Tulsa Law Review

Volume 44
Number 4 *The Scholarship of Richard A. Epstein*

Volume 44 | Number 4

Summer 2009

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Recommended Citation

Michele Goodwin, *Relational Markets in Intimate Goods*, 44 Tulsa L. Rev. 803 (2009).

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RELATIONAL MARKETS IN INTIMATE GOODS

Michele Goodwin*

This symposium is dedicated to examining the rich body of work of an enormously talented scholar and scribe of the law, Richard Epstein. With a bibliography so extensive, nearly a dozen scholars were sought to meet this inspiring challenge. As an honored participant, it was my pleasure to ruminate on the overlap between my work and that of Richard's on the body market. Of course, defining Richard Epstein's work is at times the work of defending Epstein's work. Epstein writes with intensity and integrity, unpacking that which brings about a bit of controversy—not as a trope for inciting critique—but rather speaking honestly to issues otherwise ignored, or treated with the most insincere forms of social correctness. Some might offer that he writes with an aura of defiance, often resistant to embracing conventional wisdom simply because others choose to follow that path, even within law and economics, a field that he has come to shape, define, dominate, and defend.

This project places at its intersection my shared interests with Richard Epstein, in part as a tribute to his distinguished catalogue of scholarship, and also because we share an urgent vision about organ transplant policy in the United States. The urgency for a more responsive transplant policy was publicly revealed in stark and chilling ways during the summer of 2009 through the federal indictment of Levy-Izhak Rosenbaum, a New Jersey rabbi who brokered organs on the black market.[1] In many ways, Rosenbaum's lucrative underground business of coordinating kidney transplants for a steep fee flourished as a by-product of a problematic federal system that regards creative organ procurement regimes through a punitive lens, rather than as "patient-proactive."[2] Over the years, this federal system prohibited organ swaps, frowned on directed donations from strangers,[3] discouraged solicited donations,[4] dampened enthusiasm for

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* Everett Fraser Professor of Law and Professor of Medicine and Public Health, University of Minnesota. I am grateful to Richard Epstein for inviting me to participate in this special symposium. He is a terrific scholar, but more importantly my friend. I would also like to thank the editors at the Tulsa Law Review.

1. *See Talk of the Nation*, "The International Organ Trafficking Market" (NPR July 30, 2009) (radio broad.) (transcr. available at http://www.npr.org/templates/story/story.php?storyId=111379908).

2. *See e.g.* Michele Goodwin, *The Body Market: Race Politics & Private Ordering*, 49 Ariz. L. Rev. 599, 627 (2007).

3. Though direct donations do not involve monetary transfer, given the international black market in organ trade, there is a shadow market price (value) inherent in the exchange itself. *See generally* Charles T. Carlstrom & Christy D. Rollow, *The Rationing of Transplantable Organs: A Troubled Lineup*, 17 The Cato Journal 163, 172–73 (Fall/Winter 1997) (available at http://www.cato.org/pubs/journal/cj17n2-3.html); *but see* Legality of Alternative Organ Donation Practices Under 42 U.S.C. § 274e, 31 Off. Leg. Counsel § 1 (2007) (available at http://www.justice.gov/olc/2007/organtransplant.pdf).

4. Arthur Caplan argues that solicited donations undercut the "ability of the system to get organs to those most in need." Arthur L. Caplan, James J. McCartney & Dominic A. Sisti, *Health, Disease, and Illness:*

funeral benefits from states, and treated with wary skepticism online organ matching systems like MatchingDonors.com.[5] More disturbingly, the federal system prohibits any organ exchanges that involve "valuable consideration,"[6] which could include something as innocuous as a cup of coffee or slice of bread.[7] Violation of NOTA can result in a felony conviction, with a five year prison term and fifty thousand dollar fine.[8] Some doctors and hospitals refuse to service these alternative transplants, arguing that even if the law is not enforced as to these types of donations, they violate the spirit of the transplant policy and harm the interests of waitlist patients.[9] Ultimately this restrictive system results in thousands of deaths each year.

This article moves beyond challenging the choir and debating the alienability of human biologics, to discuss how relationships create private markets and might serve as a platform in the domain of biological supply. This may be where Epstein and I part company, though, I think, only by a matter of degrees. Specifically, this article considers whether intimacy has a role in markets and if so, how intimacy functions with regard to supply and demand.

My analytical hunch, that organ platforms allowing individuals to maximize relational value—without legal penalty—could enhance organ supply, derives in part from other human biological domains, and a growing body of empirical evidence that illustrates that choice and relationships matter in human biological exchange.[10] Organ transplant waitlists reveal a grim national story of pain, delay, and death. Men and women suffering from infertility, as well as gay couples, lament their reproductive predicaments and attempt to resolve this plight usually through the explicit use of markets.[11] Women who, for a complicated and often compelling list of reasons, including what some doctors refer to as a "hostile womb," cannot carry a fetus to term, lease the wombs of other women.[12] Infertile couples less concerned about genetic matching utilize a sophisticated network of agencies—that for often exorbitant fees—connect would-be parents with the child they desire.[13]

In part, the demand for most human biologics can be attributed to advancements in biotechnology. Sophisticated laboratory techniques allow for the creation of embryos

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Concepts in Medicine (Georgetown U. Press 2004); *but see* Richard A. Epstein, *The Human and Economic Dimensions of Altruism: The Case of Organ Transplantation*, 37 J. Leg. Stud. 459, 489 (2008).

5. *See e.g.* Patrick D. Carlson, *The 2004 Organ Donation Recovery and Improvement Act: How Congress Missed an Opportunity to Say "Yes" to Financial Incentives for Organ Donation*, 23 J. Contemp. Health L. & Policy 136, 146 (2006); Epstein, *supra* n. 4, at 490–91.

6. 42 U.S.C. § 274e(a) (2001).

7. *Id.*

8. *Id.* at § 274e(b).

9. *See* Virginia Postrel, *"Unfair" Kidney Donations*, Forbes Mag. 124, 124 (June 5, 2006) (quoting Douglas Hanto, stating "we won't do them," referencing transplants that involved solicitations and negotiations outside of the UNOS waitlist process); United Press Intl., *Organ Donor Club Grows, Has Critics*, http://www.physorg.com/news69600196.html (June 14, 2006) ("Dr. Douglas Hanto of Harvard Medical School said organs should go to the person who needs it the most, not to people because they are members of a club.").

10. *See e.g.* Sharon R. Kaufman, Ann J. Russ & Janet K. Shim, *Aged Bodies and Kinship Matters: The Ethical Field of Kidney Transplant*, 33 Am. Ethnologist 81, 82 (Feb. 2006).

11. *See e.g.* Margaret J. Radin, *Market-Inalienability*, 100 Harv. L. Rev. 1849, 1928 (1987).

12. *See e.g. Ugly Betty*, "Zero Worship" (ABC Jan. 10, 2008) (TV series) (in this episode, Wilhelmina cannot carry a child because she has a hostile womb and thus seeks a surrogate).

13. *See* Cheryl Miller, *Babies for Sale*, 13 New Atlantis: A J. of Tech. & Socy. 94, 95 (2006).

outside of the womb, laparoscopic organ retrieval and transplant, and the utilization of human tissues typically discarded.[14] But there is an equilibrium problem; usually demand outpaces supply in the natural sphere and individuals must turn to alternative means to acquire the biologics they desire. This disparity between supply and demand persists across a broad spectrum of demand for biologics that can only be derived from humans, and usually, most preferably from living persons—though exceptions exist. The supply and demand regimes for ova, organs, and children, are treated differently legislatively and in public thought.

The dual statuses of intimacy are employed here—both as a metaphor for relationships and affinity linkages (based on race, gender, or even religion), and also as the term relates to the exclusively yours: biological goods, such as kidneys, ova, sperm, and babies. Does intimacy constitute a market on its own? The primary thrust of this project considers whether the law has the capacity to tolerate "markets" or "cooperatives" based on affection, affinities, or intimate relationships for human biological supplies given that they tend to discriminate. In part, the law currently acts blind to some preference grouping even when there may be a negative social impact, while policing other "members only" services.[15] Sophisticated baby markets, where complex negotiating and matching of preferences usually coincides with other forms of matching according to race, gender, and ethnicity, provide ample evidence supporting this point. On the other hand, policies that limit access to or exclude members of particular groups by race, gender, and religion are typically unconstitutional.[16]

Thus, this project analyzes market demand for intimate goods. By intimate, this project is not speaking explicitly, implicitly, or even indirectly of sex. Rather, the focus here is on children, organs, and reproductive materials. By relational, I speak to another form of intimacy—that is to say, the paper speaks to what role and authority should be given to familial and affinity bonds in markets. Specifically, the article considers whether markets in intimate goods are distinguishable from other markets for the purposes of tolerating discrimination.

Part I paints a crisper image of the contemporary demand and supply imbalance in the biological sphere. This section analyzes why we might desire special markets in certain intimate goods. The term markets is used with artistic license here, as the thrust of this section is not exclusively about financial payments for goods in demand, but rather it expands the meaning to include an understanding that relationships or affinities like race, gender, or religion at times metaphorically serve as a type of "incentive" by inspiring members of those groups to engage in projects, programs, and activities they otherwise might avoid or decline. Part II briefly addresses terminology, specifically considering what relational means in the contexts employed in this paper. Part III examines the constraints in markets and considers how we might maximize their efficiency. Here I piggy-back just a bit on Richard McAdams scholarship on discrimination, which is highlighted in this issue. In this project, I consider why we

14. *See* Laura S. Langley & Joseph W. Blackston, *Sperm, Egg, and a Petri Dish: Unveiling the Underlying Property Issues Surrounding Cryopreserved Embryos*, 27 J. Leg. Med. 167, 173 (2006).

15. Carlstrom, *supra* n. 3, at 169–70.

16. *See* U.S. Const. amend. I; U.S. Const. amend. XIV, § 1.

might want to tolerate a bit of discrimination in some markets. Part IV concludes this paper.

I. THE DEMAND FOR INTIMATE GOODS

This article starts in a space where Epstein and I share common interests, health law, and specifically, domestic organ transplant policy. We share first principles in this domain, namely that transplant policy should maximize saving lives—particularly as technology affords doctors the capacity to do so with minimal risks and resources stand readily available.[17] We agree that an optimally functioning transplant system will protect individual autonomy, avoid coercion, and guard against fraud.[18] In essence, a transplant regime that maximizes saving lives, but undermines liberty and autonomy in the process, would not fit either of our goals.

Our bottom lines are much the same, that the current altruistically-based U.S. transplant regime is imperfect, fraught by delays, patients fleeing the waiting lists for black markets, and avoidable deaths.[19] While a growing chorus of scholars, pundits, doctors, and patients with this sentiment agree, their harmonizing support for transplant regime alternatives is at times muffled, if not hushed entirely by a vigorous choir of those who believe in the primacy of altruism, and that financial considerations should never overlap with biological demand and supply regimes.[20]

Part I considers the demand for human biologics, specifically organs. By its approach, this section urges a subtle, conceptual reframing of materials derived from the body; a more transparent view of the human body as a legal object of exchange through borrowing, marketing, sharing, and other forms of exploitation. This section addresses the empirics of patient demand for human biologics. To be clear, private individuals are not the only agents interested in exchange of human biologics. Doctors, researchers, pharmaceutical companies, cosmetic firms, burn clinics, tissue banks, and others also make demands for human biologics. However, that discussion is beyond the scope of this paper, but can be found in other works.[21]

As of July 2009, over 102,000 people have formally committed themselves to the U.S. transplant waiting process.[22] That number does not reveal the totality of individuals dying—quite literally–for an organ.[23] U.S. transplant policy requires some rationing.

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17. *See* Michele Goodwin, *Altruism's Limits: Law, Capacity, and Organ Commodification*, 56 Rutgers L. Rev. 305, 324 (2004); Epstein, *supra* n. 4, at 464–65.

18. *See* Goodwin, *supra* n. 17, at 308, 312; Epstein, *supra* n. 4, at 486.

19. *See id.* at 462–63; Goodwin, *supra* n. 17, at 307, 308. *See generally* Michele Goodwin, *Black Markets: The Supply and Demand of Body Parts* (Cambridge U. Press 2006) [hereinafter Goodwin, *Black Markets*].

20. *See e.g.* Michele Goodwin, *Confronting the Limits of Altruism: A Response to Jake Linford*, 2 St. Louis U. J. Health L. & Policy 327 (2009).

21. *See* Michele Goodwin, *Formalism and the Legal Status of Body Parts*, 2006 U. Chi. Leg. Forum 317, 320. Harriet Washington's elegant work exposes the many ways in which prisoners, the poor, and other marginalized groups have been pursued as unwitting subjects of human research. Harriet Washington, *Medical Apartheid: The Dark History of Medical Experimentation on Black Americans from Colonial Times to the Present* (Random House 2006). *See also Moore v. Regents of U. of Cal.*, 51 Cal. 3d 120 (1990); *Brotherton v. Cleveland*, 923 F.2d 477 (6th Cir. 1991).

22. *See* United Network for Organ Sharing, http://unos.org (last accessed July 2009).

23. *See* Virginia Postrel, *With Functioning Kidneys for All*, http://www.theatlantic.com/doc/200907u/kidney-donation (July 9, 2009).

For example, removing very sick patients from waitlists is a form of rationing.[24] The U.S. also removes from the waitlists those deemed too elderly to warrant an organ.[25] These are the policies born out of a deadly form of rationing that responds directly to grave organ shortages. Desperate choices are made in order to preserve the system of altruistic organ procurement, which forms the ideological and legal approach to organ sharing in the U.S.[26]

Despite the significant number of individuals on the waitlists, very few will be granted the opportunity to receive the precious renewal on life. As of July 13, 2009, the United Network for Organ Sharing (UNOS), the agency that oversees federal transplant policy and programs, reported that barely 4,700 persons had volunteered to be donors in the first half of 2009.[27] That figure includes living and cadaveric donors. As a result, surgeons were unable to transplant even 10% of the waitlist. To gain a fuller understanding of what some commentators refer to as a "crisis," a brief historical overview is necessary.

