
Financial Incentives For Cadaveric Organ Donation: An Ethical Analysis

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Abstract

Despite the continued advancements in medicine and technology, the demand for organs far surpasses the supply. This gap between supply and demand can be diminished either by increasing supply or decreasing demand. Increasing efforts at disease prevention can help reduce the demand for organs by preventing or at least delaying many cases of organ failure. However, to meet the present need for organs new ways of increasing supply must also be examined. One viable option is financial incentives for cadaveric organ donation. Financial incentives for cadaveric organs are controversial but after examining them medically and ethically, there is no reason why such incentives should not be initiated. Basic economics teaches that incentives matter. The higher the incentives the more willing will be donors to overcome other costs and disincentives. This is not only good for the donor and his or her family, but it is also good for the recipients whose lives will be saved and for society as a whole who will benefit from decreased medical costs.

INTRODUCTION

Despite the continued advancements in medicine and technology, the demand for organs far surpasses the supply. This gap between supply and demand can be diminished either by increasing supply or decreasing demand. Increasing efforts at disease prevention can help reduce the demand for organs by preventing or at least delaying many cases of organ failure. However, to meet the present need for organs new ways of increasing supply must also be examined.

There were over 14,000 organ donors in the United States in 2004, an increase of 695 donors (7%) over 2003. During this time the number of living donors increased by 3% to 7,002, while the number of deceased donors grew by 11% to 7,152, the largest annual increase in deceased donors in the last 10 years. This increase in donors led to an additional 2,240 deceased donor organs recovered for transplantation from the previous year, an increase of 10%. Some of this increase can likely be attributed to efforts, such as the Organ Donation Breakthrough Collaborative that started in the fall of 2003, which focus on increasing the supply of organs for transplantation. The impact of the increase in the number of organs recovered is evident in the number of transplants performed in 2004. Just over 26,500 organs were transplanted in the United States during 2004, over 19,500 of them from deceased donors and almost 7,000 from living donors. These numbers represent an increase of 6% in total

number of organs transplanted, a 3% increase in living donor transplants and a 7% increase in deceased donor transplants compared to 2003. There were just over 7,300 deaths reported for patients waiting for a transplant in 2004. This is an increase over the number reported in 2003 (7,091). However, since the size of the waiting list also increased during this time, the overall death rate showed a slight decrease. ²

In 2005, there were 98,858 registrations on the waiting list for organ donations by the end of the year (70,642-kidney, 17,612-livers, 1,761-pancreas, 2,547-kidney/pancreas, 2,941-heart, 2,973-lungs, 152-heart/lung and 231-intestine). In this same year there were only 28,108 life-saving organ transplants (deceased donors 21,213 and living donors 6,895) performed. ³ An analysis of these statistics makes three things clear. First, even though there has been a substantial increase in cadaveric organ donation, the demand for organs far surpasses the supply. Second, a small increase in the number of deceased donors translates into a larger number of transplantable organs because of the potential for multiple organs from a single deceased donor. Third, the more that is done to promote organ donation the greater the number of organs donated from both living and deceased donors. ⁴ The greater need is to increase deceased organ donations in order to address adequately the supply and demand problem. Deceased donors are the only feasible

source of heart donations and by far the single most important source of livers, lungs, intestinal organs and pancreata. ⁵ It is true that organ donation is often related to sudden death or a tragic accident, but many donors and their families view their decision to donate as a rewarding choice. Numerous lives are saved as a result of these altruistic decisions as well as medical resources. However, with the implementation of financial incentives even more lives could be saved as a result of cadaveric organ donation.

Polls have shown in the past that 99% of Americans are aware of transplantation, and over 75% say that they would be willing to donate their organs, but fewer than half choose to donate a family member's organs when asked. In the majority of these cases, the individual had an organ donor card stating he or she agreed to be an organ donor. ⁶ A research study by Siminoff et al. in 1995 showed that on average, 85% of donor-eligible patients' families in two national regions were given the donation option, but only 48% actually consented. ⁷ In the United States, a high value is placed on altruism and many individuals freely consent to donate their organs after death, but in most situations the family of the potential donor makes the final decision. If so much good can come from organ donation, not only saving lives but saving government money on health care which benefits society, then why are new incentives not being explored? If one of the basic tenets of economics is that incentives matter, then it follows that positive incentives, like money, would not only increase the number of donations but would overcome other costs and disincentives. If financial incentives would be good for all concerned, donors/families, recipients and society as a whole, then why not institute such a program?

