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Articles

“BROTHER, CAN YOU SPARE A LIVER?” FIVE WAYS TO INCREASE ORGAN DONATION

PHYLLIS COLEMAN*

I. INTRODUCTION

Controversy swirls around a baseball legend, governor, rock singer and television star because each received his potentially life-saving organ¹ transplant in what seems to be record time. New York Yankee great Mickey Mantle was on a list for only two days before his liver transplant.² Pennsylvania Governor Robert Casey actually received his heart-liver transplant within hours.³ David Crosby—of Crosby, Stills and Nash—apparently received his new liver after slightly more than a two-week wait.⁴ Actor Larry Hagman was on a list for only three weeks when he got his new liver.⁵ Many others are not so lucky—they die before a match can be found.

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1. Organ means solid organs, including the kidney, heart, liver, lung, and pancreas. 42 U.S.C. § 274b(d)(2) (1994). These are distinguishable from renewable body parts such as blood and bone marrow from living donors and other body tissues used to enhance quality of life. Examples include corneas, bones and skin, which are not renewable but also generally are not life-saving. Mark F. Anderson, *The Future of Organ Transplantation: From Where Will New Donors Come, To Whom Will Their Organs Go?*, 5 HEALTH MATRIX: J. LAW-MED. 249, 252 n.7 (1995).

2. Peter Gorner & Peter Baniak, *Mantle's New Liver: A Question of Ethics: Experts Find No Favoritism After Speedy Transplant*, CHI. TRIB., June 9, 1995, at 3N.

3. When Governor Casey received his heart-liver transplant, the average wait for a heart was 198 days, while the average wait for a liver was 67 days. The governor had only days to live but, “[f]ortunately for him, he beat the odds and received his organs after waiting for only one day.” Anderson, *supra* note 1, at 250. Although the case ignited serious controversy concerning fairness, the explanation was that Casey was the only person on the list for two organs. A local policy provided priority to persons requiring both organs over those awaiting only a heart or liver. *Id.* at 251 n.6.

4. Rick Sky, *Crosby “Critical” Star With a New Liver Fights for Life*, DAILY MIRROR, Nov. 22, 1994, at 23.

5. Gerard Evans, *Joking JR Laughs Off His Brush With Death, You Can't Keep a Bad Man Down: Hagman As JR*, DAILY MAIL, Aug. 25, 1995, at 15. The hospital denies any favoritism. Instead, the institution asserted that after cancer was discovered in July, Hagman was placed on a priority registry and worked his way to the top. *Id.*

In fact, an inadequate supply of organs means long waiting lists, "often measured in years rather than months."⁶ Contrast,⁷ for example, Mantle's two days on the list with the 130 day⁸ average wait for a liver. Such extreme disparity causes some to claim that famous people jump ahead on the list based on their celebrity status. If true, these allegations raise legitimate ethical concerns. But, while debates about these troubling ethical issues may be interesting and even important, they cannot solve the scarcity problem. Focusing on expanding the supply of available organs, thereby eliminating the need to choose among recipients, would be much more productive.⁹

Part II of this Article contains a simple statement of the problem: the number of people who need transplants far exceeds available organs. Approximately three potential recipients wait for every donated organ.¹⁰ For example, researchers calculate a backlog of 15,000 people need a heart, 22,500 a kidney, and 5,000 a pancreas.¹¹ Part III briefly explains donation procedures. Part IV discusses the allocation process. Part V reviews previously suggested solutions to the organ donor shortage. Finally, this Article proposes new ways to increase the total number of available transplantable organs.

One suggestion—permitting death row inmates to donate organs—is bold and controversial. The others will ruffle fewer feathers and are likely to be more effective in increasing the supply of transplantable organs. One proposal simply requires that doctors and hospitals follow current law. Another would establish a nominal discount on driver's license fees for donors.

A more costly proposal is a national computer registry containing donor status and other relevant information, such as blood type and whether a person has a living will. This Article suggests that states need to create and continuously update such a registry, and draft and implement detailed procedures for police and emergency medical personnel to follow in certain accident and

6. Susan Hankin Denise, Note, *Regulating the Sale of Human Organs*, 71 VA. L. REV. 1015, 1019 (1985).

7. The average waiting time varies depending on the particular organ and the transplant region. See *infra* text accompanying notes 55-61. In fact, "unique medical and logistical factors" of different organs frequently require different treatment. Erik S. Jaffe et al., *Eliminating Artificial Barriers to the Equitable Distribution of Hearts for Transplantation*, 20 J. CORP. L. 109 (1994). Nevertheless, all organs may be grouped together for this discussion.

8. Gomer & Baniak, *supra* note 2, at 3N.

9. It is, of course, possible to make a rational, principled argument that transplants are simply too costly, and thus, represent an improper allocation of scarce resources. Nevertheless, this article presumes that Americans have concluded that the benefits outweigh the costs.

10. REPORT OF THE TASK FORCE ON ORGAN TRANSPLANTATION, ORGAN TRANSPLANTATION ISSUES AND RECOMMENDATIONS 27 (1986) [hereinafter TASK FORCE].

11. Gregory S. Crespi, *Overcoming the Legal Obstacles to the Creation of a Futures Market in Bodily Organs*, 55 OHIO ST. L.J. 1, 9 (1994).

trauma situations. Under these guidelines, law enforcement officers, paramedics, and hospital personnel would be required to ascertain donor status by checking with the national computer system as soon as possible.

Finally, to alleviate the pediatric organ shortage, this Article proposes changing the social security application form, requiring parents to designate whether they wish their child to be an organ donor.

II. THE PROBLEM

New medical technology¹² has sharply increased the number of potential transplant recipients.¹³ The number of donors has not kept pace.¹⁴ A continuing "severe and tragic shortage"¹⁵ of organs means that many people die while waiting for possibly life-saving operations.¹⁶ To put the problem in perspective: every four hours a patient waiting for a liver dies.¹⁷

12. For an interesting review of the history of transplantation seen through the eyes of a famous transplant surgeon pioneer, see THOMAS E. STARZL, *THE PUZZLE PEOPLE MEMOIRS OF A TRANSPLANT SURGEON* (1992).

13. TOM L. BEAUCHAMP & JAMES F. CHILDRESS, *PRINCIPLES OF BIOMEDICAL ETHICS* 285 (3d ed. 1989). Various advances, especially new immunosuppressant medications, have substantially improved techniques and effectiveness. One year success rates are good: the rate for both kidney and heart transplants exceeds 80 percent and for liver transplants it exceeds 70 percent. Unfortunately, transplanted organs typically last only about seven years. Anderson, *supra* note 1, at 253.

14. See, e.g., Jaffe et al., *supra* note 7, at 109. A total of 49,933 people were waiting for transplants in 1992. This represented a 66 percent increase over just four years earlier. Unfortunately, during this same period, there was only a 13 percent increase in donors. As a result of this "grim disparity," more than 10,000 people died. Robin Elizabeth Margolis, *Are Transplanted Organs Being Allocated Unfairly and Illegally?*, *HEALTHSPAN*, June 1993, at 14.

Several additional factors contribute to the problem. For example, people with diseases such as AIDS and hepatitis are not suitable donors. Rao R. Ivatury et al., *Analysis of Organ Procurement Failure at an Urban Trauma Center and the Impact of HIV on Organ Procurement at a Regional Transplantation Center*, 33 *J. TRAUMA* 424, 426-28 (1992). Ironically, as highway safety measures become more effective in saving lives, they may decrease the number of available transplantable organs. *Auto Safety and Crashworthiness*, *INS. ISSUES UPDATE* (Ins. Info. Inst.), Aug. 1996 [hereinafter *INS. UPDATE*]. See *infra* note 244.

15. Lloyd R. Cohen, *Increasing the Supply of Transplant Organs: The Virtues of a Futures Market*, 58 *GEO. WASH. L. REV.* 1 (1989). But see John A. Stein, Comment, *Rethinking the National Organ Transplant Program: When Push Comes to Shove*, 11 *J. CONTEMP. HEALTH L. & POL'Y* 197, 198 (1994) (arguing that "the shortfalls are not the result of an inadequate supply of available organs. Indeed, if more efficiently utilized, the available organ donor pool may adequately meet current transplant needs" (citations omitted)).

16. *The UNOS Statement of Principles and Objectives of Equitable Organ Allocation*, 14 *SEMINARS IN ANESTHESIA* 142 (1995) [hereinafter *UNOS Statement*].

17. Fred H. Cate, *Human Organ Transplantation: The Role of Law*, 20 *J. CORP. L.* 69, 70 (1994).

Scarcity causes death in an additional, more subtle way. A perfect match reduces the risk of rejection. However, because the number of available organs is inadequate, many transplants may not be the best match. Further, because organs cannot be preserved for long, time becomes a formidable enemy. There is simply no opportunity to subject the organs harvested from accident victims to complete immunologic matching.¹⁸ An imperfect match increases the probability of rejection and death.¹⁹ These deaths are particularly troubling because some might be preventable. If every person who died under circumstances²⁰ where organs could be donated was a donor, it might satisfy the current need.²¹ But, for a variety of reasons,²² most people are not donors, causing commentators to pen such eloquent laments as “[e]very year in our nation 200,000 useful organs are consigned to the maggots for ready conversion to swill.”²³ An obvious solution is to increase the supply of donor

18. Ian C. Pilarczyk, *Organ Donor Trusts and Durable Powers of Attorney for Organ Donation: New Trusts on the Living Trust and Living Will*, 13 PROB. L.J. 29, 34-35 (1995).

19. Denise, *supra* note 6, at 1019. *But see* Nicholas A. Halasz, *Medicine and Ethics: How to Allocate Transplantable Organs*, 52 TRANSPLANTATION 43, 45 (1991) (suggesting that “an ongoing controversy as to the effectiveness of seeking better-matched donor-recipient pairs” in cadaver kidney transplants exists).

20. Currently, donors must be “brain dead,” which requires that they exhibit no brain function. ANDREW KIMBRELL, *THE HUMAN BODY SHOP* 36-39 (1993). Because their hearts are still beating when the donation process begins, they are called heart-beating cadaver donors (“HBCDs”). ROBERT M. ARNOLD ET AL., *PROCURING ORGANS FOR TRANSPLANT: THE DEBATE OVER NON-HEART-BEATING CADAVER PROTOCOLS 1* (1995). Various aggressive attempts to increase donations have caused some to suggest expanding the pool of potential donors to include those who experience cardiopulmonary, rather than brain, death. In fact, these non-heart-beating cadaver donors were the main source of organs prior to “brain death” laws.

One problem has been, however, that organs might be severely damaged by a lack of blood between the time the heart stops and when the organs can be harvested. Nevertheless, two new methods of limiting damage and increasing organ viability have sparked renewed interest in NHBCD’s. The first, *in situ* preservation, cools body organs shortly after declaration of cardiopulmonary death. The second method is rapid retrieval of organs. *Id.* at 2. For a discussion of how heart transplants led to a redefinition of death, see DAVID J. ROTHMAN, *STRANGERS AT THE BEDSIDE: A HISTORY OF HOW LAW AND BIOETHICS TRANSFORMED MEDICAL DECISION MAKING* 158-86 (1991).

21. Robert M. Tenery, Jr., *More Patients Need Their Second Chance at Life: Solving Organ Donor Shortages*, 38 AM. MED. NEWS, Apr. 10, 1995, at 26. Mr. Tenery asserts that “[t]here are potentially more than enough organs” available. Of course, most of the approximately two million people who die each year in this country are not suitable donors. Estimates vary, but it seems that around 20,000 of these could donate, representing a potential supply of about 40,000 single kidneys and 20,000 hearts, livers and lung pairs. Theodore Silver, *The Case for a Post-Mortem Organ Draft and a Proposed Model Organ Draft Act*, 68 B.U. L. REV. 681, 687-88 n.25 (1988). These numbers would meet approximately half of the estimated need for hearts and livers. This would “dwarf” the current supply of lungs; however, comparison is difficult, for the present need is unknown. *Id.* at 688 n.26.

22. *See infra* text accompanying notes 33-47.

23. Silver, *supra* note 21, at 681.

organs. Unfortunately, despite an overwhelmingly positive public view of organ donation,²⁴ previous efforts to motivate additional donors have failed.²⁵

III. DONATION

A. *The Process*

The transplant process is currently dependent on altruism. Individuals decide to donate, presumably because they think it is the right thing to do. Donors do not—in fact under current federal legislation²⁶ cannot—receive compensation.²⁷ Instead, organ donation, like any other charitable transfer, is an uncompensated gift from donor to recipient.²⁸

People express their desire to donate organs by signing and carrying a donor card²⁹ and/or checking the appropriate authorization on their driver's

24. A "large majority" of Americans support organ donation and consider it "praiseworthy." TASK FORCE, *supra* note 10, at 37. A 1985 Gallup poll found that 93 percent of those surveyed knew about organ transplants. Of these, 75 percent approved.

25. Silver, *supra* note 21, at 681.

26. 42 U.S.C. § 274 (1994).

27. Organ procurement charges vary widely. Roger W. Evans, *Organ Procurement Expenditures and the Role of Financial Incentives*, 269 JAMA 3113 (1993). Although financial incentives may improve procurement efficiency, there is some concern that such payments might also adversely affect transplant cost-effectiveness. "Cost-effectiveness is threatened when per-procedure expenditures increase and benefits remain unchanged. Thus, even if more lives are saved due to increased organ donation, the relative cost-effectiveness of transplantation will deteriorate." *Id.* at 3117.

28. This transfer is not direct. In fact, transplant organizations generally reject attempts by donors' families to know or contact recipients. For example, the University of Miami's transplant policy is to protect donor and recipient privacy. That policy has come under attack recently. A woman who donated her son's organs attempted to meet the recipients and their families. Although she denied that she wants to become a part of their lives, she said meeting them would help her obtain closure. "I don't care what color they are or what they do for a living. I just want to meet them and hear Jeffrey's heart beating in their chest," said Kathy Bass. Tao Woolfe, *Mother Wants to Meet Those Son's Organs Saved*, FORT LAUDERDALE SUN SENTINEL, June 11, 1996, at 1B.

Some in the transplant community advocate changing this anonymity policy, at least when donors' families and recipients agree. Peter Shinkle, *Transplant Dilemma: Donors, Recipients Often Denied Contact*, SUNDAY ADVOC., Nov. 13, 1994, at 1A. But, most transplant officials claim that anonymity is necessary "because strong emotions can arise—and perhaps lead to harm—when a 'donor family' meets or learns the identity of an organ recipient." *Id.* Nevertheless, one of the most successful organ procurement organizations not only rejects anonymity, but actually insists that recipients write thank you notes to donor families. Peter MacPherson, *Live . . . and Let Live; Robert Hoffman, Director of the University of Wisconsin's Organ Procurement Organization*, 69 HOSP. & HEALTH NETWORKS 40 (1995).

