

PRIVATE ORDERING AND INTIMATE SPACES: WHY THE ABILITY TO NEGOTIATE IS NON-NEGOTIABLE

*Michele Goodwin**

KIDNEY FOR SALE BY OWNER: HUMAN ORGANS, TRANSPLANTATION, AND THE MARKET. By *Mark J. Cherry*. Washington, D.C.: Georgetown University Press. 2005. Pp. ix, 258. \$26.95.

INTRODUCTION

For prospective transplant patients, options are limited under the present organ donation model in the United States. Risk takers—patients frustrated by government bureaucracy—now leave the United States and travel straight to the black market in developing countries where the wait for organs is four weeks, instead of four years. They bargain—contract, if you will—for their organs. Nevertheless, their organs are contraband of sorts, obtained by flouting the National Organ Transplant Act,¹ which proscribes the buying and selling of body parts, as well as international protocols prohibiting trafficking in persons and organs. Both the sellers and purchasers of these organs participate in a delicate, if not dangerous, process. Kidneys, lungs, livers, and other body parts are obtained from prisoners on death row in China, from mothers in India wanting food to feed their families, from equally desperate Brazilian and South African men hustling to survive the cruel realities of poverty. Patients acknowledge that organ trafficking is a cruel process within which informed consent may be more illusory than real, but Americans line up to participate. Transplant coordinators can be found on the internet, and because of a failing U.S. transplantation system, most of these patients believe they have no other choice.

Yet most bioethicists seem wedded to the current federal model of “altruistically” obtaining organs. They argue that “organs should be understood as gifts, not commodities” (p. 4). They refuse to endorse most if not all proposals that provide incentives for organ sharing or that allow individuals to

* Professor of Law, DePaul University College of Law. I would like to thank Richard Epstein, Martha Ertman, June Carbone, Benjamin Hippen, John Paris, and James Taylor for engaging with me on the body parts as property question. Most specifically, Martha and Andrew inspired alternate ways of viewing these questions beyond the traditional commodification discourse. I am grateful to the faculty and students at Washington and Lee University, the University of Chicago Law School, and Harvard Law School where ideas expressed in this article have been presented. I would also like to thank Erin Crow for her outstanding research assistance. I am also very grateful to Noah Roth and his colleagues at the *Michigan Law Review*.

1. 42 U.S.C. § 274e (2000).

negotiate privately for organs. Most bioethicists continue to represent a global alliance against markets and private ordering in body parts, finding such practices “deeply morally repugnant” and fearing the demeaning of personhood (p. 8). Their arguments—that organ procurement incentives lead to the commodification of the human body, coercion, medical exploitation, the demeaning of human dignity, and disregard of the sanctity of life—are clearly persuasive and impact public policy. There is nearly global consensus on prohibiting the sale of organs. But whether an absolute proscription on organ sales makes sense is debatable in light of human suffering, high rates of mortality on transplantation waitlists, the rise in the number of children forced to become organ donors domestically, exploitation of people in the third world to meet our organ demand, and the acceptance of organ transplantation as a beneficial and preferred medical treatment for many illnesses and diseases.

In *Kidney For Sale By Owner: Human Organs, Transplantation, and the Market*, Mark Cherry² chronicles the bioethics movement that produced the ban on organ sales in favor of altruistic organ procurement. Cherry’s thesis, that organ sales should be legal, radically challenges conventional wisdom and represents a refreshing departure from traditional hegemonic transplantation discourse in three nuanced ways. First, he makes a moral case against altruism and rejects the gift of life concept, asserting that laws which reduce organs to a “community good” controlled by the government undermine patients’ health options and “color[] much of the debate regarding the permissibility of an organ market” (p. 5). In this, he argues, the government exploits rather than aids dying patients.

Second, Cherry critically assesses whether offering financial incentives to donate organs actually coerces the poor and exploits the economically vulnerable, rather than providing some benefit to them. Cherry challenges the conventional wisdom that incentives necessarily violate the poor. He critiques the validity of that entrenched position in light of inadequate evidence to buttress that claim.

Third, and finally, he concludes that the consensus against selling human organs is flawed because it inadequately addresses the distinction between different body parts, privacy rights, and the strength of ownership rights in bodies. In an era of increasing dissatisfaction with the inefficiency of the United States’ transplantation regime, this book issues a spirited call to re-evaluate the wisdom of an organ procurement system that relies exclusively on altruistic transfers.

Scholarship in this domain is long overdue, and Cherry builds a marvelous case for his proposal. However, the author leaves the question of racialized exploitation, one of the central objections to commodification, virtually unchallenged. Indeed, the most poignant critiques against organ selling are race-based, particularly the claim that commodification would harm racial minorities in the United States and abroad. Most scholars ignore the disproportionate demand for kidneys among African Americans, but in

2. Associate Professor of Philosophy, Saint Edward’s University.

making their case against commodification, they invoke horrific images about the exploitation of African Americans and the destitute.

Thus, African Americans are a transitional good in these intense debates. Proponents of commodification regimes in organ transplantation typically, and artfully, avoid race landmines and in doing so unnecessarily (and perhaps unwittingly) concede that African Americans will not fare better under a commodification regime or that African Americans are incapable of deciding whether or not to commodify for themselves. Cherry's fine attempt to breathe new life into a rather stagnant debate offers a slight refraction to the most crucial aspect of that debate. Before Cherry's book, African-American patients were virtually invisible, and after the book, their concerns remain static. Here is a critical opportunity to redefine the debate about financial incentives in medicine and expose how commodification of organs might work if we pay attention to the needs of African Americans and other people of color.

In this review, I wish to push the thinking about the public/private distinction a bit further and to study both analytically and empirically the legitimacy of organ commodification. I wish to uncloak the notion that public regulation always benefits the disenfranchised. In particular, this review seeks to add the concept of law and status to the public/private ordering debate and to suggest that in the context of organ and tissue demand, private ordering maximizes participation and promotes more equitable participation among those of vulnerable status, including racial minorities and children. By contrast, the federal prohibition on body-part selling undermines private ordering, exacerbates organ demand, increases waiting time, penalizes the poor, and results in thousands of unnecessary deaths per year. A market-based system that coexists with altruistic donation introduces greater reliability to the larger complex of organ procurement and distribution. Greater reliability is likely to inspire greater confidence in the organ procurement system.

