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## Why Liberals Should Accept Financial Incentives for Organ Procurement

**ABSTRACT.** Free-market libertarians have long supported incentives to increase organ procurement, but those oriented to justice traditionally have opposed them. This paper presents the reasons why those worried about justice should reconsider financial incentives and tolerate them as a lesser moral evil. After considering concerns about discrimination and coercion and setting them aside, it is suggested that the real moral concern should be manipulation of the neediest. The one offering the incentive (the government) has the resources to eliminate the basic needs that pressure the poor into a willingness to sell. It is unethically manipulative to withhold those resources and then offer payment for organs. Nevertheless, the poor have been left without basic necessities for 20 years since the passage of the prohibition on incentives. As long as the government continues to withhold a decent minimum of welfare, liberals should, with shame, cease opposing financial incentives for organ procurement.

**L**iberals and others oriented to justice in health care traditionally have had a problem with proposals to increase the supply of organs for transplant by offering financial payments or other incentives to the one supplying the organ. The debate generally has followed a pattern in which libertarians and other defenders of a free-market have endorsed payments of whatever the market would bear (Peters 1991; Williams 1984). Their position has seemed clear enough, no matter how controversial.

Those approaching the question from the left, however, have supported a more complicated position. On the one hand, these people often have been strong defenders of individual liberty, especially in the medical sphere (Caplan 1983, 1984a & b). On the other hand, they have worried that offers of money in exchange for organs would put pressure primarily on the poor

who thus would become the source of organs while, depending on the plan, the wealthy might become the recipients of them (Guttmann 1991, 1992). Finding this repulsive, they have supported bans on markets in organs.

One tactic to respond to these concerns has been to substitute more subtle incentives for more blatant money payments. Even with a more nuanced incentive scheme, however, resistance among those who focus on justice in health care has been both strong and persistent. After examining the moral arguments surrounding the proposals for substituting indirect incentives, I review the traditional arguments against permitting more explicit payment for organs. I suggest that the argument based on concern for discrimination against the poor is more complex than is often realized. I then argue that, even if some version of the argument from justice has enough plausibility to have supported the prohibition on markets in organs over the past two decades, it is time to abandon it—at least if the society continues to refuse to provide a decent minimum of health and welfare services for its most needy citizens.

In this paper, I speak generally about financial and nonfinancial incentives—both for the sale of organs from living people and for the procurement of permission from families to remove organs from the deceased. I do not address the obvious fact that, even if people have the legal authority to sell their own organs or those of their deceased relatives, it may be an unwise decision. There is increasing evidence, particularly for procurement of kidneys from living people, that the medical effects of living donation may give someone pause and even the financial benefits may not be sufficient to warrant a decision to sell (Rothman 2002; Goyal et al. 2002).

#### PROPOSALS TO SUBSTITUTE INDIRECT AND NONFINANCIAL INCENTIVES

One type of response to the concern about the unjust discrimination or coercion that is perceived to be associated with the use of market mechanisms to increase organ procurement has been to shift to more subtle or indirect incentives. Although these incentives have been proposed in countless forms, they generally have taken one of two forms: nonfinancial incentives or indirect financial payments.

#### *Nonfinancial Incentives*

If the worry is that money puts undue pressure on the poor to become the society's supplier of organs, one response is to shift from financial to nonfinancial incentives. These are sometimes called "moral" incentives.

They include proposals to award those who donate organs commemorative certificates or plaques expressing the appreciation of the people, the legislature, or the head of state. Similarly, the creation of a donor's memorial on which names could be listed would provide a mechanism for praising donors for their altruistic actions and expressing the gratitude of the public for the life-saving gifts that those individuals have given. Such a memorial currently is being planned at the United Network for Organ Sharing's offices in Richmond, Virginia.<sup>1</sup>

Such tokens of appreciation can be called "moral" incentives because, rather than providing monetary reward, they merely express the moral approval of the population. Since they are not monetary and all people generally appreciate moral approval, these incentives might not be as discriminatory in their impact.

The problem with moral incentives is usually a pragmatic one. There is doubt that they would work to increase the supply of organs sufficiently. About 4,400 people a year in the United States die while waiting for an organ. Many more kidney patients suffer for prolonged periods on dialysis while they await transplants. The number of people added to the waiting list each year is presently three-and-a-half times the number of organs that could be transplanted (depending on the organ).<sup>2</sup> Would more public recognition of cadaver or living donation of organs provide enough of an incentive to make much difference? It seems unlikely. Although there is no obvious moral objection to nonfinancial incentives, there is real doubt that they will be sufficient to produce the number of organs needed. This does not mean that such moral rewards should be opposed; merely that they probably will not work to solve the critical supply problem.