The intended purpose of this article is threefold: first, to give an overview of the organ donation options; second, to examine the viable option of financial incentives for cadaveric organ donation; and third, to give an ethical analysis of why financial incentives would be good for donor/families, recipients, and society as a whole.

ORGAN DONATION OPTIONS

The idea of financial incentives as a possible remedy to the organ shortage in the United States is not a new concept. It has been examined and debated for years by ethical, legal and medical experts. Historically, the system of organ donation in the United States began with the first successful kidney transplant at Brigham & Women's Hospital in Boston in 1954. "Liver, heart and pancreas transplants were

successfully performed in the 1960s, while lung and intestinal organ transplant procedures were begun in the 1980s." ⁸ Despite these successes, the organ donation system which is based on altruistic donation has not met the growing need for organs. Experts in the field attribute this shortage to two factors. First, reliance on donations from deceased, brain-dead donors can provide only a limited number of potential donors; it has been estimated that no more than 15,000 such donors are available each year. Second, the rate of consent for organ donation by next of kin has limited the number of organs available for transplant. Increases in the total number of organs procured have resulted largely in expansion of the donor pool, in particular, accepting older patients as donors, living related donors and from improvements in procedures for referring and requesting organ donation from families of potential donors. Many within the transplant community believe that the most promising avenue to increase the number of donations is improving consent from potential deceased donors and their families.

Improving the consent rate to encourage organ donation has been the focus of a series of legislative and regulatory efforts. Organ donation is regulated in the United States by the Uniform Anatomical Gift Act (UAGA), drafted by the National Conference of Commissioners on United States Laws in 1968 and modified in 1987. By 1973, it had been passed by all 50 states. The UAGA served to establish altruism and voluntarism as the foundation of organ procurement in the United States. The goal was to allow individuals in the United States to easily donate their organs for the good of society. In 1973, the End-Stage Renal Disease (ESRD) Program provided federal financial support for organ transplantation by funding 100% of organ procurement costs through Medicare. In 1984, Congress passed the National Organ Transplantation Act (NOTA) which increased the federal oversight of organ procurement. This law created the Organ Procurement and Transplantation Network (OPTN), which has the responsibility for setting standards and rules regarding distribution of human organs procured in the United States. This law also prohibits the sale of organs. ⁹

The second major legislative effort to encourage the donation of organs was a set of laws known as the "required request" laws. These laws directed hospitals to develop policies to assure that families of all donor-eligible patients would be given the opportunity to donate. In 1986, the Health Care Financing Administration (HCFC) made such

requests a prerequisite for Medicare reimbursement, and the Joint Commission on Accreditation of Health Care Organizations (JCAHO) made it a requirement for hospital accreditation. These laws were established with the idea that if people were asked to donate, most would freely consent. Unfortunately, the “required request” laws have had little impact on the rate of organ donation. In 1998, HCFC required hospitals to notify their local Organ Procurement Organization (OPO) about all deaths and imminent deaths and families must be approached about donation in collaboration with the local OPO. Underlying this regulation was the premise that health care professionals alone were not effectively communicating with families about donations. This regulation, too, has had little impact on actual rates of consent for organ donation.¹⁰

The third legislative effort came during the 108th Congressional session, which saw three bills introduced pertaining to ethical incentives for organ donation. First, the “Gift of Life Congressional Medal Act” (Senate Bill 325 and H.R. Bill 708) would establish a congressional commemorative medal honoring “any organ donor, or the family, or family member of any organ donor.” Second, the “Organ Donation Improvement Act” (H.R. Bill 624) would award grants of contracts to states, transplant centers, and qualified organ procurement organizations for the purpose of providing travel, subsistence, and incidental nonmedical expenses to the individuals who make living donations. Third, The “Gift of Life Tax Credit Act” (introduced as H.R. Bill 1872) and the “Help Organ Procurement Expand Act” (introduced as H.R. Bill 2090), present a refundable credit to individuals or to the estates of those who agree either to be living donors or to donate their organs upon death.¹¹ Despite the failure of these regulations to increase organ donation, many professionals in the field still believe that altruism and voluntarism must continue to be the focus of organ procurement in the United States.