Over 80,000 Americans wait on U.S. transplant lists for a kidney.[28] Thousands of sick patients are added to this list each year.[29] Roughly seven thousand will die this year, thousands more will be expelled from the list for reasons explained above, and hundreds more will be added.[30] In less than ten years, the wait list has nearly doubled.[31] In 2000, 47,280 people were waiting for kidneys.[32] Less than ten years later, not only have the number of persons admitted to the waitlist nearly doubled, but the average waiting time is practically unbearable. According to Dr. Benjamin Hippen, a renowned nephrologist and member of the UNOS board of directors, by 2010, kidney patients can expect to wait ten years for certain organs.[33] Because the waitlist identifies only 100,000 persons waiting for organs, most Americans might be surprised to learn that more than a half million could benefit from or seriously need an organ transplant.[34]

According to the National Kidney Foundation (NKF), over 485,000 Americans suffer from end-stage renal disease.[35] Some patients learn too late about their illness,

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24. *See* Ronald Munson, *Raising the Dead: Organ Transplants, Ethics and Society* 201 (Oxford U. Press 2002).

25. *Id.*

26. *See e.g.* Goodwin, *supra* n. 17, at 311.

27. *See* United Network for Organ Sharing, http://unos.org (last accessed July 13, 2009) [hereinafter UNOS] (information on waiting list candidates, transplants, and donors can be found on the introductory page).

28. *See* U.S. Dept. of Health & Human Servs., *Organ Procurement and Transplant Network*, http://optn.transplant.hrsa.gov/ (last updated Nov 1, 2009) [hereinafter OPTN].

29. *Id.*

30. *See* U.S. Dept. of Health & Human Servs., *2005 OPTN/SRTR Annual Report*, http://www.ustransplant.org/annual_Reports/archives/2005/106_dh.pdf (May 2, 2005) [hereinafter *2005 Annual Report*]; Michele Goodwin, *Organ Taboos*, Forbes Mag. 32, 32 (Oct. 15, 2007).

31. D.J. Cohen et al., *Kidney and Pancreas Transplantation in the United States, 1995–2004*, 6 Am. J. Transplantation 1153 (2006).

32. *2005 Annual Report*, *supra* n. 30 (This part of the report can be found at http://www.ustransplant.org/annual_reports/archives/2005/103_dh.pdf).

33. Benjamin Hippen, *The Case for Kidney Markets*, 14 The New Atlantis: A J. of Tech. & Socy. 47, 54 (Fall 2006).

34. UNOS, *supra* n. 27.

35. National Kidney Foundation, *End Stage Renal Disease in the United States*, http://www.kidney.org/news/ newsroom/fs_new/esrdinus.cfm (last updated Mar. 2008).

when they are too sick to be admitted to the waitlist.[36] Others, because of sketchy medical history, prior drug use, or other factors may be restricted from the list—not through a national evaluation system, but by the very subjective process left to often well-meaning doctors faced with the enormous burden to refer who gets on or is excluded from the waitlists.[37] The less fortunate—those patients who are less informed about the complex matrix involved with obtaining an organ transplant—are relegated to dialysis clinics. For them, more than 341,000 patients, transplantation is not an option.[38]

The death toll from end-stage renal disease also places the urgency for kidney exchanges in context. Nearly 87,000 patients die each year from end-stage renal disease.[39] Overwhelmingly, these are individuals who were shaved from the waitlist or never made it onto the list. A more transparent list—that leveraged all sick patients into the process—would demonstrate in undeniably stark terms the critical nature of the demand for kidneys. The list expands exponentially each year. Researchers and transplant surgeons project that in just a few years the number of patients coping with end-stage renal disease will reach well over 700,000.[40]

In a recent publication, Frances Kessling provides an elegant illustration of what that lengthy wait time means for Americans in need of kidneys.[41] In part, Kessling reveals her own personal struggle to find a donor, but as she asserts, her extensive network of friends and other social and political connections made her plight more bearable, and finding a donor more expedient than for most Americans—or the 90% of waitlist patients (this year) who have yet to find a donor. Kessling's doctors made her case clear: dialysis, transplant, or death.[42] To those more informed about dialysis, the options quickly narrow to two: transplant or death.

Dialysis does not resolve end stage renal disease (ESRD), kidney failure, diabetes, high blood pressure, hypertension, or the other conditions that lead to compromised and ineluctable kidneys. Rather, dialysis, which removes excess waste and fluids from the blood, is a short, urgent intervention on a certain road to death without an organ transplant.[43] According to a study conducted by the Government Accountability Office (GAO), "[i]n the long term, dialysis is associated with a lower quality of life and higher mortality rates than kidney transplants and is considered a less desirable treatment

36. Goodwin, *supra* n. 2, at 611 (interviewing Jack Lynch, an executive with the Illinois Gift of Hope organ procurement organization, who warns that too often patients misread the signs of end-stage renal failure, believing their condition to be urinary or related to a sexual condition or infection).

37. Laurie Abraham, *Momma Might Be Better Off Dead* (U. Chi. Press 1993). Abraham spends two years investigating health care coverage in inner-city Chicago, following a family's stoic adventure through the U.S. health care maze. A significant and quite compelling aspect of her book addresses organ transplantation and the sometimes unscrupulous ways in which doctors are forced to ration kidneys.

38. Susan Bohan, *Despite Advantages, Home Dialysis Slow to Grow*, http://www.satellitehealth.com/_docs/insideBay_308.pdf (Mar. 3, 2008).

39. Frances Kessling, *Whaddaya Have To Do Around Here To Get A Kidney*, http://www.salon.com/mwt/feature/2009/03/27/my_kidney/index.html (Mar. 27, 2009).

40. J. Stewart Cameron and Juan F. Macías-Núñez, *Chronic Renal Failure in the Elderly*, in *Oxford Textbook of Clinical Nephrology* vol. 2, 2166 (Alex M. Davidson et al. eds., Oxford U. Press 2005).

41. Kessling, *supra* n. 39.

42. *Id.*

43. National Kidney Foundation, *Dialysis*, http://www.kidney.org/atoz/content/dialysisinfo.cfm (last updated Aug. 18, 2008).

option."[44] Dialysis is an intervention with a limited shelf-life; the average lifespan for a person over forty receiving dialysis is 5–8 years.[45] The length of survival reduces by half at age sixty.[46]

Kessling ponders whether publicity about improvements in dialysis misinforms the public about the strenuous process, which takes an enormous toll not only on the individual patient, but also families, local communities and the national economy.[47] According to Kessling, "we imagine people go sit in a nice chair for four hours three times a week, read a book and then go about their daily lives."[48] In fact, dialysis requires being tethered to machines several times per week for several hours each time.[49] Patients on dialysis usually cannot work or do so in a very limited capacity; events and functions typical to a healthy life, such as travel, attending family events, and participating in community organizations are placed on indefinite hold.[50] Patients are generally so weak after treatment that they require immediate rest to recover.[51] A pragmatic evaluation of a half million individuals on dialysis, and the tens of thousands on transplant waitlists, begins to illustrate the unmitigated challenge in resolving organ demand.

The national organ demand conundrum also has economic and racial impacts, which are explained briefly here. Over one third of kidney patients are African American.[52] They experience the highest death rate, wait longer than all other groups, and seem to be in greatest risk among all ethnic groups.[53] Despite comprising nearly 35% of the kidney waitlists, African Americans[54] consistently do not receive organs in proportion to their demand, despite their placement on the list, donation rates, and public announcement appeals.[55] Whites received 62.1% of organ transplantations in 2007 while blacks and other minorities received 19.3% and 18.6% respectively.[56] Individuals awaiting organs also are disparately impacted by the current means of prioritizing organ recipients. During the period of 1999 until 2004, the median wait time for a kidney for whites was 1,255 days, whereas for African Americans the median wait time was 1,781.[57] These issues are provided a more in depth treatment in other works;[58] my

44. *See* Government Accountability Office, *End-Stage Renal Disease: Characteristics of Kidney Transplant Recipients, Frequency of Transplant Failures, and Cost to Medicare*, http://www.gao.gov/htext/d071117.html (Oct. 29, 2007).

45. Kessling, *supra* n. 39.

46. *Id.*

47. *Id.*

48. *Id.*

49. National Kidney Foundation, *supra* n. 43.

50. *See e.g.* Mayo Clinic, *Our Shared Commitment: 2007 Annual Report* 6–10, http://www.mayoclinic.org/mcitems/mc0700-mc0799/mc0710-2007.pdf (2007).

51. *Id.*

52. *See* OPTN, *supra* n. 28. Of the 56,864 candidates awaiting kidney transplants, 20,225 are African American. These statistics are based on OPTN data as of Feb. 27, 2004.

53. Goodwin, *supra* n. 17, at 346.

54. This project uses the terms African American and black interchangeably.

55. U.S. Dept. of Health & Human Services, *OPTN: Organ by Ethnicity*, http://www.optn.org/latestData/rptData.asp (at the website, choose category "waiting list" and count "candidates" and select "organ by ethnicity") (in 2007, listing 25,649 African-American kidney transplant candidates, listing 27,659 African-Americans awaiting transplant of any organ.).

56. *Id.*

57. U.S. Dept. of Health & Human Services, *OPTN: Kidney Kaplan-Meier Median Waiting Times for*

purpose here is to unpack a view of human demand that speaks honestly to U.S. transplant policy.

Finally, the economic tensions and questionable logic that underlie federal organ transplant policy deserve to be brought into clearer view. In 1973, Medicare began covering treatments for ESRD.[59] At the time, dialysis was thought to be the best option for patients, as immune-suppressant medications had yet to be refined, thereby making transplants a plausible, but riskier option for non-related donors. Fewer than 20,000 patients per year were treated with dialysis at the time.[60] Nevertheless, the costs were exorbitant, but arguably justified as fewer options existed for these patients. Fifteen years later, the list of dialysis patients expanded, and the economic consequences of ESRD became clearer. Twenty years ago, in an article published in *Physician Executive*, Hugh Long estimated that the federal government spent in excess of $3.2 billion dollars per year to treat dialysis patients.[61]

The U.S. Renal Data System places current transplant policy in economic contexts. Medicare covers over 80% of patients with ESRD.[62] Expenditures associated with ESRD more than doubled during the past thirteen years, from 11.3% of the total Medicare expenditures to 24.5%, according to the 2008 U.S. Renal Data System's Annual Report.[63] Accordingly, the report places total Medicare expenditures for treating chronic kidney disease—the path leading to ESRD—at $49 billion dollars per year. Authors of the report point out, however, that "these assessments . . . likely underestimate the true . . . cost[s]."[64] Over the past decade, economists, law and economics scholars, and surgeons, including Nobel Laureate Gary Becker, Richard Epstein, Arthur Matas, Benjamin Hippen, and others, offer incontrovertible data that billions of dollars would be saved annually if more Americans were transplanted and moved off of dialysis.[65]

II. INTIMATE MARKETS: LESSONS FROM OTHER BIOLOGICAL SUPPLY POOLS

The demand for human biological supply has reached the level of sustained public outcry, and the spheres for which biological demand grows extend beyond organs.[66] In

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Registrants Listed 1999-2004, http://www.optn.org/latestData/rptStrat.asp (when at the website, choose category "median waiting time" and choose organ "kidney" and select "waiting time by ethnicity").

58. *See* Goodwin, *supra* n. 2; Michele Goodwin, *Private Ordering and Intimate Spaces: Why the Ability to Negotiate is Non-Negotiable*, 105 Mich. L. Rev. 1367 (2007) [hereinafter Goodwin, *Private Ordering*]; Michele Goodwin, *Deconstructing Legislative Consent Law: Organ Taking, Racial Profiling & Distributive Justice*, 6 Va. J. of Law & Tech 2 (2001) [hereinafter Goodwin, *Deconstructing Legislative Consent Law*].

59. National Kidney Foundation, *Insurance Choice for Medical ESRD Patients*, http://www.kidney.org/news/pubpol/pdf/INSURANCE_CHOICE_MEDICARE_ESRD-MSP_new.pdf (May 2009).

60. Hugh Long, *Dialysis-Medicare's ESRD Program, Part I - End State Renal Disease*, Physician Executive (Mar./Apr. 1989) (available at http://findarticles.com/p/articles/mi_m0843/is_n2_v15/ ai_8134767).

61. *See id.*

62. *See* Government Accountability Office, *supra* n. 44.

63. *See* U.S. Renal Data Sys. Annual Rpt., *Chapter Five: Costs of Chronic Kidney Disease* (2008) (available at http://www.usrds.org/2008/pdf/ V1_05_2008.pdf).

64. *Id.*

65. *See* Sally Satel, *When Altruism Isn't Enough* 6 (AEI Press 2009); Gary Becker, *How Uncle Sam Could Ease the Organ Shortage*, Bus. Week 18 (Jan, 20, 1997); Richard Epstein, *Organ Transplants: Is Relying on Altruism Costing Lives?* 4 The Am. Enter 50, 55 (Nov./Dec. 1993).

66. Much has been written about organ demand in recent years. Scholars disagree as to systems to resolve

some cases, demand surpasses supply, as demonstrated by the well documented case of organs, such as kidneys. Taking a peek into other realms of intimate human biological demand such as ova, sperm, and babies could prove instructive for scholars, such as Richard Epstein, who are deeply committed to policy change and achieving equilibrium between supply and demand for organs.

In reproductive spheres, it appears that "marketized" systems successfully satisfy consumer demand, as in the cases of ova and sperm. In a third category—babies and children—data from the U.S. State Department suggests that consumers increasingly export their demand when domestic pools dry up, and import the babies they want.[67] In the cases of these biological markets, demand is not met through waitlists and rationing. Nor are prospective parents required to acquire babies or the makings of babies through altruistic processes and registering on waitlists at local ova procurement organizations. Rather, prospective parents pick and choose the sperm, ova, and children they desire by transparent processes that often include down payments, clear financial terms, contractual language, and involve very explicit decision-making based on race and gender.