### *Indirect Financial Incentives*

There is more reason to hope that explicit monetary payments might sufficiently increase the supply of organs for transplant. Nevertheless, many people find the idea of a direct payment to a "donor" or to the surviving family members crass or unseemly.

First, it is linguistically unseemly since, once the organ is supplied in response to payment, it is hard to continue to refer to the organ source as a "donor." He or she becomes a "vendor," one who is paid for a product. In what appears to be a desperate effort to hold on to the attractive metaphor of gift giving and donation, some have even proposed the concept of "rewarded gifting" (Alexander 1992; Daar 1992; Dosseter 1992; Kahan

1992; cf. Murray 1992). Under this plan organs could not be sold. If, however, someone, makes a gift of an organ, something of monetary value would be provided to the “donor” in exchange.

Giving monetary rewards in exchange for the gift of organs seems to be a blatant corruption of the language. The term “rewarded gifting” seems to be proposed only because liberal western societies are so strongly committed to the gift model that it is attractive to try to make sales sound like gifts. Regardless of whether payment of financial incentives turns out to be acceptable, calling something a “gift” when it is really a “sale” seems to be an unethical deception. It is a corruption of the obvious meaning of the terms. If one entertains monetary incentives for increasing organ procurement, one should at least be honest enough to call a payment what it is. The transfer of money is not a “reward;” it is a payment. The transaction would be a “sale.”

Even if one corrects the language to avoid this linguistic problem, however, many still would find payments discomfoting. In order to respond to that discomfort, proposals have been put forward to avoid payments of cash to the vendor either by providing something of monetary value that is not a direct payment or even by making a payment to the donor’s favorite charity (American Medical Association 1995, p. 582; Dewhurst 1987; Banks 1995, p. 78). The exact plan depends on whether the payment is to be made to the one who is the source of the organ or to a surviving relative. It also depends on whether the payment is to be made, in advance, while the organ source is still alive or after that individual is deceased.

Proposals have been put forward to make payments to those who eventually might become the source of organs. The funds either could be committed while the organ source is still alive—e.g., an insurance policy that would pay the beneficiary if and only if organs ultimately are procured—or take the form of a token payment to the potential organ source for a commitment to provide organs upon death (such as a discount on one’s driver’s license if one checks the organ “donor” box).

Such financial commitments made well in advance of procurement present some problems, however. With the proposed insurance policy, the payout would occur only if organs are procured (or only if they actually are used). This raises serious practical problems. Would those who supply many organs get larger payments than those who supply only one? What about those who willingly commit to providing all organs but turn out to have diseased hearts or livers that are not usable for transplant? If someone had signed up who turns out to have a marginal organ, could a

surviving beneficiary have a tort action against a surgeon or an OPO that refused to offer the organ to anyone on the waiting list?

Similar problems arise with the offer of a token payment for merely signing a card (no longer a “donor” card, but something else—perhaps a “vendor” card). Should larger payments be made for signing up to provide many organs? Should people who appear to have prime organs get larger payments? Since the quality of the organs would not be apparent until after the death of the organ source, it would be virtually impossible to provide fair compensation based on organ quality at the time a commitment is made. What should happen if someone signs up to provide usable organs, but his or her organs become medically unsuitable before the time to procure them? Would it make a difference if they become medically unsuitable because of life-style choices of the one committing the organs? Similar problems arise if those who sign up are later permitted to change their minds about providing organs. By then, the payment would have been spent, and expecting the individual to repay in order to have the right to change his or her mind seems impractical.

A more plausible alternative to advance payments or financial commitments is to pay only if the organs are procured (or utilized). The payment could go to the next-of-kin of a newly deceased individual who turns out to have usable organs. It could also go to an individual who provides certain organs while he or she is alive: a kidney and perhaps even a liver or lung lobe. However, this approach also poses some problems. For any scheme that pays to beneficiaries only if organs are procured, should the beneficiary of those with marginal organs have a right of action if the procurement agency rejects the card as providing unacceptable organs?

