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## Organ Transplantation: A Model Law Approach to Combat Human Trafficking and Transplant Tourism

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*“Forceable extraction of living body tissue causes revulsion to the judicial mind. Such would raise the spectre of the swastika and the Inquisition, reminiscent of the horrors this portends.”<sup>1</sup>*

### INTRODUCTION

At the end of the twentieth century, medical breakthroughs made it possible for humans to exchange certain diseased organs for healthy

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<sup>1</sup> McFall v. Shimp, 10 Pa. D. & C.3d 90, 92 (C.P. Ct. Allegheny Co. 1978) (quoting Judge Flaherty).

ones, dramatically extending lives. As technology improved and became more widespread, the need for healthy organs began to outstrip supply.<sup>2</sup> Topics on the fringe of medical ethics burst onto the scene as market-based solutions for the growing organ shortage crisis were proposed and met with fierce opposition. In response to the growing fear of the human body becoming a “commodity,” legislation in the United States was quickly passed to prevent organ sales and the emergence of a black market.<sup>3</sup> Ironically, this accelerated the shortage of organs and the emergence of a global black market in organ procurement. Driving this black market are factors of desperation and deception. Wealthy citizens of countries with robust procurement systems skirt their domestic system by travelling overseas to receive transplantation procedures. Known as “transplant tourism,” these individuals are able to dodge long wait times for domestic organs by paying top dollar to foreign medical organizations for transplants.<sup>4</sup> In the midst of this transaction are third-world “donors” who are deceived and defrauded into supplying their organs, usually a kidney.

Recently, the Council of Europe has suggested that the solution to organ trafficking and human trafficking for organ removal is an internationally binding agreement outlawing organ sales worldwide.<sup>5</sup> However, the current realities of the illicit transplantation market and the past lessons of procurement systems based solely on altruism seem to suggest that a new internationally binding agreement would not only be useless, but may prevent real solutions to the organ crisis from being thoroughly explored. Moreover, an internationally binding convention already exists, which could be easily adapted to address the transplant tourism problem and provide enough flexibility to explore meaningful procurement solutions: the Additional Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, supplementing the United Nations Convention against Transnational Organized Crime (Trafficking Protocol).<sup>6</sup> The

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<sup>2</sup> CAPLAN ET AL., COUNCIL OF EUROPE AND UNITED NATIONS, TRAFFICKING IN ORGANS, TISSUES AND CELLS AND TRAFFICKING IN HUMAN BEINGS FOR THE PURPOSE OF THE REMOVAL OF ORGANS, 20 (Directorate General of Human Rights and Legal Affairs: Council of Europe 2009) [hereinafter COUNCIL OF EUROPE STUDY].

<sup>3</sup> See National Organ Transplantation Act (NOTA), 42 U.S.C. § 274e (2008).

<sup>4</sup> K.A. Bramstedt & Jun Xu, *Checklist: Passport, Plane Ticket, Organ Transplant*, 7 AM. J. OF TRANSPLANTATION 1698, 1698 (2007).

<sup>5</sup> COUNCIL OF EUROPE STUDY, *supra* note 2, at 94.

<sup>6</sup> Protocol to Prevent, Suppress and Punish Trafficking in Persons, Especially Women and Children, Supplementing the United Nations Convention Against Transnational Organized Crime, G.A. Res. 55/25, U.N. Doc. A/55/383 (Nov. 15, 2000); 2237 U.N.T.S. 319. [hereinafter Trafficking Protocol].

Trafficking Protocol is widely ratified and requires member states to criminalize, among other activities, organ removal procured by deceit, fraud, and coercion.<sup>7</sup> Through this instrument, transplant tourism could be classified as an act that promotes human trafficking for organ removal, thus member states should criminalize it to comply with the Trafficking Protocol. Realistically, this approach should be vigorously pursued by the wealthier states whose citizens drive the illicit transplantation market through their demand because such states are better positioned to enforce effective bans on transplant tourism.

The purpose of this Note is not to take a definitive position on the procurement debate, but to encourage the debate domestically by shutting down transplant tourism. This Note explores the need to close the loopholes in wealthy “recipient” countries in order to force domestic reform and dry up demand in poorer “donor” countries. Part I of this Note shows the progression of medical breakthroughs surrounding organ transplantation and the subsequent rise of the international black market. Part II explores the international legislative and normative response to perceived ethical puzzles raised by the growing prevalence of transplantation procedures, as well as the current debate on the appropriateness of altruism and market-based procurement approaches. Part III responds to the call for an internationally binding instrument that would solidify altruism as the backbone of organ procurement, instead proposing a model law based on the Trafficking Protocol to address the growing abuses in transplant tourism and human trafficking for organ removal.

## I

### TRANSPLANTATION: BREAKTHROUGH AND BLACK MARKET

#### A. *Organ Transplantation*

The transplantation of human organs and tissues is a relatively contemporary breakthrough in medical science. Removing an organ from one person and surgically transplanting it into another, referred to as a “graft,” was likely considered either ghoulish or science fiction for most of the twentieth century. Doctors had experimented with

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<sup>7</sup> *Id.* at art. 5. Article 3 of the Trafficking Protocol defines human trafficking as: “the recruitment, transportation, transfer, harbouring [sic] or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation.” *Id.* at art. 3(a). Exploitation includes “the removal of organs.” *Id.*

transplanting organs from one animal to another living one of the same species with little success, a procedure known as an “allograft.”<sup>8</sup> However, on December 23, 1954, Dr. Joseph Murray and colleagues performed a living related-donor kidney transplant between two brothers in Hollywood, Florida.<sup>9</sup> Because the brothers were identical twins, kidney graft rejection was not an issue and the brothers were released in good health several weeks later.<sup>10</sup> This kidney transplant was a major breakthrough, and proved that it was now possible to replace diseased organs with healthy ones. But without immunosuppressant drugs, the promise of transplantation for diseased organs was limited to identical twins.<sup>11</sup>

This changed in 1963, with the development of Azathioprine, a drug that could modify the immune response of rejection, thus allowing renal transplantation between non-identical living related donors.<sup>12</sup> The combination of Prednisone and Azathioprine became a cornerstone of organ transplantation, expanding the procedure’s availability to related non-identical donor populations.<sup>13</sup> The introduction of Cyclosporin A in 1983 had a massive impact on the availability of both cadaveric and living allograft transplantations.<sup>14</sup> Organ transplantation was now a very real possibility for a broad range of individuals suffering from organ failure. Current medical technology and the acceptance of “brain death” have broadened transplantation procedures to include cadaveric and non-related living donors.<sup>15</sup>

Twenty-nine years after the creation of Cyclosporin A, organ transplantation has become widely available and success rates of

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<sup>8</sup> *Allograft Definition*, OXFORD ENGLISH DICTIONARY, <http://www.oed.com> (“A graft between genetically dissimilar individuals of the same species.”) (last visited Nov. 4, 2011); see also Arnold G. Diethelm, *Ethical Decisions in the History of Organ Transplantation*, 211 ANN. SURG. 505, 506–07 (May 1990).

<sup>9</sup> See Diethelm, *supra* note 8, at 507.

<sup>10</sup> *Id.* (“graft” is a common medical term for a transplanted organ).

<sup>11</sup> *Id.* at 507–08.

<sup>12</sup> *Id.* at 509.

<sup>13</sup> *Id.* at 510.

<sup>14</sup> *Id.* at 510–11. Cyclosporin A is a powerful immunosuppressant that drastically improves long-term graft survival. Since then, other treatments to prevent allograft rejection have also emerged (such as antilymphocyte globulin and a monoclonal antibody). *Id.* at 511. Cadaveric organs are from deceased individuals (cadavers).

<sup>15</sup> *Id.* at 511–15. However, the expansion of “brain death” definitions introduces significant technical, ethical, and legal questions that countries will have to grapple with, but are beyond the scope of this paper. See COUNCIL OF EUROPE STUDY, *supra* note 2, at 27.

kidney transplant procedures are excellent.<sup>16</sup> Advances in organ preservation, immunosuppression, xenografting, and surgical technology continue to expand the frontiers of transplantation.

Despite these successes, organ transplantation remains a very risky and complicated procedure. The most difficult aspect of the transplantation process is the procurement of an acceptable organ. Once blood ceases to flow to the organ due to severance of arteries or death, the organ begins to deteriorate rapidly from the lack of oxygen. The transplantation process must take place in a very short period of time because organs with long ischemic periods become unsuitable for transplantation.<sup>17</sup> Furthermore, organ donation and procurement is a complex process that requires highly trained professionals working together, a process that can be disrupted at any time.<sup>18</sup> The immunosuppression necessary to prevent the body from rejecting the grafted organ is an imperfect solution and over time, “grafts are lost mainly due to the widely known phenomenon of ‘chronic rejection’ and death with a functioning graft.”<sup>19</sup> The main causes of death resultant from transplants are due to diseases associated with long-term use of immunosuppression, which is necessary for the vast majority of transplant patients.<sup>20</sup>

Every organ recipient has to be successfully “matched” to a compatible donor to ensure organ survival. The matching process ensures that the donor and recipient are similar enough physiologically for the recipient’s body to accept the new organ; if not, the recipient’s body will reject the organ and attack it, leading to graft failure and further complications. Immunosuppression assists in this transition, but the two parties must still be precisely matched to ensure long-term graft survival.

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<sup>16</sup> According to 2009 data, three-year graft survival rates from deceased and living kidney donors were eighty percent and eighty-nine percent respectively. Three-year patient (recipient) survival rates from deceased and living donors were eighty-nine percent and ninety-five percent respectively. See U.S. Dep’t of Health & Human Services, 2009 ANN. REP. OF THE U.S. ORGAN PROCUREMENT & TRANSPLANTATION NETWORK & THE SCIENTIFIC REGISTRY OF TRANSPLANT RECIPIENTS: TRANSPLANT DATA 1999–2008, Table 1.13 (2009) [hereinafter 2009 ANN. REP.].

<sup>17</sup> COUNCIL OF EUROPE STUDY, *supra* note 2, at 25. Ischemia is the deficient supply of blood to an organ, which leads to tissue degeneration. See *Ischemia Definition, Medline Plus*, MERRIAM-WEBSTER DICTIONARY, <http://www.merriam-webster.com/medlineplus/ischemia> (last visited Nov. 4, 2011).

<sup>18</sup> COUNCIL OF EUROPE STUDY, *supra* note 2, at 24–25.

<sup>19</sup> *Id.* at 19.

<sup>20</sup> *Id.*

Donated organs can come from either live donors (only for kidneys or livers) or deceased donors (cadaveric). Each source has its own procurement difficulties. First, with live donors there is the inherent risk of patients paying another for their organ. Currently, most transplantation regulatory regimes are founded upon the principle of altruism, where it is illegal to buy or sell a bodily organ. The merits of such a system will be discussed in Part II. The rationale for this policy is that allowing market transactions for organs would lead to exploitation of the poor and degradation of human dignity. Thus, an altruistic system requires donors to give freely, and voluntary live donors can be hard to come by. Most regimes also require live donors to be either an immediate relative or someone who shares a close connection to the recipient.

Next, cadaveric organ procurement systems operate on altruism as well, but also face difficulties associated with the tissue degeneration problems discussed above. Coordination of cadaveric donation requires rapid identification, matching, and transplantation. These needs led to definitions of “brain death,” as well as the development of “opt-in” or “opt-out” consent systems.<sup>21</sup> An opt-in system operates under the presumption that an individual does not want to be an organ donor unless he has made an affirmative statement to the contrary. The United States currently operates under such a system.<sup>22</sup> Alternatively, the opt-out or presumed consent system presents difficult ethical wrinkles. In an opt-out system, consent for organ donation is presumed unless an individual affirmatively states otherwise. Popular in Europe, this system is widely endorsed by the European transplantation community, but its superior effectiveness is far from apparent.<sup>23</sup> Presumed consent laws may also have difficulty being accepted in some countries.<sup>24</sup> It is not uncommon for countries with presumed consent laws to still regularly ask family members for consent, respecting their decisions to the contrary.<sup>25</sup>

Finally, compounding the organ procurement difficulties are the biases between the differing systems. Scientifically, a living donor transplant is more desirable because it is an elective procedure that can be scheduled more effectively and has superior graft survival

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<sup>21</sup> Erica D. Roberts, *When the Storehouse is Empty, Unconscionable Contracts Abound: Why Transplant Tourism Should Not Be Ignored*, 52 HOW. L.J. 747, 751 (2009).

<sup>22</sup> *Id.* at 752.

<sup>23</sup> *Id.* at 761.

