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OR, ALTRUISM RUN AMUCK**

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ORGAN TRANSPLANTATION: OR, ALTRUISM RUN AMUCK

RICHARD A. EPSTEIN*

Organ transplant policy is again very much in the news, and from some of the stories in print, one might assume that the success of present policies represents a triumph of altruism over the darker forces of human nature. Earlier this year, *The New York Times* ran two moving stories showing the benefits that donors obtain from making kidney donations. One story illustrated how the parents of a seven-year-old boy, killed when a school wall fell on him, gained some small consolation by donating his organs to help some other school children to live.¹ The second story featured a picture of two healthy women (one 49 and the other 57) and then related how the younger woman was able to donate her kidney to a friend by overcoming the reluctance of a stodgy medical establishment that fears two things above all: the coercion that might undermine voluntary giving, and payment— yes, payment — for donated organs.² Organ donation is easy: “You don’t have to be crazy. You just have to be noble and altruistic,” explained Dr. Norman Fost, an ethicist at the University of Wisconsin.

Both stories allowed dramatic and moving incidents to conceal a larger and more pressing social truth. There is today an acute and growing shortage of usable organs for transplantation. Individual acts of altruism will not alleviate this shortage in the future, any more than in the past. In light of the deaths and suffering that follow, what is needed is nothing less than a fundamental rethinking of the laws and practices of organ transplantation. At pre-

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¹ Elizabeth Rosenthal, “Parents Find Solace in Donating Organs,” *NYT*, 5/11/93 B5, B8.

² Gina Kolata, “Unrelated Kidney Donors Win Growing Acceptance by Hospitals,” *NYT*, 6/30/93 at B6.

sent the dominant philosophy of organ transplants is captured by one stark opposition: to give is divine, but to sell is evil and immoral. The dominant concerns therefore are to make sure that all voluntary donations are not coerced, so that all errors are made in favor of not allowing the donation to go forward: hence the reluctance of the medical establishment to perform, let alone encourage, live donations between unrelated parties. Looming largest of all, however, is opposite side of the coin: the legal prohibition on the sale of organs that is rigidly enforced no matter how many people die in consequence of that policy. The first part of this policy is hardly exceptionable; the second part is fundamentally misguided. Altruism and donation will not make these shortages disappear. An open market in sales must be created. Altruism must be supplemented with market mechanisms that allow the free and untrammelled sale of organs, from live as well as dead organ donors. A closer look at the current situation helps explain why.

THE LENGTHENING QUEUES

At present organ donations come from two sources: cadaveric and live. First, and most importantly, are cadaveric donations— that is, those which are made by (or from) individuals who have just died. It is not easy for a dead person to qualify as an organ donor. Persons who have died of illness or disease, persons who are alcohol and drug users, persons whose organ have been damaged in an accident, and persons whose organs have lost efficiency due to age are not deemed good donors. Neither are the poor and malnourished. The ideal candidates for cadaveric organs are young individuals, typically male, who have died from a trauma that leaves their internal organs fit for use: victims of fatal head injuries from motorcycle accidents and gunshot wounds yield suitable donors, so long as the wounded can be kept alive long enough for their organs to be harvested in hospital. The supply on organs from this source is constant, or perhaps shrinking, for fewer people are dying deaths of this sort. Last year, typical in this regard, some 7,644 kidneys were harvested in this manner. That number is not likely to rise significantly in the near future.

Added to the cadaveric kidneys are 2300 volun-

tary donations from live blood related donors. In general these donations are preferred to cadaveric donations if only because kidneys from live donors are more beneficial for the recipient. Yet the transfer is surely more inconvenient for the living donor, as it requires a major incision, the removal of a rib, and several weeks of recuperation. The surgery also carries with it a very small chance for the loss of life (most recent estimates place it at 1 in 20,000), and an increased risk of some collateral disorders (e.g., high blood pressure) in the later years of life. Ironically, kidney disorder is not generally placed high on the risk list because whatever disease condition (e.g., diabetes) renders one kidney dysfunctional is likely to attack both kidneys as well — which is why there is so great a need for donated kidneys in the first place. One does not know how many potential blood-related family donors choose not to give; nor is exactly clear how much social pressure, and financial inducement take place behind closed doors for those who do.

