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Clinical transplantation of solid organs over recent decades has seen a steady stream of small technical advances and giant leaps forward, like the introduction of cyclosporine 15 years ago. Improved survival of both transplanted organs and patients has led to ever-broadening expansion of indications for transplantation. The result has been longer lives of higher quality for more people than could have been imagined just a few decades ago. Last year, 13,000 transplants of solid organs were done in this country.

There is a dark side to this success story, however. The very success of transplantation has led to a growing waiting list while the number of available organs has remained stable. Last year, there were 45,000 people on the waiting list for transplantation, and 3500 died before an organ could be found for them. The problem is not that there are not enough medically suitable organs; rather, it is that most of the suitable organs are being buried. Kidneys and lobes of livers and lungs come from living donors, but most solid organs come from people who have recently died, so called cadaveric donors. Despite public relation initiatives, widespread public and professional education, and a variety of laws aimed at increasing donation rates, cadaveric organ donation has increased only 5% per year in the past decade, while those in need of transplants has grown by 31% a year. Of all medically suitable donors, only 35% actually donated, and each donated an average of over four organs. Yet, the gap between supply and need of organ transplantation would largely evaporate if all suitable organs were donated.

The issue of race poses special problems in transplantation. Because of the prevalence of hypertensive renal disease in the black population, that group has a disproportionately high representation on the kidney transplant waiting list. While blacks compose 12% of the general population, they comprise 37% of the kidney transplantation waiting list, yet receive 25% of the kidney transplants. Other organs are not so disproportionate.

A variety of factors contribute to differences among races: biological, medical, social, and personal. Biological factors include different rates of ABO blood groups within races, as well as differences in major histocompatibility complex antigens. Because of these differences, organs from black donors have a better match with potential black recipients than white. Blacks have a lower donation rate than whites, for reasons discussed in more detail below, contributing to fewer available biologically compatible organs for blacks than for whites.

Suitability for transplantation is related to comorbid medical conditions, such as diabetes and hypertension, and social factors, such as alcoholism and drug abuse, all of which may be higher in minority communities. Moreover, there is considerable geographic variation in donation rates, and transplantation rates are highest in regions where there are more donors. Some regions with a relatively high proportion of black population also are regions of low donation rates. This will affect the national statistics on transplantation in blacks.

Personal considerations affect transplantation rates. For example, a recent survey found that while 90% of whites would accept an organ transplant if their lives would be saved by it, only 70% of blacks would. Exposure to information about transplantation was also lower among

blacks. While 70% of whites had read, seen, or heard about transplants within the previous year, only 40% of blacks did.

There is little evidence of widespread racial discrimination in transplant programs. At least one study, however, has found that not all the differences in white and black transplant rates are due to biological, medical, or personal reasons, suggesting that there may be some degree of racial bias in distribution of organs.

The donation rate in the black community has historically been low compared with that of whites. There appear to be several reasons for this difference. The most important are widespread distrust of the medical system, a belief that willingness to donate may result in a premature termination of life support, and the belief that organs donated by blacks will disproportionately go to white recipients. Assurance that black organs would go to black recipients is likely to result in a greater willingness to donate on the part of some blacks.

Increasing Donation Rate

An important cause of the organ gap may be mistaken notions in the transplant and bioethics communities regarding the moral foundations of transplantation. Stated simply, it is the position of UNOS (the national organization for coordinating procurement and distribution of organ) that the only ethically sound motivation for donation is altruism, construed as absence of personal benefit, and solidarity with the national community. Any kind of personal benefit from donation is deemed unacceptable on moral grounds. I suggest that this view of the morality of transplantation is overly narrow and thereby misses a broad range of motivations and opportunities to persuade people to donate organs. Such motivations might include personal and financial rewards.

Organs suitable for transplantation have great value. Philanthropic organizations dedicated to eliciting donations of large blocks of volunteer time and large sums of money know a good deal about what motivates people to make such donations. Certainly, serving the general good is one such motivation, but it is not a major one. Most major donations go to churches, synagogues, and other organizations which have great personal meaning to the donor. Many large donations are made through wills and trusts, while the donor lives or after he dies. In fact, some people spend large sums on estate planning designed to prevent their assets from going into general funds for the public good, preferring that their assets go to persons or causes they personally choose.

The principal that valuable resources are donated to organizations or efforts dedicated to causes for which the donor has sympathy seems so fundamental that it should be possible to use it to increase organ donation. For many years, UNOS has allowed only rare exceptions to their practice of giving no information regarding the recipient of a transplanted organ to the potential donor. Yet, such information could be used as motivation to donate.