<sup>24</sup> *Id.* at 760.

<sup>25</sup> COUNCIL OF EUROPE STUDY, *supra* note 2, at 24.

rates.<sup>26</sup> However, in the current system based purely on altruism, it is difficult to incentivize greater donation rates.<sup>27</sup> Alternatively, cadaveric donations are less susceptible exploitive arrangements,<sup>28</sup> but they suffer from lower graft quality, complicated logistical considerations, and cultural barriers.<sup>29</sup>

### ***B. Growth of the Black Market***

Regardless of its imperfections, organ transplantation is now a global practice with kidney transplants carried out in more than ninety countries.<sup>30</sup> Approximately 100,800 solid-organ transplants are performed every year worldwide, including 69,400 kidney transplants and 20,200 liver transplants.<sup>31</sup> Furthermore, forty-six percent of transplanted kidneys come from living donors.<sup>32</sup> The increasing prevalence of transplantation has caused a shortage of organs to emerge (and death rates to increase) and this shortage has caused some individuals to look to private, commercial organ transactions.<sup>33</sup>

For example, in 1983, Dr. H. Berry Jacobs proposed that the solution for organ supply shortages could be establishing an International Kidney Exchange and allowing organ sales through that exchange.<sup>34</sup> This sparked vehement condemnation from individuals

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<sup>26</sup> *Id.* at 27–29; see also 2009 ANN. REP., *supra* note 16, Table 1.13.

<sup>27</sup> Sunny Woan, *Buy Me a Pound of Flesh: China's Sale of Death Row Organs on the Black Market and What Americans Can Learn From It*, 47 SANTA CLARA L. REV. 413, 424–25 (2007); see also Curtis E. Harris & Stephen P. Alcorn, *To Solve a Deadly Shortage: Economic Incentives for Human Organ Donation*, 16 ISSUES L. & MED. 213, 223 (2001); Julia D. Mahoney, *The Market for Human Tissue*, 86 VA. L. REV. 163, 219 (2000).

<sup>28</sup> Robert D. Truog, *The Ethics of Organ Donation by Living Donors*, 353 NEW ENG. J. MED. 444, 445 (2005) (directed donation to a stranger has an inherent risk of being the product of a commercial transaction, even though such practices are illegal).

<sup>29</sup> See 2009 ANN. REP., *supra* note 16 at Table 1.13. In some regions, such as Africa, Asia, and South America, there is strong resistance to using cadaveric organs for various cultural, personal, and financial reasons. See Clare Nullis-Kapp, *Organ Trafficking and Transplantation Pose New Challenges*, 82 BULL. OF THE WHO 715, 715 (2004).

<sup>30</sup> See generally Yosuke Shimazono, *The State of the International Organ Trade: a Provisional Picture Based on Integration of Available Information*, 85 BULL. OF THE WHO 955, 955–62 (2007).

<sup>31</sup> WORLD HEALTH ORGANIZATION (WHO), *GKT 1 Activity and Practices*, <http://www.who.int/transplantation/gkt/statistics/en/index.html> (last visited Nov. 4, 2011) (based on activity data analyzed from 2008 for 104 countries, representing nearly ninety percent of the worldwide population).

<sup>32</sup> *Id.*

<sup>33</sup> Roberts, *supra* note 21, at 749.

<sup>34</sup> *Id.* at 762. (Dr. Jacob's company would have purchased kidneys from healthy, but very poor Third World citizens and sold them to wealthy American recipients); see also

and lawmakers who believed that such a system would negate altruism, exploit the underprivileged, reduce the quality of organs, and degrade the human body by reducing it to a commodity.<sup>35</sup> Ironically, opponents also believed that such a market system would open the door to organ commerce and a black market for organ trading.<sup>36</sup> These criticisms were accepted around the world, and in 1984, the United States responded to Dr. Jacob's proposal by passing the National Organ Transplantation Act (NOTA) with other nations following suit.<sup>37</sup> NOTA passed with little debate and made it "unlawful for any person to knowingly acquire, receive, or otherwise transfer any human organ for valuable consideration for use in human transplantation."<sup>38</sup> Thus, altruism was solidified as the only acceptable foundation for transplantation in the United States and abroad.<sup>39</sup>

Since the 1980s, increasing shortages in organs globally has developed into a major problem for most countries.<sup>40</sup> For example, in 2008 the United States added 33,051 new registrations to the kidney waiting list and had 139,917 patients on the waiting list for all organs.<sup>41</sup> That year, 7182 patients died while waiting and 4638 of those were waiting for a kidney.<sup>42</sup> In 2005, the median wait for a kidney transplant was approximately three and a half years.<sup>43</sup> In 2006, it was estimated that approximately 40,000 Europeans were on kidney

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Jennifer M. Smith, "Dirty Pretty Things" and the Law: Curing the Organ Shortage & Healthcare Crises in America, 12 CHAP. L. REV. 361, 369 (2008).

<sup>35</sup> Roberts, *supra* note 21, at 763; *see also* Smith, *supra* note 34, at 370 (stating that "Americans were outraged" and pressured Congress to ban the sale of organs—an initiative spearheaded by Senator Al Gore).

<sup>36</sup> Roberts, *supra* note 21, at 763.

<sup>37</sup> National Organ Transplantation Act (NOTA), 42 U.S.C. § 274e (2008); *see also* Roberts, *supra* note 21, at 764; Transplantation of Human Organs Act, 1994, No. 42, Acts of Parliament, 1994 (India); Human Organ Transplant Act, 1989, c. 31 (Eng.); Human Tissue Amendment Act 51 of 1989 (S. Afr.).

<sup>38</sup> 42 U.S.C. § 274e; *see also* Roberts, *supra* note 21, at 764.

<sup>39</sup> *See* Andrew Wancata, *No Value for a Pound of Flesh: Extending Market-Inalienability of the Human Body*, 18 J.L. & HEALTH 199, 200 (2004) (noting that in the United States and many countries throughout the world, selling non-regenerative organs for monetary gain constitutes a serious criminal offense); *see also* Jeneen Interlandi, *Not Just Urban Legend*, NEWSWEEK, Jan. 9, 2009 at 41.

<sup>40</sup> Roberts, *supra* note 21, at 757.

<sup>41</sup> 2009 ANN. REP., *supra* note 16, at Tables 1.5 & 1.6. (finding that in 2008, 99,750 patients were waiting for a kidney).

<sup>42</sup> *Id.* at Table 1.6.

<sup>43</sup> *Id.* at Table 1.5.



waiting lists and fifteen to thirty percent of them would die while waiting.<sup>44</sup>

The shortage of organs is primarily the result of longer lifespans, more reliable and available transplantation procedures, detrimental changes in diet and lifestyle, and the need for retransplantation procedures for previous recipients.<sup>45</sup> Others have pointed to the prohibition of organ sales as the major force driving organ scarcity.<sup>46</sup> Regardless of the cause, the supply of organ donors has never been enough to meet the increasing demand,<sup>47</sup> and an international black market in living donor kidney transplantation has emerged.<sup>48</sup>

The shortage of “indigenous” supplies of organs has created an international organ trade, where patients travel overseas to take advantage of regulatory loopholes.<sup>49</sup> Recipients are assisted by intermediaries or healthcare providers who arrange the procedure and recruit the donor.<sup>50</sup> Black markets are especially prevalent in poorer regions largely due to the extreme poverty, desperation, long waiting lists, and the fact that higher quality organs come from living donors.<sup>51</sup> The vulnerable poor and desperate rich come together in black market transactions, spurred by advances in technology and lagging international legislation.<sup>52</sup> However, these black market transactions are rife with insufficient information, no remedies in the event of fraud, and deadly combinations of desperation and greed.<sup>53</sup>

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<sup>44</sup> Silke Meyer, *Trafficking in Human Organs in Europe: A Myth or an Actual Threat?*, 14 EUR. J. CRIME CRIM. L. & CRIM. JUST. 208, 218 (2006).

<sup>45</sup> COUNCIL OF EUROPE STUDY, *supra* note 2, at 20.

<sup>46</sup> Liliana M. Kalogjera, *New Means of Increasing the Transplant Organ Supply: Ethical and Legal Issues*, 34 HUM. RTS. 19, 20 (2007) (“[Although] the prohibition may be ethically justified, [it] has likely contributed, at least in part, to the growing shortage.”); see also Michele Goodwin, *Bio Law: A Few Thoughts About Altruism and Markets*, 18 KAN. J.L. & PUB. POL’Y, 208, 209 (2009) (“[A] rigid prescription on altruism inspires the least favorable of markets: black and gray markets.”).

<sup>47</sup> COUNCIL OF EUROPE STUDY, *supra* note 2, at 20.

<sup>48</sup> Smith, *supra* note 34, at 372. However, as early as the 1970s, medical professionals predicted that the rising value of human body parts coupled with shortages would drive organ procurement into the underground market. See RUSSELL SCOTT, *THE BODY AS PROPERTY*, 181 (1981).

<sup>49</sup> Shimazono, *supra* note 30, at 955.

<sup>50</sup> *Id.* at 956.

<sup>51</sup> Smith, *supra* note 34, at 374.

<sup>52</sup> Joe A. Flores, *International Scientific Misconduct and the Legal System*, 9 CURRENTS: INT’L TRADE L.J. 60, 65 (2000).

<sup>53</sup> Roberts, *supra* note 21, at 767 (explaining that in the event of fraud disputes, the donor is usually left with no recourse).

Being that the current “legal” human tissue industry is estimated to be worth \$500 million a year,<sup>54</sup> the incentives associated with the organ trade are irresistible for organized crime and human trafficking. Human trafficking for organ removal is characterized by cases in which people enter into an agreement to sell their organ, but once the kidney is removed, they are cheated, paid a fraction of the agreed price, or not paid at all.<sup>55</sup> Organized crime serves as a middleman that coerces poor individuals to sell their organs through either economic incentives or force.<sup>56</sup> Both brokers and medical staff frequently lie about the procedure and its consequences.<sup>57</sup>

Organized crime can be classified into two categories: one characterized by the provision of goods and services between consenting parties, and the other characterized by the abuse or infiltration of legitimate businesses through threats, coercion, or violence.<sup>58</sup> Silke Meyer classifies trafficking in human organs as falling into the first category because the transaction is often based on mutual consent.<sup>59</sup> Generally, those donating their organs on the black market are lured, not forced, into selling their organs.<sup>60</sup> The brokers pay only \$1,000 to \$5,000 to the donor, but sell the organ to recipients for hundreds of thousands of dollars.<sup>61</sup>

Medical professionals are complicit in this trafficking because the black market for organ transplantations requires highly skilled medical staff, intermediaries or brokers to seek out donors (usually from poor communities), and well-paying clients.<sup>62</sup> Additionally,

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<sup>54</sup> Alan Zarembo & Jessica Garrison, *Profit Drives Illegal Trade in Body Parts*, L.A. TIMES, Mar. 7, 2004, at A1. See also Martina Keller & Markus Grill, *Inside a Creepy Global Body Parts Business*, SPIEGEL ONLINE (Aug. 28, 2009), <http://www.spiegel.de/international/Europe/0,1518,645375,00.html> (Euro currency conversion omitted) (“If a body were disassembled into its individual parts, then processed and sold, the total proceeds could amount to \$250,000.”).

<sup>55</sup> ELAINE PEARSON, COERCION IN THE KIDNEY TRADE?: A BACKGROUND STUDY ON TRAFFICKING IN HUMAN ORGANS WORLDWIDE 10–11 (2004) (explaining that averages are about one-third less than the promised price).

<sup>56</sup> *Id.* at 10.

<sup>57</sup> *Id.*

<sup>58</sup> Meyer, *supra* note 44, at 212.

<sup>59</sup> *Id.* “[T]he ones operating this business are often suspected to have excellent connections to official authorities.” *Id.* at 220.

<sup>60</sup> *Id.* at 221.

<sup>61</sup> *Id.* Some estimates put possible sales at prices between \$100,000 to \$200,000. See Council of Europe, *Trafficking in Organs in Europe: Report of the Social, Health and Family Affairs Committee* § II, no. 11 (2003); Nullis-Kapp, *supra* note 29, at 715.

