic role in regulation for any purpose other than providing individuals with the ability to enter into private agreements concerning their own lives.⁷² This theory would then counsel in support of very little government regulation and individuals brokering deals largely separate from any outside interference, a complete shift from the current state of affairs

The main point is clear in both theories. Compensation for organ donations fits snugly within the frameworks of each. Also, there is a strong argument to be made that organ compensation is called for under the more traditional utilitarianism theory of analysis. The long-standing principle of autonomy rests at the core of almost any argument for compensation. It is explicit that organ commodification garners great support from several bioethical philosophies.

IV. Compensatory Approaches Abroad and their Immediate Successes

⁷⁰ Furrow at 12.

⁷¹ *Id.*

⁷² *Id.*

It is very plausible that the peripheral blood stem cell market will offer an expansive illustration at what organ markets could look like if compensation were legalized in the United States. However, other countries have already experimented with various forms of organ compensation. These also provide glimpses of legalized compensation. The most prominent example would be Iran. However, Saudi Arabia and Israel both have offered various forms of compensation more recently.

A. Iran

Iran is unique in that it has in place a government regulated compensatory program for living kidney donors. This program originated in 1988 and is carried out under the authority of an organization known as the Dialysis and Transplant Patients Association (“DATPA”).⁷³ Once suitability is determined, transplants are performed in state-authorized hospitals and funded by the government.⁷⁴ The transplant surgeons have no input in selecting a donor nor do they receive any extra benefits from the procedure.⁷⁵ This serves to eliminate conflicts of interest for the physicians. Potential donors are also not permitted to contact anyone on the waiting list.⁷⁶

The donor receives compensation equal to US\$1200 following donation from the State.⁷⁷ However, compensation for the donor is not limited to this fixed amount. Donors always meet the recipient prior to the operation.⁷⁸ It is at this time when donor and recipient are able to negotiate other payments with the support of DATPA.⁷⁹ For those recipients too poor to pay the

⁷³ Ahmed, Ejaz, Anwar Naqvi, Adibul Hasan Rizvi, and Naqi Zafar, *Regulated Compensation Donated in Pakistan and Iran*, 14 *Current Opinion in Organ Transplantation* 126 (2009).

⁷⁴ *Id.*

⁷⁵ *Id.*

⁷⁶ Major, Rupert. *Paying Kidney Donors: Time to Follow Iran?*, *McGill Journal of Med.* 11(1): 68 (2008).

⁷⁷ Ahmed at 126.

⁷⁸ *Id.*

⁷⁹ *Id.*

donor, DATPA seeks support from charitable organizations to cover costs.⁸⁰ Donors are also provided one year of free healthcare afterwards.⁸¹

1. Success of the Program

By most accounts, the Iranian program from compensation has been very successful. Iran claimed to have eliminated its renal transplant waiting list by 1999, just eleven years after the program's implementation.⁸² This could be partially explained however by a much more limited access to dialysis in Iran as opposed to other countries.⁸³ Nevertheless, it should not overshadow the strides Iran's program has made. By the end of 2005, 19,609 renal transplants were performed in Iran and a staggering 15,356 of them were from living-unrelated donors.⁸⁴ This compensatory model did not prohibit Iran from developing a deceased-donor organ transplantation program either (which was not in existence before the compensatory model was established).⁸⁵ There is also some consensus that the launching of Iran's program halted many illegal and commercial renal transplants.⁸⁶ Previously, many Iranian patients without a living related donor would travel to India or Europe to receive transplants.⁸⁷ This contributed greatly to the spread of Hepatitis, among other diseases.⁸⁸ Success can also be seen in Iran's place on the global rankings of living kidney donation rates. Following the legalizing of compensation, Iran immediately jumped up to third overall on this list.⁸⁹

⁸⁰ *Id.*

⁸¹ *Id.*

⁸² Ghods, Ahad, and Shekoufeh Savaj, *Iranian Model of Paid and Regulated Living-Unrelated Kidney Donation*, *Clinical J. Am. Soc. Nephrol.* 1: 1136-1145 (2006).

⁸³ Ahmed at 127.

⁸⁴ Ghods at 1136.

⁸⁵ *Id.*, at 1140.