29. KENNETH V. ISERSON, DEATH TO DUST: WHAT HAPPENS TO DEAD BODIES? 61 (1994).

license applications.³⁰ Moreover, organs may be donated by will.³¹ Even those who have not decided in advance to donate may become donors if they die under certain conditions, and their relatives consent.³²

B. Why Don't People Donate?

Paradoxically, although the vast majority of Americans say they believe in organ donation, a substantial majority do not donate.³³ One possible explanation for this disparity is that potential donors fail to perceive or obtain any immediate personal benefit. The fact that organ donation sounds good is just not sufficient incentive to motivate people to donate.³⁴

People also do not sign donor cards because doing so represents a concession that death is inevitable. To donate, people must overcome reluctance

30. All states permit drivers to choose organ donation on their licenses. Daniel G. Jardine, *Liability Issues Arising Out of Hospitals' and Organ Procurement Organizations' Rejection of Valid Anatomical Gifts: The Truth and Consequences*, 1990 WIS. L. REV. 1655, 1656.

31. However, timing generally makes this inappropriate for most organs. Long before the reading of the will, organs are no longer viable.

32. The Uniform Anatomical Gift Act ("UAGA") permits family members to donate their deceased relative's organs when the deceased relative fails to express a preference. UAGA § 2(b), 8A U.L.A. 15, 34-35 (1983).

33. Although 85 percent of those polled in one recent Gallup survey supported organ donation, fewer than 20 percent carried donor cards. Pilarczyk, *supra* note 18, at 35. The author lists common reasons for this disparity:

- (1) a lack of understanding that a donor must be declared brain dead before organs may be salvaged for donation;
- (2) the fear among potential donors that doctors would not utilize appropriate life-saving medical procedures, so as to obtain the donors' organs for transplantation;
- (3) physicians' reluctance to make routine inquiries of family members following death of a potential donor;
- (4) physicians' reluctance to remove organs when the decedent has consented but relatives object;
- (5) the perception among potential donors that organ donation remains inequitable, with wealthier potential recipients having more opportunity to undergo transplants;
- (6) potential donors' reluctance to contemplate their own mortality;
- (7) religious objections;
- (8) the failure of physicians to make routine inquiries in a culturally-aware or sensitive manner;
- (9) potential donors' aversion to violation of their bodily integrity caused by organ removal; and
- (10) potential donors' belief that family should make organ donation decisions.

Id. at 35-37.

But see Daphne D. Sipes, *Does It Matter Whether There is Public Policy for Presumed Consent in Organ Transplantation?*, 12 WHITTIER L. REV. 505, 507 (1991) (arguing that, despite contrary claims, recent studies demonstrate religious doctrine generally does not prohibit organ donation). In fact, most religions "affirmatively encourage or passively approve." *Id.*

34. See *infra* text accompanying notes 69-146 for commentators' alternative suggestions.

to confront either their own mortality or a close family member's death.³⁵ When relatives must make the decision, they face this difficult choice at a time of imminent loss, grief, and, possibly, shock.³⁶ Furthermore, medical personnel are understandably hesitant to intrude at this painful time,³⁷ even in states where legislation requires inquiry.

Some commentators warn that people refuse to donate when they question the system's integrity.³⁸ Although this explanation is superficially appealing, the data fail to support it. Instead, highly publicized cases—even where

35. *Developments in the Law, Medical Technology and the Law*, 103 HARV. L. REV. 1519, 1618 (1990) [hereinafter *Medical Technology and the Law*]. According to the author, the UAGA did not produce a sufficient number of organs because it failed to address "two primary psychological barriers to donation." *Id.* The first obstacle is that people seem "unwilling to confront their own mortality long enough to consider organ donation." *Id.* Second, patients distrust doctors, fearing that physicians might "do 'something'" prior to their death to hasten their demise. *Id.* The UAGA does not resolve either of these concerns. *Id.* at 1618-19.

36. Crespi, *supra* note 11, at 5-6. Recent studies illustrate that how and when the request is made may "dramatically influence" whether a family consents to donate. Teri Randall & Charles Marwick, *Physicians' Attitudes and Approaches are Pivotal in Procuring Organs for Transplantation*, 265 JAMA 1227 (1991). Families who felt good about their involvement in the medical decision-making process and those who had time to accept their relative's death were more likely to donate. *Id.*

The director of one of the country's most successful organ procurement organizations says that he believes hospital personnel are the most appropriate people to approach families about donation. MacPherson, *supra* note 28, at 40. Director Robert Hoffman believes that procurement organization personnel should not be involved because they probably will be "viewed with suspicion as someone with an obvious agenda." *Id.* Instead, Hoffman trains medical personnel to approach grieving family members. "The key is that the person who has developed a relationship with the donor family is involved in the donor process." *Id.* (quoting Cathy Arnold, nurse manager of the intensive and coronary care unit at Swedish-American Hospital in Rockford, Illinois, one of the 14 hospitals on Hoffman's beat). For an example of a particularly egregious case, see *Strachan v. John F. Kennedy Mem'l Hosp.*, 507 A.2d 718 (N.J. Super. Ct. App. Div. 1986) (hospital refused to release 20-year-old suicide victim's body to his parents unless they agreed to donate his organs).

37. TASK FORCE, *supra* note 10, at 32. Nevertheless, based on benefits to families and recipients, the Task Force recommends a "routine inquiry" policy. This policy mandates hospital procedures that "offer" families an opportunity to donate. The theory is that people have more positive reactions when offered a choice. Moreover, organ donation may actually help the family grieve. Even though hospitals and medical personnel would have an obligation to assist in obtaining organs and a responsibility to help relatives cope with grief by offering them the option to donate, no unwilling person would be required to personally make the request. *Id.*

38. See, e.g., A.L. Caplan, *Problems in the Policies and Criteria Used to Allocate Organs for Transplantation in the United States*, 21 TRANSPLANTATION PROC. 3381, 3387 (1989). The author ponders the impact of "ever-present stories in the media of families desperately seeking funds, begging for money for transplants, leav[ing] an especially bitter taste in the mouths of the public" *Id.* at 3381. Dr. Caplan questions "how long can we expect the public to support transplantation with either organs or money" if doctors harvest organs from all groups but only transplant to the rich? *Id.* at 3381-82.

accompanied by questions of fairness in allocation³⁹—increase the number of donors. For example, organ donor card requests “more than doubled”⁴⁰ at the United Network for Organ Sharing (UNOS),⁴¹ apparently as a result of media attention surrounding Mickey Mantle’s liver transplant,⁴² despite serious controversy over his right to the organ.

Some people fail to donate simply because they do not know about the critical need for organs.⁴³ Many people fear that if they are donors, it will somehow affect the treatment they get: that physicians will not work as hard to save them. Others claim that they are not donors merely because they were never asked. For example, fifty percent of those questioned in a recent survey said no one ever raised the issue.⁴⁴ Even assuming that the national average of only one quarter⁴⁵ of these would actually donate if asked, this increase might swell the supply of available organs to a number sufficient to satisfy current demand.⁴⁶ But, many people seem unwilling to take the initiative to

39. Steve Twedt, *Casey Transplant Questions Being Raised All Over Again*, PITTSBURGH POST-GAZETTE, June 9, 1995, at A1. For example, in June 1993—the month Pennsylvania Governor Casey received his new organs—the region’s transplant center reported a 100 percent consent rate. The center identified 19 possible donors and all of the families consented, according to Brian Broznick, the executive director. Broznick asserts that donations increase during times of controversy. He suggests controversy “heightens the public’s awareness about the need, and there’s a tendency for more people to be asked.” *Id.*

40. Organ banks “took advantage of that really frenzied time,” but the “initial tidal wave of attention” subsided. Jeffrey Weiss, *Organ Transplant Tumult Wrenches Patients’ Lives; Kin Can Overrule Decision to Donate*, DALLAS MORNING NEWS, Aug. 27, 1995, at 1A.

41. See *infra* text accompanying notes 52-54. For a brief overview of the UNOS organization, see John C. McDonald, *The Politics of Transplantation: Paving the Way for Reform?*, 78 AM. C. SURGEONS BULL. 10, 13-14 (1993). Dr. McDonald suggests using the transplant system as a guide for resolving the national health care crisis. This model “can be used as a method for inexpensive, effective, and efficient administration of a coherent national program. It is in place, and it works.” *Id.* at 14.

42. Carolyn Susman, *Donor Cards Requests Surge*, PALM BEACH POST, Aug. 27, 1995, at 3D. See also *Healthy Ideas; Sign Away Your Organs*, CONSUMER REP., May 1995, at 57.

43. But see TASK FORCE, *supra* note 10, at 37. In an attempt to determine public attitudes about donations, Task Force members analyzed national and regional polls, consulted experts and held two public hearings. Americans, the report concluded, are “well aware” that organs and tissues are needed. However, only 27 percent said they would be likely to become donors themselves. Only 17 percent had actually completed donor cards.

44. Susman, *supra* note 42, at 57.

45. ARTHUR L. CAPLAN, *IF I WERE A RICH MAN COULD I BUY A PANCREAS?* 160 (1994). Estimates vary between 17 and 25 percent depending on the source. *Id.*

46. *Id.* at 167. No accurate number of exactly how many organs are needed exists. For a variety of nonmedical reasons, many potential recipients are never placed on a waiting list. *Id.* For example, the millions of Americans without health insurance probably do not even have a doctor to raise transplantation as an option. Another major obstacle to an accurate determination is a typical requirement that before patients will be placed on a waiting list, they must demonstrate—either by paying or proof of insurance coverage—the ability to pay for the transplant. See, e.g., *Ellis v. Patterson*, 859 F.2d 52, 53 (8th Cir. 1988). Thus, problems with getting on the lists may mask an

become donors. When no one asks or encourages people individually, they can comfortably do nothing. Thus, many organs are lost because advocates either fail to ask about donation or do not follow through. Clearly, advocates must do a better job of informing the public and overcoming apathy. However, it is not enough to just increase public awareness and encourage donations.⁴⁷

Another problem is that organs people thought they donated are sometimes lost. This may happen when the doctor or hospital fails to discover, at least until too late, that the patient was a donor.⁴⁸ Other organs are lost when people sign donor cards but avoid discussing their wishes with family members. This oversight may be critical, as relatives are frequently the final decision makers.⁴⁹

even greater disparity in need versus available organs.

47. For an interesting study attempting to assess efficiency of organ procurement efforts by state and organ procurement organizations ("OPO"), see Roger W. Evans et al., *The Potential Supply of Organ Donors: An Assessment of the Efficiency of Organ Procurement Efforts in the United States*, 267 JAMA 239 (1992). The authors conclude that state and regional donation rates "vary widely." *Id.* at 241. Efficiency also varied by state and OPO. Further, differential efficiencies were noted depending on donor classifications—class one, where death was caused solely by significant head trauma, or class two, which includes class one in addition to those where brain death was less likely. *Id.* at 239, 242. Finally, the authors acknowledge that efficiency may change from year to year. *Id.* at 242.

This wide disparity in procurement lends support to calls for national standards in allocation. In fact, rather than a national list, one commentator concluded that what is needed are national allocation standards for all transplant centers. Robert F. Weir, *The Issue of Fairness in the Allocation of Organs*, 19 J. CORP. L. 91, 107 (1994).

[T]he majority of transplant candidates, their families, and the transplant teams working with them would perceive national standards for the allocation of organs that *emphasize equality but make justifiable exceptions in cases of documented medical need* as more consistently fair than the present plurality of allocation practices from place to place.

Id.

48. Robert M. Arnold & Stuart J. Youngner, *Reply to Letter to the Editor*, 270 JAMA 1930, 1931 (1993).

49. Of those in the Task Force Study who were likely to donate, nearly half had not discussed the issue with family members, though their permission is usually required before the organs are harvested. TASK FORCE, *supra* note 10, at 37-38. This is true despite the fact that the revised UAGA provides that the deceased donor's wishes should be respected. No matter what the law, physicians generally will not harvest organs if family members object. In fact, one author warned, You could die with an organ donor card in every pocket, and another one posted on your forehead, and still no one would touch you if your current or separated but not divorced spouse, son or daughter twenty-one years of age or older, parent, brother or sister twenty-one years of age or older, or guardian, in that order, said no If you want to be an organ donor, carrying a card is much less important than making sure your relatives know your wishes.

D. Diven, *Rest in Pieces*, HARPER'S, June 1983, at 74. It is easy to question the widespread policy of permitting family members to overrule the deceased's wish to donate his organs. Most Americans strongly support a person's right to control his body, even after death. Arthur L. Caplan, *Equity in the Selection of Recipients for Cardiac Transplants*, 75 CIRCULATION 10, 14 (1987). Nevertheless, there is another side. Families enjoy "de facto veto power" because "society places a great deal of value on the desires and wishes of family members" about death and cadaver

IV. ALLOCATION

A. Background

Obtaining donor organs is only the first step. Because the number of potential recipients far exceeds available organs, someone must make difficult allocation decisions. The 1984 National Organ Transplant Act (NOTA)⁵⁰ authorized the government to contract with a private organization to operate a system for sharing organs. Since 1987, the government has contracted with UNOS to supervise this National Organ Procurement Network (OPTN).⁵¹

In attempting to create an equitable organ allocation policy, UNOS “*strikes a balance*” among several principles.⁵² In addition to increasing the number of available organs, the policy must “[a]llocate organs based upon medical criteria, striving to give equal consideration to medical utility . . . and justice.”⁵³ “Medical criteria”⁵⁴ may not include social worth, usefulness or

disposition. *Id.*

It is interesting to note, however, that organ procurement teams consistently state that many families “express regret weeks, months, and even years later at not having considered the option of organ donation, *not having acted on the stated wishes of their deceased loved one to donate*, or having refused a request for a donation.” Arthur L. Caplan, *Professional Arrogance and Public Misunderstanding*, HASTINGS CENTER REP., Apr./May 1988, at 34, 36 (emphasis added).

50. National Organ Transplant Act, Pub. L. No. 98-507, 98 Stat. 2339 (1984).

51. *UNOS Statement*, *supra* note 16, at 142. Currently, all UNOS policies are voluntary. All UNOS policies must be reviewed and approved by the Health and Human Services (HHS) Secretary. Because no policies have yet been approved, they remain voluntary. *Id.* Approximately 75 regional or local organ procurement organizations “identify donors with the cooperation of physicians and hospitals, arrange for consent and donor maintenance, and coordinate organ recovery.” Halasz, *supra* note 19, at 43. These agencies, functioning under UNOS mandate, follow UNOS allocation policies. Various HHS agencies review policy implementation.

The broad principles favoring local and regional utilization are modified by certain organ-specific considerations. For example, kidneys are offered locally first. If they cannot be locally used, they are offered within the region and finally nationwide. When an excellent match is found at a distant location, or a recipient also needs an extrarenal transplant, kidneys are shared nationwide.

Medical exigency forms the basis of a multilayered system for the allocation of hearts and livers. Here, need trumps local priority. When neither local nor high status patients can be located, geographic distance becomes the deciding factor because of the difficulty in preserving hearts and livers. *Id.* at 43-44. Another important factor in heart and liver transplants is time spent on a waiting list. By contrast, kidneys are allocated according to a formula based primarily on quality of tissue match. Although not ignored, waiting time and sensitivity are less important. Children get extra consideration. *Id.*

52. *UNOS Statement*, *supra* note 16, at 143.

