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INCREASING THE SUPPLY OF CADAVER ORGANS FOR TRANSPLANTATION: RECOGNIZING THAT THE REAL PROBLEM IS PSYCHOLOGICAL NOT LEGAL†

Orly Hazony

MEDICAL TECHNOLOGY is no longer the main factor limiting the number of human organ transplantations in the United States. The potential lifesaving benefits of organ transplantation technology have not been realized because of the growing shortage of vital organs from suitable donors. As of May 1991, over 23,000 Americans were awaiting transplantation of a vital organ. Over 60,000 people who potentially could benefit from organ transplantation die annually or are maintained on suboptimal therapy. The Center for Disease Control (hereinafter CDC) in Atlanta estimates that 20,000 people die each year from causes such as brain injuries, tumors, or strokes which would permit them to serve as organ donors. However, no more than fifteen percent of these potential do-

† This paper was written under the supervision of Rebecca Dresser, Professor of Law at Case Western Reserve University School of Law.

1. Transplantable vital organs include heart, kidney, liver, lung, and pancreas. Other retrievable organs include corneas, skin, bone marrow, and cartilage.

2. A. D. DeChesser, Organ Donation: The Supply/Demand Discrepancy. 15 HEART LUNG 547 (1986).


4. Id. at 239.

5. This number represents two percent of all hospital deaths in the United States.

nors will actually donate their organs.\textsuperscript{7}

The scarcity of organs seems incongruous in light of public opinion polls which show overwhelming support for organ donation. The most recent Gallup Poll on this subject showed that eighty-five percent of those polled were in favor of organ donation by a loved one and sixty percent said they would be willing to donate their own organs.\textsuperscript{8} In light of this apparently cooperative public attitude toward donation, the goal of increasing the supply of organs does not seem an impossible one. A plan must be implemented which will convert this willingness to donate into action.

This paper will attempt to address the apparent paradox between public opinion on cadaver organ donation and the actual rate of organ donation in the United States. In general, commentators focus on relatively drastic alternatives to increasing the supply of organs, such as commercial incentives to donation or adopting a system of presumed consent. In contrast, this paper will suggest a course of action which will significantly increase the supply of cadaver organs in a way that is least restrictive to the parties involved in the donation process—the health care professionals and the decedent’s family.

The first two sections of this article describe the current organ shortage and provide a legal history of organ procurement in the United States, as background to the rest of the discussion. The third section analyzes the multiple factors that have combined to cause the current system to fail in increasing the organ supply. It reveals that psychological issues relating to organ procurement undermine the legal systems designed to encourage donation. The interplay of these emotional issues often hinders the decedent’s family from consenting to donation and the health care providers from identifying potential donors and requesting donation from the family. Therefore, it concludes that the answer to the organ shortage lies in addressing the psychological issues involved in procurement, rather than in adoption of a more restrictive legal regime, such as presumed consent. Section four describes how the supply of organs can be increased by educating health professionals about the procurement process and more importantly, on how to approach family members in a way that respects their grieving.


\textsuperscript{8} The Gallup Organization, \textit{The U.S. Public’s Attitudes Toward Organ Transplants / Organ Donation} (1990) (Prepared for Dow Chemical Company’s Take Initiative Program).
Educating health professionals addresses only one side of the problem, however. Public awareness and cooperation are necessary to ensure that health professionals will be effective in requesting donation. In general, the American public is aware of and supports organ transplantation. However, minority populations are in desperate need of education. In particular, the organ shortage has disparate impact on the nation’s black and Hispanic populations whose incidences of end stage renal disease are the highest in the United States and whose donation statistics are very low. The final section of this article identifies the racial issues that need to be addressed when formulating a plan to increase the supply of organs nationwide in order to ensure that minorities benefit from organ transplantation technology. It concludes that a grassroots educational approach should be targeted at the nation’s minorities in order to increase their donation rates.

I. THE CURRENT DILEMMA

A. The Shortage of Cadaver Organs for Transplantation

The gap between available cadaver organs and people awaiting transplants is continually widening. In the United States, three patients on the waiting list die every day as a consequence of this shortage. Using kidney transplantation as an example, each month 1000 individuals are added to the waiting list for cadaveric kidney transplantation and 800 individuals are taken off the waiting list. Thus, the total monthly increase to the waiting list is 200. Currently, there is an average of only 300 organ donors per month. Therefore, 100 additional donors per month are needed to break even (assuming that each donor can provide kidneys for two recipients) and 300 additional donors per month are needed to significantly reverse the organ shortage crisis. The CDC estimates that two percent of all hospital deaths are potential donors. These do-

9. Id.
13. Id.
14. Cost of Success, supra note 6, at 25.
nors could provide 25,000 kidneys a year.

The shortage is even greater for other organs. Approximately thirty percent of those waiting for a heart or liver transplant die before an organ becomes available. In the United States, 28,000 people become eligible for heart transplants each year, while only 2000 hearts are donated annually. The number of donated organs is not increasing at the same rate as the number of people on the waiting list. This is partly due to a decrease in the number of available donors. Indeed, from 1986 to 1989 the annual number of donors remained virtually unchanged rising only modestly in 1990. These numbers can be attributed in large part to the effectiveness of a variety of life-saving laws that have been enacted in recent years, such as the fifty-five mile-per-hour speed limit, motorcycle helmet laws, and seat belt laws. Potential donors are often the victims of motor vehicle accidents and it is paradoxical that such safety laws are having a negative impact on the ability to save someone by performing a transplant. The acquired immunodeficiency syndrome (hereinafter AIDS) epidemic has also had a negative impact on donation by reducing the number of potential donors by at least ten percent.

The most successful organ procurement agencies (hereinafter OPAs) have retrieval rates of only thirty to thirty-five donors per million people. These OPAs operate at the local community level in close contact with transplant centers. If all OPAs were this successful, the maximum yearly retrieval rate would be 6600 donors, or 13,200 kidneys, for the 52,000 patients waiting for a kidney today. However, this level of procurement is unlikely under the current system, which has a national average retrieval rate of only sixteen donors per million people.

In economic terms, the shortage of cadaver organs is heavily taxing the limited health care budget of the federal government. Government involvement in the financing of organ transplantation began in 1972 with the passage of amendments to the Social Security Act making Medicare the primary payor for treatment of end-

15. Randall, supra note 12, at 1223.
17. The total number of donors between 1986 and 1989 averaged 4000 per year. This number increased 9.1% in 1990. Potential Supply, supra note 3, at 239.
18. Id. at 239. See also Roger W. Evans, Organ Donation: Facts and Figures, 19 DIALYSIS & TRANSPLANTATION 234 (1990).
19. Potential Supply, supra note 3, at 239.
21. Id.
stage renal disease. The Medicare/Medicaid program is currently the largest source of funding for tissue and organ transplants.

In 1990, approximately 175,000 patients with end-stage renal disease were undergoing hemodialysis at a cost to the federal government of $3.5 billion per year. It is estimated that thirty percent of these patients, or 52,000 individuals, would benefit from a kidney transplant. While the cost of the transplantation procedure is great, it is much less expensive than payment for long term hemodialysis. Thus, the Health Care Financing Administration, which administers the Medicare program, is anxious to have more organs, specifically kidneys, available for transplant. In a period where Americans are concerned about the availability of adequate health care and the federal government is being forced to cut its health care budget, the money that could be saved by transplants is much needed elsewhere.

Artificial organs, particularly the artificial heart, are potential alternatives to natural organ transplants. However, after twenty-five years of research and $260 million in federal funds, the artificial heart has been a great disappointment. The artificial heart is currently being used as a "bridge-to-transplant"—a means of giving patients on the waiting list a little more time in the hope that a

22. Medicare coverage includes both renal dialysis and kidney transplant. The costs of organ procurement are 100% cost-reimbursed to organ procurement agencies. Jeffrey M. Prottas, The Organization of Organ Procurement, 14 J. HEALTH POL., POL'Y & L, 41, 42 (1989) [hereinafter Prottas, Organization of Organ Procurement].

23. Medicare for the elderly pays for bone marrow, cornea, heart, liver, and kidney transplants. (Heart and liver transplant coverage is limited to services provided by federally designated medical centers.) Under Medicaid, organ and tissue transplants have traditionally been an optional benefit under the joint federal and state programs. The 1980s have witnessed an expansion of Medicaid transplant benefits nationwide. Currently 49 states (all except Wyoming) and the District of Columbia pay for at least two types of vital organ transplant. Ten states (Kentucky, Louisiana, Massachusetts, Michigan, Mississippi, North Dakota, Ohio, Pennsylvania, Vermont, and Wisconsin) pay for all eight possible transplants. Heart transplants are covered in 40 states. Bone marrow, cornea, kidney, and liver transplants are covered by virtually all states. Coverage is more limited for the newer procedures which include heart-lung, lung, and pancreas transplants. All but three states cover organ procurement costs incurred by the recipient and every state pays for immunosuppressive drugs.


25. Id.

26. Prottas, Organization of Organ Procurement, supra note 22, at 42.


natural heart becomes available. Moreover, when heart transplant technology improves, its exorbitant cost will preclude it from being a realistic alternative and the country will be faced with essentially the same economic problems currently being encountered with the high cost of dialysis. Thus, increasing the supply of donated cadaver organs remains the most realistic solution to the transplantation crisis.

