The Honourable Steven Fletcher P.C., P.Eng., MBA 6 Hermitage Rd., Headingley MB, R4H 1K3

Professor Harvey Cameron., Q.C.,
President Manitoba Law Reform Commission

432-405 Broadway
Winnipeg, Manitoba R3C 3L6
Canada

June 24, 2021

Regarding Law Reform Commission review on Presumed Consent

Dear Professor Cameron,

I am pleased that the Manitoba Law Reform Commission has decided to examine the issue of organ donation.

Presumed consent is one method that may be useful in increasing the rate of organ donation in Canada.

I am enclosing with this letter material that I hope may be of use to your team.

For professional and personal reasons, the issues surrounding organ donation are one of the public policy issues I pursued in public life.

All the documents have been tabled in the Manitoba Legislature and can be found in the Legislative Library.

For convenience, I have compiled 13 Exhibits in the accompanying material.

As an introduction to the Exhibits, I have provided some personal reflections on the issues related to presumed consent, with 11 recommendations.

I congratulate the Manitoba Law Reform Commission for undertaking a thoughtful review on the issue on presumed consent.

Sincerely,

Steven Fletcher

Steven Fletcher

The Honourable Steven Fletcher P.C., P.Eng., MBA, C.Mgr., ICD.D.

President Fletcher Focus International

Founder Freedom with Focus Foundation

Supplement to Letter of Submission to the Manitoba Law Reform Commission from The Honourable Steven Fletcher

Dear Manitoba Law Reform Commissions,

The importance of organ donation cannot be understated.

The framework for access to organ donation is complicated.

In our glorious democracy, every law is passed with hope and a promise.

A framework of presumed consent could bring hope and promise to many people.

Any legislation must be worded in a manner that no one is giving up their hope and promise as a human being based on what outsiders, or even the individual, believe to be human.

In short, the legislation must only apply to people who are dead.

Society must not facilitate the death of any human being.

The only exception for society to not side on life, lays in the realm of Medical Assistance in Dying.

Sourcing organs must never be associated with MAID.

As an MP, I worked extremely hard to provide Canadians, in unique situations, the opportunity to die with dignity.

During the legislative process of researching, writing, and introducing legislation on MAID a lot of issues arose.

Defending and advocating for my MAID Bills, was a profound experience.

Ultimately the Supreme Court used the wording in my legislation in their landmark decision to allow for MAID under certain conditions.

Less well known to my MAID Bill was a companion piece of legislation to require statistics to be kept on the metrics of the people who would choose MAID.

The who, the what, the when, the where, the why and the how.

Only with broad and accurate data is it possible to ensure that the best public policy is pursued.

Such data may also reveal other short coming or improvements our society can make, so that people choose life.

Recommendation One

Any legislation on organ donation includes meaningful, empirical data and information that is both quantitative and qualitative.

As a Lawmaker

As an elected lawmaker, for 14 years, at the provincial and federal level, issues relating to our individual mortality are particularly difficult to articulate in legislation.

Societal values, technologic progress, and increased education amongst the public forces us in a responsible democracy to discuss these issues as difficult as they may be.

As a small “c” Conservative, I believe the pendulum of greatest good swings with the protection of individual rights.

Everyone is a minority of one.

When we protect the rights of one, we protect the rights of minorities, especially the vulnerable.

What is Alive? What is Dead?

On the issue of organ donation, it is incredibly important to be clear on when life exists and when death occurs.

Life brings hope, and so long as hope exists, every effort should be made to protect the life.

The answer to this question may seem to be obvious.

It is not.

Hospital in the same health authority may have a different definition than a hospital five minutes away.

Does death occur 10 minutes after a heart stops, or 20 minutes, or five?

How many organs must fail before someone is considered dead?

A body that works perfectly fine based on autonomic reflects, may be attached to an individual who is brain dead.

How long does one have to be brain dead to be considered dead, or should they, or are they actually alive?

An understanding of what death is should be part of the Commission reflection when dealing with presumed consent.

The integrity of any law and the public support for a law, depends heavily on an agreement of definitions.

Life and alive are different in my opinion.

Life brings hope.

To live life is vastly different than to exist alive.

An ameba can be alive, but there is no hope.

The legislation needs to recognize the uniqueness of human existence.

Recommendation Two

A law must be clear on definitions.

Recommendation Three

If an unanticipated scenario arises that is not covered in the law, the default must be on the side of life, not just existence.

The right to life exists from the first breathe to the last.

Recommendation Four

The law on presumed consent should follow hope.

Scenarios

It may be helpful for the Commission to tests its recommendations through various scenarios no matter how difficult they may be.

Mother Nature is cruel.

Many situations (and eventually all individual's lives) lead to death.

Some questions are, how, when, and why do people die and can anything positive result?

Two Scenarios of Very Different Situations that Might Intersect

Scenario one, a young person is killed in an accident.

Scenario two, a parent with young children will die before their time due to heart failure.

Is it right to use an organ, or organs, of a young person who is dead to help the parent who could live a long and healthy life?

The victim of the accident probably has not signed a card, but time is short, and organs last hours after death.

In both cases, the individuals are not at fault.

Life is cruel, time is short, organs die, but does everyone in this scenario need to die?

Some people will say yes.

Both must die, as the first victim's body is sacred.

If the person wanted to be an organ donor, they would have provided permission before hand.

It could be that the individual would not agree to the donation had the have known ahead of time that an accident would happen.

No organ can be removed unless it can be demonstrated that the individual would have accepted the donation, or a family member provides permission.

Ironic that in a blink of an eye, in the course of life on earth, we, our generation, humans, can save lives by using organs of people who have passed away in tragic situations.

The law should follow the hope.

The young person has no hope.

History and Future

It is almost beyond our evolutionary comprehension that presumed consent could even be an issue of debate.

At any other time in our history, presumed consent would be considered vulgar, blasphemous, or the stuff of science fiction.

Yet, in North America, at this time in human history, we can do unimaginable things to allow anyone alive to reach their full potential including taking the organs from one dead person and implanting them into a living person.

On one hand, unimaginable loss of human potential and a broken expectation that one may have with God to live into their tenth decade.

Mother Nature, and Humans

Mother Nature is cruel, but our evolution, our civilization, the summation of human knowledge and our country allow for the possibility to minimize the cruelty of existence.

What is more Canadian than strangers helping strangers?

The ultimate gift from God is our lives.

The second gift from God is our ability to do.

It seems reasonable to take the ultimate gift of life, along with the God-given ability of knowledge, to improve the ultimate gift.

The most respectful and responsible use of the ultimate gift is to live our lives as long and productive as possible.

When it is not possible, why prevent someone else from having their opportunity to reach their tenth decade if we cannot.

Recommendation Five

Life is too short not to accept the occasional gift.

Our Society

Our society does have the ability, in some cases, to take the cruelness of Mother Nature and use the loss of a life to give a second lease on life to a young person, or a parent.

Our society must help individuals to reach their full potential as human beings.

In scenario one, through no fault of their own, that person will not reach their full potential.

Scenario one, with no hope, provides hope for scenario two.

Ironic and cruel, that a no hope situation for one person can bring hope to another.

Both people are victims of existence, one person may live a full and productive life.

The ultimate cruelness is allowing both individuals to die when everything needed could save one person.

Organ donation is one of the few ultimate gift strangers can make to each other and in turn make us all stronger.

Recommendation Six

Presumed consent means tragedy has occurred.

The tragedy must not be minimized.

An individual will have died.

That individual must be mourned and respected.

The importance of that individual's life in scenario one, in no way can be diminished by the thought "well at least someone else got the heart from the body."

People tell themselves all sorts of things to make them feel better about existence.

Recommendation Seven

Education and sensitivity must be provided to those who are the donors or recipients of donation.

Recommendation Eight

Education, empathy, sensitivity, and a fundamental belief that everyone is entitled to life should be part of the education of the health care practitioners that are involved in organ donation.

Politics

In my first nine of my 11 years as a Member of Parliament, I had the good fortune of being the Shadow Minister of Health for the Official Opposition, Parliamentary Secretary for Health, and five years in the Federal Cabinet.

Every moment was on a learning curve, and in my ninth year as a Member of Parliament I became a back bench MP, which allows us to MPs to pursue issues outside the main priorities of the government.

The amazing opportunities to introduce legislation in the Federal Parliament as an independent member became a possibility.

I was finally able to introduce Private Members Bills in Parliament on issues relating to medical assistance in dying.

There was huge public interest.

In fact, the interest in the Private Members Bill were so time consuming, I was unable to move forward on issues relating to organ donation as my term as a Member of Parliament came to a democratic end in October 2015.

In 2016, I was elected as an MLA in the Manitoba Legislature. As a back bench MLA, I was able to write and introduce legislation independent of the PC caucus.

In a short time, I had many pieces of legislation on the order paper, but not yet introduced for second reading.

The Gift of Life Act, which was my amendment to the Human Tissue Legislation, and allow for presumed consent.

My Private Members Bill was introduced primarily to bring attention to organ donation.

There was no possibility of the legislation passing.

Organ donation was not an issue on the government agenda.

Nor did it particularly seem controversial to my mind and certainly worth the debate.

As an MLA, I made it clear to the PC caucus that on issue around Private Members Bills I would be maximizing my Parliamentary Privilege as a Back Bench MLA on issues that the government had not prioritized.

As no debate on any issue was allowed in the caucus, (contrary to what some people think happens), I introduced my legislation on organ donation in March of 2017, seconded by the MLA from River Heights.

I did not appreciate the emotional reaction on presumed consent from some of my PC caucus colleagues.

Nor did I anticipate negative reaction from anyone based on religious affiliation.

Presumed consent offends individuals who want control of their bodies after they have passed.

The fact that no body has control over their body after they die seems to have no effect.

The fact that society dictates how bodies can be disposed be it through cremation or burial, have no effect.

The fact that autopsies are conducted, and all sorts of other things happen to bodies after death have no effect on these individuals.

Even the argument of “What harm could result from a presumed consent” or an opt-out option had no effect.

The other push back on the presumed consent legislation went along the lines of “It is against my religion, and it is against the religion of the people I represent”.

The MLAs with this point of view were mostly form rural constituencies and in every case Christians.

As a Christian myself, I was surprised to hear this argument.

I researched of organ donation in a Christian context, and could not find any doctrine or statement, Protestant, or Catholic, or Orthodox where presumed consent would violate doctrine.

I went on to discuss the matter with many religious leaders in the Christian community, and without objection.

After pointing to the evidence od Christianity and organ donation, one of the MLAs found someone of a different faith to email me a rebuke of the legislation.

The argument came from someone of the Jewish faith, and he insisted that he must be buried whole.

After more extensive research, and reaching out to leaders in the Jewish community, I learned that in fact there is no objection in the Jewish faith to organ donation.

In fact, Israel has some of the most aggressive legislation surrounding organ donation in the world.

I went on to check every religion that one may come across, and in every case the acceptance of organ donation is supported.

It is important to be clear on the facts, not what people think the facts might be.

Recommendation Nine

Knowledge of religious or First Nations traditions should be sought and reflected upon.

Recommendation Ten

Opt-out clauses should be provided to any individual for any reason.

The reason may be religious but need not be.

Individuals who feel strongly about this point may be able to sign their driver's license or put their name on a registry of some sort.

As a Human Being

It does not seem possible to me that the issue of presumed consent can occur without a deep, emotional response.

At the age of 23, I was left a quadriplegic, paralyzed from the neck down, in one nanosecond, due to a stupid moose on the road.

Fully conscience, but unable to speak and gasping for air until placed on a ventilator, unable to speak for months after the accident.

One cannot help but think of alternatives solutions.

The first go to solution is to get better and walk away, literally. Doctors are wrong and things like this never happen in real life, especially to me or people I love.

Physical pain is relentless and so profound and deep that one thinks that their head will explode.

Emotional pain builds like water behind a dam for the victim and all those who know them, it is only a question of the volume of water.

This is a bleak picture.

How can one not wonder if it would be better to die?

The pain would stop, there would be a certain kind of closure for loved ones, and one would not need to deal with any of the horrors and indignities of carrying on day-to-day.

Would it not be better for society to allow for one to pass in this scenario?

A young person could contribute strong healthy organs, perhaps 12 lives could be saved.

At 23, assuming a normal life expectancy, the costs to society could be tens of millions of dollars.

There are lines that must never be crossed in organ donation, presumed consent or not.

The first goal must be to err on the side of life.

After much thought, it should always be morally wrong to raise the issue of organ donation while an individual is alive.

The definition of alive, in the most fundamental sense, is brain activity.

Sadly, there are situation where someone may be “brain dead” but still have fully functioning organ.

In this type of situation, presumed consent seems appropriate.

At present I understand that should an individual be brain dead; the person will be allowed to pass, and no organs would result from the passage.

In this scenario, I believe most people would want their organ donated and society would accept the donation; certainly, the recipient of the donation and their families would be forever grateful.

On the balance on probabilities that the individual would have consented had they known, which is impossible, and the public good that can arise from organ donation, it seems reasonable to accept presumed consent.

Even if, in the worst-case scenario, the organs were donated and weeks or years later it was discovered that the individual would not have supported the donation, where is the harm?

Any physical disposal on land must be done so in authorized locations.

For people to have faith in the system, we all need to believe and know that no one was “sacrificed”, or a life cut short to provide organs in a timely manner for a third party.

Presumed consent should not apply to donations to science.

The intent must be to save or improve lives in the immediacy of the moment.

It should be stated for clarity in the law, that using presumed consent to harvest or gain organs for reasons other than transplant would be a criminal offense.

Recommendation Eleven

Presumed consent should not be used to gain organs for science.

Recommendation Twelve

The substandard matters surrounding presumed consent should be on statute and not regulation.

List of Recommendations

Recommendation One

Any legislation on organ donation includes meaningful, empirical data and information that is both quantitative and qualitative.

Recommendation Two

A law must be clear on definitions.

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List of Exhibits for Submission to the Manitoba Law Reform Commission

1. Combating the Problems of Human Rights Abuses and Inadequate Organ Supply through Presumed Donative Consent

2. Consent for Organ Donation — Balancing Conflicting Ethical Obligations

3. Organ Donation poll

4. Letter from Honorable Steven Fletcher MLA to “Organ donation Task Force” March 1, 2017

5. Policy Forum: Do defaults really save lives?

6. The case for “Presumed Consent” in Organ Donation – The Lancet

7. Letters of support from members of Parliament and other issues related to Organ Donation

    - Letter from Len Webber, Federal MP 1/2
    - Letter from Len Webber, Federal MP 2/2
    - Letter From Ziad Aboultaif, Federal MP

8. Presumed consent approach to organ donation library Parliament 2014

9. Introduction of Gift of Life Act 2017

10. Hansard Index of debate on organ donation and hyperlinks to legislative website

11. Index of documents tabled regarding Bill 213 Gift of Life Act, Scholarly Literature Review on Organ Donation Challenges for Members of the Manitoba Legislature for Debate on Bill 213. October 31, 2017, Prepared by: Hon. Steven Fletcher MLA Assiniboia.

12. Media articles regarding organ donation.

13. 2017 and 2018 copy of Hon. Steven Fletcher’s Reply to the Speech from the Throne where organ donation is mentioned.

Exhibit 1

Combating the Problems of Human Rights Abuses and Inadequate Organ Supply through Presumed Donative Consent

Case Western Reserve Journal of International Law

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Combatting the Problems of Human Rights Abuses and Inadequate Organ Supply through Presumed Donative Consent

Christian William

Combatting the Problems of Human Rights Abuses and Inadequate Organ Supply Through Presumed Donative Consent

Christian Williams[*]

I. INTRODUCTION

Internationally, organ transplantation has been established as a feasible solution to the problem of end-stage organ failure. As medical technology and surgical techniques improve, the capability for successful organ transplantation grows, which in turn, allows people who were once classified as terminally ill to dramatically extend their lives.[1] As organ transplantation becomes a more available therapy, the demand for transplantable organs increases. Unfortunately, not all countries have taken measures to increase domestic supplies of transplantable organs in order to meet the rising demand. Part of the cause of some countries' organ shortages is the mixed goals of their organ procurement laws; in others, society's moral or cultural biases against organ harvesting prevents effective organ procurement. Some countries have not developed a comprehensive system of organ procurement, leaving those in need of an organ to find one for themselves.

Obviously, a shortage of transplantable organs results in death when potential recipients do not receive a transplant in time. However, other problems are developing due to the worldwide organ deficit. Internationally, one of the most pronounced problems is the human rights violations occurring as a result of the highly questionable, if not illegal, methods of satisfying organ demands.[2] The current shortage of legally collected

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[*] *J.D. Candidate, Case Western Reserve University School of Law (1994).*

[1] James Warren, *A Literal Gift of Life; Organ Donations Are Saving Lives, But a Shrinking Donor Pool has Caused Many to Re-Evaluate the System for Transplants*, L.A. TIMES, Oct. 18, 1992, at 14.

> One-year success rates for most organ transplants are in the 70% to 90% range; an astounding 300,000 tissue transplants are performed each year; more than 40,000 Americans regained their sight in 1991 because of a corneal transplant, and a new generation of powerful immunosuppressive drugs to treat rejection are in various stages of clinical trials and are expected to be available in the mid-1990s.

Id.

[2] *See* Audrey Magee, *MEPs Vote to Ban Trade in Organs for Transplant*, IR. TIMES, Sept. 15, 1993, at 2 (noting that "there was a chronic shortage of transplant organs which not only reduced opportunities to save lives but also increased the danger of fraud or even more serious crimes[]"). *See also infra* notes 33-77 and accompanying

organs is due to the lack of efficacy of most domestic laws, the lack of legislative consistency from nation to nation, and the lack of consistent and aggressive enforcement of such laws.[3] The variation between legal systems has allowed abuse of the simplest method of organ procurement — organ sales from live donors. This system is generally poorly regulated and fraught with health risks to both the donor and recipient. Often, it is the poorer citizens of developing countries who are supplying organs for the members of the upper class who can afford them, either directly or through organ brokers. However, when the organ, like any other valuable commodity, cannot be bought, it is stolen resulting in flagrant violations of human rights.

Since organ demand generally is not met through legal methods of collection,[4] there are a significant number of people suffering and dying in hospitals[5] who could not only be living normal lives, but expending fewer hospital resources.[6] An organ deficit forces doctors to decide which patient receives an organ and which one does not.[7] Desperate patients who feel they can no longer wait for an organ to be legally supplied, and who can afford the high cost, look to the black market for organs.[8] If the demand for human organs was met legally and cheaply, there would be little incentive to seek organs illegally. A legal high organ procurement rate would, therefore, lead to the eventual elimination of the human rights violations inherent in the human organ black market.

Assuming that saving lives is the goal of any organ procurement and transplantation program,[9] each nation should enact uniform legislation

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text.

[3] C.R. Stiller, *Ethics of Transplantation, in* ONTARIO MINISTRY OF HEALTH, ORGAN DONATION IN THE EIGHTIES: THE MINISTER'S TASK FORCE ON KIDNEY DONATION app. (1986).

> Efficiency varies tremendously from center to center both with respect to organ retrieval and organ transplantation. As a result, wide disparities in supply and demand occur with a resulting situation in which programs have excess organs while individuals in other locations, desperate for a transplant, become susceptible to a commercial endeavor.

Id. at 10.

[4] Charles K. Hawley, *Antitrust Problems and Solutions to Meet the Demand for Transplantable Organs*, 1991 U. ILL. L. REV. 1101, 1102.

[5] Thomas G. Peters, *Life or Death: The Issue of Payment in Cadaveric Organ Donation*, 265 JAMA 1302, 1302 (1991).

[6] Lloyd R. Cohen, *Increasing the Supply of Transplant Organs: The Virtues of a Futures Market*, 58 GEO. WASH. L. REV. 1, 39 (1989).

[7] Henry Hansmann, *The Economics and Ethics of Markets for Human Organs*, 14 J. HEALTH, POL. POL'Y & L. 57, 79 (1989).

[8] *See infra* notes 13-30 and accompanying text.

[9] This is not the goal of all organ procurement systems. *See infra* note 12.

allowing for the procurement of as many organs as possible from the potential pool of adequate cadavers and willing living donors. However, there are numerous restraints that differ greatly from region to region, country to country, and religion to religion, which prevent the thorough collection of organs.[10] These factors include, but are not limited to, the education of the public concerning the benefits of organ donation; the attitude of the public toward organ donation; the attitude of the government and health professionals toward organ collection; moral or ethical objections to organ donations resulting from religious or cultural traditions or enacted laws; the possible property rights the donor or his family might have in the organs; the civil or privacy rights the donor may have in the disposition of the body; the cost of the transplant operation; hospital resources for transplants; organ resources for transplants; political or social motives to be accomplished with organ donation; and the determination of time of death in relation to the usefulness of the cadaveric organs. The ideal legal philosophy should attempt to promote prodigious collection while retaining flexibility, so as to accommodate local objections to certain practices.[11]

Section II of this Note addresses the existence of international forces of supply and demand for transplantable human organs, and discusses why domestic organ demand is not limited to national borders. Section III documents the crimes being committed by individuals and states as a result of the worldwide inadequacy of organ procurement legislation. Section IV examines the current patchwork of domestic laws in an effort to determine what states can do to maximize the safe, effective, and socially equitable collection of human organs for transplantation.[12] Section V addresses the principles of international law under which one country can prosecute another country, or its nationals' for the absence of human rights abuses. Section VI concludes that the worldwide harmonization of domestic legislation, which would enact an organ procurement system,

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[10] *See infra* notes 78-230 and accompanying text.

[11] Cohen, *supra* note 6, at 11-12. The varying systems of organ procurement "have much in common as they are all motivated by similar values. Each seeks to preserve life and reduce suffering, and at the same time to honor the autonomy of the individual and respect the property right that he and his family have in his body." *Id.*

[12] It should be noted that while this is the general philosophy in organ procurement, not all states follow it. The U.S. Task Force on Organ Transplantation, in forming its organ procurement philosophy, "believed in the importance of developing organ transplantation policies that promote 'the value of social practices that enhance and strengthen altruism and our sense of community.'" James F. Blumstein, *Federal Organ Transplant Policy: A Time for Reassessment?*, 22 U.C. DAVIS L. REV. 451, 466 (1989) (quoting U.S. DEP'T OF HEALTH & HUMAN SERV., ORGAN TRANSPLANTATION: ISSUES AND RECOMMENDATIONS (1986)).

presuming the consent of the individual to donate organs while maintaining the option to withdraw consent, will best alleviate the demand for transplantable organs. This system should also provide a framework for the extraterritorial prosecution of human rights violators, thereby eliminating the existence of the black market.

II. THE EXISTENCE OF THE INTERNATIONAL MARKET IN HUMAN ORGANS

Modern techniques of organ transplantation have so substantially increased the viability of organ transplantation as a worldwide therapy that 300,000 people annually receive an organ transplant.[13] The medical advances in transplantation techniques, incredible for their growing success rate, have resulted in increased need for transplantable organs.[14] The advent of immunosuppressant drugs that increase compatibility between donors, preservation techniques that allow for increased organ life outside of the body, increased effectiveness of recipient registries, greater numbers of transplant teams that can transport organs, and more skilled surgeons who can perform the surgery has changed organ trans-

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[13] *Discovery Journal: The Great Organ Bazaar* (Discovery Channel television broadcast, Mar. 23, 1993) [hereinafter *Organ Bazaar*]. *See also* David Price & Ronnie Mackay, *The Trade in Human Organs*, NEW L.J., Sept. 20, 1991, at 1272 (stressing that "we have regularly witnessed in the field of transplantation procedures which, only a few years earlier, would have been viewed as incredible, even miraculous . . . [these] procedures have now ceased to be viewed as experimental, and are highly successful, almost standard treatments for certain conditions[]").

[14] In 1985, commentators had already noted that "the demand in recent years has risen significantly because [of medical] improvements . . . . Unfortunately, the supply of donor organs has not kept pace with the increased demand, resulting in greater shortages than ever before." Note, *Regulating the Sale of Human Organs*, 71 VA. L. REV. 1015, 1018-19 (1985). At that time, nearly 6,000 people were waiting on dialysis for a kidney transplant. *Hearing Before the Subcomm. on Investigations and Oversights of the House Comm. on Science and Technology*, 98th Cong., 1st Sess. 128 (1983) (testimony of Donald W. Denny). As of September 30, 1992, there were 21,492 registrations in the United States for a kidney transplant. Hartford Transplant Center, ORGAN AND TISSUE DONATION: WHAT ARE THE RESPONSIBILITIES OF THE INDIVIDUAL PHYSICIAN? (Sept. 30, 1992) (on file with the *Case W. Res. J. Int'l L.*). This number will continue to grow, as there are almost 1,000 new names added each month to the list of people waiting for an organ transplant. *Organ Bazaar*, *supra* note 13. As of early March, 1993, UNOS reported that over 31,000 people were waiting for an organ transplant in the United States. *UNOS Releases 1992 Transplant Statistics*, PR NEWSWIRE, Apr. 16, 1993, *available in* LEXIS, News Library, Prnews File. It has been estimated that there are another 75,000 candidates for an organ transplant who simply do not have the money to get on a waiting list. Scott Shepard, *Diamond Aims to Spark National Debate on Organ-Procurement Issues*, MEM. BUS. J., Aug. 16, 1993, at 14.

plantation from an experimental scientific phenomenon to an accepted solution to organ failure.[15]

Unfortunately, there have not been similar advances in creating laws that facilitate increasing the supply of organs to meet the demand.[16] The initial effect of the demand for transplantable organs was a deficit on the domestic level, with the effect on particular states determined by distinct supply and demand factors. Local demand for transplantable organs is determined by the number of patients diagnosed as potential organ transplant recipients.[17] With the increased availability of medical technology making organ transplantation more of a therapy, as opposed to an experimental option, the number of patients who could be saved, but die due to a lack of transplantable organs, also increases.[18]

However, according to current classifications of patients who need a transplantable organ, a sufficient supply of potentially transplantable organs exists to meet the demand for almost every type of organ.[19] The problem is that these potential donor organs are not being adequately collected by the states. This means that, on any given day, for each patient who dies for lack of a transplantable organ, an equal or greater number of viable organs are buried in the ground.[20] While some may look at this as merely a social problem, the forces of supply and demand in this allocation system have created a market, albeit a black market, for

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[15] Hawley, *supra* note 4, at 1106-07.

[16] DAVID MEYERS, THE HUMAN BODY AND THE LAW 182-83 (2d ed. 1990) (stating that "[t]here are many who feel that . . . legal problems are the greatest present impediment or roadblock to progress in human organ transplantation[]"). *See generally* Theodore Silver, *The Case for a Post-Mortem Organ Draft Act and A Proposed Model Organ Draft Act*, 68 B.U. L. REV. 681 (1988) (discussing the failure of current organ procurement laws to produce an adequate organ supply).

[17] Roger D. Blair & David L. Kaserman, *The Economics and Ethics of Alternative Cadaveric Organ Procurement Policies*, 8 YALE J. ON REG. 403, 413 (1991) (explaining that "[i]f kidneys were not employed as an input in the production of transplant operations, there would be no demand for these organs . . . demand is derived from the demand for transplant operations which, in turn, is derived from the demand for health[]").

[18] Cohen, *supra* note 6, at 4-5.

[19] *Id.* at 6 (stating that "the current untapped supply of cadavers appears to be more than adequate to meet the current demand of all organs, with the possible but doubtful exception of the heart[]").

[20] *Id.* at 4.

human organs.[21] It is obvious that in its current condition, most state allocation schemes are failing as effective suppliers of donor organs.[22]

These problems are not only are domestic, but increasingly, they take on an international dimension due to the failure of domestic allocation schemes and the increasing relative ease of organ transplantation. There are many reports of nationals of a particular country traveling to a foreign country in search of a transplantable organ.[23] The result is that patients are traveling to the countries with the fewest restrictions on the sources of organs and the methods of procuring these organs.[24] In the current international market, this is reflected by the fact that organs are being bought and traded, virtually unregulated, in some countries.[25] States that cannot meet their domestic demand are, in effect, forcing their citizens to travel elsewhere for life-saving treatment,[26] encouraging an international market that survives on violations of basic human rights and organ sales by the poor.

Such an international procurement scheme is ineffective and undesirable. The challenge is to identify the form the international market should take, and the domestic policies that would best encourage such an international market. States need to determine what rights they have under international law in creating minimum standards to be adhered to by other states. This challenge should be met, not only because it can have a

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[21] DAVID LAMB, ORGAN TRANSPLANTS AND ETHICS 135 (1990)

The sale of human organs is no longer a myth and the wealthiest can buy life at the expense of the underprivileged . . . . Very many countries, be they poor or very rich, are also confronted with the increasing development of an organ market, whatever the ostensible ethics and whatever the legislation.

Id. (quoting REP. OF THE CONF. OF EUR. HEALTH MINISTERS 15 (1987)).

[22] Hansmann, *supra* note 7, at 60 (noting that only 15% of the 20,000 viable United States organ donors actually had their organs harvested).

[23] *See infra* notes 13-30 and accompanying text.

[24] Maud Beelman, *Body Parts Needed for Transplants: Trade in Human Organs Stirs Global Attention*, L.A. TIMES, July 16, 1989, at A6 (stating that "[t]he forces of supply and demand in the desperate world of organ transplants have created a commercial trade in human organs that worries health officials and ethicists worldwide[]").

[25] RENÉE C. FOX & JUDITH P. SWAZEY, SPARE PARTS: ORGAN REPLACEMENT IN AMERICAN SOCIETY 68 (1992) (noting that "[b]y 1990, trafficking in 'human spare parts' was a booming business in developing countries such as India, which had no organized systems for procuring cadaveric donor organs, no brain death statute, and no specific laws banning the sale of human organs and tissues[]").

[26] *See generally* Charles P. Wallace, *For Sale: The Poor's Body Parts*, L.A. TIMES, Aug. 27, 1992, at A1 (noting that "[t]he wealthy are motivated by the fact that dialysis treatments, which can replace malfunctioning kidneys, are often prohibitively expensive and can severely restrict a patient's lifestyle[]").

positive impact on other states' markets, but because better organ procurement methods elsewhere will positively affect their own domestic market.[27] It is important for states to realize that the illegal trafficking of human organs cannot be categorized as just a violation of basic human rights. Such a crime is motivated, not by politics or religion, but by greed for the potentially great profit available to unscrupulous organ brokers dealing with both donors in dire need of money, and recipients in dire need of organs.[28] Therefore, laws that deal with such criminals should not be organized around policies that address primarily religious taboos and cultural mores; rather these laws should seek to avoid the victimization and exploitation of people, both domestically and internationally.

Ideally, every domestic system would operate in a similar, efficient fashion, such that international problems and abuses could be averted. Of course, this is quite unrealistic, if only because of the disparate medical resources that exist between countries. Domestic concerns have naturally been preeminent in formulating a national policy toward organ procurement.[29] However, it is not enough to limit policy decisions to immediate domestic concerns. States must be aware that failure to satisfy demand locally will have international ramifications. Similar to other international markets, repercussions of the ill effects created by some domestic markets in organ procurement will be felt by similar markets in other nations. For example, consider the spread of disease through foreign organ transplantation and the higher percentage of unnecessary organ recipient deaths due to the lax medical standards which often accompany lax legal stan-

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[27] If other countries' organ demands are met, nationals of those countries will have a much lower incentive to enter another domestic market for transplantable organs, thereby allowing a nation to allocate more organs for its own citizens. *See* Clarisse Lucas, *Egypt Becomes Crossroads for Trade in "Human Spare Parts,"* AGENCE FRANCE PRESSE, Jan. 26, 1992, *available in* LEXIS, News Library, AFP File (reporting that Egypt banned the sale of kidneys to foreigners to meet their own needs, since Egypt's rate of kidney failure is almost twice the world average). *See also* Judy Siegel, *France Bars Organ Transplants for Israelis*, JERUSALEM POST, June 29, 1992, *available in* LEXIS, News Library, Jpost File (explaining that a state has the right to exclude foreigners from procuring domestic organs). Also, for those who participate in international organ procurement agencies, such as Eurotransplant, the greater the number of organs that participating countries procure, the greater the number of organs available for all other participating countries. *See generally* Galina Vromen, *Dutch Organ Transplant Centre Gives Hope To Thousands*, REUTER LIBR. REP., Dec. 30, 1988, *available in* LEXIS, News Library, Reuwld File.

[28] It is not uncommon in Bombay for an organ broker to make as much money from the sale of the organ as the donor makes. *Organ Bazaar*, *supra* note 13.

[29] *See, e.g.*, Blumstein, *supra* note 12, at 452-56. *See also* T.K.K. Iyer, *Kidneys for Transplant — "Opting Out" Law in Singapore*, 35 FORENSIC SCI. INT'L 131 (1987).

dards.[30] These are two of the many growing international problems, as demonstrated in the following section.

III. PROBLEMS AND ABUSES OCCURRING DUE TO THE COEXISTENCE OF DIFFERENT LAWS AND PROCUREMENT SYSTEMS

Few nations are meeting organ demand locally and as a result, more people are traveling abroad hoping to acquire an organ. Transnational travel for transplantable organs provides the basis for the assertion that organ procurement must be examined as not just a collection of domestic allocation systems, but as an international market. The domestic allocation systems that are producing the fewest organs are essentially forcing their citizens in need of an organ to obtain a transplant in a state that does not have a shortage.[31] In our current international market, the nations that procure the greatest number of organs are those that allow their residents to sell their organs and have them removed while they are still alive. Unfortunately, empirical evidence suggests that this type of system "start[s] with unregulated organ removal and end[s] with a vicious traffic whereby the poor and uneducated [are] exploited in the interest of the wealthy."[32] Further, such systems allow for human rights violations to occur, and fail to meet medical standards that protect against the spread of disease and infection. While one can argue that these are problems endemic to a particular nation, and not the international market, careful examination reveals this to be false for two reasons. First, if domestic supply met domestic demand, people would not feel the need to travel to risky, abusive markets to obtain organs. Second, patients who do travel abroad to receive an organ sometimes return with a diseased or infected organ that needs immediate emergency treatment in the patient's home state.

Poor people are being exploited through unsafe, and often unethical, sales of their kidneys, for paltry sums of money.[33] While many may

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[30] Of 149 Singaporean kidney patients who went to India and China for transplants, nine died and another nine had to have their implanted kidneys removed. "The others returned with infections like hepatitis and AIDS, or had caught diseases like tuberculosis, chicken pox, and malaria from improperly screened donors." Lisa Kong, *The Kidney Lottery*, STRAITS TIMES, May 27, 1992, at L2.

[31] However, the market with excess organs must also be willing to sell to foreigners.

[32] LAMB, *supra* note 21, at 135.

[33] FOX & SWAZEY, *supra* note 25, at 66-67. Fox & Swazey relate that "a major newspaper has described the buying of kidneys from impoverished donors for transplantation in private hospitals in Western countries. Some donations were coerced, some for meager fees . . . . It seems clear that . . . the less privileged can be exploited to

consider this a problem, there are some who prefer to look at inter-vivos sales[34] as a maximization of resources, where the patient receives a much needed organ, and the donor receives some much needed money.[35] However, the numerous horror stories exemplifying such exploitation of the poor and needy do, themselves, border on human rights violations.[36] Additionally, the World Health Organization has condemned the trade in human organs.[37]

The list of human rights violations varies from state-sponsored activities to those which are undertaken by mafia-like organ brokers who arrange organ sales. The most common state-sponsored human rights violation is the procurement of organs from criminals, both executed[38]

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improve the health of the more privileged." *Id.* (quoting COUNCIL OF THE TRANSPLANT SOCIETY 716 (1985)).

[34] An inter-vivos sale is one between a live donor and a live recipient. Hence, only a non-necessary organ can be the subject of such a sale; for example, an eye, bone marrow, or a paired kidney.

[35] *See* Bjorn Edlund, *West German Baron in Controversial Organ Business*, REUTER LIBR. REP., Oct. 27, 1988, *available in* LEXIS, New Library, Reuwld File. In 1988, a West German baron attempted to start up an organ brokerage, offering live donors $44,000 to sell a kidney. His selling point was, "[e]ven if the recipient of the kidney does not survive — you will, both medically and financially." *Id. See generally Organ Bazaar*, *supra* note 13.