<sup>62</sup> Meyer, *supra* note 44, at 211. In Taiwan, “118 patients who underwent organ transplants in China were questioned by their Department of Health, and 69 reported that their transplants were facilitated by doctors.” See also Shimazono, *supra* note 30, at 956.

unlike other forms of trafficking, the transplantation procedure cannot take place just anywhere, as it requires a medical facility with all the necessary equipment.<sup>63</sup> In some countries, these medical officials and brokers are directly linked with government officials.<sup>64</sup>

Governments themselves have turned to nefarious action in an effort to curb their own domestic organ shortages or cash in on the lucrative market. In an effort to solve its organ procurement problem, China began harvesting organs from executed prisoners for immediate transplantation into paying clients.<sup>65</sup> In 2006, approximately 11,000 of the transplants done in China were with organs from executed prisoners.<sup>66</sup> There are even reports that China purposely adjusted execution schedules to coincide with the matching requirements of potential recipients.<sup>67</sup> Although China has taken strides to reform these practices, some observers believe the efforts were merely a public relations stunt for the 2008 Olympics and will soon recede to previous practices.<sup>68</sup> Recently, reports have emerged of government officials in Kosovo being directly involved in the trafficking and execution of Serb prisoners for organ harvesting.<sup>69</sup> Working in connection with organized crime syndicates, Serb prisoners were taken into neighboring Albania where medical personnel were waiting to harvest the prisoners' organs for transplantation procedures.<sup>70</sup>

The growing prevalence of overseas medical procedures has contributed to illicit practices. Most medical tourists are drawn overseas by significant cost-savings and comparable standards of

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<sup>63</sup> Meyer, *supra* note 44, at 211.

<sup>64</sup> *Id.* at 220 (“[T]he ones operating this business are often suspected to have excellent connections to official authorities.”).

<sup>65</sup> See generally HUMAN RIGHTS WATCH, CHINA: ORGAN PROCUREMENT AND JUDICIAL EXECUTION IN CHINA (1994); see also Roberts, *supra* note 21, at 771–72.

<sup>66</sup> D.A. Budiani-Saberi & F.L. Delmonico, *Organ Trafficking and Transplant Tourism: A Commentary on the Global Realities*, 8 AM. J. TRANSPLANTATION 925, 927 (2008).

<sup>67</sup> See generally HUMAN RIGHTS WATCH, *supra* note 65; see also Roberts, *supra* note 21, at 772 n.189.

<sup>68</sup> Budiani-Saberi & Delmonico, *supra* note 66, at 928.

<sup>69</sup> Julia Zebley, *Council of Europe Demands Kosovo, Albania Investigate Organ Trafficking*, JURIST (2011), available at <http://jurist.org/paperchase/2011/01/council-of-europe-demands-kosovo-albania-investigate-organ-trafficking.php>; Paul Lewis, *Kosovo PM is Head of Human Organ and Arms Ring, Council of Europe Reports*, GUARDIAN (London) (2010), available at <http://www.guardian.co.uk/world/2010/dec/14/kosovo-prime-minister-like-mafia-boss>.

<sup>70</sup> See Lewis, *supra* note 69.

treatment at accredited facilities.<sup>71</sup> Medical tourism brokerages frequently note the quality of care provided by western-trained or licensed medical facilities and their international accreditation by the Joint Commission on Accreditation for Healthcare Organizations through its affiliate, Joint Commission International.<sup>72</sup> There are over 123 medical facilities worldwide that are accredited by this organization, and several of them are partnered with major western teaching facilities such as Harvard Medical International, the Mayo Clinic, and Johns Hopkins Medicine International.<sup>73</sup> It is estimated that in 2003, nearly 350,000 patients from developed countries traveled to developing countries for health care, and that number is projected to grow to approximately 10.5 to 23.2 million by 2017.<sup>74</sup> Cost analyses of surgical procedures for non-acute health problems estimated the annual savings to be approximately \$1.4 billion.<sup>75</sup> The promise of globalized healthcare has caused both public and private entities to explore ways to incentivize employees' use of medical tourism.<sup>76</sup> Though not necessarily unethical,<sup>77</sup> travel for medical care can quickly devolve into illicit practices when transplantation is involved.<sup>78</sup> Approximately ten percent of global transplants involve illicit practices.<sup>79</sup> Insurance companies, medical professionals, and

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<sup>71</sup> Laura Hopkins et al., *Medical Tourism Today: What is the State of Existing Knowledge?*, 31 J. OF PUB. HEALTH POL'Y 185, 189 (2010); see also Shimazono, *supra* note 30, at 955–62; Leigh Turner, *'Medical Tourism' Initiatives Should Exclude Commercial Organ Transplantation*, 101 J. ROYAL SOC'Y MED. 391–94 (2008).

<sup>72</sup> Hopkins et al., *supra* note 71, at 187.

<sup>73</sup> *Id.*

<sup>74</sup> *Id.* at 187–88.

<sup>75</sup> *Id.* at 189.

<sup>76</sup> In 2007, a U.S. company offered financial inducements for employees to receive medical treatment in India and West Virginia attempted to implement a similar policy for state employees. However, both programs failed due to condemnation and concerns over lax medical malpractice laws. Hopkins et al., *supra* note 71, at 189. A European-owned supermarket chain in the United States successfully implemented such a policy in order to deal with the high cost of U.S. healthcare. *Id.* Belgium considered legislation that would create a list of non-European hospitals that were ethically acceptable for transplantation and any foreign transplant not from these hospitals would face a fine (500–5000 euro). Bramstedt & Xu, *supra* note 4, at 1699.

<sup>77</sup> “However, not all medical tourism that entails the travel of transplant recipients or donors across national borders is organ trafficking. Transplant tourism may be legal and appropriate.” Budiani-Saberi & Delmonico, *supra* note 66, at 926; see also Francis L. Delmonico, *The Implications of Istanbul Declaration on Organ Trafficking and Transplant Tourism*, 14 CURR. OPIN. ORGAN TRANSPLANT. 116, 117 (2009).

<sup>78</sup> Hopkins et al., *supra* note 71, at 190; see also Shimazono, *supra* note 30, at 955–62; Turner, *supra* note 71, at 391–94.

<sup>79</sup> Delmonico, *supra* note 77, at 116; see also Budiani-Saberi & Delmonico, *supra* note 66, at 927.

private firms all facilitate this practice with little or no danger of prosecution.<sup>80</sup> Companies, such as United Group Programs, offer living and deceased donor transplants at their referral facility in Bangkok, Thailand. Euphemistically referred to as “medical value travel,” U.S. health insurers work with corporations to arrange for American employees to obtain living donor transplants in India, though the living donor is identified in America and flown with the recipient to the overseas facility.<sup>81</sup>

Concerns over transplant tourism highlight the possibility of exploitation because “in countries where transplantation guidelines do not exist (or are not enforced), the source of donor organs can be people who have been expressly paid to donate, as well as those who are unable to give valid informed consent.”<sup>82</sup> More often than not, it is the desperately impoverished who are approached by intermediaries with promises of financial freedom—promises that are rarely kept.<sup>83</sup> Most of these donors receive little or no follow-up treatment, a fraction of the promised price, and experience serious health complications.<sup>84</sup> As one panel of experts stated: “The majority of these [commercial living-donors] (93%) who sold a kidney to repay a debt and (85%) reported no economic improvement in their lives, as they were either still in debt or were unable to achieve their objective in selling the kidney . . . [n]inety-four percent regretted their donation.”<sup>85</sup> The most unfortunate aspect of transplant tourism is not desperate donors doing anything to meet their needs, but the desperate patient willing to do anything to survive.<sup>86</sup>

Domestically, transplant tourism presents new dangers and burdens. Preliminary research with patients who received

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<sup>80</sup> See generally Bramstedt & Xu, *supra* note 4.

<sup>81</sup> *Id.* at 1698–99.

<sup>82</sup> *Id.* at 1699.

<sup>83</sup> See PEARSON, *supra* note 55, at 10–11; see also Roberts, *supra* note 21, at 782–83.

<sup>84</sup> Smith, *supra* note 34, at 375–76; Jeffrey P. Kahn, *Studying Organ Sales: Short Term Profits, Long Term Suffering*, CNN HEALTH, [http://articles.cnn.com/2002-10-01/health/ethics.matters.selling.organs\\_1\\_kidney-donors-organ-sales-organ-donors?\\_s=PM:HEALTH](http://articles.cnn.com/2002-10-01/health/ethics.matters.selling.organs_1_kidney-donors-organ-sales-organ-donors?_s=PM:HEALTH) (last visited Feb. 24, 2011); Shimazono, *supra* note 30, at 958 (“[T]he underlying motivation of most paid kidney donors is poverty, and . . . lasting economic benefit after donation is limited or even negative because of the limited employability of such patients and the perceived deterioration of their health.”).

<sup>85</sup> Budiani-Saberi & Delmonico, *supra* note 66, at 927–28 (the responses were consistent across studies in Pakistan, Egypt, India, Iran, and the Philippines).

<sup>86</sup> Aslihan Sanal, “Robin Hood” of *Techno-Turkey* or *Organ Trafficking in the State of Ethical Beings*, 28 CULTURE, MED. & PSYCHIATRY 281, 305 (2004).

transplantation procedures found high occurrences of botched procedures and infections, including hepatitis B, fungal sepsis, and HIV.<sup>87</sup> Due to substandard medical practices, patient and graft survival rates are considerably lower.<sup>88</sup> Finally, medical records for these patients are often incomplete or unobtainable, further complicating follow-up treatment and placing the public at risk.<sup>89</sup> Physicians who would normally never be involved in the illicit practice are now forced to bear the responsibility for the medical care of those who skirt the system and return home with medical complications and possible infectious diseases.<sup>90</sup> In the United States, current federal law presents no obstacles to patients returning home and receiving post-transplantation care, further encouraging the practice.<sup>91</sup>

“Organs,” under the most basic definition, are not the only locus of controversy; a variety of tissues and cells are routinely implanted for a wide range of procedures.<sup>92</sup> Some of these tissues are corneas, heart valves, bone, dura matter, joints and tendons, skin, and fat.<sup>93</sup> In this context, observers point to the rising instances of scientific misconduct in the biotechnology industry regarding human organs, tissues, and cells.<sup>94</sup> American courts have been reticent to recognize property rights regarding one’s bodily tissues, bestowing, at best, a “quasi-property” right.<sup>95</sup> The landmark case in this instance is *Moore v. Regents of the University of California*, where tissues were removed from the plaintiff during treatment of hairy cell leukemia

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<sup>87</sup> Bramstedt & Xu, *supra* note 4, at 1700 (internal citations omitted).

<sup>88</sup> Shimazono, *supra* note 30, at 958.

<sup>89</sup> Bramstedt & Xu, *supra* note 4, at 1700.

<sup>90</sup> Budiani-Saberi & Delmonico, *supra* note 66, at 925.

<sup>91</sup> Shimazono, *supra* note 30, at 958; Francis L. Delmonico et al., *Ethical Incentives—Not Payment—for Organ Donation*, 346 NEW ENG. J. MED. 2002, 2002 (2002).

<sup>92</sup> COUNCIL OF EUROPE STUDY, *supra* note 2, at 17.

<sup>93</sup> *Id.*

<sup>94</sup> See generally Flores, *supra* note 52; Keller & Grill, *supra* note 54.

<sup>95</sup> Courts associated a quasi-property right to one’s body, but this approach has never been generally accepted “[b]ecause this quasi-property right is neither pecuniary in nature nor transferable, it falls well short of conferring true property rights” Lisa Milot, *What Are We—Laborers, Factories, or Spare Parts? The Tax Treatment of Transfers of Human Body Materials*, 67 WASH. & LEE L. REV. 1053, 1084 (2010) (citations omitted); see also Wancata, *supra* note 39, at 205–06; Brotherton v. Cleveland, 923 F.2d 477, 479 (6th Cir. 1991); O’Donnell v. Slack, 55 P. 906, 907 (Cal. 1899). But see Venner v. Maryland, 354 A.2d 483 (Md. Ct. Spec. App. 1976) (holding that defendant possibly had a property right to his own excrement, but he had legally abandoned that property); Hecht v. Superior Court, 20 Cal. Rptr. 2d 275 (Cal. Ct. App. 1993) (allowing a narrow interpretation of property rights to human cells).

and, without the plaintiff's knowledge, were developed into a patented cell line of substantial monetary value.<sup>96</sup> While the court did not expressly address whether or not the human body or its parts are property, its holding for the defendants was essentially a "statement that the law treats human tissues, organs, blood, and dead bodies as objects *sui generis*—physical objects not within the parameters of traditional personal property."<sup>97</sup> Furthermore, some laws distinguish organs and body "products" on the grounds that removal of regenerative tissue (gametes and blood) pose little hazard to a donor's life and health, so sales are allowable.<sup>98</sup>

Although profiting from human parts is expressly prohibited in most countries, companies have exploited loopholes in the system for massive financial gain. As one observer opined; "Over the last decade, the tissue and organ bank industries have boomed. These institutions are considered nonprofit, and donors envision their parts being used only in altruistic endeavors. But many such banks, closely tied to for-profit companies, essentially sell body parts for commercial research and products."<sup>99</sup> Most tissues undergo processing where they are turned into "products" that are sold to hospitals; this conversion process accounts for most of the controversy surrounding tissue donation.<sup>100</sup>

Many tissue banks are for-profit organizations.<sup>101</sup> Although NOTA prohibits the buying and selling of organs and tissues, the Act allows organ banks to charge "reasonable fees" for their services.<sup>102</sup> These "reasonable fees" allow for-profit companies to enter the procurement process.<sup>103</sup> Utilizing the altruism of organ donors or express consent programs, or offering compensation in cases such as gametes, these companies are able to commoditize human parts for sale in "legitimate" markets.<sup>104</sup> In many cases, the exploitation arises when

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<sup>96</sup> Moore v. Regents of Univ. of Cal., 793 P.2d 479 (Cal. 1990).