B. Financial Incentives to Donating Organs

In 1970, law professor Jesse Dukeminier predicted, “If the quantity of cadaver organs supplied does not equal the quantity demanded at zero price, our preference that organs not be bought will be put under increasing pressure by the demands of people fighting for life and willing to pay for it.” Medical advances in organ transplantation technology have put today’s society in the difficult position that Dukeminier foresaw, as the current organ shortage spurs numerous proposals for economic incentives to induce organ donation.

Commentators have been creative in their proposals for financial incentives to donate organs. Among the popular proposals are a $1000 death benefit to the donor’s family, a $25,000 tax credit for the decedent, and payment of burial costs. Economist Henry Hansmann proposes that the most feasible method for establishing a market in cadaver organs would be to structure a futures market where the right to harvest a person’s organs upon death must be

29. Id. at 501.
32. See H.R. 540, 98th Cong. 1st Sess. (1983) The unenacted tax bill allowed decedents to deduct $25,000 in their last taxable year for each qualified donation. Id. § 2(a). The total amount would also be deducted from the value of the decedent’s gross estate. Id. The National Kidney Foundation has opposed a tax break for donors because [t]his would detract from the humanitarian aspect of organ donation and may have little benefit in expanding the number of organ donors. Organ Transplantation: Hearings Before the Senate Comm. on Labor and Human Resources, 98th Cong., 1st Sess. 104 (1983), at 268 (draft statement of the National Kidney Foundation).
33. In a recent conference on controversies in organ donation, The National Kidney Foundation suggested that society might provide the donor family with payment for burial costs, up to a certain amount. The National Kidney Foundation, Consensus Conference on Controversies in Organ Donation: Financial Incentives, 3 (1991) [hereinafter National Kidney Foundation, Consensus Conference]. However, The National Kidney Foundation has no official position on financial incentives for organ donation. Id. at 4.
purchased from him while he is alive and well.\textsuperscript{34}

1. The Legal Framework

The Uniform Anatomical Gift Act of 1968 (hereinafter UAGA) purposely left open the question of compensation for anatomical gifts.\textsuperscript{35} The chairman of the UAGA drafting committee, E. Blythe Stason, explained this decision by noting that not every payment would necessarily be unethical and that "until the matter of payment becomes a problem of some dimensions, the matter should be left to the decency of intelligent human beings."\textsuperscript{36}

In September of 1983, H. Barry Jacobs, a doctor in Virginia whose medical license had been revoked for fraud, established a company to broker human kidneys.\textsuperscript{37} Jacobs intended to solicit healthy individuals to sell one of their kidneys. In response to Doctor Jacobs' company and public opinion opposing such a kidney brokerage, The National Organ Transplant Act of 1984 (hereinafter NOTA) effectively outlawed commercial markets in transplantable organs by making it a federal crime "for any person to knowingly acquire, receive, or otherwise transfer any human organ for valuable consideration for use in human transplantation if the transfer affects interstate commerce."\textsuperscript{38} Many states subsequently supplemented NOTA with statutes outlawing the sale or purchase of human organs.\textsuperscript{39} Thus, any effort to establish a market in organs would require repeal or amendment of federal and state legislation. However, the National Kidney Foundation suggested in a recent


\textsuperscript{37} \textit{Sale of Human Organs}, \textit{supra} note 35, at 1015.

\textsuperscript{38} The National Organ Transplant Act, Pub. L. No. 98-507, 1984 U.S.C.C.A.N. (98 Stat.) 2339 (codified at 42 U.S.C. § 274e(a) (1985)) [hereinafter NOTA]. The act specifies that its prohibition does not extend to payments made to cover costs incurred in the process of transplanting the organ. Violators of NOTA are fined a maximum of $50,000 and/or imprisoned for a maximum of five years. \textit{Id.} at § 274e(b) While the scope of the federal act is limited to interstate commerce, the courts will probably continue their broad construction of commerce clause to find that organ sales do affect interstate commerce. \textit{Sale of Human Organs, supra} note 35, at 1025.

conference on financial incentives that the legal prohibitions against receiving compensation for organ donation could be avoided if the compensation were directed at the act of altruism rather than as payment for the organ. It has yet to be seen whether this strategy can successfully circumvent the laws prohibiting payment for organs.

2. Public Opposition to Financial Incentives

Opinion polls and public reaction to the selling of organs in other countries reveal that a system of financial incentives would be repugnant to the American psyche. In a survey of donor families, only sixteen percent advocated cash payments for organ donation and only thirty-five percent advocated a system of tax credits for organ donors. Thus, the families rejection of any concrete compensation for donation illustrates the extent of their altruism in voluntarily donating the organs of kin. General public opinion polls show similar results. Forty-five percent of the public advocate a system of tax credits for donation, while thirty-one percent advocate cash payment to the decedent's family. This public sentiment was reflected in the Task Force on Organ Procurement and Transplantation's observation that "society's moral values militate against regarding the body as a commodity."

Transplant surgeons have publicly condemned the commercialization of organ donation. Three medical transplant associations adopted a resolution calling for the expulsion of any member who participates in a commercial organ market. The resolution condemned Jacobs' company as "abhorrent" and completely morally

43. Id.
44. Task Force on Organ Transplantation, U.S. Dept. of Health and Human Services, Issues and Recommendations 96 (1986) [hereinafter Task Force Report], cited in Hansmann, supra note 34, at 59. The Task Force on Organ Transplantation is mandated by the National Organ Transplant Act of 1984 to make recommendations on how to increase the supply of organs.
45. The three associations were the American Society of Transplant Surgeons, the American Society of Transplant Physicians, and the International Transplantation Society. See Procurement and Allocation of Human Organs for Transplantation: Hearing on H.R. 5580 Before the Subcomm. on Investigations and Oversight of the House Comm. on Science and
and ethically irresponsible.\textsuperscript{46}

Advocates of financial incentives argue that they will provide the necessary impetus to increase the supply of organs, particularly for minorities who currently give the fewest organs and need them the most.\textsuperscript{47} They believe that the financial incentives would not be excessively coercive and that altruism will remain the underlying impetus for donation.

Opponents of financial incentives raise several critical issues. They argue that the incentives will undermine the consent process because of their coercive nature, particularly for minority donors. However, the central argument against financial incentives rests on the important role of altruism in the organ donation process. Commentators analogize financial incentives for organs to the sale of blood. Richard M. Titmuss, in his book \textit{The Gift Relationship},\textsuperscript{48} found that the commercialization of blood donation led to the collapse of the voluntary donation system, a decrease in quality of the blood supply, and overall decrease in available blood.\textsuperscript{49} Thus, by analogy, creating a conflict between altruism and self-interest in the organ donation process would reduce our freedom to make a gift to a stranger and may have serious destructive effects on society and the organ procurement system.\textsuperscript{50}

Financial incentives would place a heavy economic burden on the federal government which reimburses organ procurement agencies for 100\% of the actual cost of procurement.\textsuperscript{51} If a $1000 death benefit or $1000 in burial costs had been paid per kidney donated in 1990, $9,560,000 would have to be invested by the federal government to be where we are today.\textsuperscript{52} “Clearly a very large increase in donations would have to occur to make direct payments to donor families a cost-efficient policy.”\textsuperscript{53}


\textsuperscript{46} \textit{Id.}

\textsuperscript{47} Problems in minority donation will be discussed in § IV of this article.

\textsuperscript{48} RICHARD M. TITMUS, \textit{THE GIFT RELATIONSHIP: FROM HUMAN BLOOD TO SOCIAL POLICY} (1971) [hereinafter TITMUS, \textit{THE GIFT}].


\textsuperscript{51} Prottas, \textit{Organization of Organ Procurement}, supra note 22, at 42.

\textsuperscript{52} 9560 kidneys were donated in 1990. \textit{White Paper}, supra note 23, at 2.

Hansmann believes that only experimentation is likely to provide clear answers as to whether financial incentives to organ donation will reduce altruism and wipe out voluntarism. However, when the experiment involves the sale of human organs, it is a very dangerous one that may result in unmeasurable damage to society and the organ procurement process. Ethicist Arthur L. Caplan warns that "there is a real danger that unless something is done to improve the efficacy of the voluntary system, advocates of a free-market solution will attempt to create a for-profit system to meet the large demand for organs." To avoid such a dilemma, Americans must take a hard look at the history of organ procurement in this country and realize that voluntarism is not enough and a different system must be instituted.