[36] In India, it was reported that a man sold one of his kidneys to raise money for drugs, and that he was willing to sell one of his eyes to buy more drugs. *India Moves Tough Bill to Stop Trade in Human Organs*, AGENCE FRANCE PRESSE, Aug. 20, 1992, *available in* LEXIS, News Library, AFP File [hereinafter *India Moves Tough*]. One desperate mother of four in Brazil was willing to sell her heart in return for jobs for her unemployed children. Lisa Genasci, *Organ Sales Legislation Could Cut Down Sales of Human Organs*, UPI, Nov. 8, 1986, *available in* LEXIS, News Library, UPI File. Loan sharks in Japan are reported to have accepted human organs as repayment for debts. Owen Bowcott, *UK Disciplinary Hearing Exposes Third World Market for Donor Organs*, REUTER TEXTLINE GUARDIAN, Apr. 5, 1990, *available in* LEXIS, News Library, Txprim File. Hotels in Cairo often put up young Somali, Nigerian, and Sudanese men who are looking for potential buyers for their kidneys. Lucas, *supra* note 27.

[37] FOX & SWAZEY, *supra* note 25, at 68 (noting that "[t]he World Health Organization thought that the practice had become so rampant and problematic that it issued a resolution condemning trafficking in human organs, asking member nations to take appropriate measures against it[]"); Gary Regenstreif, *Kidneys for Cash Increases, Sparks Moral Debate*, REUTER LIBR. REP., Aug. 23, 1989, *available in* LEXIS, News Library, Reuwld File.

[38] Mariana Wan & Simon Beck, *Organs of Prisoners Used in Ops*, S. CHINA MORNING POST, July 25, 1993, at 1, *available in* LEXIS, News Library, Schina File. A New York-based human rights group, Asia Watch, obtained a document dating back

and living.[39] According to a Bush administration study, a similar type of crime has occurred in Bosnia, where a Serbian internment camp doctor is alleged to have killed prisoners of war and removed their organs.[40] While these state practices are abhorrent, the organ brokers that prey upon the citizens of states that do not have effective organ procurement systems are even more disturbing. These type of human rights violations, many involving children,[41] have been reported in Poland,[42] Russia,[43]

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to 1984 entitled "Temporary Regulations Concerning the Use of the Corpses and Bodily Organs of Executed Criminals." This directive, allegedly issued by the six top government departments, including the Supreme People's Court and the Supreme People's Procuratorate, revealed that China has officially condoned the practice of harvesting organs from executed prisoners, despite official denials to the contrary. *Id. see also* Lynne O'Donnell, *Organs Ripped from Executed Chinese Prisoners Make Money*, REUTER LIBR. REP., Nov. 21, 1991, *available in* LEXIS, News Library, Reuwld File. In China, "[k]idneys are usually obtained from prisoners who are executed for offences [*sic*] such as rape, burglary, or political 'crimes' against the state . . . ." *Id.* (quoting Dr. Law Siu-Keung of Hong Kong's Queen Mary Hospital). Other sources have confirmed this claim. *See, e.g.*, Barbara Basler, *Kidney Transplants in China Raise Concern About Source*, N.Y. TIMES, June 3, 1991, at A1. A prominent renal specialist, Dr. M.K. Chan, explained that "[a]lmost all kidneys transplanted in China come from executed prisoners. That's the main source, along with a few donated by living relatives." *Id.* In one scenario described by the International League for Human Rights, if a patient needed an eye transplant, the prisoner was shot in the heart. O'Donnell, *supra* note 38. If a donor heart was needed, the prisoner was shot in the head. *Id.* The organs are used not only for Chinese patients, but are also sold abroad. *See* Alexandra George, *Australian Woman Travels to China for Executed Man's Kidney*, REUTER LIBR. REP., Sept. 5, 1990, *available in* LEXIS, News Library, Reuwld File. *See also* Basler, *supra* note 38; *Organ Bazaar*, *supra* note 13.

[39] "Filipino Death Row prisoners began donating organs in 1976 as a part of a program to reduce overcrowding without resorting to widespread executions . . . . [M]ost donor inmates avoided execution and some were freed after spending a few more years in prison." Beelman, *supra* note 24. This practice became part of an organ brokerage, in which Filipino prisoners were selling their organs through a Japanese middle man to Japanese patients. Isagani de Castro, *Philippines: For Sale Kidneys, at Bargain Prices*, INTER PRESS SERV., May 4, 1989, *available in* LEXIS, News Library, Inpres File. *See also* Suvendrini Suguro, *Japan: Controversy Brewing Over Overseas Organ Transplants*, INTER PRESS SERV., Aug. 12, 1988, *available in* LEXIS, News Library, Inpres File.

[40] Norman Kempster, *New Study Cites Thousands of Bosnia Atrocities*, L.A. TIMES, Oct. 23, 1992, at A4.

[41] *Human Organs Sold by Poor for Transplants, Conference Told*, XINHUA GEN. NEWS SERV., Aug. 22, 1989, *available in* LEXIS, News Library, Xinhua File ("Rosalie Bertell, a member of the International Commission of Health Professionals, said that children routinely disappear from the streets in some countries and are believed to be slaughtered for their organs, or sold for adoption and prostitution."). Children in need

Uruguay,[44] Italy,[45] Argentina,[46] and Brazil.[47] The problem is believed to be so severe that the United Nations has recommended an investigation into the existence of an international network of buying and kidnapping Latin American children for their organs.[48]

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of a transplantable organ present a unique problem because, in many instances, a child requires an organ from another child. Michael J. Butler, *The Law of Human Organ Procurement: A Modest Proposal*, 1 J. CONTEMP. HEALTH L. & POL'Y 195, 204 (1985), since an adult organ is often too large. Gordon Slovut, *Transplants: A Look Back, Ahead*, STAR TRIB., Sept. 30, 1993, at 1E. However, it is difficult to make a baby-to-baby transplant succeed, due to the powerful disease-fighting immune system of children. *Id. See also Euro MPS Seek Transplant Laws*, PRESS ASS'N. NEWSFILE, Sept. 14, 1993, *available in* LEXIS, News Library, Panews File.

[42] *Russian Mafia Controls Polish-German Trade in Kidneys*, PAP POLISH PRESS AGENCY, June 25, 1993 (alleging that "many Germans buy kidneys in Poland for 120,000 DM each and have doctors transplant them . . . . [T]he Russian mafia (also) exploits the anxieties of the terminally ill through press advertisements and direct contacts with hospitals, in order to sell transplant organs . . . . ").

[43] *See id.*; *Sales of Human Organs Thriving in Some Parts of the World* (National Public Radio broadcast, Nov. 27, 1993) [hereinafter *Body Parts Documentary*]. According to Colonel Yuri Dubiyegen, "[o]rgan transplantation is the most profitable business in Russia and it will grow. Everyone knows that you can get away with abducting people for a kidney or for any other organ and they're convinced the criminals can get off scot-free." *Id. See also* Anthony Boadle, *Film Exposes Black Market in Human Body Parts*, REUTER LIBRARY REPORT, Nov. 12, 1993, *available in* LEXIS, News Library, Reuwld File (Commercial documents obtained by the makers of a documentary entitled "The Body Parts Business" showed that one Russian company "sold 700 kidneys, hearts and lungs, 1400 livers, 18,000 thymus glands, 2000 eyes, and 3000 pairs of testicles, which are used for rejuvenating creams.").

[44] *Uruguay Cracks Ring Selling Human Organs*, CHI. TRIB., Nov. 27, 1991, at C10. Police arrested members of a trafficking ring that obtained organs from the poor and sold them for transplants abroad. Their largest market was Brazil. *Id.*

[45] *Italy: Denounce Traffic in Peruvian Children*, INTER PRESS SERV., May 28, 1991, *available in* LEXIS, Nsamer Library, Allnsa File. Italian police discovered a network of traffickers who were kidnapping children from Peru and Brazil, quite possibly to be used for their organs. *Id.*

[46] *Body Parts Documentary*, *supra* note 43. According to Bruce Harris, narrator of the documentary "The Body Parts Business," an Argentinean judge is investigating a state psychiatric clinic in Montes Dioca where it has been alleged that over 300 corneas have been stolen from the patients living there. *Id.*; Maria L. Avignolo, *Argentina: Children Robbed of Their Kidneys*, REUTER TEXTLINE SUN. TIMES, Dec. 8, 1991, *available in* LEXIS, World Library, Txtlne File (noting that Julie Cesar Araoz, the Health Minister of Argentina, reported that several children had been kidnapped, had an organ removed, and were sent back home with money in their pocket).

[47] Bowcott, *supra* note 36 (explaining that "[i]n Brazil, bodies have reportedly washed up on the beach, their kidneys surgically removed[]").

[48] Blair & Kaserman, *supra* note 17, at 416-17 (noting that "the World Health

As immunosuppressant drugs have become more effective in their role of decreasing organ rejection,[49] it has become easier to receive the organ of a stranger. Unfortunately, the medical standards at these "kidney-marts" are so poor that foreigners are being sent home with disease and infection.[50] Oman,[51] the United Arab Emirates,[52] Saudi Arabia,[53] Kuwait,[54] and Singapore[55] have all reported citizens returning home with

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Organization is encouraging member countries to outlaw organ sales . . . in part in response to undocumented reports that children from Brazil and Honduras were being sold to organ and tissue traders in other countries who were converting them into 'organ farms'"). *See also EP Debates Organ Transplants and Blood Transfusions*, REUTER EUR. COMMUNITY REP., Sept. 13, 1993, *available in* LEXIS, News Library, Reuec File; *UN Investigates Traffic of Children's Organs in Latin America*, NOTIMEX MEX. NEWS SERV., Aug. 6, 1992, *available in* LEXIS, News Library, Notimx File (reporting that children are kidnapped and bought as part of illegal traffic in organs that leads from Latin America into the United States, as well as Israel, Honduras, Guatemala, Paraguay, Mexico, and Brazil). It has been reported that a baby's kidneys can sell for £25,000, and its heart for £55,000. William Vanvolsem, *Britain Linked to Baby Smuggling*, DAILY TELEGRAPH, Aug. 13, 1993, at 10. *But see* Linda Feldman, *Soviets Smile, But Fake Stories Continue*, CHRISTIAN SCI. MONITOR, Sept. 6, 1988, at 1 (claiming that reports of Latin American children being kidnapped and slaughtered for their organs by the United States are rumors that are being perpetuated by the Soviet government); David Schreiberg, *Postcard — Mexico: Dead Babies; Persistent Media Sensationalism Keeping False 'News' Story of American Kidnapping of Mexican Children for Organ Piracy*, NEW REP., Dec. 24, 1990, at 12.

[49] *See* Sharon Begley, *Cyclosporine: The Breakthrough Drug*, NEWSWEEK, Aug. 29, 1983, at 41.

[50] Thomson Prentice, *Bombay Is Accused Over Kidney Deaths*, THE TIMES, Sept. 21, 1990, *available in* LEXIS, News Library, Times File (stating that "[t]he HIV epidemic in Bombay is expected to spread wildly since infected people continue to sell blood. Only 5 percent of the blood is checked for HIV, and the virus can be transmitted by a kidney graft even when the donor tests negative."). *See also* Wallace, *supra* note 26 (reporting that "[o]ne facility in southern China, which performs transplants by day, is a disco at night[]").

[51] *Organ Bazaar*, *supra* note 13 (illustrating that one in fifteen Omanis who received an organ transplant abroad contracted the HIV virus, and many have died); Oswald Pereira, *Oman Warning on Kidney Transplants*, MIDDLE E. NEWS NETWORK, July 9, 1992, *available in* LEXIS, News Library, Menn File ("At least five Omani patients who went abroad for kidney transplants ha[ve] died of surgical complications.").

[52] Prentice, *supra* note 50 ("Twenty-four Arabs who had kidney transplants with organs they bought from living donors in India died within a year of their operation.").

[53] Habib Trabelsi, *Wealth Corrupts Kidney Health in the Gulf*, AGENCE FRANCE PRESSE, Mar. 20, 1992, *available in* LEXIS, News Library, AFP File ("[T]hose seeking [cheaper] Indian kidneys returned with organs taken from people suffering from AIDS, viral hepatitis, or syphilis.).

[54] *AIDS Brought to Kuwait From Abroad*, ARAB TIMES, Dec. 13, 1992, *available*

an organ that was potentially more life-threatening than the one removed. Note, however, that substandard medical practices also plague intra-state organ transplantation.[56] These lax medical standards are a result of lax legal standards allowing the sale of transplantable organs between virtually any two individuals who enter the transplantation clinic.

As a result of these various offenses, a number of "problem" countries where commercial organ sales flourish, as well as many other countries, have decided to ban the practice.[57] Some of these countries include the Philippines,[58] Egypt,[59] Hong Kong,[60] Thailand,[61], Japan,[62] the United Arab Emirates,[63] Russia,[64] Venezuela,[65] Singapore,[66] Ar-

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in LEXIS, News Library, Nonus File.

[55] *India "May Ban Trade in Organs by End of Year,"* STRAITS TIMES, May 1, 1992, at 30 [hereinafter *India May Ban*].

> A Singapore General Hospital study of patients from 1986 to May [1991] showed that about 150 of the patients who went to India and China returned with serious diseases and infections such as hepatitis and AIDS. Nine died, and another nine had to have their kidneys removed because of infection and rejection.

Id.

[56] *See Kidney Transplant Patients Infected With Leukemia Virus*, KYODO NEWS SERV., May 15, 1993, *available in* LEXIS, News Library, Nonus File (noting that three Japanese kidney transplant patients from a Hokkaido hospital were infected with a leukemia virus because of unconfirmed donor blood tests).

[57] FOX & SWAZEY, *supra* note 25, at 68 (reporting that "[b]y 1989 more than 20 countries had instituted political or legal provisions against commerce in organs[]").

[58] *Bill Banning Selling of Vital Human Organs Submitted*, JAPAN ECON. NEWSWIRE, May 23, 1989, *available in* LEXIS, News Library, Jen File.

[59] Lucas, *supra* note 27.

[60] Carol Scott, *Hong Kong: Organ Traders Face Jail Term*, S. CHINA MORNING POST, Mar. 28, 1992, *available in* LEXIS, News Library, Txprim File. *See also Commercial Organ Trading Banned in Hong Kong*, XINHUA GEN. NEWS SERV., Mar. 27, 1992, *available in* LEXIS, News Library, Xinhua File.

[61] *Thailand to Ban Organ Trade*, XINHUA GEN. OVERSEAS NEWS SERV., June 23, 1989, *available in* LEXIS, News Library, Xinhua File.

[62] Masako Takuma, *Brain Death Recommendation Spurs Action*, NIKKEI WEEKLY, May 16, 1992, at 24, *available in* LEXIS, News Library, Nikkei File; Michael C. Brannigan, *A Chronicle of Organ Transplant Progress in Japan*, 5 TRANSPLANT INT'L 180, 182 (1992). After the Act Concerning the Transplantation of Cornea and Kidneys was passed in Japan in 1979, a modification was passed in March, 1980 prohibiting organ sales. *Id.*

[63] *Organ Transplant Allowed in UAE*, KHALEEJ TIMES, Nov. 19, 1992.

> Trading in human organs is prohibited and if it comes to the knowledge of a doctor that the organ has been obtained through pecuniary considerations, he should not perform the transplant . . . . Those violating the law will render themselves liable to jail terms and a fine not exceeding Dh30,000 or both.

Id.

[64] Svetlana Tutorskaya, *Henceforth, Donated Organs Cannot be Bought and Sold*,

gentina,[67] Uruguay,[68] France,[69] Canada,[70] the United States,[71] the United Kingdom,[72] and the European Parliament.[73] A number of coun-

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CURRENT DIG. OF THE POST-SOVIET PRESS, Feb. 17, 1993, at 6 (noting that the law states that if Russian legal norms do not conform to international ones, international norms will prevail).

[65] Jack C. Rodriguez, *Organ Transplants in Venezuela*, 1 INT'L J. MED. & L. 121, 122 (1979) (noting that article 6 of the Law of Transplants in Venezuela, passed in December, 1970, enumerates the punishments in criminal courts for those "engag[ing] in commerce with viscera . . . . "); Luis Cordova, *Venezuela: Police Case Reveals Problems in Organ Transplants*, INTER PRESS SERV., May 22, 1990, *available in* LEXIS, News Library, Inpres File.

[66] Human Organ Transplant Act, 1987, pt. IV, §14 (Sing.), *reprinted in* REPORT OF THE SELECT COMMITTEE ON THE HUMAN ORGAN TRANSPLANT BILL [Bill No. 26/86] [hereinafter Sixth Parliament Report].

> (1) Subject to this section, a contract or arrangement under which a person agrees, for valuable consideration . . . to the sale or supply of any organ or blood from his body or the body of another person . . . shall be void. (2) A person who enters into a contract or arrangement of th[is] kind . . . shall be guilty of an offense.

Id.

[67] CODIGO PENAL DE LA NACION ARGENTINA [COD. PEN.], Ley 21.541, art. 29, *as amended by* Ley 23.464 (Eduardo Carlos Hortel ed., 4th ed. 1989) (Arg.). Anyone caught selling or who has the intention of selling organs or other anatomical materials from persons or cadavers will be sentenced to six months to five years in prison. This law also applies to foreigners, and contains a provision for a harsher sentence if the individual is a repeat offender. *Id.*

[68] CODIGO PENAL DE LA REPUBLICA ORIENTAL DEL URUGUAY [COD. PEN], Ley 14.005 de 17 Agosto 1971, § 34, art. 14, (Antonio Camaño Rosa ed., 3d ed. 1980) (Uru.) (indicating that the transfer of organs or tissues for money or other consideration is punishable by six months to four years in prison, and that it is also illegal to receive money for the actual transplantation of an organ that has been bought).

[69] Loi No. 76-1181, 1976 J. OFFICIEL DE LA RÉPUBLIQUE FRANÇAISE 7365, art. 3, *reprinted in* 1977 RECUEIL DALLOZ SIREY: DE DOCTRINE DE JURISPRUDENCE ET DE LÉGISLATION 13 (Without prejudice to the reimbursement of all costs that may occur due to the removal of an organ done in accordance with law, one may not give the donor any monetary compensation for the organ.).

[70] Human Tissue Gift Act, R.S.O., ch. 210, §10 (1980) (Can.), *reprinted in* Randy W. Marusyk & Margaret S. Swain, *A Question of Property Rights in the Human Body*, 21 OTTAWA L. REV. 351, 363 (1989). No person shall buy, sell, or otherwise deal in, directly or indirectly, for a valuable consideration, any tissue for a transplant, or any body part or parts thereof other than blood or a blood constituent, for therapeutic purposes, medical education, or scientific research, and any such dealing is invalid as being contrary to public policy.

Id.

[71] 42 U.S.C. § 274e(a) (1988) ("It shall be unlawful 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.").

[72] Human Organ Transplants Act, 1989, ch. 31, §1 (Eng.).

tries, including Poland,[74] India,[75] and China,[76] are considering banning or limiting organ sales.[77] However, the question lingers whether such bans will be effective in stopping the trade, or whether it will only succeed in driving it underground.

IV. CURRENT LEGISLATIVE PHILOSOPHIES USED IN THE PROCUREMENT OF HUMAN ORGANS

A vast range of organ procurement systems has been employed by different nations, with some states switching from one strategy to another in the process of searching for the most effective system.[78] Typically, these systems attempt to balance the need to maximize the number of organs procured, and the restraints that religious, ethical, constitutional,

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> A person is guilty of an offense if in Great Britain he . . . makes or receives any payment for the supply of, or for an offer to supply, an organ which has been or is to be removed from a dead or living person and is intended to be transplanted into another person whether in Great Britain or elsewhere.

Id.

[73] The European Parliament adopted two resolutions on September 14, 1993: one calls for the unpaid donations of blood; while the other calls for a prohibition on the trading of human organs. Magee, *supra* note 2, at 2.

[74] *The Transplant People*, THE WARSAW VOICE, June 20, 1993 (reporting that the proposed law would make trading and transplanting commercially obtained organs illegal).

[75] *Organ Bazaar*, *supra* note 13. The Indian Parliament has proposed banning organ sales because they are unethical, and they will be harmonizing their law with the World Health Organization. Experts doubt such a ban will occur because of the fear that all the ban will do is drive kidney sales underground and make them much more dangerous. *Id. See also India May Ban*, *supra* note 55; *India Moves Tough*, *supra* note 36; *India to Outlaw Trade in Human Organs*, XINHUA GEN. NEWS SERV., Nov. 4, 1991, *available in* LEXIS, News Library, Xinhua File.

[76] *China to Crack Down on Organ Sales for Transplant*, REUTER LIBR. REP., Oct. 6, 1992, *available in* LEXIS, News Library, Reuwld File.

[77] The Council of Europe has also issued a recommendation to Member States urging a prohibition of organ sales. *Res. of the Comm. of Ministers*, Eur. Consult. Ass., Res (78)29, art. 9 (1978), *reprinted in* Council of Europe, *Removal, Grafting and Transplantation of Human Substances*, 1 INT'L J. MED. & L. 385, 387 (1979).

[78] Sixth Parliament Report, *supra* note 66, at A7-A10. Singapore decided in 1987 to switch organ procurement strategies from voluntary donations to a presumed consent system due to the ineffectiveness of the voluntary system, as well as to the success of the Spanish change from voluntary donations to presumed consent. *Id.* The Report notes that "[w]hen [Spain] introduced the [presumed consent] law in 1979 the number of transplantations was 100. But by 1984, the figure had shot up to 1000." *Id. See also* Tan L. Khoon, *Organ-Donation Law: A Necessary Transplant?*, 7 SING. L. REV. 1 (1986); Iyer, *supra* note 29.

and property rights put upon the legislature.[79] Some procurement strategies have ulterior motives, such as promoting a sense of community and volunteerism[80] or creating a profit.[81] Other states have not acted at all, creating a legal vacuum and a potential of extreme abuses.[82] Though a state's legislative body may evince a desire to procure as many organs as possible, while avoiding any restraints upon the procurement rate, legislative action typically occurs only in response to a particular factual situation requiring immediate action.[83] In the United States, the National Organ Transplant Act[84] was enacted in 1984 for the dual purposes of countering a proposal by Dr. H. Barry Jacobs M.D. to establish a brokerage in human kidneys from healthy, live donors,[85] as well as to firmly establish that voluntary donations were the method of choice in the United States. This enactment made the sale of human organs a federal crime.[86] In England, the Human Organ Transplant Act[87] was enacted in 1989 after the revelation of the story of a destitute Turkish citizen who

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[79] *See generally* Hansmann, *supra* note 7 (discussing restraints placed on organ procurement); Silver, *supra* note 16, at 694 (discussing the competing interests balanced by the authors of the 1968 Uniform Anatomical Gift Act).

[80] Blumstein, *supra* note 12, at 466.

[81] In China, "[c]ircumstancial evidence is accumulating that . . . the transplant business [is being turned into] a source of hard currency." Ronald Bailey, *Should I Be Allowed to Buy Your Kidney*, FORBES, May 28, 1990, at 365. In the past decade, eleven thousand people have reportedly been executed with a shot in the head, a method that is preferred because it maximizes a doctor's chances of harvesting viable organs from the prisoner's body so they can be transplanted into foreigners. *Id. See also Peking Offers Organ-Transplant Service by Shooting Prisoners*, CENT. NEWS AGENCY, July 5, 1990, *available in* LEXIS, News Library, Cenews File; O'Donnell, *supra* note 38. Cuba has also expressed the desire to profit from organ transplantation to foreigners. Bernd Debusmann, *Cuba Hopes to Become International Medical Centre*, REUTER N. EUR. SERV., July 4, 1986, *available in* LEXIS, News Library, Reuwld File.

[82] FOX & SWAZEY, *supra* note 25, at 68.

[83] Butler, *supra* note 41, at 201 (noting that a flurry of legislation in the United States was prompted by the "mere possibility" that organs would be traded).

[84] National Organ Transplant Act, Pub. L. No. 98-507, 98 Stat. 2339 (codified as amended at 21 U.S.C. § 321 (1988), 42 U.S.C. §§ 273-274e, 1395 (1988)).

[85] FOX & SWAZEY, *supra* note 25, at 65. Dr. Jacobs was the founder and director of International Kidney Exchange, Inc. This brokerage company wrote to 7500 hospitals in the hopes of starting an international market using the purchased kidneys of the disadvantaged to sell to Americans. In addition to stirring the United States Congress, Jacobs' plan also was denounced by The National Kidney Foundation, The Transplantation Society, the American Society of Transplant Physicians, and the American Society of Transplant Surgeons. *Id. See also* Note, *supra* note 14, at 1021-22.

[86] 42 U.S.C. § 274e (1988).

[87] Human Organ Transplants Act, 1989, ch. 31, §1 (Eng.).

had traveled to London in order to sell his kidney.[88] This act like the others, also prohibits organ sales. The hasty consideration and passage of each of these laws has recently been criticized by various commentators who are urging reconsideration of these laws as well as calling for a lifting of the ban on organ sales.[89] If these, and other countries, decide to reconsider their laws, they must remember that while organ procurement can be an emotional issue, emotion should not be the controlling factor; rather, analysis of the best method for reasonably increasing the number of organs procured must be the guiding principle.

Currently, four types of procurement systems are employed, or have been given serious consideration, by various countries. While no system has yet proven itself perfect, each possesses certain advantages and disadvantages that make it possible to consider one superior to all others. This section attempts to explore each of these systems and enumerates their differing characteristics.

A. No Domestic Organ Procurement: Importation of Organs and Traveling to Other States to Obtain Organs

There are only a few nations that have no organ procurement strategy, usually because of certain cultural taboos that are so strong that organ procurement cannot be justified. Japan and Iran are examples of these countries.[90] Although Japan has had a donor card system in place since 1977,[91] its Health and Welfare Ministry has only recently proposed setting up an organ procurement information network.[92] Strong Buddhist

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[88] Diana Brahams, *Kidneys for Sale: Legislation is Needed*, 57 MEDICO-LEGAL J. 73, 74 (1989).

[89] *See* Prerna M. Khanna, *Scarcity of Organs for Transplants Sparks a Move to Legalize Financial Incentives*, WALL ST. J., Sept. 8, 1992, at B1; David Price & Ronnie MacKay, *The Trade in Human Organs*, 141 NEW L.J. 1307 (1991).

[90] The Iranian Parliament recently rejected a bill that would have allowed family members to voluntarily donate the organs of brain dead donors. *See Iran Rejects Transplant Bill*, THE INDEPENDENT, Sept. 27, 1993, at 12 [hereinafter *Iran Rejects*]. Although the Ayatollah Khomeni issued a decree in 1986 permitting organ transplantation, and Iran's present spiritual leader, Ayatollah Ali Khamenei, as well as Iran's president, Ali Akbar Hashemi Rafsanjani, also endorsed organ transplantation, the bill was apparently rejected on religious grounds. *See Iran Rejects*, *supra* at 12; *Rafsanjani Encourages Donation of Organs of Dead*, AGENCE FRANCE PRESSE, Aug. 14, 1993, *available in* LEXIS Nexis Library, AFP File.

[91] Brannigan, *supra* note 62, at 182. Subsequently, Japan also stipulated that family consent had to be obtained, and that no particular recipient was needed at the time of removal. *Id.*

[92] *Organ Transplant Info and Liaison Network Launched*, REP. FROM JAPAN, Feb.

and cultural traditions that forbid removal of organs because of a belief that the corpse must be buried intact,[93] coupled with transplant physician mistrust,[94] and a refusal to legislatively define death as brain death instead of cardio-pulmonary death,[95] have resulted in a virtual absence of donor organs in Japan.[96] Japan satisfied kidney demands through American imports through the mid-1980's,[97] and continues to import eyes, corneas, serum, and blood.[98] Demand for kidneys and other organs today is substantially met through travel abroad to reportedly buy or otherwise obtain organs from donors in India,[99] Sri Lanka,[100] the Philippines,[101] China,[102] Australia,[103] and elsewhere.[104]

Recent concern over Japan's "international reputation as a consumer of body parts that can't be obtained at home,"[105] and the fear of "transplant friction" joining "trade friction" is adding to international anger toward the Japanese over perceived unfairness.[106] These factors have helped prompt probable reform of this system of procurement, by resulting in proposals for the establishment of a brain-death law,[107] transplant

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3, 1992, *available in* LEXIS, News Library, Rptjap File.

[93] Yutaka Sato, *A Buddhist Perspective on Transplants*, NIKKEI WEEKLY, May 16, 1992, at 24, *available in* LEXIS, Nexis Library, Nikkei File. According to Buddhist tradition, "even the nails or hair of the dead retain connection to the soul . . . ." *Id. See also* Brannigan, *supra* note 62, at 182, 183.

[94] Brannigan, *supra* note 62, at 182.

[95] Itaru Oishi, *Brain-Death Debate Keeps Organ-Donor Controversy Alive*, NIKKEI WKLY., July 27, 1991, at 2, *available in* LEXIS, Nexis Library, Nikkei File.

[96] Brannigan, *supra* note 62, at 182 ("In 1988, 11,895 of the 88,534 chronic dialysis patients were on the waiting list for kidneys from cadavers. Yet the average number of cadaver kidney transplants in Japan remained under 200 per year.").

[97] Sam Jameson, *Japan in Search of its Heart*, L.A. TIMES, Feb. 22, 1992, at A1 (showing that the importation ended when American suppliers balked).

[98] *Id.*

[99] *Id.*

[100] *Id.*

[101] *Id.*

[102] *Id.*

[103] Brannigan, *supra* note 62, at 185 ("By 1987, 22 Japanese had gone to Australia for liver transplants."); Oishi, *supra* note 95, at 2; Emiko Terazono, *Survey of Japan*, FIN. TIMES, July 14, 1993, at 14.

[104] Brannigan, *supra* note 62, at 185. Forty children with biliary atresia, a liver disease, have sought transplants overseas. There has also been media attention given to Japanese transplants in Canada and London. *Id.*

[105] *Id.*

[106] Jameson, *supra* note 97, at A1.

[107] Brannigan, *supra* note 62, at 185 (noting that by the end of 1990, 47% of the Japanese generally, and 65% of the professionals, favored brain-death criteria; addition-

hospitals,[108] and a national transplant network center.[109] In a world market that suffers from a lack of a safe and reliable supply, importation of organs is perhaps the least reliable method of organ procurement.[110]

B. Voluntary, Non-Pecuniary Donation of Human Organs

Though the precise form may differ across jurisdictions, the principle behind voluntary donation is that the donor freely gives prior consent to a medical team to remove the needed organs. By law, no financial remuneration is allowed for the organ donor, beyond any expenses incurred in connection with the harvesting of the organ from the donor.[111] The voluntary donor can be living or dead, though most often it is a cadaveric donor.[112] The motivation behind donation in such a system varies: altruism,[113] coercion,[114] and moral duty[115] have all been cited as incentives. The voluntary donor allocation system seeks to avoid

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ally, numerous government task forces and commissions are looking into the feasibility of a brain-death law). *See also Diet Panel Urges Organ Transplant Bill*, YOMURI NEWS SERV., May 20, 1993, *available in* LEXIS, News Library, Nonus File (noting that a Diet panel urged early passage of laws allowing organ transplantation, including a brain-death law); *Japan Moves Toward Allowing Heart Transplants*, REUTER LIBRARY REPORT, Dec. 3, 1993, *available in* LEXIS, News Library, Reuwld File (Japan currently is considering a bill that, while not officially defining brain death as the legal definition of death, would allow brain-death criteria to be used when considering the removal of an organ for transplant.).

[108] *See Five Hospitals Determined Suitable for Liver Transplants*, KYODO NEWS SERV., June 14, 1993, *available in* LEXIS, News Library, Jen File.

[109] *See Group Calls for National Organ Network*, YOMURI NEWS SERV., May 12, 1993, *available in* LEXIS, News Library, Nonus File.

[110] Another country that has practiced importation as an organ procurement technique is India, which imports eyes from Sri Lanka. M. Zakaria Siddiqi, *Legal Issues in Human-Organ Transplant: Indian Perspective*, 7 ISLAMIC & COMP. L. Q. 144, 159 (1987). India, however, is not alone. As of 1987, Sri Lanka had exported 19,664 pairs of eyes to 133 cities in 53 countries. *Id.*

[111] Cohen, *supra* note 6, at 12.

[112] Irwin Kleinman & Frederick H. Lowy, *Ethical Considerations in Living Organ Donation and a New Approach: An Advance-Directive Organ Registry*, 152 ARCH. INTERN. MED. 1484, 1485 (1992).

[113] Ann McIntosh, *Regulating the "Gift of Life" — The 1987 Uniform Anatomical Gift Act*, 65 WASH. L. REV. 171, 178 (1990).

[114] Kleinman & Lowy, *supra* note 112, at 1485 (noting that if a close relative's life is in the balance, donation is probably not "voluntary," but rather, coerced). *See also* Note, *supra* note 14, at 1034.

[115] *See* David Peters, *A Unified Approach to Organ Donor Recruitment, Organ Procurement, and Distribution*, 3 J. L. & HEALTH 157, 167-77 (1990).

the commercialization of organs on the premise that such an act is contrary to societal values.[116] However, numerous commentators, bolstered by public opinion polls,[117] have argued that the public is willing to accept financial incentives to increase organ procurement. Additionally, other programs, such as required request, mandated choice, and family consent are used to further bolster voluntary donations. Such programs have been implemented in nations that have found the altruistic incentive that a voluntary system offers is insufficient to meet the demand for transplantable organs.

1. Voluntary, Inter-Vivos Donations

Donation of a paired organ, such as a kidney, and the donation of other replenishable bodily products such as blood, plasma, skin, and bone marrow[118] are all possible by living donors. Other more unconventional, albeit possible, donations by living donors are feasible, including eyes,[119] testicles,[120] and parts of livers.[121] States that allow voluntary donation by living donors generally limit the potential donors to family members, on the belief that a non-family member has no real incentive to donate, and therefore, could actually be selling the organ.[122] States that have not enacted a brain-death law, yet want to avoid commercialization of organs, find themselves in the odd position of allowing only voluntary, inter-vivos donations. Such a procurement strategy results in few organs and, in effect, encourages human rights violations through organ procurement practices.[123]

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[116] Note, *supra* note 14, at 1034.

[117] Warren, *supra* note 1. In a recent poll, 56% of the United States public stated they would be willing to purchase an organ for a loved one if necessary. *Id.* Another poll found that 52% favored some sort of financial compensation for human organs, while only 22% opposed any compensation. *Id.*

[118] Siddiqi, *supra* note 110, at 144-45.

[119] *Id.* at 150 (noting that this practice is generally considered morally and ethically wrong).

[120] Chris Wood et al., *The Transplant Revolution*, MACLEAN'S, Nov. 23, 1987, at 34, 36. Doctors at the Hubei Medical College in Wuhan, China, transplanted a functioning testicle from father to son. The recipient has since had a child, who according to geneticists, is the father's half-brother. *Id.*

[121] Thomas H. Maugh, *Liver Transplant Technique Seen Having Impact Overseas, Posing Ethical Problems*, L.A. TIMES, Nov. 30, 1989, at A23.

[122] Price & MacKay, *supra* note 89, at 1307 (commenting on the British Human Organ Transplant Act). Such an attitude, however, ignores the incentives one would have in donating to a friend.

[123] Genasci, *supra* note 36. In Brazil, which has no brain-death law, 80% of the

2. Voluntary, Cadaveric Organ Donations

The cadaveric organ donor can donate at least twenty-five different body parts and fluids.[124] Most, though not all, of the organs and tissues that are collected from such an individual must be harvested while the heart and lungs are still oxygenating the body, despite the fact that the person is brain dead. Therefore, in order for such a program to work the country must have a brain-death law, because once the heart dies, the other organs die as well, and are useless for transplantation. There must also be some system through which the donor can indicate a willingness to donate, whether it is through a computer registry, the carrying of an organ donor card, executed through a will, or is indicated on a driver's license.