In order to create some distance between the decision to provide organs and the economic benefit of doing so, some have proposed that the payment be indirect. Instead of paying cash to the next-of-kin, one could pay funeral expenses—up to, say, \$3000—or pay a survivor’s expenses related to the death of the individual—e.g., hotel, transportation, and meals. Such a proposal was enacted in the state of Pennsylvania (Pennsylvania Act 1994-102 (S.B. 1662), codified as amended in 20 Pa. Cons. Stat. 8601 *et seq.*). The law permits the state of Pennsylvania to begin a pilot program that would pay up to \$3000 in hospital and other medical expenses, funeral expenses, and incidental expenses incurred by the donor or donor’s family in connection with making a vital organ donation.<sup>3</sup>

There is a problem, however. If the payments are really to be for expenses for funerals or travel or meals, it seems only reasonable that the

payments should cover real costs. Someone who dies suddenly and is committed to a very inexpensive cremation might leave relatives with no significant medical or funeral expenses, whereas other families may incur significant costs. Some mechanism must exist for documenting who is entitled to how much.

One might, of course, commit to the payment of some flat amount—\$3000—in lieu of documenting expenses. That, however, makes the payment look more and more like a payment for the organs, rather than a compensation for costs incurred. Furthermore, assuming that the relatives who receive the payment are the same ones who are the beneficiaries of the deceased individual's will, the bottom-line cash position of the relatives will be exactly the same regardless of whether the state pays them directly for the organs or, instead, pays for the funeral and medical expenses that would otherwise have been paid from the estate of the deceased. If the payment covers the funeral expenses, the estate will be larger by that amount, and the beneficiaries will be made richer by the same amount.

The only case where this would not occur is that in which the next-of-kin with organ procurement decision-making authority turns out not to be the beneficiary of the will of the deceased. In that case, however, it seems odd indeed that beneficiary rather than the decision maker would receive the payment. At the very least, the situation would tend to neutralize the incentive to consent to procurement.

I am left with the conclusion that indirect incentives—whether moral or monetary—either will not work or are immorally deceptive in the pretense that there is no payment of cash to the decision maker when, in effect, there is. I therefore generally have opposed all efforts to provide planned systematic “rewards” for “gifts” or to provide payment of end-of-life medical or burial expenses. Such plans are really gimmicks to avoid the reality that financial incentives are being paid for the organs provided.

#### TRADITIONAL LIBERAL OPPOSITION TO ORGAN MARKETS

If such fictions as rewarded gifting and indirect incentives do not provide a basis for legitimating payments for organs and there is still a desperate need for more organs, what other options exist? There are some limited alternatives within the donation model. For years I have endorsed a strategy that I call “required response” (Veatch 1991). We know that not everyone who presently is willing in principle to donate organs has indicated the desire to do so (The Gallup Organization, Inc. 1993). Inertia simply precludes taking all the actions humans would be willing to

take. Hence, many individuals never have gotten around to preparing economic wills or advance directives for medical treatments even though they indicate that they support the concepts in principle. Fifty-five percent of the population indicates the willingness to donate organs, while only 28 percent of the group has actually done so (The Gallup Organization, Inc. 1993).

To overcome this inertia, federal laws now require that the next-of-kin of deceased persons who are potential sources for organs be asked if they wish to donate (Omnibus Reconciliation Act 1986). Still, this strategy is only marginally successful. In some cases family members are unwilling to make the decision to donate on behalf of a loved one, especially if they do not know what the individual would have chosen. Moreover, even if family members are induced to donate on behalf of a deceased relative, this is, at best, a second choice option. The goal of the donation model is to give individuals rather than their relatives the opportunity to decide to donate. In a liberal society, it is the individual who is deemed to have the first priority for making decisions about his or her own body. The family member's surrogate choice is an inferior substitute.

One strategy for facilitating individual decision making while one is competent and capable of making a choice is to ask for a donation *and require the individual to respond*. This could be done on admission to a hospital or as part of the work-up in a physician's office (although these private transactions probably do not provide a legitimate basis for making response a requirement). Another option would be to make the question a part of the driver's license application and renewal, much as it presently is except that a state could require that the question be answered. A much better strategy is to make the question a part of the annual income tax return. Refusal to answer would constitute an incomplete return and it would be rejected just like an unsigned return is today. In order to avoid encouraging people to answer the question in the negative, an "I don't know" response should be offered. Anyone making that choice would be treated, just as they are now. The next-of-kin would have to act as a surrogate.