II. CURRENT U.S. SYSTEM FOR ORGAN PROCUREMENT: THE LEGAL FRAMEWORK

A. Encouraged Voluntarism Is Not Enough

Prior to the passage of The Uniform Anatomical Gift Act of 1968 (hereinafter UAGA), the system for organ procurement in the United States was a purely voluntary one based on the express consent of the donors or their families. The UAGA attempted to create a uniform set of rules and promote organ donation by simplifying the process of consent, particularly for the decedent, in three ways. First, the UAGA recognizes donor documents as a method by which a person can give legal consent to donate organs upon death. Second, the UAGA makes it illegal for family members to override the expressed wishes of the decedent. Third, the statute recognizes that the decedent's family retains control of the decedent's organs when the decedent's wishes are not known and provides for a hierarchy of relatives who may consent to donation. In

54. Hansmann, supra note 34, at 68.
55. Sounding Board, supra note 7, at 982.
58. Mehlman, supra note 56, at 22, 33.
59. UAGA, supra note 57, § 4(b).
60. Id. at § 2E. The rights of the donee created by the gift are paramount to the rights of others except as provided by Section 7(d) (medical examiner's duties).
61. Id. at § 2(b). The order of precedence among the decedent's family members is: spouse, adult offspring, parents, adult siblings, guardians, and if no kin can be contacted — public officials who are responsible for the disposal of the body.
short, passage of the UAGA signified that the United States would no longer rely on purely voluntary behavior. Instead, the law would be changed to facilitate donation. This approach was known as "encouraged voluntarism."  

By 1973, the UAGA had been adopted in every state and the District of Columbia. Donor cards are available in forty-seven states and forty-five states have a driver's license provision allowing individuals to express their desire to donate upon death. However, since only one state requires drivers to indicate whether they want to donate organs or not, there is no way to determine exactly how many people carry donor organ cards or have expressed their wishes on their driver's license. Estimates indicate that card-carrying donors account for no more than two to three percent of donated organs each year.

No state has a comprehensive procedure to be followed by law-enforcement and medical personnel to determine if potential donors are carrying donor cards or have indicated their wishes on a driver's license. In fact, medical personnel are not authorized to go through an individual's personal effects to look for a donor card and hospital procedures routinely separate patients from their possessions, including the purse or wallet that usually contains the donor document. Thus, even the small percentage of donor cards and driver's licenses that are signed often do not lead to organ donation. Yet this is not a serious concern for OPAs because few

62. Mehlman, supra note 56, at 32-33. Richard Titmuss' book, The Gift Relationship, played a key role in pushing public policy toward encouraged voluntarism. Titmuss argues that the right to act altruistically is an important human right, and that its exercise is morally and psychologically beneficial. In discussing the blood donation system, he points out that a voluntary system produces a safer and more sufficient supply than a system based on financial incentives. Titmuss, THE GIFT, supra note 48.


65. Melanie Miller, Transplantation of the Heart: A Proposed Solution to the Present Donation Crisis Based on a Hard Look at the Past, 75 CIRCULATION 20, 21 (1987). As a result of Colorado's requirement that drivers indicate whether they want to donate organs, 60% of the drivers in the state are designated donors.

66. Overcast, supra note 64, at 1561.

67. Id.


69. Overcast, supra note 64, at 1561.

agencies would act on a donor card alone even if it were found on the body.\textsuperscript{71}

Contrary to the provisions of the UAGA, consent of the decedent’s family has in practice become a social prerequisite for organ procurement even when the decedent has executed a donor document. Only four states take advantage of the UAGA provision that prevents the decedent’s family from vetoing the potential donor’s wishes.\textsuperscript{72} The usual situation is one in which, even when potential donors are identified via a donor document, hospitals refuse to harvest organs without consent from the decedent’s family.\textsuperscript{73} In fact, virtually none of the OPAs will harvest organs if unable to locate the next of kin.\textsuperscript{74} Thus, “even silence is usually sufficient to stop an organ retrieval despite an individual’s compliance with the terms of the Uniform Anatomical Gift Act.”\textsuperscript{75} This reality of the health care setting has proven that the UAGA’s assumption that the decedent’s wishes should prevail is inconsistent with cultural assumptions in the United States regarding the wishes of the next-of-kin.\textsuperscript{76}

In conclusion, the true goals of the UAGA have never been realized.\textsuperscript{77} In most states, the decedent’s wishes to donate may result in dialogue between the hospital and family but not necessarily in donation. Thus, while the donor card is an effective educational tool, it has not significantly affected the supply of cadaver organs in the United States. Essentially, under the current system:

It is now clear that the availability of organs via donor documents depends more on chance than on any defined statutory procedure—the chance that the wishes of the potential donor will be recognized, known, or even investigated at the time of his death; that donor documents will be located in time and that medical personnel will not violate the law by allowing the objection of next of kin to override the decedent’s consent; or that medical personnel will present the opportunity for donation to the potential donor’s family.\textsuperscript{78}

\textsuperscript{71} Id.

\textsuperscript{72} These states are California, Colorado, Florida, and Wyoming. In these states, the family is simply informed of the procedure as a formality. The National Heart Transplant Study, \textit{Update Number 31: Donor Organ Procurement Policies and Procedures Throughout the United States: A State By State Analysis}, 18 (1983) [hereinafter Heart Study], cited in Overcast, \textit{supra} note 64, at 1562.

\textsuperscript{73} Mehlman, \textit{supra} note 56, at 33.

\textsuperscript{74} Prottas, \textit{Rules for Asking, supra} note 70, at 186.

\textsuperscript{75} Id.

\textsuperscript{76} Id.

\textsuperscript{77} Miller, \textit{supra} note 65, at 22.

\textsuperscript{78} Id. at 22.
Increasing the Supply of Cadaver Organs

Clearly, an organ procurement system relying on chance is not adequate.

B. Required Request System Fails to Significantly Affect the Supply of Vital Organs

Recognizing that encouraged voluntarism had failed to increase the supply of organs in the United States, a new legal system of required request was adopted in the 1980s to encourage donation. The solution represented by required request was to overcome the professional and institutional resistance to requesting donation by force of the law. In theory, this system was designed to identify all potential donors by requiring health care professionals to approach the family about donation. However, the realities of the health care setting once again proved that a legal solution is not the answer to the organ supply problem.

Under a required request system, hospitals must ensure that a decedent's family is offered the opportunity to donate the decedent's organs and tissues. Required request usually applies only to patients whose conditions make them potential donors. In addition, patients or families who have known objections to donation are not approached. The responsibility to request consent lies with the hospital, not with the attending physician, because of a perceived conflict of interest between treating a patient and harvesting his organs for donation. However, the physician remains the crucial link in the procurement process because he must identify and report potential donors to the hospital.

Oregon enacted the first required request laws in 1985. A year later, the Task Force on Organ Transplantation recommended that every state enact required request legislation. The UAGA was amended in 1987 to include a required request provision and by 1988, forty-four states and the District of Columbia passed some type of required request legislation.

Paralleling the adoption of state legislation, in 1986, the United States Congress passed the Omnibus Budget Reconciliation Act

79. Mehlman, supra note 56, at 37.
81. Id at 524.
82. Task Force Report, supra note 44, at 33.
84. Twenty six states and the District of Columbia have laws requiring hospitals to request organ donation. Eighteen states require hospitals to inform families about organ dona-
which directs all hospitals to adopt required request policies. In 1988, the Health Care Financing Administration promulgated regulations stipulating that a hospital must establish written protocols to identify potential donors as a prerequisite to continued participation in Medicare and Medicaid. In addition to the federal law, the Joint Commission on Accreditation of Health Care Organizations requires hospitals to adopt policies to identify and refer potential donors or risk losing their accreditation. Such quick adoption of required request legislation indicates that American society supports organ donation in principle.

The effects of required request are just beginning to be observed. Tissue donation, including corneas, skin, bone, and tendons has increased dramatically since the enactment of required request legislation. In fact, "increases on the order of 200 to 300 percent are common". However, donation of vital organs has not increased significantly. In many states, organ donation has increased only twenty to thirty percent and in others there has been no significant change. The fact that organ donation has remained constant in some states, despite significant decreases in traffic fatality due to safety legislation, provides some evidence that required request laws are having a small positive impact on the supply of vital organs. However, this impact is clearly not what was anticipated under the required request system.

The main obstacle in the path of success for the required request system is physicians' reluctance to comply with the legislation. In

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86. Singer, supra note 80, at 524.


89. Id.

90. Safety legislation includes 55 mile-per-hour speed limit, seat belt laws, passive restraint systems for automobiles, motorcycle helmet laws, child restraint seat laws, handgun laws, and drunk driving legislation.
most states, physician compliance is less than fifty percent. In criticizing physicians' failure to approach the patient or family to request donation, commentator Melanie Miller points out:

The final gatekeeper in organ exchange is the physician . . . . He makes the ultimate judgment . . . . He acts as mediator and interpreter in the complex social system called into play by the transplantation situation . . . . The physician is not free to abrogate his responsibility nor may he exercise it arbitrarily or coercively . . . . In certain respects, the physician is under pressure to decide in favor of organ transplantation. He is propelled toward it by his own professional and personal motivation to do everything possible to save the life of his dying patient. . . .

Indeed, health care professionals strongly favor organ donation and believe that organ procurement is a professional responsibility. However, the strong psychological issues associated with organ procurement deter health care professionals from acting on their support of organ donation.

Physician noncompliance stems in part from an underlying resentment of being told what they must do by non-physicians, particularly by legislators and bureaucrats. More significantly, however, physicians are likely to avoid approaching the family to request donation because they are not adequately trained to make such a request. As a result, they are extremely uncomfortable initiating the subject of donation and are not effective when they do initiate it.