⁸⁶ *Id.*

⁸⁷ *Id.*

⁸⁸ *Id.*

⁸⁹ Ching, Leong, Alex He Jingwei, and Allen Lai Yu-Hung, *Living Organ Transplantation Policy Transition in Asia: towards Adaptive Policy Changes*, *Global Health Governance* Vol. III, No. 2 (Spring 2010), 7.

2. Motivations of the Donors

Due to the success of Iran's program the motivations of these living unrelated donors are important to examine. Undoubtedly, compensation was important to the donors. In one study, 37.3% stated their motivation for donation was solely financial, but almost 61% offered a mix of compensation and altruistic intentions as their incentive.⁹⁰ Prior to their discharge from the hospital, 86.5% of donors reported complete satisfaction with their decision.⁹¹ Three-quarters of the donors wanted to be informed of the outcome.⁹² Additionally, two-thirds of the donors were willing to make some sort of connection with the recipient following the transplantation.⁹³ Compensation was not always the sole factor in donors' decisions, but the supply was certainly increased by those for which it was the single reward. It could also easily be presumed that compensation was the tipping point for at least some portion of the 61% who had mixed motivations to donate.

B. Saudi Arabia

Other countries have adopted similar compensatory approaches as Iran, including Saudi Arabia. Saudi Arabia passed a law in 2007, which allowed the government to offer payment for organ donations.⁹⁴ The government offers substantial compensation in the form of 50,000 riyals, which is equivalent to roughly US\$13,000 as well as other benefits such as life-time medical care.⁹⁵ It was believed that this program would similarly curb illegal and transplant tourism for Saudi citizens.⁹⁶ Success of the new Saudi Arabian program is illustrated by its quadrupling of

⁹⁰ *Id.*

⁹¹ *Id.*

⁹² *Id.*

⁹³ *Id.*

⁹⁴ Ching, at 8.

⁹⁵ *Id.*

⁹⁶ *Id.*

the country's prior living kidney donor rate.⁹⁷ This catapulted Saudi Arabia to number one on the global rankings of living kidney donations.⁹⁸

C. Israel

Israel has placed greater focus on increasing organ donors in recent years as well. Recently enacted legislation passed by the Knesset allowed for the State to provide live donors with a fixed financial compensation package.⁹⁹ The package was determined by the Health Ministry and intended to largely compensate for lost earning potential due to surgery as well as recuperation.¹⁰⁰ The compensation includes a fixed sum of approximately US\$5,500, free health insurance for several years afterwards, the cost of the surgery, and psychiatric treatment.¹⁰¹ Living donors did not begin to receive these benefits, including the financial compensation until August 2010, though.¹⁰² In 2011, Israel had 117 kidney transplants from living donors, which was an astonishing 64% more than it had the previous year.¹⁰³ Many believed that the newly enacted financial compensation package was responsible for this marked increase.¹⁰⁴

V. Compensation for Organ Donation should be legalized within the United States

A. Remuneration would Alleviate the Supply Problem

NOTA has been in effect in the U.S. for almost three decades. Therefore, the U.S. has a lengthy snapshot of what total prohibition for organ compensation entails. By most statistics, the

⁹⁷ *Id.*

⁹⁸ *Id.*

⁹⁹ Ratzlav-Katz, Nissan, *New Legislation Encourages Organ Donation*, Arutz Sheva (March 25, 2008), <http://www.israelnationalnews.com/News/News.aspx/125675>

¹⁰⁰ *Id.*

¹⁰¹ The Straits Times (November 12, 2008), *Compensation: What Organ Donors get in Some Countries*, AsiaOne, <http://www.asiaone.com/Health/News/Story/A1Story20081112-100077.html>

¹⁰² Even, Dan, *Dramatic Increase in Organ Transplants Recorded in Israel in 2011*, Haaretz (January 12, 2012), <http://www.haaretz.com/print-edition/news/dramatic-increase-in-organ-transplants-recorded-in-israel-in-2011-1.406824>

¹⁰³ *Id.*

¹⁰⁴ *Id.*

situation is only growing grimmer. The number of living donors has progressively declined over the past five years.¹⁰⁵ As Andrew Klein, M.D. and Director of Cedars-Sinai Medical Center's Comprehensive Transplant Center put it, "this decline has resulted in a widening gap between the number of organs available for transplant, and the number of patients who are awaiting a donor organ."¹⁰⁶ He aptly added, "Ironically, the single largest factor in today's donor organ shortfall is that solid organ transplants have become so successful."¹⁰⁷ In other words, organ transplantation technology has rapidly increased the success of operations and the duration of life enjoyed by recipients afterwards, but supply has not kept up.