This section describes the demand for reproductive biologics, and argues that equilibrium in these markets cannot be credited to an over abundant supply, but rather, to selective preference shopping that directly connects demand to supply. To be sure, there are some societal drawbacks to relational preferences that this project acknowledges.[68]

A. Reproductive Markets

Heterosexual intimacy no longer serves as the exclusive domain of family creation. Popular understanding of reproduction now includes an intellectual if not social

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the demand dilemma, with market proponents on one side of the issue, presumed consent supporters on the other, and those committed to altruism in a sphere altogether different. Each group, however, agrees that the demand outstrips supply and that without an increase in organs, deaths will continue to rise. For a view of the issue from market proponents, *see* Epstein, *supra* n. 4; Gary S. Becker & Julio Jorge Elías, *Introducing Incentives in the Market for Live and Cadaveric Organ Donations*, 21 J. Econ. Persp. 3 (Summer 2007); Goodwin, *supra* n. 17, at 311–13. For a treatment of the issue from a presumed consent perspective, *see* Richard H. Thaler & Cass Sunstein, *Nudge* (Yale U. Press 2008); Linda C. Fentiman, *Organ Donation as National Service: A Proposed Federal Organ Donation Law*, 27 Suffolk U. L. Rev. 1593, 1602 (1993). Despite strong evidence that transplant policies that exclusively rely on altruism fail, some commentators find great salience in that approach and warn against the use of markets to resolve organ transplant shortages. *See* Radin, *supra* n. 11, at 1850; F.L. Delmonico et al., *Ethical Incentives—Not Payment—for Organ Donation*, 346 New Eng. J. Med. 2002, 2004 (June, 2002). Equally, the incredible demand for ova and sperm is illustrated not only by media accounts, but also by public advertisements in newspapers, magazines, and on-line. *See* Sarah B. Angel, *The Value of the Human Egg: An Analysis of Risk and Reward in Stem Cell Research*, 22 Berkeley J. of Gender, L. & Just. 183, 197–98 (2007). Finally, the demand for babies, particularly white babies in the United States, is revealed through studies and government statistics. But this demand is not so hidden that the public is unaware. The increased use of adoption agencies serving children from abroad as a "second-best" option is illustrated by the dramatic increase in foreign adoptions by U.S. families.

67. *See* U.S. Dept. of State: Office of Children's Issues, *Intercountry Adoption*, http://adoption.state.gov (last accessed Nov. 19, 2009) (the U.S. State Department's guide to intercountry adoption).

68. Scholars who would argue that relational preferences might advantage some groups over others are correct and their concern to be cautious about legalizing or having the law tolerate preference-shopping is entirely reasonable. As well, there could be crowding out, meaning that some potential regime participants might avoid participating in human biological exchange out of concern for the moral implications of preference shopping in particular human biological domains. Finally, there are social impacts that result from preference shopping, which currently exist in the adoption realm discussed *infra* and in greater detail in Michele Goodwin, *Baby Markets: Money and the New Politics of Creating Families* (Cambridge U. Press forthcoming 2010).

acceptance and embrace of diverse family populating unlimited to the traditional notion of a family growing from a wedded (working) man and woman committed to managing the home. Instead, homosexual couples, heterosexual couples (without marriage), the infertile, and single men and women create families with fewer stigmas than ever before. And, nowhere is the demand for human biologics articulated more forcefully and transparently than among these groups.

Evidence of persistent and specialized demands for intimate reproductive supplies extends beyond the realm of discreet advertisements in college newspapers. Indeed, the open market for reproductive supply is no longer buried in back pages, disguised in the classified sections as it could be accurately described in the early 1990s. A contemporary focus on reproductive market politics finds three distinct characteristics. First, demand expressed through mainstream media, including local newspapers, radio stations, bulletin boards, and the internet. Second, a market so widely successful that demand is no longer generalized, but quite specific and tailored to religion, race, ethnicity, and even sexual orientation. Third, and perhaps most interesting, unlike most markets, shopping in the intimate reproductive sphere is not controlled by the creative instincts or business models of designers/suppliers. Rather, the market exists and is controlled in many ways by those exercising demand. To wit, thinking about suppliers as clients would not be wholly inaccurate.

To appreciate the function and success of reproductive markets requires understanding how and why entrepreneurial men and women found the reasonably precise tipping points for supply while bypassing significant controversy, coercion, buyer's remorse, and supplier exploitation. In response to creative entrepreneurial efforts, that began with direct solicitations to college students for ova and sperm, a well organized billion dollar industry has emerged, which services the unique philosophical, religious, and ethnic demands of diverse clienteles who all desire similar outcomes: individual enrichment (expressed by suppliers through financial gain, and buyers by creating families).

1. What Shapes Reproductive Demand?

For nearly thirty years, reproductive technology has been a primary source of family making for non-traditional unions and infertile couples.[69] ART's popularity and broad use is attributable to several factors. First, reproductive technology's popularity expanded as more women delayed pregnancy to accommodate or maximize career options and employment.[70] As women age, their natural ability to reproduce declines, resulting in chromosomal abnormalities that lead to birth defects, greater chance of exposure to communicable sexual diseases, and lower sperm count in aging partners.[71]

69. Since 1981, ART has been used in the United States to help individuals create families. *See e.g.* U.S. Dept. of Health and Hum. Serv., *2002 Assisted Reproductive Technology Success Rates, Nat'l Summary and Fertility Clinic Reports* 1 (2004) (available at http://cdc/gov/ART/ART02/index.htm) [hereinafter CDC 2002 ART Success Rates].

70. Cheryl Wetzstein, *American Women Giving Birth Later; College, Careers Defer Motherhood*, Wash. Times PA08 (Dec. 12, 2002) (reporting that in the last three decades from 1970 to 2000 the average age for American women to have their first birth has increased from 22 to 25).

71. *See e.g.* Johannes L. H. Evers, *Female Subfertility*, 360 Lancet 151 (July 13, 2002).

Science reveals that women's infertility is better captured on a spectrum, rather than understood as a fixed condition. Women's infertility occurs with a gradual onset after a certain age.[72] Second, women who might otherwise forego parenting or choose to adopt are likely responding to social expectations that they should biologically "mother."[73] Third, gay couples can achieve pregnancies and biologically parent through the flexible menu of options afforded by ART. Finally, gestation is no longer a fixed notion located in the mother's womb. Prospective parents can hire-out this crucial step in the reproductive process.

Thus, while the causes leading to infertility vary, but include older maternal age,[74] environment,[75] histories of sexually transmitted diseases,[76] and poor health, the drawbacks of the condition—the inability to reproduce—can be overcome by the market's sensitive ability to "create." Studies published in *Pediatrics*, a leading peer-review journal, indicate that individually, these factors can cause sterility, infertility, higher incidences for still birth, miscarriage, congenital delays in fetuses, congenital malformations, and multiple births.[77] For these reasons, assisted reproduction, including the purchasing of other women's ova may seem like a logical solution to infertility.

Thus, what and who motivates demand in intimate reproductive spheres is quite

72. *See e.g.* Sandra Anderson Garcia, *Sociocultural and Legal Implications of Creating and Sustaining Life through Biomedical Technology*, 17 J. Leg. Med. 469, 492 (1996).

73. The idea of biologically mothering is slightly attenuated, as ART does not necessarily lead to full biological parenting. For example, the gestational mother might use a third party donor's eggs for the fertilization process, thereby making the infertile woman a "carrier" of her child, but not the biological mother. Of course, this raises questions about how motherhood and biological mothering should be defined.

74. *See e.g.* Suzanne C. Tough et al., *Delayed Childbearing and Its Impact on Population Rate Changes in Lower Birth Weight, Multiple Birth, and Preterm Delivery*, 109 Pediatrics 399 (2002); Meredith A. Reynolds et al., *Trends in Multiple Births Conceived Using Assisted Reproductive Technology, United States, 1997–2000*, 111 Pediatrics 1159, 1159 (2003) (suggesting that as "more women delay childbearing into their late 30s and 40s," greater complications arise and infertility increases) (the authors note that among the problems arising with increased maternal age are the "risk[s] for multiple birth among naturally conceived pregnancies"); Jennita Reefhuis et al., *Fertility Treatments and Craniosynostosis: California, Georgia, and Iowa, 1993–1997*, 111 Pediatrics 1163 (2003); *see also* Dawn P. Misra and Cande V. Ananth, *Infant Mortality Among Singletons and Twins in the United States During 2 Decades: Effects of Maternal Age*, 110 Pediatrics 1163 (2002).

75. Harmful environmental agents have been linked to sterility, infertility, cancer and many other chronic illnesses. *See e.g.* Robert Brent et al., *A Pediatric Perspective on the Unique Vulnerability and Resilience of the Embryo and the Child to Environmental Toxicants: The Importance of Rigorous Research Concerning Age and Agent*, 113 Pediatrics 935 (2004) [hereinafter Brent, *A Pediatric Perspective*]; Robert Brent, *Environmental Causes of Human Congenital Malformations: The Pediatrician's Role in Dealing With These Complex Clinical Problems Caused by a Multiplicity of Environmental and Genetic Factors*, 113 Pediatrics 957 (2004) [hereinafter Brent, *Environmental Causes*]; Robert W. Miller, *How Environmental Hazards in Childhood Have Been Discovered: Carcinogens, Teratogens, Neurotoxicants, and Others*, 113 Pediatrics 945 (2004).

76. Sexually transmitted diseases result in infertility, increased risk of hysterectomy, subfertility, ectopic pregnancies, and chronic pelvic pain. *See e.g.* Robert L. Brent & Michael Weitzman, *The Pediatrician's Role and Responsibility in Educating Parents About Environmental Risks*, 113 Pediatrics 1167, 1171 (2004) (noting "[s]exually transmitted disease can be life-threatening, cause infertility or sterility, and increase the risk of cervical cancer"); Evers, *supra* n. 71 (noting that women are delaying childbirth, which in turn increases the probability of sexually transmitted diseases, sperm decline in their partners, and a reduction in the quality and quantity of viable eggs); Nadereh Pourat et al., *Medicaid Managed Care and STDs: Missed Opportunities to Control the Epidemic: Lack of Organizational Priority is the Major Barrier to Providing Care for Those With Sexually Transmitted Diseases in Medicaid*, 21 Health Affairs 228, 229 (June 2002) (finding "[t]he burden of illness from STDs is exacerbated by infertility, pregnancy complications, cancer, and a greater susceptibility to HIV infection.") (footnote omitted); Brian M. Willis & Barry S. Levy, *Child Prostitution: Global Health Burden, Research Needs, and Interventions*, 359 Lancet 1417 (2002).

77. *See e.g.* Brent, *Environmental Causes*, *supra* n. 75, at 998.

elastic. The Centers for Disease Control (CDC) helps to further unpack demand dynamics. The CDC serves as a unique data sources in the reproductive realm; its researchers estimate that about 15% of women of reproductive age are infertile. [78] The agency derives this figure from reported medical data; about nine million women in the United States annually seek medical treatment or advice regarding infertility.[79] The CDC describes infertility services to include "medical tests to diagnose infertility, medical advice and treatments to help a woman become pregnant, and services other than routine prenatal care to prevent miscarriage."[80] Arguably, the demand for information and services related to infertility spills over into the demand for assisted reproductive services, specifically the purchasing of healthy ova and active sperm.

The increased demand for ART is understandable when one considers the expanded array of options afforded to infertile women, unmarried or single individuals, and gay couples. For gay couples, ART trumps the heterosexist instinct of Mother Nature, or as Martha Ertman suggests, assisted reproduction relieves same sex partners from the genetic discrimination imposed by nature.[81] ART also appeals to men and women in whose genes lurk genetic mutations and diseases. For them, ART helps to circumvent traditional reproductive processes and thus reduce or eliminate completely the risks of transmitting disabling diseases to their offspring. Women report that the services offered by fertility clinics maximize efficiency and convenience, while minimizing stigma by allowing the purchase of sperm over the internet.[82] Unlike adoption processes, which can be slow, and sometimes restricted to young, heterosexual couples, purchasing sperm and ova affords the opportunity to non-partnered men and women as well as couples to complete their families without the added social stigma, bureaucracy, and frustration of appearing to be genetically weak, inferior, or inadequate to parent.

Recent studies also confirm socially complicated data; that biologically teenagers and women of college age are at the optimal reproductive stage.[83] By contrast, well-accomplished women barely in their thirties, according to scientific research, are reproductively old.[84] Thus, the U.S. social paradigms for ideal or preferred motherhood——based on economic and social maturity—do not comport with reproductive roadmaps constructed by nature. Specifically, scientists report that fertility decline begins for women in their thirties, with a dramatic decrease in fertility at and

78. *See e.g.* CDC 2002 ART Success Rates, *supra* n. 69, at 1. Unfortunately, the information relied upon by the CDC is somewhat dated; it was gathered as part of a study conducted over ten years ago from the 1995 National Survey of Family Growth. *Id. See also* Val Davajan & Robert Israel, *Diagnosis and Medical Treatment of Infertility*, in *Infertility: Perspectives from Stress and Coping Research* 17, 17 (Annette L. Stanton & Christine Dunkel-Schetter eds., Plenum Press 1991) (stating "it has been estimated that between 10% and 15% of married couples in the United States are infertile."); Stephen L. Corson, *Conquering Infertility: A Guide for Couples* 1 (rev. ed., Prentice Hall Press 1990) ("In the United States, approximately 14 to 16 percent of all couples attempting to get pregnant have difficulty conceiving, and are defined by fertility therapists as being infertile.").

79. *See e.g.* CDC 2002 ART Success Rates, *supra* n. 69.

80. *Id.* at 3.

81. Martha M. Ertman, *Whats Wrong with a Parenthood Market–A New and Improved Theory of Commodification*, 82 N.C. L. Rev. 1 (2003).