Other ways to increase the consent rate for organ donation have been proposed. First, “presumed consent” is the notion that allows health care professionals to proceed with donation unless the patient has specifically declined donation. This form of consent has been implemented in Belgium, Austria, Finland, France, Denmark and Singapore. The results of increased organ donation have attracted significant attention in the United States.¹² A Subcommittee of the UNOS Ethics Committee that was mandated to study this issued rejected it for three reasons: First, presumed consent offers inadequate safeguards for protecting the

individual autonomy of prospective donors. Second, the Subcommittee was unimpressed with mechanisms in place in countries which employ presumed consent to protect the rights of objectors to donation. Third, the Subcommittee felt that the alternative of “required response” (all individuals would be required by public authorities to express their preferences regarding organ donation) had a more positive response as a viable alternative.¹³ Presumed consent could be viewed as an exploitation of human weakness.

Second, “required response” would mandate an individual to express a choice regarding organ donation to the public authorities. This could be done through the Department of Motor Vehicles, federal income tax forms, or if we ever had universal health insurance, the recording of individuals' donation preference on issued health insurance cards. The problem with this alternative is that it requires a centralized data bank that is not in existence at the present moment. It also requires the state to require an individual to express his or her preference in regards to organ donation. This provision could constitute a coerced burden, not to mention the burden accruing from public spending on the program of required response.¹⁴

Third, “preferred status” involves the rewarding of organ donors by providing them with a modest but definite recognition, in kind, for their willingness to participate in the system. A precedent to some degree is a credit given to blood donors should they need blood in the future. Individuals who signify their intention to be an organ/tissue donor, and maybe even first degree relatives of those who have signed up, or actually have been donors, would receive points or other value that would somewhat facilitate their likelihood of receiving an organ should they need one in the future. Advantages to this system would be the intrinsic fairness with regard to “opting in,” the fact that the special priceless organ does not represent financial payment, and that it would be equitable across strata of society. The major disadvantage is that it still represents compensation akin to purchase, that it might raise suspicion rather than increase acceptance of organ donation, that there is no ethical justification for attaching unique moral worth to willingness to give, and that the implementation would be troublesome.¹⁵

Fourth, the newest alternative is called “conscription of cadaveric organs” for transplantation. Ethicist Aaron Spital argues that maximizing recovery of organs be given priority over autonomy. “Under this plan, consent for postmortem organ recovery would be neither required nor requested.

Only conscientious objectors would be permitted to opt out of the program.”¹⁶ Spital believes conscription would increase the organ supply, would reduce the stress on staff members who must seek consent from families, and it would be less costly and complicated than the other proposals.¹⁷ Most ethicists, especially, Amitai Etzioni, dismiss conscription as extremely coercive and not even tolerated by many totalitarian governments other than China.¹⁸

Fifth, is the promotion of a previously used criterion called donation after cardiac death (DCD). Prior to the late 1970s and early 1980s, all organs were recovered from DCD or what was known as Non-Heart Beating Organ Donation (NHBD). NHBD formed the very foundation of modern clinical transplantation.¹⁹ “Death determination in the DCD patient mandates the use of a cardiopulmonary criterion to prove the absence of circulation. The cardiopulmonary criterion may be used when the donor does not fulfill brain death criteria. . . In clinical situations that fulfill either brain death or the circulatory criterion of death requires the determination of both cessation of function and irreversibility.”²⁰ It is estimated that at least 22,000 people each year who die of cardiac arrest could be potential organ donors.²¹ This potential for increasing the supply of organs however is not without its ethical and practical concerns. There are concerns about the appropriate timing for the determination of death, the administration of anticoagulants or vasodilators premortem, care and comfort measures so the donor's pain is adequately managed, and what happens in the event that the donor does not time within the required time frame for harvesting, etc. These ethical and practical issues have raised numerous questions about the practical application of this option.²²