What is known however is that the 10,000 or so kidney donations from these two major sources are not sufficient to meet the demand. In 1987, the official waiting list for kidneys was 10,000 persons; by 1991, after an intensive campaign to increase the number of voluntary donations, the waiting list stood at over 18,500; and by 1993 the number had expanded again to over 23,000 people. These numbers, it should be stressed, substantially *understate* the number of persons whose lives could be saved or bettered by a kidney transplant. The list does not include people too sick to make any list; nor does it include those who are taken off the list, only to die shortly thereafter; nor does it include the number of people who have died while on the list, waiting in vain for a needed organ. The official and public boost for altruism has not increased the number of organ donors (most of whom can give two kidneys) substantially.

So beware of glowing reports of altruism in action. Also, heed the sobering voices of failure that tell of the forty percent of possible donations that are not made for one reason or another, and of frustrated specialists able to persuade most of the assembled and distraught family of a dead young man to donate, only to be thwarted by one distant relative opposed to the violation of the dead. The bottom

line is that technological advances now make many individuals better donors or recipients than before. Yet the number of deaths for want of an organ continues, inexorably, to rise. Some very powerful ethical constraint must be at work here to block massive entrepreneurial efforts from bridging the gap. What?

PROHIBITIONS AND MARKETS

The legal source of our difficulties is not hard to find. The National Organ Transplantation Act of 1984 makes it a felony punishable by fines up to \$50,000 or five years in prison, “for any person to knowingly acquire, receive or otherwise transfer any human organ for valuable consideration for use in human transplantation.” Its narrow exception only allows people to recover the expenses of removing, transplanting, or preserving the organ, as well as for wages lost incurred during the transfer. Yet there is nothing offsetting the anxiety or pain and suffering, or for loss of some of the amenities of life that even the successful removal of an organ entails. By design, the law prevents any *gains* that could flow from the emergence of an organized market for organ transfers. Instead in textbook regulatory style, the current prohibition acts as a prelude for a set of dubious but complex procedures designed to expand the supply of organs: some statutes require physicians to make requests of a decedent’s family for use of the organs; some proposals even presume consent to donation when no opposition has been expressed. Yet both of these strategies work, if at all, only for cadaveric transplants. As resistance in many cases is high, and the number of traumatic deaths is constant or declining, the complete harvest of every usable organ would still leave shortages relative to the incessant demand. What else should be done?

The current legal constraints dictate the possible responses. On the supply side, more exhortation, which does work — occasionally. But the eighty-six reported donations between unrelated donors are only a small drop in a big bucket, and it is unlikely that this number will expand substantially even if a dozen more favorable feature stories are written. So given shortages, someone has to ration the organs in question. The nonprice mechanisms available to the federal government are surely inadequate. James Blumstein of Vanderbilt Law School rightly stresses

the tension between private and public control over donations. Do individuals have the right to select the recipients of organs, by name or by group, or are all organs thrown into a large public pool, to be then allocated by the impersonal criteria (tissue matches and lotteries) usually reserved for these occasions?

Treating all organs as “national resources” in some impersonal pool reduces the incentive for giving that comes when the donor knows, and takes an interest in, the welfare of the recipient. The powers that be in Washington (chiefly an outfit known as UNOS, United Network of Organ Sharing, whose communal title accurately reflects its working philosophy, even if no one knows how to “share” a kidney) has relented to donor in cases of individual identification, but serious issues still remain. National allocation removes organs far from the place of donation. Not only is there some (small) increased risk of organ deterioration from increased transportation time, but also a greater reluctance of individuals to donate in the first place. I have greater sympathy with those who are in my local community than those who live at a distance. After all, most volunteer and charitable work in hospitals is done at a local level for local citizens. The same dynamic works for organ donations, especially when controlled by family members of the recently departed.