The design of many state required request laws is partly responsible for the noncompliance rate because it permits physicians to exercise their discretion in deciding whether to approach patients and their families. Only four states have strong required request legislation that calls for documentation that a request was made and requires health departments to facilitate implementation of legislation by assisting hospitals in educating staff. Most states laws

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91. Professional Arrogance, supra note 88, at 35.
93. Jeffrey Prottas & Helen Levine Batten, Health Professionals and Hospital Administrators in Organ Procurement: Attitudes, Reservations, and Their Resolutions, 78 AM. J. PUB. HEALTH, 642 (1988) [hereinafter Health Professionals]. Nearly all health care professionals surveyed support organ donation, would donate their organs, and would consider giving permission for procurement of a relative's organs.
94. Id. at 643. Fifty-one percent of neurosurgeons surveyed and 75% of intensive care nurses surveyed felt organ procurement activities fall within their definition of professional responsibility.
95. Professional Arrogance, supra note 88, at 35.
96. Oregon, Massachusetts, New Jersey, and New York. Id. at 34.
have loopholes allowing the request requirement to be circumvented.\textsuperscript{97} Thus, there is no deterrent from noncompliance and physicians are left to exercise their own discretion about whether to broach the subject of donation or not. In addition, few states have included penalty clauses for failure to comply in their required request legislation.\textsuperscript{98} In fact, New York and Kentucky are the only states that explicitly mention a fine for violation of the state required request laws.\textsuperscript{99}

Several commentators call for increased penalties as a solution to the problem of physician noncompliance. However, this quick legal remedy would be counterproductive, as it fuels resentment among the medical community. The American experience with required request shows that physicians will not let their actions be dictated by legal regimes. Commentator Jeffrey Prottas points out that, "[i]t is neither possible nor, perhaps, desirable to coerce physician involvement. Too many professional judgments can stand legitimately between death and donation. Most required request laws aim at persuasion, not coercion."\textsuperscript{100} He goes on to explain that even if the laws were coercive, the medical profession's monopoly on information regarding potential donors and its strong attachment to autonomy make legal remedies an unlikely solution.\textsuperscript{101} Moreover, a legal remedy to cure a problem that does not lie in the law's realm of influence will invariably fail. "The underlying reason [sic] for these failures [of legal systems] stem from the powerful arena in which law has sought to act. Organ donation raises questions of death, guilt, and inter-family relations. The social and psy-

\textsuperscript{97} For example, in states such as New York, that do not require a request to be made if there is actual notice of an objection to donation, a hospital could explain the absence of a request notation on a death certificate by claiming an objection and there would be no easy way to verify the excuse. Similarly, most required request statutes do not mandate that a record be made of a refusal to consent by the family. Therefore, a hospital could explain that a small number of recorded consents reflects a large number of nonrecorded refusals or known objections, rather than a routine failure to request consent to donation. Maxwell J. Mehlman, Encouraging Donation of Organs for Transplantation By Requiring Request, 5 HEALTH MATRIX, Summer 1987, at 36.

\textsuperscript{98} Miller, supra note 65, at 25.


\textsuperscript{100} Jeffrey M. Prottas & Helen Levine Batten, Neurosurgeons & the Supply of Organs, HEALTH AFF., Spring 1989, at 119, 121 [hereinafter Prottas, Neurosurgeons] (describing barriers that prevent neurosurgeons from asking families of brain dead patients to donate organs).

\textsuperscript{101} Id. at 129.
chological forces operating in these areas are determinate and legal interventions are necessarily limited to peripheral impacts."\(^\text{102}\)

Ethicist Arthur Caplan admonishes society for assuming that the issues surrounding organ donation could be addressed by simply enacting legislation.

In enacting required request legislation, our society has indicated its collective desire that people routinely be given the option of organ and tissue donation . . . . 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.\(^\text{103}\)

Analysis of the causes of the failure of American required request yields valuable insight into the essential features of any successful plan to increase the supply of organs. Principally, experience suggests that the government should support its required request legislation by addressing those most in need of education and persuasion—health care professionals.\(^\text{104}\) The next section will examine in detail the psychological issues underlying health care professionals' noncompliance that need to be addressed.

III. PSYCHOLOGICAL ISSUES UNDERLYING ORGAN PROCUREMENT

Physicians, with the support of nurses and hospital administrators, have four critical tasks in the organ procurement process: (1) identification of potential donors, (2) formal determination of brain death, (3) requesting donation from the family and (4) maintaining the donor's organs until transplantation. Each of these steps contributes to the web of complex psychological issues that surrounds the procurement process and often prevents initial identification of potential donors and successful donation. As the following discussion will explain, the primary problem is inadequate education of the health care professionals in the organ procurement process to enable them to deal with these psychological issues.\(^\text{105}\)

\(^{102}\) Prottas, The Rules for Asking, supra note 70, at 192.

\(^{103}\) Professional Arrogance, supra note 88, at 37.

\(^{104}\) Id.

\(^{105}\) Id. at 35.
A. Obtaining Family Consent to Donation

It has become a social standard in the health care setting to ask the family to consent to organ donation. This standard stems in large part from the reluctance of physicians to procure organs without family consent, even in the presence of a donor document. Indeed, the National Heart Transplant Study reported that surgeons in forty-seven states require family approval for donation and only eleven percent of the surgeons surveyed said they would probably proceed with organ procurement if family members could not be located. Health care professionals are also reluctant to procure organs without family consent because they feel vulnerable and are not willing to subject themselves to a suit brought by a family who strongly objected to organ procurement. As the next section will explain, this fear of liability is unfounded. However, despite the fact that no one has been successfully sued for involvement in organ procurement, the perception of liability is there and may prevent initiation of the donation process.

A practical reason for approaching the family is that alienation of kin could be counterproductive to the moral obligation to ensure the survival of organ procurement programs. Bad press can seriously damage organ procurement efforts by discouraging people from donating. Transplant coordinators work hard to project a positive image in the community and avoid any situation that makes them look like vultures. Therefore, if a family raises strong objections to donation, the organ procurement agency is likely to forego the organs of one donor in order to avoid an incident that may decrease future donation rates.

A paradox emerges from the practical reality of the health care setting which prevents the initiation of the donation process. While it has become a social standard to request donation from the family, numerous psychological issues prevent the health professional from approaching the family with such a request. Many of these issues arise from the unique nature of organ procurement and from the emotional demands it creates.

Health professionals often do not approach the decedent's family for donation because they are concerned for the family and do not want to aggravate their grief. The fact that physicians respond positively to family or patient initiation of the subject of donation, but hesitate initiating the subject themselves, suggests that physi-

106. Heart Study, supra note 72, at 17.
107. Id. at 18.
cians avoid approaching the family not because they are uncomfortable about discussing donation but rather because they are concerned for the well-being of the donor's family.\textsuperscript{108} This perception is contrary to the reality that donor families view organ donation as a positive experience.\textsuperscript{109} Indeed, retrospective studies indicate that families come to view their consent to donation very positively once their grief subsides.\textsuperscript{110} In a recent study, ninety-eight percent of the respondents reported positive feelings about donation.\textsuperscript{111} In a second survey, seventy-nine percent said organ donation helps in the grieving process\textsuperscript{112} and eighty-nine percent reported that they would make the same decision again.\textsuperscript{113} Health professionals must be made aware of this positive perception of organ donation and realize that approaching the family for donation may help them cope with their grief rather than aggravate it. Once physicians are educated to understand that donation has an important role in the grieving process, productive dialogue about donation is possible. The next step is to train the health professionals to approach families about donation in a culturally sensitive way that respects the grieving process and will elicit a positive response to donation.

Organ procurement is unique because it requires the death of one person before the life of another can be saved. This situation ensures that the attitudes of both the public and health care professionals will always be somewhat ambivalent towards donation.\textsuperscript{114} Moreover, organ procurement is very different from the type of situation that medical professionals are trained for and dedicated to—the saving of a patient. Organ donors reflect failures of the intensive care unit to save a life, and it is very difficult to approach the family

\begin{itemize}
  \item \textsuperscript{108} Kenneth J. Bart et al., \textit{Increasing the Supply of Cadaveric Kidneys for Transplantation}, 31 Transplantation 383, 386 (1981) (supporting that systematic methods can increase kidney retrieval from donors).
  \item \textsuperscript{109} \textit{Health Professionals}, supra note 93, at 643-44. A recent survey portrays the disparity between public and physician perception of organ donation's affect on the grieving process. Eighty one percent of the public believes that organ donation helps a family with its grief, while only 66\% of the neurosurgeons polled believe this.
  \item \textsuperscript{110} R.G. Simmons et al., \textit{Gift of Life} (1977), cited in Frank P. Stuart et al., \textit{Brain Death Laws and Patterns of Consent to Remove Organs for Transplantation from Cadavers in the United States and 28 Other Countries}, 31 Transplantation 238, 240 (1981).
  \item \textsuperscript{111} D.T. Savaria et al., \textit{Donor Family Surveys Provide Useful Information for Organ Procurement}, 22 Transplantation Proc. 316, 317 (1990).
  \item \textsuperscript{112} \textit{Kind Strangers}, supra note 42, at 37.
  \item \textsuperscript{113} \textit{Id.} at 46.
\end{itemize}
and ask for donation after failing to save their loved one. While health professionals have a professional responsibility to see beyond their own perspective and possible feelings of failure in order to bring the benefit of organ donation to the donor's family and to the potential recipients, in reality it is very difficult to do so.