The income tax return has many advantages. It is completed by virtually all adults. It is already entered into a computerized data base. The IRS officials are well-prepared to protect confidentiality. The result would be a single national database with annual updates. Amitai Etzioni has argued persuasively elsewhere in this issue of the *Journal* that such requests for donation should not be presented neutrally, as if society did not care whether one donated. Rather the message should be that a good citizen will donate unless he or she has some principled reason not to do so.

Other techniques for extending the donation model may add further to the numbers of organs potentially available. Nevertheless, there is good reason to suspect that, even with required response and a presumption that a donation is an act of good citizenship, many people will fail to donate, including some who are not strongly opposed to organ procurement. Some further incentive to have people address the difficult and complex issue of being an organ source seems to be in order. Hence, many free-market libertarians have proposed direct payment of some type of incentive.

I am not concerned about the details of the incentive. Rather, I want to focus on the traditional resistance to such proposals by justice-oriented liberals who variously worry that positive incentives are either discriminatory against the poor or coercive against them.

### *The Discrimination Argument*

It seems plausible that the poor—those in desperate need of money for the basic necessities of life for themselves and their loved ones—would be more likely to respond to financial incentives.<sup>4</sup> Assuming that the poor are, in fact, more influenced by economic offers as a device for encouraging organ transfer, would such a practice constitute discrimination and, if so, is it unethical discrimination?

Discrimination refers to the act of differentiation. In ethics, it refers to treating people or groups of people differently, usually without morally justifiable reason. Thus, if the poor perceive more incentive to consent to organ procurement when financial incentives are offered, it would be consistent with English usage to say that they are treated in a discriminatory way, at least in the morally neutral sense of being treated differently. Many years ago out of concern for this problem, while writing on the use of incentives for controlling family size, I proposed that financial incentives should be “negative,” that is they should be in the form of fees rather than rewards so that larger fees could be charged for higher income people in order to make the psychological effect on all income groups more equal (Veatch 1977). In the case of incentives for organ procurement, however, this would require purchasing a license to *avoid* having one’s organs procured—a terribly implausible model for the use of incentives even if the size of the fee could be manipulated to generate as much pressure on the wealthy as on the poor.

The real question is whether the different level of perceived force from a positive financial incentive makes such incentives unethical. Those most committed to a radical egalitarian interpretation of a principle of justice

perhaps may be inclined to hold that any financial offer that moves the poor more effectively to act than it moves the wealthy is unethically discriminatory because of its differential effect. I admit to certain sympathy with that view.

One who adopts that position, however, must realize how radical the position is. Virtually any financial transaction would seem to have effects that differentiate based on income level. Most tellingly, offers to hire laborers for unpleasant or risky work would seem to move the poor much more persuasively than the wealthy. Yet, all but the most radical egalitarian communists and Christian socialists act as if they believe that some differential impact of economic offers is tolerable. One may feel uncomfortable recognizing that minimum wage is sufficient to attract some poor people to accept jobs as collectors of garbage and performers of menial and boring tasks. Most people, however, do not hold to the view that all people should be situated so as to perceive the incentive of economic offers equally. Depending on how one defines the term, one can hold either that this is discrimination that is tolerable, or, alternatively, that it should not be called discrimination at all because it is not necessarily unethical.

### *The Coercion Argument*

The real problem with economic incentives to induce offers to procure organs actually may not be that the offers are discriminatory. Rather, it may be that they are perceived as “coercive” when the offer is made to people who are destitute, who desperately need food, clothing, or medical care for themselves or members of their family. Something seems wrong when some people would perceive an offer to sell a kidney for \$5000 as irresistibly powerful while others would not be moved in the slightest. Figuring out exactly what is wrong, however, may take considerable work. This brings us squarely into the complex philosophical realm of the ethics of coercion, pressure, inducements, and irresistible offers.

Many of the best philosophical scholars working on the concept of *coercion* would appear to hold that, whatever the ethics of financial incentives to consent to organ procurement, it does not constitute coercion (Faden and Beauchamp 1986, pp. 337–73). Coercion is defined more appropriately as the use of force or the threat of force to compel someone to engage in an action against his or her will. Holding a gun to someone’s head to force him to sign a “donor” card would be coercion. So would drugging the individual and removing her kidney while she was unconscious (assuming that were done against her will). Merely offering an

inducement to motivate someone to choose to engage in a behavior is not, by this definition, coercion. It adds an additional option to the array of options previously available. In some cases, the additional option may so fit with the goals of the person that that option is preferred above all those previously available.