This review moves beyond a critique of Cherry's study to incorporate a radical new way of thinking about organ commodification as a social justice issue. Part I provides a brief empirical overview of organ demand in the United States, offering an alternative perspective and introducing data ill-examined in commodification debates. Part II challenges the notion that private ordering abandons liberal and egalitarian values in favor of individualism over communitarianism. It also acknowledges the limitations of private ordering and addresses how its more problematic features, including the abuse of power, might be avoided. Part III argues for a hybrid system that reorders regulation of intimate spaces. It proposes a system that allows incentives to coincide with altruistic donation. Finally, Part IV contends that the discussion of commodification needs to change in order to incorporate all members of society. Only after we change the discussion from whether or not to commodify to what degree of commodification is socially acceptable will this incorporation happen.

I. ORGAN COMMODIFICATION AS SOCIAL JUSTICE?:
AN EMPIRICAL OVERVIEW

Over 92,000 people in the United States wait anxiously for the elusive phone call that an organ donor has been located.³ Scattered throughout the United States, this odd mix of men, women, and some children comprises all socio-economic classes, religions, and ethnicities. The gravity of the organ procurement process may be best understood if we examine the actual waiting lists, and observe the potential kidney patients' death rates. For example, every four hours a patient waiting for a kidney dies. In 2000, 47,280 people were waiting for kidneys.⁴ As of August 21, 2006, the waitlist had increased by nearly fifty percent to 67,373.⁵ Well over one third of these patients were African-American.⁶ The median waiting period has also increased substantially.⁷ In 1994, the wait for a kidney was 715 days,⁸ and by 2001–2002 (the most recent year for which data is available) it increased to 1284 days for whites and inexplicably to 1842 days—nearly two years longer—for African Americans.⁹ Near the end of the 1990s, so few kidney transplantations had occurred as compared to need that the Organ Procurement and Transplantation Network (OPTN), which coordinates and collects data on organ transplants, found it “impossible . . . to calculate an overall median waiting time for 1996 and 1997 registrants” for its report in 1998.¹⁰ Opponents and proponents of organ commodification agree that the statistics are daunting and likely only to worsen with the increasing population of patients diagnosed with diseases that lead to kidney failure, including severe obesity and diabetes.

African Americans are disparately impacted by the organ shortage; they suffer the longest waits and experience the highest death rates on transplant

3. United Network for Organ Sharing, <http://www.unos.org> (last visited Aug. 11, 2006).

4. Organ Procurement and Transplantation Network, *2005 OPTN/SRTR Annual Report*, Table 1.3, available at <http://optn.org/AR2005/default.htm> (follow “Download 2005 Annual Report” hyperlink) (last visited Aug. 21, 2006) [hereinafter *2005 Annual Report*].

5. Organ Procurement and Transplantation Network, Data, <http://optn.org/data> (last visited Aug. 21, 2006).

6. Organ Procurement and Transplantation Network, Organ by Ethnicity, <http://www.optn.org/latestData/step2.asp> (choose category “waiting list” and count “candidates” and select “organ by ethnicity”) (last visited Aug. 21, 2006) (listing 23,368 African-American kidney transplant candidates).

7. *2005 Annual Report*, *supra* note 4, at Table 1.5.

8. Organ Procurement and Transplantation Network, *2003 OPTN/SRTR Annual Report*, Table 1.6, available at <http://optn.org/AR2005/default.htm> (follow “Download 2003 Annual Report” hyperlink) (last visited Aug. 21, 2006) [hereinafter *2003 Annual Report*].

9. Organ Procurement and Transplantation Network, *Kidney Kaplan-Meier Median Waiting Times for Registrants Listed 1997–2002*, <http://www.optn.org/latestData/latestData/step2.asp> (choose category “median waiting time” and choose organ “kidney” and select “waiting time by ethnicity”) (last visited Aug. 21, 2006).

10. *2003 Annual Report*, *supra* note 8, Table 1.6.

waitlists.¹¹ Yet their experiences are rarely treated as a cause for considering radical alternatives such as commodification or using traditional civil rights legislation like Title VI as a remedy.¹² Nor has the suffering of African-American patients and others inspired the United Network for Organ Sharing (UNOS), the private agency that organizes the United States transplantation regime, to chart an alternative vision for organ procurement.¹³ To the contrary, alternate approaches to organ procurement become stymied by liberal paternalism that generally ignores African Americans as organ consumers and recipients, and focuses almost exclusively on the quality of their organs as *donors*.

For many years, commentators predicted that African Americans would suffer most under an organ transplantation system that promotes incentives. Not only are their assumptions based primarily on deficient data,¹⁴ but to

11. Michele Goodwin, *Altruism's Limits: Law, Capacity & Organ Commodification* 56 RUTGERS L. REV. 305 (2004); Organ Procurement and Transplantation Network, Organ by Ethnicity, <http://www.optn.org/latestData/step2.asp> (choose category "waiting list" and count "candidates" and select "organ by ethnicity") (last visited Aug. 21, 2006); see also Robert S. Gaston et al., *Racial Equity in Transplantation*, 270 J. AM. MED. ASS'N 1352 (1993); J. Michael Soucie et al., *Race and Sex Differences in the Identification of Candidates for Renal Transplantation*, 19 AM. J. KIDNEY DISEASE 414 (1992); Kevin McCoy, *Deadly Disparity in Transplants: Blacks & Hispanics Deprived*, DAILY NEWS (New York), Aug. 8, 1999, at 6 (exploring "the fairness question by comparing the population of whites, blacks, and Hispanics in New York City and eight surrounding counties with racial breakdowns of patients who received transplants in the region from 1996 through 1998"); Brigid Schulte, *Minorities Face Unequal Health in U.S.: Statistics Show Ethnicities Encounter Higher Illness Rates*, FT. WORTH STAR-TELEGRAM, Aug. 2, 1998, at 1 (reporting on research conducted over several months by a team of Knight Ridder reporters, "interviewing 250 doctors, scientists, government officials, epidemiologists, minority advocates and patients"); *Nightline: America in Black and White*, (ABC television broadcast Feb. 24, 1999) (interviewing doctors, patients, and medical students about race and health, including a discussion with Dr. Clive Callender about racism in organ transplantation referral process).