Health care professionals are not social workers or psychologists who are trained to discuss issues surrounding death with families. Yet they are required to approach a grieving family and ask them to make an emotion-laden decision. Therefore, it is understandable that many nurses and physicians are uncomfortable approaching the family and choose to avoid discomfort by not approaching them about donation. Indeed, in a recent survey of neurosurgeons, sixty-seven and a half percent of those surveyed believe their colleagues are reluctant to approach a family regarding donation.

A practical obstacle to obtaining consent from family members is the fact that more than fifty percent of potential donors are declared dead within twenty-four hours of hospitalization. Indeed, most families are approached for donation less than six hours after the declaration of brain death. Under these circumstances, it is crucial that health care professionals do not hesitate to ask the family for consent. However, such a rapid death, particularly if entirely unexpected, permits very little time for effective grieving to occur and it is likely that consent to procure organs will be refused. Refusal is even more likely if the person requesting consent is not sensitive to the needs of the family. In this situation, the need to approach the family competes with the family's need to grieve, and the person making the request must be especially sensitive to and respectful of the grieving process.

Despite the time constraints of organ procurement, families are very receptive to the donation request. In fact, a majority of donor families grant permission within an hour of the request and almost all donor families grant permission within a day of the request. In recent years, seventy to seventy-five percent of all families asked

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115. Health Professionals, supra note 93, at 645.
116. Stuart, supra note 110, at 238.
117. Prottas, Neurosurgeons, supra note 100, at 125.
118. Bart, supra note 108, at 386.
119. Sixty percent of donor families were approached for consent within one day of a relative's hospitalization and 14% of donor families were approached with a request for donation within one hour of a relative's hospitalization. Kind Strangers, supra note 42, at 40-41.
120. Fifty seven percent of donor families granted permission for donation within one hour of the request, while 91% consented to donation within a day of the request. Id. at 41.
have granted permission for organ donation. Thus, the willingness of the public to donate does not represent a practical impediment to increasing the supply of organs. It appears that referral rates rather than permission rates are currently constraining the supply of organs.

B. Determination of Brain Death

1. Confusion Regarding Legal Liability and Medical Criteria

The concept of brain death is central to the success of organ procurement because the best organ donors are often those who have suffered neurological damage but whose organs are completely intact. Before these organs can be used for transplantation, the attending neurosurgeon or neurologist must make a formal determination of brain death. However, the concept of brain death is yet another psychological issue which impairs the effectiveness of the required request laws.

Under the Uniform Determination of Death Act [hereinafter UDODA] [an individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards. The acceptance of this definition of brain death is widely recognized in the United States. Forty-four states have statutory recognition of brain death or appellate decisions establishing diagnosis of brain death as sufficient for a pronouncement of death. Thus, the concept of brain death is neither legally nor medically controversial.

In the reality of the health care setting, however, neurosurgeons often shrink from making a determination of brain death because they fear being held legally liable for their determination if the decedent's family brings suit for disconnection of life support. A recent survey showed that fifty-one percent of neurosurgeons surveyed reported that physicians often express concern about their legal liabil-

122. Id.
124. UDODA § 1. Emphasis added.
125. Miller, supra note 65, at 22.
ity for terminating life support.\textsuperscript{126} This perception of possible liability, while unfounded, has a negative effect on the procurement of organs for donation.

Bioethicist George Annas points out that liability concerns have always plagued the organ procurement process. He believes that, "[t]hese concerns have always been misplaced, and the 'legal solutions' to them have thus proven irrelevant or counterproductive."\textsuperscript{127} The UDODA and UAGA are two examples of this theory. States were encouraged to enact brain death statutes. However, no new laws were needed for the medical profession to adopt this definition because it is based on the irreversible cessation of entire brain function. Thus, "The rush to legislation gave the impression that a new definition of death was being adopted just so organs could be harvested."\textsuperscript{128} The lasting negative consequences of this rush include physician fear of legal liability and public perception that physicians might hasten death to obtain organs. Likewise there is little reason to fear liability under the UAGA. The UAGA states that a physician who acts "in good faith" is protected from any legal liability.\textsuperscript{129} This definition is a broader definition of protection than exists in almost any other area of medicine.\textsuperscript{130} Indeed, no physician has been successfully sued because of involvement in organ procurement.\textsuperscript{131} Nevertheless, the perception of liability is very real to the physicians who are responsible for determining brain death.

There is also some confusion over the medical criteria for brain death, particularly among nurses and hospital administrators. In a survey, almost half of the nurses and one third of the hospital administrators surveyed did not think that brain death guidelines are "well-established."\textsuperscript{132} In another survey of 195 physicians and nurses likely to be involved in organ procurement, only thirty-seven percent correctly answered that irreversible loss of all brain function was a requirement for a patient to be declared brain dead. Thus, Annas sums up, "Doctors don't know the law, and nurses and hospital administrators don't know medicine. We have a lot of

\begin{itemize}
\item 126. Health Professionals, supra note 93, at 644.
\item 127. Annas, supra note 114, at 621.
\item 128. \textit{Id}.
\item 129. The act states, 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. UAGA, supra note 57, § 7(c).
\item 130. Prottas, Rules for Asking, supra note 70, at 190.
\item 131. Annas, supra note 114, at 621.
\item 132. Health Professionals, supra note 93, cited in Annas, supra note 114, at 621.
\end{itemize}
education to do.” Indeed, the confusion over brain death criteria shows that educational efforts must include basic medical information regarding the criteria for brain death. It is important that the person who requests donation from the family can answer the family’s questions and concerns regarding brain death. A health professional who is unclear of the criteria for brain death is not likely to receive a positive response to a request for donation.

2. Lack of Conceptual Clarity

Ninety-five percent of organ donors are declared dead in the intensive care unit (hereinafter ICU). When a potential donor is declared dead, hospital staff do not follow the customary procedures of turning off the life support machines and sending the patient to the morgue. Instead, the patient remains in the intensive care unit and monitoring and intervention continue at maximum levels. In many respects, maintaining organs for transplantation actually necessitates treating brain dead “patients” as if they were alive. For example, if a brain dead “patient” goes into cardiac arrest, resuscitation is often performed. One commentator observes that, “It is no wonder that intensive-care-unit personnel may feel confused about having to perform cardiopulmonary resuscitation on a patient who has been declared dead, whereas a ‘do not resuscitate’ order has been written for a living patient in the next bed.”

Brain dead patients even look alive because they are warm, retain healthy color, and continue to digest nutrients, metabolize, and eliminate waste. Thus, it is not surprising that health professionals who understand the criterion for brain death on an intellectual level “may find it difficult to ignore the signs of life that constantly bombard their senses as they provide brain dead organ donors with intensive and intimate medical care.”

Commentator Stuart Youngner points out that the “irreversible loss of all brain function has been widely accepted as a criterion for determining death, without a corresponding, widely accepted concept explaining exactly why brain dead patients are dead.” This lack of conceptual clarity that surrounds brain death has significant

133. Annas, supra note 114, at 621.
135. Id. at 321 n.8.
136. Id. at 321.
137. Id.
impact on the potential donor's family. Because potential donors look alive, it is difficult for the family to accept that their loved one is dead, so the family is often reluctant to consent to organ donation.

Families also struggle to understand the brain death criteria, "which defines death as a process and differs from the traditional concept of death as a 'moment' in time." In effect, the concept of brain death does not give a distinct moment of death which many people require in order to begin accepting the death. This conceptual difficulty is exacerbated by the time constraints of organ procurement. Families are approached with a request for donation within hours of the brain death declaration, so it is not surprising that they have comprehension difficulties. Indeed, in a survey of donor families, thirty percent reported that they did not really accept the fact of death when they consented to donation and forty percent reported that they found the brain death concept hard to absorb. The fact that these families consented to organ donation reflects great trust in the medical profession and is an indication of the influence that health professionals have over the family's decision to donate. Health professionals who do not completely understand the concept of brain death are likely to exert a negative influence on the family's willingness to donate.

The above discussion shows that misunderstanding of the definition and legal status of brain death affects the action of health care professionals, while a misunderstanding of the concept of brain death often prevents families from consenting to donation. Thus, while the concept of brain death is neither legally nor medically controversial, the parties involved in organ procurement believe it to be socially controversial. Education aimed at health care professionals can alleviate much of this misunderstanding.

IV. PRESUMED CONSENT AS AN ALTERNATIVE TO THE PRESENT SYSTEM

The disappointing results of required request have sparked renewed interest in alternative approaches to increasing the supply of organs in the United States. The alternative most often proposed by commentators is presumed consent. Under the current system of
encouraged voluntarism and required request, it is presumed that an individual does not consent to donation. However, under presumed consent, it is presumed that an individual consents to donation unless an objection is known. Thus, presumed consent would change the basic assumptions of consent to donation in the United States. In effect, the burden of action would shift from the health care professionals (requesting donation) to donors or their families (making their objections known).

