Organ Donation in the United States: Can We Learn From Successes Abroad?

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Organ Donation in the United States: Can We Learn From Successes Abroad?

INTRODUCTION

Despite tremendous advances in the field of organ transplantation that have occurred in the United States and around the world during the past fifty years, organ donation policies have been unable to procure enough organs for those awaiting transplants. Currently, there are almost 34,000 Americans awaiting organs for transplants.\(^1\) It is estimated that every twenty minutes, a new name is added to the national organ waiting list.\(^2\) In 1992 alone, more than 2,560 patients died while waiting for an organ to become available.\(^3\) This

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1. United Network For Organ Sharing, Numbers of Patient Registrations on the National Waitlist, By Organ (1992) [hereinafter UNOS Waitlist]. As of February 2, 1994 the United Network for Organ Sharing (UNOS) reported 33,728 registrations for organ transplants on its waiting list. Statistic obtained from telephone conversation with UNOS, Communications Department on 2/14/94. The number of people registered as awaiting transplants might be slightly higher than the number of actual patients in need of transplants, since some patients may be listed with more than one transplant center. See United Network for Organ Sharing, Facts About Transplantation in the United States (1992).


3. Reported deaths on the UNOS organ waiting list:

1988: 1,537
1989: 1,732
1990: 2,077
1991: 2,518
1992: 2,567

The year in which the death was reported may not necessarily be the year in which the death occurred. United Network for Organ Sharing, Organ Procurement Transplantation Network Annual Report, Table V, Reported Deaths on the Waiting List, by Organ 1988, 1989, 1990 (1990). 1991 and 1992 statistics obtained from telephone conversations with UNOS, Communications Department (on 2/10/93 and 2/14/94).
death toll stands, despite the fact that over 16,000 organ transplants were performed with high rates of success.\(^4\)

In the 1980s, the United States abandoned its system of encouraged voluntarism, a policy which placed the onus of donation solely on each citizen, and replaced it with systems of required request and routine inquiry. These latter systems require the health care industry to actively pursue organ donations. The effectiveness of these laws has not yet been conclusively determined. In recent years many foreign countries have instituted bold measures to reduce their organ shortages. They have abandoned their purely voluntary approaches to organ donation and have enacted presumed consent laws. These presumed consent systems place a burden only on individuals who are opposed to donating their organs at death. While the presumed consent systems differ in their scope, all of them have generated significant increases in organs procured. The apparent initial success these approaches have had in procuring organs abroad warrants consideration of such a plan for the United States.

Part I of this Note traces the recent history of transplantations\(^5\) in the United States and examines the systems of encouraged voluntarism, required request, and presumed consent used in the United States, as well as presumed consent schemes implemented abroad. Part II examines the strengths and weaknesses of these systems. Part III proposes a plan to implement a modified system of presumed consent in the United States.

\[^4\] Totals of All Organ Transplants Done in the United States:

<table>
<thead>
<tr>
<th>Year</th>
<th>Total Transplants</th>
<th>Deceased Donors</th>
<th>Living Donors</th>
</tr>
</thead>
<tbody>
<tr>
<td>1988</td>
<td>12,786</td>
<td>10,965</td>
<td>1,821</td>
</tr>
<tr>
<td>1989</td>
<td>13,474</td>
<td>11,556</td>
<td>1,918</td>
</tr>
<tr>
<td>1990</td>
<td>15,478</td>
<td>13,353</td>
<td>2,125</td>
</tr>
<tr>
<td>1991</td>
<td>16,048</td>
<td>13,766</td>
<td>2,282</td>
</tr>
<tr>
<td>1992</td>
<td>16,603</td>
<td>14,033</td>
<td>2,570</td>
</tr>
<tr>
<td>1993</td>
<td>18,077</td>
<td>15,336</td>
<td>2,741</td>
</tr>
</tbody>
</table>

United Network For Organ Sharing, *Number of Transplants Performed In the U.S. by Organ, Year and Type of Donor* (1992). 1992 and 1993 statistics obtained from telephone conversation with UNOS, Communications Department on 2/14/94.

\[^5\] This Note deals primarily with cadaveric organ donors and does not address the equally important issues regarding donation by live donors or uses for organs and tissues in genetic engineering.
I. APPROACHES: PAST AND PRESENT

A. Transplantation History and Advances

The first cadaveric kidney transplant was performed in the Soviet Union in 1936. In the United States, during the 1940s and '50s, there was a great deal of transplant experimentation performed by surgeons in the field. These efforts paid off in 1954 when doctors in Boston performed the first successful long-term kidney transplant using a living donor. In the 1960s, doctors, using the advances made with respirators and heart-lung machines, were able to maintain vital biological functions artificially in brain dead patients. This technology facilitated the preservation of organs that could be removed for transplantation.

The 1960s hailed tremendous achievements in many categories of organ transplants. The first successful larynx transplant was performed in Belgium in 1969. In 1967, Dr. Christiaan Barnard performed the first successful heart transplant in South Africa. Although the patient died from double pneumonia only eighteen days later, Dr. Barnard's efforts were duplicated in the United States ten months later, resulting in the first long-term heart transplant survivor. As of 1992, 85 percent of heart recipients survive at least one year after receiving a transplant. While only a few years ago heart transplant recipients were limited to those people with maximum ages of 45 to 50 years, it is now common to perform heart transplants on patients in their late 50s and early 60s and to see recipients out of bed, speaking and eating a mere thirty-six hours after receiving a new heart.

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7 See id.
9 Id.
11 Id.
12 Id. The transplant recipient survived another eight years after the surgery. Id.
14 See id. at 2141; see also Scott, supra note 10, at 21.
Today medical science has enabled doctors to perform transplants of many different organs, tissues, and glands. Much of the improvement in transplant results must be attributed to improved tissue typing and the development, in the early 1980s, of drugs such as cyclosporine and CyA. Advances in technology have also increased the maximum periods for which an organ can be preserved before being transplanted into the recipient. In addition, the increase in multiple organ and tissue donations from a single recipient has greatly helped procurement efforts. A single cadaveric donor can save the lives of four separate recipients, by donating his or her heart, both lungs, and liver, and can enhance the quality of life for five other recipients by donating his or her two kidneys, pancreas, and both corneas. Countless others can benefit from this same donor’s bone, skin, and other tissues.

15 These transplantable parts include blood and blood vessels, bone, bone marrow, cartilage, corneas, fallopian tubes, fat, hair, hearts, heart-lung, inner-ears, kidneys, liver, lung, muscles, nerves, ovaries, skin, tendons, testicles, and a variety of glands (adrenal, pancreas, pituitary, thyroid, and parathyroid). See UNOS Facts, supra note 2; see also Erik S. Jaffe, “She’s Got Bette Davis’[s] Eyes”: Assessing the Nonconsensual Removal of Cadaver Organs Under the Takings and Due Process Clauses, 90 COLUM. L. REV. 528, 530 (1990); see also Scott, supra note 10, at 19.

16 See Mehlman, supra note 6, at n.5. Since the introduction of CyA, the one-year graft survival rates of cadaveric kidneys increased from 50% to 85%, and those of hearts and livers from 25% to 85% and 75% respectively. See Turcotte, supra note 15, at 2140. New surgical techniques for implanting a single lung have increased one-year patient survival rates for all isolated lung transplants (single and double) from 50% to 70% (before and after 1989). Id.

Several new immunosuppressive agents currently undergoing clinical evaluation offer hope of further increasing patient survival and decreasing side effects of immunosuppressive therapy: Cyclosporine G—probably less nephrotoxic than CyA; FK 506—effective in reversing rejection in liver transplantation; Rapamycin—similar to, but more potent than FK 506; Deoxyspergualin—may be effective against antibody-mediated rejection; Monoclonal antibodies—several being assessed for clinical efficacy. Id.

17 See UNOS Facts, supra note 2.

Current possible preservation time for organs:

<table>
<thead>
<tr>
<th>Oragn</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart</td>
<td>4–6 hours</td>
</tr>
<tr>
<td>Liver</td>
<td>8–24 hours</td>
</tr>
<tr>
<td>Kidney</td>
<td>48–72 hours</td>
</tr>
<tr>
<td>Heart-lung</td>
<td>4–6 hours</td>
</tr>
<tr>
<td>Lung</td>
<td>Up to 12 hours</td>
</tr>
<tr>
<td>Pancreas</td>
<td>8–24 hours</td>
</tr>
<tr>
<td>Corneas</td>
<td>7–10 days</td>
</tr>
<tr>
<td>Bone Marrow</td>
<td>Up to 3 years</td>
</tr>
<tr>
<td>Skin</td>
<td>5 years or more</td>
</tr>
<tr>
<td>Bone</td>
<td>4 years or more</td>
</tr>
</tbody>
</table>

18 See Turcotte, supra note 13, at 2141. In over 60% of the organ removal procedures performed, a kidney and at least one other organ is donated from a single donor. Id.

19 See id.
Legislation encouraging the posthumous donation of organs is a relatively new concept. At common law, individuals were prohibited from mandating what was to be done with their body parts once they died. This prohibition was premised on the fact that no one could have a property right in a dead body. The next-of-kin, however, did enjoy a "quasi-property right" in the decedent's body immediately after death. This right was based on the belief that all individuals deserved a decent burial and that the family could best protect the interests of the deceased in this regard.

This law remained basically unchanged until the late 1940s when the international medical community accepted the viability of corneal transplants. This recognition prompted legislatures to change pertinent laws in order to reduce the barriers to cadaveric organ donation. In 1947, California's legislature passed session laws Chapter 125 and Chapter 126 which granted citizens the legal right to make posthumous donations of their entire bodies, or specified parts of them, to hospitals, universities, or "similar institutions." These laws set no limits on the uses for which body parts could be utilized by these institutions. Thus, they implicitly permitted the removal of organs for transplantation. The laws protected the decedent by prohibiting his family from vetoing his wishes. The legislation also allowed the decedent to specify his desires in a will or other written instrument. In 1957, these statutes were amended to include eye, artery, and blood banks as well as "other therapeutic services" as permissible recipients. In 1968, a further amendment elaborated procedures for tissue procurement.

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21 See id.; see also Williams v. Williams holding that "...there can be no property right in the dead body of a human being. ...a man cannot by will dispose of his dead body. If there can be no property in a dead body, it is impossible that by will or any other instrument the body can be disposed of." 20 Ch. D. 659 (1881), cited in McNeil, supra note 20, at n.9.
22 See McNeil, supra note 20, at 344.
23 See id.
24 See Scott, supra note 10, at 66. In 1991, roughly 43,000 corneal transplants were performed. Generally, these procedures result in restored vision in over 90% of the patients who undergo them. UNOS Facts, supra note 2.
25 See Scott, supra note 10, at 66.
26 Id. at 66–67.
27 Id. at 67.
28 Id.
29 Id.
30 Scott, supra note 10, at 67.
31 Id.
B. Encouraged Voluntarism

With the first successful kidney transplant in 1954, and the growing success of transplant procedures during the late 1950s and 1960s, it became clear that the existing legislation governing organ donation was insufficient to procure the number of organs needed to satisfy the demand. By the mid-1960s the majority of states had some legislation regarding organ and tissue removal, but these laws varied widely among states with regard to the following factors: who could authorize tissue removal and make gifts; who could receive such gifts; what the allowable uses were for donated parts; the formalities regarding the giving and revocation of gifts; and the degree of liability to which doctors acting in good faith were subject. In 1965, the Commissioners of Uniform State Laws appointed a subcommittee to study the issues concerning organ donation and make recommendations for a uniform law. A model law, called the Uniform Anatomical Gift Act (UAGA), was approved in July 1968 at the National Conference of Commissioners, and soon after by the American Bar Association as well as the American Medical Association. Within five years the UAGA had been adopted in some form by all fifty states and the District of Columbia.