12. *IOM Report On Increasing The Number Of Organ And Tissue Donors In The US Called Too Cautious By Some Observers*, TRANSPLANT NEWS, May 30, 2006 (noting that despite the very persuasive claims in the IOM report about transplant disparities and deaths resulting from a shortage in the supply of organs, incentives and alternate therapies such as stem cell exploration and development were omitted, rejected, or simply not recognized as viable alternatives)(citation omitted).

13. United Network for Organ Sharing, *Financial Incentives for Organ Donation* (1993), available at <http://www.unos.org/resources/bioethics.asp?index=3> (last visited Aug. 11, 2006) (sub-committee report recommending against pursuing incentives to cure organ shortages); see Richard Epstein, *Kidney Beancounters*, WALL ST. J., May 15, 2006, at A15; Charles B. Fruit, Letter to the Editor, *Organ Donors, For Love and Money*, N.Y. TIMES, May 19, 2006, at A24; see also Ian Ayres et al., *Unequal Racial Access to Kidney Transplantation*, 46 VAND. L. REV. 805 (1993); Gaston et al., *supra* note 11; Soucie et al., *supra* note 11.

14. Over the years, most opponents to organ and tissue commodification cite Richard Titmuss and his iconic 1971 work *The Gift Relationship* to buttress their claims that incentives in body parts and human tissues will result in unhealthy supply pools. Titmuss predicted that only unhealthy, "skidrow" persons and "negroes" would alienate their blood and that these groups would contaminate the blood supply. Titmuss's predictions fell short, but were particularly persuasive during the intense period of segregation and social racial divides. RICHARD TITMUSS, *THE GIFT RELATIONSHIP* (1971); see also, ARTHUR L. CAPLAN, *IF I WERE A RICH MAN COULD I BUY A PANCREAS? AND OTHER ESSAYS ON THE ETHICS OF HEALTH CARE* 158-77 (1992); MARGARET JANE RADIN, *CONTESTED COMMODITIES* (1996)(predicting that organ incentives would defile personhood and trample moral values); Leon R. Kass, *Organs for Sale? Propriety, Property, and the Price of Progress, in POLITICS AND THE HUMAN BODY: ASSAULT ON DIGNITY* 153, 171 (Jean Bethke Elshstain & J. Timothy Cloyd eds., 1995) (arguing that human dignity is compromised by treating the body in market terms); Margaret Jane Radin, *Market-Inalienability*, 100 HARV. L. REV. 1849, 1851 (1987) (arguing

date there is not any scientific evidence to support such claims. Nor have those most opposed to organ commodification and its potentially racist impact bothered to perform quantitative or qualitative research in African-American communities to test the validity or strength of their assumptions.

Nevertheless, fears that African Americans will be reduced to scientific chattel rightfully concern lawmakers, commentators, and bioethicists. The challenge, it seems, is parsing out the legitimate claims about the potential downsides of markets from the more provocative political packaging that simply arouses racial animus and fear. On the whole, conservative commodification proponents as well as liberal pessimists ignore the fact that African Americans might very well benefit from the introduction of incentives into the current transplantation system because African Americans need kidneys more than any other group.

In the movement to generate greater public consensus and support for organ commodification, proponents have made two significant mistakes. First, what they overlook in the suffering of African Americans is not simply another ethnic population on the organ transplant waitlist, but a critically important ally in the philosophical, moral, and public policy “fight” for system alternatives. The second mistake is the manner in which commodification becomes defined. Human suffering—an incredibly powerful metaphor—is typically reduced to tedious arguments of efficiency, rather than social justice. When viewed through the lens of social justice, greater access to kidneys through incentive-based programs becomes reframed, shifting from a policy perceived to benefit only wealthy white people to one that seems more inclusive and imperative for all kidney patients.

II. PRIVATE ORDERING AS COMMUNITARIAN ETHIC: RETHINKING COMMODIFICATION

Traditionally, legal scholars concerned about curing America’s organ crisis focused primarily on moral justifications for the ban on organ sales and emphasized that any legitimate system for addressing the organ shortage must place altruism at its operational core. By doing so, they directed attention to the question of whether or not to commodify, deflecting “attention away from more useful inquiries into the interactions between marketization proposals and the distribution of social power.”¹⁵ Very few new ideas develop out of this limited framework, which quickly denounces any alternatives to a free supply of organs as an immoral attack on egalitarian values and progressive social norms. Thus, more provocative proposals to readdress organ deficits get mired in minutiae, and the prevailing approach is to focus primarily on superficial issues and less significant enhancements

that the “characteristic rhetoric of economic analysis is morally wrong when it is put forward as the sole discourse of human life”); Rick Weiss, *A Look At . . . The Body Shop: At the Heart of an Uneasy Commerce*, WASH. POST, June 27, 1999, at B3 (observing that “[r]ather than reducing disparities . . . compensation for organs might exacerbate the differences, turning the poor into surgical ward slaves or feudal donors for the rich”).

15. MARTHA M. ERTMAN & JOAN C. WILLIAMS, RETHINKING COMMODIFICATION 5 (2005).

to the current procurement methods, including whether additional public service announcements or renaming organ procurement organizations might inspire greater altruistic organ donation. This type of system-tweaking fails to generate even incremental results and ultimately cannot be justified as a more enlightened moral approach in light of thousands of deaths attributable to poor public policy.

In this portion of the review, Section A briefly examines the seemingly insurmountable impasse to introducing and moving alternate policy initiatives forward. Section B argues for a radical departure from past commodification thinking by introducing the idea of private ordering to intimate spaces.

A. *Autonomy Misapplied and Reconsidered*

Cherry thoroughly documents the critical nature of the organ crisis in the United States and abroad, and the circumstances that ultimately exacerbate transplant delays and deaths, including the rise in transplant candidates over the past fifteen years and antigen and blood matching issues (pp. 2–3). The statistics Cherry presents are quite daunting, but not new; Pellegrino,¹⁶ Caplan,¹⁷ Fentiman,¹⁸ and others have also picked apart this issue and reached the same inevitable conclusion: more organs are needed. Neither the consequences nor the prescription requires translation: without an increased supply, thousands of Americans will die each year.

Why, then, have scholars, including Cherry, either avoided or overlooked examining the organ procurement dilemma as a matter of social justice? One reason is that scholars and commentators dehumanize the transplantation process, casting the most vulnerable primarily as donors and not potential organ recipients. A second possible explanation for this oversight, as discussed earlier, is that commentators perceive the theory that African Americans will suffer under a commodification system to be a powerful, unassailable argument, or at least they concede that point. One must conclude that the debate about organ supply misapplies autonomy, treating self-governance as a narrow utilitarian value applicable only to the exercise of altruistic organ donation.