An offer to hire a skilled worker away from his present employer, especially if it is at a much higher wage for similar working conditions, may be an offer that is very attractive, even irresistibly attractive, but one would not normally say that the person was “coerced” into taking the new job. Unless “coerced” means merely “presented with an option that is so much more attractive than any other that it is irresistible,” such offers are not coercion. One could call such offers “irresistibly attractive” but not “coercive.” Attractive offers may be perceived as offers that exert pressure or inducement, but they are neither coercive nor unethical offers simply because they are very attractive. In fact, offers are not necessarily unethical even if they are perceived as *irresistibly* attractive. Unless one is prepared to claim that all offers that are perceived as differentially attractive are automatically unethical, something more must be said to demonstrate that even an irresistibly attractive offer is unethical. The question, then, is when does an attractive offer become unethical?

### *The Worry about Unethical Offers*

Much of the moral opposition to financial incentives to induce consent to organ procurement seems to stem from the fact that the offer may be perceived as irresistible to the poor while it is easily resistible to the wealthy. The problem is why offers to induce consent to procure organs that are irresistible only to the poor are deemed unethical while offers of jobs and offers of basic necessities are not.

I suggest that the ethical problem with irresistibly attractive offers is not at all related to the fact that they may be irresistibly attractive compared to the alternatives available. Rather, the ethical problem must be understood in terms of the options available to the one making the offer. The case we are concerned about is one in which one party, say a poor person, is desperately in need of something possessed by another, say funds to buy basic necessities such as food for his or her children. If the wealthier party makes an irresistibly attractive offer, such as an offer to pay a financial incentive if consent is given to permit procuring an organ, the morally critical issue is whether the one making the offer has the option of addressing the desperate need in some other way. If that person could

respond to the desperate need and provide food, for example, without taking advantage of the poor person's desperate need, then intentionally withholding the food in order to create the situation in which the offer of money is irresistibly attractive is an unethical manipulation of the options of the poor person. If, on the other hand, the one making the offer has no other options, then the offer is not necessarily unethical.

Consider a closely related analogous case. Imagine a transplant surgeon who is caring for a child in liver failure and is discussing options with a parent of the child. The surgeon can offer the parent the opportunity to donate a liver lobe that has the potential to save the child's life while posing only moderate risk to the parent. The parent's liver will regenerate while the child will have sufficient liver function from the lobe to save his life while the liver grows to provide normal function. Although the surgery poses only moderate risk, it still is potentially dangerous and is undertaken only in serious cases in which no cadaver liver is available. The mortality of the procedure for the donor is uncertain, but is often given as being around 1 percent (Surman 2002).

It is plausible to view the offer of the surgeon to procure a liver lobe from the parent in order to save the child's life as an irresistibly attractive offer. I suggest, however, that it is not immoral merely because it is irresistibly attractive. If the surgeon has no other alternative available to save the child, the mere fact that the parent is so desperate to save her child is not a reason to conclude that the surgeon's offer to perform the surgery is immoral. (By that logic, such an offer would become moral in the case of the parent who really does not care too much whether his or her child lives or dies.)

If, however, the surgeon had ready access to a cadaver liver that was suitable for the child and withheld that option from the parent because the surgeon wanted to practice performing an adult liver lobe retrieval, that action certainly would be unconscionably immoral. The offer is no less resistible in the first case than the second. The moral difference is that, in the second case, the one making the offer had another option for addressing the parent's desperate concern and intentionally withheld that option in order to force the consent of the parent to the liver lobe procurement. It is the fact that the one making the offer had access to an alternative means of addressing the parent's serious concern that would make the offer to procure the liver immoral.<sup>5</sup>