It is important to realize that several states currently have a presumed consent system for corneas and pituitary glands. Most people are not aware of these laws, and litigation has resulted from several situations in which the family was never informed of the procedure and objected to the removal. Three states have considered constitutional challenges to presumed consent laws. The relevant statute was upheld in all three states with the courts holding that there is no property right in a dead body and therefore, no unconstitutional taking has occurred. However, the court in Moore v. Regents of the University of California has raised doubt upon the correctness of these decisions by holding that Moore had a property right in his spleen sufficient to sustain a cause of action for conversion. Furthermore, in a recent federal case, Brotherton v. Cleveland, the Court of Appeals for the Sixth Circuit held that state statutes permitting the removal of corneas did trigger due process requirements. While the opinion did not prescribe the procedural steps that a state is obligated to follow when removing organs, it did focus on the coroner's failure to conduct even a minimal inquiry into whether or not the family objected to removal.

143. Thirteen states have presumed consent laws for corneas and six states have presumed consent laws for pituitary glands. For a list of states and statutes see Erik S. Jaffe, Note, She's Got Bette Davis's Eyes: Assessing the Nonconsensual Removal of Cadaver Organs Under the Takings and Due Process Clauses, 90 COLUM. L. REV. 528, n.35 to n.38 (1990).
145. 249 Cal. Rptr. 494 (Ct. App. 1988).
146. The court held that plaintiff's allegation of a property right in his own tissue is sufficient as a matter of law. 249 Cal. Rptr. at 503. The case is currently on appeal to the California Supreme Court.
148. The court held that the family has a legitimate claim of entitlement protected by due process. Id. at 5.
149. Mehlman, supra note 56, at 56. It is noteworthy that the Ohio statute was amended in 1983 to delete a requirement that the coroner make a reasonable effort to notify the family of the deceased. H.B. 239, 1983 Ohio Legis. Serv. 5-370 (Baldwin).
These cases demonstrate that there may be a constitutional obstacle to the adoption of a presumed consent system in the United States, and are proof that there will be strong public opposition to such a system.

Advocates of a presumed consent system assert several arguments in favor of its adoption. First, presumed consent will contribute to the public good by significantly increasing the supply of organs. Second, presumed consent is more humane for the decedent’s families who will not be faced with the organ donation request while they are grieving. Third, public support for organ donation is so high that an assumption of consent is reasonable.150 Each of these arguments will be addressed separately.

Presumed consent presents serious ethical and practical problems. The American experience with required request is an excellent indication that a presumed consent system would not succeed in the United States.151 The federal and state legislatures may enact presumed consent legislation. However, it will not be implemented by health care professionals. Just as required request does not result in organ procurement in the absence of family consent, a new legal regime to permit action without family consent is not likely to change the practices of the medical profession which require that the family be approached. Adoption of presumed consent will simply reflect that the United States has not learned from its experience with required request that the answer to the organ shortage lies in addressing the psychological issues of the procurement process.

In theory, presumed consent should be successful because it will eliminate the need for physicians to address the psychological issues associated with approaching the family about donation. Thus, the primary problem undermining required request will be eliminated. However, a system of presumed consent is guaranteed to fail because it ignores the fact that family consent is requested in all organ procurement cases because American social standards have come to require it. This social standard is reflected internally by actions of those directly involved in the procurement process and externally by the community through public condemnation when the standard is ignored.152

The Task Force on Organ Transplantation identified five ethical

150. Id. at 187.
151. See § II(B) above.
152. Id.
values that are necessary for any organ procurement system to promote:

1. saving lives and improving quality of life
2. respecting individual autonomy
3. promoting a sense of community through acts of generosity
4. showing respect for the decedent
5. showing respect for the wishes of the decedent's family

Assuming presumed consent can significantly increase the supply of cadaver organs, it would promote the first value of saving lives and improving the quality of life. However, presumed consent is unable to promote the remaining four values. By taking away the opportunity to act voluntarily, presumed consent gives individuals less of an opportunity to be altruistic and to promote a sense of community through altruism. Furthermore "allowing organs to be removed without permission would conflict with individual autonomy and would be highly disrespectful of the decedent and of the wishes of the family." Thus, presumed consent represents a highly restrictive means of addressing the organ shortage. Indeed, in 1986, the Health and Human Services Task Force on Organ Transplantation cited public opposition to presumed consent as the sole basis for rejecting the presumed consent approach. Adoption of such a system would result in public resentment and an outcry that could undermine the entire organ donation.

Advocates of presumed consent cite its success in European countries. However, close analysis of the presumed consent systems in Europe actually strengthen the argument against presumed consent in the United States. Thirteen European countries have some sort of presumed consent. However, six of these countries notify the family before harvesting organs and have a de facto required request system. Moreover, donation statistics in these thirteen

154. Several studies have demonstrated that kidney transplants provide a better quality of life for end-stage renal disease patients than dialysis. See Mehlman, supra note 56, at n.79.
155. Id. at 47.
156. Task Force Report, supra note 44, at 30-33. The report states:
Although there are recurring proposals to extend presumed consent from corneas to other tissues and vascularized organs, both consensus derived from experts in the field and public opinion show that there is little support for this mechanism as a way of increasing the availability of donor organs. It is clear that potential organ donors and their families want to continue to be the primary decisionmakers. Thus, the Task Force believes that present efforts should focus on enhancing the current voluntary system rather than on reducing the role of actual consent.
157. Austria, Czechoslovakia, Denmark, Finland, France, Greece, Israel, Italy, Norway, Poland, Spain, Sweden, and Switzerland. Stuart, supra note 110, at 239.
158. Finland, Greece, Italy, Norway, Spain, and Sweden. Id.
countries fail to make a strong case for presumed consent, as the number of cadaver organs fails to meet the need of potential recipients in any of these countries. These statistics highlight the fact that while presumed consent increases the likelihood of organ salvage after a potential donor has been identified, it does nothing to stimulate health care professionals to aid in the identification of donors.\footnote{159} Once again, the legal solution runs up against the wall of psychological issues involved in donor identification. "To the extent that physician and nurse attitudes inhibit donation, the answer lies not in new laws, but in educational efforts and a sensitive appreciation of their needs and concerns."\footnote{160}

V. PROPOSAL TO INCREASE ORGAN SUPPLY: EDUCATIONAL EFFORT DIRECTED AT HEALTH PROFESSIONALS

The primary problem underlying the failure of procurement efforts is inadequate education of health care professionals to prepare them to deal with the psychological issues inherent to the organ procurement process, particularly with the issues involved in approaching the family for donation. Currently no state is providing an adequate level of professional education to those who bear the obligation of making the donation requests.\footnote{161} If opinion polls are to be believed, then the public knows about the need for transplants. The health care professionals, however, are in desperate need of education on social, interpersonal, and legal issues.

Organ procurement agencies represent the best educational resource for health care professionals involved in organ procurement. The nation’s network of about ninety OPAs should be utilized as an educational resource for health care professionals.\footnote{162} For many health professionals organ donation is not an everyday priority, particularly in the non-transplant setting where there is no vested interest in organ procurement.\footnote{163} Procurement coordinators, who have a vested interest in procurement, should be assigned to professional education. Currently, thirty to one hundred percent of a coordinator’s time is spent in some form of professional education. Organizational research into OPA success reveals that motivating medical

\footnote{159} Id.
\footnote{160} Annas, supra note 114, at 621.
\footnote{161} Professional Arrogance, supra note 88, at 35.
\footnote{162} Prottas, Rules for Asking, supra note 70, at 183-84.
professionals is the most important task of the OPA.\textsuperscript{164} It must "sell" health professionals on organ procurement and continually motivate them to participate in the procurement process. Because health professionals cannot ethically or legally receive compensation for their involvement in organ procurement, the OPAs are essentially "selling altruism."\textsuperscript{165} For this reason the educational content of professional education is usually small because motivation rather than information sharing is the primary goal.\textsuperscript{166} The motivational component should be more evenly balanced with the educational one in order to achieve better results.

A practical obstacle for organ procurement is the relative infrequency of potential donors in many health care institutions.\textsuperscript{167} Therefore, educational efforts should be directed at hospitals most likely to provide results in order to maximize the limited resources of OPAs.\textsuperscript{168} More importantly, educational efforts must be directed at the two professional groups that are critical to organ procurement — intensive care nurses and neurosurgeons. The key to a successful donation rests in their hands and educational efforts must address their needs and concerns.

A. The Role of Neurosurgeons in Organ Procurement

The legal and professional importance of neurosurgeons (and neurologists in the non-transplant setting) makes their cooperation essential to successful organ procurement. Neurosurgeons must give formal permission for referral of a potential donor to the local OPA and are responsible for donor maintenance as well as for the determination of brain death. While neurosurgeons are the most important health professionals in donation, OPA directors rate them as the least cooperative group.\textsuperscript{169} This combination is not a good formula for success. Clearly there are issues affecting the cooperation of neurosurgeons that must be addressed in order to increase the number of donor referrals to OPAs.