<sup>97</sup> Wancata, *supra* note 39, at 210; *see also* Moore, 739 P.2d at 489.

<sup>98</sup> Wancata, *supra* note 39, at 223.

<sup>99</sup> Zarembo & Garrison, *supra* note 54.

<sup>100</sup> Vanessa S. Perlman, *Reviews in Medical Ethics: The Place of Altruism in a Raging Sea of Market Commerce*, 33 J.L. MED. & ETHICS 163, 164 (2005).

<sup>101</sup> *Id.*

<sup>102</sup> National Organ Transplantation Act (NOTA), 42 U.S.C. §§ 273–74 (1984); *see also* Perlman, *supra* note 100, at 164.

<sup>103</sup> Perlman, *supra* note 100, at 164.

<sup>104</sup> Financial exchanges occur on a regular basis in the transplantation industry with biopharmaceutical companies engaging in a wide array of partnerships, including arrangements with university hospitals, coroners, and abortion clinics. Woan, *supra* note

these companies and practitioners fail to disclose the intended use of the tissue to the donor.<sup>105</sup> Other cases emerge from presumed consent cases where cadavers are simply harvested for their tissue by a coroner or other medical professional in contract with a biotech company or organ bank.<sup>106</sup> Observers point out that a prevailing “benevolent” view of the scientific community shields them from criticism,<sup>107</sup> while they exploit altruism for entities that “pursue their financial interests aggressively.”<sup>108</sup> While some fear that demanding altruism throughout the entire donation process would severely cripple medical research and advancement,<sup>109</sup> there certainly is a growing need for regulations to prevent large companies from profiting from donor ignorance or outright fraud.

Over the last century or so of medical advances, illicit and free markets emerged for human materials, but until recently those materials had limited economic value.<sup>110</sup> During the course of the past several decades, the revolution in medical technology has dramatically increased the economic potential of the human body.<sup>111</sup> “These dramatic technological breakthroughs have escalated the tension between preventing (or at least containing) the commodification of human body parts on the one hand and providing services that save and enhance human lives on the other.”<sup>112</sup> Although commercialization of human organs is technically prohibited in the United States and a majority of other nations, global disparities in policy and enforcement have allowed a black market in organ transactions to emerge and flourish.<sup>113</sup> Due to “the extreme levels of poverty in some regions, Americans and others have procured organs from living donors in many Third World countries with no real long-

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27, at 426; see also Michele Goodwin, *Altruism's Limits: Law, Capacity, and Organ Commodification*, 56 RUTGERS L. REV. 305, 327–28 (2004).

<sup>105</sup> Moore v. Regents of Univ. of Cal., 793 P.2d 479 (Cal. 1990).

<sup>106</sup> Goodwin, *supra* note 46, at 211. See generally Albrecht v. Treon, 889 N.E.2d 120 (Ohio 2008) (Albrecht II); Brotherton v. Cleveland, 923 F.2d 477 (6th Cir. 1991); *Organ Scandal Background*, BBC NEWS (2001), <http://news.bbc.co.uk/2/hi/1136723.stm>.

<sup>107</sup> Flores, *supra* note 52, at 63. “Acts that wrongfully allow one to have monetary gain or gain in property are criminal and are no less wrong because they were done for the sake of scientific research.” *Id.*

<sup>108</sup> Mahoney, *supra* note 27, at 175.

<sup>109</sup> *Id.* at 199.

<sup>110</sup> *Id.* at 170–71.

<sup>111</sup> *Id.* at 171.

<sup>112</sup> *Id.* at 171–72.

<sup>113</sup> Roberts, *supra* note 21, at 750.



term benefit bestowed upon the donor.”<sup>114</sup> Pakistan has been dubbed a “kidney bazaar” because of its large numbers of impoverished donors. Recipients are likely pay \$6000 to \$12,000, but the donors may net, at most, about \$2500.<sup>115</sup> In India, there are reports of day laborers being initially promised work, but later duped or threatened at gunpoint to undergo transplant operations.<sup>116</sup> The current global reality is that five to ten percent of kidney transplants performed annually are the result of organ trafficking, a business “based on despair.”<sup>117</sup>

## II THE GLOBAL STRUGGLE FOR EFFECTIVE, BUT ETHICAL ORGAN POLICY

The forces of supply and demand have fostered the growth of the black market and scientific misconduct.<sup>118</sup> The low number of organs and high demand for transplants has created a “global market that involves physicians, researchers, and dealers in organs, into a very profitable criminal market.”<sup>119</sup> The lack of safeguards encourages organ traffickers to exploit the poor and uneducated.<sup>120</sup> The solution to this problem is not simply funding current programs, but is largely dependent on international laws to curb the market.<sup>121</sup> Health authorities have been asked to update their legal frameworks to boost organ supply and curb illicit transplantation, but must do so within ethical boundaries.<sup>122</sup>

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<sup>114</sup> Smith, *supra* note 34, at 373. Other major “recipient” nations include Australia, Canada, Israel, Japan, Oman, Saudi Arabia, and EU countries. Shimazono, *supra* note 30, at 957; *see also* Nancy Scheper-Hughes, *Prime Numbers: Organs Without Borders*, FOREIGN POLICY, Jan.–Feb. 2005. Major “donor” nations include Pakistan, India, China, the Philippines, Bolivia, Brazil, Peru, Iraq, Israel, Turkey, and the Republic of Moldova. Roberts, *supra* note 21, at 769.

<sup>115</sup> Smith, *supra* note 34, at 375.

<sup>116</sup> *Id.*

<sup>117</sup> Meyer, *supra* note 44, at 219.

<sup>118</sup> Flores, *supra* note 52, at 65. Demand is virtually guaranteed by the organ shortages across Europe and supply can be understood by viewing the living standards of those willing to sell their kidneys. For example, Moldova is the main donor country in Europe and, notably, also one of the poorest. Meyer, *supra* note 44, at 217.

<sup>119</sup> Flores, *supra* note 52, at 66.

<sup>120</sup> *Id.* at 65.

<sup>121</sup> *Id.*

<sup>122</sup> Shimazono, *supra* note 30, at 959–60.

### A. *International Ban on Organ Sales*

As noted above, in 1984 the United States passed legislation banning payments for any organ used for transplantation.<sup>123</sup> The Uniform Anatomical Gift Act of 1968, which set out laws for cadavers, did not state whether direct payments for organs were allowed, but the passage of NOTA in 1984 quickly brought that legislation in line with the current prohibition of organ sales.<sup>124</sup> Since 1984, only one amendment has been made to NOTA, and it served merely to expand the definition of a human organ.<sup>125</sup>

Since the passage of NOTA, other countries have followed suit in prohibiting organ sales. For example, Germany's organ transplant act explicitly states, "[t]rading in organs or tissue intended for use in the medical treatment of others is prohibited."<sup>126</sup> In 1994, India responded to international criticism of its transplantation practices by passing the Transplantation of Human Organs Act, which makes it illegal to sell non-vital organs.<sup>127</sup> Thus, in the United States and many countries throughout the world, selling non-regenerative organs for monetary gain constitutes a serious criminal offense.<sup>128</sup> The only nation that officially allows the buying and selling of organs for transplantation is Iran, which is host to a program that has been the recipient of both interest and condemnation.<sup>129</sup>

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<sup>123</sup> National Organ Transplantation Act (NOTA), 42 U.S.C. § 274e (1984) (amended 2007) ("It shall be unlawful for any person to knowingly acquire, receive, or otherwise transfer any human organ for valuable consideration for use in human transplantation if the transfer affects interstate commerce.").

<sup>124</sup> Mahoney, *supra* note 27, at 177–78; Unif. Anatomical Gift Act (UAGA) of 1968, 8A U.L.A. 63 (1993) (superseded by the UAGA of 1987); UAGA of 1987, 42 U.S.C. §§ 273–274(f) (1994) ("A person may not knowingly, for valuable consideration, purchase or sell a part for transplantation or therapy, if removal of the part is intended to occur after the death of the decedent.").

<sup>125</sup> Health Omnibus Programs Extension of 1988, Pub. L. No. 100-607, § 406, 102 Stat. 3048, 3116 (1988); *see also* Elizabeth Pugliese, *Organ Trafficking and the TVPA: Why One Word Makes a Difference in International Enforcement Efforts*, 24 J. CONTEMP. HEALTH L. & POL'Y 181, 195 (2008).

<sup>126</sup> TRANSPLANTATIONSGESETZ (TPG) [TRANSPLANTATION ACT], May 11, 1997, BGBl'I at § 17(1) (Ger.).

<sup>127</sup> Transplantation of Human Organs Act (India), *supra* note 37.

<sup>128</sup> Wancata, *supra* note 39, at 200.

<sup>129</sup> Delmonico, *supra* note 77, at 118; Paul Garwood, *Dilemma Over Live-Donor Transplantation*, 85 BULL. OF THE WHO 5, 6 (2007); J. Zargooshi, *Iranian Kidney Donors: Motivations and Relations with Recipients*, 165 J. OF UROLOGY 386 (2001); Stephen J. Dubner, *Human Organs for Sale, Legally, in . . . Which Country?*, N.Y. TIMES FREAKONOMICS BLOG (Apr. 29, 2008, 4:20 PM), <http://freakonomics.blogs.nytimes.com/2008/04/29>.

However, the policy of outlawing incentives of any kind for organ procurement is now over twenty-five years old.<sup>130</sup> While considered morally correct in 1984, the controversies surrounding the prohibition of valuable consideration for organ donation have reemerged as it becomes more apparent that wealthy citizens are evading their domestic systems in order to get organs from “death row inmates in China, street people in Brazil, and the poor in India.”<sup>131</sup> International organizations have attempted to address the growing problem, but have largely relied on status quo principles with some evolving adjustments for incentives.

The “international consensus” is that organs for transplantation “should not be sold,”<sup>132</sup> but international organizations have grappled with whether or not incentives of some type should be allowed and to what degree. The World Health Organization (WHO) issued guidelines to avoid coercion and exploitation of donors in 1991; 192 countries endorsed the guidelines, but they are non-binding and have largely been ignored.<sup>133</sup> At a WHO consultation in Madrid in October of 2003, thirty-seven experts from twenty-three countries could not come to a consensus on how or where to draw the line between providing incentives and removing disincentives.<sup>134</sup> The Fifty-Seventh World Health Assembly in 2004 addressed the growing use of allogeneic transplantation and organ insufficiency by urging member states “to extend the use of living kidney donations . . . in addition to donations from deceased donors.”<sup>135</sup> In May of 2010, the WHO’s revised guidelines were endorsed by the Sixty-Third World Health Assembly.<sup>136</sup> Member states were encouraged to “promote the development of systems for the altruistic voluntary non-remunerated donation . . . and increase public awareness” of such systems.<sup>137</sup> The WHO also reinforced its opposition to the “seeking of financial gain or comparable advantage in transactions involving human body parts.”<sup>138</sup> However, the Guiding Principles also state that “[t]he

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<sup>130</sup> Goodwin, *supra* note 46, at 208.

<sup>131</sup> *Id.* at 209.

<sup>132</sup> Smith, *supra* note 34, at 373.

<sup>133</sup> Forty-fourth World Health Assembly, Res. WHA44.25 (May 13, 1991); *see also* Smith, *supra* note 34, at 373.

<sup>134</sup> Nullis-Kapp, *supra* note 29, at 715.

<sup>135</sup> Fifty-seventh World Health Assembly, Res. WHA57.18, § (1)(5) (May 22, 2004).