82. Jennifer Egan, *Wanted: A Few Good Sperm*, 155 N.Y. Times E44, E46 (Mar. 19, 2006).

83. *See* Anna Mulrine, *Making Babies*, 137 U.S. News & World Rep. 60, 62 (Sept. 27, 2004).

84. *Id.*

over the age of thirty five.[85] Along with the decrease in fertility, there is a heightened probability for birth defects in children conceived by "reproductively" older women.[86] Therefore using the ova of younger women cannot be attributed exclusively to infertility, but rather must be understood in its broader biological contexts for many couples. Chromosomal abnormalities, for example, occur in 40-50% of pregnancies in women ages 30-35.[87] According to a report commissioned by the Alan Guttmacher Institute, "the share of embryos that women produce that are chromosomally abnormal rises . . . to about 70% in women 40 and over."[88] Technology now affords infertile families the ability to conceive, as well as those who have diminished capacity to conceive due to delay in childbearing.[89]

But the demand for biological reproductive materials cannot be classified as exclusively a "woman's issue," as men's reproductive health appears on the decline. [90] A few years ago European scientists uncovered startling data regarding male sperm depletion. Their studies discovered that "sperm counts have dropped by almost a third in a decade."[91] A study of over 7,000 men who visited the Aberdeen Fertility Centre between 1989 and 2002 revealed "average sperm concentrations fell by nearly 30 per cent."[92]

2. Contoured Supply Pools

Relational preference helps to place in context the demand side of reproductive biologics. Unmistakably, relational preferences matching supply pools aids in the equilibrium achieved and sustained overtime in reproductive demand and supply spheres.

For example, Leland Traiman, Founder and Director of Rainbow Flag Health Services located in San Francisco, California, recruits openly gay and bisexual men specifically for supplying sperm to couples that prefer gay and bisexual men.[93] According to Traiman, Rainbow Flag Health Services & Sperm Bank (also known as GaySpermBank.com) "is a unique business,"[94] supplying gay men's sperm to lesbian and bisexual women:

> Although we have some heterosexual clients, Rainbow Flag primarily serves individual Lesbians and Lesbian couples who believe that children have a right to know their

85. *Id.*

86. *See e.g.* S. London, *Risk of Pregnancy-Related Death Is Sharply Elevated for Women 35 and Older,* 36 Persps. on Sexual & Reprod. Health 89, 89 (Mar. 2004) (noting that women 40 or older have five times as high a risk of dying from pregnancy-related causes than women 25–29 years old).

87. Patricia Edmonds, *Helping People Have Healthy Babies*, Washingtonian Mag. 175 (Dec. 2004).

88. *Id.*

89. Reynolds et al., *supra* n. 74 (looking at ART data and multiple births statistics). For many infertile women, using ART is perceived as more than a rational choice; it is a blessing. *See e.g.* Nuala O'Connor, *Open Letter to the Archbishop*, Irish Times P10 (Mar. 6, 1999).

90. Sam Lister, *Careful, Lads, That Laptop Might Burn Your Genes*, The Times (Dec. 9, 2004) (available at http://www.timesonline.co.uk/tol/news/uk/article400872.ece).

91. *Id.*

92. *Id.* Commentators identify a number of factors that contribute to male infertility, including obesity, drug use, alcohol, and smoking. Other factors include exposure to laptops "pesticides, chemicals and radioactive material." *Id.*

93. *See* Leland Traiman, *Guidelines But No Guidance: GaySpermBank.com vs. FDA*, 9 J. Gender, Race & Just. 613, 614 (2006).

94. *Id.*

> biological fathers while they are going up. Most of our donors are Gay men who have chosen not to raise children themselves but still wish to procreate and have contact with their biological offspring. Many Lesbians, fearing misunderstanding from heterosexual donors, prefer Gay donors. Symbiosis. Rainbow Flag Health Services & Sperm Bank is one of a handful of fertility services and sperm banks that does not discriminate on the basis of sexual orientation with regard to both donors and recipients.[95]

Additionally, Traiman and his colleagues "recruit donors whose identity will be revealed to the mother when the child is three months old."[96]

Ethnicity matching represents a vibrant second category of relational preferences at play. In *Confessions of a Serial Egg Donor*, Julia Derek offers a revealing account of her introduction into supplying human biologics.[97] Derek's personal trek into the reproductive realm provides stunning insight into relational preferences and the tipping point for *supplying* intimate goods. She discloses the following reflection, "I read the ad in the [*Washington Post*] before me once more: '*Egg Donor Wanted*'. Infertile couple searching for tall (5'8" minimum), athletic, green eyes, brunette egg donor between the ages of 18-30. Preferably from Northern or Eastern Europe. Very discreet. Compensation: **$3,500**.' " [98] Swedish, tall, and green-eyed, Derek found a financial calling that would allow her to stay in the U.S. (as her savings were thinning), and she was sympathetic to struggling families trying to conceive.

Derek spent little time contemplating against what seemed like an obvious choice for her: "[w]hy become a waitress when you could become an egg donor?" [99] For her, "marriage and having kids weren't things high up on [her] to-do list in life."[100] As she confesses, what she desired was a career and boyfriend—"in that order."[101]

The critical factors in what would become a series of successful egg donations by Derek directly related to the power of relational intersections. Those intersections implicitly, if not explicitly, related to preferences motivating reproductive purchasers, particularly race, height, and eye color. Not to be overlooked, however, are the triggers that provide compelling tipping points for donors and sellers like Derek. For Julia Derek, a multiple-time ova provider, compensation mattered, but so did an understanding that her contribution was not like bartering a child[102] but rather, as she describes it, "like giving someone one of my hairs."[103] More importantly, Derek realized that her unique profile matched the preferences demanded by Americans seeking to create families through assisted reproduction.

Derek's personal journey into the realm of ART offers unparalleled insight into the relational tipping points in the demand-supply courtship of reproductive biologics. For example, racial relational preferences play out across ethnicities. Southeast Asians are

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95. *Id.*

96. *Id.*; *see also* Rainbow Flag Health Services, *Known Donor Insemination*, http://gayspermbank.com/index.html (last accessed Oct. 27, 2009).

97. Julia Derek, *Confessions of a Serial Egg Donor* (Adrenaline Books 2004).

98. *Id.* at 5.

99. *Id.* at 11.

100. *Id.*

101. *Id.*

102. Derek, *supra* n. 97, at 8.

103. *Id.*

reported to pay up to $100,000 for the right ova source, advertising near the campuses of Stanford and the California Institute of Technology.[104] To them, caste matters. Even amongst African Americans, relational preferences matter. When Dr. Jane Doe, a Chicago psychologist (and participant in the 2006 Baby Markets Roundtable), sought reproductive services, she specifically targeted highly educated, Ivy-League educated black women. As she learned during her search for the "right donor," other black mothers had chosen a similar path. She wanted a surrogate that matched her racial and academic background.

Among most women in the market for reproductive biologics, choice matters. If this is correct, what the reproductive market has gotten *right* is understanding and accommodating preference. A few years ago, the New York Times reported that just one of the more popular sperm banks, sent out nearly ten thousand vials of sperm per year to women across the country.[105] The demand for the California Cryobank's popular services reflects—in part—a growing use of human reproductive material. As well, California Cryobank ships out sperm categorized not only by race, but also for very selective preference shopping by education—and, in some cases, accent. As one U.S. Professor confidentially revealed to me, her donor matched very specific preferences not only by race, eye color, and hair color, but also vocal accent (the donor was British).

3. What the Numbers Reveal

Unlike organ procurement, which at best satisfies a slim fraction of demand, reproductive pools seemingly meet the needs of prospective parents. Consider that in 2001, 384 fertility clinics were reportedly in operation.[106] Those clinics reported performing 107,587 ART cycles to the CDC, resulting in 29,344 live births and 40,687 babies.[107] To be clear, not all of these births were the result of ova and sperm purchases.[108] However, 99% of the services used at those clinics were for in vitro fertilization, and nearly 16,000 cycles were from third-party ova providers.

Data from sperm acquisition is less conclusive as some women and couples bypass the clinic process and obtain this resource independently through other third-party means. Nevertheless, ova and sperm are increasingly acquired from third parties and most clinics respond aggressively to that demand.[109] In a 2007 CDC study, 93% of clinics reported providing services for procedures involving third-party eggs and 67% for third-party embryos. Most interestingly, 91% of their services are to single women.[110]

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104. The advertisements, some full page, have run in the Stanford University student newspaper. In one such ad placed by Families 2000, a reproductive service agency in Southern California, the physical and intellectual desires of would-be shoppers are very clear, with preference for a white, under 30 woman "and an athlete 'of proven college level ability.' " For an ova exchange from a woman matching those characteristics, $100,000 would be paid as well as all expenses. San Francisco Associated Press, *Couple Offers $100K to Egg Donor,* http://www.gettingpregnantbook.com/expensive_eggs_1.html (last accessed Nov. 19, 2009).

105. Egan, *supra* n. 82.

106. Ctrs. For Disease Control and Prevention, *Assisted Reproductive Technology (ART): Introduction to the 2001 National Report,* http://www.cdc.gov/ART/ART01/nation.htm (last accessed Nov. 1, 2009).

107. *Id.*

108. *Id.*

109. Tessa Mayes, *Students Sell Their 'Anglo-look' Eggs for Thousands on Internet*, Sunday Times (Aug. 10, 2003) (available at http://www.timesonline.co.uk/tol/news/uk/article862299).

110. Ctrs. for Disease Control and Prevention, *Assisted Reproductive Technology (ART) Report: National*

Most notable in the expansion of ART services were the number of clinics that emerged to further address reproductive demand. Between 2001 and 2007, nearly an additional 50 clinics opened and ART cycles increased by over 30%. According to the CDC's 2007 Annual ART Success Rates Report, (the most recent year for data compilation), "142,415 ART cycles [were] performed," which resulted "in 43,408 live births (deliveries of one or more living infants) and 57,564 infants."[111]

This data points to ART's significant popularity, use, and growth over the past ten years.[112] Such dynamics are not apparent in the organ transplant realm, despite twenty five years of federal oversight, data keeping, monitoring, and control. Nor can this be explained by the perceived less invasive aspects of ART. Ova donation, as it turns out, is far more involved than a kidney transplant; both require general anesthetic, but supplying ova necessitates daily hormone injections leading to the extraction. This process has been described as "ovary blasting," exponentially multiplying ova beyond a natural month's supply. And, ova exchanges far exceed the transfer of organs (i.e., more ova implants from third parties take place each year than organ transplants), although both spheres exact intimate biological exchanges.

Unfortunately, the organ procurement realm cannot make similar claims. Instead of expanding a third-party pool, organ procurement's rigidly conscribed supplier pool results in only partial success in the transplant realm. Critics suggest that comparisons between organs and reproductive supply are far too tenuous and inexact. They point to specific health distinctions, including that ova and sperm are regenerative, unlike kidneys where there is only one spare, not several or hundreds in the cases of ova and sperm. They explain that organ extraction requires sophisticated, invasive surgery, unlike sperm mining.

The parallels between reproductive demand and that of organs may not be exact, but are nonetheless informative and particularly compelling for those interested in saving lives through third-party organ exchanges. In both instances a health condition or impediment is overcome by the use of third-party biological supply. In the case of organs, that biological supply, such as kidneys, can save lives.

B. Demand for Babies

Babies and children represent a third category of demand for the intimate and biological, although generally not articulated as such. According to the Evan B. Donaldson Adoption Institute, an organization that collects data on adoption, 1.5 million children residing in the United States are adopted.[113] Each year, roughly a half million

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Summary: 2007, http://apps.nccd.cdc.gov/ART/NSR.aspx?SelectedYear=2007 (last accessed Oct. 27, 2009);*see also* Keith Alan Byers, *Infertility and In Vitro Fertilization: A Growing Need for Consumer-Oriented Regulation of the In Vitro Fertilization Industry*, 18 J. Leg. Med. 265, 275–76 (1997).

111. Ctrs. for Disease Control and Prevention, *Assisted Reproductive Technology: Home*, http://www.cdc.gov/ ART/ (last accessed Oct. 27, 2009).

112. *See e.g.* CDC 2002 ART Success Rates, *supra* n. 69, at 71; *see also* Anna Mulrine, *supra* n. 83 (reporting that a clinic in Las Vegas services infertile couples that have "traveled from out of state to try again.").

113. The Evan B. Donaldson Adoption Inst., *Overview of Adoption in the United States*, http://www.adoptioninstitute.org/FactOverview.html (last accessed Oct. 27, 2009).

women seek to adopt,[114] and although this population represents a decrease in the percentage of women seeking to adopt since 1973,[115] it nonetheless represents powerful evidence of baby demand. About 130,000 adoption attempts per year result in a couple receiving a child.

According to the National Center for State Courts, the demand for babies is not entirely satisfied domestically. In fact, the reporting mechanisms for domestic adoptions remain woefully inadequate, as states "are not legally required to record the number of private, domestic adoptions,"[116] and thus the "total number of adoptions each year has not been comprehensively compiled since 1992."[117]

Adoptions also involve a high level of negotiating that reveals relational thinking and decision-making. Some prospective parents will satisfy their desire for children by negotiating and adopting abroad. And an altogether different category of prospective parents, sympathetic to the plights of children in foster care, will adopt from that pool. But foster care adoptions represent only 15% of the total number of domestic adoptions.[118]

Interestingly, adoption represents converged demand and supply pools, though it tends to be viewed as unidirectional rather than bidirectional. In other words, children also exhibit a demand for parents, and wait for that interest to be satisfied by the right type of supply.

