

Faculty Publications

---

1987

## Encouraging Donation of Organs for Transplantation by Requiring Request

Maxwell J. Mehlman

Case Western University School of Law, maxwell.mehlman@case.edu

Follow this and additional works at: [https://scholarlycommons.law.case.edu/faculty\\_publications](https://scholarlycommons.law.case.edu/faculty_publications)

---

### Repository Citation

Mehlman, Maxwell J., "Encouraging Donation of Organs for Transplantation by Requiring Request" (1987).  
*Faculty Publications*. 541.

[https://scholarlycommons.law.case.edu/faculty\\_publications/541](https://scholarlycommons.law.case.edu/faculty_publications/541)

This Article is brought to you for free and open access by Case Western Reserve University School of Law Scholarly Commons. It has been accepted for inclusion in Faculty Publications by an authorized administrator of Case Western Reserve University School of Law Scholarly Commons.

## ENCOURAGING DONATION OF ORGANS FOR TRANSPLANTATION BY REQUIRING REQUEST

MAXWELL J. MEHLMAN, J.D.

**Abstract** Requiring hospitals to request permission from next-of-kin to harvest organs from a deceased patient is a positive step toward reducing the shortage of organs for transplantation. The "required request" laws, however, should rely on immunity from liability rather than criminal sanctions to encourage compliance.

### *The Organ Shortage*

The demand for transplant organs far exceeds the supply. In 1982, for example, despite estimates that 7,000 persons were awaiting kidney transplants, and that, based on criteria of donor suitability, over 40,000 cadaver kidneys should have been available, only 3,691 cadaver kidneys were transplanted.<sup>1</sup> With the introduction of immunosuppressive drugs like cyclosporin that substantially increase the probability of a successful transplant outcome, the demand for organs has become even greater.<sup>2</sup>

Why are donor organs in such short supply? There is no serious technological impediment to their availability. Harvesting involves a relatively simple surgical procedure.<sup>3</sup> Potential donors often can be maintained on artificial systems following death long enough to permit transplant organs to be removed before they deteriorate. Following removal, organs can be preserved extracorporeally (albeit for a limited time) until transplantation can take place.

The organ shortage does not appear to be a product of unwillingness to donate. In Colorado 60 percent of those who have drivers licenses have indicated, by filling out a form on their license, their intent to donate their organs upon death.<sup>4</sup> People are just as willing to agree to have organs removed from dead relatives. In France, for example, 90 percent of those who were asked gave their consent to the removal of transplant organs from next-of-kin.<sup>5</sup>

### *The Consent System*

The problem seems to be that people are not being asked to donate, or are not being asked in the right way. There are several features of the consent system in the United States that might contribute to this.

First, the presumption is that people do not want to donate their organs or those of their next-of-kin. In order to donate,

therefore, this presumption must be rebutted by express consent, given either by the potential donor himself or by someone, such as a relative, who is authorized to consent in his stead.

Second, there is no legal requirement that people at some point declare their intent either to donate their own organs or those of their next-of-kin, or to refuse to donate.

Finally, little is done to encourage people to donate their own organs or those of their relations. Potential donors are aided in declaring their intent to donate by the provisions of the Uniform Anatomical Gift Act, which enables them to fill out donor cards or special portions of drivers licenses.<sup>6</sup> Private organ procurement agencies handle the administrative tasks of matching organs to potential recipients and facilitating shipment.<sup>7</sup> But there are few incentives to consent to donate or to request consent, beyond an individual's own sense of moral obligation.

Until recently, for example, only a few hospitals asked relatives of potential donors for permission to harvest organs, and then only infrequently. This reluctance derives at least in part from the perceived unpleasantness of forcing the family to confront the topic of donation in their time of grief.