53. *Id.* This principle explains medical utility as “*net* medical benefit to all transplant patients as a group.” In explaining justice, the principle refers to “equity in distribution of the benefits and burdens among all transplant patients.” *Id.* at 143-44. The other two principles are to provide “reasonable opportunities to be considered for organ offers within comparable time periods, taking

economic status.

B. The Process

There are actually two stages in the organ allocation process. First, patients are placed both on a waiting list and in a central registry. Restrictions on selection criteria are the same as those governing medical care generally.⁵⁵ At this stage, the primary consideration is whether the transplant would be medically beneficial.⁵⁶

Not until the second, more subjective, step of the process are organs allocated to individual recipients. In making these decisions,⁵⁷ transplant teams consider a variety of factors. Weight assigned to these criteria varies for different organs.⁵⁸ However, because most organs are only viable for a short

into consideration similarities and dissimilarities in medical circumstances as well as technical and logistical factors in organ distribution" and to "[r]espect autonomy of persons." *Id.* at 144.

54. Medical criteria include "(1) anatomical and immunological compatibility between donor and recipient, (2) medical urgency, (3) efficiency in physically moving the organ from the donor to the recipient in a way that ensures viability and enhances the probability of a successful outcome and (4) medical ethics considerations inherent in the allocation of a scarce resource." *Id.* at 145.

55. *Medical Technology and the Law*, *supra* note 35, at 1519.

56. Nevertheless, studies suggest that when some physicians select patients for the list, "they choose people most like themselves and exclude those who they deem 'unworthy.'" *Id.* at 1636. Because "prosperous white physicians" are most likely to be making the selection, minorities and poor people may have less of a chance. Although this disparity might seem to raise due process and equal protection concerns, recent court decisions indicate that organ allocation "does not fall within the ambit of either of these constitutional protections." *Id.* at 1637.

Another difficult issue concerns retransplants. Currently, between 10 and 20 percent of hearts and livers are given to retransplant patients. For a discussion of ethical issues surrounding retransplants, see P.A. Ubel et al., *Rationing Failure: The Ethical Lessons of the Retransplantation of Scarce Vital Organs*, 270 JAMA 2469 (1993).

57. To avoid any possible appearance of favoritism, ethical transplant teams, which locate and harvest organs, cannot also allocate these organs. The two functions must be kept strictly separate. "[E]quality and justice would be denied through preferential access." Eike-Henner W. Kluge, *Designated Organ Donation: Private Choice in Social Context*, in LIFE CHOICES: A HASTINGS CENTER INTRODUCTION TO BIOETHICS 429, 440 (Joseph H. Howell & William F. Sale eds., 1995). Without the separation, transplant surgeons are confronted with a serious moral dilemma: decide "not only the difficult question of when life is over, but the even more excruciating question of when life is over for one patient when another may benefit." ROTHMAN, *supra* note 20, at 56.

58. James L. Levenson & Mary Ellen Olbrisch, *Psychosocial Evaluation of Organ Transplant Candidates: A Comparative Survey of Process, Criteria, and Outcomes in Heart, Liver, and Kidney Transplantation*, 34 PSYCHOSOMATICS 314, 316-22 (1993). Kidneys are distinguishable from other solid organs in at least three ways. First, because people can function with only one kidney, transplants from live donors are possible. Persons selling their organs create particular potential for exploitation and abuse. Currently, however, most live donors are close family members. In fact, there is suspicion if a live, non-relative offers to donate a kidney. Second, recipients can wait longer to receive a kidney because dialysis can perform the kidney's function. No such mechanical alternatives to other organs exist. Finally, because kidneys can be preserved longer than other

time, organs are generally allocated by region. This means that the sickest patient with the best match may not receive the organ. Instead, a patient in the region where the organ is harvested may get the transplant ahead of a potential recipient with a more critical need. In fact, some say this system explains why Mickey Mantle received his liver.⁵⁹ There were no Status 1 liver patients⁶⁰ in the region, according to organ bank officials, and Mantle was the only Status 2 candidate.⁶¹

C. Substance Abuse

A recent spate of celebrity⁶² transplants where substance abuse played a role⁶³ sparked debate about whether a history of voluntary⁶⁴ substance abuse

organs, and because recipients can be kept alive on dialysis, more extensive tissue typing is available.

59. Even transplant experts initially questioned the speed with which Mantle received his liver. But, an investigation ultimately concluded that the liver was fairly obtained. Gerner & Baniak, *supra* note 2, at 3W. Nevertheless, an ethicist and her co-author argue that the prospect of survival provides "an overwhelming incentive to manipulate the existing systems." In fact, although they were not discussing Mickey Mantle, they said that it is not surprising that wealthy people have learned how to take advantage of the decentralized clearing systems and, in effect, jump ahead in the line. NANCY DUBLER & DAVID NIMMONS, *ETHICS ON CALL* 314-19 (1992).

60. Twedt, *supra* note 39, at A1. Status 1 patients are considered those in most urgent need of a transplant.

61. *Id.* Status 2 means that the patient is either currently hospitalized or expected to be sent to an intensive care unit.

62. Celebrity patients' physicians may face an additional conflict—the famous person's privacy might collide with the public's right to know. The interests of a zealous media, representing an inquisitive public, frequently conflict with the patient's right to privacy. Although the doctor's obligation to protect his patient's privacy is clear, some feel uncomfortable withholding information from the public. For example, tumors detected in Mantle's lungs were not revealed for almost three weeks, and not until rumors caused Mantle to disclose the extent of the cancer. *Mantle's Doctors Stretched the Truth*, *MIAMI HERALD*, Aug. 10, 1995, at 6C. "Medical ethicists say Mantle's case dramatically defines the quandary facing doctors who treat the famous. How much medical information about celebrities is public business? Did Mantle's case warrant more scrutiny because he received a valuable organ and potential donors want such organs fairly parceled out?" *Id.*

The public's right to know is not the only reason doctors might reveal confidential information. Sometimes physicians discuss their famous patients to enhance their own reputation. "In a town [Hollywood] where success is measured by the company one keeps, even psychiatrists . . . sometimes reveal more than they should about their celebrity clientele." STEPHEN FARBER & MARC GREEN, *HOLLYWOOD ON THE COUCH* 8 (1993). See also *Howell v. New York Post Co.*, 612 N.E.2d 699 (N.Y. 1993).

63. Substance abuse was at least partially responsible for Mantle's, Crosby's and Hagman's damaged livers. For example, Crosby's liver "apparently hardened and deteriorated because of decades of drug abuse that included heroin and cocaine," according to his publicist. *Rock Singer Crosby Awaits Liver Transplant*, *CHI. TRIB.*, Nov. 5, 1994, at 18N. Mickey Mantle's and Larry Hagman's livers were damaged by alcohol abuse. Both men's livers ultimately developed cancer. C. Michael Bailey, *A Dangerous Message*, *ARK. DEMOCRAT-GAZETTE*, Sept. 2, 1995, at 9B.

should be a factor in—or even a bar to⁶⁵—consideration for a transplant.⁶⁶ The question, while simply stated, is ethically difficult. Although virtually all transplant programs appear to consider current substance abuse,⁶⁷ they ignore past abuse, according to physicians at Baylor University Medical Center—where Mantle had his surgery. These doctors state that past substance abuse should not be a factor so long as the patient has been in a recovery program for at least six months.⁶⁸

Others disagree. They stake out the moral high ground, asserting that the “blameless” patient who did nothing to contribute to his condition should be given priority. This argument is appealing, but only at first blush. Who would

64. Although beyond the scope of this article, the whole issue of voluntariness is problematic. Is the addict's continued substance abuse—which accelerates the severity of disease and increases the need for a transplant—truly voluntary? How can it be when the definition of addict implies inability to control the need for the substance? The DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS IV (DSM IV) describes the compulsive use that characterizes substance dependence by stating that “[d]espite recognizing the contributing role of the substance to a psychological or physical problem (e.g., severe depressive symptoms or damage to certain organ systems), the person continues to use the substance.” AMERICAN PSYCHIATRIC ASSOCIATION, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 178-79 (4th ed. 1994).

65. Researchers recently completed a study of 103 liver transplant patients. Pamela A. Carrington et al., *Comparison of Quality of Life Between Alcoholic And Nonalcoholic Patients After Liver Transplantation*, 5 AM. J. ADDICTIONS 18 (1996). They concluded that the quality of life one to three years after surgery was the same for alcoholic and nonalcoholic patients. A self-reported rating scale was used to measure quality of life. The scale assigned “impact of disease on health, behavior, and psychosocial adjustment” in 26 different areas. *Id.* at 20-21. Although the authors concede that the sample is small, and that some sample bias might exist, they believe the data are correct, especially as they merely extend earlier findings that survival rates for alcoholic and nonalcoholic patients are comparable. *Id.* at 22. This similarity is important because it raises questions about the appropriateness of using alcoholism to exclude patients from receiving transplants. *Id.*

66. Of course, given an adequate supply of both donors and money for transplants, there would be no question. No matter what the cause, anyone who needed an organ could get one. Unfortunately, however, a limited supply of organs and money severely restricts who receives a transplant.

67. Levenson & Olbrisch, *supra* note 58, at 318. The authors surveyed U.S. transplant programs in 1989 and 1990: 122 cardiac, 217 renal and 72 liver. Response rates were sixty-four percent, seventy-one percent and sixty-four percent respectively. *Id.* at 315. Although there were some differences, current addictive drug use was a consideration in virtually all programs and acted as an absolute bar in many. *Id.*

68. David Ballingrud, *Debating Who Deserves a Transplant*, ST. PETERSBURG TIMES, June 8, 1995, at 1A. See also Weir, *supra* note 47, at 106 (indicating that, according to a recent study, “several psychosocial factors can, depending on the transplant program, represent contra-indications in organ transplant, including the following: current heavy alcohol use, . . . current tobacco use, current addictive drug use. . .”).

not feel more sympathy for the innocent six-year-old victim of liver disease than for the 53-year-old rock singer who recklessly ruined his liver with illegal drugs? Nevertheless, there are at least three problems with adopting such an absolute position without public discussion and input. First, because these are literally life or death decisions, it seems inappropriate not to at least explore the issue of who should make these value-laden judgments. Second, there is seldom only one, discrete reason a person needs a transplant. Instead, many factors—sometimes including substance abuse—contribute. Finally, choosing the appropriate place to draw the line is also a problem. Where does the patient lose his innocence? As with so many legal issues, the argument flounders on the slippery slope. Does a patient have to be completely blameless to qualify for a transplant? Would the patient whose condition resulted from illegal drugs be treated differently from someone who abused a legal substance like alcohol? With overwhelming evidence of the harmful effects of cigarettes, is the smoker responsible for his disease and eliminated from consideration? What about the obese patient? Would the answer be different if he were only slightly overweight? If so, how much weight should exclude a patient from the list? Should a person be precluded from consideration if he refuses to exercise? Would two workouts per week be sufficient? Must the workouts be at least forty minutes long?

V. POSSIBLE SOLUTIONS

Dissatisfaction with the current system spawned a variety of alternative plans.⁶⁹

A. Procurement: Market Systems

The most radical proposals suggest creating various types of commercial markets⁷⁰ for organs.⁷¹ These market advocates urge repeal of current federal

69. A UNOS subcommittee conducted a nationwide survey to determine public attitudes toward alternative methods of obtaining organs. Dilip S. Kittur et al., *Incentives for Organ Donation?* UNOS UPDATE 8 (1992). The authors warn that just as in any survey, responses might not be a true reflection if the methods were actually adopted. Nevertheless, the survey reveals interesting information. Fifty-two percent of survey respondents favored some financial or nonfinancial compensation to increase the supply of organs. Preferred status—where the donor or his relatives receive preference if they need an organ—was the top choice. This was followed by a \$2000 payment to the family. Attitudes vary by age, but not by gender. People between eighteen and thirty-four are more than twice as likely to support compensation as those over fifty-five. *Id.* at 9.

70. This market alternative may be further divided into paying donors to procure their organs and requiring recipients to purchase an organ at a price set by the market. Abuses are more likely associated with letting the market control allocation. One example is the case of a Virginia doctor who, prior to federal legislation prohibiting the sale of organs, established a company to broker kidneys throughout the world. Margaret Engel, *Va. Doctor Plans Company to Arrange Sale of Human Kidneys*, WASH. POST, Sept. 19, 1983, at A9. The doctor, H. Barry Jacobs, who had his

legislation prohibiting transferring organs for "valuable consideration."⁷² Altruism, they claim, while theoretically attractive, has failed in practice. They postulate that permitting people to sell their organs would increase the number available for transplant.⁷³ Ironically, others contend that a market system might actually decrease the number of available organs. Their hypothesis is that some people who currently donate would be offended by commercializing the process. Therefore, these people will refuse to participate, resulting in a net organ loss.⁷⁴ Both sides are firmly convinced that they are right. Without a change in federal law,⁷⁵ neither can prove its claim.⁷⁶

license to practice in Virginia revoked following a Medicare and Medicaid mail fraud conviction in 1977, said donors would set the price for the kidney and he would charge between \$2,000 and \$5,000 for his services. The recipient would pay the total price. *Id.*

There were many advertisements to sell kidneys in the early 1980s. One Georgia man, wanting to buy a restaurant, offered to sell his kidney for \$25,000. Others offered kidneys for as little as \$5,000, and California kidney sellers were asking as much as \$160,000. KIMBRELL, *supra* note 20, at 29-30.

71. The American Medical Association (AMA) concedes that proponents of financial incentives face "four widely identified ethical pitfalls: (1) reducing altruism; 2) risking decreased organ quality 3) concern that those who donate for money are not acting voluntarily and 4) people and their parts are treated as commodities." COUNCIL OF ETHICAL AND JUDICIAL AFFAIRS, Resolution 6, 1993 Annual Meeting, FINANCIAL INCENTIVES FOR ORGAN PROCUREMENT: ETHICAL ASPECTS OF FUTURE CONTRACTS FOR CADAVER DONORS 251 (Dec. 1993). The AMA analyzed the objectives and concluded that a carefully regulated future contracts system could avoid the traps while ethically encouraging organ donation. For a discussion of the AMA's endorsement of future contracts for cadaver donors, see Council on Ethical and Judicial Affairs, AMA, *Financial Incentives for Organ Procurement*, 155 ARCHIVES INTERNAL MED. 581, 582-84 (1995) [hereinafter *Incentives for Procurement*].

72. The federal statute makes it "unlawful for any person to knowingly acquire, receive or otherwise transfer any human organ for valuable consideration for use in human transplantation." 42 U.S.C. § 274e (1994). Challenges to the financial prohibition are possible, but appear doomed. For example, an argument based on due process protection for personal autonomy probably will not succeed. The Court seems very reluctant to expand this protection beyond the traditional decisions for marriage, procreation and childrearing. Further, the statute permits persons to choose whether to donate their organs. The prohibition is on paying for organs. Commercial projects traditionally receive less constitutional protection.

73. Crespi, *supra* note 11, at 1.

74. For a discussion, and rejection, of this argument, see *id.* at 17-28. Other commentators agree that compensation will not increase organ supply, but they argue another, more important reason to reject financial incentives exists. They suggest that "this proposal may distract the transplant community from effective and far less controversial measures for ending the organ shortage, including the standardization of hospital procedures to ensure a more humane and effective request process, as well as refocused public education efforts that encourage family discussion about organ donation." William Dejong et al., *Options for Increasing Organ Donation*, 73 MILBANK Q. 463, 464 (1995).