Of the three categories of demand articulated in this project—organs, reproductive (sperm and ova), and babies—adoptions fit a unique space, as more than half the U.S. population has some personal relationship to the process. Nearly 60% of Americans are personally connected to adoption—as they know someone who has adopted or is adopted.[119] Further, adoption politics are deeply contextualized. For example, adoption clearly inures a benefit to the child relieved from foster care, group homes, and other non-nuclear, non-committed living environments, and thus the imagery of "best interests for the child[ren]" would appropriately apply in most cases to those so fortunate to be adopted. Yet, adoption would mistakenly be described as being exclusively or primarily focused on relieving child suffering.[120] If such were the case, children in the United States would not languish in foster care while Americans choose to adopt from abroad. Between two ends of a spectrum, one representing child welfare and the other "adult

114. *Id.*

115. Anjani Chandra et al., *Adoption, Adoption Seeking, and Relinquishment for Adoption in the United States*, No. 306 Advance Data from Vital and Health Statistics of the Centers for Disease Control and Prevention, National center for Health Statistics, U.S. Department of Health and Human Services. 1, 5 (May 11, 1999).

116. The Evan B. Donaldson Adoption Inst., *supra* n. 113.

117. *Id.*

118. Victor Eugene Flango & Carol R. Flango, *How Many Children Were Adopted in 1992,* 74 Child Welfare 1018, 1024 (1995).

119. The Evan B. Donaldson Adoption Inst., *supra* n. 113 (stating, "[t]he Adoption Institute's 1997 Public Opinion Benchmark survey found that 58% of Americans know someone who has been adopted, has adopted a child or has relinquished a child for adoption" (footnote omitted)).

120. *See* Ruth-Arlene W. Howe, *Adoption Laws and Practices in 2000: Serving Whose Interests?* 33 Fam. L.Q. 677, 680–86 (2000) (noting that adoptions functioned as a child welfare model for abandoned, abused, neglected, and orphaned youth).

needs," the latter influences U.S. adoptions far more than imagined.[121] Instead, adoption is more accurately characterized as a means of creating families, and one that largely anticipates and fulfills adult desires.

As well, adoptions illustrate quite clearly the manner in which relationships and preferences associated with relationships, including age, gender, race, and religion, matter significantly to the acquiring parties.[122] Thus, adoption as an intimate biological market offers compelling evidence affirming both the interrogative and analytical thrusts of this project; Americans want to maximize relational preferences in the exchange of human biological supply. In the context of adoption, Americans are quite specific about the type of children they seek to bring home.[123]

Children adopted from abroad tend to be younger than children adopted from U.S. foster care. The Evan B. Donaldson Institute reports that 90% of the children adopted from abroad are under the age of five,[124] while more often than not, the children adopted from foster care are five years old or more.[125] Americans demonstrate relational preferences based on race. For example, white families articulate a stronger preference for white babies, and as a result pass over needy black babies and children in foster care.[126] Blacks also articulate relational preferences and relational exclusions. For several decades, the National Association of Black Social Workers (NABSW) lobbied against white families adopting black children.[127] Some scholars suggest that the demand for black babies declined after their efforts. Nevertheless, according to a recent study, white women expressed a preference for adopting a child with severe physical or mental disabilities rather than a preference for adopting a black child.[128]

Relational preferences are demonstrated by baby costs, too. White babies are in high demand, and as a result their adoptions command higher fees than their Asian, Latino, and black counterparts. Couples may spend upwards of $50,000 to adopt a healthy, white infant.[129] Black infants, however, are adopted for as little as $4,000.[130] Adoption agencies attempt to clarify this discrepancy by explaining that black children

121. *See* Michele Goodwin, *supra* n. 68.

122. Chandra et al., *supra* n. 115, at 4–5.

123. *Id.*

124. The Evan B. Donaldson Adoption Inst., *supra* n. 113 (International adoption data is for 1998); U.S. Dept. of Just.: Immigration and Naturalization Servs. Statistics Branch, *1998 Statistical Yearbook of the Immigration and Naturalization Service* 65 (Nov. 2000) (available at http://www.ins.usdoj.gov/graphics/aboutins/statistics/imm98list.htm) (citing table fifteen which compiles international adoption data for 1998).

125. U.S. Dept. of Health and Human Servs., *Children's Bureau, AFCARS Report: No. 6* 5 (June 2001) (available at http://www.acf.dhhs.gov/programs/cb/publications /afcars/june2001.htm) (foster care data is for 1999).

126. *See e.g.* Judith K. McKenzie, *Adoption of Children with Special Needs*, 3 The Future of Children 62, 65–66 (Spring 1993) (characterizing children of color as having "special needs" resulting in more difficult placement into an adoptive home).

127. *See* Natl. Assoc. of Black Soc. Workers, *Preserving Families of African Ancestry*, http://www.nabsw.org/mserver/PreservingFamilies.aspx (last accessed Oct. 27, 2009).

128. Chandra et al., *supra* n. 115.

129. *See* Bonnie Miller Rubin, *Adoption Bill Targets Legal Loopholes*, http://www.staterepsara.com/Press%20releases/Chicago%20Tribune_%20Adoption%20bill%20targets%20loopholes.pdf (last updated Mar. 27, 2005) (describing how the price of a [presumably white] American infant can "hit the $50,000 mark.").

130. *See* Dusty Rhodes, *Baby Trade*, http://www.illinoistimes.com/springfield/article-1823-baby-trade.html (last updated Feb. 17, 2005).

are more difficult to place than white children[131] and therefore the fees associated with adopting white children are higher. This analytical flaw could be characterized as a means of obfuscation, though it is true that black children wait longer for permanent placements.[132] Clearly, it does not cost more to do less. Adoption transaction fees reflect relational preferences, and thusly are not based *purely* on the labor and transactions involved.[133]

Adoptions are heavily influenced by market politics, including the valuing of babies based on factors such as ethnicity and race. This helps to explain why adoption fees vary across race and age. Thus, although white children are adopted very quickly, adoption agencies command the maximum fees for their placement, despite spending comparatively less time on their cases than international adoptions or attempts to place older children, or black babies. It would seem that *less work* would result in *less pay* and *lower fees*. Instead, fee structures based on race give evidence that adoption is subject to relational preferences that evince real power and meaning within the forces of supply and demand.[134] Fee structures that demand higher premiums for white babies and dramatically lower payments to adopt black babies and children are consistent with a market based approach in U.S. adoptions.

As the intuition of this project suggests, racial preference matters; bi-racial children also attract higher fees than black babies.[135] Why biracial babies are placed into adoption also reveals parenting preferences, and studying this could prove informative. Consequently, even though an "estimated 2 million American families" are looking to adopt, the majority will pass over black babies for children from abroad.[136]

If relationships matter in the supply and demand of intimate goods, should the law

131. *See e.g.* McKenzie, *supra* n. 126 (characterizing children of color as having "special needs" resulting in more difficult placement into an adoptive home).

132. *See e.g.* Carla M. Curtis & Ramona W. Denby, *Impact of the Adoption and Safe Families Act (1997) on Families of Color: Workers Share Their Thoughts*, 85 Fam. in Soc.: The J. of Contemporary Soc. Serv. 71 (2004) (stating generally that children of color wait longer in foster care to be adopted than do their white counterparts).

133. To the extent that discrimination was legally enforced and social values with regard to reproduction were delineated according to race and socio-economic status, adoption services were affected just as any other social institution. Thus, the best interest of young black children was limited to a model that restricted those adoptions to black families, a model that the National Black Social Workers Organization would later endorse. *See* Larry Elder, *Exporting Black/White Adoptions*, http://www.newsmodo.com/2005/02/28/exporting-black-white-adoptions/display.jsp?id=3811594 (last updated Feb. 28, 2005) (noting that "[a]ccording to the National Adoption Center, government still allows agencies to use variables to calculate the 'best interest of the child.' "); Jehnna Irene Hanan, *The Best Interest of the Child: Eliminating Discrimination in the Screening of Adoptive Parents*, 27 Golden Gate U. L. Rev. 167, 176–77 (1997) (describing the National Association of Black Social Workers' objection to interracial adoption as negatively affecting the formation of the child's racial identity). As a contemporary model, the disproportionately low adoption rate for black children in foster care gives some indication of the continued illusory nature of adoption as a specialized child-focused welfare service model. *See* Richard P. Barth, *Effects of Age and Race on the Odds of Adoption versus Remaining in Long-Term Out-of-Home Care*, 76 Child Welfare 285, 288 (1997) (noting that white children in the Michigan foster care system are three times more likely to be adopted than black children).

134. *See e.g.* Martha M. Ertman, *What's Wrong with a Parenthood Market?: A New and Improved Theory of Commodification*, 82 N.C. L. Rev. 1, 10 (2003) ("Children who are racial minorities, such as African-American children, are sometimes cheaper to adopt than white children, a differential that seems to turn more on supply and demand than on agencies expending more money to place white children.").

135. *See* Rhodes, *supra* n. 130 (describing how some adoption agencies charge more for biracial children than African American children).

136. *See 60 Minutes*, "Born in USA; Adopted in Canada" (CBS Mar. 10, 2005) (TV broad.).

have anything to say about it, and if so, what? For decades relational preference shopping explicitly by race has been ignored in the contexts of adoption, and some might argue that there are compelling reasons why the selection of a child's race should be left to the adopting parties even if it leads to significant social externalities, including passing over children who have waited longer in the nation's foster care system, reifying racial stigmas, and secondary problems related to children's prolonged stays in foster care.

Between the spheres of adoption in which race is explicitly considered, and organs where the federal government prohibits such considerations, a gap exists. Both organs and children derive from the biologic, but are treated differently for purposes of distribution. Is the discrepancy justified once placed in this context? An organ cannot comprehend that its de-selection or rejection was the result of relational preference, but a child might. This project proposes flipping the analysis—or inverting it a bit—to consider whether we should care at all about these very private transactions, and if for strong public policy reasons, we might wish to expand relational preferences to other domains of intimate goods.

III. RELATIONAL PREDICATES

Part III undertakes a very brief examination of relational theory. It does not attempt to survey the field,[137] as doing so would be beyond the scope of this project. Instead, this article offers two very distinct approaches to relational theory; relational theory as a negotiating instrument or space and relational theory as an analytical model to capture affinity group loyalty, attention, sympathy, and empathy.

This article does not claim that relational theory resolves or clarifies all demand-side problems. Nor does the ambition of this project limit itself to a thought experiment about the analytics of relational theory, as it does present an important pragmatic question—would the utilization of preference selection in organ procurement increase supply? The scope of this project is intentionally narrow and pragmatic. [138] Its claims about the muscularity of relational theory applies first as a question, and then as a tool for achieving equilibrium in specific types of markets. The section acknowledges the contours and diverse applications of relational theory.

A. Relational Theory As A Tool To Understand Legal Transactions

Relational theory is predicated on two distinct contributions to legal thought. First, relational theorists contend that the extra legal informs and influences the legal, meaning

137. The application of relational theory to socio-legal problems is quite extensive. *See* Craig Christensen, *Legal Ordering of Family Values: The Case of Gay and Lesbian Families*, 18 Cardozo L. Rev. 1299, 1414–16 (2007) (arguing that a relational approach to the jurisprudence involving same sex couples would bring about social justice). Relational theory has been applied to copyright scholarship. *See* Carys J. Craig, *Reconstructing the Author-Self: Some Feminist Lessons For Copyright Law*, 15 Am. U. J. Gender Soc. Policy & L. 207, 234 (2007) (arguing that "the legitimacy and success of copyright law depends upon a theoretical framework informed by feminist theory and capable of embracing the notion of the relational self/author and the principles of dialogism.").

138. Relational theory proponents embrace and apply the theory broadly, from contract discourse and feminist jurisprudence to race theory, physics, philosophy, anthropology and more. In each sphere, the term "relational" becomes a hybrid. This article does not intend to overlook the fine contributions of talented scholars plowing the fields of relational/relationship theory, as there is a growing and robustly emerging crop of scholarship in this domain.

that certain values and affinities inform how legislatures shape, courts interpret, and the executive enforces the law. Taken a step further, as this article does, *pareto superior* markets in the biological realm are not only marked by relational pairings, but to achieve equilibrium, relational preferences must be maximized. In the contexts of supply and demand of intimate goods, relational theory places a finger on what satisfies market demand.

In traditional legal contexts, relational theory purports that individuals' use of law is largely shaped by the contours of relationships. The two best known relational theorist, Carol Gilligan and Ian Macneil, hail from very different camps of the law, and, although Macneil would later replace "relational contract theory" with "essential contract theory" to describe his work, the substance of his approach to relational theory remains substantively the same.[139] His relational approach demanded attention to the factors beyond the language of contracts, suggesting they were important for the purpose of determining what the contract truly meant.[140] Macneil's approach destabilized conventional contract theory, but also gained an ardent following.