Autonomy—a principle of self-determination and independence—has its place among the most fundamental ideals of liberty and the authority to transact freely in all aspects of one's life, including negotiating and entering into contracts by making and accepting offers and the right to be free from the interference of others. Autonomy is the principal ingredient in the debates and the ultimate judicial or legislative conclusions about creating and

16. Edmund D. Pellegrino, *Families' Self-Interest and the Cadaver's Organs: What Price Consent?*, 265 J. AM. MED. ASS'N 1305 (1991).

17. Arthur L. Caplan & Daniel H. Coelho, *Allocation and Rationing: Introduction*, in THE ETHICS OF ORGAN TRANSPLANTS: THE CURRENT DEBATE 247 (Arthur L. Caplan & Daniel H. Coelho, eds.) (1998).

18. Linda C. Fentiman, *Organ Donation as National Service: A Proposed Federal Organ Donation Law*, 27 SUFFOLK U. L. REV. 1593 (1993).

destroying life: for example, that women possess the authority to choose reproductive and family planning,¹⁹ and that dying patients can refuse medical interventions.²⁰ Judge Cardozo, for example, spoke forcefully to this after the turn of the twentieth century, when in *Schloendorff v. Society of New York Hospital*,²¹ he wrote that “[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body.”²²

Equally, autonomy is a valued social norm in organ transplantation, but ironically only to the extent that individuals surrender organs without any consideration (pp. 85–86). The very meaning of autonomy has been misaligned with the issues in this debate and is now incongruent with principles and expectations of self-determination, namely the ability to govern oneself and the capacity of rational as well as irrational persons to make binding decisions. Rather, autonomous decision-making has become aligned with selflessness, sacrifice, and compassion in the transplantation realm.

By contrast, commentators portray alienation as subversive in organ transplantation, and, therefore, as incompatible with autonomous values. Yet this approach fails to consider that refusing to donate organs and deciding to alienate one’s organs are autonomous actions of equal legal, political, social, and moral value. Commodification proponents will lose the public confidence debate on organ incentives as long as their proposals are situated within the traditional paradigm. For Cherry and others, the challenge must be to reframe the traditional debate on incentives, including repositioning and appreciating African Americans as patients and not simply as donors. Further, incentive proponents should reject the very slippery, pervasive, but dishonest presumptions that incentives are not in the best interest of African Americans or that commodification leads to the exploitation of poor persons of color rather than concede the point through an obvious failure to address the racial component underlying the commodification debate. By failing to recognize African Americans in the first instance as patients, commodification proponents give unnecessary validity to the exploitation hypothesis, which happens to lack scientific merit and support.²³ Scholarly reframing of autonomy and the freedom of donors to contract away their organs would make a significant impact on the incentives debate.

19. See *Roe v. Wade*, 410 U.S. 113, 152–53 (1973).

20. See *The Patient Self Determination Act of 1990*, 42 U.S.C. § 1395 (2000); *Gonzales v. Oregon*, No. 04-623, slip op. (U.S. Jan 17, 2006); *Cruzan v. Director, Mo. Dep’t of Health*, 497 U.S. 261 (1990); *Schiavo ex rel. Schindler v. Schiavo*, 403 F.3d 1289 (11th Cir. 2005) (opining that the lower court properly denied parents’ request for a temporary restraining order requiring the resumption of nutrition and hydration for their incapacitated daughter because the parents failed to make a substantial claim that court-ordered withdrawal violated the Americans With Disabilities Act, the Eight Amendment or the Rehabilitation Act).

21. 105 N.E. 92 (N.Y. 1915).

22. *Id.* at 94.

23. See *supra* note 14.

B. Rethinking Commodification and Private Ordering

Cherry argues that Western bioethics aspires to articulate a universal medical morality, but that in doing so it reveals an insidious, invasive quality because it attempts to impose its general consensus and expertise on the rational individual (p. 64). He's right. My only disagreement arises with the implication that such impositions might be permissible if individuals are less rational, dysfunctional, or perceived as such. The liberal response is to concede that paternalism has a positive function in the lives of those less educated and well positioned. Traditionally, African Americans were lumped into those categories and continued to be judged based on the social construction of race, which carries its own political and social consequences even while it has no biological meaning.²⁴ The liberal order ignores nuanced ordering of human lives and human value where all individuals are not positioned equally, not by natural quality, but by social construct.

In the new liberal order, two significant mistakes occur. First, scholars essentialize and infantilize African Americans, in much the way that Titmuss cautioned that "negro" blood sellers were a menace to themselves and would contaminate the blood supply with insalubrious blood.²⁵ African Americans become conditioned only as donors and not as recipients, which ignores the affirmative benefits that a greater supply of organs could mean to that community. Second, African Americans are reduced to irrational beings because they might consider saving lives by selling their organs. This temperamental ordering suggests that rationality disappears from African Americans in the contexts of private ordering or contracting and reappears only when African Americans give away their organs. Paternalism of this sort belies the function of American jurisprudence. American common law jurisprudence rejects rescue doctrine, and outside of minors and the medically incompetent, courts avoid paternalistic interference in the lives of individuals.²⁶

On the other hand, Cherry does make the case that bioethical paternalism has limited merit in the lives of rational, arguably white individuals (p. 57) or what Janet Landa describes as the ethnically homogenous middleman group.²⁷ Yet, by conceding that those with limited social value are incapable of independent decision-making, liberals will continue to defeat any agendas to integrate alternatives into the broader analysis of organ

24. See DOROTHY ROBERTS, *KILLING THE BLACK BODY* (1997); see also *CRITICAL RACE THEORY: THE CUTTING EDGE* (Richard Delgado & Jean Stefancic eds., 2d ed. 2000); Derrick A. Bell, *Who's Afraid of Critical Race Theory?*, 1995 U. ILL. L. REV. 893 (1995); Richard Delgado, *Two Ways to Think About Race: Reflections on the Id, the Ego, and Other Reformist Theories of Equal Protection*, 89 GEO. L.J. 2279 (2001).