Altruism has been cited as the primary incentive for citizens during their lives to volunteer to donate their organs after death.[125] "Proponents of an altruistic system of organ recovery identify social benefits of the process of donation. Organ donation affirms socially valued human interactions. The donor's experience in enhancing or saving another's life brings the social community together."[126] Altruism was the guiding principle used by lawmakers in the United States in formulating the National Organ Transplant Act.[127] It was believed that commercial sales might lead to the collapse of the voluntary organ donor system, and result in an overall decrease in available organs.[128]

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kidneys for transplant come from relatives. The result is that out of 50,000 potential kidney transplant candidates in Brazil (determined by the World Health Organization), only 500 received kidney transplants. *Id.* Additionally, Brazil has been cited numerous times as a nation where human rights violations occur in connection with organ procurement.

[124] Cohen, *supra* note 6, at 3. This list of organs available from a cadaveric donor includes parts of the inner ear, a variety of glands — pancreas, pituitary, thyroid, parathyroid, and adrenal — blood vessels, tendons, cartilage, muscles — including the heart — testicles, ovaries, fallopian tubes, nerves, skin, fat, bone marrow, blood, livers, kidneys, corneas. *Id.* Lungs, fetal brain tissue, plasma, semen, ova, stomachs, small intestines, and eyes can also be added to this list.

[125] McIntosh, *supra* note 113, at 178.

[126] *Id.*

[127] Note, *supra* note 14, at 1034.

[128] *Id.* at 1033. This actually has occurred in Oman, where voluntary organ donations are virtually non-existent, since those needing an organ — specifically a kidney — travel to India to purchase one. *Organ Bazaar*, *supra* note 13. One Omani transplant surgeon reported that he had not performed organ transplant surgery in eight months,

It seems, however, as if "altruism" is a procurement method preferred by medical professionals[129] and the government, but not the market. Generally, the effectiveness of voluntary donation in producing maximum organ procurement is poor, though exceptions do exist.[130] There has been such a consistent lack of organs procured by such a system that various laws have been introduced to increase voluntary donation. One of these laws is the required request law that mandates that the attendant doctor or nurse ask the next of kin of a viable organ donor if the patient's organs may be donated.[131] The problem with such a system is that often the physician does not ask the family if they wish to donate the deceased's organs.[132] Additionally, many doctors still ask for familial consent even though the deceased carried an organ donor card which unequivocally gave prior consent.[133] While such a system has had

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since there were no organs to transplant. He attributed the organ shortage directly to the organ sales occurring in India. *Id.* Relatives of one Omani with end-stage renal failure refused to donate one of their own kidneys, knowing that there are those in India who will sell one kidney, and bear the risk of living with only one. *Id.*

[129] *Health Care Professionals Oppose Financial Incentives for Organ Donation*, PR Newswire, Apr. 14, 1992, *available in* LEXIS, News Library, Prnews File. "[O]rgan donation will be better off if we keep commercialism out of what should be an act of good will," according to Dr. Russel H. Patterson, Jr., chief of neurosurgery at the New York Hospital-Cornell Medical Center. *Id.*; *see also* Warren, *supra* note 1 (noting that "[a] number of polls of health care professionals have found a significant majority — 60% to 80% — firmly oppose offering payment for donation . . . . "). It is important to note, however, that the transplant doctors and nurses, the hospitals, the organ transport teams, the organ registries, and the drug companies, all receive payment or government funding.

[130] Ireland, which relies on an informal principle of informed consent of donors and their next of kin, has the one of the highest number of organ donors in Europe. Magee, *supra* note 2, at 2. Although Ireland currently enjoys a procurement rate of 20 donors per million — as compared with the 18 per million in the United States and 15.1 per million in Britain, Trish Hegarty, *Reduction in Kidney Transplants Worries Medical Authorities*, IR. TIMES, Aug. 27, 1993, at p. 2, and Austria's 60 per million, *Changes Needed to Get More Kidneys*, STRAITS TIMES, May 27, 1992, at L2 — Ireland's donation rates are leveling off, or possibly even declining. Hegarty, *supra* note 130, at 2.

[131] Cohen, *supra* note 6, at 21.

[132] John George, *Up for Debate: Improving Odds for Those Awaiting Transplants*, PHILA. BUS. J., Dec. 2, 1991, at 1. A recent study has found that routine request laws were typically being ignored. Among participating hospitals in the Delaware Valley Transplant Program, it was found that "nearly half of potential organ donors were overlooked." *Id.*

[133] Wood et al., *supra* note 120, at 35. One Canadian source noted that "most doctors honor surviving relatives' decision not to donate their loved one's organs —

the effect of increasing organ donation in the United States, there is still a vast organ deficit that voluntary donation has not solved.[134]

The resulting lack of procured organs has led some commentators to suggest that an incentive would increase organ donations. The only proposal which does not involve some sort of financial compensation is one that would give avowed organ donors priority in receiving organs should the situation arises in which the subject donor needed transplant surgery.[135] One objection to such a proposal is that it discriminates against those who refuse to donate for "valid" religious reasons.[136] Another is that it discriminates against the procrastinating donor.[137] Still another is that it may erode the incentive of pure altruism.[138] Priority may not be an effective market incentive in the voluntary donation scheme because of the public's general lack of willingness to consider their own mortality.[139]

There has even been the unique argument made in the United States that the government's exclusive control over the procurement and distribution of transplantable organs is a violation of anti-trust laws.[140] Since the government has empowered, through statute, only one agency to procure and distribute organs, this agency has a monopoly that can stifle any competition that could result in more efficient operations.[141] The fact that organ procurement and distribution is an admittedly "special" market should not matter, "since the Supreme Court has rejected arguments that the special characteristics of a particular industry justify anti-competitive arrangements on the ground that they 'will better promote trade and

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even though the victim . . . may have previously signed the organ-donation form that accompanies all provincial drivers' licenses." *Id.*

[134] *See* Cohen, *supra* note 6, at 21-24. Currently, as many as six Americans die each day waiting for a donor organ. *Organ Bazaar*, *supra* note 13.

[135] Kleinman & Lowy, *supra* note 112, at 1485.

[136] Peters, *supra* note 115, at 180-81. Note that many religions, however, have expressly declared that organ donation is acceptable. William Montalbano, *New Vatican Catechism Updates 1566 Version*, L.A. TIMES, Nov. 17, 1992, at A1 (according to the new catechism, "transplanting of organs is acceptable only when the donor consents").

[137] Peters, *supra* note 115, at 180.

[138] Kleinman & Lowy, *supra* note 112, at 1487.

[139] Cohen, *supra* note 6, at 11 (observing "[t]hat eighty percent of Americans die without a will is suggestive that, even where there are compensating personal benefits, we are reluctant to come to grips with our own mortality[]").

[140] *See* Hawley, *supra* note 4, at 1111-24.

[141] *Id.* at 1112 (noting that "[b]y virtue of NOTA, the OPTN [Organ Procurement Transplantation Network] has a monopoly over national computerized organ procurement networks, and each OPO [Organ Procurement Organization] has a monopoly over its individual service area[]").

commerce than competition.'"[142] Other arguments that have been made against voluntary donation address the property rights[143] and privacy rights[144] a donor may have in his organs and tissues. The common law tradition in the United States, however, has been that the donor may have, at best, a quasi-property interest in the disposition of his body once he has died.[145] All of these arguments are equally applicable in the next system of organ procurement — presumed consent.

C. *Presumed Consent or Opting-Out*

Presumed consent is one of the more frequently employed methods of organ procurement in Europe, among other places in the world.[146] This system has even enjoyed limited success in the United States with respect to procuring cornea transplants.[147] Under a presumed consent system, the state adopts the presumption that the donor wishes to donate organs, unless it was indicated otherwise during life.[148] France, for example, enacted an organ procurement statute employing presumed consent in 1976.[149] Known as the Caillavaet Law, a person may "opt-

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[142] Blumstein, *supra* note 12, at 491 (quoting National Soc'y of Professional Eng'rs v. United States, 435 U.S. 679, 688 (1978)). However, Blumstein notes that "[i]t is possible to argue . . . that the antitrust laws should not apply to the conduct of UNOS and the OPTN. Any claim of immunity . . . must come from either an express statutory exemption or an implied or inferred immunity." *Id.* at 493.

[143] Cohen, *supra* note 6, at 19.

[144] Karen L. Johnson, *The Sale of Human Organs: Implicating a Privacy Right*, 21 VAL. U. L. REV. 741, 754 (1987) (noting that "an individual's right to choose to sell an organ . . . should be accorded constitutional protection, and the government should not unnecessarily interfere with the individual's exercise of that right[]"). *See also* Note, *supra* note 14, at 1025.

[145] Silver, *supra* note 16, at 690-91.

[146] ONTARIO MINISTRY OF HEALTH, ORGAN DONATION IN THE EIGHTIES: THE MINISTER'S TASK FORCE ON KIDNEY DONATION 40 (1986) ("Presumed consent has been initiated in at least seventeen countries (largely in Europe) . . . ."); William N. Gerson, *Refining the Law of Organ Donation: Lessons from the French Law of Presumed Consent*, 19 INT'L L. & POL. 1013, 1019 (1987); Khoon, *supra* note 78, at 8.

[147] *See* State v. Powell, 497 So. 2d 1188 (Fla. 1986); Georgia Lions Eye Bank, Inc. v. Lavant, 335 S.E.2d 127 (Ga. 1985) (holding that a statute giving the coroner the presumed consent of the donor to remove the deceased's corneas without family inquiry is constitutional); Gerson, *supra* note 146, at 1019-20. *But see* Brotherton v. Cleveland, 923 F.2d 477 (6th Cir. 1991) (holding that a coroner violated due process by taking the deceased's corneas during an autopsy without family consent and deprived the plaintiff, the deceased's wife, of property rights in her dead husband's body).

[148] Cohen, *supra* note 6, at 15.

[149] Loi No. 76-1181, 1976 J. OFFICIEL DE LA RÉPUBLIQUE FRANÇAISE 7365, art. 2,

out" from donating organs simply by signing a writing to that effect.[150] Singapore recently passed a variation of the standard opt-out law.[151] The Singapore law includes a specific religious exemption for Muslims,[152] who must "opt-in" to the organ donation program in order to have the same priority in receiving an organ as those who are presumed to consent to organ donation.[153] Muslims were forbidden by Islamic law to donate organs when the law passed in 1987,[154] but a subsequent Fatwa, or religious decree, has found organ donation — though not organ sales — to be acceptable, as long as the organ is used for transplantation purposes.[155] An educational drive was recently mounted in Singapore which

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reprinted in 1977 RECUEIL DALLOZ SIREY: DE DOCTRINE DE JURISPRUDENCE ET DE LÉGISLATION 13 (stating that the removal may be done for scientific or therapeutic reasons on the cadaver of a person who did not make known during his life his refusal of the removal. However, if the cadaver in question is a minor or an incompetent, the removal for transplantation purposes is not possible without the consent of that person's legal representative); Gerson, *supra* note 146, at 1022.

[150] Gerson, *supra* note 146, at 1022-23.

[151] Sixth Parliament Report, *supra* note 66, pt. II, § 5.

> (1) The designated officer of a hospital may, subject to and in accordance with this section, authorise, in writing, the removal of any organ from the body of a person who has died in the hospital for the purpose of the transplantation of the organ to the body of a living person . . . . (2) [Unless] (a) [the person] has during his lifetime registered his objection with the Director to the removal of the organ from his body after death.

Id.

[152] *Id.* ("No authority shall be given under subsection (1) for the removal of the organ from the body of any deceased person . . . who is a Muslim."); Iyer, *supra* note 29, at 135.

[153] Sixth Parliament Report, *supra* note 66, pt. III, § 12.

> (2)(a) a person referred to in section 5 (2)(g) shall have priority over a person who has registered such objection only if he has made a gift of his organ, to take effect upon his death . . . (b) . . . [and] shall have the same priority as a person [who has not registered an objection].

Id.; Iyer, *supra* note 29, at 135. Previously, however, non-consenting Muslims were given the same priority as other consenting Singaporeans for receipt of dialysis treatment. The Singapore National Kidney Foundation, however, changed their policy, giving non-consenting Muslims the same priority on dialysis machines as others who have opted-out of the donor system, since the Muslims were unfairly benefiting from the law at the expense of non-consenting non-Muslims, as well as consenting non-Muslims. Mardiana Abu Bakar, *NKF: "Our Resources Are Being Drained,"* STRAITS TIMES, Sept. 23, 1993, at 5. This policy was passed in hopes of inspiring Singapore's Muslims to opt-in to the donation system. Mardiana Abu Bakar, *NKF's New Move "Tough But Fair,"* STRAITS TIMES, Sept. 23, 1993, at 5.

[154] *See generally* Iyer, *supra* note 29, at 135 (discussing the proposed law).

[155] Sixth Parliament Report, *supra* note 66, at A6.

resulted in Muslim kidney pledges (kidney donations increased by sixty-seven percent).[156]

Presumed consent, when strictly followed by the state, has proven to be the best practiced method of maximizing organ procurement.[157] For example, in Austria, sixty cadaveric kidneys are retrieved for every one million persons, a rate that is twice that of the United States and most other European countries.[158] Some commentators have actually suggested that this system is working too well, and that some surgeons have lost their sense of discrimination as to who should and should not receive kidney transplants.[159] While some may believe this is a valid objection, it is currently without merit given the dearth of procured organs world-wide. Even among presumed consent states, there remains a deficit of procured organs, though often it is because the procurement system is being improperly administered by health care professionals.[160] Despite a

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> The object of transplanting a kidney from the body of a deceased Muslim to that of a donee is primarily and exclusively to save life. On no account can a kidney be allowed to be removed from the body of a Muslim for other purposes such as carrying out medical research, advancement of medical science, etc.

Id. (quoting letter from Ridzwan Hj Dzafir, President of the Majlis Ugama Islam Singapore, to the Select Committee). *See also* Furqan Ahmad, *Organ Transplant in Islamic Law*, 7 ISLAMIC & COMP. L. Q. 132 (1987) (discussing how the principle of "dire necessity" in Islamic law validates all forms of organ transplant). This overturned an earlier fatwa made in 1974, that declared organ donation to be forbidden. Mardiana Abu Bakar, *Include Muslims in Organ Transplant Act*, STRAITS TIMES, Sept. 23, 1993, at L4. The reason given for the turnaround is *darurat*, or crisis situation. *Id.*

[156] *Muslims "Now More Aware of Kidney Plight,"* STRAITS TIMES, Sept. 8, 1992, at 25. Out of 1000 Muslims that pledged kidneys, 400 pledged during a month-long awareness program. However, this number is inconsequential when compared to the 250,000 Muslims that live in Singapore. *Id.* As of September, 1993, 1300 Muslims had opted into the donation system. Bakar, *supra* note 155.

[157] LAMB, *supra* note 21, at 147 ("If the sole criterion is a policy that will maximize the number of organs under the most efficient methods, then contracting out is the most satisfactory strategy . . . ."); MEYERS, *supra* note 16, at 192. It has been argued that legislation to date has not been adequate to provide the organs needed for transplantation. A statute creating a presumption of intent to donate organs after death, that would control in the absence of direct evidence to the contrary, would undoubtedly be more effective in producing a supply of organs. *Id.*

[158] *Changes Needed to Get More Kidneys*, STRAITS TIMES, May 27, 1992, at 2. This number is also three times better than the procurement rate in Singapore, *id.*, though this may be because Muslims are automatically exempt by law from having their organs procured. *See* Sixth Parliament Report, *supra* note 66, pt. II, § 5.

[159] James Le Fanu, *Gifts of Life Cannot be Left to Chance*, SUNDAY TELEGRAPH, July 19, 1992, at 108.

[160] ONTARIO MINISTRY OF HEALTH, *supra* note 146, at 40.

presumed consent law, there is still a waiting list for organs in France.[161] One reason is that French doctors, in an effort to avoid administrative problems, ask for familial consent to harvest the organs, even though, legally, the family has no interest in the disposition of the deceased's organs.[162] Poland has also encountered similar problems of non-consenting families accusing surgeons of illegally appropriating organs, even though Polish law presumes consent.[163] However, some countries which have laws based on presumed consent such as Finland, Greece, Italy, Norway, Spain, and Sweden, also insist that physicians consult with the deceased's relatives.[164]

Still, presumed consent countries such as France, Belgium, and Austria have higher procurement rates than altruistic systems such as the one existing in the United States.[165] Therefore, it is not surprising that seventy-eight percent of transplant surgeons in the United States were in favor of adopting a presumed consent system.[166] Other countries, like Israel, are finding that their poor organ retrieval numbers are not only

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> Presumed consent has been initiated in at least 17 countries (largely in Europe) but without evidence of increased organ retrieval. This should not be taken as proof that presumed consent is an ineffective method . . . . [T]he most significant block may be professional and, until it is removed, one will not know what impact presumed consent may have.

Id.

[161] Gerson, *supra* note 146, at 1024-25 (noting that "[i]n 1984 there were nearly a thousand kidney transplants performed in France, but almost three thousand people remained on the waiting list[]").

[162] *Id.* at 1025-27 (stating that physicians "are dissuaded by bureaucratic requirements and are unsure of their legal footing[]"); Greg Del Bigio, *Recorded Consideration: A Policy for Organ Procurement*, 9 HEALTH L. CAN. 67, 70 (1989) ("[D]espite legislation enabling them to do so, French physicians were not willing to remove organs from a cadaver without the consent of family members.").

[163] Krzysztof Grzegrzolka, *Organ Transplants: Moral Dilemma*, WARSAW VOICE, Nov. 24, 1991, *available in* LEXIS, Nexis Library, Wrsawv File. Organ procurement in Poland is done under a 1929 ordinance that was last reviewed in 1949. *Id.* "The surgeons' work is made even more difficult because Polish society is not familiar with this method of treatment and does not fully accept it." *Id.*

A Polish law is currently under consideration that would re-affirm Poland's use of presumed consent, as well as outlawing organ sales. *The Transplant People*, WARSAW VOICE, June 20, 1993, *available in* LEXIS, Nexis Library, Wrsawv File.

[164] LAMB, *supra* note 21, at 141. Compare this, however, to Austria, the Czech Republic, Denmark, France, Israel, Poland, and Switzerland, where "physicians may proceed without asking the next of kin, unless a prior objection has been raised by the family of the deceased." *Id.*

[165] Warren, *supra* note 1.

[166] *Id.*

lowering transplantation domestically, but are resulting in their exclusion from international procurement agencies.[167] Such countries are being urged to adopt a law of presumed consent.[168] In addition, transnational bodies like the Council of Europe have recommended that Member States adopt a system of presumed consent,[169] recognizing the "invaluable importance of substances for transplantation, the shortage of substances available, and the interests of sick persons."[170] To date, thirteen of the twenty-one Member States of the Council of Europe have enacted presumed consent legislation.[171]

Even though, when properly applied, presumed consent has proven to be a highly efficient means of procuring organs,[172] many jurisdictions have rejected presumed consent[173] in favor of other procurement methods preserving the legal right of the individual to make decisions concerning the disposition of the body.[174] Specifically, such critics argue

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[167] Siegel, *supra* note 27. "French health authorities recently barred all their hospitals from performing organ transplants on Israelis. Britain is expected to be the next to establish such a ban, and all the rest of the European Community will follow suit within two years." *Id.* This is due to Israel's lack of organ contribution in the Eurotransplant organ network agency. *Id.; see also* Judy Siegel, *Israel, Cyprus Sign Accord on Transplants*, JERUSALEM POST, Nov. 17, 1993, at 3. Israelis join Italians in being banned from receiving organ transplants in France. Siegel, *supra* note 27. *See also*, Siegel, *supra* note 167 (noting that under the terms of a medical accord between Cyprus and Israel, Cyprus will send organs to Israel, while Israel will reciprocate by teaching Cypriot surgeons how to perform organ transplants).

[168] Siegel, *supra* note 27. One Hadassah doctor urges that Israel adopt a law that proclaims cadaveric organs to be a national resource, removable by the state absent an opting-out during the donor's life. *Id.*

[169] *Res. of the Comm. of Ministers*, *supra* note 77, art. 9.

[170] Council of Europe, *Removal, Grafting and Transplantation of Human Substances*, 1 INT'L J. MED. & L. 385, 400 (1979). The Council also stressed the article 10 be considered a "long term aim." *Id.*

[171] LAMB, *supra* note 21, at 141.

[172] Kenneth M. Norrie, *Human Tissue Transplants: Legal Liability in Different Jurisdictions*, 34 INT'L & COMP. L. Q. 442, 461 (1985).

> There is no doubt that the approach favoured [*sic*] by these European countries, [presumed consent], is the most suitable one for the purposes of health care in general, because it is the solution which provides the largest number of organs for transplantations in societies where voluntary donation is wholly inadequate to provide sufficient numbers to satisfy demand.

Id.

[173] *Kinkel Seeks Stronger Laws on Organ Transplants*, THE WEEK IN GERMANY, June 14, 1991, *available in* LEXIS, News Library, Wkgerm File [hereinafter *Stronger Laws*] (noting that Germany has recently rejected presumed consent, as well as commercialization of human organs, in favor of voluntary donation).

[174] Cohen, *supra* note 6, at 16 (suggesting that "escheatage seeks to diminish a

that presumed consent will "lead to a situation where the poor, the uneducated, and the legally disenfranchised might bear a disadvantageous burden, and only the more advantaged groups would exercise autonomy,"[175] since only the more advantaged groups would be aware of their right to opt-out.[176] Other critics fault presumed consent with eliminating the societal benefits inherent in the charitable act of actively donating an organ.[177] Another concern centers on the legal objections family members may try to raise, as they have in France, Poland,[178] and the United States.[179] Presumed consent is also disfavored because the procrastinating or reluctant dissenter may not be able to properly exercise his right to opt-out.[180] There is also a concern that an individual who has properly opted-out may accidentally have his organs removed. Some are even concerned that physicians would become less attentive to es-

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person's property rights in his own body[]"); Johnson, *supra* note 144, at 755 (emphasizing that "[t]he decision to have an organ removed for transplant . . . involves a fundamental right since it concerns one's personal health and the integrity of one's body[]").

[175] LAMB, *supra* note 21, at 142.

[176] Del Bigio, *supra* note 162, at 70 ("Unless it could be ensured that *all* persons would be appropriately educated with respect to organ donation, the system of opting-out cannot meet the condition of autonomy." (emphasis in original)).

[177] LAMB, *supra* note 21, at 141 ("If organ donation is one of the supreme gifts that one individual can bestow on another, it is argued, society cannot afford to lose such altruistic practices, the benefits of which spread further than the demand for more transplantable organs.").

[178] Warren, *supra* note 1 ("Many experts fear that adopting presumed consent will lead to a plethora of lawsuits challenging the system's right to remove organs and tissues without family consent.").

[179] *See* Brotherton v. Cleveland, 923 F.2d 477 (6th Cir. 1991) (holding that the removal of a cornea by the coroner without actual consent is unconstitutional). Note that many states in the United States do have a presumed consent law for the procurement of corneas, and other states are considering limited presumed consent laws for other organs. *See Legislature Briefs*, HOUSTON CHRON., May 25, 1993, at 14 (stating that Texas has proposed a law that allows for removal of a cadaver's organs if the body is unclaimed for four hours); Ed Davis & Sandy Hamm, *Legislators Ponder Law to Claim Body Organs*, NEW PITTSBURGH COURIER, July 14, 1993, at A1 (relating a proposed Pennsylvania law allowing for presumed consent to donation unless the deceased had opted-out).

[180] Silver, *supra* note 16, at 706 (arguing that "[p]resumed consent, however, insidiously exploits the citizen's regrettable reluctance to dissent, even though dissent is her right . . . [and that] [e]xploitation of one's reluctance to assert her rights is not a sound basis for social policy[]").

tablishing that a donor was truly brain dead prior to removal.[181] These concerns will be addressed and countered in Section VI.

A final variation on presumed consent is one that does not allow any opting-out at all. This has also been called an organ draft or conscription — similar to a military draft.[182] Such a law would most easily be accomplished by nationalizing cadavers,[183] similar to the way many other potentially commercial goods and industries are nationalized. Such an approach, however, would present serious legal problems in many Western countries, as well as potential ethical and political problems in most other countries worldwide.

D. Organ Trade and Sales

Legal organ sales are perhaps the most controversial of all the proposed organ procurement systems. As with presumed consent, there are numerous variations of the legalized organ sale, from live organ brokerage[184] and organ futures markets[185] to an income tax deduction[186] or health insurance reduction incentive.[187] Organ sales are premised on the legal assumption that an individual has a property right in the body, both during life and after death.[188] Because this private property right exists, it is illegal for the government to limit this right by prohibiting organ sales either through a presumed consent system or a voluntary donation system.[189] Commentators who support organ sales as a method of organ procurement further bolster their argument by claiming that financial remuneration would provide the needed incentive to donate organs and reduce the organ deficit in the domestic market.[190] Hypothetically, a well-regulated commercial market provides the incentive for the procrastinating donor, the donor who does not wish to contemplate death,[191] and

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[181] Butler, *supra* note 41, at 204.

[182] For further discussion *see id.*

[183] Liz Hunt, *State "Should Have Rights to Organs,"* INDEPENDENT, Nov. 2, 1992, at 7.

[184] Note, *supra* note 14, at 1020-22; Edlund, *supra* note 35.

[185] Cohen, *supra* note 6, at 32-36.

[186] Lindsey Gruson, *Signs of Traffic in Cadavers Seen, Raising Ethical Issues*, N.Y. TIMES, Sept. 25, 1986, at A14.

[187] Hansmann, *supra* note 7, at 63-65.

[188] Cohen, *supra* note 6, at 19.

[189] *See* Hansmann, *supra* note 7. *See also* Johnson, *supra* note 144.

[190] Cohen, *supra* note 6, at 34; Hawley, *supra* note 4, at 1127 (stating that "[t]he sale of organs potentially could increase the number of donor organs procured because the profit motive is generally regarded as stronger than altruism[]").

[191] Cohen, *supra* note 6, at 10-11.

gives hospital personnel an incentive to determine if a possible candidate for organ donation is in fact an organ donor.[192]

Unfortunately, no well-regulated commercial market for human organs currently exists; those countries where organ sales are legal[193] are among the worst violators of human rights and the exploitation of the poor. This should not be seen as a problem with the particular commercial system, but as a problem endemic to the nations which procure organs in such a manner. In fact, some proponents of a commercial organ market argue that such a system would eliminate the black market.[194] The reasons most often cited for the prohibition of organ sales are ethical, moral, and are not based on empirical evidence.[195] For instance, there is a significant concern that the sale of organs will cheapen life, analogizing such a practice to selling one's self into slavery.[196] Others argue that potential sellers have no right to sell what does not belong to them.[197] A few even believe that human organs fall into the category of something that cannot be sold.[198] However, many commentators argue that "ethical"

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[192] *Id.* at 34 (suggesting that "a cause of action for negligence should be established on behalf of the estate and/or the organ purchasing agency against the hospital for the financial value . . . " of not procuring the organs of someone who has already signed a contract to sell them).

[193] Or, more appropriately, where organ sales are not considered illegal due to the absence of any legal regulations.

[194] Richard M. Boyce, *Organ Transplantation Crisis: Should the Deficit be Eliminated Through Inter-Vivos Sales?*, 17 AKRON L. REV. 283, 300 (1983) ("By making organ sales legal the state would prevent a black market from developing.").

[195] [195] Some commentators try to analogize the failure of a commercialized blood bank to the proposal for commercialized organ sales. *But see* Hansmann, *supra* note 7, at 68 (arguing that most prohibitions on organ sales are non-empirical).

[196] Cohen, *supra* note 6, at 26-29. Cohen argues that it is perfectly legal for people to participate in other degrading, dangerous, and unpleasant, yet perfectly legal things, like boxing, coal mining, cleaning toilets, etc. *Id.* at 29. However, he makes a better argument that certain organ sales, like cadaveric organ sales, are distinguishable from indentured servitude since (1) they occur after natural death, and (2) they are an expression of personal autonomy, rather than desperate poverty. *Id.* at 28 n.90.

[197] Accepting that a person has a private property interest in his/her body rather than a collective or communal one, this argument fails due to the donor's inalienable right to dispose of his/her property as he/she pleases. The deceased is already legally empowered to dispose of his/her other property through a will, as well as designate the manner in which he/she wishes to be buried. The only situation where this argument succeeds is in addressing the right of the next of kin to sell the deceased's organs. *See id.* at 26-27.

[198] This theory seems to attach a mystical or spiritual importance to human organs. Organs are already exchanged everyday without any financial compensation for the donor, although it is expected that the donor receives a psychic benefit. *Id.* at 27. It

objections such as these must be viewed as anachronistic and damaging to the goal of maximizing organ procurement.[199]

1. Inter-Vivos Sales

Inter-vivos sales are relied upon primarily in countries where there is no brain-death law,[200] or where there are insufficient preservation techniques to maintain the organ after it has been removed from the cadaveric donor.[201] However, there are only a few organs that can be removed from a living donor without committing murder.[202] There are few countries that admit to participating in the legal trade of living donors' organs,[203] though those that do generally enjoy an increasingly brisk business[204] through sales to state citizens, as well as to foreigners. Aside from the obvious potential for human rights violations, such as illegal trading and murdering for organs, the overwhelming fault of these systems is that they exploit the poor.[205] In fact, most of the states that

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might be more appropriate to say that human organs cannot have a price put on them, which may be true, since they are a rather new commodity whose cost cannot easily be quantified. This does not mean we cannot assign a dollar value to them; we assign dollar values to similar intangibles everyday, such as the award for pain and suffering in a tort suit. It just means that the organ market has not yet had an opportunity to determine a price.

[199] Blair & Kaserman, *supra* note 17, at 443-50.

[200] *For Poor Indians, Sale of Kidney Can be Price of Survival: Organ Trade Raises Ethical Questions*, ATLANTA J. & CONST., Nov. 28, 1991, at C4 [hereinafter *Poor Indians*]. "India still operates under an early 19th century law that makes the removal of organs from brain-dead patients a crime, preventing creation of a Western-type cadaver donor system." *Id.* Instead, Indian "law has regarded death as the 'apparent extinction of life as manifested by absence of heart beat and respiration.'" Siddiqi, *supra* note 110, at 154 (quoting DORLAND'S ILLUSTRATED MEDICAL DICTIONARY (24th ed., 1965)).

[201] Chris Hedges, *Egyptian Doctors Limit Kidney Transplants*, N.Y. TIMES, Jan. 23, 1992, at A5 (explaining that the lack of organ bank facilities necessitates that the patient and the donor undergo the operation together); Siddiqi, *supra* note 110, at 146.

[202] Tissue, corneas, kidneys, and possibly half of a liver, can be removed from a living donor and allow that donor to continue living.

[203] George, *supra* note 132 (noting that "[k]idneys . . . are bought and sold in India, Egypt, and Iraq . . . . ").

[204] FOX & SWAZEY, *supra* note 25, at 68 (noting that India "led the world market in buying and selling kidneys from unrelated living 'donors,' growing from an estimated 50 such transactions in 1983 to more than 2,000 in 1990[]"); Hedges, *supra* note 201.

[205] *India Moves Tough*, *supra* note 36 (noting that "organ buyers daily scour the slums of major cities preying on the poor[]"). "In India as in other countries, the

have banned commercial organ sales have done so due to the potential abuses resulting from organ sales by the poor.[205] These states assume, and probably correctly so, that the only person who would respond to a financial incentive to sell an organ during their life would be destitute. Why else would an otherwise rational person part with a kidney, unless the person was in a desperate situation?[207]

Proponents of inter-vivos sales, however, claim that these are Western attitudes that do not always apply in other countries.[208] These commentators believe that a ban on inter-vivos sales would only drive the sale underground, and subject it to many more abuses than already occur.[209] The answer, they say, is regulation and explicit legalization of living donor sales is necessary to avoid any more potential human rights abuses.[210]

2. Cadaveric Organ Sales

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donors are often poor, sometimes sick and invariably in need of the money. The patients are predominantly affluent, with many coming from the Middle East and . . . Europe." Sanjoy Hazarika, *India Debates Ethics of Buying Transplant Kidneys*, N.Y. TIMES, Aug. 17, 1992, at A20. *But see* Michelle Tan, *Kidneys: Buy or Die*, STRAITS TIMES, May 13, 1992, at L3 (giving testimony of a patient whose purchase of a kidney in India not only saved his life, but substantially bettered the life of the man from whom he purchased the kidney).

[206] German Minister of Justice Klaus Kinkel rejected legalizing organ sales, stating that "unscrupulous profiteers are increasingly attempting to use poor people, especially from the Third World, as living warehouses for the wealthy in the western industrial nations." *Stronger Laws*, *supra* note 173 (quoting Minister of Justice Klaus Kinkel).

[207] As noted by Leon Schwartzberger, a Socialist French Surgeon who recently convinced the European Parliament to outlaw organ trading:

> Under such a system, a rich and healthy person would not sell one of his kidneys. There would be a tendency for the pool of donors to be confined to under-privileged sections of society. It is reasonable to forecast that those who will be prepared to sell one of their kidneys will be precisely those whose health is most likely to suffer as a result.

Magee, *supra* note 2, at 2 (quoting Dr. Leon Schwartzberger).

[208] *Poor Indians*, *supra* note 200. "India, which possesses a proud, non-Western culture, should not be tailoring its national medical policy to U.S. or European standards." *Id.* In fact, this same commentator believes that India might be trailblazing for the West in this area. *Id.*

[209] Hazarika, *supra* note 205 ("Doctors in New Delhi and Bombay said a ban on transplants from living donors would not work, driving the practice underground and leaving patients at the mercy of agents."). *See also Organ Bazaar*, *supra* note 13.

[210] *Organ Bazaar*, *supra* note 13.

Officially, this method of organ procurement is not practiced by any nation, though certain aspects of it have been surreptitiously employed in the past,[211] as well as openly attempted quite recently.[212] The premise behind such a system is a contract, made between the organ procurement agency[213] and the potential organ donor during the donor's life. The contract includes some sort of financial consideration for the right to remove the organ if the donor dies in such circumstances so as to make donation possible.[214] The agency then sells the organ to a desparate patient. In order to create a true incentive to enter such a program, it is best if the organ procurement agency rewards the donor financially for merely signing up, and not make remuneration contingent upon actual organ harvesting.[215] The reasons for this are two-fold: first, it helps create a binding contract that hospital officials must honor or, if they do not, they can find themselves subject to a law suit by the procurement agency; second, it produces a true incentive to the donor to enlist.[216]

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[211] *See Kidney Team Found Favoring Foreigners*, CHI. TRIB., May 16, 1985, at 9 (noting that foreigners were allowed to purchase a better position on the waiting list). *See also* Don Colburn, *Gov. Casey's Quick Double Transplant: How Did He Jump to the Top of the Waiting List?*, WASH. POST, June 22, 1993, at 28 (examining Pennsylvania Governor Robert Casey's ability to procure a heart and liver for transplant in less than 24 hours, while the average wait is 198 days for a heart, and 67 days for a liver).

[212] *See* Scott Shepard, *Diamond Aims to Spark National Debate on Organ Procurement Issue*, MEMPHIS BUS. J., Aug. 16, 1993, at 14. Two Memphis men have entered a contract for sale of one of the men's organs upon his death, in the hopes of challenging the U.S. law prohibiting organ sales. The two men hope to establish a market for cadaveric organs as commodities to be sold by honest brokers, and claim to have a list of 50 members so far. The founder, David Diamond, claims that such a system is preferable for many reasons: it encourages quality; it avoids making difficult decisions at difficult times; it will increase the number of procured organs; it will discourage a black market in organs; and it will give the donor personal control over the decision to donate. *Id. See also* Monique Beaudin, *Quebec Puts Up Cash to Encourage Organ Donations*, THE GAZETTE (Montreal), Dec. 10, 1992, at A6. A provincial organ donation agency is using a $1.75 million provincial grant to increase organ donations by paying hospitals $500 for identifying potential donors, and $4500 for harvested organs that are suitable for transplant. *Id.*

[213] For the sake of argument, we will assume the procurement agency to be the state, even though this is not necessary, and for certain reasons, may not be preferred. *See generally* Hawley, *supra* note 4.

[214] Cohen, *supra* note 6, at 33.

[215] For an argument against this type of contract and for one that only offers payment for actual organs harvested, see *id.* at 33-34.