Surveys of other medical members of the procurement team

\begin{itemize}
\item \textsuperscript{164} Prottas, \textit{Neurosurgeons}, \textit{supra} note 100, at 120-21.
\item \textsuperscript{165} Prottas, \textit{Obtaining Replacements}, \textit{supra} note 53, at 245.
\item \textsuperscript{166} Prottas, \textit{The Organization of Organ Procurement}, \textit{supra} note 22, at 45.
\item \textsuperscript{167} Skelley, \textit{supra} note 163, at 37.
\item \textsuperscript{168} Large city hospitals that see most trauma patients are not always cooperative because they do not have the time to identify potential donors, while smaller suburban hospitals have few potential donors and are hard to cover. Prottas, \textit{Obtaining Replacements}, \textit{supra} note 53, at 240.
\item \textsuperscript{169} In a survey of OPA directors, 73\% rated neurosurgeons as least cooperative and 75\% rated nurses as the most cooperative. Prottas, \textit{Neurosurgeons}, \textit{supra} note 100, at 121.
\end{itemize}
show that their willingness to cooperate is greatly influenced by
their perception of physician's attitudes. They also show that
hospital administrators and ICU nurses believe that neurosurgeons
are less supportive of organ procurement than other professionals
involved in the procurement process. Therefore, neurosurgeons'
lack of cooperation is exerting a negative influence on the medical
personnel they work with.

The efficiency of an OPA influences neurosurgeons' perception
of procurement. Therefore, an OPA can improve neurosurgeons'
cooperation by minimizing time demands on them and providing
emotional support in their encounters with the family. Perhaps the
best solution is to remove the responsibility of approaching the fam-
ily from the physicians altogether. This solution would allow the
OPA staff, who are best trained to deal with the situation and have
a vested interest in donation, to approach the family. The person
who makes the request is often a very important factor in obtaining
consent. Experienced transplant coordinators are ideal because
they are skilled in interpersonal relations, appreciative of psycho-
logical dynamics of the grieving process, aware of the attitudes of
various religious and cultural groups, and technically familiar with
the retrieval process. Furthermore, removing the responsibility to
approach the family from physicians will place the physician in a
much more comfortable and familiar role of attempting to meet the
interests of patients and their families.

B. The Role of the Intensive Care Nurse in Organ Procurement

A majority of the in-hospital burden of organ procurement falls
on the intensive care nurses (hereinafter ICU nurses) who provide
primary care to the potential donor. They often are the first to
identify potential donors, they participate in the medical assess-
ment of the potential donor, and they maintain the transplantable

170. Id. at 120-21.
171. Id. at 122.
172. Id. at 130.
173. Skelley, supra note 163, at 37.
175. More than 75% of potential donors and more than 95% of actual donors die in
intensive care units. Carla Vernale, Critical Care Nurses' Interactions With Families of Poten-
tial Organ Donors, 18 FOCUS ON CRITICAL CARE 335 (1991).
176. In a survey of intensive care unit nurses 63% indicated that the nurse is the first to
identify a potential donor and 72% reported that the nurse places the call to the OPA. Laura
Ruse Sophie, Intensive Care Nurses' Perceptions of Cadaver Organ Procurement, 12 HEART &
organs in optimal condition. Most significantly, they provide the factual and emotional support necessary for the family to arrive at a decision in favor of donation. One commentator noted, "Indeed, it is generally [the ICU nurses] who take the active role, with the physician merely acquiescing." Therefore, it is important to incorporate organ procurement into the routine of the ICU nurse.

Because ICU nurses are the health professionals closest to the potential donor and family, "they have the opportunity to initiate positive interventions in all phases of organ procurement." An ICU nurse is the ideal member of a procurement team to make the request for donation, and when the family initiates donation, the ICU nurses are usually the first to receive such inquiries. Therefore, an important part of the solution to the organ shortage lies in the interaction between ICU nurses and donor families. For this reason, it is very important that the ICU nurse have a positive approach to donation. A recent survey asked ICU nurses to rank themselves as "confident" or "uncomfortable" when requesting donation from a family. Eighty-four percent of the families approached by "confident" nurses agreed to donation, while all of the families approached by "uncomfortable" nurses said "no" to donation.

ICU nurses need to learn how to approach a family in a culturally sensitive way that respects the grieving process. This is not something easily taught or learned. However, addressing the psychological issues of donation will help them to overcome their own apprehensions regarding donation and sensitize them to the family's grief. In addition, if nurses remain uncomfortable approaching the family, then they need to delegate the responsibility to someone who will make the request, rather than avoiding the issue and passing over a potential donor.

An OPA's professional education often focuses on hospital inservicing and usually takes the form of annual or biannual seminars. While these seminars reach a significant number of nurses in a short period of time, they are not an effective way to address the psychological issues hindering the nurses from approaching the family. "[I]nservice time does not typically allow for a close look at nurs-

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177. Prattis, Obtaining Replacements, supra note 53, at 241.
178. Vernale, supra note 175, at 335.
179. Id.
ing's responsibility toward organ donation as an option for bereaved families, nor does it allow for adequate discussion about personal feelings concerning potential donor conversations." ¹⁸¹ More emphasis should be placed on teaching nurses how to deal with their feelings and the feelings of donor families. Many procurement coordinators attend training seminars that include in the curriculum information about religious and cultural responses to donation and teach the coordinators how to approach the family.¹⁸² A similar seminar can easily be developed for ICU nurses. The best way to ensure that ICU nurses receive such training is to make it part of their continuing education requirement to attend a seminar on transplantation issues every few years.

Organ procurement is a very demanding task which is time-consuming and emotionally draining for the health professionals involved. The nurses who come into close contact with the family bear most of the emotional burdens of procurement. The emotional commitment receives little immediate reward and ICU nurses rarely see the outcome of their efforts. In a survey of ICU nurses, while 86.8% personally approved of cadaver organ donation, only 25% view participation in the care of a potential donor as a rewarding experience and believe it to be a worthwhile activity.¹⁸³ Part of the emotional burden can be lifted by the educational efforts discussed above that would make nurses more comfortable approaching the family. In addition, nurses may feel better about their participation if the OPA would share follow-up information with the members of the organ procurement team and perhaps, bring in patients who have benefited from the donors cared for in a particular hospital.

In summary, there is no easy solution to the organ shortage in the form of new laws or more money. The ideal solution is to remove the responsibility of requesting donation from the health care providers and give it to transplant coordinators who are better prepared for the task. However, as this may not be feasible, physicians

¹⁸¹. Id. at 277.
¹⁸². The curriculum for a one week training program for procurement coordinators, sponsored by the North American Transplant Coordinator's Association, includes seminars on:
   - The Relationship Between Ethnic Diversities and Transplantation Donation
   - Donor Family Interaction: Issues in Grief Counseling and Dynamics of Obtaining Consent
   - Concepts of Brain Death: Role of the Coordinator
(The table of contents for the seminar was provided by Life Banc, the OPA for Northeastern Ohio).
¹⁸³. Sophie, supra note 176, at 265.
and nurses must be prepared to approach the families themselves or delegate the responsibility to a colleague. Thus, the solution lies to a great extent in educational efforts directed at neurosurgeons and ICU nurses. This education must address the legal, medical, and psychological aspects of organ procurement in order to be effective. It is essential that professional training focus on approaching the family in a sensitive way that is likely to result in consent to donation.

VI. ADDRESSING MINORITY DONATION ISSUES:
A GRASSROOTS APPROACH

Educating health care professionals about organ transplantation and training them to approach the family only addresses the parties on one side of the organ procurement process. To make requesting successful, the potential donors and their families must also be educated about donation. Public opinion polls reveal that the general population in the United States is aware of organ transplantation and the need for organ donation. However, the same polls show that minority groups are less aware of transplantation issues and less willing to donate organs. Therefore, while an educational campaign should be launched to remind the general public about donation, educational efforts should also focus specifically on minority groups. Indeed, one of the recommendations made by the Task Force on Organ Transplantation was that educational efforts be undertaken, "aimed at increasing organ donation among minority populations . . . so that the donor population will come to more closely resemble the ethnic profile of the pool of potential recipients . . . ."185

Currently, America's donor population does not come close to resembling the ethnic profile of potential recipients because of the extremely low donation rates of minority groups. America's large black and Hispanic populations, which experience a high incidence of kidney failure, have much to gain from an increase in the supply of organs. In order to reach these groups, an educational campaign must be customized to respond to cultural perceptions of organ donations. This section will look at the medical and psychological issues involved in donation for black and Hispanic Americans. It will propose a way to change the entire perception of these minority groups toward organ donation so that donation becomes a regular

practice and all Americans can benefit from the increased organ supply.