25. TITMUSS, *supra* note 14, at 151–52.

26. See, e.g., *McFall v. Shimp*, 10 Pa. D. & C.3d 90 (Ch. Ct. 1978); *Yania v. Bigan*, 397 Pa. 316, 155 A.2d 343 (1959) (refusing to impose liability on defendant for failure to render aid in a drowning death).

27. Janet T. Landa, *Bounded Rationality of Homo Classificus: The Law and Bioeconomics of Social Norms as Classification*, 80 CHI.-KENT L. REV. 1167 (2005) (suggesting the existence of an economy of identity in which access to markets is controlled by appeals to homogeneity).

transplantation. Neither should we draw lines randomly at rationality. Should the less rational be excluded from the same privileges and protections afforded those better able to articulate their social status and navigate political and economic institutions? Let's examine their arguments.

Public order proponents presuppose that government regulation of private spheres promotes fairness and equity in society by maximizing the best interest of its citizenry. Accordingly, this view of the divide between public versus private ordering suggests that only the wealthy, sophisticated, and skilled benefit from private contracts, or, at least, the poor and minority are always locked in positions of significant disadvantage. While the historical impact of discrimination is well documented, this liberal view presumes that the state always acts in the best interest of its minority and poor citizens, and that all citizens are equally situated with parallel bargaining power and access to resources, including the courts, legislature, and other rule-making bodies. But it is directly in the context of organ transplantation that such theories fail. Public order proponents conclude that the state is always a competent participant and that it does a better job of protecting minorities and the poor and promoting their interests than if the government were less involved and people negotiated on their own. The current organ crisis reveals the tragic flaw in this otherwise compelling idea. Delays and deaths await individuals forced to participate exclusively in the United States organ transplantation process, which disparately impacts the lives of people of color.²⁸

Critics of private ordering denounce its lack of consistency and its possible exploitation of vulnerable populations, but these claims seem wedded to an essentialized perception of African Americans and a paternalistic welfare model that never allows the private citizen, in this case African Americans, to "go off" the dole. In this way, the liberal society handicaps the vulnerable "for their own good." Moreover, public order rationales presume a lack of sophistication among vulnerable groups, in this case racial minorities. Private ordering in the realm of body parts, so the rhetoric goes, would promote corruption, coercion, and slavery-like dynamics. This type of paternalism reinforces racial and class hierarchies, suggesting that private negotiating is bad simply because racial minorities are incapable of acting in their own interests and that spurious motivations attend all incentive considerations. Private ordering in organ transplantation might inspire African Americans to organize among themselves in churches or fraternal and sorority organizations to eliminate this health disparity in their own communities. Critics overlook that private negotiating can promote inclusion in social and economic systems that once functioned to exclude racial minorities and other politically disenfranchised groups.

Perhaps as a result of this potential for greater inclusion, scholars in less racially provocative—although no less important or controversial—domains are reconsidering the value as well as the pitfalls in commodification and

28. Barbara A. Noah, *Racial Disparities in the Delivery of Health Care*, 35 SAN DIEGO L. REV. 135 (1998).

private ordering.²⁹ Their ability to engage in those dialogues, particularly in the family law realm, indicates potential for broader consideration in the organ transplantation field. On the other hand, race, as a subtext in commodification debates, may be so polarizing that the only spaces in which private ordering or contract law is free from intense contestation happen to be in the domains where whites may be significantly more or exclusively valued (or perceived as such) as babies, embryos, mothers, and fathers.³⁰ The most rapidly expanding approach to commodification happens to be in the family law context, including women and household labor,³¹ adoption,³² and assisted reproduction.³³

Scholars in these areas indicate a new trend toward private ordering, which engages market concepts in the sacred, intimate spaces of the body and personhood itself.³⁴ Their effort contextualizes commodification and illustrates the incomplete state of commodification theory, which fails to account for social nuances and overstates commonalities or political, social, and moral realities of groups.

Once scrutinized, arguments to distinguish private negotiations in family planning and reproduction from the organ supply illuminate subtle, real differences that actually are not so compelling as to justify our failure to consider alternate transplant approaches. Rethinking organ commodification

29. See, e.g., Martha M. Ertman, *What's Wrong with a Parenthood Market?: A New and Improved Theory of Commodification*, 82 N.C. L. REV. 1 (2003).

30. Since the adoption market is largely unregulated, the cost discrepancies in adopting children of differing races are striking: the cost of adopting a white child may exceed \$50,000 while adopting an African-American child can be completed for as little as \$4,000. See Dusty Rhodes, *Baby Trade*, ILL. TIMES, Feb. 17, 2005, available at <http://www.illinoistimes.com/gyrobase/Content?oid=oid%3A3990>; Bonnie Miller Rubin, *Adoption Bill Targets Legal Loopholes*, CHI. TRIB., Mar. 27, 2005, at C1.

Additionally, newspaper advertisements show a great demand for white ova to be used in fertility treatments. See *Couple Seeks Eggs for \$100,000*, VERO BEACH PRESS J., Feb. 9, 2000, at A16 (indicating the known highest public offer seeking eggs ran in Stanford University's student newspaper, offering \$100,000 for "the eggs of a bright, young, white athlete").

31. See, e.g., Katharine Silbaugh, *Commodification and Women's Household Labor*, 9 YALE J.L. & FEMINISM 81 (1997).

32. See, e.g., Ertman, *supra* note 29; Michele Goodwin, *The Free Market Approach to Adoption: The Value of a Baby*, 26 B.C. THIRD WORLD L.J. 61 (2006); Elisabeth M. Landes & Richard A. Posner, *The Economics of the Baby Shortage*, 7 J. LEG. STUD. 323 (1978).

33. See, e.g., Lori B. Andrews & Nanette Elster, *Regulating Reproductive Technologies*, 21 J. LEGAL MED. 35 (2000); Judith F. Daar, *ART and the Search for Perfectionism: On Selecting Gender, Genes, and Gametes*, 9 J. GENDER RACE & JUST. 241 (2005); Michele Goodwin, *Assisted Reproductive Technology & The Double Bind: The Illusory Choice of Motherhood*, 9 J. GENDER RACE & JUST. 1 (2005).