As the total of people on transplant waiting lists dramatically increases over time, the percentage of them able to receive a new organ largely decreases. Some estimates show that only 20 percent of those in need for a kidney transplant receive the necessary operation.¹⁰⁸ This percentage is a marked decrease from the early 1990s when almost 50 percent of those on the waiting list would receive at least one operation.¹⁰⁹ Using 1996 as a baseline, patients who were waitlisted for kidneys in 1998, 2000, 2002, and 2004 were respectively 15%, 27%, 37%, and 42% less likely to receive the necessary transplant.¹¹⁰ Recently, even deceased donor transplantation rates have been declining.¹¹¹ Organs from deceased donors decreased in 2008 for the first time.¹¹²

¹⁰⁵ *Science Daily*, "Success Rates for Organ Transplants are Increasing, but Organ Donations are Decreasing, Study Shows," *Science News* (March 22, 2010), <http://www.sciencedaily.com/releases/2010/03/100322092051.htm>

¹⁰⁶ *Id.*

¹⁰⁷ *Id.*

¹⁰⁸ *Id.*

¹⁰⁹ *Id.*

¹¹⁰ *Id.*

¹¹¹ Charnow, Jody A., *Deceased Donor Transplantation Rates Declining*, *Renal and Urology News* (February 10, 2012, 12:00pm), <http://www.renalandurologynews.com/deceased-donor-transplantation-rates-declining/article/222675/>

¹¹² *Science Daily*, "Success Rates for Organ Transplants are Increasing, but Organ Donations are Decreasing, Study Shows."

The issue is no secret; it is merely one of supply. As a result, thousands continue to die each year awaiting their chance at a match from an unsatisfactory number of donors. From January to October of 2009, 3,363 Americans died while waiting for a kidney transplant.¹¹³ During the same period, 1,154 more died waiting for a new liver.¹¹⁴ In those countries which have adopted compensatory programs supply has been alleviated to some extent, often with immediately evident progress. Legalizing compensation for body parts presently prohibited under NOTA would best increase the supply to meet patient demands. Subsequently, this would offer the greatest opportunity to maximize the number of donor matches.

B. The Human Body is already Commodified

The *Flynn* decision re-raised the issue of precisely which materials are prohibited from compensation and why. The anti-organ commodification side has often asserted that the sale of human body parts is morally repugnant. Representative Waxman's statement that human body parts should not be akin to fenders in an auto junkyard essentially conveyed this sentiment as much. However, NOTA explicitly excluded certain bodily materials from its scope, such as blood and blood derivatives.¹¹⁵ It also excluded replenishable tissues such as sperm and eggs.¹¹⁶

All of these materials are sold within the United States today. People are paid for blood, sperm, and egg donations regularly. With the addition of the *Flynn* decision, people can now be compensated for what are more commonly known as bone marrow donations too. It is still difficult to discern why sale of these materials is not considered morally repugnant in the same manner as kidneys or livers. Moreover, the replenishable aspect of such tissues does not seem to be important since liver transplants normally involve the donor's liver re-growing the portion

¹¹³ Tabarrok, Alex, "The Meat Market," *The Wall Street Journal* (January 8, 2010), 1.

¹¹⁴ *Id.*, at 2.

¹¹⁵ S. Rep. No. 98-382, at 16-17 (1984).

¹¹⁶ H.R. Rep. No. 98-1127, at 16 (1984).

that was donated.¹¹⁷ It appears that the prohibition is broadly intended to stop compensation for solid organs while allowing it for bodily fluids. The question remains however as to why such a distinction exists. The antiquated arguments of being morally reprehensible and of replenishability hold even less weight now than they maybe once did.

Not only have these arguments lost some of their luster, but questions of fundamental fairness continue to persist. The aforementioned kidney transplant hypothetical based upon the Stanford University study served to demonstrate how the lines between what could be compensated and what could not have become even more nuanced. Following from the *Flynn* holding, an individual suffering from leukemia most likely will have a better chance at finding a match since supply of bone marrow donations should increase due to compensation. Alternatively, an individual suffering from end stage renal disease will still have the same increasingly long-shot odds at receiving a kidney transplant. This is because the supply of kidneys will remain stagnant without compensation as the waiting list likely grows. A fundamental sense of fairness would impel that supply of donors not be limited for some simply because of what particular part of their body is afflicted, at least in lieu of a more convincing reason than moral reprehensibility.