In its pure form, the UAGA provides that any person older than eighteen years can make a gift, effective upon death, of all and any part of her body. It further provides that when the deceased has not expressly made a gift or expressly objected to donation during her lifetime, the deceased’s family members can make a gift of any or all parts of her body. The UAGA restricts gift recipients to hospitals, doctors, medical and dental schools, universities, organ and tissue banks, and any specified individual in need of a transplant. It specifies that gifts of bodies or parts are only to be used for trans-

32 See Caplan, Costs, supra note 8, at 23.
33 See Scott, supra note 10, at 71.
34 Id. at 70–71.
35 Id. at 71. In 1987 the UAGA was amended in various respects. Several states have adopted the amendments in whole or in part. See Unif. Anatomical Gift Act, § 3, 8A U.L.A. (1987) [hereinafter 1987 UAGA].
36 See id.
37 The various family members are given the following priority for authorization: spouse, adult children, parents, adult siblings, guardians, any other person authorized or under obligation to dispose of the body. See Unif. Anatomical Gift Act § 3, 8A U.L.A. (1968) [hereinafter 1968 UAGA]. When the UAGA was amended in 1987, it added "a grandparent of the decedent" after siblings and eliminated the "any other person" designation. See Jaffe, supra note 15, at n.27; see also 1987 UAGA, supra note 35, § 3.
38 1968 UAGA, supra note 37, § 3.
plants, therapy, research, education, and advancement of medical or dental science.\(^{39}\) Under the UAGA, gifts can be made by will, effective immediately upon death without waiting for probate, or by donor card, and can be revoked at any time.\(^{40}\) A donee can accept or reject a gift. The UAGA shields all persons acting in good faith, in accordance with its terms, from civil and criminal liability.\(^{41}\)

The UAGA eliminated the major inconsistencies among states and clarified and facilitated the consent process.\(^{42}\) It recognized the right of next-of-kin to donate organs of individuals who had not expressed an unwillingness to do so, but it did require explicit authorization of either the deceased or the family.\(^{43}\) The UAGA also recognized the legal status of donor cards.\(^{44}\) It did not, however, address the issue of sale of human body parts. The legality of such commerce was left to the discretion of the states.\(^{45}\) In addition, the UAGA dealt only with corpses, did not address the disposition or use of unclaimed corpses, and did not attempt to regulate gifts of body parts by living donors.\(^{46}\)

The UAGA sought to protect and encourage the principles of voluntarism, express consent, and individual rights, while at the same time facilitating donation and eliminating the need to rely on purely voluntary action by a potential donor during his lifetime.\(^{47}\) The concept of achieving both of these ideals simultaneously came to be known as “encouraged voluntarism.”\(^{48}\) Although no familial consent was necessary if the deceased expressly agreed to donate before he died, in practice, physicians rarely proceeded with removal absent familial consent. Eventually this system proved insufficient to supply the number of organs needed by potential recipients. In the 1980s, encouraged voluntarism was replaced with systems of required request which placed the burden of procuring organs not only on individual citizens but on medical professionals as well.

\(^{39}\) Id.

\(^{40}\) Id. § 4.

\(^{41}\) See 1968 UAGA, supra note 37, § 7.

\(^{42}\) See B.L. Sadler, Presumed Consent to Organ Donation: A Different Perspective, 24 TRANSPLANTATION PROCEEDINGS 2173, 2173 (1992).

\(^{43}\) See Caplan, Costs, supra note 8, at 24; see also Jaffe, supra note 15, at 533.

\(^{44}\) See Caplan, Costs, supra note 8, at 23–24.

\(^{45}\) See generally 1968 UAGA, supra note 37; see also Scott, supra note 10, at 72; Jaffe, supra note 15, at 533 & n.29. The 1987 UAGA revision, however, does ban the sale of organs. See 1987 UAGA, supra note 35, § 10.

\(^{46}\) See Scott, supra note 10, at 72.

\(^{47}\) See Sadler, supra note 42, at 2173.

\(^{48}\) See Caplan, Costs, supra note 8, at 23.
C. Required Request and Routine Inquiry

Although it is often referred to by this one term, required request actually embodies two different approaches to organ procurement: "routine inquiry," whereby hospitals are simply required to inform the family of its opportunity to make an anatomical gift; and "required request," whereby hospitals are obligated to expressly ask the family to consent to donation.49 Early state laws on organ donation served as models for subsequent state legislation. There is a great deal of variation among required request and routine inquiry state laws.50 In recent years, the federal legislature has taken an increasingly active role in promoting organ donation.51 These federal laws ensure cooperation with required request or routine inquiry approaches to donation by conditioning federal aid to hospitals on compliance with these approaches.52

1. Federal Legislation

One of the early federal efforts to examine the organ shortage in the United States led directly to increased support for a system of required request. In October 1984, Congress enacted the National Organ Transplant Act (NOTA) to create a more comprehensive network of organ donors and recipients and to raise public awareness of the need for human organs.53 NOTA established an organ procurement and transplant network, the United Network for Organ Sharing (UNOS) to oversee a national registry of potential donors and a waiting list of recipients.54 It prohibited commerce in human organs but provided financial assistance to organ procurement agencies (OPAs).55 It also established a task force on organ transplantation, directed by the secretary of Health and Human Services, to examine and report on the medical, ethical, legal, economic, and social barriers to organ donation.56 The Task Force report, published in 1986, advocated that state legislatures pass

49 See Kathleen S. Andersen and Daniel M. Fox, Impact of Routine Inquiry Laws on Organ Donation, 7 Health Affairs 65, 66 (1988).
50 Id. at 67–68.
52 Id. at 40.
53 Id. at 39.
54 Id.
55 Id.
routine inquiry legislation.\textsuperscript{57} By this time several states had taken the initiative and already had enacted either required request or routine inquiry laws.

2. State Legislation

The theory behind required request proved to be appealing to the populace. In 1985, Oregon was the first state to pass required request legislation.\textsuperscript{58} New York and California followed suit that same year.\textsuperscript{59} By the end of the decade, forty-five states and the District of Columbia had passed some form of required request or routine inquiry legislation.\textsuperscript{60}

Required request laws vary greatly from state to state.\textsuperscript{61} The strongest laws require hospitals to request donation and document the approval or refusal on the death certificate.\textsuperscript{62} The weaker laws merely require that hospitals develop protocols to ensure that families are apprised of their option to donate.\textsuperscript{63} State laws vary as to whether hospitals are required merely to inform of the option to donate, or actually request donation. The stricter laws mandate high degrees of hospital monitoring, protocol, and documentation and extensive involvement of state health departments.\textsuperscript{64} These laws generally permit fewer exceptions to the requirements. State laws also vary as to the scope of immunity and penalties imposed for noncompliance.\textsuperscript{65}

a. Oregon and New York Models

Two of the first states to pass required request legislation were Oregon and New York in 1985.\textsuperscript{66} These laws require hospital personnel, in the absence of contrary indication by the patient or its family, to request consent for organ donation from the potential donor's
family. The response to such a request must be recorded on the death certificate. The New York law further requires the state health department to set implementation regulations, and requires the hospital to submit a certificate of request along with the death certificate.

b. California Model

The California statute mandates routine inquiry as opposed to required request. The hospital personnel are required to inform the family of the option to make an anatomical gift, rather than explicitly request that it do so. The California statute does not require any involvement by the state health department, nor does it require that responses be recorded. The statute does require the hospital to notify an OPA once consent is given, but not until then.

c. Variations among States

Twenty-six states and the District of Columbia have adopted some version of required request legislation—legislation which imposes an affirmative duty on hospitals or procurement agents to request donation, either from the patient upon admission to a hospital, or from the patient's family when death has occurred or is imminent.

Eighteen states have passed routine inquiry laws—imposing an affir-

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67 See Andersen & Fox, supra note 49, at 68.
68 Id.
69 Id.
70 Id. at 69.
71 Id.
72 Id. at 69.
73 Id.
mative duty on hospitals and procurement agents to inform the patient or his family of the option to donate. Most of these laws fall squarely into one of the two categories. At least four states, however, have laws which combine aspects of both types of legislation, depending on whether the living patient is approached for consent, or his family is first approached after his death. Two states have laws which require the hospital or procurement agent to inquire whether the patient is or was a donor, but place no further duty to obtain consent or inform the patient or his family of the option to donate. Iowa has adopted the UAGA but has no specific state law governing the duty to obtain consent or inform of the option to donate.

i. The Role of the Health Department

Some states like Oregon and New York impose the responsibility of establishing implementation regulations on the state health department. Some states require the health department to establish rules that hospitals must follow in training the organ request staff.

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76 Delaware (routine inquiry from patient, required request from deceased’s family) Del. Code Ann. tit. 16, § 2721 (1993); Hawaii (routine inquiry from patient, required request from deceased’s family) Haw. Rev. Stat. § 327-5 (1993); Pennsylvania (required request from patient, routine inquiry from deceased’s family) 20 Pa. Cons. Stat. § 8008 (1993); and Texas (required request “if it is unclear whether the decedent is or is not a donor,” and routine inquiry “if the decedent is not a declared donor”) Tex. Health and Safety Code Ann. §§ 692.013—014 (West 1993).

77 Mississippi’s law requires that the family be asked whether the deceased was a donor or if the family is a donor family, but places no further duty on the hospital, stating, “the family may be informed of the option to donate. . . .” (emphasis added). Miss. Code Ann. § 41-39-15 (1993) as amended by 1993 Miss. Laws 423. Kentucky simply requires its hospitals to encourage organ donation and identify potential donors. The sole duty its law places on hospitals is to notify a federally-certified organ procurement organization of any potential availability of an organ. Ky. Rev. Stat. Ann. § 311.241 (Baldwin 1993).


79 Andersen & Fox, supra note 49, at 69.

80 Id.
Other states mandate that the health department establish procedures to facilitate coordination between hospitals and OPAs. Some states also allow the health department to establish the permissible exceptions to the request or inquiry requirements.  

ii. Permissible Exceptions

In almost all state statutes, hospital staff is exempt from the request or inquiry requirement if there is actual notice that the deceased or his family has objected to donation. Other exceptions apply if the health department has deemed the hospital unable to comply with the requirement, or if the need for organs and tissues has been met. This latter exception protects the hospital from having to request organs for which there is no need. Some states waive request requirements when it is known that organ donation is contrary to the decedent’s religious beliefs. At least one state, Connecticut, also considers the family’s religious beliefs for this exception. Other states allow exceptions if the attending physician has "special and peculiar knowledge of the decedent and/or the circumstances surrounding the death of the patient." Further exceptions may waive requirements when approaching the family members would cause them undue emotional stress, the organ would not be medically suitable, or there is a valid, previously signed donor card.

iii. Immunity and Penalties

Immunity granted under the state statutes varies as well. Some states’ required request statutes are silent on the immunity issue, relying on the UAGA’s immunity clause which applies to any person acting in good faith. Other statutes grant immunity for any person, while some grant immunity only for hospitals or physicians. Some

81 Id.
82 Id. at 70.
83 Andersen & Fox, supra note 49, at 69.
84 Id. at 70.
85 Sipes, Approach, supra note 51, at 42.
86 Id.
87 Andersen & Fox, supra note 49, at 70.
88 See Sipes, Approach, supra note 51, at 47. The 1968 UAGA states: "[a] person who acts in good faith and in accord with the terms of this Act or with the anatomical gift laws of another state [or a foreign country] is not liable for damages in any civil action or subject to prosecution in any criminal proceeding for his act." 1968 UAGA, supra note 37, § 7.
states grant only civil immunity while others grant civil and criminal immunity with exceptions in cases of negligence.89 Penalties for noncompliance vary as well. Kentucky, for instance, imposes fines ranging from $100 to $500 for noncompliance.90 Michigan imposes denial or revocation of hospital licenses for failure to comply.91