Finally, financial incentives would be any material gain or valuable consideration obtained by those directly consenting to the process of organ procurement, whether it be the organ donor himself or herself, the donor's estate, or the donor's family. Proponents of this notion argue that it would increase the supply of organs and thereby secure the basic ethical concern of saving lives that may otherwise be lost due to lack of this resource.²³ An example would be the state of Pennsylvania that passed such a program in 1999, which would allow the payment of \$300 to families of organ donors to help cover funeral costs. The problem is that this program was never implemented because of the federal ban.²⁴ Even one of the most vocal opponents of financial incentives, ethicist Robert Veatch, has recently argued for lifting the ban on marketing organs because the present

system has failed and lives hang in the balance.²⁵ Opponents argue that there would be potentially decreased emotional gain for the donor family, decreased respect for life and the sanctity of the human body, and a loss of the personal link that currently exists in the donation process. There was also great concern about the potential for rich versus poor phenomena and the fact that financial need should not be linked in a coercive way to giving consent for organ procurement.²⁶ All of these proposals have some degree of merit but after examining them in depth it appears that the one that could increase the supply of organs and not only save lives but benefit society as a whole by saving medical resources is financial incentives for cadaveric organ donation.

PROS AND CONS OF FINANCIAL INCENTIVES

When the issue of financial incentive is discussed in regards to organ donation immediately there is a negative connotation. The word “donor,” which has a positive connotation, is replaced with the word “vendor” and “incentive” is replaced with the word “payment.” The term financial incentives should refer to “any material gain or valuable consideration obtained by those directly consenting to the process of organ procurement, whether it be the organ donor himself/herself (in advance of his/her demise), the donor's estate, or the donor's family.”²⁷ Financial incentives can take various forms.

- First, direct payment of a lump sum to the decedent's family or estate.
- Second, a set reimbursement for funeral expenses, as a less direct means of reimbursement.
- Third, a form of “donor insurance” or “future market” in organs, whereby an individual agrees in advance to donation, with payment to his beneficiaries or his estate taking place only after donation. This would allow individuals to “opt in” to the donation process while still living and their families or estate be compensated at such time as they actually become donors.²⁸
- Fourth, the “Gift of Life Tax Credit Act of 2001,” which would amend the Internal Revenue Code of 1986, would allow a refundable credit to individuals who donate their organs.²⁹

Since blood and reproductive material can be legally sold many question why viable organs should be treated

differently. The American Medical Association and the United Network of Organ Sharing both have endorsed pilot studies of potential benefits and harms of financial incentives for cadaveric organ donation which are limited to small populations, which investigate the effects of financial incentives for the purpose of examining and possibly revising current policies in the light of scientific evidence. Pilot studies of the effects of financial incentives for cadaveric organ donation should be implemented only after certain considerations have been met, including:

1. Consultation and advice is sought from the population within which the pilot study is to take place.
2. Objectives and strategies as well as sound scientific design, measurable outcomes and set time frames are clearly defined in written protocols that are publicly available and approved by appropriate oversight bodies, such as Institutional Review Boards. Transparency is a must to avoid any suspicion.
3. Incentives are of moderate value and at the lowest level that can be reasonably expected to increase organ donation.
4. Payment for an organ from a living donor is not a part of the study.
5. Financial incentives apply to cadaveric donation only, and must not lead to the purchase of donated organs; the distribution of organs for transplantation should continue to be governed by the United Network for Organ Sharing (UNOS), based on ethically appropriate criteria related to medical need.³⁰