Furthermore, physicians and hospitals are concerned about potential legal liability for harvesting organs without adequate permission. Lack of consent to harvest might subject the health care provider to civil and criminal penalties for theft, conversion, and possibly violation of state laws governing disposal of the dead. Asking next-of-kin for permission without sufficient sensitivity might give rise to an action for intentional infliction of emotional distress.<sup>8</sup> Obtaining ostensible permission from the family might not insulate the harvester from suit if there were an interfamily conflict over whether or not to consent to donation, or if the family later alleged that its consent was invalid due to duress or incapacity by virtue of grief.

Moreover, the structure and functioning of provider institutions militate against requesting donation. The treating physician, who is in the best position to know that a patient is dead or dying, and thus to initiate the donation request, typically is not involved in and derives no specific benefit from organ transplantation. Obtaining consent to donation would take his time away from his priority activity: the treatment of other patients. In addition, if consent is obtained, the donor often must be kept on life support systems beyond the point of death to maintain the suitability of his organs for transplantation until they can be harvested by a transplant surgeon. This requires equipment and skilled care that might be devoted instead to salvageable patients.

Finally, economic incentives for donation are virtually

---

Maxwell J. Mehlman is Associate Professor of Law and Director of the Law-Medicine Center at Case Western Reserve University School of Law. He received a B.A. from Reed College in 1970 and another B.A. from Oxford University in 1972. He was awarded a J.D. from Yale Law School in 1975.

nonexistent. Under federal law, no person may receive valuable consideration for acquiring, receiving, or transferring an organ for transplantation.<sup>9</sup> Thus, neither donors nor procurers may recover more than reasonable compensation for their costs.

### *Steps to Increase the Supply of Donor Organs*

Against this background, a number of steps might be taken to increase the supply of donor organs. For example, we could spend more on education programs to encourage people to donate their own organs or those of their next-of-kin. Or we could reward willingness to donate with a priority claim on future transplant organs for the donor or for a designated beneficiary.<sup>10</sup> Alternatively, we could relax the prohibition on economic incentives for donation—such as by permitting a market in organs or by offering tax credits to donors.<sup>11</sup> All of these approaches, however, are disfavored. Educational programs are expensive, and the marginal cost of stimulating additional organs for transplantation may be deemed to be excessive. A priority system based on donation would disadvantage those who were unable to donate for medical reasons and would be difficult to administer. Tax credits would disproportionately benefit persons in higher tax brackets. Finally, a market in organs would favor the wealthy, who could outbid the poor, and might result in fewer rather than more organs available for transplantation.<sup>12</sup>

Another approach would be to switch from the presumption that individuals do not wish to donate unless they expressly take action to the contrary, to a system in which individuals are presumed to consent to donate unless they express their unwillingness to do so. This is known as “presumed consent,” and has been adopted in France.<sup>13</sup> The question that arises is what opportunity must be provided for unwillingness to be expressed? Is the burden to come forward on the individual—say by executing an instrument that prohibits donation? If so, how is the existence of the instrument to be made known to organ harvesters?<sup>14</sup> On the other hand, if organs cannot be harvested unless the donor or next-of-kin have waived their right to object, the presumption has shifted back to one of presumed nonconsent—the system currently in operation in the United States.

A more extreme alternative is mandatory harvesting, with neither the donor or next-of-kin having the ability to block donation.<sup>15</sup> While this can be supported on the basis that any property rights that an individual has in his organs should lapse upon death, or at least that they are subordinate to the need to save other human lives, this approach is unacceptable in view of religious objections to cadaver mutilation and the trend in favor of patient autonomy.