<sup>136</sup> Sixty-third World Health Assembly, Res. WHA63.22 (May 21, 2010).

<sup>137</sup> *Id.* at § 2(2).

<sup>138</sup> *Id.* at § 2(3).

prohibition on sale or purchase of cells, tissues and organs does not preclude reimbursing reasonable and verifiable expenses incurred by the donor, including loss of income, or paying the costs of recovering, processing, preserving and supplying human cells, tissues or organs for transplantation.”<sup>139</sup> Thus, some forms of compensation are allowed while outright sales are condemned.

Professional organizations have also attempted to set standards in an effort to combat the illicit organ trade. In 2008, the Transplantation Society and International Society of Nephrology convened an International Summit on Transplant Tourism and Organ Trafficking in Istanbul, Turkey.<sup>140</sup> The Istanbul Declaration calls for transplant commercialism, the buying and selling of organs, to be prohibited, citing Resolution 44.25 of the Forty-fourth World Health Assembly.<sup>141</sup> It also carved out an exception for comprehensive reimbursement of donors, which “does not constitute a payment for an organ but is rather part of the legitimate costs of treating the recipient.”<sup>142</sup> Stating that unethical practices, such as transplant tourism, are the “undesirable consequence of the global shortage of organs for transplantation,” the Declaration called for states to become domestically self-sufficient in organ donation rates and to enhance deceased donor programs to minimize the use of living donors.<sup>143</sup>

Taking a more direct approach that same year, the American Medical Association specifically advocated for the modification of NOTA to rescind its prohibition of direct payments to donors, allowing for researchers to conduct pilot studies on the effectiveness of financial incentives on donation rates.<sup>144</sup>

Following the United States, the Council of Europe established bans on organ sales in 1999.<sup>145</sup> However, in 2009, the Council of

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<sup>139</sup> WHO, WHO GUIDING PRINCIPLES ON HUMAN CELL, TISSUE AND ORGAN TRANSPLANTATION Guiding Principle 5 (as endorsed by the Sixty-third World Health Assembly, Res. WHA63.22 (May 21, 2010)) [hereinafter WHO GUIDING PRINCIPLES].

<sup>140</sup> *The Declaration of Istanbul on Organ Trafficking and Transplant Tourism*, 3 CLINICAL J. AM. SOC. NEPHROLOGY 1227, 1227 (2008).

<sup>141</sup> *Id.* at 1228.

<sup>142</sup> *Id.* at 1229 (allowing for reimbursement of “actual, documented costs of donating an organ”).

<sup>143</sup> *Id.* at 1227.

<sup>144</sup> AM. MED. ASS’N, DIRECTIVES OF THE AMA HOUSE OF DELEGATES 153 (2008); see also Milot, *supra* note 95, at 1062.

<sup>145</sup> Council of Europe, *Convention for the Protection of Human Rights and Dignity of the Human Being with Regard to the Application of Biology and Medicine: Convention on Human Rights and Biomedicine*, Council of Europe, Apr. 4, 1997, C.E.T.S. No. 164

Europe called for a binding international instrument that sets out the principle prohibiting financial gain from the human body and its parts.<sup>146</sup> The European *Convention on Human Rights and Biomedicine* adopted this principle in 1999, but by 2008 the convention had not been widely accepted beyond the European Union despite being open to any interested state.<sup>147</sup> The Council places the utmost importance in this principle and declares that “[l]egislation on the recovery of organs . . . for transplantation should be passed in all countries and should conform to this principle”<sup>148</sup> because such legislation is believed to protect the donation system based on altruism.<sup>149</sup> However, such judgment may be premature, since the debate on the effectiveness of the altruistic system is not as settled as these organizations’ efforts may present.<sup>150</sup>

### ***B. The Procurement Debate and the Limits of Altruism***

With widespread organ shortages worldwide and the emergence of the black market in transplantations, the infallibility of the altruistic system has increasingly been the object of criticism. As one scholar stated, “[t]he moral certainty of altruism suffers if in the wake of its reach, thousands die each year and exponentially more suffer when a cure is in reach.”<sup>151</sup> Thus, “[t]he significant risks of prolonged waits and the depleted quality of life for those waiting for kidneys, has

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(entered into force Dec. 1, 1999) [hereinafter *Convention for the Protection of Human Rights*].

<sup>146</sup> COUNCIL OF EUROPE STUDY, *supra* note 2, at 94.

<sup>147</sup> Convention for the Protection of Human Rights, *supra* note 145. See also, *Protocol to the Convention on Human Rights and Biomedicine Concerning Transplantation of Organs and Tissues of Human Origins*, Council of Europe, Jan. 24, 2002, C.E.T.S. No. 186 (entered into force May 1, 2006), art. 21. 25 [hereinafter *Protocol to the Convention on Human Rights and Biomedicine*]. The Protocol to the Convention on Human Rights and Biomedicine concerning Transplantation of Organs and Tissues of Human Origins reinforces this principle, but also allows for donors to be compensated for loss of earnings or other justifiable expenses associated with the procedure, as well as any damages incurred from the procedure that are not natural to transplantation. The Protocol only has twenty signatories, eight of which have ratified it. *Id.*

<sup>148</sup> COUNCIL OF EUROPE STUDY, *supra* note 2, at 94.

<sup>149</sup> *Id.* at 7.

<sup>150</sup> Nullis-Kapp, *supra* note 29, at 715 (“What is needed is a critical and thorough analysis of the different proposals that have been made particularly with regard to expanding the use of living donors, by providing incentives and/or removing disincentives.”) (quoting Dr. Nikola Biller-Andorino).

<sup>151</sup> Goodwin, *supra* note 46, at 214.

recalibrated the discourse around altruism and markets. We are forced to rethink the assumptions about what is morally correct to do.”<sup>152</sup>

Over the past decade, significant debate has centered around the appropriateness of market-based procurement alternatives to deal with rampant organ shortages and the illicit organ trade.<sup>153</sup> The American Medical Association (AMA) has called for the modification of current prohibitions in order to conduct pilot studies on the feasibility of a market-based procurement system.<sup>154</sup> The British Transplantation Society, an opponent of a market system, still agrees that a public debate should occur over the merits and flaws of a market-based system.<sup>155</sup> But the debate is not limited to highly-developed Western countries. For example, in Turkey, a well-known destination country for transplant tourism, there is a significant split within the medical community. Some doctors feel the life of the patient outweighs any ethical considerations, while others believe ethical limits are necessary to prevent other injustices.<sup>156</sup>

Proponents of the current altruistic system vociferously oppose any form of direct payment to donors or any other arrangement that leads to monetary gain. Some scholars have posited that all body parts could be seen as so “integral to the [human] self” that they cannot be “vulgar, fungible market commodities,”<sup>157</sup> and that “only those things inherently separate from the human self can be alienated from it.”<sup>158</sup> Thus, they believe that “‘once market value enters our discourse’ in regards to a certain object in the primary instance of sale, a slippery slope will result, and ‘market rhetoric will take over and characterize every [future] interaction in terms of market value.’”<sup>159</sup> Therefore, profiteering from the human body must be banned and, as shown, this

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<sup>152</sup> *Id.* at 208.

<sup>153</sup> For example, New Zealand has one of the lowest donor rates in the developed world and should “have the balls” to consider commercialization. *Experts Advocate Controlled Sale of Organs*, OTAGO DAILY TIMES, Apr. 8, 2010, <http://www.odt.co.nz/100752/experts-advocate-controlled-sale-organs> (quoting Stephen Munn, Auckland Renal Transplant Group clinical director).

<sup>154</sup> AM. MED. ASS’N, *supra* note 144, at 153-54.

<sup>155</sup> Lewis Smith, *Sale of Human Organs Should be Legalised, Say Surgeons*, INDEPENDENT (U.K), Jan. 5, 2011, <http://www.independent.co.uk/life-style/health-and-families/health-news/sale-of-human-organs-should-be-legalised-say-surgeons-2176110.html>.

<sup>156</sup> *See generally* Sanal, *supra* note 86.

<sup>157</sup> Wancata, *supra* note 39, at 203 (quoting Margaret Jane Radin, *Market-Inalienability*, 100 HARV. L. REV. 1849, 1906 (1987)).

<sup>158</sup> Wancata, *supra* note 39, at 203.

<sup>159</sup> *Id.* at 204 (quoting Radin, *supra* note 157, at 1914).

thinking is engrained in many of the international, professional, and legal frameworks.<sup>160</sup> The rationales for banning the sale of organs are that it could limit access to life-saving organs to only those who can afford them,<sup>161</sup> it could lead to the exploitation of the desperate poor willing to sell,<sup>162</sup> it would undermine the current altruistic system,<sup>163</sup> and it would degrade human dignity and freedom.<sup>164</sup> Dabbling with profit-driven motivations is dangerous, for “[g]iven the life-or-death consequences of the procedure, organ donation should not be governed by the ethics of caveat emptor.”<sup>165</sup>

The primary vehicle for procurement endorsed by altruists is cadaveric donations through presumed consent laws.<sup>166</sup> Countries such as Belgium and Spain have long-standing presumed consent systems,<sup>167</sup> and Spain is widely hailed as having one of the highest donation rates of any country.<sup>168</sup> Regardless of the successes with presumed consent laws, most countries with that system still experience organ shortages.<sup>169</sup> Other countries, such as the United States, have had limited success with presumed consent experiments because they run counter to the expectation of autonomy engrained in most segments of society.<sup>170</sup>

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<sup>160</sup> See generally WHO GUIDING PRINCIPLES, *supra* note 139; *Convention for the Protection of Human Rights* *supra* note 145; *Protocol to the Convention on Human Rights and Biomedicine* *supra* note 147, at art. 21; *The Declaration of Istanbul on Organ Trafficking and Transplant Tourism*, *supra* note 140.

<sup>161</sup> Delmonico et al., *supra* note 91, at 2004; see also Everton Bailey, Comment, *Should the State Have Rights to Your Organs? Dissecting Brazil’s Mandatory Organ Donation Law*, 30 U. MIAMI INTER-AM. L. REV. 707, 716–17 (1998–1999); Garwood, *supra* note 129, at 5.

<sup>162</sup> Gary S. Becker & Julio Jorge Elias, *Introducing Incentives in the Market for Live and Cadaveric Organ Donations*, 21 J. ECON. PERSP. 3, 21 (2007) (“If organ sales are permitted, the supply of human organs from living donors will come largely from the poorer segments of our society. Although some scholars argue that this concern is overly and needlessly paternalistic, poor people are often exploited in the United States and abroad.”); see also Budiani-Saberi & Delmonico, *supra* note 66, at 928; see also Delmonico et al., *supra* note 91, at 2004; Bailey, *supra* note 161, at 716–17.

<sup>163</sup> Budiani-Saberi & Delmonico, *supra* note 66, at 928.

<sup>164</sup> Delmonico et al., *supra* note 91, at 2004; see also Garwood, *supra* note 129, at 5; Meyer, *supra* note 44, at 228.

<sup>165</sup> Truog, *supra* note 28, at 446.

<sup>166</sup> COUNCIL OF EUROPE STUDY, *supra* note 2, at 32; see also Bailey, *supra* note 161, at 711–18; Roberts, *supra* note 21, at 751.

<sup>167</sup> Roberts, *supra* note 21, at 761.

<sup>168</sup> Sanal, *supra* note 86, at 293; Garwood, *supra* note 129, at 5; Roberts, *supra* note 21, at 760.

<sup>169</sup> Roberts, *supra* note 21, at 761; Bailey, *supra* note 161, at 714.

<sup>170</sup> Delmonico et al., *supra* note 91, at 2002.

A stark example of this is Brazil. In 1997, after facing years of organ shortages, Brazil adopted presumed consent laws in an effort to increase cadaveric donations and reduce organ trafficking.<sup>171</sup> However, there was severe public outcry over the law.<sup>172</sup> Opponents to the law feared that the law would disproportionately burden the poor and illiterate because they were the most likely to be unaware of their right to opt-out.<sup>173</sup> The Federal Council on Medicine challenged the constitutionality of the bill on the grounds that the bill violates both the individual rights of citizens and medical ethics because it forces doctors to engage in practices that violate their consciences.<sup>174</sup> The law was subsequently repealed a year after its adoption.<sup>175</sup>

Given that, despite the current system's best efforts, organ shortages persist, there is growing acceptance of trial programs involving direct payments for organs.<sup>176</sup> Proponents of market-based approaches believe that a myopic adherence to a purely altruistic system has hindered the success of organ procurement<sup>177</sup> and severely limited the available options for addressing current procurement dilemmas.<sup>178</sup> They attack the altruistic system on the grounds that it has simply failed to produce the promise its supporters espouse.<sup>179</sup> Although many altruists claim that the introduction of commercial activity into organ procurement would completely undermine the current altruistic system, proponents are quick to point out it is impossible to know what effect a regulated market would have without actual test markets.<sup>180</sup>

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<sup>171</sup> Lei No. 9.434, de 4 de Fevereiro de 1997, DIÁRIO OFICIAL DA UNIÃO [D.O.U.] de 05.02.1997 (Braz.). See also Bailey, *supra* note 161, at 708 (“[u]nless manifestation of will to the contrary, in the scope of this Law, it is presumed that authorization is given for the donation of tissues, organs and human body parts for the purpose of transplantation or treatment of diseases”); Roberts, *supra* note 21, at 760.