34. See MARTHA ALBERTSON FINEMAN, *THE NEUTERED MOTHER, THE SEXUAL FAMILY, AND OTHER TWENTIETH CENTURY TRAGEDIES* 228–30 (1995); June Carbone, *What Do Women Really Want? Feminism, Justice and the Market for Intimate Relationships*, in FEMINISM CONFRONTS HOMO ECONOMICUS 405 (Martha Albertson Fineman & Terrence Dougherty eds., 2005); Eric Rasmussen & Jeffrey Evans Stake, *Lifting the Veil of Ignorance: Personalizing the Marriage Contract*, 73 IND. L.J. 453 (1998); Barak D. Richman, *Essay, Firms, Courts, and Reputation Mechanisms: Towards a Positive Theory of Private Ordering*, 104 COLUM. L. REV. 2328 (2004); Silbaugh, *supra* note 31; Viviana A. Zelizer, *Intimate Transactions*, in THE NEW ECONOMIC SOCIOLOGY: DEVELOPMENTS IN AN EMERGING FIELD 274 (Mauro F. Guillén et al. eds., 2002).

offers an opportunity for commentators to move beyond the all-or-nothing approach to commodification, to explore which aspects of commodification we can live with in a modern, biotechnology-rich society, and to distinguish those from the cruder, more debasing types of private ordering.

III. PRIVATE ORDERING AND ALTRUISM RECONCEIVED

How do we shape a procurement system that embraces social justice, promotes organ procurement, and respects individual autonomy? The answers may be far less complicated than prior scholarship would lead us to believe. The organ crisis, after all, has little to do with a shortage of organs. Rather, federal legislation prohibits and criminalizes the use of any organ obtained outside of altruistic procurement.³⁵ The challenge, then, is repealing the National Organ Transplant Act and crafting procurement alternatives that balance the need to avoid “bloodlessness” and the courage to move beyond an arranged marriage to altruism.

Several alternatives are immediately available to enhance organ procurement in the United States: presumed consent, directed donations, and commodification. Each could potentially increase organ supply. Cloning, stem-cell therapies, and xenotransplantation also offer future alternatives for organ enhancement or supply, but are far too premature to guarantee success. However, these alternatives are not without controversy. The problems as well as the benefits that attend to these models are worthy of detailed scrutiny and consideration. But the proposal that I find the most promising is a hybrid system that supports donor altruism but allows for a market in cadaveric organs to thrive alongside the contemporary model.

This hybrid approach would maximize organ supply without disturbing altruism or minimizing the value of autonomous decision-making. Those who prefer the all-or-nothing approach to commodification might critique this proposal as a less robust commodification plan. For others, according to Cherry, “[o]ne possible concern is that the market will intimidate charitably inclined persons who will thereby view themselves as precluded from giving away organs” (p. 87). Moreover, critics of altruistic organ donation, who rightfully illuminate its problematic, less altruistic side (compelled donations from children, coercion, pressure, and guilt from dying relatives) might want to abandon that system altogether. These weaknesses and limitations must be acknowledged in all transplantation proposals and this one in particular. Yet, as discussed below, the proposed hybrid system embraces greater transparency and, unlike prior commodification proposals, fully focuses on social justice. Furthermore, a more palatable incentive-based system might provide the necessary testing ground for a later, more progressive system of incentives.

Section A further develops a coordinated model of altruism and commodification. It also briefly discusses the secondary unique benefits associated with introducing a market in the intimate space of organ negotia-

35. 42 U.S.C. § 274e (2000).

tions. Section B argues that rather than undermine personhood, direct incentives to organ sellers reorder power dynamics, giving individuals greater control over their bodies.

A. *The Model Defined*

This is a simple model with one clear distinction from other commodification proposals. In this proposed hybrid market model, harvesting would be restricted to posthumous organ removal, thereby avoiding the murkier and far more problematic issues involved in living incentive donations. This model would be *pareto superior* were a market to be legalized. *Pareto superior* requires that in market transactions for limited social goods, at least one person be made better off and that no one be made worse off.³⁶ The application of this principle fits neatly within the proposal's goals of promoting social justice and the efficient procurement and distribution of organs. Individuals would not be paid for living donations, but could be reimbursed for expenses associated with living donations such as loss of income, medical expenses, travel costs, and other financial expenditures resulting from their donations. These would not be payments for the organ(s), but would clearly help families recover from the economic burdens associated with donations. This model would also permit individuals to negotiate for organ transfers upon death. Family members, the decedent's estate, or charitable organizations could be compensated for the organs. Finally, federal oversight is an essential component of this model. The Food and Drug Administration performs a vital role in monitoring the health and safety of biological, pharmaceutical, and medical devices introduced to the market, and I perceive its role to be equally important in the domain of organ selling.

The hybrid approach is novel, but not necessarily new to market paradigms or uncontroversial. For example, some scholars believe that *pareto superior* transactions are misleading. According to them, it is impossible for one person's position to be enhanced without somehow making the other worse off (i.e., *pareto inferiority*). In this way, they would suggest that both sellers and purchasers are "worse off" because both parties have demeaned their personhood and degraded themselves in the process. As discussed in Part II, altruism and markets coexist in the reproductive realms of ova donation and selling, as well as in adoption through both state-facilitated foster care to adoption processes and private adoptions that involve lawyers, brokers, and agencies. In these scenarios as well as in my proposal, altruism competes minimally with markets. Indeed, my proposal only expands the realm of permissible coexisting spheres of markets and altruism, which already consist of other essential, though non-biological, "goods" and services, including food, clothing, health care, and medical insurance.

Proffered *pareto inferiority* claims which attempt to respond to incentive-based organ procurement are overstated and potentially misleading, but

36. See Adam J. Kolber, *A Matter of Priority: Transplanting Organs Preferentially to Registered Donors*, 55 RUTGERS L. REV. 671, 704 & n.154 (2005).

that is not to suggest that the alienating party has not experienced a loss of certain kind. How we describe those losses can further explain and distinguish whether the commodifier's potentially "worse off" status is attributable to organ alienation or other exogenous circumstances existing in her life, including housing, food, and other costs. In the altruism-based system, much of the public rhetoric assumes an automatic life transformation that unlike incentive proposals ignores the possibility of any subsequent negative equilibriums.