3. Continuing Federal Efforts

Throughout the late 1980s, the federal government continued to ensure that all states comply with some form of required request regardless of whether or not they had passed their own state statutes. Responding to the Task Force report issued in 1986, Congress passed the 1986 Omnibus Budget Reconciliation Act (OBRA) which requires hospitals to develop routine inquiry protocols similar to those included in California’s routine inquiry statute.92 Mandatory protocols include informing the patient or family of its opportunity to donate, waiving the requirement when hospital personnel would be uncomfortable with the action, identifying potential donors, and notifying OPAs of potential donors.93 The OBRA supersedes state law but does not prevent states from establishing stricter requirements.94

To further ensure compliance with routine inquiry, on July 31, 1987, the Health Care Financing Administration (HCFA) proposed rules which basically require hospitals to comply with the 1986 OBRA regulations in order to retain their eligibility for Medicare and Medicaid reimbursement.95 The HCFA rules became effective on March 31, 1988.96 The rules do not affect the majority of states because most states have enacted legislation with more stringent requirements than those required in the Medicare regulations.97

4. The UAGA Revised

While passage of the HFCA rules was pending, the National Commission on Uniform State Laws revised the UAGA model law of

89 Sipes, Approach, supra note 51, at 47.
90 Andersen & Fox, supra note 49, at 70.
91 Sipes, Approach, supra note 51, at 47.
92 See Andersen & Fox, supra note 49, at 72; see also discussion supra part I.C.2.b.
93 See Andersen & Fox, supra note 49, at 72.
94 Id. at 66.
95 Id. at 73.
96 Id.
97 Id. at 74–75.
The revised UAGA of 1987 includes both routine inquiry and required request provisions. Under this act, hospital personnel are required to ask each patient admitted if she is an organ donor, and if she is not, they must inform the patient of her option to donate. If the medical records do not indicate the patient’s wishes and the patient is a medically suitable donor, hospitals are required to request donation from the patient’s family upon the patient’s death. The 1987 UAGA also affirmatively requires the hospital’s emergency staff to search for information indicating whether a patient, near death or dead, is a donor.

National efforts continue to encourage hospitals to comply with organ procurement regulations. Recently, the Joint Commissioners for Accreditation of Health Care Organizations began examining hospital organ donation policies as part of their annual accreditation reviews. Despite the prevalence of required request and routine inquiry legislation currently in place, there are still thousands of U.S. citizens who die each year while awaiting an organ transplant. This reality has caused many critics to push for presumed consent legislation, that is, laws which offer a more aggressive approach to organ procurement.

D. Presumed Consent

Dissatisfaction with encouraged voluntarism and required request has caused a resurgence of interest in organ procurement approaches involving “presumed consent.” Under encouraged voluntarism and required request, the general presumption is one of nonconsent. Therefore, individuals or their families must explicitly “opt into” the system if they wish to make an anatomical gift rather than “opt out” if they do not wish to donate. A system of presumed consent reverses the presumption, and presumes that the decedent is willing to have her organs removed for transplant upon death unless she or her family has expressly objected. In the

98 1987 UAGA, supra note 35.
99 Id. § 5.
100 Id.
102 Id. at 72.
103 Virnig & Caplan, supra note 58, at 2155.
104 See supra note 3 and accompanying text.
105 Mehlman, supra note 6, at 1.
106 Id.
107 Id.
absence of an objection, the hospital is entitled to assume that it has permission to remove any needed organs and can do so with immunity from liability. The concept of presumed consent is not new. It was first advocated by Dukeminier and Sanders, a U.S. lawyer-doctor team, in 1968, when transplant technological successes first raised awareness of national organ shortages.

Not all systems of presumed consent are identical. A pure system of presumed consent mandates that only the decedent can opt-out during his lifetime. The family’s wishes are not sought, nor are they grounds for a hospital to refrain from procuring the organ. In less strict applications of presumed consent, the family may, of its own volition, object to donation, but its wishes are not actively sought by the medical staff. Under such a system, however, health care professionals may not proceed with removal if they are aware of the decedent’s or the family’s objection. Not only does presumed consent reverse the presumption concerning one’s willingness to donate, it also shifts the burden of determining whether consent exists from the health care worker to the potential donor and her family. Individuals unfamiliar with U.S. organ donation laws, often perceive presumed consent as an unnecessarily drastic solution to the organ shortage. These same individuals are often unaware that varying degrees of presumed consent legislation have already been enacted and legally upheld in the United States.

1. Modified Presumed Consent and Reasonable Effort Laws in the United States

Several states currently have laws which allow coroners or medical examiners to authorize the removal of corneas or pituitary glands when the coroner or examiner knows of no objections by the deceased or the next-of-kin. These laws do not require the coroner

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108 Id. at 5.
109 Id.
110 See Mehlan, supra note 6, at 16; see also discussion infra part I.E.3.
112 See id.
113 See Mehlan, supra note 6, at 5.
114 See Jaffe, supra note 15, at 535.

Other requirements include the following:
(1) a request for such tissue for the purposes of transplant or therapy must be made by an authorized recipient;
to make any affirmative effort to determine the preferences of the deceased or her next-of-kin.\textsuperscript{115} Hawaii’s law goes even further and allows the coroner to remove any tissues regardless of whether or not there is a known objection.\textsuperscript{116} Vermont allows pituitaries to be removed unless a religious objection is brought.\textsuperscript{117}

Other states have less discretionary, more limited presumed consent laws which require the coroner to make a “reasonable effort” to notify the appropriate persons and obtain their consent for donation.\textsuperscript{118} Once a reasonable effort has been made and fails, however, the coroner may proceed with removal.\textsuperscript{119} The UAGA’s 1987 revision permits removal of all organs after a reasonable effort by the coroner.\textsuperscript{120} Many foreign countries have enacted more extensive presumed consent laws than those currently in existence in the United States.

(2) the removal would not interfere with the course of an autopsy or other investigation and;

(3) the removal would not alter the decedent’s facial appearance.

The laws also grant the coroner immunity from liability in the event that the family sues after the removal claiming they objected to the removal. States which have such limited presumed consent laws are: Arkansas (pituitary); California (pituitary and cornea); Colorado (pituitary); Connecticut (pituitary and cornea); Delaware (cornea); Florida (cornea); Georgia (cornea and eye); Kentucky (cornea); Maryland (cornea); Michigan (cornea); Missouri (pituitary); North Carolina (cornea); Ohio (cornea); Oklahoma (pituitary); Tennessee (cornea); Texas (cornea); and West Virginia (cornea). See id. & n.35.

\textsuperscript{115} See id. at 536.

\textsuperscript{116} Mehlman, supra note 6, at 9.

\textsuperscript{117} Id.

\textsuperscript{118} See Jaffe, supra note 15, at 536–37. States with reasonable effort laws include the following: Arizona (corneas—diligent effort); Arkansas (all parts); California (all organs and pacemakers); Colorado (corneas); Hawaii (all parts); Idaho (all parts); Illinois (corneas); Louisiana (eyes, kidneys, heart, lungs, liver, soft tissue, and bone—good faith effort); Maryland (internal organs); Massachusetts (corneas—good faith effort); Mississippi (all parts); Montana (all parts); North Dakota (all parts); Rhode Island (all parts); Texas (nonvisceral organs); Utah (all parts); Washington (corneas). Arkansas’ and California’s laws authorize removal not just by coroners but by hospitals in general. Id. at 537 & n.39.

\textsuperscript{119} See id. at 537.

\textsuperscript{120} See id. The added requirement of making a reasonable effort to obtain consent seems to impact procurement results significantly. While Florida, Georgia, Maryland, Michigan and Texas—states which require only that no objection be known—harvest more corneal tissue than they need; states like Arizona, Colorado, and Utah require reasonable efforts and still have to import corneal tissue from other states. See P.T. Menzel, The Moral Duty to Contribute and Its Implication for Organ Procurement Policy, 24 Transplantation Proceedings 2175, 2178 (1992).
E. Presumed Consent Abroad

1. Presumed Consent in France

The French have had a system of presumed consent for organ donation since 1976. On December 22, 1976, the French legislature, acknowledging a growing shortage of kidneys for transplantation,\(^{121}\) passed the Law of France No. 76–1181, also called the Caillavet Law, after Senator Henri Caillavet who introduced the bill.\(^{122}\) The law provides, in pertinent part:

An organ to be used for therapeutic or scientific purposes may be removed from the cadaver of a person who has not during his lifetime made known his refusal of such procedure. If, however, the cadaver is that of a minor or a mentally defective person, organ removal for transplantation must be authorised by his legal representative.\(^ {123}\)

The law also grants France’s highest advisory and dispute-resolving judicial body, the Council of State, the authority to determine how the law is to be administered.\(^ {124}\)

On March 31, 1978, the Council of State issued an application decree which specified the law’s procedural requirements.\(^ {125}\) The decree granted the potential donor the right to object to the donation of his or her organs “by any means,” either at the time of admission to the hospital or any other time.\(^ {126}\) Any objection made would be registered in a hospital register maintained for that purpose.\(^ {127}\) It also authorizes anyone bearing witness to a patient’s ob-

\(^{121}\) In France in 1976, roughly 350 kidney transplants were performed, while more than 1,800 patients awaited available kidneys. Scott, supra note 10, at 17–18.

\(^{122}\) See id. at 76. Some say that the Caillavet law was based on a decree of October 20, 1947, which authorized cadaveric organ removal to take place for therapeutic or scientific purposes without familial consent, provided the decedent had made no objections, and certain other conditions were met. See J.A. Farfor, Organs for Transplant: Courageous Legislation, Brit. Med. J. 497, 497 (Feb. 19, 1977). There is some debate, however, that the decree, issued so long before viable transplants were performed, was solely designed to facilitate official autopsies, allowing the medical community to retain tissues removed during those procedures, and not to authorize organ removal for transplantation purposes. See Scott, supra note 10, at 67–68. This decree was followed by Public Law No. 49.890 enacted on July 7, 1949, which pertained to tissue procurement for the purpose of transplantation, authorizing the “practice of corneal grafting with the aid of voluntary eye donors.” See id. at 68.

\(^{123}\) See Farfor, supra note 122, at 497.

\(^{124}\) See Gerson, supra note 111, at 1022 & n.49.

\(^{125}\) See id. at 1022–23; see also Scott, supra note 10, at 77.

\(^{126}\) See Gerson, supra note 111, at 1023.

\(^{127}\) Id.
jection to register the patient's refusal in the same hospital register. Any physician who is responsible for removing organs from a patient recently deceased must check the hospital register to verify that no objection has been made. The law requires, in effect, that a reasonable effort be made to determine whether any objections have been registered, but does not require, as do some of the U.S. presumed consent laws, a reasonable effort to obtain consent from the family of the deceased.

A Circular of the Ministry of Health and Social Security, issued on April 3, 1978, further refined the law's procedural requirements. It prohibits the physician from proceeding with the removal if, even after finding no objections on the hospital chart, the doctor obtains direct knowledge of the decedent's objection via a written document or a third person. The law is intended to respect only the wishes expressed by the decedent, and not the independent wishes of her family, although the family is allowed to register objections on behalf of the decedent. It was however, realistically impossible to prevent a family from issuing an objection of its own under the guise of the decedent's wishes because the decedent was no longer available to contradict his family's claim. Therefore, in 1983, the Council of State issued a decision that a donor's family cannot prevent organ removal when the now-deceased patient did not object to donation while alive. In practice, however, physicians rarely remove organs if the family objects.