75. Some states also forbid paying for organs. Denise, *supra* note 6, at 1022. These statutes would have to be repealed.

Some commentators fear that lifting the ban on organ sales might cause exploitation of the poor.⁷⁷ Indeed, certain proposals—for example, restricting compensation to burial and funeral expenses, discounted medical insurance or credit toward college tuition⁷⁸—clearly target the poor. But targeting the poor and exploiting them are not synonymous. The Susan Sutton case highlights the merit in policies providing financial aid to donor families. Ms. Sutton was declared brain dead after a self-inflicted gunshot wound to the head. Her parents agreed to donate her organs. Doctors, hospitals and the nonprofit agency coordinating the transplants received thousands of dollars. Her parents received nothing and, because they could not even afford a headstone, Ms. Sutton was buried in an unmarked grave.⁷⁹ Proponents of compensation object to this inequitable process where everyone else receives money, while the donor cannot even afford a proper burial.

To minimize abuse, most plans prohibit payment to the donor. Instead, families would receive the money, but not until the organs were successfully retrieved.⁸⁰ Financial compensation for live donors would still be prohibited.⁸¹ But, these safeguards may not be sufficient. Because many poor people worry about how their families will survive after they die, donations might not be

76. A UNOS subcommittee suggests an experimental program, suspending the prohibition for a limited area. Kittur et al., *supra* note 69, at 10. The AMA Council on Ethical and Judicial Affairs also suggests implementing a pilot program of financial incentives. *Incentives for Procurement*, *supra* note 71, at 581. Prospective competent donors would enter into future contracts. After the donor's death, when the organs were located and determined medically suitable for transplant, the donor's family or chosen beneficiary would be compensated. To respond to concerns—such as ensuring that the health of donors and recipients are not jeopardized and quality of organ supply is not diminished—the Council proposed additional regulatory safeguards. These include paying “the lowest amount that can reasonably be expected to encourage organ donation.” *Id.* at 588. Further, the prohibition on incentives in allocating organs must be maintained. Distribution “should continue to be governed only by ethically appropriate criteria relating to medical need.” *Id.*

77. See, e.g., R.A. Sells, *Resolving the Conflict in Traditional Ethics Which Arises from Our Demand for Organs*, 25 *TRANSPLANTATION PROC.* 2983 (1993).

78. Crespi, *supra* note 11, at 31-32 n.136.

79. Cate, *supra* note 17, at 85.

80. For example, one commentator suggests a \$1000 death benefit payment. Thomas G. Peters, *Life or Death: The Issue of Payment in Cadaveric Organ Donation*, 265 *JAMA* 1302 (1991). Payment would be enough to motivate families without being coercive. In addition, the type of payment “may most favorably affect the socially disenfranchised through increased organ transplantation in minority populations.” *Id.* For a discussion of the problems with minority transplants, see *infra* text accompanying notes 203-05.

81. This means, for example, that although a person can live with one kidney, sale of the person's other kidney is not permitted.

completely voluntary.⁸² Instead, fears about their families' welfare—rather than a wish to donate—may coerce consent.⁸³ Other ideas to avoid exploiting the poor include reducing a donor's estate tax⁸⁴ or offering other tax incentives.⁸⁵ These options should comfort those who fear that the market system would exploit the poor. Tax incentives target the rich rather than the poor; they benefit wealthy donors.⁸⁶ Nevertheless, some commentators object to any type of payment, arguing that operations should only be for therapeutic purposes, not to make money.⁸⁷

B. Non-cash Payments

To avoid the prohibition on paying for organs, compensation could be limited to non-monetary benefits. For example, donors and their families could be given priority if they subsequently need transplants.⁸⁸ Organ trading represents another alternative for live, intrafamily donors. Under this plan, a donor whose organ is not suitable for a family member could trade his kidney for one which was compatible.⁸⁹

C. Required Requests

Another idea is "required request."⁹⁰ Hospitals would be responsible for designating a trained person to ask family members about organ donation at the

82. B. Cohen & J. D'Amaro, *Contemporary Ethical Considerations Related to Organ Transplantation*, 28 *TRANSPLANTATION PROC.* 144 (1996). "[T]he consequence of measures like this will surely be that the financially weak are put in a position where the donation of organs is not the result of a personal conviction but for financial reasons." *Id.*

Further, exploitation is a particular concern because patients must fully understand the risks before giving proper informed consent. But, because paid donors will "always be relatively poor, and may be underprivileged and undereducated," they may not fully understand the risks. Sells, *supra* note 77, at 2983. This argument is paternalistic and offensive. Poor people are neither all stupid nor uneducated.

83. One proposed response is to establish a local "Donors' Trust." Donor and recipient could be evaluated, and a case-by-case fee and compensation calculated. *Id.*

84. *See, e.g.*, H.R. 540, 98th Cong. (1983).

85. Cate, *supra* note 17, at 85.

86. Danielle M. Wagner, Comment, *Property Rights in the Human Body: The Commercialization of Organ Transplantation and Biotechnology*, 33 *DUQ. L. REV.* 931, 955 (1995).

87. *See, e.g.*, Sells, *supra* note 77, at 2983.

88. Denise, *supra* note 6, at 1036.

89. *Id.* at 1036-37. Doctors face ethical dilemmas when removing a live donor's healthy kidney. Retrieving the kidney actually constitutes "a purposeful infliction of harm." ROTHMAN, *supra* note 20, at 154. In fact, the operation poses several dangers, including the anesthesia, surgery, and long-term risk of something happening to the donor's remaining kidney. Further, serious questions exist as to the validity of the consent. Can consent be truly voluntary when a loved one's life depends on the donation? *Id.* at 154-55.

90. CAPLAN, *supra* note 45, at 153.

time of death.⁹¹ In fact, most states already have laws requiring that institutions approach relatives of potential donors,⁹² and federal law mandates required requests for institutions receiving Medicare or Medicaid funds.⁹³ A slight increase in donations has been reported,⁹⁴ even though many physicians and other health care professionals ignore the law.⁹⁵

D. Presumed Consent

Presumed consent represents a more extreme proposal than required request.⁹⁶ This system creates a rebuttable presumption that everyone wants to be an organ donor. Organs would be removed unless an individual "opts out" prior to death.⁹⁷ Several, primarily European, countries have adopted presumed consent. Although the evidence is not overwhelming, presumed consent seems to increase organ supply.⁹⁸

91. To assure compliance, one suggested procedure mandates noting the request on the death certificate. *Id.*

92. James F. Childress, *Ethical Criteria for Procuring and Distributing Organs for Transplantation*, 14 J. HEALTH POL. POL'Y L. 87, 94 (1989). The revised UAGA also recommends required requests.

93. 42 U.S.C. § 1320b-8(a)(1)(A)(i) (1994).

94. Childress, *supra* note 92, at 94.

95. Caplan, *supra* note 49, at 37. In this thoughtful report, Arthur Caplan rejects the claim that the primary obstacle to increased donations is public ignorance. Instead, he suggests that health care professionals, rather than the general public, are "in desperate need" of information about their duties concerning organ procurement. He says they need to be educated about how to delegate the procurement duty to others.

In enacting required request legislation, our society has indicated its collective desire that people routinely be given the option of organ and tissue donation as a last act of respect for the dead and their families and as an expression of concern for those who will die unless more organs and tissues are made available. It has not yet put its money where its ethical concerns are in the form of resources to train health care professionals to feel comfortable rather than angry in discharging their obligations to the dead and those who are dying. Until these resources are forthcoming and directed to the audience of health care professionals where they are most needed, the ethical, clinical, and legal impact of required request will remain unknown.

Id.

96. One commentator argues that current law actually "presumes an unwillingness to donate." Cate, *supra* note 17, at 81. As a result, Professor Cate concluded that legislation "largely impedes donation." *Id.*

97. Christian Williams, Note, *Combating the Problems of Human Rights Abuses and Inadequate Supply Through Presumed Donation Consent*, 26 CASE W. RES. J. INT'L L. 315, 362 (1994).

98. There is no evidence of an increase in available organs after at least 17 countries adopted presumed consent. ONTARIO MINISTRY OF HEALTH, ORGAN DONATION IN THE EIGHTIES: THE MINISTER'S TASK FORCE ON KIDNEY DONATION 40 (1986), cited in Williams, *supra* note 97, at 341. Nevertheless, countries with presumed consent do have a better procurement record than donor countries like the United States. "Presumed consent, when strictly followed by the state, has proven to be the best practiced method of maximizing organ procurement." *Id.* at 340. Concerned about

Nonetheless, legitimate constitutional objections exist.⁹⁹ The primary problem is whether presumed consent satisfies due process.¹⁰⁰ Presumed consent¹⁰¹ implicates the substantive rights to bodily integrity and to privacy in intimate decisions concerning a person's body.¹⁰² If courts agree that these fundamental rights are involved, harvesting organs through presumed consent would require substantial protections.¹⁰³ But, even if there were an aggressive, educational blitz, many people would either not know about presumed consent or not understand what it means or how to opt out.¹⁰⁴ For people who do not know or understand this process, an opt out provision cannot satisfy due process.

E. Conscription

Some suggest a National Organ Draft¹⁰⁵ or conscription.¹⁰⁶ Under these

an international system which fosters illegal sales of organs from poor countries, this student author advocates presumed consent as "the most efficient and least violative" organ procurement method. *Id.* at 364.

99. See Anderson, *supra* note 1, at 264.

100. In the United States, presumed consent is already the rule for some tissue donations. These have survived some constitutional challenges. Childress, *supra* note 92, at 97. However, harvesting organs is arguably more intrusive than procuring tissue. As a result, the standard of review might be higher and presumed consent unconstitutional if applied to organs.

101. One commentator proposes legislation combining presumed consent with treating organ donation as a community service. Linda C. Fentiman, *Organ Donation as National Service: A Proposed Federal Organ Donation Law*, 27 SUFFOLK U. L. REV. 1593, 1598 (1993). As with the Peace Corps or volunteer military, donation would be encouraged through subsidized education, health and other benefits. *Id.* See also Randall & Marwick, *supra* note 36, at 1228 (discussion of Mexico's attempt to designate donors as "Heroes of the Nation"). Donors would be treated the same as war veterans. *Id.*

102. This is the right which permits a woman to decide whether to abort, at least early in her pregnancy. *Roe v. Wade*, 410 U.S. 113 (1973). The Court has been extremely reluctant to expand this right. But, an attempt to use presumed consent implicates this right. It seems just as invasive to presume that a person wants to donate his organs as to interfere with a woman's right to terminate her pregnancy.

103. What process is due depends on the importance of the right balanced against the government's interest. In 1976, the Court established a three-pronged test. *Mathews v. Eldridge*, 424 U.S. 319, 335 (1976). Since then, courts must apply the balancing test to determine what process is due when a government would deprive a person of a constitutionally protected interest. JOHN E. NOWAK & RONALD D. ROTUNDA, *CONSTITUTIONAL LAW* 524-33 (4th ed. 1991). Presumed consent is likely to fail the test.

104. This ignorance is predictable based on the number of people who claim that they do not know about the current organ shortage. See *supra* text accompanying note 43.

105. *A National Plan for Providing Organs*, *NEWSDAY*, April 2, 1991 [hereinafter *National Plan*]. Under this proposal, infants would be tissue and blood-typed and information sent to a National Organ Draft registry. Prior to declaring a person dead, or removing life support, the national data bank would be notified. The data bank would cross-match the patient with waiting recipients.

proposals, organs would be removed without seeking consent from anyone. Even the donor might have no right to object, although some recommend that the donor be allowed to refuse through a formal channel prior to death.¹⁰⁷

F. New Perfusion Technique

A new perfusion technique could save some organs which might otherwise be lost because doctors fail to locate either donor cards or family members in time.¹⁰⁸ This new technique is used to extend organ viability in brain-dead, non-heart-beating donors. The preservation solution doctors send through perfusion tubes "flushes the organs, keeps them cool, and does not disfigure the body."¹⁰⁹ Ethical concerns about the impact on the deceased's and his family's rights have prevented the transplant community from embracing this procedure. Even though the technique does not disfigure the donor, it is invasive and performed without consent.¹¹⁰ Another problem is that the procedure is for a third person's benefit, not the deceased's.¹¹¹

G. Pennsylvania's Answer

The Pennsylvania legislature recently took a bold step in attempting to resolve the scarcity problem when it created an Organ Donation Awareness Trust Fund.¹¹² Up to ten percent of the money from the fund may be used "for reasonable hospital and other medical expenses, funeral expenses and incidental expenses incurred by the donor or donor's family in connection with

This proposal really isn't as radical as it seems. After all, society has the right to require that living individuals surrender their bodies into the military. Society has the right to order autopsies. Doesn't it make more sense to mandate organ donation as our last social obligation than to turn hospital waiting rooms into organ flea markets?

Id.

106. A.H. Barnett & David L. Kaserman, *The Shortage of Organs for Transplantation: Exploring the Alternatives*, 9 ISSUES L. & MED. 117, 123 (1993).

107. *Id.*

108. Teri Randall, *Too Few Human Organs for Transplantation, Too Many in Need. . . and the Gap Widens*, 265 JAMA 1223, 1223-27 (1991).

109. *Id.* (citing Felix Rapaport, M.D., director of transplantation service and chair of surgery at State University of New York, Stony Brook).

110. This procedure might even give rise to a lawsuit by family members. Injection of this material might support a cause of action for mutilation of a dead body. This action is based on the survivors' rights to bury the body in the condition when life ended. To support this claim, courts are "not primarily concerned with the extent of the mishandling or injury to the body, per se, 'but rather with the effect of the same on the feelings and emotions of the surviving relatives, who have the right to burial.'" *Kirker v. Orange County & Gore*, 519 So. 2d 682, 684 (Fla. Dist. Ct. App. 1988) (quoting *Jackson v. Rupp*, 228 So. 2d 916, 918 (Fla. 1970)).

111. Randall, *supra* note 108, at 1227.

112. 20 PA. CONS. STAT. ANN. § 8622(a) (West 1995).

making a vital organ donation."¹¹³ The statute limits expenditures to \$3000 per donor, and requires that payment be made directly to the service provider, rather than to the donor's family or estate.¹¹⁴

The state seems to have two ways to circumvent the federal prohibition on payment for organs. First, the legislature established an advisory committee to develop a pilot program for disbursing these funds.¹¹⁵ They might simply seek an exception for this pilot program.¹¹⁶ Second, Pennsylvania could claim that, because payment is not made directly to the donor's family or estate, compensation to the provider is not "valuable consideration" to "acquire, receive or otherwise transfer" the organ. This argument is flawed. If the provider was not paid by the Fund, the donor's estate would be liable. Therefore, patients who are worried about hospital bills or funeral expenses may well feel the same pressure to help their families and donate as if the money were being paid directly to their heirs.