<sup>172</sup> Roberts, *supra* note 21, at 760.

<sup>173</sup> Bailey, *supra* note 161, at 709.

<sup>174</sup> *Id.* at 710.

<sup>175</sup> Roberts, *supra* note 21, at 760.

<sup>176</sup> Smith, *supra* note 34, at 367. “The sale of human organs, once viewed as repugnant to most Americans, is becoming increasingly more acceptable. More scholars, physicians and policymakers are encouraging the development of a commercial market for human organs from living donors.” *Id.* at 362.

<sup>177</sup> Harris & Alcorn, *supra* note 27, at 223.

<sup>178</sup> Woan, *supra* note 27, at 424–25; see also Harris & Alcorn, *supra* note 27, at 223.

<sup>179</sup> Mahoney, *supra* note 27, at 217; see generally Woan, *supra* note 27.

<sup>180</sup> J.D. Jasper et al., *Altruism, Incentives, and Organ Donation: Attitudes of the Transplant Community*, 42 MED. CARE 378, 384 (2004); see also Mahoney, *supra* note 27, at 216.



The only market-based model to observe is Iran, which is the only country that allows for regulated kidney purchases, and where organ shortages are virtually nonexistent.<sup>181</sup> Referred to as the “Iranian Model,” it is now widely known that regulation has not been realized.<sup>182</sup> Secret payments from the recipient’s family to the donor’s broker are customary and well-known.<sup>183</sup> Many of the donors express regret and shame for their decision and do not seek or receive follow-up medical care.<sup>184</sup> However, the Iranians readily admit that the project requires revision before it can be presented as a workable model for other countries.<sup>185</sup>

Market-based proponents also point out that the altruistic procurement solutions are not without their own burdens as well. Altruism actually disproportionately burdens African-Americans, as they represent one-third of kidney waitlist patients but experience the highest death rate on transplantation lists.<sup>186</sup> This is largely due to matching disparities in antigen distribution, a critical criterion.<sup>187</sup> Quite frankly, there are not enough altruistic donations of organs suitable for African-American matching—an issue that could be addressed through market inducements.<sup>188</sup> Even presumed consent laws, which are commonly referred to as one solution for organ shortages, would disproportionately affect the poor and racial minorities because they are more likely to be uninformed of their option to opt out.<sup>189</sup>

Finally, market-based proponents argue that the entire procurement system, not just the black market, is already completely commercialized.<sup>190</sup> “[T]he debate over the commercialization of the human body is not about commercialization at all, but rather about

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<sup>181</sup> Delmonico, *supra* note 77, at 118. “Although Iran clearly does not serve as a model for solving most of the world’s problems . . . its method for solving its organ shortage is well worth examining.” Dubner, *supra* note 129 (quoting BENJAMIN E. HIPPEL, CATO INST., NO. 164, ORGAN SALES AND MORAL TRAVAILS: LESSONS FROM THE LIVING KIDNEY VENDOR PROGRAM IN IRAN 1 (2008), available at [http://www.cato.org/pub\\_display.php?pub\\_id=9273](http://www.cato.org/pub_display.php?pub_id=9273)).

<sup>182</sup> Delmonico, *supra* note 77, at 118.

<sup>183</sup> *Id.*

<sup>184</sup> Garwood, *supra* note 129, at 6.

<sup>185</sup> Delmonico, *supra* note 77, at 118.

<sup>186</sup> Goodwin, *supra* note 46, at 213.

<sup>187</sup> *Id.*

<sup>188</sup> *Id.*

<sup>189</sup> *Id.* at 210–11.

<sup>190</sup> Mahoney, *supra* note 27, at 165.

how the financial benefits available will be apportioned.”<sup>191</sup> Every step of the procurement process allows for compensation, except for the one that means the most—the actual donation of the organ. Both organ and tissue donors’ willingness to give may sometimes stem from the mistaken belief that their donation is not entering into a market.<sup>192</sup> Their donations essentially are a gift to an intermediary, which is then sold as part of a package for transplant services. Mahoney asserts that “[t]he argument that patients pay only for medical treatment, and never for human organs, is no more persuasive than contending that restaurants sell not food, but only ‘dining services.’”<sup>193</sup> Current legislation, as well as protocols and guidelines, provide for *reasonable* fees for medical staff, hospitals, and procurement agencies, but not directly to donors.<sup>194</sup> “Reasonable” is a relative term, which allows these organizations and individuals to charge handsome prices for their services.<sup>195</sup> Thus, in a system based on noncommodification, everyone gets paid but the donor, which does nothing to address the present reality that donors in many countries actively seek compensation for their “gift of life.”

As the debate progressed over the past decade, there was some convergence surrounding incentives and compensation. While the altruistic system is still vigorously defended, many of its biggest proponents recognize that there needs to be some allowance for ethical incentives, or at least removing disincentives.<sup>196</sup> Some of the suggestions for incentives, short of direct monetary payments to donors, include lifelong comprehensive health care,<sup>197</sup> reimbursement of funeral expenses, medical leave for donors, priority on organ lists for previous donors, and donor insurance.<sup>198</sup> Current international

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<sup>191</sup> *Id.*

<sup>192</sup> *Id.* at 194–95.

<sup>193</sup> *Id.* at 182. “One can argue that the organ is not sold, and that patients pay only for medical services, but in fact the services have no value without the organ, and patients have no opportunity to acquire organs in a separate transaction.” *Id.*

<sup>194</sup> See, e.g., Uniform Anatomical Gift Act of 1987 § 10(b) (amended 2006); National Organ Transplant Act (NOTA), 42 U.S.C. § 274e(c)(2) (2008); WHO GUIDING PRINCIPLES, *supra* note 139; *Declaration of Istanbul*, *supra* note 140, at 1229; *Convention for the Protection of Human Rights*, *supra* note 145, at art. 21.

<sup>195</sup> Roger W. Evans, *Organ Procurement Expenditures and the Role of Financial Incentives*, 269 J. AM. MED. ASS’N 3113, 3115–16; see also Mahoney, *supra* note 27, at 180.

<sup>196</sup> Nullis-Kapp, *supra* note 29, at 715; see generally Delmonico et al., *supra* note 92.

<sup>197</sup> Smith, *supra* note 34, at 384.

<sup>198</sup> See Jasper et al., *supra* note 180, at 379; see generally Delmonico et al., *supra* note 91.

proposals on transplantation policy include some form of indirect incentive for donors.<sup>199</sup> Whether or not the incentive could ever allow for a direct payment to the donor is still contested, but it is acknowledged by market advocates that such payments cannot take place in an unregulated system and probably not on a wide scale.<sup>200</sup>

The Council of Europe report seeks to finally solidify an international procurement system based on altruism,<sup>201</sup> even in the midst of altruism's resounding failure and rampant black markets.<sup>202</sup> The report focuses on the "commodification" of the human body and its parts and seeks a binding international agreement to solidify its norm, but the growth of the black market in organs has called the current norm into question.<sup>203</sup> Whether or not an enforceable ban on commodification would be an effective tool to combat illicit transplantation practices is still unsettled. There has been scant research into public and professional opinions on incentives for organ donation and the initial research conducted shows that medical professionals are more receptive to the idea than altruists care to accept.<sup>204</sup> Public and professional views on incentives should be assessed before the option is summarily dismissed.<sup>205</sup>

While the Council of Europe searches for a binding international agreement, one such agreement already exists that is capable of addressing the most heinous aspects of the organ trade: the Additional Protocol to Prevent, Suppress and Punish Trafficking in Persons,

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<sup>199</sup> *Declaration of Istanbul*, *supra* note 140, at 1229; WHO GUIDING PRINCIPLES *supra* note 139; COUNCIL OF EUROPE STUDY, *supra* note 2.

<sup>200</sup> Goodwin, *supra* note 46, at 211 ("[M]arkets are not boundless, nor should we aim for them to operate as such."). See also PEARSON, *supra* note 55 (arguing that for a regulated market system to succeed, clear guidelines must be strictly enforced and it should be a national system in line with the country's cultural values); Smith, *supra* note 155.

<sup>201</sup> COUNCIL OF EUROPE STUDY, *supra* note 2, at 7. "At United Nations level, there is no legally binding instrument which sets out the principle of the prohibition of making financial gains from the human body or its parts." *Id.* at 94.

<sup>202</sup> Goodwin, *supra* note 46, at 209 ("[A] rigid prescription on altruism inspires the least favorable of markets: black and gray markets.").

<sup>203</sup> Woan, *supra* note 27, at 432 (citations omitted) ("[T]he sale of organs is banned in almost every country and condemned by virtually all medical associations around the world. . . . [T]his should not be taken to mean that such an alternative is not worth exploring.").

<sup>204</sup> Jasper et al., *supra* note 180, at 385.

<sup>205</sup> *Id.* at 379.

Especially Women and Children, supplementing the United Nations Convention against Transnational Organized Crime.<sup>206</sup>

### *C. Utilizing the Trafficking Protocol*

Although the Study considers trafficking in persons to be only a “marginal phenomenon” compared to the trafficking in human organs, tissues, and cells,<sup>207</sup> this is only so if the referent object is the organ and not the donor. It is true that trade in organs, tissues, and cells is an enormously expansive and lucrative enterprise, engaged in by both legal and illicit organizations. If the referent object is the donor in these transactions and not the organ itself, then the question becomes whether or not the exchange took place with the full informed consent of the donor for a legal purpose. The world community has become aware that “the issue [is] exploitation.”<sup>208</sup>

Focused on issues of exploitation and building upon the foundations of the United Nations Convention Against Transnational Organized Crime,<sup>209</sup> the international community adopted the Protocol to Prevent, Suppress, and Punish Trafficking Persons.<sup>210</sup> The Trafficking Protocol requires “a comprehensive international approach” that includes measures to prevent and punish human trafficking.<sup>211</sup> Human trafficking includes the recruitment, transportation, transfer, harboring, or receipt of persons by coercive or deceptive means for exploitive purposes.<sup>212</sup> One form of exploitation enunciated by the Trafficking Protocol is the removal of organs.<sup>213</sup> However, the definitions of exploitation are “a minimum,” allowing other elaborations of exploitation.<sup>214</sup> Illicit conduct of biomedical research on a person,<sup>215</sup> as well as removal of tissues and cells could be added to the definition.<sup>216</sup>

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<sup>206</sup> G.A. Res. 55/25, U.N. Doc. A/55/383 (Nov. 15, 2000) (entered into force Dec. 25, 2003); 2237 U.N.T.S. 319.

<sup>207</sup> COUNCIL OF EUROPE STUDY, *supra* note 2, at 93.

<sup>208</sup> Pugliese, *supra* note 125, at 189.

<sup>209</sup> Trafficking Protocol, *supra* note 6.

<sup>210</sup> *Id.*

<sup>211</sup> *Id.* at pmb1.

<sup>212</sup> *Id.* at art. 3(a).

<sup>213</sup> *Id.*

<sup>214</sup> *Id.*

<sup>215</sup> U.N. OFFICE ON DRUGS AND CRIME, MODEL LAW AGAINST TRAFFICKING IN PERSONS, at 43, U.N. Sales No. E.09.V.11, (2009).

<sup>216</sup> See Law No. 64 of 2010 (Regarding Combating Human Trafficking), *Al-Jarida Al-Rasmiyya*, art. 2 (Egypt). The Trafficking Protocol simply uses the term “removal of

Furthermore, the Trafficking Protocol is meant to supplement existing national legislation criminalizing human trafficking.<sup>217</sup> The scope of its application appears to be limited to offenses “transnational in nature and involv[ing] an organized criminal group,”<sup>218</sup> but other official interpretations require criminalization of trafficking acts regardless of location, movement, or parties involved.<sup>219</sup> Utilizing the Trafficking Protocol in this manner finds its true value when addressing the common pathway of the organ black market: transplant tourism.