[216] Boyce, *supra* note 194, at 296 ("Although a financial incentive may entice someone into a post-mortem organ transfer contract, the lack of immediate payment

The other commonly proposed alternative is a system that pays money to the donor's estate or pays for burial costs.[217] While these are both strong incentives, they do not directly benefit the donor, but rather his next of kin. Since the donor receives no direct benefit, such incentives may prove insufficient and ineffective as an organ procurement maximizer. However, all one needs to do is look at the millions of dollars spent annually on life insurance to see that people do not need an immediate personal benefit to inspire them to prepare for their death.

Whatever form payment takes, there are a number of advantages that cadaveric organ sales have over others. The first two have been previously mentioned — the respect for personal autonomy and privacy rights, and the increased incentive to donate created by compensation. Cadaveric organ sales have additional advantages over inter-vivos organ sales in that they do not exploit the poor,[218] and can be entered into solely by the donor, thereby avoiding the possible human rights abuses committed by third parties.

However, in countries where no brain-death law exists, cadaveric organ sales are virtually impossible because organs must be retrieved while the blood is still oxygenating them. Otherwise, the organs would deteriorate and be of no use. In countries where the hospital facilities are not as numerous or advanced as in the United States, there is less of a chance that the organ can be procured from the cadaver, preserved, and sent to the recipient before the organ dies. Even in the United States and other developed countries, there are logistical problems posed by such a contract. One commentator asks if organ sellers, in order to meet their organ contracts, will:

> be required to keep the organ buyers on notice as to their whereabouts, or will the contract specifically restrict the seller's freedom of movement to a designated geographical area? If the performance of the contract is blocked by a logistical problem, will the seller's estate be liable in damages, or will the defenses of impossibility and frustration be available?
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> Other problems have been pointed out, such as the quality or merchantability of the organs. A products liability suit may lie against a seller whose organ is defective . . . . [D]oes the contract imply that the seller will maintain the organ in merchantable condition by abstaining

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may give rise to the same problem from which [voluntary donation systems] suffers - apathy.").

[217] *See generally* Peters, *supra* note 5.

[218] A wealthy person would have almost as much incentive to receive compensation for cadaveric organ donations due to the lack of substantial sacrifice on his or her part.

> from alcohol, drugs, and other harmful substances? Will the contract expressly set out a lifestyle for the seller, deviation from which could give rise to an action in partial breach?[219]

Further, critics of cadaveric organ sales are concerned that a market in human organs would lead to a decrease in the number of organs donated, and an overall increase in the cost of organ transplantation operations and research.[220] There is also a worry that such a system would bring lower-quality organs.[221] The biggest problem confronting any type of organ sale is deciding if the seller has any legally recognizable property interest in the organ. At common law, there is no true property interest in a cadaver; rather, the next of kin have a quasi-property interest which allows them to have custody and possession of the body for the purposes of burial or disposal.[222] The body is considered held in trust by those with an interest, subject to the protection of the public.[223] This principle was recently reaffirmed in *Georgia Lions Eye Bank, Inc. v. Lavant*,[224] *State v. Powell*,[225] and *Brotherton v. Cleveland*,[226] noting that traditional English and American common law gives a quasi-property interest to the surviving kin in the decedent's body, limited to the burial or other lawful disposition of the cadaver.[227]

Other organ market proposals which on their face appear to be excellent ideas, are in fact, also subject to certain problems. For instance, one commentator proposed that a health insurance deduction be made available to those who pledge their organs.[228] One problem with this

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[219] Boyce, *supra* note 194, at 296-97.

[220] Randy W. Marusyk & Margaret S. Swain, *A Question of Property Rights in the Human Body*, 21 OTTAWA L. REV. 351, 373 (1989) ("The advancement of scientific medical research absolutely depends on the availability and free exchange of experimental tissue, especially in the non-profit university research community.").

[221] *Id.* at 373 ("Furthermore, the pressure of demand will often result in a drop in the quality of the substance available. Persons wanting to sell tissue for financial gain may cover up facts regarding their lifestyle in order to qualify."). *But see* Blair & Kaserman, *supra* note 17, at 442-43.

[222] Marusyk & Swain, *supra* note 220, at 360-61.

[223] MEYERS, *supra* note 16, at 183.

[224] 355 S.E.2d 127 (Ga. 1985).

[225] 497 So.2d 1188 (Fla. 1986).

[226] 923 F.2d 477 (6th Cir. 1991).

[227] *Id.* at 481. However, the court did go on to find a "substantial interest," amounting to a "legitimate claim of entitlement," existed under the due process clause of the 14th Amendment, seemingly due to the body's increased pecuniary value as a result of biotechnology advances. *Id.* at 481-82.

[228] Hansmann, *supra* note 7, at 63-65. Hansmann proposes a plan where insurers would offer a reduction in health insurance premiums to those who pledged their

plan is that not every nation has a strong private health insurance system like the ones in the United States. This severely limits the number of potential donors to those who have insurance. Second, nations that have a public health insurance plan, like Canada, offer no financial incentive for donation, since there can be no reduction in health insurance premiums. Thus, a regulated cadaver organ sale program could work in some Western industrialized countries, but may not be as practical in other parts of the world.

The biggest problem with cadaveric organ sales, as evidenced by all the nations that have outlawed organ sales,[229] is that organ sales are not palatable to the general public, government, or health professionals.[230] Still, this practice continues, virtually unchecked in some countries. If these countries are unable, or unwilling, to halt the organ trade flowing through their country and into others, then states need a way that they can legally prosecute, and hopefully eliminate, such a crime. Section V explores how international principles of extraterritorial jurisdiction may offer a solution.

V. EXTRATERRITORIAL JURISDICTION

Extraterritorial legislative jurisdiction is the application of one state's laws within another state.[231] Normally, such actions are a violation of

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organs for donation. The reduction, albeit a nominal one of roughly $10 per year, is believed to be enough of an incentive to increase donations. Additionally, Hansmann says that the option would automatically renew itself yearly unless the donor changed his/her mind and decided not to be a donor, an option he/she would be free to exercise. *Id.* at 63.

[229] *See supra* notes 56-77 and accompanying text.

[230] Butler, *supra* note 41, at 200-01 (noting that, "[a]lthough logically appealing . . . as a means for increasing the availability of organs without significant government intrusion . . . the bottom line is that our society is simply not comfortable with the concept [of organ sales]").

[231] Note the difference between prescriptive and enforcement jurisdiction: prescriptive jurisdiction allows one state to enact a law that may apply to a person who is not a national nor within the territory of the promulgating state. Enforcement jurisdiction is the ability to enforce that law within a territory. While a state may have prescriptive jurisdiction, it may not have enforcement jurisdiction since the person the state wishes to prosecute is within another state's territory. Since it would be a violation of the foreign state's sovereignty for the prosecuting state to attempt to enforce its laws in the other state's territory, the prosecuting state must either ask the foreign state's permission to enter and apprehend the suspect, ask the foreign state to extradite the suspect, or hope that the suspect enters the prosecuting state's territory. *But see* United States v. Alvarez-Machain, 112 S. Ct. 2188 (1992) (holding that the abduction by the United States of a suspect in the murder of a United States DEA agent from Mexico

state sovereignty, since it is recognized as international law that only the domestic state has the right to promulgate and enforce laws within its territory. There are, however, five different principles by which one state can exercise prescriptive jurisdiction within another state: the territorial principle, nationality principle, passive personality principle, universal principle, and protective principle. Briefly explained, the territorial principle requires that some part of the action[232] occurs within the territory of the prosecuting state.[233] The nationality principle gives the prosecuting state jurisdiction to apply a domestic law to a national in a foreign state.[234] The passive personality principle requires that one of the prosecuting state's nationals is injured by the national of another state.[235] The state applying the protective principle seeks to prosecute a foreign national for actions that are injurious to the sovereignty of the prosecuting state, though not to any one national in particular.[236] Finally, the universal

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was not a violation of the U.S.-Mexico Extradition Treaty or of Mexico's sovereignty).

[232] For purposes of this Note, "action" will refer to any criminal or tortious act.

[233] Mali v. Keeper of the Common Jail (Wildenhus' Case), 120 U.S. 1 (1887). The United States was held to have legislative jurisdiction over the murder of one Belgian by another Belgian aboard a Belgian ship docked in Jersey City, New Jersey. The Court stated that

> if crimes are committed on board [a foreign ship] of a character to disturb the peace and tranquillity of the country to which the vessel has been brought, the offenders have never, by comity or usage, been entitled to any exemption from the operation of the local laws for their punishment.

Id. at 8.

[234] Blackmer v. United States, 284 U.S. 421, 443 (1932). The U.S. Supreme Court held Blackmer, a United States national living in France, in contempt of court for refusing to appear after being issued a subpoena. The Court felt that it cannot "be doubted that the United States possesses the power inherent in sovereignty to require the return to this country of a citizen, resident elsewhere, whenever the public interest requires it, and to penalize him in case of refusal." *Id.* at 437.

[235] United States v. Yunis, 681 F. Supp. 896 (D.D.C. 1988). The United States was deemed to have jurisdiction over Yunis, a Lebanese national accused of hijacking a Jordanian aircraft carrying three American nationals. The court used the alternative grounds of both passive personality jurisdiction — based on the three Americans that were taken hostage — and universal jurisdiction — based on piracy — to justify legislative jurisdiction by the United States. The court noted that only "serious and universally condemned crimes" should be used as the basis for pursuing passive personality legislative jurisdiction, so as to avoid "unlimited and unexpected criminal liability." *Id.* at 902.

[236] United States v. Noriega, 746 F. Supp. 1506 (S.D. Fla. 1990). Manuel Noriega, former head of State of Panama, was found to be under the legislative jurisdiction of the United States under the protective, or objective extraterritoriality principle, for various narcotics offenses. The Court noted that "international law principles have expanded to permit jurisdiction upon a mere showing to produce effects in this country,

principle applies to those crimes deemed so heinous as to be crimes against all states, and prosecutable by any state.[237] Determining whether a state may exercise legislative jurisdiction over the nationals of another state for possible human rights violations or other crimes related to the illegal transplantation of an organ is crucial; for without the legislative jurisdiction to prosecute, there can be no further cause of action.

In determining whether a statute can be affected extraterritorially, it is necessary to ask three questions: (1) does the statute purport to reach the particular conduct? (2) will the extraterritorial application of the statute raise serious issues about its constitutionality, or be a violation of customary or conventional international law? and (3) will expansive interpretation of the statute's reach pose a risk of serious conflict with other countries?[238] It is important to avoid statutory overreach, and to keep within the general interests of the international community as a whole.[239] For a country to try to do otherwise may be seen as an attempt to violate the sovereignty of another country, and may constitute a violation of international law. Consequently, there are not as many difficulties in applying extraterritorial jurisdiction using the nationality principle[240] or the territorial principle,[241] as there are in establishing a passive personality, protectionist, or universal theory of jurisdiction. Since most states that seek to legislate organ procurement and transplantation already explicitly include their national's activities within their own territory,[242] this section will focus on the other three theories of jurisdiction, passive personality, protective principle, and universal principle. It will also focus on how a state can justify prescriptive jurisdiction under each theory. Section VI will recommend what type of laws would best create extraterritorial jurisdiction.

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without requiring proof of an overt act or effect within the United States." *Id.* at 1513.

[237] Filartiga v. Pena-Irala, 630 F.2d 876 (2d Cir. 1980). The United States was ruled to have legislative jurisdiction under the universal principle in a case where one Paraguayan was suing another Paraguayan for acts of torture that occurred in Paraguay. *Id.* The Court noted that "[a]mong the rights universally proclaimed by all nations . . . is the right to be free of physical torture. Indeed, for the purposes of civil liability, the torturer has become - like the pirate and slave trader before him - *hostis humani generis* - an enemy of all mankind." *Id.* at 890.

[238] HENRY J. STEINER & DETLEV F. VAGTS, TRANSNATIONAL LEGAL PROBLEMS 813-14 (3d ed. 1986).

[239] *Id.* at 814.

[240] A national of a state is considered property of the state under international law. RESTATEMENT (THIRD) OF FOREIGN RELATIONS LAW OF THE UNITED STATES § 402(2) (1987).

[241] *Id.* § 402(1).

[242] *See supra* notes 56-77 and accompanying text.

A. *Passive Personality*

The passive personality principle seeks to protect a state's nationals from serious and universally recognized crimes[243] when they travel abroad.[244] In order for this theory to apply, a harm needs to have been suffered on the part of the national. Possible harms that a national could suffer by obtaining an organ transplant extraterritorially include a doctor's negligence,[245] failure to obtain informed consent,[246] and assault and battery.[247] Additionally, a national who travels abroad to donate an organ can suffer not only these same harms, but in the case of cadaveric donations, death can be falsely ascertained, the corpse can be mutilated,[248] or the national can be murdered for the organ.[249]

Physicians conducting organ transplantation are, like any other physician, subject to the duty of care established by the "general principles of the legal system to which the surgeon is subject."[250] Such a standard has been interpreted to require that the physician be qualified to perform the transplantation, the operation must be absolutely essential, and all other more conventional methods of treatment have failed.[251] Additionally, the physician has the duty to insure that the organ is fresh and does not harbor any infectious diseases that can be passed to the recipient.[252] The problem with trying to prosecute a physician from another jurisdiction, however, is that the physician owes the patient a standard of care as proscribed by his legal system, not the patient's; to hold otherwise would not put the physician on notice that he was at risk for liability. On the other hand, prosecuting a physician under his own country's duty of care standard might at best be considered a difficult choice of law question, and at worst, a breach of that country's sover-

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[243] *Id.* at 902.

[244] *See* United States v. Yunis, 681 F. Supp. 896 (D.D.C. 1988).

[245] Norrie, *supra* note 172, at 443-48.

[246] *Id.* at 449-56.

[247] M. L. Norton et al., *Organ Transplantation: Medico-Legal Considerations*, 2 MED. & L. 291, 292 (1983).

[248] *Id.* at 292.

[249] *See supra* notes 31-77 and accompanying text.

[250] Norrie, *supra* note 172, at 443.

[251] *Id.* at 444.

> Thus, if a patient's kidney failure would possibly have been susceptible to drug treatment, but a doctor recommends and carries out a renal transplantation, then the patient may have a good ground of action if the operation leaves him worse off than he would have been had the drug treatment been provided.

Id.

[252] *Id.* at 445.

eignty. The best possibility for establishing negligence, then, is if the doctor and the patient are subject to the same jurisdictional definition of negligence and if the doctor is on notice of the duty of care owed to the patient owed.[253] Absent some universal standard of care for a transplantation operation, however, it is unlikely that such circumstances would arise.

Physician liability for failing to obtain the informed consent of the patient also suffers from the lack of an international standard; rather, "the development of informed consent is strongly based on traditional American moral and legal concepts of basic human rights."[254] Failure to obtain informed consent is a tort,[255] as well as an element in an action for assault and battery.[256] There are two elements to informed consent: the physician's duty of disclosure and the patient's consent for the proposed treatment.[257] To constitute disclosure, the physician must tell the patient (1) the type of treatment proposed; (2) the complications of that procedure or treatment; (3) any alternatives to the treatment; (4) the benefits that the physician hopes to derive; and (5) the probable outcome if the procedure is not carried out.[258] In the case of organ transplantation, this would include, in particular, the risks of organ rejection by the body, the consequences if nothing is done, and the alternatives, such as drug therapies.[259] For the donor-patient, not only do these same elements apply, but there is also a concern that the donor potentially does not have the capacity to consent because of infancy or incompetence.[260] There are also fears that the donor's consent could be coerced, through either familial pressure,[261] economic strife,[262] or some other method.

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[253] This would be the case, for example, if the doctor received schooling in the patient's jurisdiction.

[254] William J. Morton, *The Doctrine of Informed Consent*, 6 MED. & L. 117, 117 (1987).

[255] *Id.* at 122. *See* Canterbury v. Spence, 464 F.2d 772 (D.C. Cir. 1972).

[256] Norton et al., *supra* note 247, at 292.

[257] Morton, *supra* note 254, at 118.

[258] *Id.* at 119. Canterbury, 464 F.2d at 786-88.

[259] Norrie, *supra* note 172, at 451. Even the consequences of success need disclosure, such as the necessity to take anti-rejection drugs for the rest of the recipient's life. *Id.*

[260] *Id.* at 453-54.

[261] Norton et al. *supra* note 247, at 294.

[262] MEYERS, *supra* note 16, at 201. In India, Dr. K.C. Reddy tests potential organ sellers. He gives them intelligence tests and has them interviewed by a psychologist to be certain that he has their informed consent. However, it is questionable if the consent truly is informed. One interview with a mother whose husband had already sold one of his kidneys went like this:

Again, absent some universal standard requiring informed consent, it would be difficult to gain extraterritorial jurisdiction.

Finally, there are the crimes of mutilation of the corpse, death falsely ascertained, and murder of a national for his organs. The latter two fit under the more generalized crime of murder, for which passive personality jurisdiction may be obtained. However, even though it is possible to attain jurisdiction in this manner, there remains the question of whether a foreign state's sovereignty would be violated by prosecuting that state's national for the murder, especially since there would probably be concurrent jurisdiction over the crime. The crime of mutilation or desecration of a corpse suffers from the same defect that negligence and informed consent do; varying legal standards from jurisdiction to jurisdiction make it impossible to establish an internationally recognized legal standard from which to prosecute.

B. Protective Principle

The protective principle of extraterritorial jurisdiction allows a state's laws to apply to actions occurring within other states, or within international space, due to those actions' deleterious effect upon the first state.[263] The law to be applied needs to be examined to determine whether it was intended to apply extraterritorially. If the failure to recognize extraterritorial application would frustrate the aims of the statute, then the protective principle probably applies.[264] This principle

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Interviewer: Why are you selling your kidney?
Woman: Because they don't have a kidney.
Interviewer: Do you know where the kidney is?
Woman: In the side.
Interviewer: How many are there?
Woman: They say there are two.
Interviewer: What work do they do?
Woman: I don't know.
Interviewer: We hold things with our hands. So what do the kidneys do?
Woman: I don't know. I haven't been to school; if I'd been, I'd know.

Organ Bazaar, *supra* note 13.

[263] United States v. Aluminum Co. of Am., 148 F.2d 416 (2d Cir. 1945). The Court noted that "it is settled law that any state may impose liabilities, even upon persons not within its allegiance, for conduct outside its borders that has consequences within its borders which the state reprehends." *Id.* at 443.

[264] Mortensen v. Peters, 5 Sess. Ca.(J) 121, 141 (Edwin Adam ed., 1906). The court allowed the extraterritorial application of a prohibition on trawling within a body of water that was mostly outside of British jurisdiction, for the reason that the object of the statute would be frustrated "by a construction of the enactment which, while it restrained British subjects from trawling within any part of the protected area . . .

has been expanded even further to include "a mere showing of intent to produce effects within [another] country, without requiring proof of an overt act or effect . . . ."[265] Applying this principle to organ transplantation, either a deleterious effect, or the intent to create such an effect by a person within another state,[266] would merit use of the state's domestic law. In addition, a state would need to have a law directly prohibiting the activity, and this law would have to be deemed to apply extraterritorially; too indirect or tangential an effect would not be actionable. As the U.S. Second Circuit Court of Appeals stated concerning the application of U.S. antitrust law abroad:

> Almost any limitation of the supply of goods in Europe, for example . . . may have repercussions if there is trade between the two. Yet when one considers the international complications likely to arise from an effort in this country to treat such agreements as unlawful, it is safe to assume that Congress did not intend the [Sherman] Act to cover them.[267]

In order to apply the protective principle to organ sales, it is necessary to examine some of the statutes nations have passed in making organ sales illegal. For example, a statute like Singapore's most likely would not be found to have extraterritorial effect, since it neither explicitly states that sales abroad are illegal, nor does its language imply that the failure to construe an extraterritorial meaning frustrate the statute's purpose.[268] However, a statute like Great Britain's, which states:

> (1) A person is guilty of an offence if in Great Britain he (a) makes or receives any payment for the supply of, or for an offer to supply, an organ which has been or is to be removed from a dead or living person and is intended to be transplanted into another person whether in Great

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permitted foreigners to trawl as they pleased over the greater part of it." *Id.*

[265] United States v. Noriega, 746 F. Supp. 1506, 1513 (S.D. Fla. 1990).

[266] For example, trafficking an organ to another state, or transplanting diseased organs into nationals of other states who have traveled abroad to receive the organ and then return to their domestic state with the diseased organ.

[267] 148 F.2d at 443.

[268] Sixth Parliament Report, *supra* note 66, pt. IV, § 14.

> (1) Subject to this section, a contract or arrangement under which a person agrees, for valuable consideration . . . to the sale or supply of any organ or blood from his body or the body of another person . . . shall be void. (2) A person who enters into a contract or arrangement of th[is] kind . . . shall be guilty of an offense.

Id.

> Britain *or elsewhere*,[269] explicitly intends extraterritorial effect. Another example would be the U.S. statute prohibiting organ sales from entering interstate commerce,[270] which defines interstate commerce as "commerce between any State or Territory and any place outside thereof."[271]

Applying the protective principle to the transplantation of a diseased organ, however, is more difficult because none of the statutes on organ transplantation specifically prohibit such an act; rather, most countries appear to rely on standard tort remedies for negligence to regulate this act.[272] This does not mean that there is no harm occurring. It was reported that from 1986 to May, 1991, 150 Singaporeans had gone to India or China for transplants and returned with infections or diseases such as tuberculosis, malaria, chicken pox, hepatitis, or AIDS.[273] Not only do such transplants severely endanger the patient, but they also harm the patient's domestic state, for when that patient returns home immediate treatment is needed for both the diseased organ which must be removed — and if possible, replaced — and for the illness contracted. One possible way to prosecute such occurrences is through the prosecution of organ sales abroad, since these diseased organs are typically purchased. However, it may also be possible to prosecute extraterritorially solely for the implanting of diseased organs into a state's nationals, since this does inflict a harm upon the domestic state.

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[269] Human Organ Transplants Act, 1989, ch. 31, § 1 (Eng.) (emphasis added).
[270] 42 U.S.C. § 274e (1988).
[271] 21 U.S.C. § 321(b)(1) (1988).
[272] *See* Norrie, *supra* note 172, at 443-48.
[273] *Risks to Buying Kidneys*, STRAITS TIMES, May 13, 1992, at L3.

C. *Universal Principle*

It is highly unlikely that any cause of action could be maintained through the universal principle of jurisdiction, since this principle applies to an extremely limited type of crimes. The universal principle is used to prosecute crimes against states themselves, and has been restricted to piracy, genocide, and most recently, torture.[274] Only the person who has violated the "law of nations," a code governing the relationships between states, can be prosecuted under this principle.[275] There is no currently recognized custom or practice of international law under which some action relating to organ transplantation could give rise to universal jurisdiction.

VI. SOLUTIONS TO THE INTERNATIONAL MARKET FAILURE

Relying on the present international market to provide a sufficient number of transplantable organs is clearly unacceptable. The practice of problematic inter-vivos organ sales, coupled with generally inefficient and unfollowed voluntary procurement systems, has proven ineffective at meeting the goal of obtaining the maximum number of organs while violating the fewest number of rights possible. What is needed is a general system that can be adapted to fit an individual state's cultural, ethical, and religious standards or constraints. Presumed consent of the individual, coupled with an option to withdraw consent and a priority incentive for those who do not withdraw consent, will provide the best, safest, and least violative method of increasing organ supply. Additionally, these factors provide a working model for uniform legislation regarding extraterritorial jurisdiction, and also help decrease human rights transgressions.

However, before an argument recommending presumed consent can be made, it must be established that a state should have an organ procurement system. Aside from the abuses that occur as a result of ineffective or nonexistent legislation outlined in Section III, there is also the argument that people have a right to health care.[276] Although the right to health care does not fall within the traditional notions of human rights, it does fall under a generalized notion of a right to life.[277] The right to health care will always be constrained by practical considerations, such as

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[274] Filartiga v. Pena-Irala, 630 F.2d 876 (2d Cir. 1980).

[275] *Id.*

[276] Amnon Carmi, *Human Rights in Medicine and Law*, 7 MED. & L. 409, 410 (1987) ("Good health is considered by many to be so important that it should become regarded as the human right of every person.").

[277] J.D. van der Vyver, *The Right to Medical Care*, 7 MED. & LAW 579, 580-81 (1989).

the strength of a country's health care system and the frailties of the human body.[278] This does not mean that a country cannot; at a minimum, insure safe, sanitary organ transplantation; and, at most, insure that a sufficient number of organs are procured so that most people can obtain a life-saving organ for transplantation.[279] Harmonizing organ procurement legislation around the most effective and ethical means acceptable, while simultaneously prohibiting activities such as organ commerce, will best attain this right to a safe transplant.

The law that Singapore has enacted is an excellent example to consider. Singapore's law is based upon the presumed consent of all citizens to have their organs removed for transplantation in the event of accidental death, except those who have opted-out; those who are below the age of twenty-one, those who are above the age of sixty, those who are incompetent, or who are Muslim.[280] For those whose consent is not presumed, it may either be given by a legal guardian — in the case of minors and incompetents — or by opting-in — for Muslims and those who had previously opted-out.[281] One lesson Singapore's legislature has learned from the sale of organs, and which is incorporated into this law, is that the lack of incentive to donate generates fewer donations. Therefore, this Act gives priority to those who do not withdraw their consent to posthumously donate their organs over those that do withdraw their consent to donate organs in the event that two such people were in need of the same organ.[282]

As discussed previously, presumed consent, when strictly adhered to, is the most efficient method of procuring organs.[283] Not only does such a system provide more organs for transplantation, thereby saving more lives, but it also eliminates other problems. For instance, an increase in the supply of cadaveric organs would lead to improvements in tissue matching between donor organs and recipients, as well as allowing

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[278] Carmi, *supra* note 276, at 411.

[279] Del Bigio, *supra* note 162, at 69.

> Because many transplant operations may now properly be regarded as being a part of ordinary health care . . . it is in accordance with a person's right to health care that a reasonable effort will be made to ensure that a person will be able to receive a transplant when needed. This means that . . . there exists a system that will provide a sufficient number of organs . . . for purposes of transplantation.

Id.

[280] *See* Sixth Parliament Report, *supra* note 66, pt. II, § 5.

[281] *Id.* §§ 5, 12.

[282] *Id.* § 12. The law also provides that for those who opt-out, then opt back in, there is a two-year waiting period before they obtain the same priority as a presumed consenter. *Id.*

[283] *See supra* note 157 and accompanying text.

surgeons to be more selective about which organs are procured.[284] Contrary to some criticisms, presumed consent allows for more careful application of brain-death criteria, since the increased supply of donor organs eliminates any temptation to obtain organs through "inappropriate" methods.[285] In countries like the United States, which has a federally funded dialysis program[286] which has climbed in cost to taxpayers from $228.5 million in 1974 to almost $2 billion in 1982[287] to close to $4 billion a year as of 1992,[288] a presumed consent system would result in lower costs to the government. It currently costs $32,000 per year for dialysis for one patient, as compared to $56,000 for the first year of a kidney transplant, and $6,000 per year thereafter.[289] Additionally, as kidney transplantation becomes a more practiced therapy, one can expect costs to fall even further.[290] Increased cadaveric procurement numbers would also reduce the current reliance on the living donor.[291]

There are other advantages to a presumed consent system that proponents of procurement systems — such as altruism and organ sales — try to obscure by criticizing as unethical. For example, many critics charge the presumed consent system takes advantage of "reluctant" or "procrastinating" dissenters, in that those who delay opting-out for whatever reason end up not truly expressing their desire to opt-out. This, however, is not an ethical problem that should concern the state any more than the state should be concerned about someone who, after having federal taxes withheld by the government, does not actively pursue their right to a refund of any overpayment.

Others are more concerned that the presumption itself is a problem, in that it restricts or in some way takes away an individual's freedom, and could somehow lead to a cheapening of human life.[292] It would

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[284] Blair & Kaserman, *supra* note 17, at 429.

[285] Butler, *supra* note 41, at 204.

[286] *See* Pub. L. No. 100-360, § 202, 102 Stat. 683 (1988).

[287] Blair & Kaserman, *supra* note 17, at 409.

[288] FOX & SWAZEY, *supra* note 25, at 76.

[289] *Id.* at 75. *See also Organ Prices Quadrupling, U.S. Study Says*, TORONTO STAR, June 23, 1993, at A32. According to a U.S. study, "[r]oughly $1.5 billion was spent last year on the 16,475 U.S. organ transplant operations and the after-care of patients . . . . The study found that the median hospital charges for organ [procurement] in 1988 [was] $12,290 for a kidney, $12,578 for a heart, $16,281 for a liver, and $15,400 for a pancreas." The study found that these charges were often four times the actual cost, due to the fact that insurance companies and Medicare leave unspecified as to what is an allowable expenditure for an organ. *Id.*

[290] Blair & Kaserman, *supra* note 17, at 430.

[291] *Id.*

[292] LAMB, *supra* note 21, at 140.

seem that this can be true only if society in general was opposed to the idea of organ transplantation donation. However, polls in Singapore,[293] Canada,[294] Great Britain,[295] and the United States,[296] as well as other countries, have shown that as a society we do not oppose organ donation, but support it as a therapy for organ failure. General support for organ donation, coupled with the fact that presumed consent allows for an individual to opt-out, would seem to counter such an argument. If anything, presumed consent with the ability to opt-out affirms an individual's freedom by expressly ensuring that a donor's wishes are respected, instead of allowing the next of kin to either donate, or forbid donation, of an individual's organs after death.[297]

Other critics claim that eliminating altruistic feelings that the positive act of donation provides would be a loss that even increased organ numbers could not justify.[298] Such a belief indicates that (1) a person cannot experience any sort of altruistic feelings by simply remaining within the donation system, and (2) the state has no right to enact a law that will reflect the altruistic nature of society. Many countries, in times of war, enact civilian draft laws to increase military enlistment. These individuals, though drafted, often experience altruistic feelings of patriotism, as does the rest of society. Assuming society is in favor of organ donation, why would similar patriotic feelings not develop? An even more basic argument for supporting the altruistic nature of a presumed consent system is that it would be consistent with traditional humanist values on the presumption that one favors life and life-saving; putting the burden on

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[293] Sixth Parliament Report, *supra* note 66, at A8 (noting that 85% are in favor of organ donation).

[294] ONTARIO MINISTRY OF HEALTH, *supra* note 146, at 41 (noting that "62% of individuals would [donate their own organs] . . . [and] approximately 20-30% in any population surveyed is opposed to giving consent for their own organ donation, and presumably they would record 'no'[]").

[295] MEYERS, *supra* note 16, at 191 (noting that "75% of the surveyed British public express a willingness to donate their organs after death to aid others . . . . ").

[296] Cohen, *supra* note 6, at 9 (noting that "[a] 1985 Gallup poll estimated that 75% of all American adults approved of the concept of organ donation and transplantation[]").

[297] Sixth Parliament Report, *supra* note 66, at A8-A9 ("[Presumed consent] is not against individual freedom. Instead it reaffirms the individual Singaporean's ownership of and responsibility for his own body. People are therefore better able to ensure that their wishes are followed because their and not their next of kin's acceptance or objection has to be respected.").

[298] Del Bigio, *supra* note 162, at 69 ("Thus, concerns of efficacy will always be constrained by the moral considerations of donation as a gift, sensitivity and compassion, and autonomy.").

the individual who would deny someone life by withdrawing consent for organ removal.[299]

Another benefit of a presumed consent system is that it would be an easier system to manage than the traditional voluntary consent. If there was no registered objection to organ removal, the physician removing the organ could proceed without contacting the deceased's next of kin for consent. If doctors were assured they were on solid legal ground, they could proceed with the organ removal without the hesitation that plagues French doctors.[300] Shortening the time between death and determination of consent also insures that the organ is as fresh as possible, increasing the transplant's chance for success. But, perhaps the biggest advantage to doctors is that they would not feel inhibited in initiating the donor process, since they would not have to "bother" a grieving family when the family is arguably not prepared to make decisions concerning organ donation.[301] While it is not hard to envision a family perhaps becoming upset because they did not get to participate in this critical choice, this problem can be overcome by (1) educating the public about the presumed consent law; (2) telling the family that if the deceased had wished to give or withdraw consent for organ removal, the deceased would have done so during life; and (3) assuring the family that the organ will be used to save another person's life. Complete public education is not only imperative in gaining the support of the next of kin, but also in insuring that each individual is aware of their own right to opt-out if they choose.

While harmonizing legislation around a presumed consent model would help to insure that each nation's procurement system was working effectively, it is also imperative that effective prohibitions on organ sales, especially those that sink to the level of human rights violations, are passed and enforced. While many nations have passed prohibitions on organ sales, few have written their statutes such that extraterritorial jurisdiction can be obtained. Illegal organ sales directly harm nations operating under a presumed consent system because such sales only serve to undermine the low-cost, safe, equitable, and efficient alternative offered by presumed consent. Using the protective principle of extraterritorial jurisdiction, it would not be difficult for nations with statutes prohibiting organ sales to prosecute those that engage in such commerce extraterritorially.

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[299] Butler, *supra* note 41, at 204-05.

[300] *See* Gerson, *supra* note 146.

[301] M.A. Robinette et al., *Donation Process*, *in* ONTARIO MINISTRY OF HEALTH, ORGAN DONATION IN THE EIGHTIES: THE MINISTER'S TASK FORCE ON KIDNEY DONATION 91, 97 (1986) (noting that 50% of doctors and nurses felt inhibited by initiating the donation process).

VII. CONCLUSION

An international system as complex and interactive as the one proposed can not occur immediately. States must act domestically to enact legislation that aims to maximize organ procurement while minimizing rights violations. States acting to strengthen domestic markets will in effect strengthen the international market by limiting the incentive for abuse to their organ supply through sloppy, illegal sales to foreigners. Presumed consent is the most efficient and least violative of the procurement methods currently in existence, and should be adopted by nations worldwide in conjunction with a ban on all organ sales.

Exhibit 2

1991

Presumed Consent to Organ Donation: A Reevaluation

Maxwell J. Mehlman

PRESUMED CONSENT TO ORGAN DONATION: A REEVALUATION

Maxwell J. Mehlman†

AS THE DEMAND for transplant organs continues to exceed the supply,[1] various methods are being considered for increasing the availability of organs from cadaveric donors. One alternative is "presumed consent." Currently in the United States,[2] a person is presumed to be *un*willing to donate his or her organs at death unless the person, or the family, gives permission. In other words, ours is a system of "presumed nonconsent." Under presumed consent, on the other hand, the decedent would be presumed to be willing to have his or her organs harvested upon death unless he or she, or the family, actively objected.

This paper examines the presumed consent approach from a practical, legal and ethical perspective. It concludes that presumed consent for harvesting cadaveric organs [3] may be a viable policy alternative, but that research in a number of specific areas is needed before the policy can be endorsed.

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† Professor of Law and Director, The Law-Medicine Center, Case Western Reserve University School of Law. B.A. Reed College, 1970; B.A. Oxford University, 1972; J.D., Yale Law School, 1975. This paper was prepared at the request and with the support of the National Kidney Foundation. The Author would like to thank Susan Gornik for her research assistance, Odette Wurzburger for her help in obtaining information from Europe, Stephen Post for insights into religious viewpoints on organ donation, Rebecca Dresser for her comments on an earlier draft, and June Omslaer-Sliker for her help in preparing the manuscript. The views expressed herein are solely the author's.

1. Approximately 100,000 people are on waiting lists for organ or tissue transplantation. Rivers, Buse, Bivins and Horst, *Organ and Tissue Procurement in the Acute Care Setting: Principles and Practice-Part 1*, 19 ANNALS OF EMERGENCY MED. 78, 79 (1990) [hereinafter "Rivers"]. There were 9,123 kidney transplants in 1988, but 13,000 patients are still waiting for kidney transplants. *Id.* The National Heart Transplant Study found that 14,000 to 15,000 patients need a heart transplant but only 1,647 patients received transplants in 1988. *Id.* at 78-79.