That distinction goes far to explain why some of us have, until now, opposed markets in procuring organs. In 1983, I testified before the Sen-

ate Subcommittee for Investigations and Oversight of the Committee on Science and Technology in its hearings on “Procurement and Allocation of Human Organs for Transplantation” (Veatch 1984). These hearings led to the passage of the National Organ Transplantation Act, including its title III on the “Prohibition of Organ Purchases,” which states that it is unlawful for any person to knowingly acquire, receive, or otherwise transfer any human organ for valuable consideration for use in human transplantation” if the transfer affects interstate commerce (National Organ Transplant Act 1984). In that hearing, I, and almost everyone else involved, endorsed the prohibition on marketing of organs in the United States. Part of the motivation was the testimony of a physician named Barry Jacobs who was proposing to become a broker in human organs who would connect, for a fee, those who wanted to sell and those who wanted to buy. The impression he left was one of the worst imaginable. Even those who came into the sessions open to the possibility of some kind of financially-based incentive system to encourage organ procurement left appalled at the possibility that organs might be marketed to the highest bidder like deodorant or potato chips. Any possibility of a more sophisticated and regulated market seemed lost in the huckster-quality of his presentation. More recent proposals, for example, to separate the use of markets in the procurement of organs from their use in allocating organs (Cohen 1989, p. 33; Hansmann 1989, p. 62; Gill and Sade 2002, p. 19) were not yet on the horizon. Under these proposals, economic incentives would be used to encourage people to provide organs to a national, governmental organ procurement agency while that agency would use medical criteria to allocate the organs independent of recipients’ ability to pay. The financial incentive would be designed to overcome inertia and presumably would increase supply while not permitting ability to pay to influence who ended up with the organs.

In the 1983 hearings, I stated that I was, for the time, opposed to permitting economic transactions even in the procurement of organs. My opposition was based on the belief that it would be the very poor who would differentially feel pressured to consent to selling their organs, either while alive or after their deaths. What was unethical, I suggested, was that the ones contemplating the authorization of economic incentives to procure organs—i.e., the United States Congress—had at their disposal the means to address the desperate situations of the very poor in the United States. They could rather easily have raised the minimum wage, offered a guaranteed annual income, provided a minimally decent standard of liv-

ing for all in the United States, or undertaken some other plan to address the desperation of the poorest of the poor. It was the fact that the decision makers, in effect, would be forcing the poor to sell their organs by withholding alternative means of addressing their problems that made an American policy of legalizing a market in organs unethical.

I was aware at the time and have stated publicly since then that the same reasons for banning a market in organs might not apply in some other cultures (Veatch 2000, p. 152). A Bombay physician, K. C. Reddy, has conducted such a market, functioning as broker in what appears to be a reputable alternative to an uncontrolled back-alley system outside of medical supervision (Reddy 1992). I have met with Dr. Reddy and found his case for such a market in Bombay credible. I came away with an acute sense that I, as a Westerner, did not have adequate knowledge to assess whether the Indian government and the elites of Bombay had the resources necessary to address in some other manner the desperation of those selling their kidneys through Dr. Reddy.<sup>6</sup> My judgment in 1983 and still today is limited to the relatively wealthy United States in which I remain convinced that the needs of the very poor could be met by some other means thus removing the concern that any resident of the United States would find the offer of an incentive to part with his or her organs irresistibly attractive. It was the fact that the legislators considering whether to ban markets in organs had the resources to address in other ways the needs of those who might find a market irresistibly attractive that led me to testify against legalization of a market.

#### IS IT TIME TO REASSESS?

At the time I testified in 1983 against legalization of a market in organs I said that it was with ambivalence that I endorsed a law that would block the access of the very poor to a means of addressing their desperation. I said at the time that, if the United States continued to refuse to provide a decent minimum standard of living, the issue would have to be reexamined. In particular, I said that, if the problem was not addressed in the next 20 years, we as a society would have to re-think the prohibition on marketing organs.

That 20 years has now passed. It is clear that, although the standard of living of some of the very worst off members of our society has improved at least marginally, others still are being forced to live at intolerably low standards of living. Single parents are raising large numbers of children on irresponsibly low levels of resources. People are still homeless, chronically unemployed, and without basic medical care. We have had more

than one opportunity to pass universal health insurance, provide a minimally decent standard of living, and guarantee a job to everyone who is willing and able to work. We have not done so.

There are still people desperate to provide the most basic necessities for themselves and their families. The kidney in their body may be their most valuable and marketable possession. They might be quite willing to adjust their values and their priorities to consent to either cadaveric or live organ procurement in exchange for an economic payment.

The ethical situation is similar to that of 1983 with one exception. We now have a situation in which a wealthy society still has the capacity to meet the basic needs of all residents, but now has demonstrated that it is unwilling to do so. An offer to the poorest of the poor to permit them to sell their organs might still be irresistibly attractive. It is still an immoral offer provided those making the offer have the resources to address those needs in some other way.