### *Required Request*

A middle ground between the largely voluntary system

that traditionally has prevailed in this country and more coercive measures, called “required request,”<sup>16</sup> has been gaining acceptance in the last several years. This alternative focuses on the main cause of the shortage of cadaver organs: the failure to ask permission for donation. Under required request, the hospital (and perhaps other institutions such as hospices) must establish a mechanism for insuring that a deceased patient’s next-of-kin are asked to consent to donation.<sup>17</sup> Required request laws have now been passed in twenty-four states.<sup>18</sup> A bill to facilitate state-required request programs has been introduced in Congress.<sup>19</sup>

While required request laws are probably a step in the right direction, they raise several questions. First, it is not clear how they are to be enforced. New York reportedly levies a \$1000 fine for each violation;<sup>20</sup> Kentucky imposes a fine of between \$100 and \$500.<sup>21</sup> By and large, however, the required request statutes do not create explicit criminal or civil sanctions for noncompliance. Enforcement would therefore seem to depend on enforcement actions by government officials or private parties, which would result in court orders mandating compliance on penalty of contempt, or on the deterrent effect of actions for damages that might be brought by potential organ recipients claiming to have suffered injury as a result of the hospital’s failure to request consent.

In either case, detecting the violation of the required request law would be difficult. Some required request laws facilitate this by requiring that the making of the request be noted on the death certificate.<sup>22</sup> Potential plaintiffs—such as state health officials, organ procurement agencies, or patient groups—could monitor the records to determine if the notation is absent, and suit could be brought against a hospital that routinely failed to comply. (In the absence of a requirement that a public record be made, violations could be detected only by more problematic devices such as interviews of next-of-kin or disclosures by hospital staff.) But even where the making of a request must be noted on the death certificate, the statutes contain broad exceptions. No request need be made in New York, for example, if there is “actual notice of opposition” by the decedent or next-of-kin, or reason to believe that donation is contrary to the decedent’s religious beliefs.<sup>23</sup> A hospital could therefore explain the absence of a request notation on a death certificate by contending that a member of the family objected or that the decedent belonged to a religion that was known to oppose organ harvesting, and there would be no simple way of determining the validity of the excuse. It is also likely that a health professional who simply did not want to raise an unpleasant issue with next-of-kin would rely on one of these exceptions, with little risk of being penalized.

Furthermore, most required request statutes do not mandate that a record be made of a refusal of consent by the family,<sup>24</sup> and even fewer provide for recording that a request was not made because of known religious or other objection.<sup>25</sup> Hospitals therefore could defend an enforcement action premised on a small number of recorded consents on the ground that

this reflected a large number of nonrecorded refusals or known objections, rather than a routine failure to request consent.

The lack of effective enforcement provisions may well be deliberate. State legislatures may be reluctant to impose sanctions on providers, or may believe that providers will adhere to the legislative command without threats. Indeed, it is arguable that providers welcome the laws as an excuse that can be given to family members when the issue of donation is raised. Moreover, one method of facilitating enforcement—requiring a public record of why a request was not made or refused—might raise the objection that it interfered with the privacy and religious rights of patients or their families.

In the absence of more effective enforcement tools, however, the question is whether the required request statutes will overcome reluctance to request donation. As noted earlier, this reluctance stems from the psychological relationship between providers and next-of-kin, the structural relationship between members of the hospital staff, and concerns about liability. A number of laws provide for special training for the hospital personnel who will make the request;<sup>26</sup> this might alleviate some of their resistance to raising the issue with relatives. But the statutes do little to address the other two problems, and some actually exacerbate them.

As noted earlier, the hospital's staff structure frustrates organ harvesting by instead emphasizing treatment of salvageable patients; the treating personnel are relatively insensitive about the patient's status as a potential donor, and therefore make little effort to facilitate donation. But this also has an important benefit: it reduces the chance that the patient's treatment will be compromised or that the patient prematurely will be pronounced dead, in order to foster harvesting. The possibility of such conflict of interest is reflected, for example, in the Uniform Anatomical Gift Act, which stipulates that the physician who tends the donor, or who certifies the death, may not be part of the transplantation process.<sup>27</sup> This safeguard is absent from most of the required request statutes, however;<sup>28</sup> by and large, they do not mandate separation of functions between treating and harvesting personnel. This oversight should be avoided in future required request legislation and corrected in existing laws.