Commodification exponents' most salient claims of *pareto inferior* consequences of organ alienation might relate to other factors (though not absolutes) in alienation of intimate spaces. In particular, the more economically destitute might suffer non-economic intangible losses such as embarrassment, shame, and humiliation if their lives are not transformed by organ alienation. It would be unwise to ignore this line of argument, especially because it resonates in the legal and cultural spheres. However, this reasoning does not merit the weight or status incentive opponents would wish that we grant it. These claims, which have resonance in civil agreement law, are less well placed here because they are too difficult to police (and accommodate), too difficult to afford a remedy, they involve prior established informed consent, and most importantly they compete with far more important values such as self-determination, autonomy, and the rule of law. The role of the law is not to remedy every instance in which we would like to change our minds or reward those instances in which we believe that fair market value was lower than the worth of our goods. This well-settled concept is challenged by the intimate nature of organ alienation, but no less firmly supported by jurisprudence and custom.

Beyond increasing the supply of organs, private ordering in organ transplantation will likely benefit society in several meaningful ways. First, there would be more of an incentive to avoid buying organs on the black market since more organs would be available in regulated transparent domestic spheres. Black market organ shopping has the advantage of a reduced waiting time, but exposes the purchaser and seller to numerous health and social risks. Second, a more reliable system emerges with the use of incentives. Currently, the altruistic procurement system is mired by waitlist problems, including delays, deaths, unpredictability, and unreliability.

There are several key features of the proposed system:

- (A) Regulation is important and an essential part of business operation, and in organ markets, regulation would be important to promote and maintain transparency, privacy, health and safety.
- (B) This hybrid model maximizes participation in the procurement process. It allows individuals to negotiate between themselves, brokers, and insurance companies and maximizes one's ability to enter the market for organs at any time.
- (C) This model would also allow family members to alienate their relatives' organs. The consent issues and lines of priority would be similar to cur-

rent practices described in the Revised Uniform Anatomical Gift Act.³⁷ Unless the deceased prior to death objected to organ donation and alienation, her closest of kin would be permitted to altruistically donate or alienate the organs for financial incentives.

- (D) Social as well as medical histories from the supplier or her relatives would be required as a condition to organ transacting. Social histories reveal behaviors and other habits likely to impact the quality of organs. Negative social history would not foreclose the party from donating. To the contrary, as described below, an “impacted organ”—one less salubrious—might satisfy the needs of an individual with a similar health condition who realizes that an optimal organ would not reverse her most severe medical condition, such as HIV/AIDS, hepatitis, or cancer, but might nonetheless provide a quality of life currently absent from her life.
- (E) Measures to protect the psychological health of both parties should be incorporated in any and all human biological alienation processes. Most importantly, we would wish to reduce the risk of harassment, litigation, and breaches of confidentiality and abuse of privacy. Obtaining psychological as well as medical and social histories would likely provide valuable information to assist in the selection process.
- (F) Finally, organ suppliers should represent broad classes of individuals, including those who might have suffered from certain conditions that minimally affected his organs. Such organs may be less appealing to an otherwise disease-free recipient, but might be far more attractive to a patient with HIV or another condition who wishes to avoid an imminent death. In this way, no one is shut out from the procurement process—a process that could save a life—and disclosure of conditions is an unburdened exchange.

Third, incentives will likely promote better health outcomes for potential sellers and purchasers. Those interested in alienating organs at higher market values will have an incentive to stay healthy during their lives so that their organs will be “picked” for transplantation. The benefits here inure not simply to the individual, but extend also to families and sellers’ communities.

Fourth, economically disadvantaged individuals have an incentive to pursue better screening for illnesses both as suppliers and recipients. “According to Jack Lynch, African Americans are diagnosed for end-stage renal failure too late.”³⁸ Often, their doctors (or emergency room attendants) deliver fatal news of their medical condition in emergency rooms.³⁹ Prior to this complicated, life-altering time, these patients have avoided medical attention, doing

37. UNIF. ANATOMICAL GIFT ACT, 8A U.L.A. 29 (1987).

38. MICHELE GOODWIN, *BLACK MARKETS: THE SUPPLY AND DEMAND OF BODY PARTS* 87 (2006).

39. *Id.*

what Lynch refers to as the “ostrich move” explaining that “it’s out of sight and out of mind.”⁴⁰

In contrast, participants in the private ordering of families incorporate medical care, psychological evaluations, and sometimes therapy into their negotiation processes. All parties have an incentive to be as medically suitable and healthy as possible. Those who wish to become parents desire to pass psychological screening processes and attain a health status suitable for carrying a child. Likewise, ova donors have an incentive to be healthy. Medical screening and support has evolved into a standard benefit associated with the adoption and surrogacy processes. Similarly, in the context of organ selling, medical screenings to determine the health and vitality of the sellers will likely be a health benefit to participants and not simply a moment of objectification.

I have described a proposed organ-transplant incentive system that draws upon both altruism and markets, limited only by death as a prerequisite for incentive-based transactions. Yet to describe only the benefits disserves my interests as well as my attempt here to expand the dialogue about incentives, pitfalls, and creating a sustainable system to increase the odds of survival for patients dying from illnesses that are treated by organ transplantation.

B. *Preexisting Commodification*

According to Cherry, “[a]ll systems of procurement and allocation objectify and commodify human body parts, even donation” (p. 151). Whether for profit or not-for-profit, procurement industries “recast[] organs as a scarce medical resource and a “product” of exchange” (p. 151). In each instance, there are conditions stipulated as to which party bears the costs of organ harvesting, processing, distribution, and transplantation. Doctors, nurses, procurement organization specialists (paid professional solicitors), and hospitals receive financial compensation at some point connected directly to facilitating the transplant. Thus, according to Cherry, it is improper to criticize commercial markets as nefariously introducing market norms to organ transplantation without also examining the altruistic procurement process (p. 151). In short, he notes, the real debate in organ procurement is “less about commodification [and more] about who should receive the medical resources and who should bear the costs of appropriation and transfer” (p. 151).

Indeed, the answer to who, if anyone, should profit from providing life-saving services provides some indication that the “gift of life” concept in organ transplantation is a seductive fiction. Often the first and last person contributing anything altruistically is the organ donor. Commodification of services as well as body parts already exists and will likely continue.