2. Presumed Consent in Belgium

In June 1986, following recommendations issued by the Council of Europe, Belgium passed a presumed consent law which was implemented in February 1987. Belgium has a computerized central

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128 Id.
129 Id.
130 See supra note 118 and accompanying text.
131 See Gerson, supra note 111, at 1023-24 & n.57. This Circular is an administrative regulation issued pursuant to a statute and, therefore, has the full force of law. Id.
132 Id. at 1024.
133 Id.
134 Id.
135 See discussion infra part I.E.
136 L. Roels et al., Effect of Presumed Consent Law of Organ Retrieval in Belgium, 22 Transplantation Proceedings 2078, 2078 (1990) [hereinafter Roels, Effect of Presumed Consent]. There is some evidence that presumed consent has been practiced in Belgium since 1965.
Health Authority registry continuously accessible to transplant centers through which objections to postmortem organ removal can be registered. 137 This computer network works in conjunction with nationwide informational campaigns designed to educate the public about the need for organs, and to educate health care professionals about advances in transplant technology. 138 Although, like the French law, the Belgian law allows doctors to remove organs without familial consent, in practice Belgian doctors also inform families of their option to refuse and ask if they object. 139

3. Presumed Consent in Austria

The only country which has a "pure" system of presumed consent—one which does not offer the next-of-kin an opportunity to object to donation of the deceased's organs—is Austria. 140 Austrian physicians appear to exercise their discretion granted under the law and do not discuss donation with the family, unless the family raises the issue, or unless the deceased is a minor or a foreigner. 141 An Austrian citizen who wishes to object to donation must do so in writing, in order for the refusal to be legally valid. 142 The physician, however, has no affirmative duty to search for documents indicating consent or nonconsent. If there is doubt regarding the decedent's wishes, removal is permitted. Interestingly enough, the means by which citizens are allowed to object are not specified in the legislation. 143

when a regulation was introduced in the teaching hospital of the University of Ghent by Professor R. Dierkens, Secretary-General of the World Association for Medical Law. Although the regulation was followed in other Belgian teaching hospitals, it did not have the force of legislation. See Farfor, supra note 122, at 498.

137 See Roels, Effect of Presumed Consent, supra note 136, at 2078.
138 Id. at 2079.
139 Mehlman, supra note 6, at 16.
140 Id. at 16, 27.
141 See id. at 16–17. There seems to be conflicting analysis regarding the law’s applicability to foreigners. Mehlman reports that exceptions to the practice are made for foreigners, whereas Land and Cohen contend that the law is applicable to foreign tourists who die in Austria. The latter do concede, however, that the incidence of organs procured from foreign tourists is "very low." See W. Land and B. Cohen, Postmortem and Living Organ Donation in Europe: Transplant Laws and Activities, 24 TRANSPLANTATION PROCEEDINGS 2165, 2165–66 (1992).
142 See Land & Cohen, supra note 141, at 2165.
143 The Austrian law is derived from a decree of Queen Maria Theresa (reign 1740–1780) which authorized nonconsensual organ removal during autopsies. Id.
4. Presumed Consent in Singapore

In 1987, Singapore became the first Asian country to enact presumed consent legislation for cadaveric kidney donation.144 The Human Organ Transplant Act (HOTA) creates a presumption that all non-Muslim, permanent residents of Singapore between the ages of twenty-one and sixty and of sound mind agree to donate their kidneys upon death unless they have signed an objection form during their lifetime.145 Persons below the age of twenty-one or of unsound mind cannot be donors without the express consent of their parent or legal guardian.146 Persons and organs not covered by the HOTA are still covered by the Medical (Therapy, Education and Research) Act of 1972 (MTA).147 This earlier act provided a legal framework for the voluntary donation of all organs, much like the UAGA did for the United States.148 The HOTA, despite its title, pertains only to kidney removal and not to other human organs. The law governs the removal of kidneys from the bodies of accident victims only.149 It defines death as an irreversible cessation of all brain functions (brain death), a determination considered by some to be a critical element of any organ transplant law,150 and stipulates the conditions which must be met before any removal can occur.151 Lastly, it prohibits the commercial trade of organs and blood products.152 The law remains silent on the issue of living donors.153

The HOTA imposes specific procedural requirements upon participating hospitals. The coroner must determine the nature of the accident and consent to all removals before one can be carried out.154 The hospital has an affirmative duty to conduct “reasonable

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145 Id.
148 See id.; see also discussion supra part I.B.
149 See Soh, supra note 144, at 1323. Accident victims often provide suitable organs since they are almost always brought to hospitals and are often likely to be young adults without chronic medical problems. See Iyer, supra note 146, at 134.
150 See Soh, supra note 144, at 1323.
151 Id.
152 Id.
153 See Iyer, supra note 146, at 140.
154 See Soh, supra note 144, at 1323.
and proper" inquiries for registered objections before removal.\textsuperscript{155} The determination of brain death can be made only after a series of tests have been performed by two senior physicians. To ensure that premature determinations are not made, the authorized physicians cannot be associated with the transplant team or be involved in the care and treatment of the proposed recipient.\textsuperscript{156} The law grants civil and criminal immunity from liability to medical professionals and hospitals involved in the procurement and transplantation procedures.\textsuperscript{157} In addition, it imposes criminal penalties for violations of HOTA, imposing maximum fines of 100 Singapore dollars and/or one year of imprisonment.\textsuperscript{158}

The opting-out methods in Singapore appear to be more fully developed than those found in France, Belgium, and Austria. Objection forms to donation are "widely available" and can be obtained at post offices and other easily accessible public institutions.\textsuperscript{159} In addition, all Singaporeans receive a letter just prior to their twenty-first birthday, informing them of their duty to opt-out if they so desire.\textsuperscript{160} Once an objection is registered, it is sent to the director of medical services, processed within 24 hours, and is entered on a confidential computerized registry accessible to the five major general hospitals in Singapore.\textsuperscript{161} Objections can be withdrawn by filing a form similar to the original objection form.\textsuperscript{162}

II. Discussion

The United States has yet to eradicate shortages of transplantable organs. To determine why U.S. policies, past and present, have failed, and to propose a more effective policy of donation, one must understand the strengths and weaknesses of each of the various donation systems. There is no consensus among scholars and transplant professionals as to whether required request has conclusively failed. Yet the significant numbers of people still awaiting organs

\footnotesize{\textsuperscript{155} See id.  \\
\textsuperscript{156} See id.  \\
\textsuperscript{157} See Iyer, supra note 146, at 133.  \\
\textsuperscript{158} Id. at 134.  \\
\textsuperscript{159} See Soh, supra note 144, at 1323; see also Iyer, supra note 146, at 134.  \\
\textsuperscript{160} See Soh, supra note 144, at 1323.  \\
\textsuperscript{161} See id. The computerized registry is not open to the public. It keeps confidential not only the names of objectors but also the names of persons from whom kidneys are removed and their recipients. See Iyer, supra note 146, at 134.  \\
\textsuperscript{162} See Iyer, supra note 146, at 134.}
suggests that the system has been ineffective. A thorough appreciation of the gains achieved by presumed consent policies in the United States and abroad will help to determine whether the United States should now consider replacing required request legislation with presumed consent laws.

A. The Demise of Encouraged Voluntarism

Initially, encouraged voluntarism was lauded because it "encourage[d] socially desirable virtues such as altruism and benevolence without running the risk of abusing individual rights." Encouraged voluntarism views the requirement of consent as necessary to protect individual rights and maintain public confidence in the medical profession. Significantly, the system of encouraged voluntarism is also based on the traditionally held belief that the family has the authority to decide what will happen to the deceased prior to burial, and that the family is most likely to represent the true intent of the decedent regarding her desire to donate her organs.

At the time of its inception, the system that the UAGA implemented was criticized. Some felt that, given the lack of prohibition in many states on the sale of body parts and of donation by living persons, adoption of the UAGA would produce a commercial market in organs. Both living donors and next-of-kin would have an interest in selling body parts and could authorize the removal of such parts. Some critics felt that the high costs of promoting such a system through educational campaigns was unnecessary given the willingness of Americans—reflected in public opinion polls—to have their organs used to benefit others upon their death.

Although some commentators lauded the UAGA for respecting individual rights, there were others who felt the Act did not provide enough protection. They objected to the overriding power which

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163 See Caplan, Costs, supra note 8, at 24.
164 See Jaffe, supra note 15, at 535.
165 See C. Cohen, The Case For Presumed Consent to Transplant Human Organs After Death, 24 TRANSPLANTATION PROCEEDINGS 2168, 2168 (1992). Under § 2b of the 1968 UAGA, it is illegal to ignore the wishes of the decedent in favor of those of the family. For example, if the decedent has a valid donor card, the physician is not supposed to allow the family’s refusal to override the decedent’s wishes. 1968 UAGA, supra note 37, § 2; see also Mehlman, supra note 6, at n.69.
166 See Caplan, Costs, supra note 8, at 23.
167 Id.
168 Id.
169 See Scott, supra note 10, at 72–73.
the UAGA granted to the state. The UAGA allowed the coroner to conduct legally required autopsies or postmortem examinations which, if done, would annul any anatomical gift. Some critics felt that individual autonomy was betrayed any time a physician requested familial consent when the deceased had already expressly consented by completing a donor card. This practice, they argued, undermined the philosophical aim of the UAGA: to give priority to the wishes of the deceased over that of the family.

Critics at the other end of the spectrum, however, objected that the UAGA gave too much weight to individual autonomy. They argued that the rights of patients who would die if they did not receive an organ transplant should supersede the wishes of the deceased and her family in order to more significantly benefit society. Others felt that the UAGA disrespected the long-followed tradition of granting the deceased's family the right to determine what would be done with the corpse prior to burial. The individual autonomy granted by the UAGA challenged, in theory if not in practice, the family's right in this respect. These critics argued that the family should always have the final say regarding organ donation because decisions of proper treatment of a corpse are "inextricably linked with how a family will deal with its grief." The deceased, they argued, should not be able to decide a matter which properly should be left to the grieving family.

Although the medical community had high hopes for the success of encouraged voluntarism and for the role the UAGA would play in that success, by the mid-1980s it was widely acknowledged that the system had failed. Several factors were responsible for the growing gap between the demand for and supply of organs. As transplant technology and patient survival rates improved, the demand for organs increased. Despite widespread availability of organ donor cards and public education campaigns, the number of actual organ donors did not increase in proportion to the increased demand.

170 Id.
172 Id.
173 See Scott, supra note 10, at 72–73.
174 Id.
175 See Matas, supra note 171, at 256.
176 Id.
177 See Mehlman, supra note 6, at 4.
178 See Sadler, supra note 42, at 2173.
179 Id. In 1989, 1,878 patients died while waiting for a transplantable organ. Id.
Encouraged voluntarism proved inadequate to overcome the many factors that contribute to the shortage of organs. Some of these factors relate to potential donors’ reluctance, reluctance on behalf of the family, and inadequate efforts on behalf of the medical community.

1. Personal Reluctance to Donate One’s Own Organs

Under encouraged voluntarism, organ procurement is easiest when the deceased dies carrying a valid organ donor card, and the family does not object to the deceased’s desire to donate. The vast majority of U.S. citizens, however, do not carry organ donor cards.\(^\text{180}\) In addition, individuals who have valid cards often do not have them in their possession at the time of their death.\(^\text{181}\) There are a myriad of reasons why individuals are reluctant or unwilling to become donors. Some people are reluctant to face their own mortality, or are simply disgusted with the thought of donating their organs.\(^\text{182}\) Many individuals fear that if the hospital knows they are donors, the medical staffs, in their zeal to obtain organs, will not make every effort to save them, or will actually allow their organs to be removed before the individuals are, in fact, dead.\(^\text{183}\) A segment of the population objects on religious grounds to the removal of organs or to the acceptance of brain death as a definition of death.\(^\text{184}\) Others

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\(^{180}\) See Mehlman, supra note 6, at 4. A 1985 Gallup poll found that although 75% of the people surveyed favored organ donation, and 27% responded that they were very likely to donate their organs, only 17% had signed donor cards. Other studies showed even lower rates of card carriers. See id. at n.12.