The required request laws also generally do not address liability concerns on the part of those involved in obtaining consent to donation.<sup>29</sup> Unlike the Uniform Anatomical Gift Act,<sup>30</sup> they do not immunize persons acting in good faith to obtain consent. They thus omit an important positive incentive for providers to responsibly increase the supply of donor organs.

Because the enforcement of required request sanctions is ineffective, a carrot rather than a stick approach seems preferable. Immunity from civil and criminal liability would be the positive incentive for requesting donation. This would offer protection for anyone (hospital, medical staff organization, physicians, nurses, social workers, organ procurement agency operatives) who acted in good faith in requesting organs for

donation. They would avoid liability to the family of whom the request was made (for example, for intentional infliction of emotional distress), and also to potential donees (who otherwise might complain that inadequate measures were taken to obtain transplant organs).<sup>31</sup>

## REFERENCES

1. A. Caplan, Organ procurement: It's not in the cards, 10 *Hastings Center Rep.* 9 (Oct. 1984).
2. See Iglehart, Transplantation: The problem of limited resources, 309 *New Eng. J. Med.* 123:125 (July 1983).
3. See Report of the Massachusetts task force on organ transplantation, 13 *Law, Med & Health Care* 8, 17 (1985).
4. See Overcast, Problems in the identification of political organ donors, 251 *J. Am. Med. Assoc.* 1559:1560 (March 1984).
5. See Caplan, *supra* Note 1 at 11.
6. The Uniform Anatomical Gift Act, Unif. Anatomical Gift Act U.L.A. 15 (1983) creates a legal mechanism by which donors or next-of-kin may authorize removal of organs upon death. It has been adopted in all states.
7. For a description of these activities, see Skelley, practical issues in obtaining organs for transplantation, 13 *Law, Med. & Health Care* 35 (1985).
8. While there are no reported cases involving requests to donate, actions for intentional infliction of emotional distress in other contexts have been particularly successful where the victim is a relative of a decedent. See e.g. *Meyer v. Nottinger*, 241 N.W. 2d 911 (Iowa 1976) (suit against funeral home); *Johnson v. Women's Hospital*, 527 S.W. 2d 133 (Tenn. App. 1975) (suit against a hospital).
9. See National Organ Transplant Act, Pub. L. No. 98-507, S301(a), 98 Stat. 2346 (1984). However, the Act does permit "reasonable payments associated with removal, transportation, implantation, processing, preservation, quality control, and storage of a human organ. . ." *Id.* S301(c) (2).
10. See Caplan, *supra* note 1 at 10.
11. *Id.*
12. If the price of organs were allowed to be set according to the demand, wealth maldistribution could exclude those who were unable to forego other goods and services in order to pay the organ price. Subsidizing those less well off could alleviate this problem, but, by increasing demand, might encourage people to sell their organs inappropriately—such as when the medical consequences of lacking the organ create externalities that push the supply beyond optimal levels.
13. Personal communication from Professor H. Kveis, Paris Hospitals, to Charles L. Plante, National Kidney Foundation, Feb. 10, 1984. Caplan incorrectly describes the French system as one in which consent is presumed