A. Organ Donation and America’s Black Population

1. The Medical and Psychological Obstacles

The organ shortage has disparate impact on America’s large black population, particularly in relation to kidney donation. As the largest minority in the United States, blacks make up twelve percent percent of the population.\(^{186}\) However, they have four times the risk of kidney disease than whites\(^ {187}\) and represent thirty percent of dialysis patients in the United States suffering from end-stage renal disease.\(^ {188}\) The figures are even more disproportionate in areas with large black populations, such as the southeastern United States. A survey conducted by the South East Organ Procurement Foundation (hereinafter SEOPF) found that seventy percent of dialysis patients in the region were black, while less than ten percent of kidney donations came from black donors.\(^ {189}\) This disparity between demand for kidneys and organ donation results from a combination of health related and psychological issues that must be addressed if blacks are to benefit from organ transplantation technology.

Once a kidney has been transplanted, blacks do more poorly than whites. Immunological studies show that mismatches for certain histocompatibility molecules occur with greater frequency in blacks than in whites.\(^ {190}\) As a result, kidney transplantations in blacks are on average ten to twenty percent less successful than they are in whites. In fact, two years after a transplant, blacks have a graft survival rate of seventy-five percent compared to a white survival rate of eighty-nine percent.\(^ {191}\) The procurement of more organs from blacks bearing similar antigens may be a key factor in


\(^{188}\) Paul Delaney, Myth Fighters Seek Organ Donors, N.Y. TIMES, Nov. 6, 1991 at B9.


\(^{190}\) Callender, Critical Frontier, supra note 10, at 444. See also C. O. Callender, The Results of Transplantation in Blacks: Just the Tip of the Iceberg, 21 TRANSPLANTATION PROC. 34007, 3409-10 (1989) [hereinafter Callender, Tip of the Iceberg].

\(^{191}\) Id. at 3410.
increasing the graft-survival rates in black transplant recipients. Therefore, the low donation rates among blacks greatly exacerbate the health problems associated with black transplants.

Socioeconomic problems and distrust of the medical establishment are components of the low donation rate for blacks. However, a more important issue is one which follows a vicious circular pattern—racism. Fewer blacks donate because of fears that blacks will not receive donated organs and in turn, the lack of organs donated by blacks makes successful transplantation to blacks more difficult. Organ procurement groups cannot break this cycle by guaranteeing black organs will be transplanted in blacks because race is only one factor in determining the best match for a donor organ. As a result of this cycle, blacks have to wait twice as long as whites to receive a kidney transplantation.

The preference of blacks that their organs be given to blacks stems from an underlying distrust of the medical establishment and feeling that whites will benefit from increased organ donation rather than blacks. This distrust raises a broader issue in transplantation—why would any minority want to donate organs if their community will not benefit from the donation? In order to answer this question, educational efforts need to be directed at these communities to explain that an organ from someone of the same race may not be the best match for a patient awaiting transplant. The following section will lay out such an educational plan. In addition, the altruistic gift of life needs to be emphasized so that donation to anyone will be viewed in a positive light. While the issue of minority access to healthcare is beyond the scope of this paper, it is realistic to assume that an increase in the supply of organs will result in more minority organ recipients.

2. Tackling the Psychological Issues

In 1982, Dr. Clive Callender, the senior black transplant surgeon in the United States, was approached by SEOPF with its donation statistics and asked to find out why donation rates for blacks are so low. Dr. Callender proceeded to conduct a survey consist-

193. Delaney, supra note 188.
194. Id.
196. Callender, Tip of the Iceberg, supra note 190, at 3407.
ing of intensive two-hour interviews of forty black men and women designed to uncover some of the critical elements underlying the low donation rate. The interviews revealed that the main reasons for the low donation rates are: (1) lack of awareness of the status of organ transplantation and the urgent need for organs by blacks, (2) religious beliefs, superstitions, and misconceptions, (3) general distrust of the medical establishment, (4) fear of premature declaration of death if a donor card is signed, and (5) preference by blacks to assure that donated organs will be given preferentially to blacks. Initially, ninety percent of the interviewees were unwilling to sign a donor card. However, after the interview, each participant agreed to sign a donor card. These results point to a need for further education of the black population on organ donation and personal contact with potential donors to elicit a positive response to a request for donation.

The face-to-face grassroots approach employed in the survey has become a basis for more extensive programs to encourage blacks to become organ and tissue donors. In 1982, the National Kidney Foundation in conjunction with Howard University Hospital initiated the District of Columbia Organ Procurement Project (hereinafter D.C. Project). At the beginning of the program, twenty-five donor cards were signed each month. By 1989, 750 cards were being signed per month, effectively doubling the number of black donors in the District of Columbia, which has the highest incidence of end-stage renal disease in the country. The project coordinators attribute these results to the project’s novel approach to the problem of organ donation among blacks, which includes:

1. Elaboration of a message specifically tailored to the particular community
2. Intensive use of volunteers.
3. Use of black transplant recipients and patients awaiting transplant as ideal spokespersons.
4. Emphasis on coordination of all educational activities with local community activities.
5. Support from the private sector.
6. Collaborative efforts involving both transplantation programs and private community organizations.

This grassroots approach has “generated the kind of reciprocal ex-

197. Callender, Critical Frontier, supra note 10, at 442.
198. Id.
199. Id. at 442-43.
201. Callender, Critical Frontier, supra note 10, at 443.
change of information that is indispensable for constructive interaction between physicians and laypersons.”202 Furthermore, it contributes to the feeling of community empowerment as a group begin to feel that they have control over an issue that is important to their members.203

Historically, publicity campaigns were not aimed specifically at minority groups.204 However, the success of the grassroots approach has indicated a need for targeted educational campaigns. The current programs need to be expanded to other regions with high minority populations. The results of these programs in black communities “support the concept that if any given community, black or not, is appropriately challenged and exposed to the facts, it is most likely to respond in a positive manner.”205

B. Organ Donation and America’s Hispanic Population

Hispanics make up the second largest minority group in the United States and are the fastest growing minority group.206 They place close to blacks in the need for organ transplantation. Hispanics have three times the incidence of end-stage renal disease than whites and low donation rates. In San Antonio, Hispanics comprise fifty-two percent of the population and eighty percent of the organ recipients, while only fourteen percent of the donors are Hispanic.207 The American Hispanic population has inherited a mix of genotypes from Spanish ancestors, American Indians, and blacks. This diverse genetic background magnifies the need for Hispanic donors because histocompatible donors are most likely to come from other Hispanic Americans.208

The grassroots approach that this article advocates for America’s black population can be adapted to reach the Hispanic population.209 It is important that the educational campaign be in both English and Spanish in order to reach the entire Hispanic com-

202. Id. at 444.
204. Delaney, supra note 188.
205. Callender, Critical Frontier, supra note 10, at 443-44.
207. Pugh, supra note 10, at 135.
208. Teri Randall, Key to Organ Donation May be Cultural Awareness, 265 JAMA 176 (1991) [hereinafter Cultural Awareness].
209. See § VI(A) above.
community. A message in Spanish will reach the numerous Hispanics in this country who do not speak English. Furthermore, Spanish is often the language that is spoken at home and the personal nature of the donation issue makes it appropriate to send the educational message in the language in which it will be discussed. The message can be put in popular Hispanic magazines and broadcast on Spanish radio and television stations. One commentator suggests incorporating the transplantation and donation issues into the story line of a popular Hispanic soap opera.210

Transplant coordinators and those requesting donations in areas with large Hispanic populations must be sensitive to Hispanic culture in order to receive a positive response to their request for donation. Much of this sensitivity involves understanding Hispanic family structure. In Hispanic families, the mother and especially the grandmother are the ones who make the healthcare decisions. Therefore, a person requesting donation should approach the mother rather than the father with the request.211 As another example, English-based law and the UAGA recognize the spouse as the next of kin.212 However, Hispanic culture determines the next of kin by blood. Therefore, the opinion of the decedent's parents has greater weight than the spouse's opinion and should be honored by the transplant coordinators.213

Sensitivity to Hispanic culture and educational campaigns calculated to reach the Hispanic community will have an impact on the donation rates. Once Hispanics and other minorities begin donating more organs, the benefits of organ transplantation will be seen in the minority communities and even more organs will be donated.

V. CONCLUSION

The current system of organ procurement in the United States is clearly not achieving its goal of significantly increasing the supply of cadaver organs for transplantation. In the past, the answer to the organ shortage was thought to be in legislation, first in the UAGA and then in required request laws. However, experience has proven that legislation is not the answer to increasing the supply of organs

210. Id. at 177.
211. Id. at 176.
212. UAGA, supra note 57, § 2(b). See text, supra note 61.
213. Cultural Awareness, supra note 208, at 176.
because the problems undermining the success of the organ procurement system are psychological, not legal.

The least restrictive way of successfully increasing the supply of organs involves addressing the complex psychological issues surrounding organ donation which affect the actions of the health care professionals involved and the donor or his family. Addressing these issues by educating health care professionals about the legal, ethical, and social aspects of organ procurement will make them more comfortable with the donation process and more effective in their requests for donation. In addition, minority populations, particularly the black and Hispanic population, need to be educated about organ donation. This can be effectively accomplished by following the grassroots community approach of the models, such as the D.C. Project, already in place.

An educational approach to the organ shortage will increase the supply of cadaver organs for transplantation by facilitating the cooperative relationship between health care professionals and the public that is the key to a viable organ procurement system. In addition, it will foster the American tradition of relying on altruism in the organ procurement process.