Current practices usually involve patients from affluent countries with strong transplantation prohibitions skirting their systems by traveling to less regulated countries for transplantation procedures.<sup>220</sup> If crafted properly, a law based on the Trafficking Protocol could close that jurisdictional loophole. The Trafficking Protocol requires parties to “adopt or strengthen legislative or other measures . . . to discourage the demand that fosters all forms of exploitation of persons . . . that leads to trafficking.”<sup>221</sup> If individuals participate in transplantation procedures involving exploited individuals, then they are to be held criminally liable under the protocol. Transplant tourism largely relies on donors who have been coerced or deceived into selling their organs, so such actions would have to be outlawed for a state to be in compliance with the protocol. Currently, the Trafficking Protocol has 143 parties that are bound to their obligations to criminalize trafficking practices and are regularly evaluated on their progress.<sup>222</sup> The adjustment of an existing framework as broad as the Trafficking Protocol has a greater chance of success due to preexisting standards, monitoring, and support.

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organs,” which could be expanded to include tissues and cells for a more comprehensive definition. See Trafficking Protocol, *supra* note 6, at art. 3(a).

<sup>217</sup> Trafficking Protocol, *supra* note 6, at Art. 9(5).

<sup>218</sup> *Id.* at art. 4.

<sup>219</sup> MODEL LAW AGAINST TRAFFICKING IN PERSONS, *supra* note 215, at 7. See also, Janie Chuang, *Beyond a Snapshot: Preventing Human Trafficking in the Global Economy*, 13 IND. J. GLOBAL LEGAL STUD. 137, 152 (2006) (“The movement of [a] person to [a] new location is not what constitutes trafficking; the force, fraud or coercion exercised on that person by another . . . is the defining element of trafficking in modern usage.”) (alteration in original) (quoting U.S. DEP’T OF STATE, TRAFFICKING IN PERSONS REPORT 9–10 (2005)).

<sup>220</sup> PEARSON, *supra* note 55, at 16–20.

<sup>221</sup> Trafficking Protocol, *supra* note 6, at art. 9(5).

<sup>222</sup> *Id.*

The Council of Europe wishes to address the illicit trade in organs, tissues, and cells in order to prevent any transplantation activity not founded on the principles of non-commodification and altruism. Even if a universal agreement on what constitutes an acceptable incentive could be achieved, it is doubtful that such an altruistic system could stem the illicit activity it inadvertently helped spawn. The procurement debate shows that despite attempts to solidify altruism as the cornerstone of international donation regimes, the organ shortages continue unabated, and more creative solutions need to be encouraged through open discourse and experimentation.

This is not to say that market-based solutions are boundless. In the midst of the procurement debate are people dying every day from organ failure and others being exploited mercilessly for their “gift of life.” What is needed is flexible, but effective legislative and law enforcement action. In order to gain this flexibility, the central concern should not be the status of the organ, but the means by which an entity came into possession of it. Illicit transplantation and tissue procurement preys upon vulnerable individuals through coercion and deceit.<sup>223</sup> If the organ or tissue was procured from a person using any of the means enunciated in the Trafficking Protocol, then it is human trafficking for organ removal, and the member states are obligated to combat it.

Acts that promote human trafficking, including trafficking for organ removal, need to be effectively criminalized in order to close any loopholes in enforcement. Chief amongst these loopholes is transplant tourism, which allows wealthy individuals to evade legitimate procurement regimes, expose poor individuals in weak procurement regimes to extreme forms of exploitation, and then return home with impunity. Meaningful public discourse and procurement reform will not be explored as long as wealthy individuals, who can arguably exert the most pressure on political factors, are allowed to simply avoid the debate by traveling overseas for a quick and callous solution. Any proposed legal reform must deter states’ own citizens from feeding the global black market, but allow for innovative, domestic solutions to the organ shortage crisis. An international system that allows for only altruistic methods and shuts out any innovation will not accomplish justice for the exploited and will only fuel the black market. The Trafficking Protocol is well-

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<sup>223</sup> “The appellant has peddled deceit, trafficked in organs and profited from misery.” *Wang Chin Sing v. Public Prosecutor* [2008] 1 SLR(R) 870 (Singapore).

established and can provide flexible legislation, as well as necessary action on transplant tourism.

The following section provides a model law utilizing the Trafficking Protocol and is accompanied by some explanatory sections. The model law is to be interpreted in conjunction with the Model Law against Trafficking in Persons developed by the UNODC.<sup>224</sup> The UNODC's model law is sufficiently comprehensive for legislating anti-trafficking laws, but was silent on specific provisions concerning trafficking for organ removal. Therefore, the model law developed for this paper is meant to provide those absent provisions.

### III MODEL LAW UNDER THE PROTOCOL

With the procurement debate far from settled and organ shortages dominating most developed countries, a more flexible approach to an internationally binding instrument to combat trafficking for organ removal should be explored. Contrary to the Council of Europe's call for an instrument that flatly prohibits monetary incentives for procurement, national legislation based on the Trafficking Protocol can be easily adjusted to encompass both the removal of organs as exploitation and the criminalization of transplant tourism as an act that promotes trafficking. An example of such a law is as follows:

#### I. Definitions

"Trafficking in persons for removal of organs, tissues, or cells" means the recruitment, transportation, transfer, harboring or receipt of persons, by means of the threat or use of force or other forms of coercion, of abduction, of fraud, of deception, of the abuse of power or of a position of vulnerability or of the giving or receiving of payments or benefits to achieve the consent of a person having control over another person, for the purpose of exploitation.<sup>225</sup>

"Exploitation" means the removal of human organs, tissues or cells for

- (a) transplantation into another person, or
- (b) biomedical research and development;

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<sup>224</sup> MODEL LAW AGAINST TRAFFICKING IN PERSONS, *supra* note 215.

<sup>225</sup> Adapted from: Anti-Trafficking in Persons Act of 2003, Rep. Act No. 9208, art. 2, § 3(c) (June, 21 2009) (Phil.) [hereinafter Anti-Trafficking in Persons Act].

in order to derive any benefit, monetary or otherwise, from the transaction.

“Transplant tourism” means an individual traveling outside their country of permanent residence for the purpose of undergoing an organ transplantation procedure and the organ donor is:

- (a) a foreign national, and
- (b) not genetically related to the recipient.<sup>226</sup>

“Permanent residence” means a person’s true, fixed, and permanent home and principal establishment, and that person has the intention of returning to it whenever they are absent therefrom.

- (a) No one factor, not even place of voting registration, or a declaration of domicile or residence made for official purposes, is controlling.
- (b) Statements of intention may carry considerable weight, but will not prevail over contrary facts evidencing actual intent.
- (c) Influential factors are *inter alia* the place where civil and political rights are exercised, taxes paid, real and personal property located, driver’s and other licenses obtained, bank accounts maintained, location of club and church membership and places of business and employment.

## II. Offenses

### (1) Transplant Tourism

The following shall constitute the crime of transplant tourism.<sup>227</sup>

#### A. Traveling with the Intent to Engage in Transplant Tourism

A person who travels outside their country of permanent residence with the intent to engage in a transplant procedure shall be fined and imprisoned for up to [duration]. The penalty shall include forfeiture of travel documents and any property used or intended to be used to commit or promote commission of the offense.

#### B. Traveling and Engaging in Transplant Tourism

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<sup>226</sup> Some experts assert that travel for transplantation can be ethical if: (1) the recipient has dual citizenship and undergoes a transplantation procedure with a family member in a country of citizenship that is not their residence; or (2) the donor and recipient are genetically related and wish to undergo transplantation in a country not of their residence. See Delmonico, *supra* note 78, at 117.

<sup>227</sup> The following section was adapted from parts of the Prosecutorial Remedies and Tools Against the Exploitation of Children Today Act (PROTECT Act) OF 2003, Pub. L. No. 108-21, 117 Stat. 650 (effective Apr. 30, 2003). The PROTECT Act criminalized child sex tourism and is an apt framework for transplant tourism legislation.



A person who travels outside their country of permanent residence and engages in an organ transplantation procedure with a foreign citizen shall be fined and imprisoned for up to [duration]. The penalty shall include forfeiture of travel documents and any property used or intended to be used to commit or promote commission of the offense. The organ itself shall not be considered property subject to forfeiture.

C. Attempt and Conspiracy

Attempt or conspiracy to commit the crime of transplant tourism is punished with the same penalty provided for commission of the crime of transplant tourism.

(2) Transplant Tourism as a Form of Trafficking in Persons

It shall be considered an act of trafficking in persons when a person undertakes tours and travel plans consisting of tourism packages or activities utilizing a foreign citizen for organ transplantation.

(3) Liability of Corporate Persons

Any legal person directing, organizing, promoting, procuring, or facilitating the travel of a person with the knowledge that such a person will engage in transplant tourism shall be liable. Penalties include closure of business, withdrawing of licenses or authorizations, and freezing or confiscation of proceeds of the crime.

(4) Liability for Medical Professionals

Any medical establishment, attending physician, or medical practitioner who has any knowledge of or learns of facts or circumstances that give rise to a reasonable belief that a person has engaged in transplant tourism shall immediately report the same, either orally or in writing, to law enforcement. Failure to do so shall be a ground for an administrative proceeding, without prejudice to criminal liability under the Act, if evidence warrants.<sup>228</sup>

**A. Core Concepts**

The above law is merely a suggestion for possible language to criminalize transplant tourism and combat human trafficking for organ removal, but it is based on the central principles of the Trafficking Protocol: the means used for exploitation and consent. According to the Trafficking Protocol, if any of the “means” elements

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<sup>228</sup> Adapted from: Anti-Trafficking in Persons Act, *supra* note 224, at art. 4, § 13.

are present, then a victim's consent is irrelevant.<sup>229</sup> In the context of medical procedures, the consent of a victim would be irrelevant because "[a]n uninformed decision to follow the recommendation or suggestion of a medical professional is in effect a choice *coerced* by the medical professional."<sup>230</sup> American courts have also held that consent cannot exist when valuable information is withheld from the patient.<sup>231</sup> Securing consent without providing the patient with adequate information constitutes redressable negligence<sup>232</sup> and surgery without informed consent has long been recognized as battery.<sup>233</sup>

When a patient has given full informed consent, three main elements are present: disclosure, capacity, and voluntariness.<sup>234</sup> The duty of disclosure arises from an individual's right to self-determination, which requires one to know the truth and receive all information related to the decision.<sup>235</sup> A "reasonable patient" standard is applied and looks to what a reasonable patient would want to know in order to make an informed medical decision. This usually centers on the procedure being fully explained, as well as disclosing any anticipated risks and consequences.<sup>236</sup>

Capacity refers to a patient's ability to understand information related to a proposed procedure and fully appreciate the consequences

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<sup>229</sup> Trafficking Protocol, *supra* note 6, at art. 3(b) ("The consent of a victim of trafficking in persons to the intended exploitation set forth in subparagraph (a) of this article shall be irrelevant where any of the means set forth in subparagraph (a) have been used. . . ."). The "means" in subparagraph (a) are: the threat or use of force or other forms of coercion, abduction, fraud, deception, abuse of power or a position of vulnerability, or the giving or receiving of payments or benefits to achieve consent of a person having control over another person.

<sup>230</sup> J. Steven Svoboda et al., *Informed Consent for Neonatal Circumcision: An Ethical and Legal Conundrum*, 17 J. CONTEMP. HEALTH L. & POL'Y 61, 66 (2001) (emphasis added).

<sup>231</sup> *Keogan v. Holy Family Hospital*, 622 P.2d 1246, 1252 (Wash. 1980) (finding if the physician has not given the patient all the information that a patient needs to make a knowledgeable decision regarding the medical care, any consent the patient gives is ineffectual).

<sup>232</sup> Svoboda et al., *supra* note 230, at 64.

<sup>233</sup> *Newmark v. Williams*, 588 A.2d 1108, 1115–16 (Del. 1991) (holding that an operation without informed consent constituted battery).

<sup>234</sup> Svoboda et al., *supra* note 230, at 64. For a more in-depth elaboration, see, University of Washington School of Medicine, *Informed Consent: Ethical Topic in Medicine*, ETHICS IN MEDICINE, <http://depts.washington.edu/bioethx/topics/consent.html> (last visited Nov. 4, 2011).

<sup>235</sup> Svoboda et al., *supra* note 230, at 64.