2. For information on other countries, *see infra* notes 55-67, 72-73, 86-88 and accompanying text.

3. This paper does not address the question of how to increase the supply of transplant organs from living donors.

I. HISTORICAL BACKGROUND

Although the first cadaveric kidney was transplanted in 1936,[4] significant concern with assuring an adequate supply of transplant organs only began to be expressed following the marked success of renal transplantation in the late 1960's and 1970's.[5]

Initially, the United States relied on a purely voluntary approach to organ donation. The law provided that in general an individual, or his family, could consent to the removal of organs following the individual's death, but that harvesting organs without this permission could subject the persons removing the organs to civil and criminal penalties.[6] Apart from this basic rule, however, the legal principles governing consent to donation, which were established by state courts and legislatives, varied from state to state. The result was a confusing patchwork. Moreover, in many cases there were no clear answers to such important questions as what should happen if the family disagreed with the wishes of the decedent.[7]

To remedy these problems, the National Conference of Commissioners on Uniform Law began to draft model state legislation in 1965, and in 1968, approved the Uniform Anatomical Gift Act.[8] By 1972, the UAGA had been adopted throughout the United States.[9] The UAGA was more than an effort to clarify state law on organ donation and to create a uniform set of rules, however; it was also an attempt to promote organ donation by simplifying the pro-

4. The first cadaveric kidney transplant was performed in the Soviet Union in 1936 and a great deal of experimentation was done in the United States during the 1940's and 1950's. Hamilton, *Kidney Transplantation: A History*, in KIDNEY TRANSPLANTATION: PRINCIPLES AND PRACTICE 5-8 (P. Morris ed. 2d. ed. 1984).

5. Tissue typing and the use of cyclosporine have contributed to the improved success rates. *See id.* at 8-11. At the end of the 1980's, one year graft survival rates were 75-85 percent and patient one-year survival rates were greater than 95 percent. Suranyi and Hall, *Current Status of Renal Transplantation*, 152 W. J. MED. 687 (1990).

6. For a discussion of the early history of the disposition of dead bodies, *see* Naylor, *The Role of the Family in Cadaveric Organ Procurement*, 65 IND. L. J. 167, 169-73 (1989).

7. *See id.* at 172-73. *See also* Silver, *The Case for a Post-Mortem Organ Draft and a Proposed Model Organ Draft Act*, 68 B.U.L. REV. 681, 688-93 (1988); Dukeminier and Sanders, *Organ Transplantation: A Proposal for Routine Salvaging of Cadaver Organs*, 279 N. ENG. J. MED. 413, 413-15 (1968).

8. 8a U.L.A. 16 (1983) [hereinafter "UAGA(1968)"].

9. *See* Uniform Anatomical Gift Act, 8A U.L.A. 22-23 (Supp. 1991) [hereinafter "UAGA(1987)"]. The UAGA was amended in 1987 in various respects. *Id.* at 2. A number of states have adopted the amendments in whole or in part. *See* 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, 532 (1990) [hereinafter "Columbia Note"].

cess of consent, especially by the decedent.[10] For example, the UAGA recognized donor cards as a method by which a person could give legally valid consent to donate organs upon death.[11] Passage of the UAGA, in short, signified that the nation would no longer rely on purely voluntary behavior. Instead, the law would be changed to facilitate donation. This approach was known as "encouraged voluntarism."[12]

By the mid-1980's, it had become clear that the policy of encouraged voluntarism embodied in the UAGA was not producing enough donors. Few persons signed donor cards.[13] Even when potential donors with signed cards were identified, hospitals refused to harvest their organs without familial consent, and doctors were reluctant to approach families to ask for permission.[14] The supply of cadaver organs remained limited at the same time that advances in transplant technique and immunosuppressive therapy improved the success rate of transplants, thereby increasing demand.[15] The continued shortage of donor organs prompted the search for an alternative to the principles of encouraged voluntarism. One proposal was presumed consent.[16] Under the name of "routine salvage,"

10. *See, e.g.*, Columbia Note, *supra* note 9, at 535 ("[t]he UAGA(1968) did not live up to its expectations for encouraging a sufficient supply of organs . . . "); Naylor, *supra* note 6, at 173 ("[w]ith the 1968 UAGA and the statutes modeled after it, legislators attempted to reduce the family's role and use individual consent in order to procure more organs").

11. UAGA(1968) § 4(b).

12. *See* Caplan, *Organ Transplants: The Cost of Success*, 13 HASTINGS CTR. REP. 23 (Dec. 1983); Sadler, Sadler, Stason and Stickel, *Transplantation: A Case for Consent*, 280 NEW ENG. J. MED. 862 (1969).

13. A 1985 Gallup Poll found that 27 percent of those surveyed stated that they were very likely to donate their organs, but only 17 percent had signed donor cards. THE GALLUP ORGANIZATION, INC., GALLUP SURVEY: THE U.S. PUBLIC'S ATTITUDES TOWARD ORGAN TRANSPLANTATION/ORGAN DONATION 19 (1985), *cited in* Naylor, *supra* note 6, at 174. Manninen and Evans reported that only 14 percent of respondents in a telephone survey of a national probability sample stated that they carried donor cards. Manninen and Evans, *Public Attitudes and Behavior Regarding Organ Donation*, 253 J. A.M.A. 3111, 3112 (1985).

14. *See* Matas, Arras, Muyskens, Tellis and Vieth, *A Proposal for Cadaver Organ Procurement: Routine Removal with Right of Informed Refusal*, 10 J. HEALTH POL., POL'Y & L. 231, 232-34 (1985) [hereinafter "Matas 1985"].

15. The introduction of cyclosporine in 1983 was particularly significant. *See* U.S. DEPT. OF HEALTH AND HUMAN SERVICES, TASK FORCE ON ORGAN TRANSPLANTATION, REPORT TO THE SECRETARY AND THE CONGRESS ON IMMUNOSUPPRESSIVE THERAPIES 10 (1985).

16. *See, e.g.*, Note, *Refining the Law of Organ Donation: Lessons from the French Law of Presumed Consent*, 19 INT'L L. & POL. 1013 (1987) [hereinafter "French Note"]; Butler, *The Law of Human Organ Procurement: A Modest Proposal*, 1 J. CONTEMP. HEALTH L. & POL'Y 195 (1985); Matas and Vieth, *Presumed Consent for Organ Retrieval*, 5 THEOR. MED. 155 (1984); Starzl, *Implied Consent for Cadaveric Organ Donation*, 251 J. A.M.A. 1592 (1984); Cwiek, *Presumed Consent as a Solution to the Organ Shortfall Problem*, J. A.M.A. 4 PUB. L. F. 81 (1984).

Dukeminier and Sanders had advocated this approach back in 1968 when transplantation successes first began to stimulate interest in increasing the supply of donor organs.[17] As envisioned by Dukeminier and Sanders, presumed consent would eliminate the need for donors to carry donor cards, and for physicians to intrude on the family's grief just when they had learned of the death of a loved one. In essence, the burden of taking action would shift from the surgeon wishing to remove the organs to the donor and his family. There would be no need for the doctor to obtain explicit consent to donation; instead, it would be up to the family, or to the decedent while still alive, to assert an objection. In the absence of an objection, the doctor would be entitled to assume that he had permission to retrieve any organs that were needed, and he could remove the organs without fear of legal liability.[18]

Despite the possibility that its adoption would provide more organs for transplantation, the presumed consent idea did not receive wide endorsement. David Ogden, then President of the National Kidney Foundation, objected that it was "relatively coercive, compared to the more classical freedom of choice that characterizes our way of life."[19] Others repeated Paul Ramsey's concern that presumed consent "would deprive individuals of the exercise of the virtue of generosity."[20] The most telling objection, however, was that presumed consent was not acceptable to the public. A widely cited opinion poll, for example, reported that only 7 percent of the public supported the concept.[21] Indeed, when a federal task force on organ transplantation rejected presumed consent in 1986, it gave lack of popular support as its only reason.[22]

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17. Dukeminier and Sanders, *supra* note 7.

18. Dukeminier and Sanders wrote:

> At present the surgeon is told: "You may not remove cadaver organs to save the life of a living person unless you have obtained consent from the deceased or his next of kin." He ought to be told: "You may remove cadaver organs to save the life of a living person unless the decedent notified you that he objected or the next of kin now objects."

Id. at 418.

19. Ogden, *Another View on Presumed Consent*, 13 HASTINGS CNTR. REP. 28 (Dec. 1983).

20. P. RAMSEY, THE PATIENT AS PERSON 209-10 (1970), cited in, e.g., Steinbrook, *Kidneys for Transplantation*, 6 J. HEALTH POL., POL'Y & L. 504, 510-511 (1981).

21. Manninen & Evans, *supra* note 13, at 3111.

22. U.S. DEPT. OF HEALTH AND HUMAN SERVICES, REPORT OF THE TASK FORCE ON ORGAN TRANSPLANTATION: ISSUES AND RECOMMENDATIONS 30-31 (1986) [hereinafter "1986 Task Force Report"]. 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 polls show that there is little support for this mecha-

An additional factor may have been that the presumed consent concept was being confused with an entirely different approach, that of "required request." In 1983, Arthur Caplan had called for a shift from encouraged voluntarism to a system in which hospitals would be required by law to ask potential donors or their families if they had any objection to the removal of organs following death.[23] Since people would be asked if they objected to donation rather than if they consented,[24] Caplan felt that this amounted to creating a presumption in favor of removing organs. His proposal differed from Sanders' and Dukeminier's original presumed consent scheme in the key respect that, under Caplan's approach, organs could be harvested only if the donor or family expressly stated that they had no objection, while according to Sanders and Dukeminier, organs could be removed without any action by the donor or the family, so long as neither the donor nor the family had voiced an objection. Caplan's position thus in fact occupied a middle ground between encouraged voluntarism and presumed consent, as Matas and his colleagues pointed out in 1985.[25] Nevertheless, Caplan termed his approach "presumed consent."[26]

Eventually, the distinction between asking donors and families if they consented to donation and asking them if they objected, which had formed the basis for Caplan calling his scheme "presumed consent" in the first place, disappeared. All hospitals would simply be required to ask donors or their families for permission to remove organs. Caplan advocated this middle-ground approach as the solu-

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nism 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."

23. *See* Caplan, *supra* note 12, at 27-28.

24. *Id.* at 28 ("[f]amilies should be asked not whether they will consent to the donation of organs but whether they have any objections").

25. Matas 1985, *supra* note 14, at 231 ("[o]ur proposal charts a middle path between the current ineffective policy based on 'encouraged voluntarism' and 'presumed consent' policies that promise effectiveness at the cost of violating traditional ethical and legal principles"). Matas and his colleagues proposed that families be told the following prior to removal of organs:

> "As you probably know, it is official practice here, and everywhere else in our state, for suitable organs to be routinely removed from patients with brain death. Unless you and the rest of your family object, we will surgically remove one or more of your relative's vital organs in order that some other needy patient might live. In case you do object, we will certainly respect your wishes."

Id. at 238.

26. *Id.*

tion to the failure of encouraged voluntarism.[27] Although he now used the more accurate term "required request," his original use of the term "presumed consent" may have led some who had favored Sanders' and Dukeminier's proposal to believe that the two approaches were substantially the same.

In any event, required request became the preferred alternative in the mid-1980's. A number of state legislatures adopted it, beginning with Oregon in 1985.[28] In 1986, the Task Force on Organ Transplantation of the U.S. Department of Health and Human Services endorsed it.[29] The UAGA was amended in 1987 to include a required request provision,[30] and eventually the federal government added the establishment of required request policies to the list of conditions that hospitals have to fulfill in order to be eligible for reimbursement under Medicare.[31]

The historical background of the present debate over presumed consent would be incomplete without mention of a further key development, and one that is not widely known. Although it is generally true that, in the mid-1980's, the principles of presumed consent were rejected in favor of required request, a number of states in fact enacted a presumed consent approach to organ removal. A recent survey, for example, shows that seventeen states permit coroners or medical examiners to remove corneas and/or pituitary glands without obtaining the consent of either the donor or the next-of-kin.[32] In these states, removal of organs is permissible so long as the coroner or medical examiner is unaware of an objection.[33] In addition, Hawaii permits any tissues to be removed regardless of whether or not there is an objection,[34] and Vermont allows pituitaries to be removed unless an objection is made based on religious grounds.[35] While the authority of the coroners and medical examiners in these

27. Caplan, *Organ Procurement: It's Not in the Cards*, 14 HASTINGS CNTR. REP. 9 (1984).

28. *See* Burris, Marquette, Gordon, Iwata and Tanne, *Impact of Routine Inquiry Legislation in Oregon on Eye Donations*, 6 CORNEA 226 (1987) [hereinafter "Burris"].

29. 1986 Task Force Report, *supra* note 22, at 31-34.

30. UAGA(1987) § 5.

31. *See* 42 U.S.C. § 1320b-8.

32. *See* Columbia Note, *supra* note 9, at 535, n.35-37 and accompanying text. The states are: Arkansas (pituitary); California (both); Colorado (pituitary); Connecticut (both); Delaware (cornea); Florida (cornea); Georgia (cornea and eye); Kentucky (cornea); Maryland (cornea); Michigan (cornea); Missouri (pituitary); North Carolina (cornea); Ohio (cornea); Oklahoma (pituitary); Tennessee (cornea); Texas (cornea); and West Virginia (cornea).

33. *Id.* at 535.

34. *See id.* at 536, n.38.

35. *Id.*

states is limited to removing organs from bodies in their custody, passage of these laws demonstrates that presumed consent currently is acceptable to some state legislatures under some circumstances.[36]

II. EXPERIENCE WITH REQUIRED REQUEST

Required request was devised to deal with what were believed to be the underlying reasons for the failure of encouraged voluntarism. Opinion polls showed that few people voluntarily donated their own organs or those of members of their own families. Yet the polls also showed that an overwhelming majority approved of organ donation in principle, and hospitals found that, when asked, most families consented to removing the organs of dead relatives.[37] Asking families rather than the donors themselves therefore seemed the best approach to increasing the supply of organs. The problem was that, under encouraged voluntarism, the families were not being asked.[38] Physicians and nurses were reluctant to ask families to consent to donation while their loved ones were still alive, and, once death had occurred, caregivers did not like to interrupt families during their time of grief.[39] Physicians were also reported to be held back from discussing donation by the notion that the death of the patient was a medical failure.[40] The typical separation of treatment and transplant teams within the hospital community also reduced structural incentives for establishing effective request procedures.[41]

The solution represented by required request was to overcome this professional and institutional resistance by using the force of the law. Accordingly, state and federal laws were amended to require hospitals to request donation from the families of suitable donors.

Although required request has been in operation for only a few years, there seems to be a growing sense that it has failed to solve the organ shortage problem. The data on whether or not required request has increased the rate of donation are mixed. Burris and his

36. For a discussion of court decisions upholding these statutes, *infra* notes 125-29 and accompanying text.

37. *See* Caplan, *Requests, Gifts, and Obligations: The Ethics of Organ Procurement*, 18 TRANSPLANTATION PROC. 49, 53 (Supp. 2 1986).

38. *See* 1986 Task Force Report, *supra* note 22, at 43.

39. *See id.* at 44.

40. *Id.*; Youngner, *Brain Death and Organ Procurement: Some Vexing Problems Remain*, 19 DIALYSIS & TRANSPLANTATION 12, 14 (1990).

41. The organ procurement agency, which is responsible for recovering, preserving and distributing organs for transplantation, depends on the referring physician to identify and refer potential organ donors. *See* Rivers, *supra* note 1, at 80.

colleagues report that monthly collections of eyes in Oregon increased 135 percent during the first year of routine request.[42] The President of the Eye Bank Association of America claims that hospital donations of eyes increased 66 percent following the switch to required request.[43] The New York State Department of Health reports that, in the year after the legislature passed a required request law in New York State, heart donations increased by 94 percent, livers by 96 percent, kidneys by 23 percent, and eyes by 58 percent.[44] Other data present a less favorable picture. Kittur and his colleagues in Baltimore attribute a phenomenal 400 percent increase in donor referrals and a 500 percent increase in tissue donations to a vigorous "donor advocacy" program, but while their data show that more people were being asked to consent, the consent rate remained at only 39 percent of those asked, and the ratio of donations to requests increased only 3 percent compared to the year immediately preceding the inception of the program.[45] Andersen and Fox state that, while eye, bone and skin donations in Oregon increased, kidney donations decreased the first year after required request was enacted.[46] They also report no increase in the number of organ donors in Los Angeles and San Francisco following adoption of required request in California.[47] Caplan, who is perhaps most closely associated with the required request concept, admits that, while donations have increased in many places, "these numbers ought to be even greater given the large number of persons who could donate tissue upon their deaths."[48] Finally, even if required request laws have increased the availability of donor organs, it is clear that the

42. Burris, *supra* note 28, at 226.

43. Letter from Tom Moore, 19 HASTINGS CNTR. REP. 44 (March/April 1989).

44. NEW YORK STATE DEPARTMENT OF HEALTH, THE IMPLEMENTATION OF THE REQUIRED REQUEST LAW: A REPORT TO GOVERNOR CUOMO AND THE LEGISLATURE INCLUDING A STUDY OF TRANSPLANT SERVICES IN NEW YORK STATE (July 1987) *cited in* Andersen and Fox, *The Impact of Routine Inquiry Laws on Organ Donation*, HEALTH AFFAIRS 65, 75 (Winter 1988).

45. *See* Kittur, McMenamin and Knott, *Impact of an Organ Donor and Tissue Donor Advocacy Program on Community Hospitals*, 56 AM. SURGEON 36, 38-39 (1990).

46. Andersen and Fox, *supra* note 44, at 75. The authors state that kidney donations increased 12 percent during the second year after required request was imposed, but do not indicate what the increase was in reference to.

47. *Id.*

48. Caplan, *Professional Arrogance and Public Misunderstanding*, 18 HASTINGS CNTR. REP. 34, 35 (April/May 1988). Caplan states that donation has increased from 10 to 20 percent in many states, but that there has been no increase in others. However, he argues that the fact that donations have remained constant in those states despite significant declines in traffic fatalities suggests that required request has had "a small positive impact." *Id.*

number of organs still falls substantially short of the need.[49]

Caplan cites two problems that procurement officials and state health department representatives believe to be responsible for the lack of success of required request laws. First, health professionals who must make the requests are not adequately trained to be effective, and second, physicians, regarding required request laws as a bureaucratic intrusion into the practice of medicine, refuse to comply.[50] The design of many state required request laws is also partly responsible: the laws often contain major loopholes allowing the requirements to be circumvented and in many cases no penalties are established for failure to comply.[51]

It might not yet be time to write off required request. Better efforts to educate those who must deal with families of potential donors, perhaps coupled with more stringent legal requirements, might increase the frequency and effectiveness of donation requests.[52] Greater monitoring of hospital compliance with Medicare required request requirements also could help.[53] Nevertheless, disappointment with required request has sparked renewed interest in other approaches, including presumed consent.[54]

III. POTENTIAL BENEFITS OF PRESUMED CONSENT

A. Increasing the Supply of Organs for Transplantation

Interest in presumed consent stems chiefly from the expectation that it would significantly increase the supply of transplant organs. European experience with presumed consent is frequently cited in support. Benoit and his colleagues report that transplantation has

49. *See* Rivers, *supra* note 1 and accompanying text. Andersen and Fox state that "[b]y itself, routine inquiry is not likely to affect significantly the supply of organs after early attention by the media." Andersen and Fox, *supra* note 44, at 77. Even enthusiastic supporters of required request admit that waiting lists of prospective donees persist. *See, e.g.* Burris, *supra* note 28, at 230.

50. *See* Caplan, *supra* note 48, at 35. Caplan reports that, in many states, no more than 50 percent of physicians comply with required request laws. *Id.*

51. *See* Mehlman, *Encouraging Donation of Organs for Transplantation by Requiring Request*, V Health Matrix 36-37 (1987).

52. More severe penalties might provoke a backlash from physicians, however. *See* Caplan, *supra* note 48, at 35 (physicians object to being told "what they *must* do," emphasis in original).

53. The enforcement of Medicare conditions of participation, which include the required request requirements, has been criticized as generally inadequate, however. *See* INSTITUTE OF MEDICINE, NATIONAL ACADEMY OF SCIENCES, I MEDICARE: A STRATEGY FOR QUALITY ASSURANCE 132-34 (1990).

54. Another approach that is receiving renewed attention is allowing transplant organs to be bought and sold. *See, e.g.* Hansmann, *The Economics and Ethics of Markets for Human Organs*, 14 J. HEALTH POL., POL'Y & L. 57 (1989).

increased since the introduction of presumed consent in France — from 551 to 1808 kidneys; from 15 to 622 hearts and hearts/lungs; from 7 to 409 livers; and from 2 to 43 pancreas.[55] Roels and his colleagues state that the adoption of presumed consent in Belgium resulted in an 86 percent increase in cadaveric kidney procurement, and a 183 percent increase in the total number of organs available for transplant.[56] They also report much higher transplantation rates in three countries that they claim have presumed consent systems — Belgium, France and Austria — compared with three other countries that do not — the United Kingdom, the Federal Republic of Germany, and the Netherlands.[57] In a paper reporting more recent data from 1989, Roels and his colleagues state flatly that "data presented show that, at least in Europe, the problem of chronic organ shortage can adequately be solved in the setting of an [sic] opting-out legislation."[58]

Unfortunately, the information from Europe can be deceiving. While France technically adopted a presumed consent approach in 1976,[59] French physicians routinely ask families for permission before removing organs.[60] Therefore, the experience in France reflects the operation of an encouraged voluntary or routine request system, rather than a true presumed consent approach. A similar practice prevails in Belgium; although physicians in Belgium are permitted legally to remove organs without permission, as a practi-

55. Benoit, Spira, Nicoulet and Moukarzel, *Presumed Consent Law: Results of its Application/Outcome from an Epidemiologic Survey*, 22 TRANSPLANTATION PROC. 320 (April 1990) [hereinafter "Benoit"].

56. Roels, Vanrenterghem, Waer, Gruwez and Michielsen, *Effect of a Presumed Consent Law on Organ Retrieval in Belgium*, 22 TRANSPLANTATION PROC. 2078 (August 1990) [hereinafter "Roels 1990"].

57. *Id.* at 2078-79. The authors conclude that "the relationship of organ availability and legislation within these countries shows clearly the beneficial effect of national legislations [sic] based on the principle of presumed consent." *Id.* at 2079.

58. ROELS, VANRENTERGHEM, WAER, CHRISTIAENS, GRUWEZ AND MICHIELSEN, THREE YEARS EXPERIENCE WITH A [SIC] "PRESUMED CONSENT" LEGISLATION IN BELGIUM: ITS IMPACT ON MULTI-ORGAN DONATION IN COMPARISON WITH OTHER EUROPEAN COUNTRIES 4 (undated, supplied to author by the National Kidney Foundation) [hereinafter "Roels Update"].

59. Loi No. 76-1181 du 22 decembre 1976, 1976 J.O. 7365, 1977 Dalloz-Sirey, Legislation [D.S.L.] 13. The law was called the Caillavet Law after its sponsor. French Note, *supra* note 16, at 1022.

60. Communication from Pierre Korman, Director, French Transplant Association (Nov. 12, 1990). *See also* French Note, *supra* note 16, at 1025 (" . . . some French doctors simply disregard the Law and seek the permission of the family in every case possible, thereby continuing the 'long-established custom' which was to have been eliminated by the 1976 law"). Benoit reports that French physicians ask families for permission in 82.2 percent of cases. Benoit, *supra* note 55, at 321.

cal matter they inform families of the option to refuse and ask if the families have any objections.[61]

One true presumed consent system in Europe is found in Austria.[62] A patient who does not wish to donate organs must state his objection in writing. Donation is not discussed with families unless they raise the issue. The only exceptions are cases involving pediatric patients and foreigners.[63]

It is therefore noteworthy that the latest data from Eurotransplant on the availability of kidneys for transplantation show that Austria not only has a significantly higher rate than the Federal Republic of Germany, Luxemburg and the Netherlands, all of which have voluntary donation systems, but also a rate more than 11 percent higher than Belgium, which, despite its *de jure* presumed consent system, operates *de facto* on the basis of encouraged voluntarism or routine request.[64] The Austrian data on heart and liver donation are not as clear. If presumed consent provided more organs than other donation approaches, it would be expected that, as a percentage of the population, more hearts and livers would be

61. Personal communication from Bernadette Haase, General Manager, Eurotransplant (Dec. 17, 1990). Roels and his colleagues seem to realize the weak foundation for their claim that the experience in Belgium demonstrates the efficacy of presumed consent when they admit that, according to their data, the major reason for the increase in organ donation in countries like Belgium was "the participation of an increasing number of smaller non-university hospitals in organ procurement." Roels Update, *supra* note 58, at 4.

There is confusion among other scholars regarding whether various countries have encouraged voluntary, routine request, or presumed consent systems. For example, Silver states that presumed consent systems operate in Finland, Greece, Italy, Norway, Spain and Sweden, whereas Matas and Vieth state that the laws in these countries require physicians to ask families if they object to donation. *Compare* Silver, *supra* note 7, at 703, *with* Matas & Vieth, *supra* note 16, at 156. If Matas and Vieth are correct, this undercuts Silver's claim that European countries with presumed consent systems still lack sufficient organs for transplantation. *See* Silver, *supra*, at 706. But Matas and Vieth themselves describe the French system as one of presumed consent. *See*, Matas and Vieth, *supra*.

62. Personal communication from Bernadette Haase, General Manager, Eurotransplant (Dec. 17, 1990) and Herman Fetz, Transplant Coordinator, University Hospitals of Innsbruck, Austria (Dec. 18, 1990). It is not clear that presumed consent actually operates in any other European countries.

63. Personal communication with Herman Fetz, *supra* note 62.

64. *See* EUROTRANSPLANT FOUNDATION, ANNUAL REPORT 1989, Table 1.7 (1989). The number of kidneys available per million inhabitants in 1989 was 52.1 in Austria; 40.9 in Belgium; 30.3 in Germany; 20.0 in Luxemburg; and 24.9 in The Netherlands. In 1988, the rates were 39.3 (Austria); 38.0 (Belgium); 26.9 (Germany); 26.7 (Luxemburg); and 25.5 (The Netherlands). *Id.* Eurotransplant does not provide data on France, and therefore its data do not permit the kidney donation experience in Austria to be compared with the experience in France. A table in a paper by Roels and colleagues shows that Belgium and France in 1988 transplanted more kidneys per million inhabitants than Austria, but the question is not how many kidneys were transplanted, but how many were available through donation. See Roels 1990, *supra* note 56, at 2079, Fig. 2.

donated in Austria not only in comparison with countries that have *de jure* and *de facto* voluntary systems, like the United Kingdom, Germany and The Netherlands, but also in comparison with Belgium and France. According to Roels and his colleagues, Austria, Belguim and France all have much higher numbers of hearts and livers available for transplantation per million inhabitants than the United Kingdom, the Federal Republic of Germany and The Netherlands.[65] But while Austria has a somewhat higher rate for livers than either France or Belgium, it has a lower rate for hearts.[66] The Austrian experience therefore provides some support for the notion that adopting presumed consent increases the supply of donor organs over other donation approaches, but the data are incomplete, and a number of questions remain unanswered.

A significant question arises, however, regarding the relevance of the Austrian experience to the United States. Unlike the U.S. and other European countries, Austria has long permitted autopsies to be performed without consent, and this practice has been ingrained in physicians through their training.[67] Austrian physicians therefore are likely to be more willing to remove organs for transplantation without express consent than their American or European colleagues. Since Austria is the only European country with a history of autopsy without consent, this also would explain why physicians in Austria refrain from seeking permission from families when that practice has overwhelmed the *de jure* presumed consent systems in countries such as France and Belgium.

B. More Humane for Families

While the prospect of increasing the supply of organs for donation is the major benefit anticipated from a shift to presumed consent, there may be other important benefits as well. To begin with, since presumed consent would eliminate the need to confront bereaved relatives with requests for donation, it may be more humane than required request. "To someone whose relative is about to die," wrote Dukeminier and Sanders, "asking for the kidneys may seem a ghoulish request."[68] The same may be true for relatives whose loved one has just been declared legally dead.[69]

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65. See Roels Update, *supra* note 58, fig. 2.

66. *Id.*

67. Personal communication with Bernard Cohen, Director, Eurotransplant (Feb. 25, 1991).

68. Dukeminier and Sanders, *supra* note 7, at 416.

69. The distastefulness of approaching families may be compounded when the body is

C. Increased Patient Autonomy and Informed Consent

Presumed consent may increase the likelihood that decisions about donation are voluntary and informed. Since the decision to object to donation would be made voluntarily by the patient or the family (depending on how the presumed consent system were designed), the decision could be made at a time when the decisionmakers were not confronting their own or their loved one's death. It therefore might be more deliberative and dispassionate than a decision under required request.[70]

Presumed consent also may enhance patient autonomy. Under required request, the ultimate decision to donate typically is made by the patient's family, rather than by the patient. Even in the infrequent case in which the patient had signed a donor card or otherwise expressed a desire to donate, surgeons are unlikely to remove organs unless the family has given permission.[71] When the family disagrees with the patient's disposition, required request therefore may frustrate the patient's actual wishes.

Depending on how it was implemented, presumed consent might reduce the ability of the family to override the decedent.[72] The family might be given no right to object when the patient, as-

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being maintained on life support systems to preserve the viability of the transplant organs. *See* Youngner, *supra* note 40, at 14; Martyn, Wright and Clark, *Required Request for Organ Donation: Moral, Clinical, and Legal Problems*, 18 HASTINGS CNTR. REP. 27, 29 (April/May 1988) [hereinafter "Martyn"] ("[t]he family also is faced with a significant psychological burden as they are confronted with their loss and attempt to comprehend a diagnosis of death belied by their observation of an apparently breathing, pulsating, and warm body").

70. *See* Matas 1985, *supra* note 14, at 240 ("[i]n the charged atmosphere of sudden death of a family member, it is doubtful that genuinely informed and autonomous consent is often given for organ removal"); Caplan, *supra* note 12, at 26 (same). Some commentators have gone further and charged that required request actually may coerce the family into donation. *See* Martyn, *supra* note 69, at 29 ("[t]he request for donation may thus set the stage for undue influence on or psychological manipulation of the family").

71. Misunderstandings about the legal status of this widespread practice is reflected by the fact that Gallup polls have repeatedly asked respondents if they are aware that "even with a signed donor card, family consent must be obtained before organs can be removed for transplantation." *See* THE GALLUP ORGANIZATION, INC., GALLUP SURVEY: THE U.S. PUBLIC'S ATTITUDE TOWARD ORGAN TRANSPLANTATION/ORGAN DONATION (1985, 1986, 1987, 1990) (commissioned by the Dow Chemical Company's Take Initiative Program on Transplantation) [hereinafter referred to by the term "Gallup Poll" and the year of the survey]. This question may give the impression that the law requires families to give permission even when there is a signed donor card, and that in the absence of permission from the family, the donor's wishes can be ignored. Under the 1987 UAGA, however, it is illegal to ignore the wishes of the decedent in favor of those of the family. *See* UAGA(1987) § 2(h).

72. *See* French Note, *supra* note 16, at 1020 ("[i]n practice donor cards are generally ignored, leaving the decision entirely in the hands of the family . . . [;] a policy of presumed consent, rather than quashing individual rights, would make the donor the primary, and perhaps exclusive, decision-maker in organ donation").

suming he or she was competent, had not refused donation. More likely, the role of the family might be limited, at least nominally, to expressing what they believed to be the patient's desires rather than their own.[73]

D. Effectuating Public Preferences

Although it is commonly believed that the public is opposed to presumed consent, some commentators argue that most people in fact are favorable or indifferent and simply cannot admit it or act upon it.[74] In support, these commentators cite the fact that far more people state that they are willing to donate their organs than fill out donor cards. This suggests that people are in favor of donation in the abstract, but that psychological factors involved in contemplating their own deaths, or those of their loved ones, make them unable to articulate their true wishes.[75] By eliminating the need to confront donation actively in order to donate, presumed consent might overcome these psychological impediments and allow individuals to give effect to their true beliefs.

Before leaving the subject of why presumed consent might be beneficial, it is worth pointing out that, while it is important to attempt to create a donation system that is more humane, in which decision-making is more autonomous and informed, and that is more consistent with underlying personal beliefs, the chief purpose of presumed consent is to increase the supply of donor organs. Therefore, even if presumed consent did not provide any of these secondary benefits, it still might be preferred to existing approaches so long as it yielded a significantly greater number of transplant organs.

IV. OBJECTIONS TO PRESUMED CONSENT

Opponents of presumed consent raise ethical, religious, legal

73. This is the rule in France, whereby law the family is only supposed to assert the patient's own objections. *See* Ministere de la Sante et de la Securite Sociale, Circulaire du 3 avril 1978 concernat le Decret No. 78-501 du 31 mars 1978, 1978 J.O. 1530, 1978 Bulletin Legislatif Dalloz [B.L.D.] 249, sec. II (B). As a practical matter, however, the family often will express, or be asked to express, its own preferences. *See* Benoit, *supra* note 55, at 321 (study showed French families asked for their own wishes 51.4 percent of the time).

74. *See* Silver, *supra* note 7, at 697; Matas 1985, *supra* note 14, at 236.

75. *See* Silver, *supra* note 7, at 697 ("[t]hat seventy-five percent of the populace should say 'yea' to organ donation from an armchair, while eighty-three percent say 'nay' from the deathbed, suggests that most people believe they should donate their organs but cannot bring themselves to do so"); Matas 1985, *supra* note 14, at 236 (pointing out that people find organ donation "too troubling or frightening to think about," or "cannot really comprehend their own death or do not wish to think about it").

and practical objections. In the first place, they doubt that presumed consent would increase the supply of donor organs.[76] Citing the experience in France, critics assert that health professionals in the United States would behave no differently than their French counterparts, and would refuse to harvest organs without express permission.[77] This is an empirical question, and underscores the need for definitive data from Austria and other countries demonstrating the impact of presumed consent on organ availability.

Critics of presumed consent do not rest on this point, however. They take the position that, contrary to those who argue that presumed consent would yield the secondary benefits described above, such a system would be so inhumane, manipulative and unpopular that it must be rejected for those reasons alone. In other words, the end does not justify the means. The question then is, assuming that presumed consent *would* significantly increase the supply of donor organs, must it be rejected for other reasons?

A. Ethical Objections.

The ethical objections to presumed consent can best be summarized by referring to the five ethical values that the Task Force on Organ Transplantation of the Department of Health and Human Services in 1986 identified as necessary for any organ procurement system to promote:

1) "saving lives and improving quality of life";

2) "promoting a sense of community through acts of generosity";

3) "respecting individual autonomy";

4) "showing respect for the decedent"; and

5) "showing respect for the wishes of the family."[78]

There would seem to be little disagreement that, assuming that presumed consent significantly increased the supply of cadaveric organs, it would promote the first value of saving lives and improving

76. *See, e.g.*, French Note, *supra* note 16, at 1029. Youngner argues, for example, that "the notion that we can quickly resolve our society's ambivalence with laws and regulations is misguided," and states that such an approach will create a "rebound" effect that will reduce rather than increase donations. Youngner, *Organ Retrieval: Can We Ignore the Dark Side?*, 22 TRANSPLANTATION PROC. 1014, 1015 (1990). *See also* Youngner, *supra* note 40, at 14 (attempting to bypass resistance to donation through laws and regulations "will, in the long run, prove no more productive than pointing accusatory fingers").

77. *See* French Note, *supra* note 16, at 1029 ("... if the French experience is to serve as a guide, such a change would have little, if any, effect on the supply of organs for transplant").

78. 1986 Task Force Report, *supra* note 22, at 28.

the quality of life. Several studies have demonstrated, for example, that kidney transplants provide a better quality of life for end stage renal disease patients than dialysis, and that transplantation is more economical.[79]

Ethical objections to presumed consent therefore must be based on its inability to meet one or more of the other four objectives. The second objective is a restatement of Ramsey's defense of voluntary behavior, which was mentioned earlier: the more the state takes away the opportunity to act voluntarily, the less of an opportunity individuals have to be altruistic, and therefore the less virtuous our community will be.[80] Since presumed consent laws eliminate the need to express our willingness to donate organs, they arguably reduce our ability to act generously.