A number of different options have been advanced for financial incentives regarding cadaveric organ donation. Payment to donors does not need to be monetary. One proposal advanced by a Pittsburgh-based coalition would allow representatives for organ procurement agencies to approach families after a relative has been pronounced brain dead and offer \$5,000 to families who authorize a deceased relative's organs to be used for transplantation as a way of saying thank you for the gift of life. The money would then go to the deceased person's estate.³¹ Other proposals advanced include: tax breaks, guaranteed health insurance for the donor's immediate family, college scholarships for

their children, deposits in their retirement accounts, donation to a charity of the donor's choice, etc. A recent poll by researchers in Pennsylvania found that “59% of respondents favored the general idea of incentives, with 53% saying direct payment would be acceptable.”³² Public opinion is important because some argue that financial incentives would raise added suspicion and fear about the organ donation system. If public opinion is in favor of some form of financial incentives, then it seems odd that we are so timid in examining this idea realistically. Even the Institute of Medicine's recent report entitled, “Organ Donation: Opportunities for Action,” recommended only one new initiative for expanding donors, that being expanding donor eligibility to patients who died of cardiac arrest. In fact the report recommends against financial incentives for various reasons ranging from financial incentives might cause a drop in donations for altruistic reasons to they might disproportionately affect the poor and the marginalized groups.³³ There seems to be a disconnect between public opinion and some in the medical establishment on this option.

Proponents argue that failure to allow for financial incentives not only interferes with an individual's autonomy but conflicts with our social standards of individual liberty.³⁴ Basically, you would be denying people the right to make their own choices. Opponents argue financial incentives would lead to commercialization and exploitation of lower income groups. The underprivileged would sell their organs and the wealthy in most cases would be the beneficiary. In the event that family members of the underprivileged donors needed a transplant in the future odds are that they would not have the financial means or the health care benefits needed to receive the transplant they needed. Some even question whether the financial pressures to donate in some circumstances would present such a conflict of interest that donors or donor families would be unable to give informed consent. Proponents would argue that to deny low income people this option implies that they are incapable of making decisions. Secondly, we allow low income people to be involved in many things and engage in activities that rich people will not do (like join the military or work in mines) that have even greater risks than organ donation.³⁵ The fears of exploitation and commercialization would be minimized if the financial incentives were government regulated to ensure that “donors would receive education about their choices, undergo careful medical and psychological screening and receive quality follow-up care. We could even make a donation option that favors the well-off by rewarding

donors with a tax credit. Besides, how is it unfair to poor people if compensation enhances their quality of life?"³⁶

Other critics of financial incentives such as Dr. Francis Delmonico a transplant surgeon at Massachusetts General Hospital argue that, "any attempt to assign a monetary value to the human body or its body parts, even in the hope of increasing organ supply, diminishes human dignity and devalues the very human life we seek to save."³⁷ This argument seems illogical. If the best interest of the donor is protected and these incentives save lives and save medical resources that in the long run will benefit society, then how is the dignity and respect for human life devalued? By donating one's organs after brain death, the donor is giving to others and society the gift of saving human life. If we believe as social beings our good, our flourishing, our best interests are inextricably bound up with the well-being of others,³⁸ then cadaveric organ donation is also good for the donor. More than 6,000 patients die each year waiting for organs. Allowing viable organs from post-mortem donors to be wasted when thousands of lives could be saved seems to diminish human dignity and devalue human life. Secondly, a 10% to 15% increase in transplants could save the nation millions of dollars in health care costs. One example of this potential savings would be to increase kidney transplants. Logically, to place individuals on immunosuppressants and remove them from dialysis machines would seem to be much more cost effective for society as a whole. One could argue this would increase human dignity by valuing human life.