C. Curtailment of the Black Market & Transplant Tourism

By increasing the supply of available organs in the United States through compensation, American citizens would have less reason to travel elsewhere to pay for an organ. For example, Aadil Hospital in Lahore, Pakistan advertises two transplant packages catered towards foreign patients: \$14,000 for the first transplant and \$16,000 for the second if the first organ fails.¹¹⁸ If

¹¹⁷ National Institute of Health, "Liver Transplant," <http://www.nlm.nih.gov/medlineplus/ency/article/003006.htm>

¹¹⁸ Carney, Scott, "Why a Kidney (Street Value: \$3,000) Sells for \$85,000," *Wired* (March 8, 2007), http://www.wired.com/medtech/health/news/2007/05/india_transplants_prices

demand dried up from foreign citizens, transplant tourism in these countries would take a major hit because brokers would fetch lower sums for organs they procure. Statistical information is difficult to come by for obvious reasons, but presumably American citizens make up a substantial percentage of the tourist patients seeking a new organ they cannot attain domestically. As one report about impoverished Bangladeshi villagers taken advantage of for their organs succinctly stated, “Most of those organs ended up transplanted into American citizens.”¹¹⁹ The black market for organs in other countries is not fueled by local patients. Rather, it is driven upwards and out of control by those American as well as European citizens who cannot acquire what they need domestically.¹²⁰ One estimate is that the black market accounts for as high as twenty percent of all kidney transplants worldwide.¹²¹ Nadley Hakim, transplant surgeon for St. Mary’s Hospital in London, offered an interesting take on this problem of the black market when he said, “this trade is going on anyway, why not have a controlled trade where if someone wants to donate a kidney for a particular price, that would be acceptable? If it is done safely, the donor will not suffer.”¹²² Within the past month, an indigent Chinese teenager sold his kidney so that he could purchase an iPad and iPhone.¹²³ The unnamed teenager now suffers from renal deficiency.¹²⁴ Sadly, the boy received roughly ten percent of what the buyer paid, with the rest

¹¹⁹ Dye, Lee, “Organs for Sale: Impoverished Bangladeshis Try to Sell Kidneys on Black Market, End up Poor and Ill,” ABCNews (March 16, 2012), <http://abcnews.go.com/Technology/organs-sale-living-cadavers-sell-kidneys-bangladesh-cash/story?id=15930876>

¹²⁰ See, Siddiqui, Taha, “Kidney Trade: Sell an Organ, Become Worse Off,” International Herald Tribune (January 2, 2012), <http://tribune.com.pk/story/315333/kidney-trade-sell-an-organ-become-worse-off/>

¹²¹ Gregory, Anthony, “Why Legalizing Organ Sales would Help to Save Lives, End Violence,” The Atlantic (November 9, 2011), <http://www.theatlantic.com/health/archive/2011/11/why-legalizing-organ-sales-would-help-to-save-lives-end-violence/248114/>

¹²² *Id.*

¹²³ Krumboltz, Mike, “Charges Filed against Five who Removed Teen’s Kidney,” Yahoo! News (April 6, 2012), <http://ca.news.yahoo.com/blogs/upshot/charges-filed-against-those-removed-teen-kidney-180938499.html>

¹²⁴ *Id.*

going to the surgeon and others involved in coordinating the operation.¹²⁵ If those American citizens with the means to purchase were not forced abroad to find an organ, it is very possible that stories like this would become much less commonplace.

However, legal compensation could also serve to limit the domestic black market as well. It would prevent situations such as that of “The Kidney Guy,” recently captured by the FBI.¹²⁶ Levy Izhak Rosenbaum, a Brooklyn man with strong ties to the Orthodox Jewish community, pled guilty to taking cash related to acquiring human organs for transplants.¹²⁷ Rosenbaum allegedly took payments of \$120,000 or more for brokering various kidney deals.¹²⁸ Rosenbaum’s case is important because it illustrates that legalizing compensation could also cut off the domestic black market as well. With the proper amount of regulation of a compensatory market, middle men or brokers like Rosenbaum would not need to exist.