One response to this objection is that presumed consent laws facilitate rather than reduce altruistic behavior. This follows from the argument, described earlier, that people really want to donate their organs, or those of their loved ones, but for psychological reasons cannot bring themselves to do so.[81] According to this argument, presumed consent allows people to fulfill their altruistic impulses by refraining from objecting, which is psychologically easier for them than having to give their express consent. While altruistic action ideally might be preferred to altruistic *in*action, altruistic behavior, even of an inactive sort, is better than nonaltruistic behavior.

In addition, Ramsey's position seems to lead to an absurd result. Imagine telling a patient waiting for a life-saving transplant that he will be allowed to die just in case someone decides at the last minute to be benevolent and to donate the needed organ. Given the fact that people have not been willing to donate enough organs under encouraged voluntarism and required request, it is hard to accept the idea that we should avoid saving lives and improving quality of

79. *See* Simmons and Abress, *Quality-of-Life Issues for End-Stage Renal Disease Patients*, 15 AM. J. OF KIDNEY DISEASES 201 (1990) (successful transplant patients have a higher quality of life than dialysis patients); Bremer, McCauley, Wrona and Johnson, *Quality of Life in End-State Renal Disease: A Reexamination*, 13 AM. J. OF KIDNEY DISEASES 200 (1989) (transplant patients quality of life higher than dialysis patients); Eggers, *Effect of Transplantation on the Medicare End-Stage Renal Disease Program*, 318 NEW ENG. J. MED. 223, 228 (1988) (dialysis costs approximately three times as much as successful transplantation); Morris and Jones, *Transplantation Versus Dialysis: A Study of Quality of Life*, 20 TRANSPLANTATION PROC. 23 (1988) (transplant patients report better quality of life than dialysis patients).

80. *See supra* note 20 and accompanying text.

81. *See supra* notes 74-75 and accompanying text.

life on the off-chance that people's behavior suddenly will change.[82]

The potential failure of presumed consent to promote the remaining three values in these task force's list is a more telling objection. By allowing organs to be removed without permission, it might be said, presumed consent would conflict with individual autonomy and would be highly disrespectful of the decedent and of the wishes of the family. Imagine the horror of the family upon learning that, not only was their loved one dead, but that his organs had been removed without consent. The suffering that this would inflict on the family, the disempowering of the patient that would result from denying him an opportunity to control the disposition of his own body, and the distrust of health care providers that this would breed are so significant that they could outweigh any benefit that transplantation might provide. Indeed, they could undermine the organ donation system as a whole.

As suggested earlier, the objection that presumed consent would interfere with patient autonomy may be misplaced if presumed consent is being compared with required request, since required request as a practical matter allows the family to override the patient's wishes with regard to donation.[83] Nevertheless, there is such an inescapable, underlying unease created by the prospect that health care providers will be permitted to perform acts on dead bodies regardless of the wishes of the patient and the family that a presumed consent system must address these concerns in order to be a viable policy option.

One alternative would be to adopt a presumed consent system but to conceal it from public knowledge. After all, if patients and their families were unaware that organs were being removed, they would have no occasion to be upset. Assuming families retained the option of viewing the dead relative at the funeral, this would not only entail harvesting organs in such a way that the absence of the organs would not be noticeable, which would be desirable anyway to spare the family, but refraining from conducting any public information programs about the donation system.

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82. Ramsey's position is reminiscent of Cahn's approach to the classic lifeboat dilemma in which he argues that no one should be thrown overboard even though this means everyone will drown. *See* E. CAHN, THE MORAL DECISION: RIGHT AND WRONG IN THE LIGHT OF AMERICAN LAW 71 (1955). As Cahn makes clear, however, he does not actually intend for everyone to die; instead, he hopes that some altruistic occupant will sacrifice himself to save the others. *Id.* Even if this were to occur, it would have the paradoxical result that the person who most deserved to live inevitably would die — either by committing suicide or by being drowned with the others.

83. *See supra* notes 72-73 and accompanying text.

This approach would be both unethical and impractical. By attempting to hide the truth, it would deprive patients and their families of a meaningful opportunity to object to donation. The result would not be a system of presumed consent, but of mandatory organ removal.[84] Physicians are unlikely to accept such an approach. Nor could such a system be kept secret for long. For one thing, the press would be sure to find out and to seize upon it.[85] The resulting public backlash would almost certainly lead to legal action against providers and force the repeal of any presumed consent legislation that had been passed.

A better approach would be to educate patients and their families about how presumed consent worked and to construct an effective opting-out method by which they can express their objections to donation. In this way, a presumed consent system can be consistent with the ethical objectives of achieving individual autonomy and respecting the decedent and the wishes of the family, at the same time that it increased the supply of transplant organs by avoiding the need for express consent.

Constructing an effective educational program and opting-out system would not be easy. Experience with encouraged voluntarism and required request shows that educating the public and providers about organ donation is expensive and difficult. Furthermore, little attention has been given to how to design an opting-out system for the United States. The experience of European countries with presumed consent legislation is of little value. In Austria, a patient's objections must be made by written document, and there does not appear to be any method by which a family's objections can be asserted.[86] France allows objections to be recorded by individual hospitals, but makes no provision for coordinating this information so that the objection will be honored if the patient is treated at another institution.[87] Belgium employs a computerized central registry where objections may be recorded and which may be accessed by transplant centers.[88] However, there is considerable opposition in

84. For a defense of such a system, see Silver, *supra* note 7. One of Silver's arguments in favor of his "organ draft" proposal is that people would not be sufficiently aware that a presumed consent system was in operation to object to donation, and that presumed consent therefore would represent mandatory harvesting in disguise. *Id.* at 706.

85. One is reminded of Alexander's expose of the operation of the Seattle Artificial Kidney Center during the dialysis crisis of the 1960s. *See* Alexander, *They Decide Who Lives, Who Dies*, 53 LIFE, Nov. 9, 1962, at 102-04.

86. Personal communication with Herman Fetz, *supra* note 62.

87. *See* Benoit, *supra* note 55, at 320.

88. *See* Roels 1990, *supra* note 56, at 2078.

the United States to the use of centralized computer registries.[89] In any event, the practice of physicians in France and Belgium of requesting permission to remove organs suggests that neither country has established an opting-out system that is satisfactory.[90]

Furthermore, the opting-out system would have to address a number of thorny issues. What should the role of the family be in relation to the patient? Should objections by the family be able to override a patient's wishes to donate? Under the current system, the decedent's instructions are controlling, so long as the decedent complies with the requirements of the UAGA.[91] Effectuating the decedent's wishes under a presumed consent system would be more difficult, however. If the decedent wanted to donate his organs, he merely could refrain from registering an objection under whatever opting-out system was adopted. However, the same lack of objection would occur in the case of a decedent who did not want to donate but who was unaware of the need to object. In either case, there would be no binding instructions left by the decedent, and therefore no way to determine if an objection from family members was consistent with or contradicted the decedent's wishes.[92]

A presumed consent system also would need special rules to govern removal of organs from minors, from patients who had never been competent, and from patients who died without family members being available. Under the UAGA, for example, a minor cannot make a binding disposition of his organs; only the family can grant permission for organs to be removed.[93] A similar approach might be taken under presumed consent, in which case organs could be removed unless the family objected. Alternatively, the minor's inability to make binding decisions may justify an exception to the

89. *See, e.g.*, 1986 Task Force Report, *supra* note 22, at 49-51 (rejecting national registry for recording willingness to donate voluntarily).

90. One commentator asserts, for example, that physicians in France are concerned that people are not sufficiently informed about the law to make known their objections, and feel that having to check hospital records for objections is more burdensome than merely asking families. *See* French Note, *supra* note 16, at 1025-26.

91. *See* UAGA(1987), § 2(h) ("[a]n anatomical gift that is not revoked by the donor before death is irrevocable and does not require the consent or concurrence of any person after the donor's death"); § 3(a) (family may donate organs "unless the decedent, at the time of death, has made an unrevoked refusal to make that anatomical gift"); UAGA(1968) § 2(b) (family may donate "in the absence of actual notice of contrary indications by the decedent").

92. The opting-out system also would have to establish a priority list of relatives to sort out disagreements within the family. Such a priority list is incorporated in the UAGA. *See* UAGA(1987) § 3(a); UAGA(1968) § 2(b). A similar priority list is proposed for presumed consent systems in Note, *The Constitutionality of 'Presumed Consent' for Organ Donation*, 9 HAMLINE J. PUB. L. & POL'Y 343, 357 (1989) [hereinafter "Hamline Note"].

93. *See* UAGA(1987) §§ 2(a), 3(a); UAGA(1968) §§ 2(a), 2(b).

usual rule of presumed consent and necessitate adopting a requirement that the family give express permission to donation. Finally, the opting-out system would need an effective means by which a decedent who had objected to donation could change his mind.[94]

While it would be difficult to design an acceptable opting-out system, the problems might not be insurmountable. With adequate research, it is possible that an opting-out system could be constructed that, on the one hand, was not so burdensome for decedents, families or health providers that it unduly discouraged organ retrieval, and on the other hand, satisfied ethical concerns by giving adequate consideration to the participants' wishes and sensibilities.

B. Religious Objections

In addition to the objection that presumed consent would not be sufficiently sensitive to the feelings of decedents and their next-of-kin in general, some of its opponents are particularly concerned that it would conflict with religious views against donation and transplantation.[95] This could make enactment of presumed consent laws extremely difficult politically, and could lead courts to declare them unconstitutional on first amendment grounds.[96]

There is considerable confusion over the extent of valid religious objections to donation and transplantation. Despite its rejection of presumed consent, for example, the HHS Task Force on Organ Transplantation in 1986 asserted that "no major religious group in the United States opposes organ donation as a matter of formal doctrine."[97]

One source of religious opposition, however, is believed to be orthodox Judaism. An Israeli rabbi, Mordechai Halperin, was quoted in 1985 as saying that "Jewish law would treat as 'murder' the removal of organs from a body whose heart was beating but whose EEG record was flat," voicing a traditional Jewish objection

94. The UAGA sets forth a number of methods by which an anatomical gift may be revoked, including by a communication from a terminally ill patient addressed to a physician or surgeon. *See* UAGA(1987) § 2(f)(3); UAGA(1968) § 6(a)(3). More elaborate methods for revoking an objection to donation might be needed under a presumed consent system to ensure that the wishes of decedents and their families were being respected.

95. *See, e.g.*, Matas 1985, *supra* note 14, at 238 ("[g]roups professing disapproval of organ donation on explicitly religious grounds could argue convincingly that a 'presumed consent' policy would make it especially difficult for their members to practice their chosen faith . . .").

96. *See id.* For a discussion of first amendment issues, *see infra* notes 142-43 and accompanying text.

97. 1986 Task Force Report, *supra* note 22, at 38.

to accepting brain death as a definition of death.[98] On the other hand, a leading orthodox Jewish ethicist, Fred Rosner, explains that opinion is shifting on the brain death issue and that "[w]hether or not total, irreversible brain stem death, as evidenced by sophisticated medical testing, is the Jewish legal equivalent of decapitation [and therefore qualifies as a criterion of death] is presently a matter of intense debate in rabbinic circles."[99]

Aside from the issue of the determination of death, which relates to the availability of suitable cadaveric organs,[100] Jewish doctrine is unclear on the issue of donation itself. Halperin, for example, believes that "[t]he removal of livers for transplantation would be permissible because artificial organs are not available, but kidney transplants are not always justifiable because kidney dialysis is possible."[101] Rosner states however that "[a]ll rabbinic authorities would agree that such a case [kidney transplantation] constitutes *piku'ach nefesh*, or danger to life, and, therefore, the prohibitions revolving around the dead donor would all be set aside for the overriding consideration of saving a life."[102] Rosner notes that there is less consensus when life is not at stake, such as when the issue is corneal transplants, but concludes that "corneal, renal and cardiac transplantation are sanctioned by most rabbis and even mandated by some . . . ."[103]

Persons of Asian descent are also thought to object to donation and transplantation for religious reasons.[104] In Japan, an attempted heart transplant in 1968 and a simultaneous kidney/liver transplant in 1984, using organs obtained from brain dead patients, triggered criticism and, in the former incident, prompted an investigation by the prosecutor.[105] Moreover, Japanese lawmakers continue to resist establishing any legal definition of death, much less a brain death criterion. However, legislation in 1979 allows kidneys and corneas to be removed upon the donor's written request or with the permission of the family, and one commentator observes that, "in the fu-

98. Meyers, *Medicine Confronts Jewish Law*, 318 NATURE 97 (1985) [hereinafter "Nature"].

99. F. ROSNER, MODERN MEDICINE AND JEWISH ETHICS 251 (1986).

100. Maintaining respiration and circulation in brain dead individuals by artificial means greatly increases the usefulness of their organs for transplantation.

101. Nature, *supra* note 98, at 97.

102. Rosner, *supra* note 99, at 270.

103. *Id.*

104. Personal communication from Stephen Post, Ph.D., Center for Biomedical Ethics, Case Western Reserve University School of Medicine (Dec. 18, 1990).

105. Feldman, *Defining Death: Organ Transplants, Tradition and Technology in Japan*, 27 SOC. SCI. MED. 339, 341 (1988). No formal charges were made.

ture Japan will become as active in organ transplantation as most nations in the West."[106]

Religious concerns are believed to be in part responsible for the lower donation and transplant rates for African-Americans.[107] A recent Gallup poll found that, while 29 percent of white respondents stated that they are very likely to want to donate their organs and 80 percent stated that they would give permission for the organs of a loved one to be donated, the figures for African-Americans dropped to 17 and 71 percent respectively.[108] Yet the effect of religious opposition in this population may be small in comparison with other factors, such as lack of information, financial constraints and distrust of the white medical establishment.[109]

In summary, although the extent of religious opposition may be uncertain, and although some religious groups may be moving toward a more favorable attitude toward donation and transplantation generally, religious concerns cannot be ignored in designing a presumed consent program. For one thing, both the orthodox Jewish and Japanese Shinto religions seem to be dead set against any approach that would deny the family the right to object to donation.[110] Educational efforts that accompanied the adoption of presumed consent therefore would have to pay particular attention to religious groups with known objections, and the methods for opting-out would have to be highly effective and "user-friendly." It might even be necessary for the opting-out system to include special mechanisms for ensuring that religious objections were identified and respected.[111] Given an adequate opting-out system, however,

106. *Id.* at 341-42.

107. Engel, *Project's Goal Is To Increase Blacks' Contribution of Organs*, Wash. Post, July 26, 1984, at C1 ("[r]eligious fears, lack of information and distrust of a mostly white medical community are all factors in the low rates of donors who are black").

108. *See* Gallup Poll 1990, *supra* note 71, at 3.

109. *Cf.* Engel, *supra* note 107. The Gallup survey did not investigate the relative impact of these factors.

110. *See* Rosner, *supra* note 99, at 261, 265 (removal of organs without consent would be theft, according to Jewish doctrine); Feldman, *supra* note 105, at 342 (Shinto beliefs "reflect a commitment to the idea that the family should have the ultimate say in what happens to the corpse after death").

111. One alternative would be to reverse the presumption in favor of donation when the decedent was known to be a member of a religious group that was opposed to donation, and instead to require express consent by the donor or the family in order for organs to be removed. This would increase the administrative burdens and liability risks on health providers, however. Another issue is whether public policy towards religious objections to donation should be reciprocal in terms of access to transplantation — that is, whether members of religious groups that oppose donating organs for religious reasons ought to be disqualified from receiving donor organs.

religious concerns need not preclude the adoption of presumed consent.

C. Legal Objections

Legal concerns raised by presumed consent fall into two general categories — constitutional issues, and criminal and civil liability. Neither area presents any serious impediments to adopting a presumed consent approach.

1. Constitutional Concerns

Constitutional issues arise because of the need for government involvement in implementing and operating a presumed consent system. Since presumed consent would alter the existing legal rules regarding organ donation, it would have to be adopted by state legislative action. In particular, states would have to replace or amend the UAGA.[112] In addition, the opting-out system might be supervised or sanctioned by the government.

The presence of governmental or "state" action means that presumed consent would have to meet constitutional requirements.[113] Two major constitutional principles are involved — the first amendment prohibition against government interference with the free exercise of religion,[114] and the fifth amendment, which prohibits the government from depriving persons of liberty or property without due process, or taking private property for public use without just compensation.[115]

It is extremely unlikely that a court would declare a presumed consent law with an effective opting-out system unconstitutional on the basis that it deprived persons of substantive property rights in violation of the fifth amendment. Most courts have not regarded

112. Federal legislation may require hospitals and other health care providers to establish presumed consent procedures in order to qualify for Medicare and Medicaid, although this could create a serious conflict for providers in states whose legislatures have not yet amended the UAGA.

113. This paper addresses these issues from the perspective of the U.S. Constitution. There is no reason to believe that a presumed consent program that complied with federal constitutional mandates would encounter any problems from the provisions of state constitutions, but this question may require further research when a presumed consent system has been more fully outlined.

114. The first amendment states, *inter alia*, that "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof . . . . " U.S. CONST. Amend. I, cl. 1.

115. *See* U.S. CONST. amend. V. The provisions of the fifth amendment are applicable to actions under state (as opposed to federal) law under the due process clause of the fourteenth amendment.

donor organs as property within the terms of the amendment. Historically, English law conferred jurisdiction over the disposition of corpses on ecclesiastical courts rather than on the secular authorities and their common law courts.[116] As a consequence, English common law, which was the source of the legal principles governing property rights in the United States, never included dead bodies or their constituent parts within its rules. American courts followed suit, holding that neither the decedent nor the next of kin have a property right in the body in the usual sense.[117] Instead, family members at most have a right to dispose of the deceased's remains, consistent with laws and government regulations on the subject.[118] While this right is often referred to as a "quasi-property" right,[119] most courts have held that it does not confer upon the family the type of property rights that are protected by fifth amendment.[120] However, the Court of Appeals for the Sixth Circuit recently held that families had a "substantial interest in the dead body" that was protected by due process.[121]

Even if organs were accorded the status of constitutionally protected property, a presumed consent system would not necessarily constitute a "taking" under the due process clause of the fifth amendment. Assuming that the body were returned to the family in a condition suitable for burial following removal of organs for trans-

116. *See* Columbia Note, *supra* note 9, at 550, n.106; Naylor, *supra* note 6, at 170; Silver, *supra* note 7, at 689, n.29; Dukeminier and Sanders, *supra* note 7, at 414.

117. *See, e.g,* State v. Powell, 497 So. 2d 1188, 1192 (Fla. 1986); Gray v. Southern Pac. Co., 21 Cal. App. 2d 240, 246, 68 P.2d 1011, 1015 (Dist. Ct. App. 1937); Williams v. Williams, 20 Ch. D. 659, 665 (1881).

118. *See, e.g.*, In re Johnson, 94 N.M. 491, 494, 612 P.2d 1302, 1305 (1980); Spiegel v. Evergreen Cemetery Co., 117 N.J.L. 90, 93, 186 A. 585, 586 (1936); Yome v. Gorman, 242 N.Y. 395, 152 N.E. 126 (1926); Pettigrew v. Pettigrew, 207 Pa. 313, 56 A. 878 (1904); Pierce v. Properties of Swan Point Cemetery, 10 R.I. 227 (1872).

119. *But see* Naylor, *supra* note 6, at 175 ("the family's right to the corpse is now explicitly based on protection from mental distress rather than quasi-property rights"), *citing* Strachan v. John F. Kennedy Memorial Hosp., 109 N.J. 523, 531, 538 A.2d 346, 350 (1988). Naylor also quotes the statement in Prosser and Keeton that the family's quasi-property right "is something evolved out of thin air to meet the occasion, and . . . in reality the personal feelings of the survivors are being protected, under a fiction likely to deceive no one but a lawyer." W. KEETON, D. DOBBS, R. KEETON & D. OWEN, PROSSER AND KEETON ON THE LAW OF TORTS § 12, at 63 (5th ed. 1984).

120. *See* State v. Powell, 497 So. 2d 1188, 1192 (Fla. 1986) (no constitutionally recognized property right in dead bodies); Georgia Lions Eye Bank, Inc. v. Lavant, 255 Ga. 60, 335 S.E.2d 127 (1985) (same). *See also* Moore v. Regents of the Univ. of Calif., 51 Cal. 3d 120, 271 Cal. Rptr. 146, 793 P.2d 479 (1990) (patient has no property right in cells removed from him for research and commercial purposes).

121. Brotherton v. Cleveland, No. 89-3820 (6th Cir. Jan. 18, 1991) (available on Lexis, 1991 U.S. App. Lexis 779) [hereinafter "Brotherton"] (family has "legitimate claim of entitlement" protected by due process). *Id* at 5.

plantation, the family would not be deprived of its right to dispose of the body or of any of its value.[122] Furthermore, the opting-out system would allow the family to prevent removal of organs (assuming no contrary indication by the decedent), so that the family's failure to exercise its opting-out rights could be deemed to be acquiescence, rather than a taking without permission. In any event, in view of the legal prohibition against the sale of organs,[123] it is hard to imagine how donors or their families could receive "just compensation" under the takings clause of the fifth amendment.[124]

The constitutionality of a presumed consent law under the property clauses of the fifth amendment is supported by recent state court decisions upholding the constitutionality of state statutes authorizing nonconsensual removal of corneal tissue. In *State v. Powell*,[125] the Florida Supreme Court, by a vote of six to one, held that the removal of corneal tissue for transplantation during statutorily required autopsies was not a constitutionally protected taking of private property.[126] It is noteworthy that the Florida law does not establish an explicit opting-out system; the coroner is permitted to remove corneal tissue so long as he does not know of an objection by the next of kin.[127] The Georgia Supreme Court reached the same result in a case involving a similar statute.[128]

In a recent federal case, however, *Brotherton v. Cleveland*, the

122. *See* Hamline Note, *supra* note 92, at 369 ("[t]he value of a dead body to the next of kin [assuming that the next of kin does not want the cadaver organs for their own transplant] is not appreciably diminished when one or several organs are removed"). *But see*, Brotherton, *supra* note 121 ("[a]fter the cornea is removed, it is not returned and the corpse is permanently diminished").

123. Federal law prohibits any person from receiving valuable consideration for acquiring, receiving or transferring an organ for transplantation. *See* National Organ Transplant Act, Pub. L. No. 98-507, 98 Stat. 2346 (1984). A similar prohibition is found in the 1987 version of the UAGA. *See* UAGA(1987) § 10.

124. The prohibition on the sale of organs also would preclude calculation of a fair market value for the organs for purposes of establishing just compensation. *See* Columbia Note, *supra* note 9, at 571-72.

125. 497 So. 2d 1188 (Fla. 1986).

126. 497 So. 2d at 1192. While the court was construing the statute under the Florida constitution, the language of the state and federal constitutions, while different, presumably impose the same requirements. *Compare* U.S. CONST., amend. V *with* FLA. CONST., art. X, § 6 (1968 revision) ("[n]o private property shall be taken except for a public purpose and with full compensation therefor paid to each owner or secured by deposit in the registry of the court and available to the owner").

127. *See* Fla. Stat. Ann. § 732.9185 (West 1990).

128. Georgia Lions Eye Bank, Inc. v. Lavant, 255 Ga. 60, 335 S.E.2d 127 (1985). In a brief dissent, one judge asserted that the failure of the statute to provide notice to the next of kin and "a realistic opportunity to object" violated due process. *Id.* at 129. Conceivably, an appropriate opting-out system would satisfy even this dissenter.

Court of Appeals for the Sixth Circuit held that state statutes permitting removal of corneas did trigger due process requirements.[129] In that case, the plaintiff alleged that the hospital in which her husband died had asked her for permission to harvest his organs, and that, based on her husband's wishes, she had refused. She further alleged that her refusal was recorded on the hospital's "Report of Death." The body was taken to the county coroner's office, and the corneas were removed. The hospital records did not accompany the body, so the coroner did not review the medical records or hospital paperwork to ascertain if an objection had been asserted.[130] The plaintiff discovered that the corneas had been removed when she read the autopsy report, and brought suit under section 1983 of title 43 of the U.S. Code on the basis that the coroner's action had deprived her of a right secured under the U.S. Constitution. The court, with one judge dissenting, held that the plaintiff had an interest in her husband's body that was protected under the due process clauses. This interest was premised on the provisions of the UAGA, which, according to the court, expressly gave the plaintiff the right "to control the disposal of Steven Brotherton's body," and on prior cases that recognized a right in the spouse to possess the body and to recover damages against those who mishandle it.[131]

The opinion did not prescribe the procedural steps that the state was obliged to follow. For the most part, the court seems to focus on the coroner's failure to conduct even a minimal inquiry into whether or not the family objected to removal. The opinion refers to what it termed the coroner's "intentional ignorance," which was "induced" by the Ohio corneal removal statute. According to the court's opinion, this statute "allows the [coroner's] office to take corneas from the bodies of deceased without considering the interest of any other parties, as long as they have no knowledge of any objection to such a removal."[132] In this regard, 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."[133] Thus, the court might simply be saying that there must be some procedure for notifying the coroner when the hospital is aware of an objection, and that failure to do so is a violation of

129. *See* Brotherton, *supra* note 121.

130. Personal communication with Philip L. Zorn, Jr., Assistant Prosecutor, Cincinnati, Ohio (Feb. 22, 1991).

131. *Id.*

132. *Id.*

133. H.B. 239, 1983 Ohio Legis. Serv. 5-370 (Baldwin).

due process. If this was what the court had in mind, however, it could easily have said so. Instead, it remanded the case to the district court for further proceedings. Furthermore, in discussing the requirement of due process, the court pointed out that "[t]he Supreme Court has often reiterated that a property interest may not be destroyed without a hearing."[134] This suggests that the court would insist on a predeprivation hearing of some sort before corneas could be removed.

If the Sixth Circuit is insisting that a formal hearing be held before organs could be donated, this could invalidate current donation procedures, including the donor card system provided for in the UAGA. Arguably, these procedures might not satisfy a formal hearing requirement, particularly if due process rights inhere in the family and given that the UAGA permits the donor's disposition to override the family's wishes.

If removal of organs for transplantation under state law triggers due process requirements, and if this means that there must be an actual administrative or judicial hearing before organs can be removed, then a presumed consent approach would be largely useless. Hearings would be expensive and cumbersome and would cause delay that might reduce or eliminate the usefulness of the organs for transplantation purposes. More importantly, since the next-of-kin would be interested parties entitled to participate in the hearing, requiring a hearing would be tantamount to prohibiting removal of organs without express familial permission for donation.

One way to avoid this result is for the *Brotherton* case to be overturned. The losing parties may petition the U.S. Supreme Court to review the case, and the Court may overrule the Court of Appeals. Even if the case is not overturned, it does not control the law in jurisdictions outside of the Sixth Circuit.

Another approach would be for the Ohio legislature to state that the family possesses no property rights in the deceased other than those rights expressly granted under state law, or that the family has no property right that triggers due process requirements. Since *Brotherton* involves the imposition of due process requirements on state action through the fourteenth amendment, and since fourteenth amendment rights are contingent on state law,[135] the impact of *Brotherton* could be avoided if the legislature clarified that it did

134. Brotherton, *supra* note 121, at 10 (citing Logan v. Zimmerman Brush Co., 455 U.S. 422, 434 (1982).

135. *See* Board of Regents v. Roth, 408 U.S. 564, 577 (1972).

not intend to create property-type rights when it passed the UAGA, or that whatever rights had inadvertently been created were extinguished.[136] Finally, even if the decision in *Brotherton* were allowed to stand, it need not be read to preclude the adoption of a presumed consent approach so long as the system incorporated an effective opting-out mechanism. In *Mathews v. Eldridge*, the Supreme Court set forth the following balancing test to determine what process was required by the fifth amendment:

> First, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, additional or substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute requirement would entail.[137]

Given the limited nature of the private interest in donor organs and the public interest in increasing the supply of transplant organs, an opting-out system that reasonably reduced the risk of an unintended donation would be likely to satisfy the requirements of due process.[138] Under such a system, the family would be deemed to have waived its rights to a "hearing" unless it objected to donation. Nor would a hearing be required in the event the family did *not* waive its right to one, since this would mean that the family had asserted an objection, that the organs would not be removed, and that therefore the family would not have its property rights diminished. In order for the opting-out system to satisfy due process in this fashion, however, it might be necessary to show that the family had received notice of the existence of the presumed consent system and had understood how it operated. This would entail a comprehensive educational program, and would probably require some sort of actual notification of the family, such as by posting a notice in hospitals and providing the family with written information.

Apart from questions arising under the property clauses, the presumed consent law might be challenged on the ground that it deprived persons of liberty without due process as required by the fifth amendment. In *State v. Powell*, the Florida Supreme Court

136. This might give rise to a claim that the state was "taking" property in dead bodies without just compensation. *See supra* notes 116-21 and accompanying text.

137. 424 U.S. 319, 335 (1976).

138. *But see* Brotherton, *supra* note 121, at 11 ("[t]he only governmental interest enhanced by the removal of the corneas is the interest in implementing the organ/tissue donation program; this interest is not substantial enough to allow the state to consciously disregard those property rights which it has granted").

rejected the argument that the right of the next of kin to dispose of the body of a loved one amounted to the type of fundamental right protected under either the federal or state constitution.[139] Similarly, an appellate court in Michigan rejected a fifth amendment argument against that state's cornea removal statute, holding that constitutional rights concerning the integrity of the body ended with death.[140] The recent decision in the *Cruzan* case,[141] in which the U.S. Supreme Court upheld a state court's requirement of clear and convincing evidence before a person in a persistent vegetative state could be deprived of nutrition and hydration, is further evidence that liberty interests will be narrowly construed in cases involving the rights of persons who are no longer competent to make their own decisions, and perhaps in cases involving the rights of their families as well.

Constitutional objections to presumed consent laws also might be asserted on first amendment grounds. The court in *State v. Powell* expressly noted that the plaintiffs had not alleged that their objection to the removal of corneal tissues was based on religious convictions,[142] suggesting that the case might have come out differently if they had. As discussed earlier, however, a well-designed opting-out system that permitted religious objections to block organ retrieval ought to avoid the first amendment's ban on laws prohibiting the free exercise of religion.[143]

2. Civil and Criminal Liability

Apart from confronting constitutional issues, persons who removed organs without express permission from the decedent or the family might be concerned that they could be subject to criminal and civil liability. State law generally makes it a crime to mutilate or to mistreat a corpse.[144] The term "mistreatment" is usually defined as an act that offends or outrages ordinary sensibilities. While removing organs for transplantation need not leave the corpse in a condition at the time of burial or cremation in which it appears to

139. 497 So. 2d at 1193. The court held that the constitution only recognized rights involving relationships between living persons. *Id.*

140. Tillman v. Detroit Receiving Hosp., 138 Mich. App. 683, 687, 360 N.W.2d 275, 277 (1984).

141. Cruzan v. Director, Missouri Dept. of Health, 110 S.Ct. 2841 (1990).

142. 497 So. 2d at 1193.

143. *See* Silver, *supra* note 7, at 709-12; Hamline Note, *supra* note 92, at 360-63.

144. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 7052 (West 1990); MASS. GEN. LAWS ANN. ch. 272, § 71 (West 1990); N.Y. PUB. HEALTH LAW § 4218 (McKinney 1990); OHIO REV. CODE ANN. § 2927.01 (Baldwin 1991).

have been mutilated, it may be deemed to have been mistreated if removal without express permission is regarded as offensive or outrageous.

Removing organs under a presumed consent approach might also give rise to civil liability for tortious interference with the right of burial. The Restatement (Second) of Torts, which attempts to codify the common law, states that "[o]ne who intentionally, recklessly or negligently removes, withholds, mutilates or operates upon the body of a dead person or prevents its proper internment or cremation is subject to liability to a member of the family of the deceased who is entitled to the disposition of the body."[145] The family might seek damages on the theory that removing organs without express permission was an intentional operation upon the deceased.

In a recent Florida decision, *Kirker v. Orange County*,[146] a state appellate court held that the mother of a deceased child stated a cause of action for intentional infliction of emotional distress when she alleged that the county medical examiner had removed the child's eyes over the mother's objection. The mother claimed that she discovered that the eyes had been removed after she noticed at the funeral that the eyes appeared depressed. Furthermore, she asserted that the child's attending physician had asked for permission to remove the child's corneas and kidneys, that the mother had refused, and that the refusal had been noted on the child's hospital chart. Finally, the mother claimed that the medical examiner had been aware of her objection and had attempted to cover up the unauthorized removal by falsifying the autopsy report.[147]

The *Kirker* case is distinguishable on its facts from a presumed consent case in which the body is returned to the family without visible signs of organ removal, in which no express objection to removal has been made by the decedent or the family, and in which no attempt has been made to conceal unauthorized behavior. In a recent Tennessee case, *Hinze v. Baptist Memorial Hospital*,[148] the court held that an eye bank and a hospital had not violated the UAGA by removing a decedent's eyes without permission when the decedent had not refused donation, the hospital had obtained writ-

145. RESTATEMENT (SECOND) OF TORTS § 868 (1979).

146. 519 So. 2d 682 (Fla. Dist. Ct. App. 1988).

147. 519 So. 2d at 682-83. The charge of a cover-up was based on the allegation that the autopsy report described the child's eyes as blue and as having a certain size and shape when the child's eyes in fact were brown and had been removed prior to the autopsy.

148. No. 27253 T.R. Tennessee Court of Appeals, Western Section, Aug. 23, 1990, *reported in* 18 HEALTH L. DIG. 13 (Oct. 1990).

ten consent from someone purporting to be the decedent's grandson and representing himself as authorized to consent, and the hospital had not been given actual notice that anyone authorized to consent had objected. The facts showed that the defendants had not acted in bad faith, and, under the UAGA, good faith is a defense.[149] Good faith compliance with a presumed consent law similarly might avoid liability under the approach in *Kirker*.[150]

Nevertheless, the court in *Kirker* characterizes the family's right of burial in such broad terms that even those who acted in good faith in removing organs might be liable for damages. The court states that the right of action for mutilating a corpse is based on the right of the surviving family members to bury the body "in the condition found when life became extinct."[151] Arguably, a body whose organs had been removed for transplantation, even though without any visible signs that this had been done, would no longer be in the same condition as at the time of death. Furthermore, the opinion notes that "[t]he courts are not primarily concerned with the extent of the mishandling or injury to the body, per se, 'but rather with the effect of the same on the feelings and emotions of the surviving relatives, who have the right to burial.' "[152] This suggests that family members who were foreseeably distressed upon learning that organs had been removed from their next of kin without express permission might be able to recover for their emotional upset regardless of the manner in which the organs had been removed and regardless of the appearance of the corpse.[153]

The possibility that physicians and hospitals who complied with presumed consent legislation nevertheless might be subject to civil and criminal liability can be eliminated, however, by enacting carefully drafted immunity provisions as part of the legislation. Such provisions should not only contain general protection for good faith

149. *See* UAGA(1968) § 7(c) ("[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 criminal proceeding for his act"). The 1987 version of the UAGA, which was not involved in *Hinze*, insulates a person from liability if he or she "attempts in good faith" to act in accordance with the statute. UAGA(1987) § 11(c).

150. The plaintiff in *Kirker* does not appear to have alleged a violation of the UAGA.

151. 519 So. 2d at 684, *quoting* 22 AM. JUR. 2D, Dead Bodies, §§ 31, 32 (1965).

152. 519 So. 2d at 684, *quoting* Jackson v. Rupp, 228 So. 2d 916, 918 (Fla. Dist. Ct. App. 1969), *affirmed* 238 So. 2d 86 (Fla. 1970); *see also* Kirksey v. Jernigan, 45 So. 2d 188, 189 (Fla. 1950).

153. To recover, however, the plaintiffs would have to show that they were not peculiarly susceptible to emotional distress but rather, that the defendants had acted in a manner that would outrage ordinary sensibilities. *See* RESTATEMENT (SECOND) TORTS § 46 (intentional or reckless infliction of emotional distress).

behavior, as in the UAGA,[154] but should spell out precisely what steps providers must take to verify the absence of an objection to donation in order to satisfy the good faith criterion.