The overblown communitarian rhetoric of UNOS thus reveals the usual weakness of such grandiose philosophies. It falsely assumes that the rate of collection is wholly unaffected by policies of ultimate distribution. Even within a world in which sales are prohibited, the first task is to maximize the number of organs collected. When no one has reliable information about the relative worth of the lives saved or sacrificed, distribution is at best a secondary consideration. Yet UNOS acts as the proverbial 900 pound gorilla, for under the 1986 Budget Reconciliation Act, which extended its powers, UNOS has a de facto monopoly over every aspect of organ transplantation.³ Every hospital has to dance to the UNOS tune for all organ transplants, or face the intolerable

³ James Blumstein, "Government's Role in Organ Transplant Policy," in *Organ Transplant Policy, Issues and Prospects* 5 (J. Blumstein & F. Sloan, eds. 1989) contains an excellent summary of the mechanisms involved.

loss of Medicare and Medicaid reimbursement, not only for organ transplants but for all medical services. And UNOS now sets the rules for all transplant programs that are carried on at any center, regardless of where or how the organs are procured. In practice a program that does not satisfy UNOS criteria cannot continue running its transplantation programs at all. The government does not simply maintain a registry to help people arrange for good matches privately. Unfortunately, a benevolent dictatorship exerts monopoly power over organ transplantation and persists in holding to its no sale policy in the face of enormous and predictable shortages.

UNOS also is unable to respond to other problems of organ distribution. With payment banned, who gets organs? Most often the experts rely on systems of so-called antigen matchings — to see whether the recipient is more likely to prosper with the organ than some rival claimant to it. Antigen matching is the ultimate criterion of the technocrat. A perfect six-antigen match prevails over any less than perfect match. Thereafter, five may be preferred to four, four to three and so on down the line. Lotteries may be used to break ties. But all soft-criteria, such as matters of past conduct, family situation, and prospective benefit are quite simply too hot to handle.

Even within this limited frame of reference, ambiguities abound. Unhappily, the “neutral” criterion of antigen matching carries with it an unintended but well-established race spin. On balance white kidneys do better in white recipients; and black kidneys do (relatively) better in black recipients — although overall white survivorship rates are higher. Yet the suspicion or alienation of potential black donors and their families is so high that a far higher percentage of potential white donors give than potential black donors. A policy of local preference might increase the rate black contributions.

Worse still, the percentage of blacks who suffer from various kidney related diseases is far higher than the percentage of whites who suffer from the same conditions. The numbers are striking. If blacks constitute about one-eighth the total population, then (as of 1988 at least) they constituted about thirty-five percent of the population (about 37,000 out of 104,000) with end state renal disorders (ESRD), the condition that triggers the transplant

or confines people to a fate almost as bad as death itself — dialysis. Yet by the same token about seven percent of the needy white population receive kidney transplants each year, and only about five percent of the black population (4900 white recipients versus 1,500 black recipients). Still requiring an even distribution of black and white recipients will increase the overall number of deaths. But the size of any increase is subject to sharp disagreement, now that immunosuppressive drugs increase the success of donations with imperfect matches.

Some ethicists have proposed that blacks be allowed to designate other blacks as their preferred organ recipients.⁴ However, it is far less clear whether these same ethicists would accord similarly situated whites (or for that matter Protestant, Catholics or Jews) an identical privilege. Unfortunately the entire issue will be caught up in the endless debate between the color-blind and affirmative action views of the antidiscrimination principle. These weighty issues cannot be resolved here, save to say that both sides of the current debate are wrong and for the same reason: they support different forms of state regulation on matters properly reserved to the domain of individual choice. All persons should be allowed to choose the objects of their affections, both for individual and for class gifts, with organs as with common stock.⁵ The current gridlock is therefore likely to continue as debate over organ donations are waged in the wrong forum.