\(^{181}\) See Caplan, Costs, supra note 8, at 24.

\(^{182}\) See Matas, supra note 171, at 236; see also Caplan, Costs, supra note 8, at 24. This is also a popular reason people die without having made a will, or lapse into a vegetative state without having made a living will.

\(^{183}\) See Cohen, supra note 165, at 2171. This fear is addressed specifically in literature disseminated to potential donors by the National Kidney Foundation: “Donors receive the same high quality care that non-donors receive. Medical personnel must follow very strict guidelines before death can be pronounced and the donor’s organs and tissue are removed.” National Kidney Found., About Organ and Tissue Donation 10 (1990 ed.).

\(^{184}\) See Cohen, supra note 165, at 2171. Some Orthodox Jews object to the recognition of brain death as death, and therefore, object to the removal of organs upon brain death. Some followers of religions who believe in the resurrection of their bodies in the afterlife oppose donation. Id. Orthodox Jews and Japanese Shinto religion adherents seem to be unequivocally opposed to any approach that would deny the family the right to object to donation. Opposition among these various religions may vary, however, depending upon which organ is considered, whether non-transplant alternatives exist, and how great the probability is that a life will be saved through transplant. See Mehlman, supra note 6, at 32, 34. For a more complete discussion of the Jewish orthodox position see id. at nn.96–97 and accompanying text.
simply believe that the decision whether to donate should be left to the surviving family, not the deceased.\textsuperscript{185}

2. Reluctance on Behalf of Next-of-Kin to Authorize Removal

Public opinion surveys often reflect a widespread willingness of individuals to authorize the donation of body parts belonging to a loved one who has not objected during his lifetime. Statistics show, however, that a greater percentage of individuals refuse to authorize donation when actually confronted with the decision.\textsuperscript{186} Several possible explanations for this discrepancy exist. The family, approached at the height of its grief, may be psychologically or emotionally unable to make such an important decision.\textsuperscript{187} If the patient has not yet died, the request for organ removal seems to eliminate all hope that the patient might recover, and thus authorization may be too painful to give.\textsuperscript{188} Often the family of a brain dead patient does not believe the patient is "actually dead" because the patient may still have a heartbeat, normal color, or "functioning" digestive, metabolic, and elimination systems, albeit sustained by machinery.\textsuperscript{189}

3. Inadequate Efforts on Behalf of Medical Personnel

The medical profession has also received wide criticism of its efforts at obtaining organs from suitable donors.\textsuperscript{190} Often doctors...
are reluctant to approach the family and request permission for organ removal because they feel that the family should not be subjected to difficult decisions at the time of its deepest grief. Doctors may be inadequately trained to tactfully broach such a difficult subject, or may fear an organ request would serve to aggravate their "failure" of not having been able to save the patient.\textsuperscript{191} In most cases, even when the patient possesses a valid donor card, the doctor will nonetheless request the family's consent, either out of respect for the family's wishes, or out of fear that legal liability might result if the doctor were to carry out the wishes of the decedent over the objections of the family.\textsuperscript{192} In such cases, family refusal results in the denial of what would otherwise be a successful, and legal removal.\textsuperscript{193}

A problem unrelated to obtaining consent is the failure of medical personnel to identify potential donors. In most states, a person is legally dead upon brain death.\textsuperscript{194} Organs that are harvested as soon as possible after death have the greatest success for transplant.\textsuperscript{195} Therefore, it is critical for transplantation success that potential donors be identified either before they are brain dead or immediately upon death. Polls show, however, that many health care professionals have a poor understanding of brain death, and this, in turn, greatly impedes their ability to identify donors and obtain consent.\textsuperscript{196}

\textsuperscript{191} See Youngner, supra note 189, at 14.
\textsuperscript{192} See Mehlman, supra note 6, at 4; see also Caplan, Costs, supra note 8, at 24. According to a 1985 article, no organ procurement agency will remove organs solely on the approval of a signed donor card, although the existence of one may encourage the family to consent. See Andersen & Fox, supra note 49, at 67.
\textsuperscript{193} Some critics of encouraged voluntarism argue that the practice of obtaining familial consent, even when the deceased has a valid donor card, undermines the philosophical aim of the UAGA which was to give priority to the wishes of the deceased over that of her family. See Matas, supra note 171, at 235.
\textsuperscript{194} See id. at 234; see also Youngner, supra note 189, at 12. At least 37 states and the District of Columbia statutorily define death as brain death, based on criteria developed in 1968, known as the "Harvard criteria." The 1986 Task Force recommended that those states that had not adopted the Uniform Determination of Death Act should do so, since the act provides a uniform definition of brain death. See Sipes, Approach, supra note 51, at 40 & n.28.
\textsuperscript{195} "For purposes of transplantation, [r]ecovering organs from heart-beating cadavers minimizes cellular injury to the organ." Sipes, Approach, supra note 51, at 40.
\textsuperscript{196} See Youngner, supra note 189, at 12. In a study of 195 health professionals, including neurosurgery residents, medical and surgical intensive-care-unit attending physicians and nurses, medical residents, operating room nurses and anesthesiologists at four university-affiliated hospitals in Cleveland, published in 1990, researchers found that only 63\% correctly identified irreversible loss of all brain function as the medical criterion for declaring a patient brain dead. \textit{Id}. 
All of these practical, psychological, and ethical conflicts have worked together to produce insufficient supplies of transplantable organs. The crucial fact is that there are a sufficient number of deaths each year to supply all of the needed organs—enough to transplant into each adult and child waiting for an organ.\textsuperscript{197} By 1985, this realization led the medical profession, bioethicists, and legislatures to acknowledge that encouraged voluntarism under the UAGA had failed, and spurred their search for feasible alternatives to a system which had once held such promise.

B. \textit{Required Request and Routine Inquiry}

The adoption of required request and routine inquiry statutes in the 1980s was an attempt to understand and eliminate the discrepancy between the high numbers of people who claimed to be willing to donate their organs and the organs of their loved ones, and the small number of organs actually procured.\textsuperscript{198} Given the public's apparent willingness to donate when asked by a physician, transplant scholars felt that the puzzling discrepancy was due, in large part, to the failure of health care professionals to request donation from the family of the deceased.\textsuperscript{199}

In theory, a system of required request or routine inquiry can increase organ procurement simply by ensuring that opportunities to request consent are not overlooked by the medical community.\textsuperscript{200} Required request is appealing from an ethical standpoint since it modifies only slightly the system of encouraged voluntarism. It encourages altruism, protects individual autonomy, and respects the rights of the family while potentially increasing the supply of procured organs.\textsuperscript{201}

Required request is premised on the belief that both the medical staff and the family will suffer less psychological stress if organ requests are made routinely.\textsuperscript{202} Medical personnel will grow more

\textsuperscript{197}This is not meant to imply that all transplants will be successful, but with the rapid improvement in transplant technology, and the already high success rates, there is no reason why an adequate supply of organs could not, in the near future, result in almost perfect survival rates of all people in need of a transplant and receiving one.

\textsuperscript{198}See Virnig & Caplan, supra note 58, at 2155.

\textsuperscript{199}Id.

\textsuperscript{200}See Andersen & Fox, supra note 49, at 67.

\textsuperscript{201}See Virnig & Caplan, supra note 58, at 2155; see also Arthur L. Caplan, Requests, Gifts, and Obligations: The Ethics of Organ Procurement, 28 Transplantation Proceedings 49, 53 (1986) [hereinafter Caplan, Requests, Gifts, and Obligations].

\textsuperscript{202}See Virnig & Caplan, supra note 58, at 2155; see also Caplan, Requests, Gifts and Obligations, supra note 201, at 54.
comfortable with the process of requesting consent as such requests become standard operating procedure.\footnote{203}{See Virnig & Caplan, supra note 58, at 2155.} Similarly, the public will soon come to expect such requests and will consider them a normal part of the process of a hospital death.\footnote{204}{See Caplan, Requests, Gifts and Obligations, supra note 201, at 54.} This expectation of being asked to donate, it is reasoned, may cause family members to discuss their desires concerning donation while they are alive.\footnote{205}{Id.}

Under a system of required request, organs cannot be removed from an individual unless the deceased has explicitly consented while living, or the deceased’s family has consented.\footnote{206}{Id.} Some proponents of required request contend that since the family is usually responsible for the disposition of the body, such as arranging for burial, an additional inquiry regarding organ donation is unlikely to overly burden the family.\footnote{207}{Id.} Although the effects of required request and routine inquiry laws have not been conclusively established, nine years after the first required request laws were enacted, there are still approximately 34,000 U.S. residents waiting for available organs.\footnote{208}{See UNOS Waitlist, supra note 1.} This has fostered a growing perception that such laws have failed to solve the organ shortage crisis.\footnote{209}{See Mehlman, supra note 6, at 11.}

Studies evaluating the success of required request legislation have varied greatly in their findings.\footnote{210}{See id.} This is due to the small number of studies that have been executed and the inadequate reporting systems that characterize many of the required request laws.\footnote{211}{See Andersen & Fox, supra note 49, at 75.} According to several studies, required request legislation has resulted in increases in organ donations.\footnote{212}{See Mehlman, supra note 6, at 11.} In Oregon, monthly collections of eyes increased 135 percent during the first year of required request, and bone and skin donations increased 20–25 percent.\footnote{213}{Id.} In New York, data revealed a 94 percent increase in heart donations, 96 percent increase in livers, 23 percent increase in kidneys, and 58 percent increase in eyes during the year following the passage of required request legislation.\footnote{214}{Id.}
While these statistics appear promising, other studies reveal much less favorable results. In Maryland, studies showed no increase in the consent rate despite an increase in donor referrals to organ procurement agencies.\textsuperscript{215} The ratio of donations to requests increased only 3 percent after the enactment of required request.\textsuperscript{216} In Oregon, despite increases in eyes, skin, and bone donations, kidney donations dropped during the first year that required request was implemented.\textsuperscript{217} In Los Angeles, the number of referrals to OPAs increased during the first year of routine inquiry requirements, but the number of donors remained approximately the same as it had been before the legislation was passed.\textsuperscript{218} Additionally, in 1987, local referrals to Los Angeles OPAs dropped by approximately five hundred.\textsuperscript{219} New Jersey experienced similarly disappointing results following its enactment of legislation. One study of the Southern region of the state found no statistically significant change in organ procurement after the passage of New Jersey’s legislation.\textsuperscript{220} Further, a 1989 survey of OPAs in states with required request (and routine inquiry) legislation revealed that although nine out of ten respondents had experienced an increase in referrals, only two reported a major increase in vital organ donations.\textsuperscript{221}

While these findings are insufficient to establish conclusively the failure of required request legislation, it is evident that substantial weaknesses still exist. Experts attribute several factors to the disappointing results of the legislation.\textsuperscript{222} Often health professionals responsible for requesting organs are inadequately trained to do so.\textsuperscript{223} Occasionally physicians will refuse to comply or will do so half-heartedly because they regard required request laws as "bureaucratic intrusions into the practice of medicine."\textsuperscript{224} Often physicians are provided little incentive to request donation because there are in-

\textsuperscript{215} Id. at 12.
\textsuperscript{216} Id.
\textsuperscript{217} Mehlman, \textit{supra} note 6, at 12. This drop, however, may have been due to an unexplained drop in mortality that year. See Andersen & Fox, \textit{supra} note 49, at 75. In Oregon, the data obtained cannot be attributed conclusively to required request legislation, since the state also experienced a growth in the number of its transplant programs that year. \textit{Id}.
\textsuperscript{218} See \textit{id}. at 75–76.
\textsuperscript{219} See \textit{id}. at 76.
\textsuperscript{221} See \textit{id}. at 822.
\textsuperscript{222} See Mehlman, \textit{supra} note 6, at 10.
\textsuperscript{223} Id. at 13.
\textsuperscript{224} Id.
sufficient penalties for noncompliance. The existence of "loopholes" sometimes allows physicians to easily circumvent the requirements. Finally, legislation is ineffective in states that lack legislatively defined criteria for brain death.