Macneil's relational approach relies heavily on *ex post* considerations of *ex ante* behaviors in an effort to achieve social justice in contracts. Yet, that formula often fails to offer much relief to those less capable of proving their *ex ante* intent. Nevertheless, the import of his contribution to contract law was that social justice or "getting it right" mattered as much if not more than terms the acting parties disputed.[141]

This was the hallmark of Macneil's scholarship, both disturbing conventional wisdom by suggesting that exogenous factors influence the formulation of contracts as much as if not more than the language of the legal document itself. Arguably, Macneil's scholarship in this domain revealed the relative weakness in what the law purports to accomplish. That is to say, if contracting does not truly reflect the terms reduced to paper, then predictability is certainly undermined. In short, Macneil's approach to relational theory was to suggest that contracts cannot be defined exclusively by what is reduced to paper. Instead, under his framework contracts are a matter of negotiations and subjective understandings between negotiating parties.[142]

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139. Ian Macneil, *Economic Analysis of Contractual Relations: Its Shortfalls and the Need for a "Rich Classificatory Apparatus*, 72 Nw. U. L. Rev. 854, 900–01 (1978). Macneil urged a view of contracts that attracted as many supporters as detractors, but offered keen insights into the formulation of contracts, or the sociology of contract-making. Macneil suggested that contracts form based on connections and relationships. Relational contracts are, in general terms, those in which the parties' obligations are not fully specified at the outset, as in the "classical" form of contract. Macneil, much like Stuart Macaulay, emphasized that contracts involved social behaviors and connections not reduced to writing. To Macneil and Macaulay, an ideal if not appropriate approach to interpreting contracts involves reaching beyond the language of contract to examine the actors, studying their interactions, how they negotiate, and the contexts in which they negotiated to achieve just outcomes. *Id.*

140. *Id.*

141. The inefficiencies and pitfalls inherent in Macneil's approach seem clear at the start, as he requires looking beyond the language of contract, which necessarily demands more resources, including time, money, and possibly third parties, while forcing courts to evaluate subjective intentions. Such an approach reveals itself to be counter-contractual in an instant. And employing more resources to interpret the true meaning of a contract will not necessarily result in desirable outcomes for contracting parties lacking resources. Thus, as a social justice project, Macneil's approach has its share of weaknesses. *Id.*

142. Macneil urged that lawyers, specifically contract scholars, would benefit from learning sociology, anthropology, and the psychology of contracts. After all, how would lawyers come to know what the parties expected from their contracts without having a more sophisticated set of tools to unpack the true intentions of

The starting point for most relational approaches is the conviction that social goals can be achieved by examining the relationship between negotiating parties, whether in tort, contract, family law, or constitutional jurisprudence. Feminist legal theory offers no exception to this approach and its conclusions.[143] Feminist legal scholars claim to employ relational theory as a tool to unearth meaning.[144] That is to say, their scholarship examines the interconnections between legal actors as a first step in determining what social justice would demand of the legal response.[145] The intersection of feminist legal theory and relational theory is concerned about how courts interpret what legal actors intended or should have intended across a sphere of legal doctrines.[146]

B. Relational Theory As A Tool To Understand Human Dynamics

Thus, a second distinct view of relational theory recognizes that it is predicated on the assumption that affinity group status engenders important values such as empathy, sympathy, attention, and understanding. In other words, feminist legal theory urges that (shared/similar) life experiences form the core of relational bonds. Feminist legal theory suggests that biology cannot be the exclusive site where relational bonds form. Rather, the social practices that define, construct, and enforce the status and liberty of women forges a bond between women based on similar life experience. Arguably, then, it is because of social history, cultural norms, and life experiences that women are implicitly biased in favor of other women. According to this approach, women bring a more universalized understanding of gender empowerment/disempowerment to most social and personal interactions. Girlhood or womanhood becomes a shorthand that permits (and expects) trust, loyalty, and confidence to emerge between women.[147]

Feminist relational theory presumes a kinship based on the implicit understanding—whether accurate or not—that most women and girls share a set of universal dynamics that essentially link them. And it is this supposition of shared experience and assumption that experiences are inherently interchangeable or fungible among groups that inspires empathy, sympathy, understanding, and attention. Most importantly, feminist relational theory emphasizes bi-directionality and mutuality as key components of the feminist relationship structure.[148] Feminist legal theory provides a compelling framework to understand what motivates and inspires trust, empathy, affection, sympathy, and attention from among members of that group. At its core,

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contracting parties? *Id.* at 893–94.

143. As a caveat, I recognize the potential for the conflation of legal ideas when examining feminist legal theory. It would be a mistake to characterize the intersection of feminist legal theory and relational theory as one well defined body of scholarship. To do so would be reductive.

144. Carol Gilligan, *In a Different Voice* 24–63 (Harv. U. Press 1993); Sharon Freedberg, *Re-Examining Empathy: A Relational-Feminist Point of View*, 52 Soc. Work 251, 258 (July 2007).

145. Stephanie S. Covington, *The Relational Theory of Women's Psychological Development* in *Female Offenders: Critical Perspectives and Effective Interventions* 113 (Ruth Zaplin ed., Aspen Pub. 1998) (arguing the importance of a relational critique in the criminal justice system, particularly as related to women).

146. *Id.*

147. *See* Virginia Goldner, *Toward a Critical Relational Theory of Gender* in *Gender in Psychoanalytic Space: Between Clinic and Culture* 63 (Muriel Dimen & Virginia Goldner eds., Other Press 2002). Goldner emphasizes that the dichotomized gender norm evolves from and is reified by "cultural practices and relational arrangements that construct and enforce" inequitable gender norms. *Id.* at 74.

148. Freedberg, *supra* n. 144.

feminist relational theory anticipates predictable life experiences that plot a course through a woman's life. This approach to relational theory accommodates both a social construction of gendered norms as well as the biological, both of which become intertwined at times. As to the biological, the presumptions are quite clear and unnecessary to capture and explore in excessive detail here; women's shared biology from puberty to pregnancy, labor, birthing, and menopause are unique to their gender (although not all women will ever become pregnant). To state the obvious, men cannot biologically experience any of these life occurrences. Presumably, these shared biological experiences inure a valuable understanding between women about those specific experiences.

Biological landmarks across women's lives do not occur in vacuums. Instead, they involve interactions with other people and institutions. In the case of a pregnancy, most women in the United States will give birth at hospitals after intense contractions of at least several hours. Part of this process will involve pain and chewing on ice chips—benign but relatable details acknowledged by women who have given birth. This process of living the biological embodies a unique social dimension often defined by cultural and social interactions that occur alongside biological landmarks. Biological experiences inform how women recognize and predict—emotional (pleasure, stress, joy, and anger) as well as physical (pain and relief)–experiences in other women. It is the relatable quality of the biological that forges sympathy and understanding.

Sharing mutual life occurrences advantages women over men in their capacity to intuit, offer support, and empathize with women navigating similar biological spaces. Relational theory is also predicated on the notion that social constructions and practices uniquely situate women. Feminist legal scholars offer historic examples such as coverture laws and the denial of a right to vote.[149] More recent examples such as employment discrimination (lower pay than male counterparts for similar work) and domestic work (caring for children and older relatives) are used to bolster the claim that social patterns that create social affinities based on gender are deeply entrenched in society.[150]

Aside from the framework's tendency to err slightly on essentializing women and the weaknesses in its long-term predictability, relational theory's constructive intuition is nonetheless apparent. The intuitional component of relational theory—that women will bond over similar life experiences—is a rational, reasonable hypothesis. Indeed, empirical evidence suggests that the intuition of relational theory in the feminist context is fairly accurate. And while it is reasonable to assume that as social norms change, the predictability of the life experiences of women will necessarily diminish, certain core features of society, biology, and law remain entrenched.

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149. See e.g., Reva B. Siegel, *She the People: The Nineteenth Amendment, Sex Equality, Federalism, and the Family*, 115 Harv. L. Rev. 947 (2002) (calls for restructuring of sex discrimination doctrine).

150. See e.g., Vicki Schultz, *Life's Work*, 100 Colum. L. Rev. 1881 (2000) (arguing for a restricting of paid work to allow men and women the chance to be equals in the workplace and in life); Vicki Schultz and Allison Hoffman, *The Need for a Reduced Workweek in the United States*, in *Precarious Work, Women, and the New Economy: the Challenge to Legal Norms* 131 (Judith Fudge and Rosemary Owen, eds., Hart Publg. 2006) (argues for universal measures that benefit all workers including women); Mary Becker, *Caring for Children and Caretakers*, 76 Chi.-Kent L. Rev. 1495 (2001) (responding to arguments within the care movement).

However, relational theory need not be complicated by, limited, nor shackled to a particular conceptual framework. In other words, it need not be defined as an exclusively feminist, gendered construction. To the contrary, groups shape affinities across defined categories of shared experiences religion, race, class, sexual orientation, and across conceptual, synthetic spaces, including organizational commitments, such as groups and clubs. Relationships are important to groups of people—and not only women.[151]

Indeed, the law grants status to relationships, as in the cases of families and marriages. In these spheres, courts and judges recognize (legally and symbolically) the status of "relationships" as nearly on par with that of the individuals comprising the relationship. Beyond its efforts to respond to the best interest of children, a principle concern of family law urges the preservation and promotion of the family relationship. Equally tort law manifests respect for, and concerns about preserving relationships; family immunity doctrine provides a muscular example of civil law's interest in relationships and family matters by limiting disgruntled and aggrieved persons' ability to litigate against family members. Criminal law's effort to privilege and protect communications between spouses also acknowledges law's respect for and intuition about relationships forged by marriage.

The weaknesses in relational approaches to legal problems are obvious, as societies might rightfully be in conflict over what values actually matter most in interpreting contracts, constitutional law disputes, or family law matters. Thus criticism of the relational approach cannot be dismissed. A rightful and fruitful critique of relational theory cautions against essentialism and the pitfalls of communitarianism—or believing that everyone holds shared views within a given community or society.

However, it is difficult to ignore the saliency of shared life experiences between groups (relationships) and the strengths and nuances of those bonds to matters of law and society, including contracts, family law, and potentially other matters where the law serves to mediate disputes or negotiate resources, including organ supply and demand. Context matters. In this domain it becomes quite clear that affection, affinity, and bonds of friendship, loyalty, trust, and cooperation matter most.

IV. RELATIONAL MARKETS AND INTIMATE SPHERES: THE CASE FOR KIDNEYS

This article makes several claims. First, affinity relationships matter and carry significant power in human biological spheres. Second, markets maximize access to relation-building. Third, affinity preferencing creates ideal, relational markets. Lastly, individuals are more inclined to participate in biological exchanges when their preferences are maximized. In other words, individuals shape their preferences according to relational norms and utilize the market to further specific types of relationship building. Research confirms the underlying assumptions of this project: choice matters, including the option to exercise relational preferences.

Part IV applies the article's intuition to organ supply and demand. It makes the

151. *See* Mary Becker, *Caring for Children and Caretakers*, 76 Chi.-Kent L. Rev. 1495 (2001); *I Love You Man* (Dreamworks 2009) (motion picture).

case that organ supply would likely increase among groups where demand is greatest if the ability to maximize by relationship were institutionalized. Specifically, the article hypothesizes that choice without penalty, to designate the recipient (or recipient group) of organs, would increase supply. This section also acknowledges the potential for push back against institutionalizing preference maximization along affinity lines. The project urges a nuanced approach to affinity preference maximization to overcome the negative social impacts that can result from relational shopping.

A. Why A Relational Approach To Organ Transplantation?

Why a relational approach to organ transplantation? Numerous empirical studies reveal serious weaknesses in the current, altruistic system of organ procurement. Researchers describe the U.S. transplant system as one that fails to generate an adequate supply of organs to satisfy a growing demand. Deaths, delays, and a growing lack of confidence in the U.S. transplantation system are, they argue, the inevitable outcomes. The U.S. transplant system is characterized by distress and inefficiencies. Procurement efforts are tethered to unsuccessful publicity campaigns and slogans to promote organ donation. These problems are more acute among African Americans, who comprise a third of the kidney transplant waitlists, wait longer than all other groups, and suffer the highest death rate among all groups. Thus, resolving organ demand among African Americans would significantly reduce patient suffering and considerably ease transplant waitlists.

After twenty-five years, Congress continues to predicate organ transplantation on prospective donors' blind, altruistic contributions to the organ pool. This experiment results in significant inefficiencies and externalities with catastrophic consequences. The sad reality that over 80,000 Americans wait for kidneys unlikely to ever materialize pales in comparison to more than a quarter million patients on dialysis that would benefit from an organ transplant. Preemptive rationing, including the utilization of a non-uniform process in determining who qualifies for an organ transplant, serves to artificially narrow the list of registered kidney patients. Thus an already skewed demand-supply ratio happens to be far worse than what the waitlist purports.

The U.S. transplant regime problem relates directly to input. Too few organs come into the procurement system and thus, supply cannot satisfy demand. Thousands will be terminated from the U.S. waitlists this year because they became too old or sick.[152] Others will succumb to preventable deaths because organs did not materialize in time.[153] The current federal organ regime is marked by extended delays and high rates of death. Yet the problem could be resolved quite simply by increasing organ supply.

However, this excessive resistance to value-based donations likely serves as the most significant impediment to organ procurement by members of Congress. Currently, Congress bans organ sharing based on valuable consideration.[154] Indeed, the National Organ Transplant Act (NOTA) imposes criminal penalties and fines on those persons willing to exchange an organ for remuneration or considerations as innocuous as a cup of

152. *See generally* Goodwin, *Black Markets*, *supra* n. 19.

153. *Id.*

154. *See* Pub. L. No. 98-507, 98 Stat. 2339 (1984).

orange juice or a spa treatment. Some scholars argue that this Congressional approach spares the poor from being coerced and limits their exposure to greedy patients needing organs. However, NOTA also prohibits a donor's estate from receiving assistance to bury the donor or pay her medical bills.

Unpacking the supply-side question illuminates the serious weaknesses in our legislative approach to organ procurement. Altruism is not enough. Blind considerations do not inspire organ donation at a rate necessary to make a reasonable dent in the demand for organs. For these reasons, this article hypothesizes that sensitivity to relational dynamics might help to overcome the bias against donation. Specifically, allowing relational transfers for organs will likely reduce organ demand.

B. Affinity Maximization

At the most obvious level, relationships situate individuals within communities, institutions, and even families. A relational approach may allow us to "predict new ways of seeing [the] law."[155] Most importantly a relational approach may sensitize us to what drives certain markets, what will sustain others. Or it may give warning—a clarion call of sorts—about market failures and externalities that we may wish to avoid.

This article calls attention to a more dynamic view of relational theory, one that recognizes what motivates exchanges in intimate goods and asks what can be learned from that. Thus at its core, the project does not make a statement about, nor is it concerned with gender relations, race relations, or other relationships as between parents and children *per se*. Rather, the purpose of the relational model critique or application here is simply that relationships and affinities matter to some participants conducting intimate exchanges. It happens that those who most seek (or desire) to acquire certain intimate goods such as ova and organs, happen to be represented among groups typically considered marginalized (women and blacks). If this is true, a relational theory approach can enhance understanding of how markets function, specifically intimate markets.