Bringing over the antidiscrimination debate into the transplantation area does have one predictable consequence: it makes it possible to take dead aim at foreigners seeking organ transplants at an American hospital. UNOS policy makes organs a national asset, not a world-wide one. While this nation includes permanent aliens from all ports of entry, it does not include those opportunists who come to our shores in search of reliable organs. Yet hospitals love to place them at the top of the queue, because the money that cannot be legally paid to the organ

⁴ Wayne B. Arnason, "Directed Donation — The Relevance of Race," *Hastings Center Report* 13 (Nov.-Dec. 1991)

⁵ For a fuller account of the mischief of the antidiscrimination laws in employment, see Richard A. Epstein, *Forbidden Grounds: The Case Against Employment Discrimination Laws* (1992).

donor can now be paid to the transplanting hospital, free of any and all Medicare restrictions. Yet rich foreigners are not a protected class, nor do they vote, and so first UNOS and then the Congress bears the brunt of a heavy America first campaign: American organs for American bodies. UNOS already subjects any transplant center to a special review if more than ten percent of its organs are transplanted into foreign individuals and Congress is now considering more stringent restrictions. Free trade respects no foreign boundaries, but the politics of communitarian benevolence is confined to local borders.

A FUTURES MARKET IN ORGANS?

Current organ policy fails on two fronts. The forces of altruism work too spasmodically to generate an adequate supply; and government-controlled allocations works on impersonal, technical, and arbitrary criteria that have no independent legitimacy of their own. If ever there was a time to rethink a major portion of government policy, that time is now. The one policy alternative that deserves the most forceful endorsement is the one legally banned and ethically condemned: markets. A perfect negative fit.

To those lacking refined ethical sensibilities, a shortage in organs, like tomatoes or rental housing, is simply evidence of a malfunctioning market. No surprises here, just the usual unfortunate consequences — queues and intrigue — when markets are banned. To relieve this situation, a number of able scholars have already proposed *limited* market systems for organ transplants. Henry Hansmann and Lloyd Cohen independently suggested the creation of a *futures* market in organ transplants, that is, pay the organ donor for giving the government or some private firm the right to harvest that organ in the event of death. Hansmann wants the donor to receive an annual reduction in health care premiums.⁶ Cohen prefers a lump sum payment at death to those persons designated by the decedent.⁷

This is a good start, but it won't work. Too many

⁶Henry Hansmann, "The Economics and Ethics of Markets for Human Organs," in *Organ Transplantation Policy: Issues and Prospects*, (eds. James F. Blumstein & Frank A. Sloan).

⁷Lloyd Cohen, "Increasing the Supply of Transplant Organs: The Virtues of a Future Market," 58 *Geo. Wash. L. Rev.* 1 (1989).

years and obstacles lie between the 1993 promise and a possible death a generation later. Who will be around to see that its terms are rigorously enforced? And no matter what the contract says, the system of multiple vetoes will allow lone relatives to block desired transfers. After death no one has absolute property rights in his or her own body, for no matter how many times we amend the Uniform Anatomical Gift Act to say they do, transplant surgeons and bereaved families beg to differ. The living cannot secure control of their own bodies after death. So long as that belief system holds true, no market can emerge, even if legal prohibitions on organ sale are removed. Nor do the Hansmann and Cohen proposals respond to the gridlock created on the recipient side of the market. UNOS does the collecting and allocation.

AN OPEN MARKET IN LIVE ORGAN TRANSFERS

Only one alternative is left, and it might work. Forget the medical ethicists: *allow market sales of organs by living donors to unrelated parties*. The proposal will stop the shortage in needed hearts. It might help a bit with liver transplants now that partial transplants are viable, especially for children. But open markets could make a big dent for the most acute shortage: kidneys. Purchased transplants present no greater technical difficulties and no greater risks than live kidney donations between unrelated parties, for the cash going in one direction has little to do with the organ that travels in the opposite direction.

Before yielding to any predictable howls of ethical revulsion, note some of the advantages. First, it generates gains from trade. No one would doubt that several weeks of rest and rehabilitation, the loss of a rib, and an ugly scar are best avoided. But these costs are small next to the sustained suffering, endless dialysis, morbidity, loss of life, and family burdens. Everyone knows that the loss in utility to the donor is far smaller than the gain in utility to the donee. Could we imagine unleashing the forces of altruism if recipient gains were smaller than donor losses?

Yet here is the rub. It is one thing to speak of *aggregate* gains. It is quite another to speak of gains shared by both parties. With live altruistic dona-

tions, all the tangible gains go in one direction and all the tangible losses go in the other. There is a classic divergence between private loss and social gain that cries out for redress. Compensation paid from the gainer to the loser is the best way to redress that private imbalance. Once the net social gain is shared by both parties, then the level of transfers should increase because the gain from transferring (not donating) increases as well. This is not the most subtle and profound account of human motivation, perhaps, but it is the most reliable.