D. Public Opposition

As noted earlier, public opposition was cited by the HHS Task Force on Organ Transplantation in 1986 as the sole basis for rejecting the presumed consent approach.[155] An article in the *Journal of The American Medical Association* in 1985 reported, for example, that presumed consent "would not be very popular among the American public."[156] This conclusion was based on a survey finding that "an overwhelming majority of Americans (86.5 percent of all respondents surveyed) believe that physicians should not have the power to remove organs from people who have died and who have not signed an organ donor card without consulting the next of kin."[157]

In fact, the survey reported in *JAMA* is the *only* opinion poll to report that the public is opposed to presumed consent. It is widely believed that the Gallup organization, which routinely conducts public opinion surveys on public attitudes toward organ donation, has reported similar results.[158] However, the closest that the Gallup poll has come to inquiring about attitudes toward presumed consent is when it asked respondents in its 1985 and 1986 surveys if they agreed or disagreed with the statement: "Even if I have never given anyone permission, I wouldn't mind if my organs were donated upon my death."[159] The question used by Gallup does not make it clear whether or not organs would be donated only if the family had been asked, and therefore the responses cannot be said to bear directly on the respondent's attitudes toward presumed consent. Nevertheless, the fact that 62 percent of respondents in 1985 and 61 percent in 1986 stated that they would want their organs donated even without their ever having given permission can hardly be construed as opposition to presumed consent.

This leaves the report in *JAMA* as the only survey that claims to demonstrate public opposition to presumed consent. Yet the valid-

154. *See supra* note 149 and accompanying text.

155. *See supra* notes 22-23 and accompanying text.

156. Manninen and Evans, *supra* note 13, at 3114.

157. *Id.*

158. Personal communication from Stuart Youngner, M.D., Center for Biomedical Ethics, Case Western Reserve University (Jan. 2, 1991).

159. Gallup Poll 1985, *supra* note 71, at VII; Gallup Poll 1986, *id.* at iv.

ity of its findings is questionable. The question that was asked about attitudes toward presumed consent apparently was: "Should doctors have the power to remove organs from people who have died but have not signed an organ donor card without consulting the next of kin?"[160] The question made no mention of the possibility of opting-out. Respondents may have assumed that no objection could be made to donation. The question therefore may have elicited negative attitudes toward a system of mandatory harvesting without a right of refusal, rather than toward a system of presumed consent. In addition, it appears that the survey asked the "presumed consent" question after it had asked respondents about their willingness to donate their own organs, and that the question about donating one's own organs was asked after a question about willingness to donate the organs of a relative.[161] It is well-known that people report a greater willingness to donate someone else's organs than their own.[162] Therefore, the questions appear to have been asked in an order that was likely to produce a decreasing percentage of positive responses, which may well have biased the results.

In short, public attitudes toward presumed consent presently are unknown. It is conceivable that an unbiased survey that explained the operation of an opting-out system and then asked if respondents would agree that organs could be removed if neither the decedent nor the next of kin had registered an objection would reveal a large degree of support. Depending on how the question were asked, support for presumed consent might well come close to the level of strong support for donating one's own organs, which, according to Gallup polls, has hovered around only 30 percent over the last five years.[163]

In fact, if public opinion polls reveal anything, it is that the pub-

160. Manninen and Evans, *supra* note 13, at 3113. The authors of the report describe the presumed consent question as quoted in the above text, but do not state that this was the actual form of the question.

161. At least, this is the order in which the results of the survey are reported. *See id.* at 3112-13.

162. *See id.* at 3111 (53 percent willing to donate relative's organs while 50 percent willing to donate own organs). The Gallup organization reported in 1985 that, while 73 percent of respondents stated that they were very likely to donate the organs of a relative, only 27 percent were very likely to donate their own organs. Gallup Poll 1985, *supra* note 71, at IV. The results for 1986 were 70 percent very likely to donate the organs of relatives, 32 percent very likely to donate their own. Gallup Poll 1986, *id.* at iii. The results in 1987 were 66 percent and 30 percent. Gallup Poll 1987, *id.* at 2, 5 (author's pagination). The form of questions changed for the 1990 survey, with 78 percent reporting that they were very likely to donate the organs of a relative and 28 percent reporting that they were very likely to donate their own organs. Gallup Poll 1990, *id.* at 2 (author's pagination).

163. *See id.*

lic by and large seems to be upset by the notion of death and the prospect of removal of organs for transplantation, and would rather not be confronted with having to think about it. A presumed consent program that did not force people to consider these issues might be relatively noncontroversial, as appears to be the case with state statutes permitting medical examiners to remove corneas and pituitaries without consent.[164] Most people are probably unaware, for example, that after a man dies, string is tied around his penis, cotton is stuffed up his rectum and his body is exsanguinated before burial.[165] If told about it, people might well be uncomfortable about being told, rather than about what was done.

Removal of organs for transplantation does raise one particular concern in the minds of some members of the public that might be exacerbated by a presumed consent approach. There are people who are afraid that "over-zealous" organ procurers might pronounce them dead prematurely or even hasten their deaths to obtain their organs.[166] For example, the 1985 Gallup poll found that 20 percent of respondents who did not want to give permission for their organs to be removed rated as a very important reason the fear that "doctors might hasten my death if they needed my organs," while 23 percent rated as very important the possibility that "they might do something to me before I am really dead."[167] This is a fear created by organ donation programs in general. However, a presumed consent system might be especially suspect because eliminating the need to get permission from the family might be seen as reducing the ability of the family to protect patients from unscrupulous physicians.[168]

The UAGA deals with this concern by prohibiting either the attending physician at the time of death or the physician who determines the time of death from participating in the removal or transplantation of organs.[169] Additional safeguards might be needed under a presumed consent approach if these protections were regarded as insufficient.

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164. *See* HASTINGS CENTER, ETHICAL, LEGAL AND POLICY ISSUES PERTAINING TO SOLID ORGAN PROCUREMENT 20 (1985) ("weak presumed consent laws pertaining to corneas have generated little controversy in those states that have adopted them").

165. *See* Dukeminier and Sanders, *supra* note 7, at 416.

166. *See* Naylor, *supra* note 6, at 168, 186.

167. Gallup Poll 1985, *supra* note 71, at VII.

168. *See* Naylor, *supra* note 6, at 186.

169. *See* UAGA(1968) § 7(b). The 1987 version will allow either of these two physicians to participate in removal or transplant of organs if the document of gift designates that particular physician or surgeon. UAGA(1987) § 8(b).

V. PRACTICAL PROBLEMS

Assuming that presumed consent is viewed as an attractive theoretical possibility, policymakers must address a number of practical difficulties before it can become a reality and be expected significantly to increase the supply of transplant organs. One critical problem has been discussed earlier: the need to design an effective opting-out system that would permit large numbers of organs to be removed at the same time that it comported with ethical, religious and due process requirements. A lingering question is whether adopting a presumed consent approach would produce a change in provider behavior. As noted above, the unwillingness of physicians and hospital staff to approach families to seek consent was the major reason for the failure of encouraged voluntarism, and also has been blamed for the lack of success of required request. The French and Belgian experience suggests that providers might continue to insist on express familial consent even if a presumed consent law were enacted.

Careful design of the opting-out system and drafting of immunity provisions may help to alleviate provider concerns.[170] Greater information about how presumed consent works in Austria may suggest ways of reducing provider resistance. The key is likely to be a successful educational campaign aimed at providers.[171] However, it is unclear how these efforts could be made more successful under a presumed consent approach than they have been under required request.

Finally, an attempt to enact presumed consent legislation would have to overcome significant political obstacles. Politicians would need to be convinced that increasing the supply of transplant organs was important and worth taking some political risks. The design of the opting-out system would have to mollify religious and ethics lobbies. Public opinion polls either would have to be redone in a less biased fashion, or disregarded. The provider and hospital communities would have to be mobilized in favor of the proposal. The

170. Another approach would be to impose civil, criminal or regulatory sanctions on providers who did not harvest organs in the absence of an objection by the decedent or the family. Medicare's requirement that hospitals establish required request policies in order to qualify for Medicare reimbursement is a step in this direction. However, providers are likely to oppose an attempt to enact such penalties, and it is doubtful that presumed consent legislation could be passed without strong provider support.

171. *See* Caplan, *supra* note 48, at 37, for an argument that educational efforts aimed at providers rather than at the public are what is needed to increase donations under required request. For a discussion of the need for educational programs in connection with the movement to adopt required request, *see* 1986 Task Force Report, *supra* note 22, at 45-49.

public would have to be persuaded that presumed consent would not result in premature deaths. In short, passage of presumed consent legislation would require a massive and highly sophisticated lobbying effort.

The most promising approach might be to try to enact a presumed consent approach on an experimental basis in a single state. Legislation would be needed to suspend conflicting provisions of the UAGA and to provide immunity from liability. Lobbying efforts could highlight actual persons in need of lifesaving transplants, and emphasize the economic benefits of transplantation. After a sufficient amount of time, the success of the experiment could be assessed in terms of the effect on the number of organs available for transplantation. Dramatic, positive results could lead to adoption of presumed consent legislation in other jurisdictions, and eventually to uniform state laws along the lines of the required request system embodied in the 1987 version of the UAGA.

VI. CONCLUSIONS AND RECOMMENDATIONS

Given the benefits expected from an increased availability of cadaveric organs for transplantation, and in view of the shortcomings of the current required request approach to donation, it is worthwhile to conduct further research on a system of presumed consent. Research is necessary in order adequately to assess the merits and feasibility of presumed consent, and to design a system that would fulfill ethical, religious and legal requirements. The following specific areas for further research have been identified:

1) Designing an opting-out system that would enable persons who objected to donation to refuse to donate in a manner that was sensitive to the feelings of patients and their families, that was efficient and cost-effective, and that met religious, ethical and legal requirements.

2) Designing an educational program for both providers and the public that addressed their concerns and that educated them about the benefits and operation of a presumed consent approach.

3) Designing and executing a public opinion survey that ascertained reactions to an appropriately designed presumed consent system.

Exhibit 3

CARP members show strong support for organ donation

TORONTO, Oct. 26, 2017 - When polled, the vast majority of Canadians are in favour of organ donation. But only a small percentage of them actually fill out their donor cards. This phenomenon is common in other countries as well.

In order to address this issue, the Honorable Steven Fletcher has introduced a private members bill in the Manitoba legislature which would presume consent to donate organs. Thus, rather than requiring individuals to specifically **opt in** to be an organ donor, individuals would have to **opt out** if they chose not to do so.

Wanda Morris, CARP's VP of Advocacy noted, "CARP members are overwhelmingly in favour of organ donation. The number of our members who have opted in to be organ donors far exceeds the national average. A majority of CARP members (60 per cent) also agree with the principle of presumed consent for organ donation."

When polled on the issue, CARP members responded passionately:

- 93 per cent are in favour of organ donation
- 68 per cent are already registered organ donors
    - An additional 13 per cent are not currently donors, but have been meaning to register
- 60 per cent believe that switching to a presumed consent registration is the proper way forward
    - A further 14 per cent are undecided
    - 26 per cent are not in favour of presumed consent organ donation registration

About CARP
CARP (formerly known as the Canadian Association of Retired Persons) is a national, non-partisan, non-profit organization that advocates for financial security and improved health care for Canadians as we age. With more than 300,000 members and local chapters across Canada, CARP plays an active role in the creation of policy and legislation that impacts older Canadians. CARP works closely with all levels of government and collaborates with other organizations to advocate on health and financial issues.

To coordinate an interview with a CARP representative, please email:
media@carp.ca

Exhibit 4

MEDICINE

Do Defaults Save Lives?

Eric J. Johnson* and Daniel Goldstein

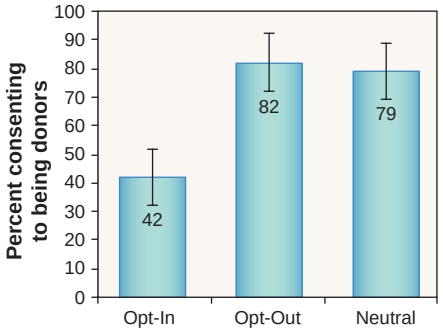
Since 1995, more than 45,000 people in the United States have died waiting for a suitable donor organ. Although an oft-cited poll (*1*) showed that 85% of Americans approve of organ donation, less than half had made a decision about donating, and fewer still (28%) had granted permission by signing a donor card, a pattern also observed in Germany, Spain, and Sweden (*2*–*4*). Given the shortage of donors, the gap between approval and action is a matter of life and death.

What drives the decision to become a potential donor? Within the European Union, donation rates vary by nearly an order of magnitude across countries and these differences are stable from year to year. Even when controlling for variables such as transplant infrastructure, economic and educational status, and religion (*5*), large differences in donation rates persist. Why?

Most public policy choices have a no-action default, that is, a condition is imposed when an individual fails to make a decision (*6*, *7*). In the case of organ donation, European countries have one of two default policies. In presumed-consent states, people are organ donors unless they register not to be, and in explicit-consent countries, nobody is an organ donor without registering to be one.

According to a classical economics view, preferences exist and are available to the decision-maker—people simply find too little value in organ donation. This view has led to calls for the establishment of a regulated market for the organs of the deceased (*8*, *9*), for the payment of donors or donors' families (*10*, *11*), and even for suggestions that organs should become public property upon death (*12*). Calls for campaigns to change public attitudes (*13*) are widespread. In classical economics, defaults should have a limited effect: when defaults are not consistent with preferences, people would choose an appropriate alternative.

A different hypothesis arises from research depicting preferences as constructed, that is, not yet articulated in the minds of those who have not been asked (*14*–*16*). If preferences for being an organ donor are constructed, defaults can influence choices in three ways: First, decision-makers might believe that defaults are suggestions by the policy-maker, which imply a recommended action. Second, making a decision often involves effort, whereas accepting the default is effortless. Many people would rather avoid making an active decision about donation, because it can be unpleasant and stressful (*17*). Physical effort such as filling out a form may also increase acceptance of the default (*18*). Finally, defaults often represent the existing state or status quo, and change usually involves a trade-off. Psychologists have shown that losses loom larger than the equivalent gains, a phenomenon known as loss aversion (*19*). Thus, changes in the default may result in a change of choice.



Effective consent rates, online experiment, as a function of default.

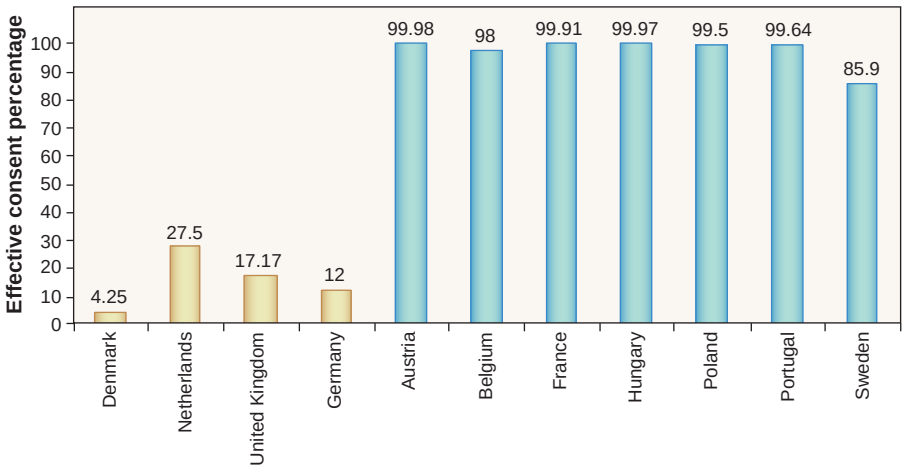
Governments, companies, and public agencies inadvertently run "natural experiments" testing the power of defaults. Studies of insurance choice (*20*), selection of Internet privacy policies (*21*, *22*), and the level of pension savings (*23*) all show large effects, often with substantial financial consequences.

Defaults and Organ Donations

We investigated the effect of defaults on donation agreement rates in three studies. The first used an online experiment (*24*): 161 respondents were asked whether they would be donors on the basis of one of three questions with varying defaults. In the opt-in condition, participants were told to assume that they had just moved to a new state where the default was not to be an organ donor, and they were given a choice to confirm or change that status. The opt-out condition was identical, except the default was to be a donor. The third, neutral condition simply required them to choose with no prior default. Respondents could at a mouse click change their choice, largely eliminating effort explanations.

The form of the question had a dramatic impact (see figure, left): Revealed donation rates were about twice as high when opting-out as when opting-in. The opt-out condition did not differ significantly from the neutral condition (without a default option). Only the opt-in condition, the current practice in the United States, was significantly lower.

In the last two decades, a number of European countries have had opt-in or opt-out default options for individuals' decisions to become organ donors. Actual decisions about organ donation may be affected by governmental educational programs, the

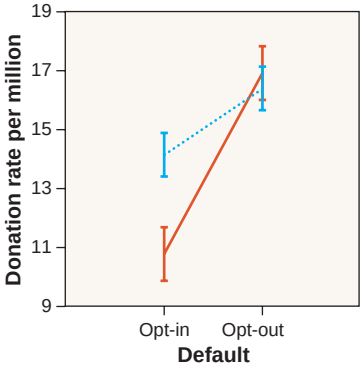


Effective consent rates, by country. Explicit consent (opt-in, gold) and presumed consent (opt-out, blue).

The authors are at the Center for Decision Sciences, Columbia University, New York, NY 10027, USA.

*To whom all correspondence should be addressed: ejj3@columbia.edu

efforts of public health organizations, and cultural and infrastructural factors. We examined the rate of agreement to become a donor across European countries with explicit and presumed consent laws. We supplemented the data reported in Gäbel (*25*) by contacting the central registries for several countries, which allowed us to estimate the effective consent rate, that is, the number of people who had opted in (in explicit-consent countries) or the number who had not opted out (in presumed-consent countries). If preferences concerning organ donation are strong, we would expect defaults to have little or no effect. However, as can be seen in the figure (page 1338, bottom), defaults appear to make a large difference: the four opt-in countries (gold) had lower rates than the six opt-out countries (blue). The two distributions have no overlap, and nearly 60 percentage points separate the two groups. One reason these results appear to be greater than those in our laboratory study is that the cost of changing from the default is higher; it involves filling out forms, making phone calls, and sending mail. These low rates of agreement to become a donor come, in some cases, despite marked efforts to increase donation rates. In the Netherlands, for example, the 1998 creation of a national donor registry was accompanied by an extensive educational campaign and a mass mailing (of more than 12 million letters in a country of 15.8 million) asking citizens to register, which failed to change the effective consent rate (*26*).



Estimated donation rate, opt-in versus opt-out, as a function of default, 1991–2001. Means ± SEM; this paper, blue; Gimbel *et al.* (*5*), red.

Do increases in agreement rates result in increased rates of donation? There are many reasons preventing registered potential donors from actually donating. These include: families' objections to a loved one's consent, doctors' hesitancy to use a default option, and a mismatch with potential recipients, as well as differences in religion, culture, and infrastructure.

To examine this, we analyzed the actual number of cadaveric donations made per million on a slightly larger list of countries, with data from 1991 to 2001 (*27*). We analyzed these data using a multiple regression analysis with the actual donation rates as dependent measures and the default as a predictor variable. To control for other differences in countries' propensity to donate, transplant infrastructure, educational level, and religion, we included variables known to serve as proxies for these constructs (*5*) and an indicator variable representing each year.

This analysis presents a strong conclusion. Although there are no differences across years, there is a strong effect of the default: When donation is the default, there is a 16.3% ($P < 0.02$) increase in donation, increasing the donor rate from 14.1 to 16.4 million (see figure, this page, blue line). Using similar techniques, but looking only at 1999 for a broader set of European countries, including many more from Eastern Europe, Gimbel *et al.* (*5*) report an increase in the rate from 10.8 to 16.9, a 56.5% increase (see figure, this page, red line). Differences in the estimates of size may be due to differences in the countries included in the analysis: Many of the countries examined by Gimbel *et al.* had much lower rates of donation.

Conclusions

How should policy-makers choose defaults? First, consider that every policy must have a no-action default, and defaults impose physical, cognitive, and, in the case of donation, emotional costs on those who must change their status. As noted earlier, both national surveys and the no-default condition in our experiment suggest that most Americans favor organ donation. This implies that explicit consent policies impose the costs of switching on the apparent majority (*28*).

Second, note that defaults can lead to two kinds of misclassification: willing donors who are not identified or people who become donors against their wishes. Balancing these errors with the good done by the lives saved through organ transplantation leads to delicate ethical and psychological questions. These decisions should be informed by further research examining the role of the three causes of default effects. For example, one might draw different conclusions if the effect of defaults on donation rates is due primarily to the physical costs of responding, than if they were due to loss aversion.

The tradeoff between errors of classification and physical, cognitive, and emotional costs must be made with the knowledge that defaults make a large difference in lives saved through transplantation.

Our data and those of Gimbel *et al.* suggest changes in defaults could increase donations in the United States of additional thousands of donors a year. Because each donor can be used for about three transplants, the consequences are substantial in lives saved. Our results stand in contrast with the suggestion that defaults do not matter (*29*). Policy-makers performing analysis in this and other domains should consider that defaults make a difference.

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32. This research has been supported by the Columbia University Center for Decision Science and the Columbia Business School Center for Excellence in E-Business. We thank L. Roels for providing the data on actual donation rates.

Supporting Online Material

www.sciencemag.org/cgi/content/full/302/5649/1338/DC1

Exhibit 5

March 1st 2018 letter to Task Force

Hon. Steven
FLETCHER
MLA ASSINIBOIA

March 1, 2018

Dear Mr. Helwer:

I am pleased that the private members bill the "Gift of Life Act" I introduced in March 2017 has generated a huge amount of public interest in organ donation.

The public interest in this issue can be demonstrated by the fact that my PMB (seconded by MLA Judy Klassen) generated media coast to coast including over 5300 shares on the CBC website alone. (The average story out of the legislature may get 50 shares. See attached.)

Again, a private members bill need not to be passed to be successful.

I was pleased to have the opportunity in the fall of 2017 to call for a vote and a debate on my PMB. The debate was very interesting. Again members of the official opposition and independent members associated with the Liberal Party provided additional perspectives.

It was disappointing that no one in the government participated in the debate. Not one word was mentioned, not one word came from the government benches on that October 31, 2017 debate. It was sad to see.

However, hope was provided by the health minister when it was announced the next day that a special standing committee would be struck to deal with the issue of organ donation. (Hansard October 31, 2017 QP).
A standing committee provides many advantages including public presentations, permanent record of the presentations, a multi-party venue, which allows questions from any MLA. Witnesses can present in person in a manner that simply does not come through in a written document.

Sadly, the government immediately removed one of the most progressive and innovative suggestions on increasing organ donation rates-presumed consent.

Presumed consent has met with great success in jurisdictions where it has been implemented. Organ donation awareness increases as does the organs that come available for transplant. Individuals for any reason can opt out of this program.

It is disappointing that the government spokesperson immediately reduced the scope of this new standing committee to ensure it excludes presumed consent.

It was also bizarre the rational for the exclusion of presumed consent. The MLA for Brandon West stated "There are implications for particular religions that want to see their loved ones buried whole. There's all kinds of things that have to be covered off on this."

Manitoba Legislative Building
Room 137 - 450 Broadway
Winnipeg, MB R3C 0V8
204-945-7073
Steven.Fletcher@leg.gov.mb.ca

Assiniboia Constituency Office
3723 Portage Avenue
Winnipeg, MB R3K 2A8
204-944-1049
stevenfletchermla@gmail.com

Hon. Steven
FLETCHER
MLA ASSINIBOIA

It is unclear which religion the MLA is referring to. Every major religion and denomination accepts that organ donation is "a gift of life". It is this misunderstanding of religion that undermines the credibility of the MLA charged with chairing the standing committee.

I have attached a summary of where major religions stand on the issue of organ donation.

I have also attached letters from MP's in the Federal Conservative Party who have been involved in the issue of organ donation at a national level and support the "Gift of Life Act".

On February 14 of this year the government announced a Task Force on the issue of organ donation. This is disappointing as a standing committee on organ donation is what is recorded as promised in Hansard and the media.

A Task Force is far weaker in impact then a standing committee. Accepting only written submissions minimizes the impact that organ donation has on the recipients family and the donors family, not to mention the recipient themselves. This would likely have provided moving and emotional testimonies by those that are most affected by organ donation.

It is difficult to think of another public policy issue more emotional and impactful as organ donation. It is important for decision makers to be open to creative public policy solutions. To say only "education" as suggested by comments made in the media by the government is simply not enough. This approach is a continuation of the status quo, it is not working, and the lives that could be saved or improved are lost.

Therefore, the government should fulfill its commitment for a standing committee rather than this "task force." The standing committee mandate should be open to all possibilities. To dismiss presumed consent without examination is irresponsible and demonstrates a disingenuous discussion on organ donation.

Manitoba should lead Canada in organ donation public policy, quantify the success of any new initiatives and integrate donors and recipients on an national level. The larger the pool of potential organs for donation, the more likely there will be matches for those who need the organ.

Sincerely,

Steven Fletcher

Steven Fletcher

Manitoba Legislative Building
Room 137 - 450 Broadway
Winnipeg, MB R3C 0V8
204-945-7073
Steven.Fletcher@leg.gov.mb.ca

Assiniboia Constituency Office
3723 Portage Avenue
Winnipeg, MB R3K 2A8
204-944-1049
stevenfletchermla@gmail.com

Exhibit 6

Published in The Lancet, Volume 351, Issue 9116, 30 May 1998, Pages 1650-1652
http://www.sciencedirect.com/science/article/pii/S0140673697082123

The case for "presumed consent" in organ donation

I Kennedy, R A Sells, A S Daar, R D Guttmann, R Hoffenberg, M Lock, J Radcliffe-Richards, and N Tilney

Is there a moral case for changing the law regulating organ donation from a system of "contracting in" to "contracting out" or "presumed consent" in those countries that have not yet done so? Contracting in refers to a system in which the law requires that donors and/or relatives must positively indicate their willingness for organs to be removed for transplantation. In a contracting out system, organs may be removed after death unless individuals positively indicate during their lifetimes that they did not wish this to be done, a system also known as presumed consent.

We start with the premise that any measure that increases the supply of organs for transplantation is a good thing. If the contracting out system were to achieve this, the onus would then be on those who oppose it to demonstrate that the benefit that flows from it is outweighed by the harm.

Why change the law?

Since 1990 in those countries that have a contracting in system in place the number of cadaver organs available for transplantation has not kept up with demand; indeed the gap is widening.[1,2] Nonetheless, many people believe that the law should not be changed, arguing that a significant improvement in supply could result from public and professional education and measures to simplify the process of donation and retrieval of organs. Although not discounting this possibility, we believe that a contracting out system would achieve the same effect with greater certainty, as has been shown in countries that have changed to this option. Therefore we believe that it is morally unjustified to perpetuate a system that falls short of increasing the availability of organs to people who might benefit from transplantation.

Current situation

The guiding principles issued by WHO in 1991[3] state that organs may be removed from the body of a dead person if: (a) any consents required by law are obtained; and (b) there is no reason to believe that in the absence of any formal consent given during life the dead person would have objected to such removal.

In countries where transplantation is widely practised, the law permits removal of organs from the cadaver of a person who made known the wish to donate while alive. In practice most people have not made any such formal declaration. In these circumstances the law looks to the relatives for consent. Since most donors will have spent some time in the intensive care unit before death is pronounced, the relatives will be present when the decision is taken to withdraw life support and are then approached. They decide whether organs may be removed and used for transplantation, and their power is in turn laid down by the law.

The laws of different countries fall into five categories. In the absence of a wish expressed by the donor during life, organs may be removed in the following circumstances.

● Only with the consent of the person lawfully in possession of the body and subject to express objection of the deceased or objection of the relatives, if available (UK).[4]

● After the relatives have been informed of the intention to remove organs, but irrespective of their consent (except for that of the nearest relative, Norway).[5]

● Once it has been ascertained that the relatives do not object (Italy).[5]

● Where the dead person had not expressed an objection, this is confirmed by the relatives and consent is then presumed (Belgium).[5]

● Irrespective of the relatives' views (Austria).[5]

Does contracting out increase the supply of organs?

The difference in the rates of organ donation between countries can be explained by several factors, such as the supply of potential donors (which may vary according to the rate of road-traffic accidents or gun laws, for example), religious and cultural responses to death and to the body after death, and practical issues—eg, the number of intensive-care beds available. Adverse publicity can seriously reduce the supply by reducing the number of potential donors or the consent of relatives. Supply can be increased by energetic educational campaigns,[6–8] by having more transplant coordinators,[8] by the provision of specialist teams to take over the care of potential donors,[9] and by provision of financial incentives to encourage doctors and institutions to refer patients. All these factors are independent of the nature of the prevailing law.

In three western countries there is evidence that changing to a contracting out system resulted in an increase in organs—Spain,[9] Austria,[10] and Belgium[11]—but the change in legislation has not achieved this rise on its own. In Spain, for example, additional measures included the appointment of more co-ordinators and provision of financial incentives. In the case of Belgium there is well documented and convincing evidence that a change in the law from contracting in to contracting out in 1986 led to an increase in organ supply.[11] Staff at the organ-transplantation centre in Antwerp were strongly opposed to the new law and retained a contracting in policy accompanied by enhanced public and professional education; by contrast, at Leuven the new law was adopted. In Antwerp, organ donation rates remained unchanged; in Leuven they rose from 15 to 40 donors per year over a 3-year period. In the whole country organ donation rose by 55% within 5 years despite a concurrent decrease in the number of organs available from road-traffic accidents. Citizens who wish to opt out of the scheme may register their objection at any Town Hall; since 1986 less than 2% of the population have done so. Use of a computerised register has simplified ascertaining the existence of any objection. In Belgium, despite the existence of this law, doctors are encouraged to approach the relatives in all cases and practitioners may decide against removing the organs if in their opinion this would cause undue distress or for any other valid reason. Less than 10% of families do object compared with 20–30% elsewhere in Europe. Another benefit has been an increase in the number of referrals of cadaver donors from collaborating centres, suggesting that the intensivists have found the new law favourable to donation.[12] It would seem from the Belgian experience that relatives may be reluctant to take a personal decision about the removal of organs, but they find it easier to agree

if they are simply confirming the intention of the dead person. If this is so, a contracting out system has a moral benefit of relieving grieving relatives of the burden of deciding about donation at a time of great psychological stress.

A change in the law thus achieves the dual effect of increasing the supply of organs and lessening the distress of relatives. Those who have moral objections to it must produce convincing evidence that the harm that would follow such a change would outweigh these clear benefits.

Possible moral objections

The right of the individual to refuse to donate organs

This right is allowed for both in principle and in practice by the Belgian model, in which objection can be registered by law and doctors have the discretion to desist if they feel that removal of organs will better reflect the individual's wishes to avoid undue distress to the relatives. It is essential to ensure that simple mechanisms for registering an objection are easily available. In developed countries it should not be difficult to ensure that an opportunity is provided whenever any official business is transacted—eg, when applying for a passport or driving licence. The safety mechanism of checking the decision with the relatives should minimise the possibility of erroneous interpretation of the dead person's wishes. We conclude that a sensitive, secure, and robust system could be introduced, preceded by a reasonable period of notice and publicity to give time to those who wish to register their objection. Whether this approach recommends itself to developing countries, where other priorities compete, is a separate matter.

The rights of relatives

In most legal systems, relatives have no property claim over the body of the deceased. Furthermore, any claim they may seek to assert seems rather weak when set against the claims of the person in need of a transplant. This is not to argue that relatives' interests should be ignored, and indeed the Belgian model takes them into account. This version of the contracting out system, as opposed to one in which the wishes of the relatives are ignored, is consistent with the recommendations of the Conference of European Health Ministers and WHO. The primary role of relatives is thus to corroborate that the dead person did not actually register an objection. They are not put into the position of having to make the decision themselves, but simply to confirm the facts. As a result the refusal rate is much lower.

Possible counterproductive consequences of changing the law

It may be argued that this change in public policy would invoke such social unease and disquiet that people would turn away from the whole concept of transplantation. This has not been the experience in countries that have changed, where, if anything, the general population and medical professionals are happier with the new law than with the old. In Belgium and Spain an increase in organ supply has been achieved despite a fall in the number of potential donors.

Another objection is that the state already has a big enough stake in our lives—eg, through the tax law, and further incursion into our affairs by assuming possession of our body parts and the right to distribute them to others by law would be a step too far. A study by the King's Fund Institute in 1994[13] concluded that, in the UK, the medical professions, the transplantation community, and the

public were split over the ethics of the contracting out law and it would be inappropriate to recommend a change in the law because this might provoke an acrimonious debate that could damage confidence in transplantation technology as a whole. Others may argue that people would feel pressure not to contract out because this would be socially unacceptable. Both arguments are rebutted by the ready acceptance of the law in Belgium and elsewhere, and the immediate benefit it achieved in increasing the supply of organs.

Clearly, from a moral standpoint, the social context in which any law is to operate and any medical action that arises from it must be a significant consideration in determining policy. Before any such law is promulgated, there will have to be an informed public debate and a clear demonstration that it would be morally acceptable to most people. Much of the objection to change would be mitigated by appropriate public education.

We feel that this debate should now take place and, unless there is a majority view against change, the contracting out system of organ donation should be introduced.

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Exhibit 7

Letters from Federal MP's

Letter from Len Webber, Federal MP 1/2

Letter from Len Webber, Federal MP 2/2

Letter From Ziad Aboultaif, Federal MP

HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Len Webber, M.P.
Calgary Confederation

OTTAWA
October 25, 2017

Hon. Steven Fletcher, PC, MLA
Legislative Assembly of Manitoba
450 Broadway
Winnipeg, MB R3C 0V8

Dear Mr. Fletcher,

Thank you for your email of October 24, 2017 in which you raised our shared interest in organ and tissue donation in Canada.

I am pleased to enclose a letter in support of Bill 213, *The Gift of Life Act* which may be distributed to the Members of the Legislative Assembly of Manitoba. Please keep me posted of any progress as this will potentially set a higher bar for other provinces to follow suit.

Ironically, my involvement began at the provincial level and is now active at the federal level.

Bill C-316 has been crafted in such a manner as to fully respect provincial jurisdiction insofar as it does not require the provinces to take any action. Instead, the federal government would utilize existing mechanisms to pass along a database of those who have indicated a willingness to be a donor. It would then be up to the province to determine how they use this information. Technically, they could choose to do nothing with this valuable resource, but I suspect that would not be the case.

I am very pleased that you reached out to me on this important issue and I look forward to remaining in contact as both our proposals move forward.

Kind regards,

Len Webber, MP
Calgary Confederation

Calgary
2020-10th Street NW
Calgary, AB T2M 3M2
(403) 220-0888
Len.Webber.c1@parl.gc.ca

www.LenWebber.ca

Ottawa
812, Confederation Bldg.
Ottawa, ON K1A 0A6
(613) 996-2756
Len.Webber@parl.gc.ca

HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Len Webber, M.P.
Calgary Confederation

OTTAWA
October 25, 2017

Members of the Legislative Assembly of Manitoba
450 Broadway
Winnipeg, MB R3C 0V8

Dear Members of the Legislative Assembly,

I am pleased to write to you in support of Bill 213, *The Gift of Life Act* which will come before you shortly and has the potential to save many lives, including the 200 Manitobans currently awaiting a life-saving transplant.

As a former MLA and Minister in Alberta, I was instrumental in the creation of the Alberta Organ Donor Registry. Today I continue this work in Ottawa as a Member of Parliament with my Bill C-316 which seeks to enhance tax forms so that Canadians can indicate their desire to be an organ donor more easily.

Organ donation is overwhelmingly supported by Canadians, but current opt-in registration systems have failed to connect the potential supply with the growing demand for transplant organs. Ninety percent of Canadians support organ donation but almost three-quarters of those are not registered.

It is my belief that an opt-out system for organ donation in Canada would dramatically increase the supply of needed organs while also preserving the right of any individual to opt-out if they so wished. Very shortly, you will have the opportunity to better the lives of all Canadians, perhaps even your own one day, and I strongly encourage you to seize this opportunity and support Bill 213.

I thank you for your time and consideration and look forward to your support of Bill 213.

Kind regards,

Len Webber, MP
Calgary Confederation

Calgary
2020-10th Street NW
Calgary, AB T2M 3M2
(403) 220-0888
Len.Webber.c1@parl.gc.ca

www.LenWebber.ca

Ottawa
812, Confederation Bldg.
Ottawa, ON K1A 0A6
(613) 996-2756
Len.Webber@parl.gc.ca

HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Len Webber, M.P.
Calgary Confederation

OTTAWA
October 25, 2017

Members of the Legislative Assembly of Manitoba
450 Broadway
Winnipeg, MB R3C 0V8

Dear Members of the Legislative Assembly,

I am pleased to write to you in support of Bill 213, *The Gift of Life Act* which will come before you shortly and has the potential to save many lives, including the 200 Manitobans currently awaiting a life-saving transplant.