The key to success seems to lie in educating health professionals to better identify suitable candidates, accept the importance of organ donation, and learn how to approach families for consent in the most effective manner. The need for public education, as well, cannot be overestimated. It is vital that the public increase its awareness of the need for organs. It is imperative that an individual choose whether to become a donor during his or her lifetime and that he or she, while still living, make those wishes known to his or her family. Finally, the only way to determine the effectiveness of required request legislation is to improve monitoring and reporting mechanisms of hospitals complying with required request laws.

It is evident that more comprehensive studies must be carried out in order to assess accurately the performance of required request legislation. Many experts in the transplant community feel, however, that no further analyses of required request are necessary, given the huge numbers of patients still waiting for organs and the estimated 2,567 patients that died while waiting for available organs, in 1992 alone. These statistics, they claim, speak for themselves and indicate that the time for more drastic measures has arrived.

C. Can Presumed Consent Solve the Organ Shortage?

1. The Advantages of Presumed Consent

The issue of presumed consent raises several difficult ethical and moral dilemmas. Advocates of presumed consent hail its advantages over both encouraged voluntarism and required request. It eliminates the need to carry donor cards and other affirmative expressions of donor willingness, tools which have proven to be both underused and ineffective. Additionally, presumed consent eliminates the need for health care professionals to inflict further grief

225 Id.
226 Id.
227 See Ross, supra note 220, at 822.
228 Statistic obtained from telephone conversation with UNOS, Communications Department on 2/14/94.
229 See generally Matas, supra note 171.
230 See Mehlman, supra note 6, at 4-5.
on family members who have just recently learned of their loved one’s death. An effective system of presumed consent provides the public with ample opportunities to register its objections to donation. Advocates reason that individuals under a system of presumed consent will make their decisions regarding donation at rational times, and not during their moments of loss and grief. Thus, the decision may be more deliberate and dispassionate than those made under systems of encouraged voluntarism and required request.

Presumed consent would eliminate the problems caused by doctors who are reluctant to ask for consent, or who ask without being firmly committed to the cause and who, therefore, get poor results. Less extreme systems of presumed consent prohibit removal of organs from individuals whose families cannot be located and therefore cannot object even if they wish to do so. Those who advocate these more moderate systems argue that they would still produce a supply of organs sufficient to meet demand. Some supporters argue that enacting a system of presumed consent would save the health care industry money because fewer public education campaigns would be needed than under a system of encouraged voluntarism where the public must constantly be reminded of the need to donate organs.

A strong argument in favor of presumed consent is that such a system more adequately reflects society’s wishes concerning organ donation. Since the public opinion surveys show that the overwhelming majority of Americans are in favor of organ donation and transplantation, the proper presumption is one which presumes a willingness, rather than an unwillingness, on behalf of the public to donate. Presumed consent can avoid various psychological impediments, such as reluctance to face one’s own mortality, which prevent individuals from taking affirmative action to donate while alive.

2. Disadvantages of Presumed Consent

Although a system of presumed consent is appealing in its potential for dramatically increasing the supply of procured organs, it is

231 Id.
232 See id. at 19.
233 For further discussion of doctor reluctance see Ross, supra note 220, at 822.
234 See Caplan, Costs, supra note 8, at 28.
235 See id. This position is questionable, however, because great sums would be required to ensure that individuals were aware of their duty to opt-out if they so wished.
236 See Mehlman, supra note 6, at 21.
often met with strong opposition on various practical, ethical, legal, and theological grounds.

a. *Ethical Objections*

Critics of presumed consent feel that such a system is overly coercive and antithetical to the values of a democratic society since it appears to devalue freedom of choice.\textsuperscript{237} Some feel it is "so inhumane, manipulative, and unpopular" that even if it does increase the supply of organs, its end does not justify its means.\textsuperscript{238}

Certain bioethicists argue that a system of presumed consent is not morally desirable since it, through the state, removes an opportunity to act charitably, and thus, renders our community less virtuous.\textsuperscript{239} Others argue that it removes the moral dignity of donation by making it mandatory.\textsuperscript{240} There is, however, little reason to believe that individuals would not derive equally altruistic satisfaction from refraining from objecting under a system of presumed consent than they would from explicitly consenting under our current system. An individual who has made a conscious decision not to deprive a donee of an organ will most likely derive pleasure from that decision, regardless of what means are used to register his choice. Further, as one proponent of presumed consent has stated, "preserving the privilege of the few to exercise their virtue is not a morally sufficient ground for standing in the way of a policy that could save numerous lives."\textsuperscript{241}

b. *Practical Shortcomings*

From a practical standpoint, some critics insist that health professionals would ignore the freedom that an opting-in system provides and would continue to ask the family for their consent even if they were not legally obligated to do so.\textsuperscript{242} If explicit consent were sought routinely, presumed consent would operate no differently than our current system in that it would not eliminate the problems of doctor reluctance to obtain consent, and thus would not increase the supply of procured organs.\textsuperscript{243} Also, an effective opting-out system would

\textsuperscript{237} See id. at 6.
\textsuperscript{238} Id. at 22.
\textsuperscript{239} See id. at 24.
\textsuperscript{240} Caplan, Requests, Gifts and Obligations, supra note 201, at 53.
\textsuperscript{241} Matas, supra note 171, at 242.
\textsuperscript{242} See Mehlman, supra note 6, at 22.
\textsuperscript{243} See id. at 50.
probably require a centralized computer registry whereby objections could be recorded during one's lifetime and consulted upon one's death. The 1986 Task Force on Organ Transplantation considered and rejected the use of such centralized mechanisms to indicate donor willingness to donate. Further, from a financial perspective, opponents of presumed consent insist that a central registry capable of protecting both the right of every person to opt-out as well as handling constant modifications and updates would be prohibitively expensive.

c. Insufficient Safeguards

Much of the criticism of presumed consent reflects a cynicism that a thorough and effective opting-out mechanism could never be achieved. If a potential donor or her family were opposed to donation but did not know that there existed an affirmative duty to object, organs could be removed contrary to their wishes. This situation, it is argued, could substantially increase the family's grief and could hurt the medical profession generally by increasing public distrust of health care professionals. Some ethicists are simply uncomfortable with a system that, despite its noble intentions, benefits from an individual's or a family's ignorance of the rules. Similarly, opponents reason that presumed consent would exacerbate the public's fear that a physician, in his or her zeal to procure an organ, will not try to save a patient's life or will remove organs before the patient is actually dead. Since the family is not approached for its consent, no interested party is there to act as a safeguard to prevent such occurrences.

d. Unfavorable Public Opinion

Critics contend that although the majority of Americans do favor organ donation, this does not mean that they would favor a system.

\[244\] See Caplan, Requests, Gifts and Obligations, supra note 201, at 53.
\[245\] Mehlman, supra note 6, at n.87 and accompanying text.
\[246\] Caplan, Requests, Gifts and Obligations, supra note 201, at 53.
\[247\] See Mehlman, supra note 6, at 26.
\[248\] See id. at 26-27.
\[249\] See Matas, supra note 171, at 237.
\[250\] See Mehlman, supra note 6, at 49. The UAGA attempts to eliminate this fear by prohibiting the attending physician at the time of death and the physician who determines the time of death from participating in the removal or transplantation of organs. See id. The public's fear, however, persists either because of ignorance of this safeguard or the belief that the safeguard is not adequate to protect the patient from premature removals.
of presumed consent. They disapprove of presumed consent advocates using statistics which show support for organ donation generally, as proof of popular support for presumed consent. In fact, the 1986 Task Force cited lack of popular support as its only reason for rejecting presumed consent as a feasible method of organ procurement.\textsuperscript{251}

e. Legal Obstacles

Since the adoption of presumed consent would necessitate state action in the form of new state legislation, the system adopted would have to be designed so as not to violate state or federal constitutions. Challenges to presumed consent would most likely come under the First Amendment's prohibition against government interference with the free exercise of religion, or the Fifth Amendment's due process protection, or its prohibition against government takings of private property without just compensation.\textsuperscript{252}

i. Fifth Amendment Challenges

If the U.S. government takes private property for public use without providing just compensation to the citizen from whom the property is taken, the government has violated the takings clause of the U.S. Constitution.\textsuperscript{253} Some legal scholars have argued that the taking of cadaveric organs without the explicit consent of the deceased constitutes such a violation. Currently, however, the courts do not recognize property rights in a corpse.\textsuperscript{254} The law does recognize, however, a “quasi property right” of the family to dispose of the decedent’s remains in a manner consistent with its state’s laws.\textsuperscript{255}

\textsuperscript{251} See id. at 6. In the Gallup poll of 1985 only 7% of the respondents supported a system of presumed consent, compared to 75% who approved of organ donation. Id. Some scholars in the transplant community insist that public attitudes about presumed consent are currently unknown. They assert that previously conducted public opinion surveys have been biased and inconclusive because of the way the questions were asked. See id. at 46–48. A 1985 survey reported in the Journal of the American Medical Association found that “an overwhelming majority of Americans (86.5% of all respondents surveyed) believe that physicians should not have the power to remove organs from people who have died and who have not signed an organ donor card without consulting the next of kin.” Mehlman, supra note 6, at 45–46 (quoting Manninen & Evans, Public Attitudes and Behavior Regarding Organ Donation, 253 JAMA 3111, 3114 (1985)). The question, however, did not discuss the opportunity to opt-out during one’s lifetime. It is therefore possible that respondents regarded the system described to them as one of mandatory removal without the right of refusal, instead of one of presumed consent. See id. at 45–47.

\textsuperscript{252} See id. at 36.

\textsuperscript{253} U.S. Const. amend. V.

\textsuperscript{254} See Mehlman, supra note 6, at 37.

\textsuperscript{255} Id.
A property right of this nature, though, is not likely to be constitutionally protected. In the 1986 case of State v. Powell, the Florida Supreme Court ruled that the nonconsensual removal of corneal tissue for transplantation during statutorily required autopsies was not a constitutionally protected taking of private property. Further, the federal prohibition on the sale of human organs would likely render it impossible to be "justly compensated" for one's organs.