Two additional provisions are noteworthy. First, Pennsylvania residents can opt to contribute to the Fund either when they file their state income tax returns¹¹⁷ or apply for driver's licenses or renewals and identification cards.¹¹⁸ A second, critical statutory provision imposes a duty on police and emergency personnel to "take reasonable steps to insure" evidence of donor status accompanies individuals to the health care facility.¹¹⁹

H. Cadaver Organ Donor Act

One important step toward increasing donors would be the adoption of the Cadaveric Organ Donor Act.¹²⁰ This proposed Act includes several essential provisions. For example, the Act provides for the creation and maintenance of a national registry¹²¹ and identifies several opportunities for donors to

113. *Id.* § 8622(B)(1).

114. *Id.* The law establishes an advisory committee to implement and review organ donation education and policies. *Id.* § 8622(C).

115. *Id.* § 8622(B)(1).

116. *See supra* note 76.

117. 20 PA. CONS. STAT. ANN. § 8618 (A) (West 1995). Residents can voluntarily contribute as much as they wish. The amount designated will be deducted from their tax refund. *Id.* § 8618(B).

118. *Id.* § 8621. Applicants are asked to contribute \$1.

119. *Id.* § 8620.

120. *Proposed Federal Statutes—Cadaveric Organ Donor Act*, 18 J. CORP. L. 527 (1993).

121. *Id.* at 530. Proponents argue that a national list would diminish the appearance of unfairness, and should, therefore, increase the supply. Consequently, they advocate national lists, even if a small percentage of organs are wasted.

register.¹²²

Registry information would be made available to all health care institutions, organ procurement organizations, and any other person the HHS Secretary designates.¹²³ The Act imposes a duty on health care institutions to determine—when patients are admitted or as soon after admission as possible—whether they are donors. Patients who are not donors must be provided with donor forms, but the choice whether to donate remains the individual's.¹²⁴ Institutions must immediately forward all information to the Registry.¹²⁵

VI. PROCUREMENT—PEDIATRIC DONORS

Because of their body size, children need pediatric donors.¹²⁶ Matching a donor with an infant recipient is particularly difficult.¹²⁷ Increased public awareness of transplant success in young children may partially solve this problem by swelling the number of waiting recipients, making it easier to find a good match. Unfortunately, that same awareness will also intensify the already critical shortage of small organs.¹²⁸ The problem is so bad that up to

122. People could register when (1) applying for a social security number, (2) a driver's license, (3) alien registration or (4) by filing specific forms. *Id.* § 201(b). Forms would also be available for competent adults not registered under any other section. *Id.* § 201(4)(A). A minor's parents or an incompetent's guardian could submit a different form if the minor or incompetent was not already a donor under a different section. *Id.* § 201(4)(B).

123. *Id.* § 201(8)(3)(B).

124. *Id.* § 202(d)(1).

125. *Id.* § 202(d)(4).

126. One recent study suggests that families of pediatric patients are much more likely to donate than the relatives of adults. John A. Morris Jr., et al., *Pediatric Organ Donation: The Paradox of Organ Shortage Despite the Remarkable Willingness of Families to Donate*, 89 PEDIATRICS 411 (1992). In fact, when physicians asked eighteen of nineteen families of eligible pediatric donors about donations, all agreed. The authors suggest that the other family probably did not donate because they were not even approached. *Id.* at 414. Inquiries are particularly important because a substantial number of pediatric patients die under circumstances where they could be donors. *Id.* at 415. *But see* Committee on Bioethics, *Infants with Anencephaly as Organ Sources: Ethical Considerations*, 89 PEDIATRICS 1116 (1992) [hereinafter *Infants with Anencephaly*] (arguing that the shortage is exacerbated because the circumstances of death in most young children mean that their organs are generally not acceptable for transplant).

127. Joyce L. Peabody et al., *Experience with Anencephalic Infants as Prospective Organ Donors*, 321 NEW ENG. J. MED. 344, 350 (1989).

128. *Id.* The authors suggest, therefore, the need for alternatives to increase the donor pool. These include xenotransplantation and use of anencephalic infants, which would require changing current standards for when death occurs. *Id.* See *infra* text accompanying notes 130-46.

fifty percent of children die before an organ is available.¹²⁹

Another troubling ethical issue is whether to use anencephalic infants¹³⁰ as organ donors.¹³¹ Even absent much of a brain, skull and scalp, the brain stem allows infants with this fatal genetic defect to breathe and their hearts to beat.¹³² Although they lack higher brain function and will die within a short period of time, according to traditional brain death criteria, these infants are alive.¹³³ Consequently, their organs may not be harvested. But, if allowed to die naturally, these children generally experience medical problems which make their organs unusable.¹³⁴

The dilemma is clear: permit anencephalic infants to die naturally and lose organs which might help many other children live, or harvest organs before children are legally dead.¹³⁵ Neither option is good, and concerns about the

129. David T. McDowell, Comment, *Death of an Idea: The Anencephalic as an Organ Donor*, 72 TEX. L. REV. 893 (1994). This compares with approximately 33% of all people awaiting a liver or heart transplant. Raja B. Khauli, *Issues and Controversies Surrounding Organ Donation and Transplantation: The Need for Laws That Ensure Equity and Optimal Utility of a Scarce Resource*, 27 SUFFOLK U. L. REV. 1225, 1225 (1993).

130. Anencephaly is actually attributed to both genetic and environmental factors, making predictions of availability of organs difficult. Kenneth J. Ryan, *Tissue Transplantation from Aborted Fetuses, Organ Transplantation from Anencephalic Infants and Keeping Brain-Dead Pregnant Women Alive Until Fetal Viability*, 65 S. CAL. L. REV. 683, 690 (1991). Because of improved testing and diagnosis techniques, and the number of these infants who are stillborn, estimates are that only 300 to 500 anencephalic infants per year could be organ donors. *Id.*

131. Anencephalic infants are born without a brain; they only have a brain stem. J. Steven Justice, Casenote, *Personhood and Death—The Proper Treatment of Anencephalic Organ Donors Under the Law*: In re T.A.C.P., 62 U. CIN. L. REV. 1227 (1994).

132. McDowell, *supra* note 129, at 893.

133. See *supra* note 20; *infra* note 135.

134. Ryan, *supra* note 130, at 689.

135. Some advocate modifying brain death criteria for anencephalic infants. They stress that "the irreversible absence of cognitive function represents the absence of personhood." *Infants with Anencephaly*, *supra* note 126, at 1118. Others suggest that anencephalics are "sufficiently 'brain-absent' to be treated as if they were dead." *Id.* Nevertheless, "a convincing case for challenging the law has not been made." *Id.* Further, serious questions exist about whether such a modification would be wise. Because the number of anencephalics who can actually be donors is low, and decreasing, it is not clear if this change would have much of an impact. *Id.* at 1118-19. Additionally, amending the definition

might produce decreased respect for human life in other areas, or it might have no such effect. It should also be noted that an amended law could trigger public fears that organs are or will be taken from other humans not fully brain dead. As a result, donations in general might fall, further reducing the overall gain in lives saved from changing the law.

Id. at 1119.

slippery slope¹³⁶ of discriminating against people with disabilities have led many to reject anencephalics as donors.

Although the concerns are justifiable, the case of Baby Theresa¹³⁷ highlights the tragedy of a policy rejecting anencephalics as donors.¹³⁸ During the eighth month of pregnancy, Baby Theresa's parents discovered that their fetus was anencephalic. Wanting to at least help others, the parents decided to carry the baby to term and donate the organs to infants who needed them to survive.¹³⁹ However, after she was born, doctors refused to harvest Baby Theresa's organs because she was not legally dead.¹⁴⁰ Her heart beat spontaneously, and she was able to breathe. She also did not satisfy brain death criteria because her entire brain had not stopped functioning.¹⁴¹

Baby Theresa's parents fought, but the Florida Supreme Court refused "to expand the common law to equate anencephaly with death."¹⁴² The court acknowledged that harvesting the organs might save other infants' lives. However, because there is no consensus as to the utility of these transplants, the ethical issues involved, or the existing legal and constitutional problems, "[t]he scales clearly tip in favor of not extending the common law."¹⁴³ Further, the statutory "'whole-brain death' exception" only applies when cardiopulmonary function is artificially maintained.¹⁴⁴ The justices said that they were "deeply touched" by Baby Theresa's parents' altruism. In fact, they said that her

136. One student author suggests that "the only way to avoid placing the legal and medical communities on a 'slippery slope' as to what constitutes death is to declare a moratorium on efforts to modify medical treatment or attempts to obtain an anencephalic infant's organs before the infant meets currently accepted standards of death." McDowell, *supra* note 129, at 894. See also Lisa E. Hanger, *The Legal, Ethical, and Medical Objections to Procuring Organs from Anencephalic Infants*, 5 HEALTH MATRIX 347, 356-57 (1995).

137. *In re T.A.C.P.*, 609 So. 2d 588 (Fla. 1992).

138. The issue of whether to use anencephalic infants as organ donors sparks a great deal of debate. For example, 239 articles were published on the topic between 1988 and 1991. R.E. Cranford, *Anencephalic Infants as Organ Donors*, 24 TRANSPLANTATION PROC. 2218 (1992).

139. *T.A.C.P.*, 609 So. 2d at 589. Baby Theresa's mother underwent a caesarean section delivery to minimize damage to the organs. *Id.*

140. *Id.* Health care providers refused the parents' request to declare T.A.C.P. legally dead because they feared civil or criminal liability. The trial court rejected the parents' petition because, under the governing statute, so long as the child's brain stem functioned, she could not be legally dead. The appellate court affirmed, but certified the order to the Florida Supreme Court. *Id.* The Florida Supreme Court framed the issue as follows: "Is an anencephalic newborn considered 'dead' for purposes of organ donation solely by reason of its congenital deformity?" *Id.*

141. *Id.* at 589, 595.

142. *Id.* at 595. Under the common law, a person with "irreversible cessation of circulatory and respiratory functions" is dead. *Id.* at 593.

143. *In re T.A.C.P.*, 609 So. 2d 588, 595 (Fla. 1992).

144. *Id.*

parents showed "great humanity, compassion, and concern for others."¹⁴⁵ Nevertheless, because the court would not expand the common law, and the statutory exception did not apply, the justices concluded that Baby Theresa was not dead and, thus, her organs could not be legally retrieved.¹⁴⁶

VII. ALLOCATION

Allocation decisions are difficult because the number of waiting recipients far exceeds the supply of transplantable organs. Dissatisfied with the current system, commentators have proposed alternative methods of distributing organs.

A. Market System

Most people reject suggestions that recipients purchase organs at a price set by the market.¹⁴⁷ In fact, while some favor a market system, an unregulated supply and demand policy presents serious ethical concerns. Everyone recognizes that the affluent enjoy many advantages that the poor cannot afford,¹⁴⁸ but the idea of actually sanctioning a system where only the rich have access to life-saving transplants is simply unacceptable.

B. Lottery

Some commentators suggest a lottery is the "ultimate equalizer" because all potential recipients have an equal chance of receiving an organ.¹⁴⁹ However, although lotteries based on a first come, first served basis may seem fair, they actually favor the rich. This is because the affluent generally are more knowledgeable and have better access to referral networks.¹⁵⁰ Potential inequity is exacerbated because patients must have either the money for the transplant¹⁵¹ or proof of insurance before being placed on a waiting list.¹⁵² Moreover, some doctors do not even tell certain patients about transplants,

145. *Id.* at 594.

146. *Id.* at 595.

147. *See, e.g.,* Barnett & Kaserman, *supra* note 106, at 125.

148. A great disparity already exists in organ allocation between the rich and the poor. This inequality is especially pronounced for minorities. Stein, *supra* note 15, at 200.

149. *See, e.g.,* George J. Annas, *The Prostitute, the Playboy, and the Poet: Rationing Schemes for Organ Transplantation*, 75 AM. J. PUB. HEALTH 187, 188 (1985).

150. *Id.*

151. Transplants are expensive. "Hundreds are turned away from transplant centers simply because they can't afford the \$200,000 price tag." SCOTT MCCARTNEY, *DEFYING THE GODS* xv (1994). Almost ten years ago, Arthur L. Caplan dubbed this artificial barrier the "green screen." Arthur L. Caplan, *Obtaining and Allocating Organs for Transplantation*, in HUMAN ORGAN TRANSPLANTATION 5, 6 (Dale H. Cowan et al. eds., 1987).

152. *See, e.g.,* Ellis v. Patterson, 859 F.2d 52 (8th Cir. 1988)

which means that they have no chance to be chosen. Not surprisingly, poor people frequently fall into this group. Further, some factors used to exclude patients from consideration—for example, ability to obtain expensive post-operative medication and submit to periodic monitoring—may also handicap the poor.¹⁵³ Additional questions of fairness and efficiency arise because no distinctions are made for quality of life, survivability or strength of desire. Nevertheless, lottery advocates conclude that modifying the first come, first served system is “the most reasonable” solution.¹⁵⁴ But, even these proponents agree that patients who are at risk of imminent death, and for whom a transplant is likely to mean long term survival, should jump ahead in line, only when the person who would have received the organ first is “reasonably assured” to survive long enough to get another.¹⁵⁵ Recognizing “[s]ome unfairness” in permitting people to skip to the top of the list, the argument suggests that “this advantage should decrease sharply as public awareness of the system grows.”¹⁵⁶

VIII. PROPOSALS—ADULT DONORS

A. *Death Row Inmates*

One radical step would be to permit death row inmates to donate organs. Some condemned men have made this request,¹⁵⁷ but, despite attempts to allow this,¹⁵⁸ no state has adopted legislation permitting inmates to donate.

153. Annas, *supra* note 149, at 189.

154. *Id.*

155. *Id.*

156. *Id.*

157. For example, Florida rejected similar requests. Delaware granted a prisoner a short stay to donate a kidney before they executed him. Frank J. Murray, *Death-row Organ Donor Hands Court a Puzzle*, WASH. TIMES, Dec. 4, 1995, at A1. Death row inmates have generally not been permitted to donate organs after execution. Gloria J. Banks, *Legal and Ethical Safeguards: Protection of Society's Most Vulnerable Participants in a Commercialized Organ Transplantation System*, 21 AM. J.L. & MED. 45, 60 n.122 (1995).

158. For example, an Arizona legislative committee recently failed to report out a death row inmate donor bill (H.B. 2271, 42d Leg., 2d Reg. Sess. (Ariz. 1996)). Christopher Johns, *Should Prisons Be Organ Farms?: 'Harvesting' Bills Raise Scary Implications*, ARIZ. REPUBLIC, Feb. 18, 1996, at H3. The issue was also raised in Indiana in 1995. The Interim Committee on Criminal Justice Issues debated the question, but “dismissed the idea of organ harvesting as more humorous than realistic.” Editorial, *Organ Harvesting in Indiana*, INDIANAPOLIS NEWS, Aug. 25, 1995, at A08. Nevertheless, the proponent argued that the suggestion was simply to give inmates the option. “It was not at all intended to be an organ harvesting measure. Organ harvesting implies taking organs against someone’s will. That was not the intent, and I would not support such a measure.” *Id.* (quoting Rep. Jon Padfield, R-Kokomo).