A second hidden benefit of live transfers is that it reduces the fear of undue influence and coercion so likely in close family situations unless side payments can be made to help out the donor. But an expectation of mutual gain reduces the need for informal coercion, and hence the likelihood of its use. The ethicists are right to worry about coercion, but *for that reason* they are wrong to deplore the payment system that helps achieve that end.

Live organ sales also overcome the bane of future markets, the huge temporal gap between contract formation and contract performance. Now cash is paid on the barrelhead when the operation takes place. Property rights are no longer indefinite or insecure. The person who does not own his body after death can control the disposition of organs during life. He can make an intelligent decision at peak competence: no more frantic efforts to persuade shocked and grieving family members to be altruistic at the time of their greatest loss. Instead, the extended family is kept at a distance, and calculations and determinations can be made in a less pressured setting; for the organ will keep quite well until its owner decides, with or without consultation, to sell. So long as there are a substantial number of buyers and sellers, fraud and foul play should be effectively curbed and controlled. There is too much information on the going rate for someone to take advantage.

Most importantly, these changes are likely to boost supply. Don't ask whether *you* would sell your organs. You may be no more likely to do that than to commit murder. But just as criminal sanctions influence those closest to the edge, so too our organ markets will respond to those most likely to donate for a price. Millions of people have good organs and strong constitutions. If even a small fraction of one

percent of them sell, the shortages in question, at least for kidneys, will be over. And the donor is protected as well for if something goes wrong with his remaining kidney, he too has a chance to return to the market at some later time.

This market in live organs sales obviates virtually all of the objectionable features of the current system of allocation. Foreigners are not subject to discrimination or exclusion. No board sits in judgment to decide who is the most worthy recipient. Lotteries could be a thing of the past. And persons with inferior technical matches can still pay the going price even if they are unable to persuade wary bureaucrats of the strength of their claim.

THE OBJECTIONS TO MARKETS

So with all the generative power of market, why then the opposition? It is possible here to identify two separate traditions that have opposed the development of markets for organ transplant. One stresses natural rights, and the other the communitarian tradition.

Unnatural acts. The ablest exponent of this modern tradition is Leon Kass who has raised a wide variety of objections to the sale of organs, either at death or during life.⁸ Kass is extraordinarily uneasy about his position, and candidly admits that if the life of his daughters were on the line, he would put aside his philosophical misgivings and participate in such a market if he thought he could save their lives. On the general issue, Kass should follow his instincts and not his own arguments, which are nuanced and difficult to summarize. At the deepest level, his view is that the sale of an organ is an unnatural act because it flies in the face of the ends of all organisms, namely, their own flourishing and survival. Transfer of organs during life is regarded as a form of self-mutilation and partial murder; and at death it defiles the integrity of the body and mocks the life of the person who has died. Taken at one level, Kass's arguments are so strong that they would preclude gifts as well as sales, but he distinguishes between the two cases on the ground that one is motivated by

⁸ Leon Kass, "Organs for Sale? Propriety, Property and the Price of Progress," *The Public Interest* 67 (No. 107, Spring 1992).

good will while the other is not. For him organ sales are simply out of bounds, for while individuals own their bodies, in the sense of having exclusive control over them, they do not (or should not possess) the right to dispose of their body parts by contract. Even if the gain to the buyer is greater than any loss, subjective or objective, to the seller, the commodification of body parts is just too repellent to tolerate whatever practical advantages it promises.