What then is the critical difference? Our society now has demonstrated a moral weakness of the will to address those needs by some other means. If it is immoral to make an offer to buy organs from someone who is desperate because those making the offer refuse to make available the alternative solutions, it must be even more immoral to continue under these circumstances to withhold the right of the desperate to market the one valuable commodity they possess. If we are a society that deliberately and systematically turns its back on the poor, we must confess our indifference to the poor and lift the prohibition on the one means they have to address their problems themselves.

It is thus with shame and some bitterness that I propose that the time has come to lift the ban on marketing organs. There has never been any serious moral problem with permitting financial incentives to nudge middle and upper class people to think about their willingness to consent to organ procurement. The offer has never been irresistible to them. For those who do find such an offer irresistible, it is that very desperation that requires that, if we are going to intentionally withhold the alternative solutions, we must at least get out of the way and let them address the problem themselves in the best way that they can. In a strange twist, the very same reason that made a market in organs unethical 20 years ago, today makes it a moral necessity, at least if we continue to live in a society in which desperate poverty is tolerated amidst affluence. The time has come to admit defeat, join with the conservatives who have always accepted monetizing of the body, and legalize financial incentives to encourage

consent to procure organs from both cadaveric and living sources. They will no longer be donors, they will be vendors selling their bodies because the alternatives are all foreclosed to them.

## NOTES

1. The memorial is described at the UNOS web site under the heading “UNOS National Donor Memorial Plans Take Shape.” The full account can be located on the UNOS site ([http://www.unos.org/frame\\_Default.asp?Category=Newsroom](http://www.unos.org/frame_Default.asp?Category=Newsroom)) and scrolling down to the story dated 18 July 2002.
2. In 1999, 36,952 organ transplant candidates were added to the waiting list while only 10,659 organs were donated.
3. Apparently, the present policy is to pay a maximum of \$300 per donor and to limit payments to family expenses related to the death of the one who is the source of the organs.
4. One might argue to the contrary that in many cases the better educated and higher income members of the population are actually less opposed to organ procurement and therefore more susceptible to the power of incentives to overcome inertia. Many who are poorly educated may be more influenced by fundamentalist religious factors, alienation from the medical establishment, and unexamined psychological revulsion than are the higher socio-economic strata (Callender 1996). Someone who believes that God will provide a bodily resurrection and worries about being resurrected without all his or her organs may be totally immune from economic incentives to provide organs. For someone with religious objections, what may be needed is a more sophisticated theological education. At least within Christianity, concern about the state of the body has been a worry since the Middle Ages. Sophisticated orthodox Christians affirm a resurrection of the “new and perfect” body—sort of a completely fixed copy of one’s present earthly body. This doctrine was a great comfort to medieval Christians who worried about a loved one whose body was consumed in a fire or was damaged in a crushing accident. However, getting poorly educated fundamentalists either to understand this doctrine or to adopt a more secular skepticism about any form of bodily resurrection is a complex undertaking.
5. This analysis, which rests on whether the one making the offer could make other options available, follows closely my discussion years ago of the Krugman Willowbrook experiments in which a researcher wanting to study hepatitis went to a facility for the mentally retarded in which hepatitis was endemic and offered parents of newly arriving children the option of a clean, safe, hepatitis-free ward if only they would volunteer to permit him to ad-

minister hepatitis intentionally for the purposes of testing his vaccine. He relied on the fact that the children were going to get hepatitis anyway to justify his administering hepatitis to them for research purposes. My claim was that, if the researcher had the power to use his medical skills and administrative authority to clean up the standard wards, it would be immoral to refuse to clean up those wards and to take advantage of the parents' desperate desire for a clean ward to obtain parental permission to intentionally give the children hepatitis. If, however, cleaning up the standard wards was beyond the researcher's ability, then his offer might be more justified (see Veatch 1974).

6. I also am aware that recent evidence suggests that the poor who have sold their organs in India may not have come out as medically or financially well off as expected and that many have reported that they would not engage in the sale if they had it to do over again (Goyal et al. 2002). I am in no way suggesting that a market in organs—particularly a market in organs procured from the living—is a prudent policy, merely that the traditional moral arguments about discrimination and coercion against the poor may not stand up to moral scrutiny.

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