<sup>236</sup> *Id.* at 66.

of their decision.<sup>237</sup> This requirement “reflects the belief that persons unable to make rational decisions about their medical care should be protected from making decisions that are harmful or that they would not make if they were able.”<sup>238</sup>

Voluntariness means that patients are able to exercise their right to make healthcare decisions free from manipulation and undue influence.<sup>239</sup> Manipulation can occur through distortion or omission of information in order to induce a specific choice by the patient.<sup>240</sup> Furthermore, the danger of undue influence is especially acute in light of the power imbalance between doctor and patient.<sup>241</sup> Presumed undue influence can be established by a showing that there was a relationship of trust and confidence between the victim and the defendant of such a nature that it is fair to presume the wrongdoer abused that relationship in order to compel the victim into the impugned transaction. Once a confidential relationship has been established, the burden shifts to the wrongdoer to show the victim entered into the transaction freely (possibly by showing the victim had independent advice). Certain relationships, as a matter of law, raise the presumption that undue influence has been exercised, such as those between lawyer and client or doctor and patient.<sup>242</sup>

In the context of transplant tourism, it is easy to see that informed consent in many cases is either defective or wholly lacking. As discussed above, many donors in developing countries are assured by recruiters and medical personnel that the transplantation procedure will have little impact on their future health.<sup>243</sup> However, as a result of the surgery, many are left unable to walk, run, or work.<sup>244</sup> In some studies, more than eighty-five percent reported their health declined after the donation and almost eighty percent recommended against donating a kidney.<sup>245</sup> At some point, many of the donors in poor countries are acquired through means of fraud, deception, and abuse

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<sup>237</sup> *Id.* at 70.

<sup>238</sup> *Id.* at 70–71.

<sup>239</sup> *Id.* at 71.

<sup>240</sup> *Id.*

<sup>241</sup> *Id.*

<sup>242</sup> *Barclays Bank v. O'Brien*, [1993] UKHL 6, [1994] 1 A.C. (H.L.) [180] (appeal taken from Eng.).

<sup>243</sup> Roberts, *supra* note 21, at 782–83.

<sup>244</sup> Smith, *supra* note 34, at 376.

<sup>245</sup> Kahn, *supra* note 84.

of a position of power—all key “means” elements of the Trafficking Protocol.

The most prevalent “means” element utilized by traffickers is also the most opaque: the abuse of a position of vulnerability. While there are currently some experts attempting to clarify how this element is being defined,<sup>246</sup> an applied standard is far from being achieved. Often, “vulnerable victim” is narrowly defined as “a victim who is unusually vulnerable due to age, physical or mental condition, or who is otherwise particularly susceptible to criminal conduct.”<sup>247</sup> However, vulnerability has been expanded in some jurisdictions to include states of poverty and economic desperation.<sup>248</sup> “Abuse of power or of a position of vulnerability” was not defined in the Trafficking Protocol and the *Travaux Préparatoires* shows that the exact meaning was disputed during the drafting of the protocol.<sup>249</sup> However, the *Travaux Préparatoires* does include an interpretive note stating that the abuse of a position of vulnerability “is understood as referring to any situation in which the person involved has no real or acceptable alternative but to submit to the abuse involved.”<sup>250</sup> Other approaches have associated vulnerability to linguistic barriers, social isolation, physical disability, or a precarious financial, psychological or social situation.<sup>251</sup>

Looking at organ donors in impoverished countries, one has to be mindful of whether or not they may be able to truly make a fully

<sup>246</sup> For example, Simone Heri at the UNODC’s Anti-Human Trafficking Unit, who is undertaking a project to fully assess international interpretations of “vulnerability” in legislation derived from the Trafficking Protocol.

<sup>247</sup> Mohamed Y. Mattar, *Incorporating the Five Basic Elements of a Model Antitrafficking in Persons Legislation in Domestic Laws: From the United Nations Protocol to the European Convention*, 14 TUL. J. INT’L & COMP. L. 357, 385 (2005); see also Tadros v. Peel Regional Police Serv., (2009) 97 O.R. 3d 212, ¶ 7 (Can. Ont. C.A.).

<sup>248</sup> R. v. Royal Borough of Kensington & Chelsea, [1996] 29 H.L.R. 147, 160 (Eng.) (Simon Brown L.J.) (“The question therefore reduces to this: is the fact that the appellants’ vulnerability is the consequence of total resourcelessness rather than, say, some physical handicap, fatal to their claim . . . ? I see no good reason why someone likely to suffer ‘injury or detriment’ through a total inability to clothe, feed or shelter himself should be any less entitled to [remedy] than someone vulnerable through age or disablement.”); see also JONATHAN HAUGHTON AND SHAHIDUR R. KHANDKER, HANDBOOK ON POVERTY AND INEQUALITY 3 (2009).

<sup>249</sup> *Travaux Préparatoires* of the Negotiations for the Elaboration of the UNITED NATIONS CONVENTION AGAINST TRANSNATIONAL ORGANIZED CRIME AND THE PROTOCOLS THERETO, UNITED NATIONS OFFICE ON DRUGS AND CRIME, at 3 U.N. Sales No. E.06.V.5, (2006); see also ANNE T. GALLAGHER, THE INTERNATIONAL LAW OF HUMAN TRAFFICKING 32 (2010).

<sup>250</sup> GALLAGHER, *supra* note 249, at 32.

<sup>251</sup> *Id.* at 32–33.

autonomous decision to undergo the transplantation procedure, even if they technically understand the nature and consequences of the procedure. It has been stated that poverty is living “without fundamental freedoms of action and choice,”<sup>252</sup> so consent given free from all forms of coercion may be impossible for many donors involved in transplant tourism. This is where the nexus between transplant tourism and trafficking for organ removal is most apparent. Instances where the donors are blatantly deceived and defrauded are obvious cases of human trafficking for organ procurement, but many of the procedures may simply be the product of the desperate poor doing what is necessary to free themselves of poverty’s shackles.<sup>253</sup> Individuals engage in this type of risky behavior for money frequently and in many widely accepted professions. Therefore, the ethical lines of incentivized procurement should be left to the individual states to decide for themselves. As discussed, organ shortages are a major global problem and possible solutions have to be culturally conducive, or, as in the case of Brazil’s presumed consent law, they will inevitably fail.

### ***B. Pragmatic Enforcement***

The most practical solution at the moment is to criminalize transplant tourism, especially in the wealthiest and most developed countries. Currently, trafficking for organ removal is driven by organ shortages in developed countries and weak enforcement in less developed countries.<sup>254</sup> The reality is that many of the transplant tourism destinations lack adequate laws and enforcement mechanisms to regulate the practice.<sup>255</sup> These countries, as ratifiers of the Trafficking Protocol, are equally obligated to accomplish meaningful anti-trafficking measures, but in the ocean of the various trafficking initiatives (forced labor, sex slavery, etc.), they simply do not have the resources or capacity to police strict organ procurement regimes. Since the key recipient countries of international organ procedures are largely Western or wealthy countries, the burden should initially fall on them to stem their citizens’ engagement in transplant tourism. Most recipients of foreign transplantation procedures will require follow-up care with their domestic medical physician at some point,

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<sup>252</sup> WORLD BANK, *Attacking Poverty*, in WORLD DEVELOPMENT REPORT 1 (2001).

<sup>253</sup> Shimazono, *supra* note 30, at 958; *see also* Bramstedt & Xu, *supra* note 4, at 1699.

<sup>254</sup> Kalogjera, *supra* note 46, at 21; *see also* Chuang, *supra* note 219, at 144.

<sup>255</sup> Kalogjera, *supra* note 46, at 21.

so there is a natural bottleneck in the process that would allow for easier law enforcement monitoring. That is why the clause mandating reporting of local medical staff to law enforcement is so critical to the viability of stemming trafficking cases. While some medical professionals may decry doctor-patient confidentiality, disclosure for suspected criminal behavior is already widely practiced in emergency rooms across the United States.<sup>256</sup> Furthermore, the health risks posed to the general public by recipients returning from overseas justifies stiffer medical responsibility.<sup>257</sup>

### CONCLUSION

Human trafficking for organ removal is the product of decades of myopic organ procurement legislation and the resulting procurement shortages. In response, a large black market in organ procurement emerged and is supported by deception and desperation. The difficulty with this form of organized crime is that at some point in the process all of the parties involved, including the victims, have benefited from illicit activity and violated the law in one form or another.<sup>258</sup> Another difficulty is that sufficient enforcement of anti-trafficking legislation will probably collide with medical regulations such as doctor-patient confidentiality and inaccessibility of medical records.<sup>259</sup> Even though there are obvious trafficking “bottlenecks” at capable medical facilities, which should intuitively make investigation *easier*, it is very difficult in practice to trace medical histories of recipients and data from the institutions performing the procedures.<sup>260</sup>

Criminalization of trafficking for organ removal must come first, but will not solve the problem alone because the root of the illicit trade is disparity in living standards.<sup>261</sup> There is no comprehensive effort to address the root cause of poverty and short-term strategies of

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<sup>256</sup> For example, the Privacy Rule of the Health Insurance Portability and Accountability Act (HIPAA) of 1996 allows for disclosure of a patients’ medical information when the disclosures are “required by law.” 45 C.F.R. 164.512(a) (2011). Transplant tourism prosecutions would more than likely be prosecuted at the Federal level and the Federal Rules of Evidence do not recognize any privilege for doctor-patient confidentiality. FED. R. EVID. 501.

<sup>257</sup> Shimazono, *supra* note 30, at 958.

<sup>258</sup> Meyer, *supra* note 44, at 225.

<sup>259</sup> *Id.*

<sup>260</sup> *Id.*

<sup>261</sup> *Id.* at 228; *see also* PEARSON, *supra* note 55, at 18; Zargooshi, *supra* note 129, at 386.

public awareness are employed.<sup>262</sup> There are limits to strictly “law and order” approaches to trafficking. Addressing poverty, unemployment, and other factors that increase an individual’s vulnerability to trafficking requires creative and long-term approaches.<sup>263</sup>

The purpose of this Note is to propose a “law and order” approach that utilizes current international law, but remains flexible enough to allow for more organic, regional solutions to emerge. Countries, such as the United States, could take an active role in discouraging its citizens from engaging in transplant tourism by amending their national legislation to criminalize the practice and include both criminal and civil penalties; sanction other countries that permit and perform transplants for their citizens; and pursue new methods of organ procurement.<sup>264</sup>

Other measures can also have a solid impact on the matter as well. For example, it has been suggested that although NOTA only criminalizes the sale and purchase of human organs within the United States, the statute could be interpreted to include sales and purchases by U.S. citizens overseas.<sup>265</sup> Thus, a *de facto* outlaw of transplant tourism would be in effect for Americans. Other scholars have suggested that the Federal Trafficking Victims Protection Act (TVPA), the central anti-trafficking legislation in the United States, could be amended to include trafficking for organ removal in its definition of human trafficking in order to bring it into accord with the Trafficking Protocol.<sup>266</sup> The TVPA created Trafficking in Persons Report, released by the U.S. State Department, is a major influence on international efforts against human trafficking because nations wishing to avoid being listed on the Special Watch List are more inclined to invest in TVPA definitions of trafficking.<sup>267</sup>

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<sup>262</sup> Chuang, *supra* note 219, at 154.

<sup>263</sup> *Id.* at 163.

<sup>264</sup> Roberts, *supra* note 21, at 784.

<sup>265</sup> *Id.* Roberts suggests, “[t]he act of purchasing a commodity in another country and returning that commodity, such as an organ, back into the United States could be classified as affecting interstate commerce.” *Id.* Section 274e only criminalizes persons who buy or sell an organ “if the transfer affects interstate commerce.” National Organ Transplantation Act (NOTA), 42 U.S.C. § 274e.

<sup>266</sup> Trafficking Victims Protection Act (TVPA) of 2000, Pub. L. No. 106-386, § 103(8), 114 Stat. 1464, 1471 (2000) (current version at 22 U.S.C. § 7102 (2008)) (currently the only forms of trafficking recognized are forced labor, sexual servitude, and travel for illicit sexual conduct).

<sup>267</sup> Pugliese, *supra* note 125, at 199.

Ideally, the real solution is preventing people from having kidney failure in the first place through good medical care.<sup>268</sup> However, in the meantime, the major “recipient” countries must do what they can to close the transplant tourism loopholes in their own system and all countries must have the flexibility to explore procurement regimes, even if that means testing out market-based solutions. The Trafficking Protocol provides an established framework of binding international law with the correct focus: the autonomous choice of the individual.

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<sup>268</sup> Garwood, *supra* note 129, at 4-5 (Dr. Francis Delmonico stated, “[w]e have a global epidemic of kidney failure [leading to shortages and trafficking].”).