A change in policy has been recommended to allow potential donors or their families to honor and commemorate the life of the donor by permitting their participation in selecting a recipient of the donated organs. Under such a program, UNOS would continue to maintain a list of medically indicated recipients. Each person, through an advance directive, or a family at the time of death could specify the characteristics of the recipient in terms of local or national community, younger or older age, membership in certain organizations or churches, and the like.

Contemporary information technology could make instantaneously available a wide range of information about each potential recipient. The process could be as simple or as complex as the

person or family wishes. It could be as simple as allowing UNOS to make all decisions regarding the recipient, as they do now, or as complex as specifying geographic location, age, religion, race, severity of illness, as well as other specifics. A program like this is consistent with current law, and is consistent with ethical principles as well. What prevents its implementation is a narrow view currently widespread in the transplantation community that the only acceptable motivation is community solidarity without personal benefit.

Such a program is likely to disproportionately benefit the rate of transplantation in the black community. Blacks donate organs at a lower rate than whites. There are many reasons for this, but prominent among them are distrust within the black community of the health care system and of medical authority, and the belief that donated organs from blacks will go to other races. A system in which black persons could specify that their organs could go only to other blacks would give them a special reason to donate. An additional benefit of an increase in black donation rate is that blood groups and histocompatibility antigens have different distributions in different races. Therefore, as the black donation rate goes up, the number of transplants into blacks will increase, and longevity of the implanted organs will improve as well.

Financial Rewards For Organ Donation

Another kind of personal benefit that could provide incentive to donate organs is financial rewards. Such payment, however, has been illegal since 1984. In the market for medically suitable transplantable organs, the economic effect of prohibiting financial rewards is to fix monetary value (price) of organs at zero. Fixing prices artificially low inevitably leads to shortages. In economic terms, the organ gap exists because insufficient benefit to donors leads to decreased likelihood that donation will occur, and the supply falls substantially below the demand. Paying people for donating organs would increase the supply, diminish the organ gap, and save thousands of lives each year.

Why, then, is payment prohibited? In the case of cadaveric donors, it is because of the narrow view cited in the previous section, that the only morally acceptable reason to donate is community solidarity with no personal benefit. If that position is overly narrow, as I have claimed, and certain personal benefits may also provide morally acceptable reasons to donate, then financially rewarding the estate of donors or their families directly could be an acceptable way to increase donation rates.

The greatest current need is for kidneys (the waiting list is ten times greater than it is for other organs). Because this is a paired organ, living persons can and do donate one of their kidneys under some narrowly circumscribed circumstances. Many thousands of additional kidney donors could be recruited if paying the donor were allowed. But payment is prohibited to living donors as well as cadaveric.

The rationale behind the prohibition of financial rewards to living kidney donors is that it is morally outrageous, and therefore intolerable, to pay people for organs. Moreover, nearly all of us react to the idea of paying for organs with a feeling of repugnance. On close inspection of these issues, we will see that moral arguments against payment for organs are extremely weak, and that the real basis of prohibition is emotional.

One argument in favor of prohibition is based on presumption of ignorance: truly informed consent is not possible because large numbers of people, perhaps most, cannot possibly understand the short-term and long-term risks and other implications of donation. While there may be some truth to this position, it misses the point that ignorance is not an irremediable

condition. Medical facts and personal implications can be explained and clarified, at least to the extent they can for any other medical intervention. Moreover, if consent to donation in exchange for financial reward must be invalid because it is necessarily uninformed, it follows inescapably that *voluntary* donation is also ruled out, since voluntary donation also requires informed consent, and voluntariness does not dispel ignorance.

Issues of exploitation and paternalism are also used to justify prohibition of the sale of organs. *Paternalism* occurs when a person is coerced for his own benefit. *Exploitation* occurs when a person is coerced for another's benefit. *Coercion* is generally understood to occur when one person reduces the options available to another, so that the other suffers a loss from his own viewpoint. Either form of coercion may be justified or unjustified.

Perhaps an example will clarify this. Jack has something that he can keep for his own use, give away, or sell. John has the power to prevent Jack from selling it, and does so. Jack has been coerced: even if he sees selling as his best option, he cannot do it.