The commodification of body parts, as well as the patenting of human biological resources, is well established in our health care and economic

40. *Id.*

systems.⁴¹ Recent headlines illustrate not only markets in body parts, but also the nefarious consequences when “donor” control is minimized.⁴² Even a cursory review of the headlines and recent investigative reports illuminates a robust industry in which informed consent is rendered meaningless when university hospitals, organ procurement organizations, funeral homes, and other industries involved in “death trade” purloin and sell altruistically donated body parts, thereby directly flouting the National Organ Transplant Act and the Uniform Anatomical Gift Act, both of which ban body-part selling. Recipients and their physicians purchase these life-saving purloined body parts from companies that trade on global stock exchanges.⁴³ Currently, the revenue resulting from the trade in human tissues annually exceeds one billion dollars.⁴⁴

IV. PRIVATE ORDERING & CITIZENSHIP

Whether individuals should be free to opt out of federal regulations in favor of private agreements or to structure private relationships where none currently exist are questions of significant political and legal magnitude. For some scholars, these are moral questions that strike at the heart of how we value and protect certain members and classes in society. Liberal scholars traditionally reject private ordering in favor of government regulation, arguing that law and economics theory maximizes efficiency, but at the risk of more important social values, including “individualism over community.”⁴⁵

Critics of private ordering rightfully cite civil rights legislation, environmental protection laws, and policies that dismantle institutionalized gender discrimination in employment, education, and even sports as testaments to government power to promote equality and correct social wrongs. Others who critique contract theory argue that “references to freedom and autonomy to describe contractual terms or decisions where choice is constrained and freedom circumscribed” extend a false bill of goods: private

41. Michele Goodwin, Commentary, *Commerce in Cadavers Is an Open Secret*, L.A. TIMES, Mar. 11, 2004, at B15.

42. See, e.g., David Snyder, *A Dispute Over Brain Donations; Families Allege Improper Consent in Lawsuits Against Bethesda Institute*, WASH. POST, June 30, 2005, at B1; see also, e.g., *Former Lifequest (FL) Organ Recovery Director Arrested On Charges Of Selling Organs to His Own Company*, TRANSPLANT NEWS, April 14, 2003, at 1; Tom Mashberg, *Med Examiner's Office Has Secret Body-Parts Deal*, BOSTON HERALD, May 20, 2002, at A1 (“The cash-strapped state Medical Examiner’s Office has a secret contract with a company that harvests body parts from donors without telling their next-of-kin the remains are often used for lucrative cosmetic surgery, documents reviewed by the Herald show.”).

43. See, e.g., Biotissue Technologies, <http://www.biotissue-tec.com> (last visited Aug. 21, 2006); CryoLife, Inc., <http://www.cryolife.com> (last visited Aug. 21, 2006); Exactech, Inc., <http://www.exac.com> (last visited Aug. 21, 2006); Regeneration Technologies, Inc., <http://www.rtix.com> (last visited Aug. 21, 2006).

44. Renie Schapiro, *Banking on the Gift of Tissue*, MILWAUKEE J. SENTINEL, May 2, 2005, at G1.

45. See Elaine A. Welle, *Freedom of Contract and the Securities Laws: Opting Out of Securities Regulation By Private Agreement*, 56 WASH. & LEE L. REV. 519, 521 (1999).

ordering, they suggest, is not the panacea some of us wish it to be.⁴⁶ They are correct that at times there are “blatant violations of liberal norms” in contract negotiations. Sometimes there is not any negotiating at all—simply signed contracts.

This type of Rawlsian idealism belies reality in many ways. Contract law is about freedom, and more importantly it is about power: the power to negotiate, bargain, consider, evaluate, and accept or decline opportunities. Commitment to bargain and to terms of agreements reached through a negotiating process is an ideal worth striving for. These are ideals which can exist in the ordering of private intimate spaces, as demonstrated in the realm of adoption and insemination.

Contracts and private ordering can equally be tools for social justice. Certainly, limiting or thwarting individuals’ ability to enter binding agreements does nothing to reinforce their status as full citizens. Rather, it further disadvantages the marginalized by proscribing their ability to participate in a fundamental expression of political, social, and legal power. To suggest that there is never any benefit even to the disadvantaged player in contract negotiations ignores that even marginal benefit can be a good. To be clear, I too agree that the legal system serves a function in discouraging and ultimately providing a forum for remedy for oppressive terms in contracts of adhesion. I am also fully aware that pay-day lending institutions and others of the kind prey on the poor and minority. Yet it is important to distinguish contracting in intimate spaces from its more problematic cousins.

Arguing that human flourishing cannot coexist with organ markets deflects attention not only from affirmative benefits of incentives, but also from the varying degrees between commodification models. In other words, unless we are absolutely opposed as a society to all incentives and markets, we might better serve the future discourse in this domain if we distinguish what forms of commodification are worse than others by degrees. Incentives are, by design, meant to lure individuals into considering options that might normally be less attractive. Incentives are tools of persuasion.

Yet it would be a mistake to lump all incentive programs together, to conflate their usefulness, or to suggest that they are always negative tools or that they promote negative social behaviors. Nor should acceptance of incentives imply that activities associated with the incentive are immoral or unethical. For example, scholarships are incentives often used to attract the most competitive students by providing a commitment of financial support. Financial support viewed in this context transforms the incentive into an insurance policy against the student’s parents becoming ill, unemployed, or somehow unable to pay tuition. Likewise, incentives to attract individuals to participate in medical studies as well as programs to attract healthy young men and women into military service represent different points on a spectrum of seemingly acceptable commodification. Yet even within those

46. Deborah Post, *Beyond the Bargain Model: Status and Power in the Law of Contracts*, N.Y.U. REV. L. & SOC. CHANGE (forthcoming 2007, on file with author).

spheres some incentives might be conceived as less conscionable or more coercive than others.

The consequences of ignoring the possible advantages of cadaveric sales and reimbursements for living organ donations to cure organ deficits, and thereby enhancing the health opportunities for all Americans, especially African Americans, are extreme. Although organ donation by African Americans has increased in recent years, demand still dramatically exceeds supply. High blood pressure, diabetes, hypertension, and stress, conditions disproportionately affecting African Americans, contribute to widespread organ failure. African-American patients will continue to experience the longest waits on America's transplantation waitlists until more organs become available for transplantation. Because they suffer the highest rate of mortality while on the transplantation waitlists, this issue deserves urgent address.

CONCLUSION

Cherry's scholarship contributes to the growing discourse on human commodification and curing the organ deficit. His effort is quite impressive and will offer much in the way of discussion for scholars and researchers interested in examining the varying valances of commodification. What I offer here is an analysis and proposal that moves his very timely contribution toward a more substantive engagement about commodification as a tool for social justice.