Other concerns are that the health care relationship will be harmed by financial incentives but there is no evidence to support this claim. In other instances of sales, people (surrogate mothers) receive wonderful care. Opponents also believe that religious organizations will object to financial incentives, but the separation of church and state necessitates that churches and other religious organizations cannot dictate public policy. However, they can influence it so with the proper education, safeguards and regulations in place the chances of churches and religious organizations objecting to financial incentives is diminished considerably. Finally, individuals may lie about their health in order to receive the financial incentives and thus the organ donation system could be abused. Every candidate would be properly screened so this fear would be eliminated. There is also the fear that families who donate organs for altruistic reasons may be turned off by financial incentives and donations may actually decrease in the long run. The compensation that is

being given is not such that it would eliminate altruistic donations. True altruism, which is an unselfish regard for the welfare of others, should not be deterred by financial incentives that can help donors and donor families. Finally, there is also the fear that family members may stop treatments earlier than is in the best interest of the patient and do so to obtain the financial incentives. One would hope that medical professionals would be the safeguard to verify that families are acting in the best interest of the patient.³⁹ The possibility of abuse is always present but fear of abuse cannot become a road block for the good that will benefit donors/families, recipients and society as a whole. To determine if financial incentives are in the best interest of donors/families, organ recipients and society as a whole this issue will also be examined from an ethical perspective.

ETHICAL ANALYSIS

The demand for organs is causing some of the more than 98,000 citizens on the official waiting lists to seek other means to save their lives. One such means is Internet Organ Matching. Supporters of this recent initiative believe that it "can dramatically improve the odds of finding a donor and that learning about the recipient can motivate more people to become donors."⁴⁰ Various organizations such as "LinksForLifeCampaign.com" and "MatchingDonors.com" have been successful in finding appropriate organ matches and saving lives. "MatchingDonor.com" has caused some controversy because it charges a fee of \$595 for unlimited access or \$295 per month. The founders of this website claim that the fees go toward running the Website and that if there are special circumstances the fee can be waived. The site has over 2,000 potential donors and over 100 possible recipients.⁴¹ The major problem with internet organ matching is that it is totally unregulated. Donors might not be telling the truth about their health, there could be future extortion from recipients and there is no screening going on of their psychiatric and psychological stability to name just a few concerns. Many may be altruistic people but there are others who may be depressed, who have a low self-esteem and who may suffer from mental illness.⁴² Other skeptics argue that it could also promote racial and religious discrimination and facilitate illegal trafficking in organs.⁴³ In order to protect both donors and recipients there must be a more viable option to increasing the supply of organs to meet the ever increasing demand. The issue set before us is whether financial incentives for cadaveric donation are ethical. This author will argue that under respect for persons, beneficence, nonmaleficence and justice the appropriate use

of financial incentives for cadaveric organ donation is not only ethical but medically and socially responsible.

Respect for persons refers to the right of a person to exercise self-determination and to be treated with dignity and respect. The principle of respect for persons divides into two separate moral requirements: the requirement to acknowledge autonomy and the requirement to protect those with diminished autonomy. ⁴⁴ Polls show that 99% of Americans are aware of transplantation and more than 75% say they would donate if asked. ⁴⁵ Therefore this is an issue that is not unfamiliar to Americans and any additional information or incentives might encourage even more to donate. Autonomy allows a person to make decisions about one's own body and to interfere with this right violates one's individual liberty that is a social standard in the United States. The ability of a person to decide to donate one's organs because of a financial incentive falls under a person's right of autonomy. This is not to say that there are not ethical concerns concerning one's right to autonomy. There are concerns about informed consent, coercion, and even exploitation of the most vulnerable. These are legitimate concerns but safeguards can be put in place to address them so that the donor's dignity is protected. For example, opponents argue that the poor will be exploited because financial concerns will override their judgment or be used as a form of coercion. If UNOS is given the responsibility of regulating these financial incentives, such as a \$5000 voucher that goes toward funeral expenses, and distributing the organs according to need, this would eliminate the possibility of wealthy people buying their way off waiting lists. It would also help to decrease the sense of mistrust that exists in minority communities and among low income groups that this could be a form of commercialization that exploits the poor and minority communities. UNOS is a well-respected organization known for treating all people fairly and equitably. Placing the financial incentives under their jurisdiction would help to remove many of the fears regarding coercion, informed consent and exploitation surrounding financial incentives. As argued in the previous section, to deny financial incentives for fear of exploiting low income individuals and minorities implies that they are incapable of making voluntary decisions. Prohibiting low income people from receiving financial incentives for donating their organs for fear of abuses doesn't really help them, it just leaves them poor. ⁴⁶ With the proper educational safeguards in place and with government regulation of the financial incentives for donation the informed consent of all people would be protected. If the wishes and the desires of

the donor or donor's family are informed, then to deny that patient or his or her surrogate the request for donation would not only violate the donor's informed consent but would violate his or her basic dignity and respect. This not only harms the donor but also harms those who may be helped by the possible donation.