There are questions for the law in this domain. For example, should the exclusion of others in relational exchanges be an issue for the law to do anything about? Should the desire of blacks to share their kidneys primarily among themselves cause pause? What about the preference shopping of white baby shoppers to primarily adopt only white children—should the law care about that and if so, why or why not?

Interestingly, discontent over markets does not capture these issues. Backlash against markets at times flows from the very communities that demand intimate exchanges of the kinds that are the subjects of this project. Often, the language of markets is not used as opponents in these contexts prefer to define or mischaracterize these exchanges as purely altruistic—only with service fees attached. At other times, resistance to markets is dominated by a type of paternalism that seems difficult to take seriously, particularly when it assumes that women and minorities lack sophistication and are incapable of navigating intimate exchanges in the marketplace (i.e. blacks would handle compensation for organs irresponsibly and therefore should never receive an incentive for sharing an organ). Ultimately, the critical question to explore is who might

155. Victoria Nourse, *Law's Constitution: A Relational Critique*, 17 Wis. Women's L. J. 23, 28–29 (2002).

benefit from and who is likely to be harmed by relational markets? In this context, a relational market need not be contingent on economic exchanges. Instead, bartering across affinity status, for purpose of this project, constitutes market participation.

1. Markets

Typical markets have certain features. Market players assume that there are numerous parties on both sides of the market, believing that there are broad trading options. In addition, as Richard Epstein points out, there are two additional features of competitive markets: 1.) full information about the relevant goods, and 2.) that the legal system supplies perfect enforcement of basic exchange obligations.[156] Missing is an understanding of what motivates these exchanges, information vacuums, and insider buying—essentially the use of preference and choice.

In the realm of intimate goods, there are market/exchange constraints, which often force buyers and sellers into greater stigmatized markets. Consider the criminal trials of two couples from the United States currently being prosecuted in Egypt.[157] Their plight reveals two important issues for purposes of this project. The first is the robust demand for children. That the demand is being satisfied with a financial exchange indicates the existence of a market. The second important issue to recognize in the Egyptian adoption cases is the constraints on markets in intimate goods. Buyers will go underground *because of* or *when* legal conflicts exist or stigma is high. Thus markets in intimate goods tend not to operate like typical markets. And this may be good and bad.

As Epstein points out, "often the . . . assumption" that governs markets, is that they deal in fungible goods.[158] This is very often not the case. The assumption Epstein refers to is that the goods are of quality, but also of equal aesthetics. This is less true in markets of intimate goods. For prospective buyers, not all intimate goods are fungible.

Intimate goods are valued differently depending on relationships or perceived affinities or affection to the goods. Thus, we value intimate goods differently based on gender, religion, race, class, and other values. This may be a good thing if what the supplier provides has relatively strong value within the market. It can be perceived as a bad thing if some exchanges suffer or do not come to fruition because the value of the good is based on its gender or race and that particular gender or race happens to not be in demand. This may matter less when the bargained for items are sperm, ova, and embryos, but it takes on a different meaning when we speak of children.

But Epstein also urges caution with the lexicon of exchanges. To him there is an imprudent rush to presume that markets are in operation whenever individuals are engaging in voluntary exchanges as buyers and sellers.[159] In this way a one-time ova seller is not really a market player—she is the occasional, casual participant. The same

156. Richard Epstein, Keynote Lecture, *In Cautious Praise of the Commodification of Genetic Materials* (Chicago Apr. 4, 2008) (available at http://www.law.uchicago.edu/lawecon/events/commodities.html).

157. Cynthia Johnston, *Egypt Court Jails U.S. Couples Over Illegal Adoptions*, http://www.reuters.com/article/domesticNews/idUSTRE58G2M720090917 (last updated Sept. 17, 2009) (on September 17, 2009, in a much publicized case, an Egyptian court sentenced two American couples to two years in prison for allegedly buying babies in Egypt).

158. Epstein, *supra* n. 156.

159. *Id.*

will be true with organ donors—*one heart is all you've got to give*—and that should hopefully be at death. The benefit of the market is that there is greater protection for the single transaction users—on both ends.

It is also worth thinking about the intersection of morale, trust and markets. When morale and trust are low in intimate exchanges—fewer of them will occur. Harriet Washington provides a sophisticated treatment of this issue as it relates to African Americans and medicine. [160] Washington documents a troubling history of medical abuse and exploitation targeted at African Americans, including nonconsensual medical experimentation and lack of full disclosure in medical trials.[161] The Tuskegee Syphilis Study ranks among many that Washington and other scholars document on this point.[162] In that study, illiterate African American sharecroppers were unwitting subjects in a medical experiment to document the ravages of syphilis on their bodies. Thus, while they believed the pink pills they received from doctors were to treat syphilis, instead the tablets were placebos. The impact of that medical experiment and others, according to Washington, continues to undermine trust and loyalty in the medical profession for African Americans.[163] However, relational markets could help to overcome that internal group bias against the medical profession.

During the years 2002 through 2004, an empirical survey of 588 African Americans assessed their perception of the current altruistic donation system for organ transfer (African American Organ Transplant Study I "AAOTS I").[164] The study evaluated whether the existing differential between American approval of organ donation and donor registration was due to registration obstacles alone, or rather to a more general, but overlooked, "breach of confidence and lack of trust in the current transplantation and procurement systems."[165] The study was followed by forty in-depth qualitative interviews (African American Organ Transplant Study II, "AAOTSII"). Combined, the two studies revealed a more subtle race tension that exists when African American's interact with the current organ procurement and allocation system—"participants perceived the altruistic process to be manipulative and a veiled effort to sacrifice African Americans to save White Americans."[166]

Sophisticated study participants, including a banker, physician, nurse, and school teachers, shared similar doubts and perceptions about the efficiency and fairness of the U.S. transplant system as their working class counterparts. In sum, they believed that a bias plagues the transplant allocation system, if not by race, then by socio-economic status.[167] Study participants were generally cynical about whether the UNOS allocation

160. *See* Washington, *supra* n. 21.

161. *Id.*

162. *Id.* at 157.

163. *Id.* at 157–85.

164. Goodwin, *Black Markets*, *supra* n. 19, at 49–53.

165. *Id.* at 48.

166. *Id.* at 49.

167. Interview with D.B. (Nov. 21, 2003). D.B., a school teacher, believed that African Americans were lower on the transplant waitlists because of their "socio-economic situation." *Id.* D.B. also thought African Americans should be paid to donate their organs because of this. *Id.* He went further to say financial incentives might be ok if it provided a "means of breaking a horrific cycle which your family may be in as far as economics are concerned and you wanted your children to have a better chance at life to be on the same playing field as our white counterparts, I think that it will be a decision that I would make without

system benefits African Americans. Some of the participant responses verged on mild hysteria; one participant suggested that "efforts to encourage African Americans to donate were part of a conspiracy 'because they were going to use Black people as spare parts . . . when White people are sick . . . they'll have a means to get their organs.' "[168] It became clear in the study that blacks perceive a lack of choice and control in the altruistic process. D.B., a Chicago area school teacher, underscored the point about relational bonds mattering in organ exchange. He urged blacks to "stay[] together as a people," implying that African Americans should be able to determine the recipients of their organs.[169] Allowing for potential donors to control the racial, cultural, religious, or gender of their recipient may be one way in which an organ transfer system can provide this type of control. Further data from the AAOTS I and II studies suggest the same:

> For example, in AAOTS I when survey participants were asked whether they are registered to donate, only 36% answered affirmatively. However, when asked whether they would be willing to donate if the recipients were Black, over 58% answered positively. Thus, the concept of organ sharing is not the problem; fewer than 10% of those surveyed opposed donation. Indeed, Blacks were more willing to donate when they believed African Americans would be treated equitably in both the procurement and allocation process.[170]

The critical issue for African Americans in organ transplantation may be "control," or the perceived lack of it. As one participant concluded after being asked whether mandatory donations would benefit African Americans, "no, because they are going to give it to the white person."[171] This participant suggested that even poorer, working class white Americans would be privileged with receiving organs over their African American counterparts.[172] Another African American teacher, Y.C., attributed present organ donation among African American to the desire to save the lives of blacks. According to Y.C., African Americans participate in organ donation, "because they want to insure that African Americans get the organs that they need."[173]

2. Relational Markets, Organs, and a Thought Experiment

At the heart of this project is a desire that the current transplant process become equitable, efficient, and effective. Despite some progressive efforts, achieving the "Three Es" has eluded policy makers and UNOS, the organization that governs transplant policy in the U.S. Achieving the Three Es may not be as complicated as some might suggest. However, better success in the organ realm might require borrowing methodology and practice from other domains such as ART, improving upon those practices, and strict monitoring so that negative social impacts do not come to define

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hesitation . . . ."

168. Goodwin, *Black Markets*, *supra* n. 19, at 50 (footnote omitted).

169. Interview with D.B., *supra* n. 167.

170. Goodwin, *Black Markets, supra* n. 19, at 52.

171. Interview with S.B. (Nov. 21, 2003). S.B. was 34 years old at the time that she participated in our study. She was clear to acknowledge that she would readily surrender a kidney to a relative, but seemed very mistrustful of organ donation in general because she believed African Americans would more likely be passed over on the allocation side.

172. *Id.*

173. Interview with Y.C. (Oct. 27, 2003).

organ transplantation. Maximizing organ sharing through relational transfers could maximize saving lives and in the process remove stigma associated with affinity based sharing. Until now, pushback on affinity related accommodations were in direct response to the institutionalized subordination of women and blacks. Employment discrimination or exclusions were practices emanating from a vile racial history, and certainly were not programs to save the lives of dying individuals. Rather, they were motivated and carried out by animus.

This project highlights that responding to relational building is inspired less by an attempt to discriminate, but more by a collective sense to help a member in a group to acquire a needed resource that would not likely come available (voluntarily) from any other source. Thus, if religious groups, sororities, or fraternities, or groups of professors decided to share organs among themselves, this effort would not fall on the repugnant end of a spectrum. To the contrary, their efforts would appear morally good and the moral social impact would appear neutral. Here is why.

In 2008, almost 50,000 people added their names to organ waitlists.[174] Waitlist addition increases an average of 10% per year.[175] Yet, fewer than 16,000 organs became available for transplant in 2008, an increase of less than four percent from the year before.[176] The organ supply conundrum cannot be resolved by increased government spending for advertisement campaigns promoting organ donation, because such efforts appear to do very little in creating an equilibrium in the demand and supply matrix.[177]

At present, potential organ donors must respond positively to a single binary question in order to become an organ donor: do you wish to become an organ donor.[178] This question exposes the lack of choice in the transplant system. Either a prospective organ sharer agrees to that rigid option (in a system mired by efficiency problems and race disparities) or the potential donor refuses to donate at all.

The constrained option approach cannot fit within a relational framework. Choice matters, but the mechanics of how it is facilitated is not the primary concern of this project. An approach as simple as checking a box indicating affinity preference could suffice.[179] More sophisticated measures could be implemented utilizing technology and

174. *See* OPTN, *Waiting List Additions by Ethnicity,* http://optn.transplant.hrsa.gov/latestData/rptData.asp (last updated Nov. 13, 2009) (choose category "waiting list additions" and organ as "all" and count "candidates" and select "organ by ethnicity.").

175. *Id.* The percent calculation was performed by dividing the marginal increase in individuals added to organ waitlists over the total number of yearly additions. The result was then multiplied by 100%.

176. *See* OPTN, *Donors Recovered in the US by Donor Type,* http://www.optn.org/latestData/rptData.asp (last updated Nov. 13, 2009).

177. *See generally* H.R. Subcomm. on Oversight & Investigations of the Comm. on Energy & Commerce, *Assessing Initiatives to Increase Organ Donation*, 108th Cong. 36 (June 3, 2003) (see prepared statement of Richard M. Devos: "[e]ducational campaigns, advertisements, enrollment drives, and all the methods tried up to now have yielded less than 40% of the population signing, where available, on the back of driver's licenses or donor cards, and proportionally even less people joining potential donor organizations.").

178. Some states also allow organ donors to specify which organs they are willing to donate. *See e.g.* Conn. Dept. of Motor Vehicles, *Donor Registration Card,* http://www.ct.gov/dmv/lib/dmv/20/29/B-142.pdf (last accessed Nov. 19, 2009).

179. Instead of a single question, donor registration forms could also ask respondents to select a desired recipient race, if any, by checking one of several boxes. Alternatively, an individual could simply indicate in writing the desired race of their organ recipient. Individuals who do not wish to select a racial preference for their organ recipient could abstain from doing so either by affirmatively checking a box indicating this preference or by failing to specify a racial preference after indicating their desire to become an organ donor.

maximizing privacy to avoid stigma associated with checking off relational preferences.

For example, private organizations, such as Matchingdonors.com,[180] provide living donors the ability to go online and select their organ recipient. Profiles of individuals awaiting organ transplants include pictures and personal histories. Implicitly, if not explicitly, selection on the basis of affinity preferences is possible. This venue allows living donors to foster relationships otherwise not available through anonymous altruistic donation. And although financial considerations are absent from exchanges through Matchingdonor.com, donor pairs participate in a process that has life-saving value.[181] Building affinity through this process only enhances the forming of bonds and building trust and confidence in the transplant system.

Should the law treat affinity donations based on social group affinities such as sororities, fraternities, or special clubs versus race differently? Not necessarily. Allowing for racial preferences during donor registration may save lives, foster a relational connectivity between donors and recipients, reduce national and state health care costs, and restore families. These same positive dynamics exist whether the affinity is based on religion, race, gender, or book club. Thus, an affinity-based policy in organ transplantation (or blind omission to affinity preferencing) should not be rebuffed simply over concerns regarding the use of race, gender, or religion as selection criteria.

This project does not attempt to map what or how affinity exceptions might be built into state and or the federal model. States are theatres of experimentation and can contour exchanges that fit within a measured rubric. But, here are some initial thoughts. Affinity grouping incorporates particular aspects of an organ transfer system based on free market principles. It supplants government decisions with those of "market participants." To increase HLA matching, individuals could utilize affinity as is facilitated in reproductive markets where participants exercise preferences for race, athleticism, IQ, or other characteristics when working with sperm banks or acquiring ova directly from donors.