Due Process challenges to limited presumed consent laws also have failed. In State v. Powell, the court held that the right of the next-of-kin to dispose of a relative's corpse was not a fundamental right protected under either the Federal or Florida State Constitutions. In 1984, the Michigan Court of Appeals rejected a Fifth Amendment challenge against the state's limited presumed consent law, holding that constitutional rights regarding the integrity of one's body end at death.

ii. Civil and Criminal Liability

Any thoughtfully drafted presumed consent law would provide immunity clauses, similar to the UAGA's, for those acting in good faith. Such clauses, however, would also have to protect against tort claims of infliction of emotional distress by families whose objections were not sought and thus were not heeded. In 1988, the Florida Court of Appeals, in defining the family's right of burial, focused not on the good faith effort of the physician, but on "the effect of the same on the feelings and emotions of surviving relatives, who have the right to burial." Tort claims could prove fatal to presumed consent laws.

f. Divergent Views On the Ethics of Presumed Consent

Many of the debates over presumed consent center around the issue of individual autonomy. Proponents hail presumed consent as a means of protecting autonomy while opponents insist that it seri-

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256 Id.
258 See Mehlman, supra note 6, at 38.
259 See Powell, 497 So.2d at 1192; see also Mehlman, supra note 6, at 40.
260 See Tillman v. Detroit Receiving Hospital, 360 N.W.2d 275, 277 (Mich. Ct. App. 1984); see also Mehlman, supra note 6, at 40.
261 See Mehlman, supra note 6, at 44; see also Kirker v. Orange County, 519 So.2d 682, 684 (Fla. Dist. Ct. App. 1988) (quoting Jackson v. Rupp, 228 So.2d 916, 918 (Fla. Dist. Ct. App. 1969), aff'd 238 So.2d 86 (Fla. 1970); Kirksey v. Jernigan, 45 So.2d 188 (Fla. 1950)).
ously jeopardizes the right. Those who view presumed consent as a threat to individual rights stress that the system unfairly presumes the deceased is willing to donate even when the deceased’s wishes are unknown. Presumed consent, therefore, may violate the actual desires of the deceased.262

Advocates of presumed consent criticize required request by pointing out that under a system of required request, as it is currently practiced, the ultimate decision whether to donate is made by the family.263 Even if the deceased carried a valid donor card at the time of her death, the hospital will still seek her family’s consent. If the family’s desires happen to conflict with those of the deceased, the hospital will respect the family’s decision, in effect allowing it to overrule the autonomous wishes of the decedent.264 A pure system of presumed consent, one which does not entertain the wishes of the family, certainly respects individual autonomy if the individual has expressly consented during his lifetime. This express consent under our current system, however, occurs infrequently. Advocates insist that in an effective system of presumed consent where an individual is given ample opportunities to opt-out and chooses not to do so, his inaction should be treated as acceptance rather than refusal. Under our systems of required request and routine inquiry, failure to consent explicitly is construed as an unwillingness to donate. Some proponents suggest a modified form of presumed consent where the family may register its refusal only if it expresses what it believes to be the decedent’s wishes, not that of the family members.265 This safeguard, while palatable in theory, would be practically impossible to ensure.266

Supporters reason that presumed consent best reflects the public’s actual desires. They insist that shifting the presumption of willingness to donate is morally superior, and further, that the desire to donate is not a charitable virtue, but a moral duty.267 Proponents argue that all systems of organ procurement make presumptions about the desires of the public. Our current system assumes that, absent explicit authorization, the decedent wishes that his organs not be willed for beneficent medical uses.268 Some scholars insist that

262 See Mehlman, supra note 6, at 20.
263 See id.
264 See id.
265 See id.
266 See discussion supra part I.E.1.
267 See generally Cohen, supra note 165.
268 See id. at 2168.
such a presumption is contrary to the actual wishes of most Americans. By establishing a presumption of nonconsent, required request necessitates that the family be asked to make decisions at an extremely stressful time. At worst, it results in the death of a person who could not wait for the hospital to find a potential donor’s family and rebut such a presumption.

Supporters of presumed consent argue that a reversal of the current presumption would reflect more accurately the actual desires of the majority: “whether we require consent to be expressed or require refusal to be expressed should depend upon what we believe the majority would have done in fact, if all had registered their views.” Mistakes can be made under any system. It is, however, socially and morally preferable to remove, by mistake, an organ without consent, consequently saving someone’s life, than to refrain, by mistake, from removing an organ from a consenting donor, thus allowing someone to die needlessly. Finally, some supporters feel that the debate surrounding the consent to organ donation issue is based on a misguided attitude about a citizen’s duty to donate. If society viewed organ donation not as simply a charitable act, but as a moral duty, it would change the presumptions upon which our current system is based, as well as our expectations of those from whom we seek consent. Since the field of cadaveric organ procurement is relatively new and society is poorly informed of its complexities, it is necessary to design a system that guarantees that the rules of opting-out and their implications are clearly understood by all. Opponents of presumed consent feel that such a system has yet to be proposed and until it is, it would be unwise and dangerous to switch to a system of presumed consent. Finally, advocates remind their detractors that limited presumed consent laws already exist in the United States. They contend that the fact that many state legislatures have elected to adopt presumed consent laws in certain circumstances reveals an underestimation of the public’s willingness to support such an approach to organ procurement.

260 Id. at 2169.
269 See id.
271 Id. at 2172.
272 See Cohen, supra note 165, at 2171.
273 See Caplan, Requests, Gifts, and Obligations, supra note 201, at 55.
274 Id.
276 See id.
The ethical debates concerning presumed consent will undoubtedly continue as long as the organ shortage continues. Both proponents and opponents of presumed consent should obtain a full understanding of the effects this approach has had in countries where it has been enacted. Presumed consent does pose difficult legal and ethical hurdles, but they are not insurmountable. If France, Belgium, Austria, and Singapore truly have diminished their organ shortages through presumed consent, one cannot ignore the potential benefit of enacting more extensive presumed consent laws in the United States.

D. Success of the French System

For years after its inception, the Caillavet law produced disappointing results regarding organ procurement. Finally, however, France is showing encouraging increases. Since its 1978 decree, France has regularly increased its annual number of transplants. Recently, France has ranked among the top six European countries in number of postmortem donors per million of inhabitants per year. It is unclear, however, from the available research,

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277 In 1984, while almost 1,000 kidney transplants were performed in France, 3,000 people remained on the waiting list. See Gerson, supra note 111, at 1024-25.
279 Kidneys: from 551 to 1808; hearts and heart/lungs: from 15 to 622; livers: from 7 to 409; and pancreas: from 2 to 43. Id.
280 See Land & Cohen, supra note 141, at 2166.

<table>
<thead>
<tr>
<th>Country</th>
<th>Transplant Rates 1989-1990</th>
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<tbody>
<tr>
<td>Austria</td>
<td>27 pmp/1989; 30 pmp/1990</td>
</tr>
<tr>
<td>(pure presumed consent)</td>
<td></td>
</tr>
<tr>
<td>Madrid, Spain</td>
<td>30.5 pmp/1990</td>
</tr>
<tr>
<td>(presumed consent law in effect but not practiced)</td>
<td></td>
</tr>
<tr>
<td>Catalania</td>
<td>22.7 pmp/1990</td>
</tr>
<tr>
<td>(presumed consent law in effect but not practiced)</td>
<td></td>
</tr>
<tr>
<td>(no transplant law)</td>
<td></td>
</tr>
<tr>
<td>(presumed consent law enacted but physicians still request permission)</td>
<td></td>
</tr>
<tr>
<td>France</td>
<td>19.2 pmp/1990</td>
</tr>
<tr>
<td>(presumed consent law enacted but physicians still request permission)</td>
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"The estimated number of donors from a specific region must be regarded with great caution because the estimated number of inhabitants in that region is not precisely known." Id. at 2165.
whether France’s recent improvements can justly be used to support the effectiveness of presumed consent, since the French system, as practiced, functions more like a voluntary system of organ procurement than a system of presumed consent. This is because, despite the autonomy granted to physicians under the Caillavet law, French physicians notify the deceased’s family of their intention to remove organs in approximately 90.7 percent of cases.

Doctors disregard the law for a variety of reasons. Ethically, they may be opposed to ignoring the family’s wishes, or fear they could be held legally liable for doing so. They may distrust the efficiency of the hospital’s opting-out procedure or fear that the family has not affirmatively objected on behalf of the deceased because it is ignorant of its duty to do so. Finally, the doctor simply may not wish to spend time searching for objections on poorly maintained hospital charts.

In a study of 97 percent of Parisian hospitals, researchers found the following practices: strict application of the law—questioning of the family to determine solely the deceased’s wishes (30.8 percent of the time); questioning of the family to determine only the wishes of the family, not the deceased (15.4 percent); questioning to determine both the family’s and deceased’s wishes (36 percent); and notification of the family without any questioning (18 percent). In 50 percent of the cases, the physicians elicited the family’s wishes before taking any action regarding procurement of the deceased’s organ(s). This represents a significant departure from the intended application of presumed consent. Inevitably, once the physician requests familial consent, the number of refusals significantly decreases the amount of organs harvested.

Some physicians justify their reluctance to exercise their rights under the French law because they feel that the opting-out mechanisms are flawed and public awareness of the law is low. Critics of the system point to the inadequacy of independent hospital objection registries. Under the French system, there is no centralized

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281 Mehlman, supra note 6, at 16.
282 Benoit, supra note 278, at 321.
283 See Gerson, supra note 111, at 1026.
284 See Benoit, supra note 278, at 320–21.
285 See id. at 321.
286 Id.
288 See id. at 1026; see also Benoit, supra note 278, at 320.
289 See Benoit, supra note 278, at 320.
national registry which documents the refusal of all French citizens. Therefore, citizens are unable to voice their objections before they are admitted to a hospital, and if seriously injured, are unable to do so when admitted to the hospital.290 To determine what correlation exists between its organ procurement totals and its law, further research must be done.

E. Success in Belgium

In Belgium, physicians deviate from a pure system of presumed consent and ask the deceased's family if it objects before removing organs.291 Despite this practice, Belgium’s presumed consent law does appear to have greatly increased the number of organs procured and transplanted.292 A 1990 study found that, following the adoption of presumed consent, cadaveric kidney procurement had increased by 86 percent, total organ procurement by 183 percent, and total organs transplanted by 140 percent.293 A 1991 study reported an increase of 119 percent for kidneys procured, and even greater increases for multi-organ procurement compared with the period preceding presumed consent legislation.294

The significance of these improvements is currently debated.295 Some scholars feel that Belgium’s improvement rates are not attributable to its presumed consent law, but to an increase in the number of hospitals participating in the organ procurement process.296 Other experts, however, feel that the increase in participating hospitals is a direct result of the presumed consent legislation.297

290 The Prime Minister, however, has stated that "persons who intend to refuse postmortem organ removal, have every liberty to announce or notify their refusal." Land & Cohen, supra note 141, at 2165.
291 Mehlman, supra note 6, at 16.
292 See Roels, Effect of Presumed Consent, supra note 136, at 2078–79.
293 Id.
294 L. Roels et al., Three Years of Experience With a 'Presumed Consent' Legislation in Belgium: Its Impact on Multi-Organ Donation in Comparison With Other European Countries, 23 TRANSPLANTATION PROCEEDINGS 903, 903 (1991) [hereinafter Roels, Three Years].
295 See Mehlman, supra note 6, at n.60.
296 Id. at 16.
297 See Roels, Three Years, supra note 294, at 904.
explain that prior to the legislation, many smaller non-university hospitals were reluctant to participate in organ procurement for fear of legal liability.298 Supporters of presumed consent are confident that Belgium can double the number of kidneys it presently pro­cures within just a few years.299 To these experts, the improvements that Belgium has experienced prove that the problem of chronic organ shortage can be solved by enacting presumed consent legis­lation.300 They feel that a system of presumed consent which allows ample opportunity to object or consent during one’s lifetime “re­spects maximally the individual’s right of self-determination.”301

F. Success in Austria

At first glance, the success of Austria’s uncompromising presumed consent laws seems apparent. Austria has a higher rate of postmor­tem organ donors than any other country as a whole.302 Not only does Austria have a significantly higher rate of procured kidneys than (formerly West) Germany, Luxembourg, and the Netherlands, three countries similarly situated in terms of social and economic status, but it also rates 11 percent higher than Belgium.303 One can speculate that this superiority results from Austria’s strict application of its law compared to Belgium’s de facto system of encouraged voluntarism or required request.304 Austria, however, exhibits certain inconsistencies in its results. If Austria’s high rates of procurement were due only to its presumed consent law, one would expect it to outpace other countries in all categories of organs covered by the law. This, however, is not the case. Austria rates only slightly higher than France or Belgium in livers procured, and rates lower in the number of hearts procured.305 Austria’s high rates may derive more from its two very active transplant teams in Innsbruck and Vienna, which attract patients from outside of Austria, than from its system of presumed consent.306 Despite the correlation between Austria’s increased organ donation rates and its legislation, its success war-