The domestic black market does not just involve individual brokers like Rosenbaum, though. Whether aware or not, U.S. hospitals could be aiding a domestic black market by barely inquiring into the source of organs for transplantation due to the lucrative payments for performing such operations.¹²⁹ Donna Luebke, former board member at the United Network for Organ Sharing has said that many hospitals use staffers who might not look too hard for red flags.¹³⁰ If the staffer is not truly independent there are said to be “too many conflicts of interest.”¹³¹ If some hospital staffers are in on such illegal activity, they could also be largely stopped by legalizing compensation and with some regulation. Both the domestic black market

¹²⁵ *Id.*

¹²⁶ Maddux, Mitchel and Josh Margolin, “Kidney Broke Pleads Guilty,” New York Post (October 28, 2011), http://www.nypost.com/p/news/local/brooklyn/kidney_broker_pleads_guilty_9pf53omFrU1NrBGjnYL0aO

¹²⁷ *Id.*

¹²⁸ *Id.*

¹²⁹ “Do U.S. Hospitals push Organ Black Market?” CBSNews (July 30, 2009), http://www.cbsnews.com/2100-201_162-5197720.html

¹³⁰ *Id.*

¹³¹ *Id.*

and transplant tourism could be significantly hampered by legalizing organ compensation in the United States. The positive effects of this would once again far outweigh the negatives and more people would be helped rather than harmed.

VI. Conclusion

The *Flynn v. Holder* decision was remarkable for those in need of bone marrow transplants. Although the holding was expressly limited, these specific patients will be likely to see many more donors and thus, many more matches, in the near future. As a market begins to develop compensation could easily move well beyond \$3,000 in either housing subsidies or scholarships.¹³² Donors should then increase greatly and thus bolster further support for compensation of other organs. Once fully up and running, the peripheral blood stem cell market could give a functional picture of what organ markets in the U.S. would look like in practice.

As wonderful as the *Flynn* decision should turn out to be, it still left roughly the same debate on organ commodification that existed when NOTA was enacted. On the other hand, the evidence has moved drastically in the past thirty years towards compensation for organs. Organ transplant technology has become incredibly successful and recipients live longer than ever. However, the numbers on the waiting lists only continue to skyrocket. Meanwhile, supply drops continuously amongst living donors. The deceased donor rate has also dropped. International examples of compensatory systems have shown instant alleviations of the supply problem. Saudi Arabia jumped to the top spot in the world's living kidney donor rate. Iran claims that it eliminated its waiting list within a decade. Israel saw a 64% increase of living donors in the first year alone.

¹³² A plaintiff in *Flynn v. Holder* was a California nonprofit corporation that was seeking to offer these awards to donors in order to incentivize bone marrow donation. The holding itself offered no express limitations on forms of compensation. Thus, it is presumed that eventually cash payments will be offered for bone marrow stem cell donations under the apheresis method, the same way that they currently are for blood, eggs, and sperm.

No system is perfect. The poor will always be the majority of organ sellers under any system.¹³³ This by itself does not mean that compensation should not be allowed. The distributive justice argument has demonstrably failed despite NOTA's original intentions because, "health care middlemen have dramatically marked up the cost of transplant related services to capture much if not all of the surplus that was intended to go to the recipient."¹³⁴ Essentially, economists have shown that organs are still being allocated on the basis of ability to pay today.¹³⁵

Regenerative medicine may be the answer in the next decade or two when those in need can simply have organs grown from their own stem cells in a laboratory.¹³⁶ This would certainly alleviate the supply problem and be an immeasurable success. Unfortunately, this does nothing for the people presently who die every single day, unnecessarily waiting for a match. Of course, supply will likely never reach one hundred percent efficiency given the size of the gap in the United States, but compensation for organs would certainly take the mountain and help turn it into a mere hill.

¹³³ Calandrillo, at 102.

¹³⁴ *Id.*, at 99.

¹³⁵ *Id.*, at 100.

¹³⁶ See, AFP, "World's First Synthetic Organ Transplant," Discovery News (July 8, 2011), <http://news.discovery.com/human/first-artificial-organ-transplant-110708.html>, and "Medicine's Cutting Edge: Re-Growing Organs," CBSNews (February 11, 2009) (Suggesting that investment capital is already pouring in to commercialize and mass produce custom-made body parts).