Some may argue that the proposed use of racial preferences to incentivize organ donations will reveal or create nefarious distributional consequences. To this end, scholars fear that white donors, who comprise the largest percentage of organ donors currently,[182] will use racial preferences to restrict their donations to only white individuals. As a result, they caution, greater inequality in organ allocation will occur among racial groups than is present within the current system. The gravity of such concerns should not be dismissed entirely, yet should be treated with measured reasoning and answered with empirical data. Empirically, the argument itself is unpersuasive.

Given no increase in absolute number of organs donated, if 50% of kidneys procured from blacks are directed to black recipients and only 20% of kidneys donated

180. *See* MatchingDonors.com, *Organ Donors, Organ Transplant, Organ Donor Services*, http://www.matchingdonors.com/life/index.cfm (last accessed Nov. 19, 2009).

181. *See id.* Patient and Donor profiles and stories available on front-page of website. To the extent that the donor receives existential benefits, "giving the gift of life" is not an entirely selfless act. Value is exchanged; it is simply non-pecuniary in nature.

182. 10,190 of the 14,755 donors in 2006 were white. 2,061 of the 14,755 donors were black. However, blacks represent 28.2% of those individuals awaiting organ donation. Data includes both living and cadaver donations. *See* OPTN, *Donors Recovered in the US by Donor Type*, http://www.optn.org/latestData/rptData.asp (last updated Nov. 19, 2009).

from white donors are directed to white recipients, the allocation ratio of black kidney recipients to white kidney recipients changes to 0.463. Unsurprisingly, this ratio increases as the percentage of kidneys directed to black recipients from black donors increases and the percentage of white within race donation decreases. Thus, even without increasing the actual number of kidneys distributed, a gain in social equity is possible by allowing some amount of directed allocation.

If allowing directed affinity donation on the basis of race does, in fact, incentivize blacks to participate as organ donors, then the picture crystallizes. Assuming that black participation rates increase to the national average for minority populations[183], and assuming that black within-race directed donation was perfect (100%), then organ allocation equity would increase even if 95% of white donors directed their organs to white recipient.

B. Tolerating A Bit of Discrimination?: Law, Economics, and Social Impacts

Affinity grouping in organ exchanges raises policy questions as to how much our society should tolerate preferences and whether all forms of discrimination are necessarily bad or illegal. In the context of ART, affinity grouping or matching has a socially neutral impact. Creating children that look like their parents is not an issue that deserves serious critique. Scholars are more concerned with sophisticated technologies such as pre-implantation genetic diagnosis (PGD), which allows parents to select amongst embryos certain characteristics they might desire to prune from the bunch, such as a particular gender, eye color, or inheritable genetic disease. Some scholars caution that PGD can be a slippery slope leading to eugenics practices. An attentive eye to PGD should not be discouraged—on a scale it represents the maximization of choice in the ART realm and thus would be (on a scale) closer to the point of creating social impacts, although not completely there.

Preference shopping in adoption raises a different set of concerns than ART and organs. In the adoption domain, states allow individuals to pass over children who need homes in order to select for race, gender, and age. One might suggest that this disserves a broader social and economic agenda to remove children from foster care and compromised living conditions. The social impacts here relate as much to exacerbating the stigmatization of children who are left behind and considered unworthy as to the privileging of an image of children in demand. In this context, children in demand could be perceived as more socially valued within our society. These issues are addressed in finer detail in prior works.[184]

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183. Participation rates are based on the study conducted by the Gallup Organization for the Division of Transplantation Health Resources and Services Administrations. *See* OrganDonor.gov, *2005 National Survey of Organ and Tissue Donation Attitudes and Behaviors*, http://www.organdonor.gov/survey2005 (last accessed Jan. 21, 2010) (reporting that 61% of whites, 31% of blacks, and 52.7% on average grant permission for organ and tissue donation on their driver's licenses).

184. *See* Michele Goodwin, *The Free-Market Approach to Adoption: The Value of a Baby*, 26 B.C. Third World L. J. 61 (2006).

> To the extent that those individual decisions can negatively impact society–economically, morally, or burden social services, the state arguably has a role in regulation. In the context of adoption, individuals make choices that can have significant implications for a broader society, about which society should be concerned.

Here are some initial thoughts to be fine tuned, further massaged, and recalibrated over time regarding organs. First, given a choice to direct donation by affinity—or in the contexts of organs by race, greater equality in organ allocation is possible even without a corresponding increase in overall donor number. In this project, the proposal is not to incentivize organ sharing by paying for it, which distinguishes this type of affinity based preference shopping from that in ART or adoption because no funds change hands. On scale, this minimizes some of the social pushback that might result from implementing a plan such as this. Notwithstanding, organ patients are uniquely situated within these biological frames and it is only in this context where lives are saved, so even recognition of an affinity based exchange through a tax break or a financial perk falls more neutral on scale than current ART and adoption practices.

Secondly, the inclusion of racial preferences is likely to stimulate organ donation to recipients of color. African Americans, who do not donate as frequently as whites, might be incentivized to donate their organs to black recipients.[185] Third, assuming all other racial groups donate organs at the same rate, an increase in the absolute number of black organ donors can both increase the absolute number of transplantable organs and decrease the inequity of the current organ allocation system. Fourth, it is unlikely that the altruistic white donor who contributes without preference to race currently will make animus-based racial decisions simply because the opportunity is available. Finally, even if the use of racial preferences incentivizes certain non-black individuals previously unwilling to donate to give organs to other non-black patients, the net impact will be positive for people of color awaiting a transplant.

The most salient objections to affinity transplants converged on the point that racial harmony might be impacted by donors selecting recipients by affinity. But such arguments ignore the fact that current efforts at transracial, colorblind organ transplants do not foster racial harmony. Indeed, organ transplants are not intended to create racial harmony in our society—such is not their function, goal, or medical objective. Contemporary transplantation, however, does add to racial anxiety because of the disparities that persist within the current system.

Might affinity preferencing help blacks overcome disparities within the current color-blind system? In addition to deaths resulting from unmet organ demand in black communities, the disparate impact of organ allocation creates economic consequences. For each African American on dialysis, his or her family suffers the economic

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> If the byproducts of free adoptions are two-tiered racial systems or racial hierarchies, it is an issue worth greater social scrutiny. Beyond race, society might also be concerned about middle class whites (and other groups) being priced out for white babies, which has a double negative effect. [If] the market responds only to the highest bidder with regard to white babies, it is possible that white babies will only be placed with wealthier families. The problem created by the free market [adoption] is the legitimization of a troubling normative view that adoption should only be among the wealthy and ignoring the class diversity in the United States, which could have a deterrent effect on "class diverse" adoptions.

Id. at 75–76.

185. African American philanthropic preferences may more closely align with church affiliation rather than race. *See* Alice Gresham Bullock, *Taxes, Social Policy, and Philanthropy: The Untapped Potential of Middle- and Low-Income Generosity*, 6 Cornell J. L. & Pub. Policy 325, 350 (1997) ("Historically, the Black church has been the core of philanthropy in the African American community."). This suggests that religious, rather than racial, preferences are a more appropriate "framing" to incentivize black organ donation.

consequences of that lost income. The ripple effect of that economic loss extends to their communities, both through a loss of taxable income for local infrastructure, including schools, and through a loss of philanthropic donation to community organizations, including churches, community centers, and fraternal organizations. These losses are not insignificant as they happen to be critical in sustaining healthy, well-functioning, safe communities.

African Americans have considerable spending power, and the economic potential of their community has the power to increase. In 2003, black spending power was estimated at $656 billion dollars,[186] a figure comparable to the gross domestic product of the twentieth wealthiest country in the world—the Netherlands.[187] In 2006, black spending power was estimated at $799 billion dollars,[188] a figure comparable to the GDP of the eighteenth wealthiest country in the world—Australia.[189] Moreover, the projected percentage increase in black purchasing power is greater than that of the overall purchasing power in America.[190] In turn, not only is the economic value of a black person significant to the American economy as a whole, it is becoming more valuable each day.

Given that the black population of America is roughly 38.3 million, the GDP per capita of an African American in 2004 was $17,728.[191] Even when completely discounting costs saved from medical care and dialysis treatments, removing just 1,000 blacks from organ waitlists each year could add $17 million in purchasing power to the U.S. economy. If 5,000 organs are successfully transplanted, over $80 million in purchasing power would be added to the U.S. economy. In addition, considering the federal savings from removing blacks from dialysis, roughly $60–90,000 is saved per year, per African American patient.[192] Again if only 100 African Americans were removed from dialysis, $6–9 million dollars is saved in the first year. Over five years, the savings multiply up to $45 million dollars by simply removing 100 African Americans from dialysis. Consequently, removal from and successful transplantation of 100 black dialysis patients could result in a net economic gain of $46.7 million.

More importantly, transitioning African American patients off of dialysis allows them to regain their lives and economic potential. The costs of dialysis extend beyond financial—they impact daily, family, and community life. Treatments usually require at

186. *See* Target Market News: The Black Consumer Authority, *Consumer Expenditure Data: From "The Buying Power of Black America,"* http://www.targetmarketnews.com/buyingpowerstats.htm (last accessed Nov. 19, 2009).

187. *See* Central Intelligence Agency, *The World Factbook: Country Comparison–GDP (Purchasing Power Parity)*, https://www.cia.gov/library/publications/the-world-factbook/rankorder/2001rank.html (last accessed Nov. 19, 2009).

188. *See* Vicky Eckenrode, *Sway at the Supermarket: Minorities in Florida and Georgia are Spending Record Amounts*, Fla. Times-Union D1 (Sept. 1, 2006).

189. *See* Central Intelligence Agency, *supra* n. 182.

190. *See* Jeffrey M. Humphreys, *African-American Buying Power by Place of Residence: 1990–1999*, 58 Ga. Bus. & Econ. Conditions 1, 1–2 (Jul./Aug. 1998).

191. GDP per capita is calculated by dividing the GDP for African Americans by the number of African Americans in the United States. In 2004, this meant dividing 679 billion by 38.3 million.

192. *See e.g.* Michael J. Lysaght, *Maintenance Dialysis Population Dynamics: Current Trends and Long-Term Implications*, 13 J. Am. Socy. of Nephrology S37, S37 (2002).

least three days per week and several hours each session.[193] Thus, both quality of life and work potential are significantly diminished.

There is also reason to believe that such numbers are under-estimates. Transplantation is not only the optimal medical treatment but also the most cost-effective treatment for patients suffering from kidney failure. The federal government funds both dialysis treatment and transplantation procedures for almost all Americans.[194] Yet, after assuming such burdens, the Health Care Financing Administration noted that transplantation was the most cost-effective means of treating patients with irreversible kidney failure.[195] Medicare direct dialysis costs routinely exceed $55,000 per patient, per year. Not surprisingly, congressional efforts to legalize paired kidney donation, which may spur transplants, are estimated to save $500 million dollars over a 10 year period.[196]

V. CONCLUSION

This project urges a rethinking of transplant policy to specifically allow for ties of emotion, affection, and more explicitly religion, race, gender, and other groupings to serve as a "market" to meet organ demand. But here, I've placed the cart before the horse. There remains the question as to whether there should be any markets in intimate goods; whether such markets obstruct the law or how we believe the law should be—if we had thought that far ahead. Richard has observed that the recent cries of "commodification" do not point to "how market institutions introduced standardization that makes voluntary exchanges possible," rather, the contemporary parlance, "has exactly the opposite valence."[197] Here the contemporary cries are an effort to "explain why those supposed efforts at standardization and voluntary exchange, especially for valuable consideration, run against the moral grain."[198] Further, contemporary observations about markets in intimate goods urge the prohibition of such exchanges, evoking images of abused and coerced poor people, exploited women, and manipulated minorities.

However, what is missing from that discourse is that women, poor people, and minorities might indeed want to participate in intimate markets. That in fact, their

193. *See* Stella L. Smetanka, *Who Will Protect the "Disruptive" Dialysis Patient?* 32 Am. J. of L. & Medicine 53, 54–55 (2006).

194. Congress intended "to provide *access* to life-saving therapy for all who needed it where the costs of treatment were beyond the means of practically all individuals." Richard A. Rettig & Ellen L. Marks, *Implementing the End-Stage Renal Disease Program of Medicare: Prepared for the Health Care Financing Administration, U.S. Department of Health, Education, and Welfare* 25 (Rand 1980).

195. *See generally* Roger W. Evans, *Organ Transplantation and the Inevitable Debate as to What Constitutes a Basic Health Care Benefit*, in *Clinical Transplants 1993*, 359 (J. Michael Cecka & Paul I. Terasaki eds., UCLA 1994).

196. *See* Organ Donation and Recovery Improvement Act, Pub. L. No. 108-216, 118 Stat. 584 (2004). *See also* Press Release, Congressman Jay Inslee, *House Honors Fallen Colleague by Passing Kidney-Donation Bill: Norwood-Inslee Legislation Offers Hope to Patients on Transplant List* (Mar. 7, 2007) (available at http://www.house.gov/inslee/issues/health/house_passes_ norwood_bill.html) (estimating that such a measure could save Medicaid at least $220,000 in dialysis costs per patient. Also containing an estimate by "[t]he Congressional Budget Office . . . that legalizing paired kidney donation would save about $30 million over 5 years and $500 million over 10 years"). *See also* Goodwin, *supra* n. 2.

197. 197.Epstein, *supra* n. 156.

198. *Id.*

participation is not one-sided, but exists on both sides of the market exchange.

Relationships matter to prospective parents where markets or market based dynamics can satisfy demand to create families. Adoption and assisted reproductive technology exemplify markets where families attempt to maximize relational preferences. Relation building need not take place exclusively within markets, however, when supply is left to biological lotteries individuals may be less inclined to participate, such as with organ donation.