It is easy to understand the natural revulsion toward the sale of body parts. Surely during our dim evolutionary past, both live and cadaveric transplantations were self-destructive acts. It was natural, therefore, that some strong revulsion grew up about them, for that sentiment served to protect transferors (alive or dead) and recipients against the consequences of foolish acts. Technology, however, moves faster than the glacial rate of change of ingrained biological attitudes. Now that transplants are both possible and safe, why give pride of place to a set of basic instincts that no longer serve their intended function? The body has developed all sorts of natural mechanisms to ward off invasion by foreign bodies. Yet no one wants to ban surgery as an unnatural act simply because anesthesia and sterile instruments are required to overcome the body's natural defenses. We must fight our natural instincts in order to obtain the gains that modern medicine promises. The systems of thought that were perfectly congenial to their own time repeatedly need some cautious revision in the light of changed circumstances. The principles of gift, contract, and exchange are also very old, and often defended in natural rights language as well. They should be given their day now that new techniques have made it possible to breach the once inviolate body in ways that better serve human interests. Today's ban on organ transplants is in reality no more than a misguided sense of paternalism with harmful consequences to both parties to the transactions. Kass's categorical rejection of voluntary transplants should be rejected even by those sympathetic with the natural rights tradition of which he is a part.

Communitarian responses. The communitarian objections to organ transplantations follow much the same lines as Kass's arguments. Commodification figures extensively in their overall story as well, and for their bottom line, communitarians encour-

age gifts as strongly as they reject sale. Their arguments have exerted a virtual stranglehold over public policy, but are, I believe, both mischievous and wrong, even wrong-headed. Ethicist Thomas H. Murray of the Case Western Center for Biomedical Ethics, in an influential piece on the subject, has best articulated the standard line: "Gifts to strangers affirm the solidarity of the community over and above the depersonalizing, alienating forces of mass society and market relations."⁹ But why and how does this impersonality happen? Lots of markets depend on close relations of trust. Legalizing the sale of organs does not require a donor to be indifferent to the fate of the donee, or to take only the highest price for the organ. Gifts do not become illegal because sales are allowed, and in many contexts (e.g., extended families) legalizing sales might invite blended sale and gift transactions.

Nor must markets drive altruism to the fringes of human life. Hospitals get paid for their facilities and equipment; transplant surgeons are richly compensated for their services. Not all this money comes from lucky transplant recipients. Charitable donations can be used to pay organ donors as well as organ transplant teams. The rich have no more advantage with organs than with surgeons. Everyone benefits as queues shrink for rich and poor alike.

Murray says that "wealth is merely a means to an end, and that not all valuable things can be purchased, among them love, friendship, fellow-feeling and trust." But when last I looked, market exchanges were also means to ends. Love and friendship are not for sale, even though no law as yet bans that transaction. What is desperately needed is some new effort to end this appalling loss of life. If no one comes forward to sell organs, then we have lost little, and can take some small comfort that no stone has been left unturned. If there are abuses in the market, first try to correct these without closing down the entire market. But I suspect that this note of pessimism is misplaced, for the enormous gains from trade should lead to flourishing markets that are free of most of these problems.

⁹ Thomas H. Murray, "Gifts of the Body and the Needs of Strangers," 17 *Hastings Center Rep.* 30 (1987).

So, the inevitable retort will be: how far would I go in the sale of human flesh? What about lethal transplants which require the killing of the donor in order for the donee to live? Surely I should ban those, since no rational person would ever sign his own death warrant. But not necessarily. Let me recount a tragic vignette from Elizabeth Rosenthal's *New York Times* article on solace through transplants. A 48 year-old quadriplegic woman with end-stage multiple sclerosis had one wish: to give, not sell, her organs after her death. After much deliberation, the physicians agreed to wean her from the respirator to die. Several hours later she died, passively. But during this painful death, her internal organs became useless for transplant from lack of oxygen. Even the categorical rule against lethal transplants has its counterexamples. And if she wanted to sell the organs to leave something for a devoted friend or her needy child, should that be regarded as immoral?

The moral is that our centralized policy on organ transplantation, like all centralized policies, misses the point. I have no doubt that most Americans, like most people the world over, are drawn intuitively to positions like Kass's. They are uncomfortable with organ transplants, and opposed to organ sales. Cutting out an organ is painful; it is self-destructive and unnatural; it gnaws at instincts of survival that predates the emergence of human beings on this planet. So we shut down a market, and feed our fears. Yet the stubborn shortages are large and getting larger. Do we want a set of unpersuasive ethical objections to seal the needless death of thousands? Perhaps live organ sales will help. If so, then we should ignore our present squeamishness. Too many lives are at stake to do anything less.

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