As of September 1, 1995, 3028 people awaited execution on death rows across the United States.¹⁵⁹ States executed fifty-six people in 1995,¹⁶⁰ the highest number since 1957,¹⁶¹ and more than twice as many as the previous year.¹⁶² Most of these convicted men and women were probably reasonably healthy prior to execution.¹⁶³ In fact, failure to provide health care prior to execution would violate the Eighth Amendment.¹⁶⁴ Although some prisoners would not be suitable donors, because the time, place and cause of death would be known in advance, the uncertainty associated with most traumatic deaths is eliminated. Moreover, tissue typing and immunologic testing could be done prior to the execution, ensuring better matches and increasing the likelihood of successful transplants.¹⁶⁵

159. Mark Russell, *Embracing a Quicker Death: Effect of Maryland Law Curbing Appeals Should be Faster Executions*, DAILY REC., Oct. 16, 1995, at 1.

160. Mark Hansen, *With Federally Funded Appeals From Capital Punishment on the Way Out, Lawyers Are Wrestling with Questions About Who Will Pursue the Arguments to Keep Condemned Inmates from Death's Door*, A.B.A. J., June 1996, at 58, 62. Thirty-eight states currently permit the death penalty. *Id.* See Paul W. Valentine, *Md. High Court Blocks Execution of Police Killer; Case Renews Debate Over Death Penalty, Race*, WASH. POST, June 1, 1996, at B06. The District of Columbia does not permit the death penalty. *Human Rights: Many on Death Row, But the Wait is Long*, INTER PRESS SERV., June 20, 1995.

161. Elizabeth Fernandez, *Execution Rate May Quicken; 435 on Death Row, Most in Nation*, S.F. EXAMINER, Feb. 25, 1996, at A-1.

162. Penelope Lemov, *Long Life on Death Row*, 1996 GOVERNING MAG. 30.

163. Some people raise concerns that death row inmates may be drug addicts or victims of fetal alcohol syndrome. Johns, *supra* note 158, at H3. This objection is puzzling for several reasons. First, the average wait on death row is ten years. Fernandez, *supra* note 161, at A1. During this time, inmates presumably cannot continue abusing illegal drugs. As a result, at least some of their organs might be suitable for transplant. Second, although fetal alcohol syndrome may cause alcohol-related birth defects, some organs will be suitable for transplant. Moreover, a mother's alcohol abuse during pregnancy frequently causes mental retardation. G. Hoegerman et al., *Drug-exposed Neonates*, 152 W. J. MED. 559 (1990). Retardation may be a mitigating factor in sentencing. See, e.g., *Penry v. Lynaugh*, 109 S. Ct. 2934 (1989) (although not a bar, retardation is a compelling mitigating factor); GA. CODE ANN. § 17-7-131(j) (1996). This should minimize the number of individuals with fetal alcohol syndrome on death row. It will not eliminate them. In fact, the California Supreme Court recently approved the execution of an inmate who argued fetal alcohol syndrome required mitigation. *People v. Arias*, 913 P.2d 980, 1043 (Cal. 1996). Third, all inmates on death row are not either drug addicts or persons with fetal alcohol syndrome. The fact that some inmates' organs may not be acceptable should not support a ban on all prisoners' organs. Finally, no one is suggesting lowering the standards for organ quality—only medically satisfactory organs would be retrieved.

164. *Estelle v. Gamble*, 429 U.S. 97 (1976). A recent Oklahoma case spotlights the irony of healing a prisoner so that he can be executed. On the day of his scheduled execution, the inmate attempted suicide. After hospital personnel revived him, the death penalty was imposed. Janan Hanna & Sue Ellen Christian, *Death Row Con Says He's Too Sick to Die; Execution Delay Asked After His Heart Attack*, CHI. TRIB., Nov. 3, 1995, at 1N. "We are deprived of something very valuable when a criminal escapes punishment, even if he does so by dying," wrote Walter Berns, a political scientist and author of "For Capital Punishment." *Id.*

165. See *supra* text accompanying notes 18-19.

To preserve the organs so that inmates could donate, some states would have to change execution methods. One solution, already at least an option in thirty-two states,¹⁶⁶ is some form of lethal injection. In fact, that is what Dr. Jack Kevorkian suggests. Kevorkian said that both kidneys and the liver could be retrieved “‘immediately after death’” if the prisoner were executed by lethal injection.¹⁶⁷ Further, he said, if the inmate were anesthetized “‘like a brain-dead person,’” his heart and lungs could also be harvested while he was alive.¹⁶⁸

Recently, Larry Grant Lonchar, a triple murderer on Georgia’s death row,¹⁶⁹ asked the state to use this execution method—to anesthetize him, and then remove his heart and lungs.¹⁷⁰ Based on state law, which provides that condemned prisoners must be electrocuted, Georgia refused. Following Lonchar’s request, the Georgia legislature considered, but rejected, a bill¹⁷¹ permitting condemned prisoners to choose execution by guillotine.¹⁷² Despite understandable visceral negative reactions,¹⁷³ the guillotine is actually no more barbaric than other execution methods,¹⁷⁴ and it would facilitate organ

166. Reynolds Holding, *Death of a Serial Killer: The Evolution of Executions Injection Now Seen as Most Humane*, S.F. CHRON., Feb. 17, 1996, at A1.

167. Rhonda Cook, *Condemned Inmate Wants to Donate Organs; Kevorkian On Case: Larry Lonchar Wants a Death That Won’t Ruin His Organs*, ATLANTA CONST., June 16, 1995, at 1D (quoting Jack Kevorkian).

168. *Id.*

169. In 1987, Larry Grant Lonchar was sentenced to death for killing three people. Throughout the process, Lonchar refused to cooperate with his attorney and said he wanted to die. *Lonchar v. Thomas*, 116 S. Ct. 1293, 1295-96 (1996). He also objected to the appeals that his siblings filed. The state issued a death warrant for the week of June 23, 1995. Just prior to the scheduled execution, Lonchar filed a state habeas corpus petition, with the goal of getting the state to change the execution method so he could donate his organs. Immediately after the state petition was denied, he filed a federal habeas petition. *Id.* The Supreme Court remanded for a hearing by the district court on the habeas petition. *Id.* at 1303.

170. Laura Williamson, *Lonchar Gets Another Stay at Last Minute; Supreme Court Will Hear His Case in ‘96*, ATLANTA J., June 30, 1995, at 6C.

171. H.B. 1274, 143d Leg. (Ga. 1995).

172. Murray, *supra* note 157, at A1. Legislators also rejected a later bill to replace electrocution with lethal injection. Editorial, *Injection Bill the Lesser Evil*, ATLANTA CONST., Feb. 3, 1996, at A10 [hereinafter *Injection Bill*].

173. “That’s right—guillotine. Fresh dead body. What’s next? The Vulcan death grip?” Johns, *supra* note 158, at H3.

174. It is difficult to conceive of more troubling problems than some encountered using present execution methods. See, e.g., *Utah Execution by Firing Squad May Shape Legislation*, CORRECTIONS PROF., March 4, 1996, at *1, available in LEXIS, News Library (In discussing the problems with lethal injections, a Utah Department of Corrections official said that because so many inmates were drug abusers with collapsed veins “[o]ne time, it took an hour and a half to get a vein. They finally had to do a cut away on the leg.”); Kyle Hughes, *Death Penalty Secrecy*, GANNETT NEWS SERV., June 13, 1995.

[During an electrocution in New York, the inmate] rocked back and forth in the chair

donation.¹⁷⁵ Organs could be removed immediately, and physician participation would not be necessary until after someone pronounced death.¹⁷⁶ Nevertheless, the legislature adjourned without changing the execution method. As a result, despite the Supreme Court's delay in his execution, Lonchar said that he is ready to die.¹⁷⁷ The only remaining issue is whether Lonchar can donate a kidney¹⁷⁸ prior to his electrocution. The state steadfastly refused to permit the donation.¹⁷⁹

An Arizona prisoner donor bill¹⁸⁰ did not even pass out of committee. This bill permitted death row inmates to choose either lethal injection or dying "by the harvesting of vital organs for the purpose of organ donation."¹⁸¹

to free himself and spewed from the mouth as the initial jolt of electricity hit him for 17 seconds. Thinking Kemmler [the inmate] was dead, the warden shut off the power, only to have Kemmler go into spasms and begin groaning. They hit him again, after waiting two minutes for the dynamo to get to full power. They kept the switch on for 70 seconds, until smoke rose from Kemmler's head. A hole was burned into the base of his spine and 'the flesh was fairly roasted to the bone,' one account said.

Id. Jack Cheevers, *State Readies for 1st Execution by Lethal Injection*, L.A. TIMES, Jan. 15, 1996, at A1:

During the 1990 electrocution of Jesse Joseph Tafero in Florida, a synthetic sponge in a headpiece caught fire and flames erupted around his shaved head. . . . In 1988, an intravenous tube funneling lethal fluids into the arm of another Texas convict with a history of drug abuse sprang a leak, spewing chemicals toward witnesses.

Id. Editorial, *Cruel and Unusual*, USA TODAY, Oct. 6, 1994, at 8A ("[A] former San Quentin warden describes death in the gas chamber this way: 'At first there is evidence of extreme horror, pain and strangling. The eyes pop. The skin turns purple and the victim begins to drool. It is a horrible sight.'").

175. The bill's sponsor says, "People are squeamish about the blood (from guillotines) but they are currently frying people alive." *Injection Bill*, *supra* note 172, at A10 (quoting Doug Teper (D-Atlanta)). The editorial writer disagrees: "As the 21st century is about to dawn, we don't need to return to the days of the French Revolution, do we?" *Id.*

176. *See infra* text accompanying notes 183-91.

177. In fact, Lonchar consistently asked to die. His only deviation was when he filed his habeas petition so that he could donate his organs. Rhonda Cook & Bill Rankin, *The Death GAME: Appeal, Counterappeal, Motion, Counter-motion—Carrying Out the Death Penalty Means Playing the System. But What About Justice?*, ATLANTA J. & CONST., July 23, 1995, at 1N.

178. Ironically, Lonchar wants to donate his kidney to the detective, Melvin Ferguson, who led the investigation which resulted in his imprisonment. Mark Curriden, *Inmate's Last Wish is to Donate Kidney*, A.B.A. J., June 1996, at 26. The officer's kidneys failed during his 1994 heart surgery. *Id.* The Corrections Commissioner refused to permit tissue-matching because he said that he feared Lonchar's request was a hoax. The detective's lawyer said that the state should let Ferguson worry about that. Frank J. Murray, *High Court's Ruling May Enable Condemned Man to Donate Kidney*, WASH. TIMES, Apr. 3, 1996, at A6.

179. In addition to the fear that the request is a hoax, officials express security concerns. A lawyer for Lonchar said that the inmate could be anesthetized during the trip to the hospital to prevent escape. Murray, *supra* note 178, at A6. *See also* *Kidney in Capital Case*, NAT'L L.J., Mar. 25, 1996, at A8.

180. H.B. 2271, 42d Leg., 2d Reg. Sess. (Ariz. 1996).

181. *Id.*

Concerns about the suitability of the organs—such as fears of “a medical history fraught with complications arising out of everything from intravenous drug use to fetal alcohol syndrome”¹⁸²—were exaggerated. No one suggested using organs which have not passed usual rigorous medical standards. Naturally, inmates would not be able to donate damaged organs.

The American Medical Association (AMA) represents a major stumbling block to permitting inmates to donate organs. As early as 1980, the AMA declared that it is unethical for a physician to participate in executions, except to certify death.¹⁸³ However, if inmates are permitted to donate, preserving their organs through proper procedures is especially important. If some form of lethal injection is chosen, physicians are obviously the most qualified professionals to prepare and inject the lethal drug.¹⁸⁴ Nevertheless, the AMA's position prevents ethical doctors from participating in the execution process, from inserting the intravenous tube, and certainly from suggesting or preparing the lethal substance.¹⁸⁵ This obstacle is not, however,

182. Johns, *supra* note 158, at H3.

183. COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, AMERICAN MEDICAL ASSOCIATION, CODE OF MEDICAL ETHICS: CURRENT OPINIONS WITH ANNOTATIONS 2.06, at 9-12 (1994) [hereinafter CODE OF MEDICAL ETHICS]. Based on reports that physicians participated in executions in Illinois and Missouri, the AMA confirmed and strengthened its 1980 statement. Beverly Merz, *AMA: Keep Doctors Out of Execution Process*, 33 AM. MED. NEWS 5 (1990). In addition to repeating that it is unethical for doctors to participate in executions, the 1990 resolution mandates that the AMA inform all state licensure and certification boards that physician participation should be considered a serious ethical violation. *Id.* To protect physicians who do participate, Illinois guarantees anonymity. The law provides for payment in cash to avoid a paper trail. Colman McCarthy, Editorial, *Doctors in The Death Chamber*, WASH. POST, May 28, 1994, at A29. *But see* D.S. Hsieh, *Physicians Should Give Injections*, 261 JAMA 132 (1989) (arguing that doctor participation in executions is ethical and actually a civic duty). Nevertheless, the vast majority of physicians are opposed to it. *See, e.g.*, Robert D. Troug & Troyen A. Brennan, *Participation Of Physicians In Capital Punishment*, 329 NEW ENG. J. MED. 1346 (1993).

184. As compared to other methods—electrocution, hanging, firing squad or gas chamber—lethal injection requires greater medical competence. McCarthy, *supra* note 183, at A29 (The Ninth Circuit recently determined that lethal gas constitutes cruel and unusual punishment and, thus, violates the Eighth and Fourteenth Amendments. *Fierro v. Gomez*, 77 F.3d 301 (9th Cir. 1996)). Indeed, the absence of physicians may create serious problems. A Texas execution provides a troubling illustration. Untrained non-medical personnel incorrectly inserted the intravenous lines; they improperly pointed the lines toward the inmate's fingers, rather than toward his heart. As a result of this “seemingly minor mistake . . . [the inmate] suffered excruciating pain for more than ten minutes before he died.” Stacy A. Ragon, *A Doctor's Dilemma: Resolving the Conflict Between Physician Participation in Executions and the AMA's Code of Medical Ethics*, 20 DAYTON L. REV. 975 (1995). Numerous other examples exist. *Id.* at 976. Nevertheless, even when physicians do participate, “[b]lotchings occur. Veins can't be found, dosages are miscalculated, injection devices fail.” McCarthy, *supra* note 183, at A29.

185. AMA guidelines provide that physician participation in an execution by lethal injection includes:

- selecting injection sites; starting intravenous lines as a port for a lethal injection device,
- prescribing, preparing, administering, or supervising injection drugs for their dose or

insurmountable.¹⁸⁶ Generally, states which use lethal injection employ health care professionals—other than physicians—to perform the procedure.¹⁸⁷ Obviously, if the inmate donates his organs, the waiting transplant team would include physicians. But, that should not be a problem if these doctors only act after someone pronounces, and another physician certifies,¹⁸⁸ the prisoner's death.

On the other hand, the Arizona proposal would create an ethical dilemma for transplant surgeons. Under this plan, the inmate would die on the operating table "by the harvesting of vital organs."¹⁸⁹ The AMA position¹⁹⁰—to only retrieve organs "after the prisoner has been pronounced dead and the body removed from the death chamber"¹⁹¹—clearly prohibits this.