Beneficence is the obligation to prevent harms and remove harms and to promote the good of the person by minimizing the risks incurred to the patient and maximizing the benefits to them and others. Beneficence includes nonmaleficence, which prohibits the infliction of harm, injury, or death upon others. In 2005, over 6,000 people died while waiting for an organ transplant. An increase in the supply of organs would not save these lives, but with the demand for organs increasing yearly, it could have a powerful effect on saving the lives of many others. As medicine and technology continue to develop and advance more individuals will be candidates for organ transplants. Unless the supply of organs increases the number of people dying while on waiting lists will continue to increase. Individuals have the right to donate their organs and tissue if they give informed consent. Financial incentives for cadaveric organ donation could increase the supply of organs by increasing awareness of the need for organ donation and, as a result, could save the lives of many recipients waiting for such organs. This will not only benefit the donor and his or her family by doing something that will help others and also receiving financial remuneration, it has the potential to save other's lives and would be good for society as a whole because it would save medical resources. Organ harvesting does not harm the donor; instead, it allows the donor to give something back to the community. However, failure to harvest these organs does violate the principle of beneficence, because it inflicts more harm on potential recipients by increasing their suffering and failing to prevent their imminent death. Some will argue that the possibility of abuses to the poor and the marginalized do not outweigh the benefits to recipients. Fears of sinister organ farms, trafficking in body parts and exploitation of the poor by the rich are being used by opponents of financial incentives to negate this option. Yes, the slippery slope is always possible and abuses may occur. However, these risks and possible abuses can be countered by government regulation of financial incentives. Fear that families will withdraw or not initiate medical treatments on their loved ones that may be beneficial in order to obtain financial incentives can be minimized by medical safeguards. Donors must be declared brain dead by an independent medical team separate from the harvesting team

and it is determined and verified by a brain death protocol. Physicians have the medical and ethical responsibility to do what is in the best interest of their patients. In the event that a physician or medical team believes that a family is not acting in the best interest of the donor, there are legal measures that can be initiated, such as legal guardianship, to protect the donor. Medical professionals serve as advocates for their patients and are entrusted with the duty to prevent harm, remove harm and act in the best interest of their patients. Failure to act in the best interest of their patient and even to cause harm would violate one of the basic tenets of the Hippocratic Oath. Pilot programs that advocate for financial incentives have been initiated and can be expanded to include larger and more diverse populations to show these skeptics that their concerns are being addressed. Increasing the supply of organs by financial incentives not only will benefit the donor and his or her family, it will also benefit recipients by saving their lives and increasing their quality of life and it will benefit society by saving medical resources. Failure to allow for financial incentives not only fails the test of beneficence but also fails the test of nonmaleficence, because you would fail to maximize the benefits to donors, recipients and society and minimize the harms.

Justice recognizes that each person must be treated fairly and equitably, and be given his or her due. Justice also pertains to distributive justice, which concerns the fair and equitable allocation of resources, benefits and burdens, according to a just standard. As social human beings we ought to want to contribute to the good of others and society as a whole.

Cadaver organ donation is a service to individual recipients and to society as a whole. Raising awareness about the need for organs encourages donors/families to give the gift of life to others in need. This gift will not only increase the supply of organs for recipients, but will benefit society by decreasing medical costs and allowing for a more just allocation of resources. It is estimated that over 20 years, the expected savings to the health system of getting a kidney versus staying on dialysis are about \$95,000.⁴⁷ Critics of financial incentives for cadaveric organ donation claim that this is just the first step on the slippery slope toward allowing wholesale buying and selling of organs. They argue that with the present scarcity of organs in the United States and around the world, many fear that people will start advocating for allowing living donors to sell their organs. One example of this is Pakistan's unregulated and fast growing kidney transplant trade, where foreigners can buy kidneys from impoverished Pakistanis in contravention to established medical norms. The marketing of kidneys has