Whether John's action was paternalism or exploitation depends on concrete circumstances. Imagine that Jack is 14 years old and John is his father. The thing in question is a bicycle that Jack bought with money he earned from summer jobs, so it clearly belongs to him. Jack wants to sell it in order to buy a subscription to Playboy magazine, and his father forbids the sale. John's coercion is paternalistic: his action is for Jack's good, and may be justified by Jack's immaturity and the inappropriateness of his intentions. Now imagine that Jack wants to sell his bicycle because he never rides it, and he has dreamed for years of buying a music system for his bedroom. John, however, enjoys riding Jack's bicycle on weekends, so tells Jack that he cannot sell the bicycle nor can he give it away, but he can either keep it or give it to his father. Though Jack would rather sell the bike and buy a music system, this best option is denied to him. John's coercion in this case is exploitative: his action is for his own benefit, not Jack's, and is probably unjustified.

The paternalistic rationale for prohibiting the sale of organs is that prohibition protects both the poor seller from the risks of operation, and the desperate buyer from the risk that a seller may conceal medically harmful conditions like hepatitis or HIV-positivity. This paternalism seems not to be justified. All trades involve rational risk-taking: there are always potential benefits and harms, and a voluntary trade will take place only if both parties, in this case, the donor and the recipient, anticipate more benefit than harm. In the case of the poor seller, only he is in a position to calculate whether the possibilities that open up to him from having more money outweigh whatever risks there may be in a donor operation. The poorer the seller, the more heavily benefits outweigh the harms. In the same way, the buyer must also make rational calculations of the risks of receiving a contaminated organ against the alternative which, for many potential recipients, is death. Such a weighing of benefits and harms cannot be done once, for all people by a central authority, which cannot possibly know all the relevant details of each transaction. Such decisions must be made by each person, considering his or her own values. Prohibition of organ sales might be justified if there were a special reason why information regarding benefits and harms were less available in this case than in other areas of medical decision-making, but no such reason has been given. Furthermore, if it could be successfully argued that that sellers and recipients require protection from making their own decisions, the same protection would be required for volunteer donors. If paternalism in prohibiting sale of organs were justified, it must also prohibit voluntary donation.

The exploitation argument in favor of prohibition runs something like this: poor people don't have the same range of choices as others, so offering money for organ donation coerces them into selling their organs for the benefit of someone else (the recipient). But coercion results when one person reduces another's options so that the other suffers a loss from his own viewpoint. If a seller of organs decides that he has no good options in the face of his poverty, but that selling an organ is the best of those few bad choices available to him, then it is not the selling of an organ, but its prohibition that coerces the potential seller. In this way, prohibition limits the freedom of poor people to make their own choices. In short, when someone is offered money for donating an organ, the offer *increases* his options, and is therefore not coercive. Asking people to give valuable organs away while prohibiting them from receiving a financial consideration *reduces* the options of the prospective donor, so it is prohibition rather than permissiveness toward organ sales that exploits the poor.

Proponents and opponents of organ sales share the same moral concerns: Freedom for people to manage their own lives, and freedom from exploitation and coercion are morally good. Premature death, suffering, and loss of control by persons over their own lives are morally bad. It should be clear after the above discussion that issues of informed consent, paternalism, and exploitation support financial reward for organ donation, not its prohibition. Furthermore, arguments against the sale of organs equally argue against voluntary donation of organs, a logical conclusion that few would support.

If moral arguments undermine opposition sale of organs, why then is support of the ban on such sales so widespread? I suggest that the reason lies not in moral or ethical concerns. Rather, it lies in the emotional reaction of repugnance to the thought of selling parts of human bodies that leads to support of prohibition. Emotional reactions, however, provide a poor foundation for law. Legal prohibition of the sale of organs makes such sales absolutely wrong, regardless of individual concrete circumstances that could justify such a sale. It also focuses public discussion on how best to ration organs that are in short supply, and on methods to increase the supply that for two decades have proven only marginally effective. Many ethical issues arise from the problem of rationing scarce organs: how to weigh severity of illness, geographic location, racial inequities, for example. These issues would simply not exist if the supply of organs were adequate.

The effect of prohibition has been disproportionately adverse on poor minorities. Organs, both from living donors and cadavers, have great value, and financial benefit to donors disproportionately harms poor people. Prohibiting the sale of organs reduces special incentives for poor people to donate, and the disproportionate number of blacks in that group translates into reduction of availability of biologically suitable organs for blacks in particular. While prohibition of organ sales harms everyone, its disproportionate effect on blacks means that reversing it would disproportionately benefit them.

There are strong moral and ethical arguments that lead to the conclusion that absolute prohibition of the sale of organs should be rejected. By changing the focus from rationing of scarce organs to increase the numbers of organs available for transplantation, we will at least be free to discuss, as we are not now, what kind of financial rewards would work best in assuring an adequate supply of organs. Increasing the range of policy choices in this way may smooth the road toward disappearance of the organ gap.