Of course, as is true with any donor, the choice would belong to the individual prisoner. No organs could or would be taken without his consent. There should be little fear of coercion because inmates would not receive

types; inspecting, testing, or maintaining lethal injection devices; consulting with or supervising lethal injection personnel.

Physician Participation in Capital Punishment; Committee on Ethical and Judicial Affairs, American Medical Association, 270 JAMA 365, 368 (1993) [hereinafter *Physician Participation*].

186. Kevorkian said he is aware of "at least two 'pre-eminent surgeons in the transplant field' who could do the procedure." Cook, *supra* note 167, at 1D.

187. *Doctor's Presence Required at Executions in Louisiana*, SUNDAY ADVOC., June 12, 1994, at 12A. Although prison officials refused to reveal names or qualifications of individuals "who prepared the intravenous tube attached to Sawyer's [inmate] arm and injected the lethal drugs," they did say that they were not physicians but were "qualified to hook up IVs." *Id.* (quoting Warden John Whitley). This may become a problem in the future. For example, the North Carolina Medical Society extended the participation prohibition to personnel who are physicians' agents. "The goals of physicians assistants, nurses, medical technicians and other allied health personnel are in a similar spirit of dedication to preserving life." UPI, May 8, 1983, available in LEXIS, Nexis Library, UPI File.

On the other hand, in Maryland, for example, "[t]rained guards, following step-by-step instructions," insert the needle. Paul W. Valentine, *Execution of Thanos Went 'Like Clockwork'; 12 Witness; Md.'s First Use of Lethal Injection*, WASH. POST, May 18, 1994, at D1.

188. A physician may ethically certify death after the inmate has been pronounced dead by someone else. *Physician Participation*, *supra* note 185, at 366-67.

189. H.B. 2271, 42d Leg., 2d Reg. Sess. (Ariz. 1996).

190. The AMA would only permit organ donation if

- 1) the decision to donate was made before the prisoner's conviction, (2) the donated tissue is harvested after the prisoner has been pronounced dead and the body removed from the death chamber, and (3) physicians do not provide advice on modifying the method of execution for any individual to facilitate donation.

CODE OF MEDICAL ETHICS, *supra* note 183, at 10.

191. *Id.*

financial or other benefits.¹⁹² It would, however, be important to keep the inmate's decision from those involved in his appeals to avoid any suggestion that eagerness for organs somehow improperly influenced the process.¹⁹³

The goal of this proposal is increasing organ supply.¹⁹⁴ The potential benefit of saving lives should be sufficient incentive to try to resolve the serious ethical concerns this proposal raises.¹⁹⁵ These include the warning that "[i]t sounds awfully Nazi-like."¹⁹⁶ Nevertheless, concerns that a judge or jury might impose a death sentence to retrieve a prisoner's organs seem—rather than "scary"¹⁹⁷—simply far-fetched.

Allowing a condemned man to donate his organs permits at least some good to come from evil. Family members, of both victims and condemned persons, can gain a measure of comfort from the fact that, although their loved one is gone, others will live. Death penalty opponents can find solace in the fact that the government's deprivation and degradation of human life has at least some positive consequence. Further, the inmate has a chance to do something

192. "Either way we are dead, so it's not like we are avoiding our death sentences. The most important fact is other people could live." Cook, *supra* note 167, at 1D (quoting Larry Lonchar, letter to The Atlanta-Journal Constitution). Further, "[t]here is no harm to the donor. This guy is on death row, for heaven's sake." Curriden, *supra* note 178, at 26 (quoting Mike Deming, lawyer to potential recipient).

193. Obviously, however, certain prison officials and transplant teams must be informed so that appropriate plans for execution methods and transplant teams could be made.

194. "We're talking about saving at least three lives and maybe six' if Larry Grant Lonchar's organs can be harvested for donation, Kevorkian said. 'What's going to be gained by frying this guy?'" Cook, *supra* note 167, at 1D.

195. Opponents raise a number of objections: 1) "[i]his proposal treats condemned criminals—and, by inference, the rest of us—as mere chattel, property to be used, kept alive or killed at government's whim," 2) "inmates waiting, on life support, until the exact combination of their available organs is needed," 3) subversion of the Fourth, Fifth, Sixth, Seventh and Eighth amendments, 4) limitation or elimination of the appeals process, and 5) "capital punishment extended to habitual criminals, drunken drivers, tax evaders, jaywalkers—all are scofflaws with a need 'to pay back society.'" Reader's Views, *Padfield's Heinous Proposal*, INDIANAPOLIS NEWS, July 13, 1995, at A09.

One question is whether organ recipients should be told that the state executed their donor. In other words, would recipients want to know, for example, that their donor was put to death for the rape and murder of several adolescent boys? Would the recipient have the need or right to know? Most people would probably respond that recipients should be told, probably because they themselves would want to know. But, after the initial visceral reaction, people should recognize that generally recipients are not told of their donors' identities. See *supra* note 28. There seems to be no reason to change the procedure for this specific situation.

196. Curriden, *supra* note 178, at 26 (quoting Ed Larson at the University of Georgia). A Georgia prison official also expressed ethical concerns. "Will we be viewed as killing people just to harvest their organs?" *Id.* (quoting Mike Light, a Georgia legal-medical ethics expert).

197. *Id.*

positive. This final act can never erase the heinous crime¹⁹⁸ which landed him on death row, but it does give him the opportunity to try to make amends.

It is important to remember that the criminal justice system has several goals: "to punish justly, to deter future crime, and to return imprisoned persons to society with an improved chance of being useful, law-abiding citizens."¹⁹⁹ How does the death penalty meet these goals? Execution is indisputably the ultimate punishment. Further, it effectively deters at least this particular person.²⁰⁰ But, of course, executing inmates means that they have no opportunity to become "law-abiding citizens."²⁰¹ Nevertheless, permitting death row inmates to donate organs offers them a real chance at "being useful."

198. The Supreme Court limited the death penalty to cases which provide a "meaningful basis for distinguishing the few cases in which it is imposed from the many cases in which it is not." *Gregg v. Georgia*, 428 U.S. 153, 188 (1976) (quoting *Furman v. Georgia*, 408 U.S. 238, 313 (1972) (White, J., concurring)). This was further refined to reject the death penalty in a case which did not illustrate "a consciousness materially more 'depraved' than that of any person guilty of murder." *Godfrey v. Georgia*, 446 U.S. 420, 433 (1980). In fact,

[i]n the wake of *Gregg* and *Godfrey*, the state courts have generally sought to adopt and apply a principled construction of statutory aggravating circumstances focusing on the heinousness, cruelty, or depravity of a killing, so as to limit their application to murders involving a level of brutality or moral corruption greater than that present in the 'normal' first-degree murder.

Thomas M. Fleming, Annotation, *Sufficiency of Evidence, For Purposes of Death Penalty, To Establish Statutory Aggravating Circumstance that Murder Was Heinous, Cruel, Depraved, or the Like—Post-Gregg Cases*, 63 A.L.R. 4TH 478, 488 (1988). See also Richard A. Rosen, *The "Especially Heinous" Aggravating Circumstances in Capital Cases—The Standardless Standard*, 64 N.C. L. REV. 941, 941-43 (1986).

199. *Rhodes v. Chapman*, 452 U.S. 337, 352 (1981).

200. A plethora of studies conclude that the death penalty is not a deterrent to other criminals. See, e.g., M. Watt Espy, Jr., *Capital Punishment and Deterrence: What the Statistics Cannot Show*, 26 CRIME & DELINQ. 537, 544 (1980)

If the purpose of the death penalty is to deter people from committing capital crimes, then I submit that at least in the foregoing cases, selected from my files containing accounts of approximately 12,000 executions, it has failed. . . . When Jesse Bishop, asphyxiated at the Nevada State Prison on October 23, 1978, was sentenced to die, he was asked by a reporter whether he thought the death penalty was a deterrent. His reply was, "Did it stop me?"

Id. *Speak Out*, PORTLAND PRESS HERALD, May 18, 1996, at 1D ("Those states that have the death penalty have a higher murder rate than those that do not, illustrating the fact that capital punishment is not a deterrent to murder.").

201. It is interesting to note that there has been a substantial decrease in the number of people who believe that the purpose of prison is rehabilitation. In a 1971 poll, seventy-six percent cited "rehabilitation" as a goal. Contrast this with 1994, when only twenty-five percent favored "rehabilitation," while sixty-one percent said that they wanted "punishment." David Holmstrom, *Death Penalty's Forward March*, CHRISTIAN SCI. MONITOR, Jan. 4, 1995, at 2. Permitting organ donation might have a positive effect, returning the public to a more forgiving posture.

Paradoxically, a common objection to the death penalty provides an argument that supports using inmates' organs. The objection is based on discrimination: black offenders are much more likely than whites to be sentenced to death. In fact, although blacks represent only twelve percent of the population, more than sixty percent of the men on death row²⁰² are African-Americans. More than thirty-three percent of the 49,000 people on transplant waiting lists are black.²⁰³ However, fewer than ten percent of donated organs come from African-Americans. Further, kidney transplant survival rates are between ten and fifteen percent poorer than in all other ethnic groups.²⁰⁴ Because antigen matching contributes to improved survival rates, more minority donors are needed.²⁰⁵ If inmates are permitted to donate, the disproportionate number of blacks on death row might actually benefit waiting African-American recipients.

B. Comply With Patient's Wishes

Ironically, doctors could increase the organ supply simply by obeying current law. The law is clear—the decision to donate is the patient's.²⁰⁶ Nevertheless, doctors generally refuse to retrieve organs if relatives object, even if the deceased indicated a clear intent to donate.²⁰⁷ Doctors and hospitals must start complying with the law by following decedents' wishes.²⁰⁸ So long

202. Mumia Abu-Jamal, *DEAD or ALIVE, In the Ultimate Lottery, Some Are Too Wealthy to Die*, STAR TRIB., Aug. 27, 1995, at 17A.

203. *Hearing of the Senate Labor and Human Resources Committee: Organ and Tissue Donation*, reprinted in FED. NEWS SERV., Apr. 23, 1996 (testimony of Dr. Clive Callender, founder and principal investigator of National Minority Organ and Tissue Transplant Education Program). Further, in the southeastern United States, fifty to seventy percent of dialysis patients are black. *Id.* The government recognizes the inequity and is responding with methods for increasing minority donations. Some of these plans include "expanded' or 'marginal' donors. These donors are generally older, and have a medical history that would have precluded donation five years ago." *Id.* (testimony of Jack Mahoney, deputy administrator, Health Resources Services Administration). Among many other projects are increasing community awareness and improving the way that requests are made. *Id.*

204. *Id.* For example, in 1982, blacks represented ninety-five percent of transplant patients at Howard University's transplant center, but only twenty percent of the donors. *Id.*

205. *Id.* (testimony of Jack Mahoney, deputy administrator, Health Resources Services Administration).

206. UNIFORM ANATOMICAL GIFT ACT § 2(h), 8A U.L.A. 34 (1993) ("An anatomical gift that is not revoked by the donor before death is irrevocable and does not require the consent or concurrence of any person after the donor's death."). All states have adopted this uniform act. *Brotherton v. Cleveland*, 923 F.2d 477, 483 (6th Cir. 1991) (Joiner, J., dissenting).

207. See *supra* note 49.

208. Louisiana attempted to do this by creating still another special form. Peter Shinkle, *Plan to Allow Organ Harvest Without Kin*, SUNDAY ADVOC., Oct. 23, 1994, at 1A. The new documents are available where drivers apply for licenses. Prior to the change, donors could indicate a wish to donate on their license. However, that was not a legal document. *Id.*

as the donor's intent was clearly expressed, physicians' fears of civil or criminal liability are misplaced.²⁰⁹

Equally important for the physician are his or her ethical and professional obligations.²¹⁰ These also require complying with the decedent's wishes, regardless of contrary pressure from surviving relatives.

Buttressing the legal, ethical and professional requirements to comply with the decedent's wishes is the fundamental privacy right to make intimate decisions concerning personal matters. Of course, this constitutional right only protects people from government interference. Nevertheless, this argument is relevant for at least two reasons. First, the government is involved in obtaining and distributing organs.²¹¹ Second, the situation is analogous to the abortion and personal decision cases.²¹²

Another theory suggests that people have property rights in their own bodies.²¹³ Although courts reject the idea of a commercial property right in a dead body,²¹⁴ some have granted families a quasi-property right in the decedent's body.²¹⁵ Nevertheless, this right is not broad enough to permit countermanding the decedent's wish to donate his organs. Instead, the right is

The Louisiana Organ Procurement Agency (LOPA) plans to use the signed documents to convince relatives that the decision was made by the deceased. In fact, LOPA's executive director said that many survivors will be grateful because they "want all those decisions made for them." *Id.* Although the project began in 1994, the intent was to continue asking family members about donation for at least four years. Officials said the delay would permit residents to sign the new documents and provide time for educating the public, doctors and nurses about the change. *Id.*

209. In fact, one commentator even proposes a cause of action for failure to follow the donor's wishes. Potential donors would be suing medical personnel that they believed would not retrieve their organs if family members objected. Jardine, *supra* note 30, at 1667-78.

210. The Hippocratic Oath states, "I will follow that system of regimen which, according to my ability and judgment, I consider for the benefit of my patients, and abstain from whatever is deleterious and mischievous." Oath of Hippocrates, *quoted in* BARRY R. FURROW ET AL., *BIOETHICS: HEALTH CARE LAW AND ETHICS* 29-30 (2d ed. 1991).

211. *See supra* text accompanying notes 26-27, 50-54.

212. *See supra* note 102.

213. *See, e.g.,* Moore v. Regents of the Univ. of Cal., 793 P.2d 479, 517 (Cal. 1990) (Mosk, J., dissenting). The National Organ Transplantation Act (NOTA) prohibition is limited to selling organs for transplantation, leaving "many issues concerning the ownership of body parts unresolved." William Boulier, Note, *Sperm, Spleens and Other Valuables: The Need to Recognize Property Rights in Human Body Parts*, 23 *HOFSTRA L. REV.* 693, 713 (1995).

214. *See, e.g.,* Snyder v. Holy Cross Hosp., 352 A.2d 334, 340 (Md. Ct. Spec. App. 1976). Also, at the time he decides to donate, the donor is alive and has the right—with certain, irrelevant limits—to do what he wants with his body. *See supra* note 102.

215. Brotherton v. Cleveland, 923 F.2d 477, 480 (6th Cir. 1991).

limited to "possession of the body for the purpose of burial, sepulture, or other lawful disposition."²¹⁶

C. License Fee Discount

Granting a small discount to drivers applying for a license or renewal might also increase organ donation. The incentive of a discount is necessary because, although most states already allow people to indicate on driver's license or renewal forms that they want to be an organ donor, many applicants do not exercise this option.²¹⁷ Even with additional information being provided at license bureaus,²¹⁸ people do not donate either because they are not aware of the opportunity²¹⁹ or because they do not perceive any immediate personal benefit.²²⁰

In fact, the absence of any immediate, tangible return is a primary problem with the present system. While it may be neither commendable nor desirable, Americans have been trained to expect payment in exchange for something valuable. Even with a gift, the donor generally receives some benefit. For example, although it may not be legal consideration, the donee's pleasure in the gift is value to the donor, especially as most gifts are given to friends or family,

216. *Kirker v. Orange County*, 519 So. 2d 682, 684 n.2 (Fla. Dist. Ct. App. 1988).