- regardless of the wishes of the deceased or of next-of-kin. See Caplan, *supra* note 1, at 10-11.
14. One alternative is a computerized, national registry in which willingness-to-donate could be recorded and that would have to be consulted before organs could be harvested.
  15. Caplan incorrectly calls this "strong presumed consent." Caplan, *supra* note 1 at 10. By virtue of the complete lack of choice on the issue of whether to donate or not, the donor and next-of-kin have not consented at all, presumptively or otherwise.
  16. The term was coined by Caplan. See Caplan, *supra* note 1 at 10.
  17. Caplan distinguishes between a "strong" and "weak" version of required request. The latter is described in the text. The former would require that "every citizen . . . be asked to indicate his or her willingness to participate in organ donation, perhaps by means of a mandatory check-off on applications for a driver's license, a social security card or on tax returns." *Id.* at 10. Caplan is silent on whether there would be a sanction against non-compliance in a "strong" system. The failure to respond to the check-off requirements conceivably could disqualify the applicant from obtaining the license or social security card, or the taxpayer from filing the return; but these consequences may well be considered too harsh. Alternatively, failure to comply could result in automatic, implied permission to donate, but this is better classified as "presumed consent" rather than "required request."
  18. Personal communications from Gigi Politoski, National Kidney Foundation, New York, NY (July 23, 1986), and David Kinsman, Eye Bank Association, Washington, D.C. (July 23, 1986). The states are: Alabama, Arizona, California\*, Connecticut, Delaware\*, Florida, Georgia, Hawaii, Indiana\*, Kansas, Kentucky, Louisiana, Maryland, Maine\*, Michigan, Missouri, New Hampshire, New Jersey, New York\*, Oregon\*, Tennessee, Washington\*, West Virginia, and Wisconsin. Those with asterisks (\*) are states whose laws have been obtained and reviewed by the author.
  19. See H.R. 4945, 99th Cong., 2d Sess. 1986, S. 2455, 99th Cong., 2d Sess. (1986). These identical bills would require the Secretary of Health and Human Services to aid states in implementing required request programs, and to report to Congress on the actions taken.
  20. See 13 *Health Lawyers News Report* 7 (Sept. 1985); personal communication from David Kinsman, *supra* note 19.
  21. Ky. Rev. Stat. Ann. S216 B.990 (4) (Baldwin 1969, Supp. 1986).
  22. See, e.g., Ore., S1 (2); NY Pub. Health Law S4351 (McKinney 1985, Supp. 1987).
  23. NY Pub. Health Law S4351 (McKinney 1985, Supp. 1987). Other than to avoid political opposition from religious groups to enactment of the statute, there would seem to be no reason to refrain from asking next-of-kin for consent regardless of religion, since they could always refuse on religious grounds.
  24. Exceptions include Delaware (Del. Code Ann. tit. 16 S2723 (1974, Supp. 1986) and Maine (Me. Rev. Stat. Ann. tit. 22 S2910) (2) (1964, Supp. 1986).
  25. Delaware is one example. See Del. Code Ann. tit. 16 S2723 (1974, Supp. 1986) ("The hospital shall . . . keep a record of each instance in which a request under this subchapter was not made, and the reason such request was not made.")
  26. See Del. Code Ann. tit. 16 S2721 (1974, Supp. 1986); Me. Rev. Stat. Ann. tit. 22 S2910 (5) (1964, Supp. 1986); NY Pub. Health Law S4351 (McKinney 1985, Supp. 1987), Ore. S1 (4).
  27. Unif. Anatomical Gift Act S7(b) U.L.A. 15 (1983) ("The time of death shall be determined by a physician who tends the donor at his death, or, if none, the physician who certifies the death. The physician shall not participate in the procedures for removing or transplanting a part.")
  28. For an exception, see Me. Rev. Stat. Ann. tit. 22 S2910 (1) (B) ("A person who determined the death of the decedent may not make the request for that decedent.")
  29. Exceptions include Delaware (Del. Code Ann. tit. 16 S2726 (1974, Supp. 1986) ("A hospital or physician who acts in good faith in accord with the terms of this subchapter is not liable for damages in any civil action or subject to prosecution in any criminal proceeding for his act.") and Washington (Wash. Rev. Code Ann. S68.08.660. (1961 Supp. 1987) ("No act or omission of a hospital in developing or implementing the provisions of . . . this act, when performed in good faith, shall be a basis for the imposition of any liability upon the hospital.") Neither of these is broad enough: the former does not cover nurses, while the latter only extends immunity to hospitals, and arguably not to physicians, medical staffs, or nurses.
  30. Unif. Anatomical Gift Act S7(c) U.L.A. 15 (1983) ("A person who acts in good faith in accord with the terms of this Act . . . is not liable for damages in any civil action or subject to prosecution in any initial proceeding for his act.")
  31. It is not clear that immunity should extend to failures to harvest organs properly once consent was obtained.