become a lucrative business in Pakistan.⁴⁸ Ethically, the very wealthy are the buyers and the poor are the sellers. This unequal distribution of medical resources is completely unjust. The vulnerable could be coerced into donating their organs out of financial necessity. As mentioned above, there are also concerns about the recent trend of soliciting organs over the internet. Bioethicist David Magnus of Stanford University argues that "our organ allocation system is imperfect, but there is a lot of effort and a lot of thought to make it as fair as possible. Once you go down this road and allow people to jump ahead in the queue through a popularity contest through the Web, you can be assured justice goes out the window."⁴⁹ Both of these trends would be socially disruptive because it is just one more way that minorities and other vulnerable groups would be exploited for the sake of the wealthy. This would be a blatant form of injustice. However, cadaveric organ donation does not have to lead to the slippery slope. One way to eliminate unfairness would be for the government to regulate financial incentives to donors and then to regulate the distribution of the organs to recipients. With safeguards and government regulations, the supply of organs may increase enough to eliminate the need for financial incentives for living donors. The principle of justice claims that all people have the right to be treated fairly and equitably. Promoting financial incentives for cadaveric organ donation is ethically responsible because the intention is to do what is good and just for not only the donors but for recipients and society as a whole.

CONCLUSION

Organ donation is a complex and multi-faceted issue that not only impacts on the donor but also on families of the donor, recipients, and society as a whole. Altruistic organ donation in the United States is premised on the appeal to give a gift of life by an individual decision-maker. But is relying solely on altruism enough? "Our current organ procurement system is based on financial gain for all concerned (physicians, surgeons, coordinators, social workers, hospitals, etc.), the altruistic 'gift' upon which so many recipients depend has been described as unfair and insensitive to donor families and the source of basic distrust of the system by the public. It has been argued that the donor and the family are the only participants not directly benefiting from the process and therefore, some form of compensation is the right thing to do, even if the number of donors and cadaveric organs does not appreciably increase."⁵⁰ In addition, "financial incentives have become a part of medicine (Drs, preferred providers, etc.). . . Under such an evolving system, a single fixed payment incentive for organ donation could potentially

be interpreted as a message to prospective donors and their families that this process does not involve a unique moral decision, but only what is assumed as a societal obligation and expected of everyone who participates in the system.”⁵¹ The medical, ethical and social justifications for financial incentives stem from the 5 to 10 year waiting list for organs, the increased number of deaths among those on the waiting list, and the fact that the projected supply cannot meet the growing demand for organs. For financial incentives to be effective the following recommendations must be considered:

1. Petition Congress to amend the 1984 National Organ Transplantation Act to allow for financial incentives for cadaveric organ donation after brain death has been established.
2. Examples of financial incentives would include: \$5000 for funeral expenses that would be paid to the funeral home directly, a \$5000 tax credit to the donor's estate, a \$5000 payment to the charity of choice of the donor or the donor's family, etc. These incentives would be under the jurisdiction of UNOS.
3. Post-mortem donations would be controlled by UNOS who would verify that organs would be distributed as they are, based on medical need and time on the waiting list. This would insure the equitable allocation of organs for transplantation and allow for transparency in the process.
4. Pilot programs, that are broad based, should be initiated and expanded to evaluate the potential effects of financial incentives, in order to assess the balance between harm and good.

Efforts should continue to increase voluntary organ donations as well as increasing the efforts at disease prevention that would help reduce the need for organs. Financial incentives for cadaveric organs are controversial but after examining them medically and ethically, there is no reason why such incentives should not be initiated. Basic economics teaches that incentives matter. The higher the incentives the more willing will be donors to overcome other costs and disincentives. This is not only good for the donor and his or her family, but it is also good for the recipients whose lives will be saved and for society as a whole who will benefit from decreased medical costs. This issue is important for all of us because not only could each of us

become potential donors in the near future, we could also become potential recipients.

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