298 See Roels, Effect of Presumed Consent, supra note 136, at 2079.
299 See Roels, Three Years, supra note 294, at 904.
300 Id.
301 Id.
302 See supra note 280 and accompanying text. The only other statistics in Austria’s range were those of the Madrid region of Spain, but these rates were not experienced in Spain as a whole. Land & Cohen, supra note 141, at 2166.
303 See Mehlman, supra note 6, at 17.
304 See id. at 17–18.
305 See id. at 18.
306 See Land & Cohen, supra note 141, at 2166.
rants closer examination of the Austrian system. In particular, it could be instructive to determine what social factors cause Austrian doctors to respect the letter of the law and refrain from approaching families for consent, when physicians in so many other countries seem unwilling to remove an organ without familial consent.307

G. Success in Singapore

Singapore’s adoption of presumed consent appears to have diminished its organ shortage significantly. Under its voluntary system of organ donation, between 1970 and 1987, only 4.7 kidneys were procured per year.308 This rate, however, escalated to an average of 31.3 kidneys per year for the three years after the HOTA was enacted (1988–1990).309 Of the ninety-four kidneys procured from 1988 through 1990, fifty-five (58.5 percent) of them were retrieved as a result of presumed consent, and thirty-nine (41.5 percent) were retrieved from donors who had opted-in.310 The public education campaigns aimed at increasing acceptance of presumed consent also reaped great benefits for the voluntary program. After 1988, voluntary donations rose from 4.7 per year before 1988 to thirteen per year.311 Much of the success of Singapore’s law is attributed to the efforts of the National Kidney Foundation and the Ministry of Health which launched public education campaigns to educate the population on the need for organs and for support of the law.312 There was also extensive professional and public debate conducted prior to the enactment of the law which heightened public awareness.313

Singapore’s ethnic, racial, and religious diversity presents some particular challenges to the successful implementation of its organ donation policy. Muslims comprise roughly 16 percent of its three million inhabitants.314 Traditionally, Muslims have opposed organ

307 See Mehlman, supra note 6, at 18.
308 See Soh & Lim, supra note 147, at 1337. In addition, between 1983 and 1987 Singapore was forced to import 33 kidneys from the United States, Canada, and Western Europe. See S.M.L. Lim et al., Organ Donation In Singapore, 22 TRANSPLANTATION PROCEEDINGS 2179, 2179 (1990). The survival rates of the imported kidneys were substantially lower than those retrieved domestically, probably due to the delays resulting from importation. See id.
309 Soh & Lim, supra note 147, at 1337.
310 Id.
311 Id.
312 See Iyer, supra note 146, at 133.
313 See Soh & Lim, supra note 147, at 1337.
314 Id.
In 1983, the Muslim Religious Council reversed this position and sanctioned organ donation provided that Muslim donors consent in advance in writing, that the organs of Muslim donors be transplanted immediately, and that the organs not be stored in organ banks. Given the limitations which still exist, and the large number of Muslims who still object, the HOTA excludes Muslims from its jurisdiction and alleviates their burden by allowing them, instead, to opt-in under the MTA. A Muslim who opts into the system may have his or her wishes vetoed by the family if its members personally object to donation. Ethical debate continues over the provision of the HOTA which stipulates that only those Muslims who have opted-into the system receive priority classification for receiving kidneys. Proponents of the HOTA’s policy argue that individuals who do not wish to respond to the general needs of society cannot be allowed to reap its benefits later on.

Despite its success, Singapore has not eliminated its kidney shortage completely—an estimated 310 patients still await kidney transplants. Singapore’s small population and well-documented organ retrieval results make it an ideal country to examine when analyzing the feasibility of presumed consent. Singapore’s success symbolizes the possibility of creating a functional, publicly accepted system of presumed consent.

III. A Proposal for the United States

The encouraging results of presumed consent legislation abroad underscore the need to consider alternative policies in the United States. However immediate the need to improve our current system, the demands of a democratic society require that changes be publicly supported by an informed electorate. One possible plan to accomplish these changes consists of an initial stage of education and assessments of existing organ procurement policies in this country and abroad, followed by a second stage of enactment of new legislation to deal more appropriately with the shortages than is accomplished by our current policies.

315 See NKF Religious Views, supra note 184, at 35.
316 Id.
317 See Iyer, supra note 146, at 135.
318 See id.
319 See id.
320 See id. at 136-37.
321 See Soh & Lim, supra note 147, at 1337.
A. The Initial Five Year Period

During the first five years of the plan, efforts should focus on several major issues. The following areas are essential for positive change: 1) serious and widespread efforts to educate the public; 2) continuing efforts to train and educate the medical community; 3) implementation of increased means by which to register one's choice whether to donate; and 4) significant attempts to assess conclusively the results of major donation policies in the United States and abroad.

1. Educating the Public

Advocating increased public education is not a new concept. Almost every scholar of organ donation, regardless of his preferred policy, insists that public awareness of the need for organs and of the duty to choose whether or not to donate, are essential to the success of any donor program. Despite the difficulty of such a task, public perception will not change, and any legislation proposed will not succeed, if the transplant community cannot raise the public's awareness. First, citizens must recognize the need for transplantable organs, and acknowledge the number of U.S. citizens that suffer as a result of their indecision. The medical community must effectively communicate the procedural safeguards currently employed in declaring a patient dead. The public must understand that its fears of being left to die or having its organs removed prematurely are unfounded.

Further, individuals must accept the necessity of informing their families about their wishes regarding donation. Under our current system of required request, since the family is almost always asked to consent even if the deceased has signed a valid donor card, it is imperative that the family know how strongly the deceased believed in donation. If, as is usually the case, the deceased has not affirmatively consented to donation while alive, the family's decision whether to consent will be made less difficult if the family knows whether the deceased favored donation. Individuals should be motivated by the fact that informing their families can significantly decrease the stress their family will undoubtedly suffer upon the individual's death.

Additionally, religious leaders must be entreated to educate their followers on their religion's position regarding donation and transplantation. The leaders also should encourage their adherents to affirmatively choose an option based on their personal and religious
convictions. Lastly, citizens in states with modified presumed consent legislation for corneal and pituitary removal by coroners, should be made aware that these laws currently exist and have not caused adverse societal consequences.

2. Educating and Training the Medical Profession

The initial five year period should also focus on continuing to educate and train the medical establishment to request consent effectively and comfortably, and to understand and recognize when brain death has occurred. Simultaneously, efforts should be made to enact brain death legislation in those states which still do not legally recognize brain death as death.

3. Increasing Opportunities to Opt-In or Out

Citizens should be given much broader opportunities to choose whether or not they wish to donate. It is socially desirable to have every citizen decide for herself—at a rational point in time, unburdened by impending illness—whether she wishes to donate her organs. Citizens should be made to feel a greater duty to make a choice while alive. Legislation should be passed which requires citizens to choose: 1) “yes” and if so, to specify which organs; 2) “no,” always having the opportunity to reconsider; or 3) “let my next-of-kin decide upon my death.” This last option will protect those individuals who believe that the decision to donate is one which rightly belongs to the surviving family, not the deceased.

Forms for registering one’s choice could be made available on many occasions: when renewing one’s driver’s license; when registering with selective service; when registering to vote; when donating blood or sperm; or anytime one addresses matters of health or mortality—e.g., when buying health, life or car insurance, when applying for medicaid or medicare, when drafting wills or living wills, or when buying cemetery plots or arranging for cremation.

4. Determining the Success of Other Systems

Throughout this initial five year period, the scientific community should increase its efforts to conclusively assess the success of required request and routine inquiry legislation in all states that have these systems. Such studies should consider all relevant factors that affect donation results. Additionally, transplant scholars must obtain more specific and reliable data on other countries that follow some
variation of presumed consent. These countries must be scrutinized to determine how their systems work in practice, not just in theory. Only by analyzing these systems closely will we gain a sufficient understanding of what changes must be implemented in the United States.

B. The Second Phase—Legislation

At the end of five years, legislation should be enacted that requires citizens to choose one of the "yes," "no," or "next-of-kin" donation options. If efforts during the first phase of the plan are successful by this time, the majority of the population will have already voluntarily registered its choice with the state. Eligibility for a variety of government services can be conditioned on having registered. It is time that individuals accept the burden of making an affirmative decision regarding organ donation. The needless consequences of their inaction, thousands of deaths each year, justify imposing such a burden on the members of society.

During this second stage, assuming that substantial organ shortages still exist, legislators should enact a modified system of presumed consent, one requiring "reasonable efforts." These reasonable effort laws would function essentially like those currently enacted in some states, but would apply not only to coroners and medical examiners but to all hospital transplant professionals. The laws would cover all organs, rather than the limited array of organs covered in most of the existing "reasonable effort" laws. The laws should require that a reasonable effort be made to inquire whether the family objects to the routine removal of organs, not to inquire if the family affirmatively consents. While this may seem an insignificant distinction, it may be less emotionally burdensome for grieving family members to exercise their right to object, than it would be to force them to affirmatively choose to donate if they had never contemplated the decision.322

Since legislation requiring individuals to choose an option while alive would be enacted in the initial stage of the plan, this reasonable effort law would only apply to the limited situations where, despite the law, the individual had not registered her choice or where the

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322 This is essentially the argument made by Matas in his 1985 article in which he advocates a system of "routine removal with right to informed refusal." See Matas, supra note 171, at 238.
individual had opted to let her family decide. Mandating that a reasonable effort be made by hospital personnel would not add to the burden that our current system of required request already imposes on the professional responsible for requesting consent or informing the family of its options. If, as a result of the educational efforts proposed in the initial stage of the plan, individuals began to accept that they have a duty to decide for themselves while alive, an expansive reasonable effort law would be much more acceptable to the public than it may be now. In order to respect autonomy, the system should honor the explicit, registered wishes of the deceased over those of the family. This means that, if the deceased had consented while alive, the hospital would have no duty to ask the family if it objected. In the event that a donor had explicitly consented to donate, the hospital simply would be required to inform the family that it was proceeding with removal since it was required by state law to respect the deceased’s wishes. Conversely, if the deceased had explicitly refused donation, the hospital would not be allowed to ask the family to override those wishes either.

Under our current system, each year thousands of adults and children awaiting organs sit idly by, hoping that somewhere an individual has been sufficiently moved by the spirit of generosity to grant that his organ, or that of a loved one, be used to save the life of an unfortunate donee. The injustice of a system that allows, or indeed requires, this type of behavior justifies an immediate change in organ donation policy. Organ transplantation is one of the few areas of medical science in which the major barriers to resolving the medical crisis are not due to a lack of scientific or technological know-how. Society has a duty to take whatever steps are necessary—as long as they are legally, ethically, and morally acceptable—to eradicate the organ shortage, especially since it already has the capability to do so.

**Conclusion**

The United States has a long history of actively encouraging posthumous organ donation for transplantation. The medical community, and in turn the legislature, has adapted its approach to organ donation over the years in order to procure greater numbers of organs. In doing so, they have always endeavored to protect the rights of individuals. The time has come to reevaluate the systems of required request and routine inquiry currently employed in the
United States. Critical to this evaluation is an appreciation of presumed consent laws presently in force around the world. The increases in organ procurement experienced by countries such as France, Belgium, Austria, and Singapore can prove instructive in modeling a presumed consent approach to organ donation in the United States.

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