217. Although almost all states permit drivers to sign a donor form as part of their license application, only a small percentage actually sign. Carl E. Schneider, *Emerging Paradigms in Bioethics: Bioethics with a Human Face*, 69 IND. L.J. 1075, 1082 (1994).

218. *See, e.g.*, Shinkle, *supra* note 208, at 1A. Although additional information has not increased donation in the past, material about organ donation could be included in driver's education materials and the handbook drivers study for the written test. Brochures should also be available in licensing offices, and forms should include a box to check "yes" or "no" to organ donation. This is necessary because, although some states currently require asking license applicants whether they want to be donors, *see, e.g.*, FLA. ADMIN. CODE ANN. r. 10D-70.001 (1995), license bureau personnel frequently do not raise the issue. Employees probably will not be disciplined, unless the failure is intentional. *See, e.g.*, FLA. ADMIN. CODE ANN. r. 15.3001 (1995). According to the Florida rules, employees can be penalized for "willful (1) failure to complete a specific assignment or duty that is expected as a part of the employee's job or, (2) performance of such task at a substandard level." *Id.* If, however, there is a space on the application form—rather than inquiry by bureau personnel or a separate form—applicants will see the request and, at the least, have to think about donation. Providing information to doctors and other medical personnel is also critical. In addition, hospitals should provide brochures and other information to family members.

219. Clerks are supposed to ask all applicants whether they wish to donate, but many do not. Probably for a number of reasons—including no immediate incentive to do so—applicants do not raise the issue themselves, and the opportunity is lost.

220. Even permitting organ sales would not address this concern. To respond to fears about commercialization, commentators suggest a futures market. This means that the donor receives no immediate benefit. The incentive, of course, is to help ease his family's financial burden. *See supra* text accompanying notes 80-83.

or at least a favorite charity. Organ donation is different.²²¹ With rare exceptions, the person who donates his own organs will not even be alive²²² to witness the benefit that recipients enjoy. In addition, virtually all donors and their families do not know who receives their organs.²²³ Donors have no special desire to please nameless, faceless strangers. In fact, organ donation seems more abstract than most other charitable donations. A donor to a large charity might not be able to trace his money directly, but he can still take pride in the overall good the charity does and know that without him—and many more like him—the good could not be accomplished. While this is true to a degree in organ donation—without donors²²⁴ there could be no transplants—the return is much more attenuated and intangible. The gift is not real to the donor at the time he donates, and later—when the organs are retrieved—it is too late because he is dead.

This distinction between most charities and organ donation means that altruism will probably continue to be inadequate in obtaining sufficient organs for all who need them. To increase the likelihood that applicants will more aggressively choose to be organ donors,²²⁵ those who do should be granted a \$5 discount on their driver's license fee. This nominal discount would combine the benefits of the current altruistic model and the commercial market, while avoiding the problems.

Tying donation to driver's licenses is appropriate because states already permit drivers to note organ donor status on their licenses. This means that at

221. One commentator raises another interesting distinction. Eike-Henner W. Kluge points out that, unlike other gift transactions, the gift of an organ—absent "active social involvement and intervention"—is meaningless. Kluge, *supra* note 57, at 431. Distinguishable from other gifts, where the *transfer* of items from one to another is the value, for the transfer of an organ to be useful a transplant team plus a complete group of support services is required. Thus, organ donation is not only a personal act, it is also social.

It is a social act not solely because it is embedded in a social context—most gift transactions have that nature—but because it requires society's direct and immediate participation. Society itself becomes a participant giver, and the organ, which as issue was merely a private good, becomes a social good when it is an organ-as-donated.

Id. at 431.

222. Because people are born with two kidneys but can live with only one, there have been successful kidney transplants from live donors.

223. See *supra* note 28.

224. Xenographs are beyond the scope of this article. Obviously, however, if success improves, this procedure holds promise for the future.

225. In fact, a 1991 Louisiana survey showed that sixty percent of people would donate "if it were made easier." Shinkle, *supra* note 208, at 1A.

least a rudimentary procedure for identifying possible interest exists.²²⁶ Modifying the process to provide the immediate incentive of a discount for donors should not be difficult.

Further, states could grant the discount without losing revenue.²²⁷ State legislatures establish license fees. By increasing the cost to all applicants by \$1.50, states could probably offer a \$5 discount to donors without decreasing total income.²²⁸ Applicants could be offered the opportunity to return their discount to the program, further reducing the state's overall cost. Individuals who wanted to keep their organ donation completely altruistic could choose this option. Applicants could also be given the choice to voluntarily contribute to a fund earmarked to support the discount. At least one state recently created a similar fund.²²⁹

This discount might not even require a change in the law. The federal statute prohibits "acquir[ing], receiv[ing] or otherwise transfer[ing]" an organ for "valuable consideration."²³⁰ Arguably, the discount is remote enough not to be considered exchanging "valuable consideration" for the organ, if and when it is harvested. If Pennsylvania can avoid the prohibition by paying the service provider directly,²³¹ this discount should also be permitted. Moreover, policy arguments against paying for organs simply do not apply. For example, a \$5 discount is not sufficient to create the kind of incentive²³² to exploit the poor

226. For example, the Florida Administrative Code provides that donor cards are to be available to all driver's license applicants. FLA. ADMIN. CODE ANN. r. 15A-1.029(1) (1995). All license stations must display donor cards, brochures and small plastic pouches for the donor card and the license. FLA. ADMIN. CODE ANN. r. 15A-1.029(2), 10D-70.001, 10D-70.002(2) (1995).

227. Money from driver's license application fees generally goes into general revenue for use by the state's highway safety and motor vehicles department. *See, e.g.*, FLA. STAT. ANN. § 322.21(5) (West 1995).

228. In 1993, states had issued 173,149,000 driver's licenses. U.S. BUREAU OF THE CENSUS STATISTICAL ABSTRACT OF THE UNITED STATES: Table No. 1023 (115th ed. 1995). A small percentage of these people are already organ donors. Assuming that the national average of twenty-five percent donate, *see supra* text accompanying note 45, an extra \$1.50 per applicant should generate more than enough to support the \$5 discount, as well as cover any additional administrative costs.

229. *See, e.g.*, 20 PA. CONS. STAT. ANN. § 8621 (West 1995) (establishing an "Organ Donation Awareness Trust Fund"). *See supra* text accompanying notes 112-119.

230. 42 U.S.C. § 274e(a) (1995).

231. *See supra* text accompanying note 114. Of course, the Pennsylvania statute is new and has not been challenged.

232. Other inexpensive, creative incentive plans are possible. For example, places where people must wait for hours to obtain a driver's license could separately schedule appointments for organ donors. Applicants would receive an immediate, tangible benefit—valuable time saved. Avoiding lengthy waits might encourage some people to at least consider organ donation and would not violate the federal prohibition on payment because no clear definition exists for the statutory prohibition on "valuable consideration." However, it appears that non-monetary benefits would not

that direct payment for organs might.²³³

D. National Registry and Detailed Procedures

Establishing a national registry²³⁴ and developing detailed procedures for queries are essential. Too frequently, accident victims or other potential donors may either not be carrying their donor cards or the cards or licenses are not located in time.²³⁵ Consequently, an additional, reliable backup system is necessary.²³⁶ A national computer registry could provide timely critical information,²³⁷ including donor status, blood type and whether the victim had a living will.²³⁸

But, a national registry is only valuable if someone checks it. Therefore, it is also necessary to create a procedure ensuring that police, emergency medical personnel, doctors or hospitals verify donor status immediately, whenever the circumstances warrant. The computer system which currently permits police to check driver's licenses, arrests, and other criminal information could be modified to include this information. When police arrive at an accident

be illegal. Denise, *supra* note 6, at n.92.

233. For example, because the discount is only for the donor, problems with brokers and others entering the "market" would not exist. See *supra* note 70 and accompanying text.

234. Of course, adding this information to a national registry would be "a monumental, costly, and time-consuming task." Roger W. Evans, *Trauma Registries and Organ Transplantation (letter to the editor)*, 263 JAMA 1913, 1914 (1990). Dr. Evans suggests that including additional data in trauma registries could help in estimating the size of the potential organ donor pool. *Id.*

235. Ironically, despite legislation in most states requiring police and medical personnel to try to locate donor cards, emergency fire and hospital worker procedures actually separate accident victims from their wallets. Cate, *supra* note 17, at 82. When accident victims, who are otherwise healthy people, die as a result of head trauma, they are a primary source of organs. Crespi, *supra* note 11, at 4. Therefore, increased highway safety measures may actually reduce the number of available transplantable organs. Although motor vehicle deaths increased by 1.3 percent from 1993 to 1994, the number of deaths per hundred million miles traveled was actually the lowest on record. The 1993 fatality rate was 1.8, compared with a 2.7 rate in 1983. This decrease is attributed to "safety belts, child safety seats and other safety devices." INS. UPDATE, *supra* note 14.

236. The Pennsylvania statutory provision, which imposes a duty on police and emergency personnel to deliver donor status documentation to health professionals, see *supra* text accompanying note 119, is insufficient. A national computer registry would be quicker and more accurate.

237. Systems like that in Florida, where the information is kept on microfilm, FLA. ADMIN. CODE ANN. r. 15A-1.0293 (1995), are problematic because searching would be too time-consuming.

238. Luis Kutner coined this term in 1969. A living will is a document signed by a competent adult which explains what he wants done if he should become incapacitated. "The document is a will in the sense that it sets forth the individual's directions. It is 'living' because it takes effect prior to death." GEORGE J. ANNAS, *STANDARD OF CARE: THE LAW OF AMERICAN BIOETHICS* 110 (1993). More than forty states have enacted living will statutes "giving effect to a person's choice of medical treatment in the event of incompetency." Sanford H. Kadish, *Letting Patients Die: Legal and Moral Reflections*, 80 CAL. L. REV. 857, 861 (1992).

scene where there are life-threatening injuries,²³⁹ they could check whether victims are organ donors. Naturally, that information would not be used to do, or refrain from doing, anything which might affect the chance of recovery.²⁴⁰ If there is no hope for the injured person, however, steps could be taken to preserve his organs. Health care professionals must also have access to the registry and a specific, detailed procedure for how and when to ask for donor information.

IX. PEDIATRIC DONORS

A no-cost, non-intrusive method of easing the critical shortage of pediatric donors would be to include a question about organ donation on social security card applications.²⁴¹ Shortly after a child is born, parents apply for his or her social security number. Changing the form so that parents have to check "yes" or "no" to donation would compel them to at least consider organ donation.²⁴² Obviously, parents—or the child, no matter what his age—²⁴³ could rescind the consent at any time. A duty should be imposed on the Social Security Administration to immediately forward the information to the national registry.

The present system of asking parents to consent to donation when a child dies in an accident²⁴⁴ is problematic because medical professionals are loath

239. Approximately eighty-five percent of females and eighty percent of males killed in car accidents in 1994 were under age forty-five. U.S. DEPT. OF TRANSP., NAT'L HIGHWAY TRAFFIC SAFETY ADMIN., TRAFFIC SAFETY FACTS 1994, Table 56, at 88. Assuming that they were otherwise healthy at the time of the accident, this age group represents good candidates for donation.

240. This point must be made very clear, because many people who refuse to donate believe and fear that doctors will either do something to them, or not do as much as possible to save them, simply to get their organs.

241. Adults applying for a social security card or replacement could also choose to donate at that time.

242. Obviously, to harvest a child's organs, parents must consent. However, a parent's consent is only effective once the child is declared dead. Thus, in cases of anencephalic infants, the parent cannot consent until the child is pronounced dead. This frequently means that the organs are no longer viable. See *supra* text accompanying notes 133-34.

243. Although a minor should not be able to consent to organ donation, if he objects, his wishes should be respected. In fact, as soon as the child is capable of understanding the issue, parents should discuss their decision with him.

244. Transportation injuries are the leading cause of death among children. Donald Reed, *Moving Kids Safely; Department of Transportation Child Safety Awareness Program; Government Action*, AUTOMOTIVE ENGINEERING, Aug. 1995, at 93. In fact, the leading cause of death among Americans between five and thirty-two are motor vehicle accidents. INS. UPDATE, *supra* note 14. Transportation accidents kill more than 3200 children per year. Head injuries account for eighty-five percent of the accidental deaths. Reed, *supra*, at 93. This is particularly important, of course, because people who die from head trauma are among the most suitable potential donors.

Gunshot victims represent another fertile source of children's organs. Unfortunately, guns killed 5751 children under twenty in 1993. Lee Bowman, *A Child Killed by Gunfire Every 92 Minutes in U.S.*, PITT. POST-GAZETTE, April 9, 1996, at A3. Many of these children could be

to approach these grieving parents—even when required by law.²⁴⁵ A better time to ask would be shortly after the child is born, when parents are joyfully celebrating the gift of life.

X. CONCLUSION

The critical organ shortage spawns controversial decisions. Conflict is not limited to allocation. For example, Jim Guy Tucker escaped jail time²⁴⁶ for his Whitewater conviction because he is waiting for a liver transplant. The former Arkansas governor's physicians argued he "is sick, needs a liver transplant, is suffering now, and a prison sentence might well have amounted to capital punishment."²⁴⁷

Absent a substantial increase in donors, it will be necessary for transplant officials to continue making troubling allocation decisions. Many people will die while awaiting potentially life-saving transplants. Current methods for obtaining organs are simply not working.

The impact of implementing these five proposals is impossible to predict with precision. Nevertheless, if enacted in combination, they should greatly increase organ supply, preventing numerous unnecessary deaths. But, adopting these proposals would be the right thing even if they save the life of only one person.

donors. Further, the number is growing; in fact, it reflects an 84 percent increase over 1983 statistics. *Id.* Although slightly more than half who died were white, young black males between fifteen and nineteen were ten times as likely as whites of the same age to be killed by guns, according to a Children's Defense Fund report. *Id.* This troubling statistic causes some commentators to fear an inequitable system where older, middle class whites benefit from tragedy in the black community. See, e.g., Mark F. Grady, *Politicalization of Commodities: The Case of Cadaveric Organs*, 20 IOWA J. CORP. L. 51, 68 (1995).

245. This is true even though donation may actually help the parents' grieving process. Many parents are comforted by the notion that at least some good will come from their apparently senseless tragedy. Their child's death makes it possible for several children to live. Other parents feel good that their child is still "alive" because their child's organs continue to function in another child's body.

246. Co-defendant Susan McDougal and her ex-husband James McDougal were also convicted of using loan money for purposes other than stated on the application. Susan McDougal was sentenced to twenty-four months in prison. Sentencing for James McDougal, convicted on eighteen of nineteen fraud and conspiracy charges, was postponed because he is cooperating with prosecutors. J.I. Duffy, *McDougal Faces Jailing Monday Unless She Agrees to Answer About Clinton*, COM. APPEAL, Sept. 5, 1996, at 1A.

247. P. Greenberg, Editorial, *Whitewater Sentences Raise Howls*, MONTGOMERY ADVERTISER, Aug. 29, 1996, at 16A.