As a former MLA and Minister in Alberta, I was instrumental in the creation of the Alberta Organ Donor Registry. Today I continue this work in Ottawa as a Member of Parliament with my Bill C-316 which seeks to enhance tax forms so that Canadians can indicate their desire to be an organ donor more easily.

Organ donation is overwhelmingly supported by Canadians, but current opt-in registration systems have failed to connect the potential supply with the growing demand for transplant organs. Ninety percent of Canadians support organ donation but almost three-quarters of those are not registered.

It is my belief that an opt-out system for organ donation in Canada would dramatically increase the supply of needed organs while also preserving the right of any individual to opt-out if they so wished. Very shortly, you will have the opportunity to better the lives of all Canadians, perhaps even your own one day, and I strongly encourage you to seize this opportunity and support Bill 213.

I thank you for your time and consideration and look forward to your support of Bill 213.

Kind regards,

Len Webber, MP
Calgary Confederation

Calgary
2020-10th Street NW
Calgary, AB T2M 3M2
(403) 220-0888
Len.Webber.c1@parl.gc.ca

www.LenWebber.ca

Ottawa
812, Confederation Bldg.
Ottawa, ON K1A 0A6
(613) 996-2756
Len.Webber@parl.gc.ca

HOUSE OF COMMONS
CHAMBRE DES COMMUNES
CANADA

Len Webber, M.P.
Calgary Confederation

OTTAWA
October 25, 2017

Hon. Steven Fletcher, PC, MLA
Legislative Assembly of Manitoba
450 Broadway
Winnipeg, MB R3C 0V8

Dear Mr. Fletcher,

Thank you for your email of October 24, 2017 in which you raised our shared interest in organ and tissue donation in Canada.

I am pleased to enclose a letter in support of Bill 213, *The Gift of Life Act* which may be distributed to the Members of the Legislative Assembly of Manitoba. Please keep me posted of any progress as this will potentially set a higher bar for other provinces to follow suit.

Ironically, my involvement began at the provincial level and is now active at the federal level.

Bill C-316 has been crafted in such a manner as to fully respect provincial jurisdiction insofar as it does not require the provinces to take any action. Instead, the federal government would utilize existing mechanisms to pass along a database of those who have indicated a willingness to be a donor. It would then be up to the province to determine how they use this information. Technically, they could choose to do nothing with this valuable resource, but I suspect that would not be the case.

I am very pleased that you reached out to me on this important issue and I look forward to remaining in contact as both our proposals move forward.

Kind regards,

Len Webber, MP
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2020-10th Street NW
Calgary, AB T2M 3M2
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Len.Webber.c1@parl.gc.ca

www.LenWebber.ca

Ottawa
812, Confederation Bldg.
Ottawa, ON K1A 0A6
(613) 996-2756
Len.Webber@parl.gc.ca

Ottawa

Room 548, Wellington Building
Ottawa, ON K1A 0A6
Tel: 613-992-0946
Fax: 613-992-0973
ziad.aboultaif@parl.gc.ca

Ziad Aboultaif
Member of Parliament / Député
Edmonton Manning

Edmonton

#204A, 8119-160 Avenue
Edmonton, AB T5Z 0G3
Tel: 780-822-1540
Fax: 780-822-1544
ziad.aboultaif.c1@parl.gc.ca

Members of the Legislative Assembly of Manitoba
450 Broadway
Winnipeg, MB
R3C 0V8

October 23, 2017

Dear Members of the Legislative Assembly,

I am writing today in support of the Honourable Steven Fletcher's Bill 213, The Gift of Life Act.

Organ donation. Everyone is in favour. On the other hand, registering to be a donor is something we all intend to do, but most of us, for various reasons, neglect until it is too late. It can be a matter of life and death for many. It was for my family.

In 2003, I made a living donation, giving part of my liver to my son Tyler. This was not something I did lightly. It is a dangerous operation for both the donor and the recipient.

For Tyler, it was life or death. I love my son. No matter the risks, I could not watch him die.

Since that time, I have become increasingly aware of the unmet need for organ donations in Canada. There are literally thousands of people waiting for that telephone call that will change their lives and the lives of their family members. Tragically, for more than 200 Canadians each year, the time runs out before the call comes.

More than 90% of Canadians support organ and tissue donation in theory, but less than 25% have made plans to donate. Canada's organ donation rate is among the world's worst, yet one donor can benefit more than 75 people and save up to eight lives.

Sometimes, organ compatibility is not enough. Shortly after that transplant, the portion of my liver that Tyler received began to die. For me to donate again was not possible. Another donor was needed or my son would die.

On Christmas Eve 2003, it looked like Tyler's time had run out. His life expectancy was days, perhaps hours. Almost miraculously, a liver became available from a Quebec man who had just died. We were told it was not a perfect solution. It would only buy time, but time was what we desperately needed.

My wife Liz and I were so thankful to the family of that anonymous donor. In their grief at the loss of a loved one, they cared enough to think of others. We will be forever in their debt. Their gift gave us our son when we thought we would lose him.

However, with Tyler's second transplant, our journey was not yet over. We knew that the liver he received was not a long-term solution. After a decade it too began to fail. Once more we entered the medical system, our emotions a mixture of hope and fear. There were no guarantees. We knew the statistics. We knew the odds. We prayed yet again for a miracle.

Once again, a grieving family offered a loved one's organs for the good of the community, and a match was made. This time we hope Tyler has a liver that will be with him for the rest of his life. We are so grateful to have a healthy son, now a young man beginning to make his way in the world, someone of whom we are very proud.

Having experienced the organ donation system first-hand, I became acutely aware of the need for a more coordinated effort in this area, both locally, provincially and nationally. I became an advocate for all those like Tyler, people in need of a life-saving transplant. All too often, it seems to me, the difference between life and death is one of simple awareness. People do not know the good they could do. Tragically, they don't register to become organ donors. When they die it is too late.

While some provinces have a large percentage of citizens who have indicated they wish to be organ donors, others have very few, far below the national average. Canada is far behind other countries in the percentage of citizens who have let authorities know of their willingness to be organ donors. That is why I support Steven Fletcher's Bill 213, The Gift of Life Act.

The intent of this legislation is to save lives by increasing the number of potential organ donors. Instead of people having to sign up to donate, they would only register if they did not wish to do so. This system of presumed consent on the behalf of the deceased would greatly increase the potential number of donors, while preserving the rights of those who do not wish to donate.

Last year in Manitoba 11 people received lung transplants and another 57 kidney transplants. Thirteen Manitobans traveled outside the province for liver transplants, while eight others received a new heart in out-of-province surgery. The need is great; the number of donors not enough.

Manitoba's online donor and tissue organ donation registry, www.signupforlife.ca has had more than 15,000 people register since it was started in 2012. Yet the need keeps increasing. At any given time, there are 200 Manitobans on the waitlist for a kidney transplant. Another 20 are waiting for a heart, lung or liver transplant. Given that about 10,000 Manitobans die annually, passage of The Gift Of Life Act, would indeed offer a gift of life and hope to many Manitoba families.

For most people there is no reason to not be an organ donor. Bill 213 is good public policy.

Please feel free to call me in either Ottawa or Edmonton if you would like to discuss this Bill further. It is a subject I feel passionately about, one where legislators can rise above partisan politics and do something good for all citizens.

Sincerely,

Ziad Aboultaif, MP
Edmonton Manning
Shadow Minister for International Development

P.S. If you are not yet registered as an organ donor, you can sign up at http://www.transplantmanitoba.ca/. It would be the right thing to do.

Exhibit 8

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THE PRESUMED CONSENT APPROACH TO ORGAN DONATION

Martha Butler
Aboriginal Affairs and Social Development Section
Parliamentary Information and Research Service

Sonya Norris
Social Affairs, Health and Infrastructure Section
Parliamentary Information and Research Service

28 August 2014

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INTRODUCTION

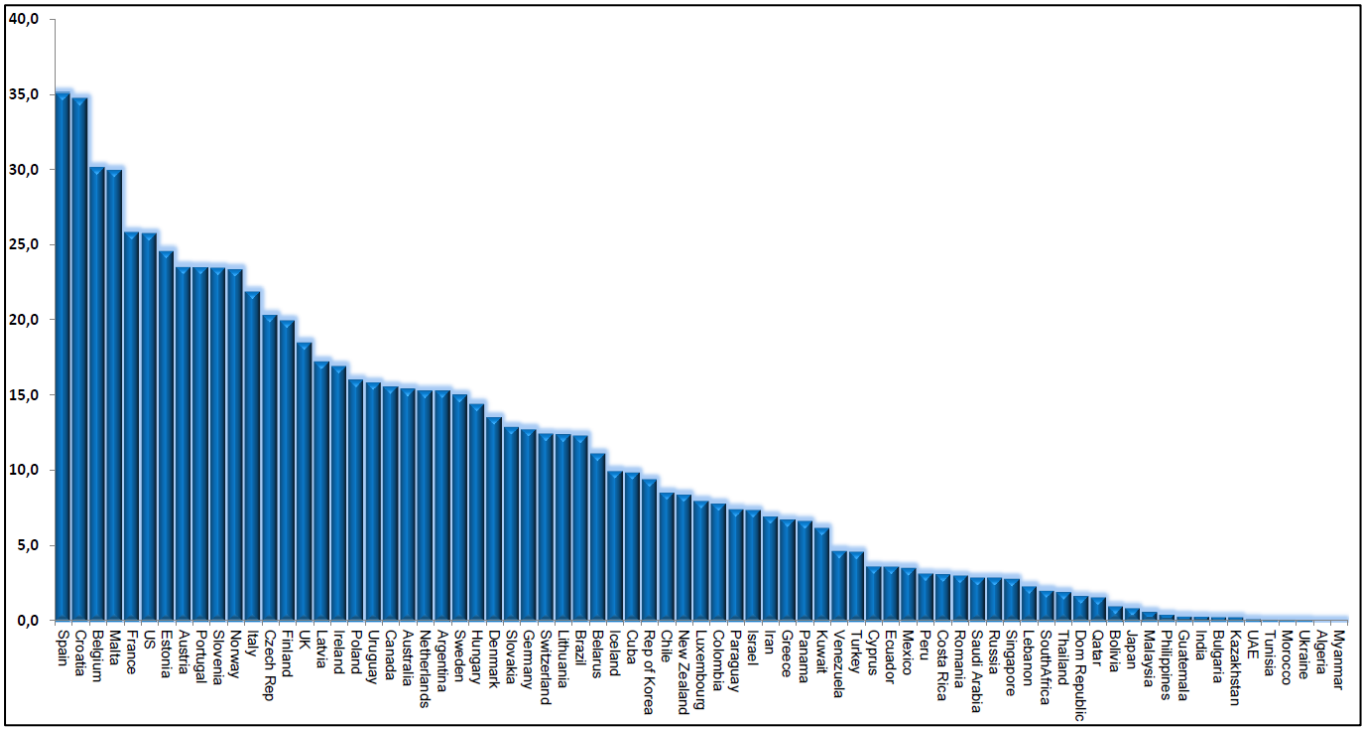
This document provides a short analysis of the issue of presumed consent as it relates to organ donation. It provides a description of this approach as well as its alternative (required or explicit consent), discusses the jurisdictional authority over consent in Canada, lists some of the experiences in other countries in this regard and offers a review of previous relevant legislative attempts both federally and provincially in Canada.

CONSENT TO DONATE: PRESUMED VERSUS EXPLICIT

A. Description

Canada's "deceased donation rate" is lower than that of many of the countries to which it is compared. International comparisons of deceased organ donor rates usually include Spain and the United States (U.S.A.), whose donor rates are reportedly 35 and 26 donors per million population (PMP) respectively. Overall, Canada ranked 20th in 2012, at about 16 donors PMP for deceased organ donor rates among the 75 countries that were surveyed.[1]

Figure 1 – Donor Rates in Various Jurisdictions (2012 data)



Source: Global Observatory on Donation and Transplantation, *Organ Donation and Transplantation Activities 2012*, Report prepared for Government of Spain, Ministry of Health and Social Policies, and World Health Organization, slide 13.

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1 Information about USA and Spanish donation rates are 2012 statistics from Global Observatory on Donation and Transplantation, *Organ donation and Transplantation Activities 2012*, Report prepared for Government of Spain, Ministry of Health and Social Policies, and World Health Organization, slide 13 (ignore log in).

It is important to note that the term “donor” is defined differently in the U.S.A. and Spain than it is in Canada. Whereas Canada’s donor rate refers only to deceased individuals from whom at least one organ was retrieved and successfully transplanted into a patient, the U.S.A. and Spain both consider donors to be deceased persons who have been identified as potential donors but includes those whose organs may not have been transplanted. This discrepancy in donor definition inflates the U.S.A. and Spanish statistics relative to the Canadian ones. The Canadian Institute for Health Information, under its Canadian Organ Replacement Register, provides data on “referred donors,” “potential donors” as well as “actual donors.” Canada’s deceased donor rate reflects only “actual donors.”[2]

An option often suggested as a way to increase donor rate is to implement presumed consent, sometimes called the opt-out system. Under this approach, consent to donate is presumed unless a person has expressly indicated otherwise during his or her lifetime. Canada operates under an explicit consent system (also referred to as required consent or explicit consent) whereby individuals express the intention while they are alive to become a donor upon their death. However, failure to express a desire to donate during one’s lifetime is not necessarily deemed a refusal to become a donor. Under most circumstances, the family becomes the ultimate source for consent.

B. The Debate

Proponents of the presumed consent approach note that the vast majority of Canadians are in favour of organ donation when polled, but that only a small percentage of them actually fill out their donation cards. Additionally, proponents suggest that there is no legal requirement to either solicit or respect the wishes of family if consent to donate had been provided by the potential donor. Opponents of presumed consent insist that it is not the method of consent that affects donor rate but rather the supporting donation and transplantation infrastructure that brings about increased donation rates. They also suggest that regardless of the legal requirements, family wishes will continue to be determinative in this country and that imposing a presumed consent system would not be received well in Canada.[3] Below is an overview of some of the main issues of contention in the debate about presumed consent, which may explain, in part, why an explicit consent approach to organ donation is in place in Canada.

C. Growing Waiting Lists for Organ Transplants

In Canada as well as in all countries with transplant facilities, the number of people awaiting organ transplants is greater than the number of organs available for transplant. Proponents of the presumed consent approach state that the number of deceased organ donors will inevitably increase if there is a presumption of consent to donate. It should be emphasized, however, that even the theoretical increase is not as large as most people assume because, for a variety of reasons, few people are considered as potential donors upon death. Although the criteria are now broader than they have been in the past, essentially donor candidates are limited to those who die of stroke or heart attack and those who are victims of incidents like car accidents and gun violence. Even then, only a portion of the individuals who fall into these categories are considered. Candidates must be considered to have been generally in good health, up until the fatal event. As such, despite the theoretical pool of the entire population under a presumed consent system, only a small fraction of it becomes a candidate for organ donation.

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2 For more discussion on organ donation and increasing the donor rate, please refer to Sonya Norris, *Organ Donation and Transplantation in Canada*, Publication No. 2011-113-E, Parliamentary Information and Research Service, Library of Parliament, Ottawa, 10 November 2011. A revised version of the publication will be available shortly.

3 Mark Ammann, “Would Presuming Consent to Organ Donation Gain Us Anything But Trouble?,” *Health Law Review*, Vol. 18, No. 2, 2010, pp. 15–24.

D. Public Support for Organ Donation

Proponents of the presumed consent approach note that the vast majority of Canadians are in favour of organ donation when asked, but that only a small percentage of them actually fill out their donor cards. This phenomenon is common in other countries as well. Supporters of presumed consent suggest that potential donors are not being pursued because few have expressed in writing their desire to become donors regardless of their support for donation. The supporters suggest that implementing a presumed consent approach is consistent with the strong public support for donation and that individuals who do not wish to participate may withdraw from the system. Opponents of the opt-out system point out that countries with high donor rates, such as the U.S.A. (opt-in system) and Spain (opt-out system) are able to reach almost the same level of consent to donate from the families of potential donors. Spain has a 90% consent rate from families[4] and the U.S.A. has a 75% consent rate.[5]

E. Informed Consent and Altruism

Opponents of the presumed consent approach assert that it contravenes the tradition of obtaining informed consent for medical procedures. They emphasize that individuals who may have never given any thought to organ donation could still become donors, and as such were deprived of making an informed choice on the issue. In addition, opponents claim that deceased organ donation, like living organ donation and blood donation, is based on altruism, sometimes called voluntary beneficence, and that presumed consent would fundamentally change this focus.[6]

F. Family Wishes

Many jurisdictions ultimately rely on the consent of family for organ donation. Jurisdictions with an explicit consent system may override a person's stated will to donate should his or her family refuse to consent at the time of potential donation. Similarly, in many of the countries where legislation has been passed to implement a presumed consent system, including Italy and France (as well as Spain, the best performer in terms of deceased organ donor rates), in practice, donation does not proceed without the informed consent of family.[7] The observation that family consent usually determines whether donation proceeds illustrates that presumed consent laws are rarely enforced.[8]

Jocelyn Downie, a health law scholar, has argued that families have no legal authority in Canada to oppose a family member's valid consent to post-mortem donation, except in Manitoba and Quebec.[9] Despite this situation, she notes that studies indicate that physicians generally assume that families' wishes would be respected over those of the donor. Further, she suggests that health care workers' lack of understanding of the law, their concern for the feelings of family members, and a fear of lawsuits might account for this tendency to override valid consent.

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4 Elena Anatolyevna Kirillova and Varvara Vladimirovna Bogdan, "Actual Problems of Post-Mortem Organ Donation by Bequest in the Law of Succession in Russia: A Comparative Legal Analysis," *Middle-East Journal of Scientific Research*, Vol. 15, No. 8, 2013, p. 1099.

5 Donate Life California, *Presumed Consent*.

6 Swiss National Advisory Commission on Biomedical Ethics, *On presumed consent to organ donation-Ethical considerations*,2012.

7 Alberto Abadie and Sebastien Gay, "The Impact of Presumed Consent Legislation on Cadaveric Organ Donation: A Cross-Country Study," *Journal of Health Economics*, Vol. 25, No. 4, July 2006, p. 602 and Appendix C, pp. 617–619.

8 Ibid., p. 612.

9 J. Downie et al. "Family Override of Valid Donor Consent to Postmortem Donation: Issues in Law and Practice," *Transplantation Proceedings*, Vol. 40, pp., 2008, 1255-1263.

G. Health Care System Infrastructure

Opponents of the presumed consent system argue that donation rate is a reflection of the healthcare system in general, and the transplantation system specifically, rather than a reflection of the type of consent used. This relates to health expenditures and gross domestic product, which researchers have established are associated with donor rates. Opponents of presumed consent also point to the fact that jurisdictions operating under that system have donation rates that range from a high in Spain of 35 deceased PMP to a low in Greece of 7.3 PMP (2011 rates).[10] This disparity is evident when donation rates of presumed consent nations are compared to donation rates of required consent countries.[11] Both groups show a wide range of donation rates and rates tend to be higher in wealthier countries that have higher health expenditures. A noted exception to this observation is the performance of Japan, a required consent country. In that country, there is a negative attitude towards transplantation that is attributed to such issues as views on death, skepticism of the criteria used to determine death with respect to organ donation, resistance to western medicine, etc.[12] Japan's healthcare system is similarly unprepared to undertake organ donation and transplantation at levels seen in other wealthy countries. Centres do not all have the necessary equipment or properly trained professionals to recruit donors or to conduct procedures.[13]

H. Public Awareness and Trust

Spain has enjoyed high deceased organ donor rates for many years, during which time there has been a presumed consent approach to donation. However, donor rates initially remained stagnant in Spain following the implementation of presumed consent in 1979. It was not until the Spanish government dedicated resources not only to the donation and transplantation system so that centres had the capacity to identify potential donors, approach family in the most appropriate way, efficiently identify potential recipients and successfully conduct transplants, but also to a comprehensive public awareness campaign, that donor rates climbed.[14] In this way, the public became aware of the issue, gained trust in the system, became more comfortable with the concept of becoming a potential donor and initiated discussions with family about their wishes.[15]

THE APPROACHES OF OTHER COUNTRIES

Several countries have adopted the presumed consent approach (a 2012 article on the role of next-of-kin authority provides a list of 54 countries and whether each operates under an explicit or presumed consent model for deceased organ donation.[16]) A 2006 study reported that there is no direct correlation between organ donor rates and presumed consent, but suggested that after allowing for other

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10 Donate Life California, *Presumed Consent*.

11 Lucy Horvat et al., "Informing the Debate: Rates of Kidney Transplantation in Nations With Presumed Consent," *Annals of Internal Medicine*, Vol. 153, 2010, p. 646.

12 Rihito Kimura, "Organ Transplantation and Brain-Death in Japan. Cultural, Legal and Bioethical Background," *Annals of Transplantation*, Vol. 3, No. 3, 1998, pp. 55-58.

13 Jessica Ocheltree, "Japan slowly learning to embrace organ donation," *Japan Today*, 23 February 2011.

14 Ammann (2010), p. 18.

15 Beatriz Dominguez-Gil et al., "Ethical and Social Issues of the Spanish Model on Organ Donation and Transplantation," *eLS*, 2012.

16 Amanda M. Rosenblum et al., "The authority of next-of-kin in explicit and presumed consent systems for deceased organ donation: an analysis of 54 nations," *Nephrology, Dialysis Transplantation*, 2012, Vol. 27, pp. 2533–2546.

determinants, there may be some advantage gained by such an approach.[17] Although presumed consent is the approach used in Spain, the country with the highest reported organ donor rate, several other countries that have also adopted that approach have donor rates that are far lower than countries that operate an explicit consent system. For example, Poland and Sweden, which both operate presumed consent systems, report lower donor rates than does Canada. The U.S.A., United Kingdom (U.K.) and Ireland, which are among the countries with relatively high donor rates, have required consent systems. The same observations were reported by the Global Observatory on Donation and Transplantation in 2012.[18]

Other common-law countries to which Canada is often compared in the development of legislative and policy initiatives include the U.S.A., the U.K., Australia and New Zealand. All of these countries operate under an explicit consent model for organ donation. This may be consistent with an argument forwarded in 2006 in the U.S.A. by the Committee on Increasing Rates of Organ Donation that presumed consent is unpopular in countries where personal autonomy is highly valued. The right to self-determination with respect to one's body and the right to refuse medical treatment have long been carefully protected common-law principles.[19] In Canada particularly, personal autonomy in all medical decisions is a feature of our health, or medical, legislation.[20]

JURISDICTIONAL AUTHORITY OVER ORGAN DONATION AND TRANSPLANTATION IN CANADA

The division of federal and provincial powers with respect to health in Canada prevents Parliament from imposing consent legislation with respect to organ donation. Organ donation and transplantation legislation in Canada is largely provincial or territorial. Each province and territory has legislation in place governing donation and transplantation activities, including consent, and in all cases consent must be explicit for organ donation.[21]

A. Constitutional Division of Powers

Jurisdiction over health is not assigned to a single level of government; some aspects of health fall under federal jurisdiction, while others fall under provincial jurisdiction. The *Constitution Act, 1867* sets out several areas of jurisdiction (also known as heads of power) relevant in the health context, including:

- section 91(27): criminal law;
- sections 91(1A) and 91(3): federal spending power; and
- section 91: peace, order and good government (POGG) power.

Many areas of health, particularly health care delivery, fall under provincial jurisdiction. The relevant provincial heads of power include the following:

- section 92(7): the establishment, maintenance, and management of hospitals;

17 Abadie and Gay (2006), p. 20.

18 Global Observatory on Donation and Transplantation, "Donation from deceased persons (pmp)," *Organ Donation and Transplantation Activities – 2012*, January 2014.

19 Ammann (2010), p. 19.

20 Ibid.

21 Only the safety of donated organs and tissues is regulated federally. This is done under the *Safety of Human Cells, Tissues and Organs for Transplantation Regulations* pursuant to the *Food and Drugs Act*.

- section 92(13): property and civil rights in the province; and
- section 92(16): all matters of a merely local or private nature in the province.

Courts have interpreted section 92(7) as allowing the provinces to legislate in the area of hospital care, but also health care delivery more broadly.[22] Under section 92(13), provinces have authority over "property and civil rights in the province," which covers matters such as health insurance and the regulation of health care professionals.[23] Finally, section 92(16) grants provinces legislative authority over "matters of a merely local or private nature in the province," which courts have interpreted as allowing provinces to legislate with respect to certain public health matters.[24]

1. Criminal Law Power

The criminal law power is used in many areas of federal jurisdiction over health.[25] It is the authority upon which the *Criminal Code* was enacted. The *Criminal Code* does not include any offences related to organ donation or retrieval. Although s. 182(b) of the *Criminal Code* prohibits interference with and mutilation of dead bodies, this section has not been invoked in the context of organ retrieval, and if it were, it is unlikely that it would result in a finding of criminal liability.[26]

For a court to find that Parliament has enacted valid health legislation based on its criminal law power, the legislation must address a "public health evil."[27]

> [T]he criminal law power may validly be used to safeguard the public from any injurious or undesirable effect. The scope of the federal power to create criminal legislation with respect to health matters is broad, and is circumscribed only by the requirements that the legislation must contain a prohibition accompanied by a penal sanction and must be directed at a legitimate public health evil.[28]

In her analysis of cases in which the Supreme Court of Canada upheld federal laws on the basis that they addressed a public health evil, Chief Justice Beverly McLachlin identified the following three features: "(1) human conduct (2) that has an injurious or undesirable effect (3) on the health of members of the public."[29]

2. Spending Power

The federal spending power is inferred from two subsections of section 91 of the Constitution: section 91(A), "the public debt and property," and section 91(3), "the raising of money by any mode or

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22 *Schneider v. The Queen*, [1982] 2 SCR 112 [*Schneider*].

23 Peter Hogg, *Constitutional Law of Canada*, 5th ed., Carswell, Toronto, 2013, p. 32-2.

24 *Schneider*.

25 For a recent discussion of the criminal law power in the health context, please see *Canada (Attorney General) v. PHS Community Services Society*, 2011 SCC 44.

26 Downie (2008) p. 1257 and Eric Nelson, "Alberta's New Organ and Tissue Donation Law: The Human Tissue and Organ Donation Act," *Health Law Review*, Vol. 18, No. 2, 2010, pp. 5-14.

27 *RJR-MacDonald Inc. v. Canada (Attorney General)*, [1995] 3 S.C.R. 199 at para. 32

28 Ibid.

29 *Reference re Assisted Human Reproduction Act*, 2010 SCC 61, at para. 54.

system of taxation." Pursuant to its spending power, however, Parliament may create a grant for the provinces and attach any conditions to such a grant that it sees fit. Leading constitutional scholar Peter Hogg explains as follows:

> [T]he federal Parliament may spend or lend its funds to any government or institution or individual it chooses, for any purpose it chooses and that it may attach to any grant or loan any conditions it chooses, including conditions it could not directly legislate. … There is no compelling reason to confine spending or lending or contracting within the limits of legislative power, because in those functions the government is not purporting to exercise any peculiarly governmental authority over its subjects.[30]

3. Peace, Order and Good Government

The "peace, order, and good government" power is found in the opening text of section 91. The Supreme Court of Canada has held that this power allows the federal government to enact laws on public health in relation to issues "of national concern" that are beyond the scope of a single province.[31] This test is considered to be a high standard, to the extent that if a given province failed to address the issue, there would be repercussions for other provinces.[32] This power is not relied upon as frequently in the health context as the two other federal powers discussed above.

4. Federal or Provincial Jurisdiction?

Legal authorities writing on organ donation generally assert that organ donation falls under provincial jurisdiction.[33] It does not appear that Canadian courts have addressed this issue directly, so it is difficult to determine whether the basis for provincial jurisdiction is related to their legislative authority over matters related to health care delivery or to property and civil rights in the province. The fact that all provinces and territories have enacted organ donation and consent legislation might suggest, however, that courts would tend to see the issue of organ donation as one that falls under provincial jurisdiction.

B. Possible Legislative Option

Although legislation regulating organ donation might face jurisdictional challenges, there may be a legislative option available. Pursuant to its spending power, Parliament might adopt an approach similar to that it used with the *Federal Framework for Suicide Prevention Act*.[34] This Act could have encountered constitutional challenges if it had purported to exercise authority over mental health care delivery. In fact, the Act calls only for action on the part of the federal government and consultation with the provinces and so likely would not be considered by courts to be outside of federal jurisdiction. The Act calls for many actions that might be useful in organ donation, for example:

- providing guidelines to improve public awareness and knowledge;
- disseminating information, including information about prevention;

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30 Hogg, pp. 6-18–6-19.

31 *R. v. Hydro-Québec*, [1997] 3 S.C.R. 213; *R. v. Crown Zellerbach Canada Ltd.*, [1988] 1 S.C.R. 401.

32 See generally *Hydro-Québec*.

33 See for example Ammann (2010), p. 15.

34 *Federal Framework for Suicide Prevention Act*, S.C. 2012, c. 30.

- making publically available existing statistics and related risk factors;
- promoting collaboration and knowledge exchange across domains, sectors, regions and jurisdictions;
- defining best practices; and,
- promoting the use of research and evidence-based practices.[35]

LEGISLATIVE INITIATIVES

A search of the bills that have been tabled since the 36th Parliament revealed none pertaining to consent for organ donation. Additionally, there are no bills currently before any provincial or territorial legislature that propose to implement a presumed consent approach to organ donation. A media search revealed, however, that at least two provinces, Ontario and Nova Scotia, have raised the issue for debate. In Ontario a bill was introduced in 2008 on the subject, however it was not voted on during that legislative session and has not been reintroduced. Rather, the issue was referred to a committee that found the current system of consent to donate should be retained.[36] According to news reports, in April of this year, the Minister of Health in Nova Scotia indicated that a public consultation would be launched on the issue of presumed consent.[37] However, there is no indication on the Nova Scotia Department of Health website that such a consultation has been initiated.

CONCLUSION

Presumed consent may increase rates of donation once other determinants of donation have been accounted for, such as family consent and effective identification of donors within the health care setting, but most analysts agree that it cannot be implemented on its own and be expected to increase donor rates. Once other factors have been adequately addressed, such as awareness campaigns that reinforce the need to voice one's intentions to family, and professional awareness and training programs that ensure donor identification and recruitment are done under a specific set of guidelines and policies, then further benefit might be gained from a presumed consent system. As stated in a 2012 article that compared explicit and presumed consent countries, "deceased donation programs are complex, affected not only by law, administration and infrastructure but also ideology and values. It is improbable that any single strategy or approach will cause a marked improvement on deceased donation rates."[38]

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35 Ibid, s. 2(*b*).

36 Ammann (2010), p. 19.

37 Kelly Grant, "Nova Scotia eyes making organ donation automatic," *The Globe and Mail* [Toronto], 24 April 2014.

38 Amanda M. Rosenblum et al, (2012), p. 2543.

Exhibit 9

Introduction of Gift of Life Act March 2017

LEGISLATIVE ASSEMBLY OF MANITOBA

Thursday, November 23, 2017

The House met at 1:30 p.m.

Madam Speaker: O Eternal and Almighty God, from Whom all power and wisdom come, we are assembled here before Thee to frame such laws as may tend to the welfare and prosperity of our province. Grant, O merciful God, we pray Thee, that we may desire only that which is in accordance with Thy will, that we may seek it with wisdom and know it with certainty and accomplish it perfectly for the glory and honour of Thy name and for the welfare of all our people. Amen.

Please be seated.

ROUTINE PROCEEDINGS

INTRODUCTION OF BILLS

Bill 204–The Electoral Divisions Amendment Act

Hon. Steven Fletcher (Assiniboia): I move, seconded by the member from The Maples, that Bill 204, The Electoral Divisions Amendment Act; Loi modifiant la Loi sur les circonscriptions électorales, be now read a first time.

Motion presented.

Mr. Fletcher: Madam Speaker, we are over-governed in Manitoba. In this day and age, with technology, it is possible that a single representative can certainly represent more people. We have larger city council wards than we have MLA areas. The Premier (Mr. Pallister) has clearly demonstrated that you can govern from afar. We don't need as many MLAs that we have now. We should reduce them for the greater good of the people of Manitoba. And this bill should be enacted.

Thank you, Madam Speaker.

Madam Speaker: Is it the pleasure of the House to adopt the motion? Agreed? *[Agreed]*

The honourable member for Assiniboia, on a further first reading.

Bill 209–The Gift of Life Act (Human Tissue Gift Act Amended)

Hon. Steven Fletcher (Assiniboia): I move, seconded by the member from The Maples, that Bill 209, The Gift of Life Act (Human Tissue Gift Act Amended); Loi sur le don de la vie (modification de la Loi sur les dons de tissus humains), be now read a first time.

Motion presented.

Mr. Fletcher: I am pleased that the government has agreed to create a legislative committee to look at the important issue of organ donation. However, the concern is that already in the comments the government has ruled out presumed consent. This is an obvious option. The committee should not make decisions on the outcome of the committee before the committee has even heard from stakeholders.

Moreover, unfortunately, the member for Brandon West (Mr. Helwer) made some unfortunate comments about religion and organ donation which I think will perhaps tarnish the discussion.

Therefore, I am reintroducing the bill on presumed consent to ensure it gets a fair hearing.

Madam Speaker: Is it the pleasure of the House to adopt the motion? *[Agreed]*

Committee Reports? Tabling of Reports?

MINISTERIAL STATEMENTS

Madam Speaker: The honourable Minister for Sport, Culture and Heritage, and I would indicate that the required 90 minutes notice prior to routine proceedings was provided in accordance with our rule 26(2).

Would the honourable minister please proceed with her statement.

Holodomor

Hon. Cathy Cox (Minister of Sport, Culture and Heritage): Madam Speaker, I rise today to recognize the Holodomor, and to remember the millions of Ukrainian lives cut short more than 80 years ago in a country often called the breadbasket of Europe.

Translated into English, Holodomor means death by hunger. In 1932 and 1933, an artificial famine in the Ukraine was created through the deliberate seizure of land and crops. Ukraine was forced into a land of human suffering without rescue or escape. Millions of people, including children, starved to death.

Exhibit 10

Legislative Assembly Debates Hansard 41st Assembly

Hansard Selections on Gift of Life Act and Organ Donation Between 2017-2019

Gift of Life Act (Human Tissue Gift Act Amended) (Bill 213)

Session 2

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Debate, 3295-3296
https://www.gov.mb.ca/legislature/hansard/41st_2nd/hansardpdf/76a.pdf#page=3

Questions, 3296-3298
https://www.gov.mb.ca/legislature/hansard/41st_2nd/hansardpdf/76a.pdf#page=4

Opt-out options, 3297
https://www.gov.mb.ca/legislature/hansard/41st_2nd/hansardpdf/76a.pdf#page=5

Organ donation wait-times, 3296-3297
https://www.gov.mb.ca/legislature/hansard/41st_2nd/hansardpdf/76a.pdf#page=4

Organ harvesting concerns, 3297
https://www.gov.mb.ca/legislature/hansard/41st_2nd/hansardpdf/76a.pdf#page=5

Presumed consent, 3296, 3297
https://www.gov.mb.ca/legislature/hansard/41st_2nd/hansardpdf/76a.pdf#page=4
https://www.gov.mb.ca/legislature/hansard/41st_2nd/hansardpdf/76a.pdf#page=5

Religious based objections, 3297
https://www.gov.mb.ca/legislature/hansard/41st_2nd/hansardpdf/76a.pdf#page=5

Session 3

Session 4

Exhibit 11

Bill 213 Gift of Life Act

Scholarly Literature Review on Organ Donation Challenges for Members of the Manitoba Legislature for Debate on Bill 213

Prepared by: Hon. Steven Fletcher
MLA Assiniboia

October 31, 2017

Index of Academic Literature for Organ Donation Challenges

Combating the Problems of Human Rights Abuses and Inadequate Organ Supply through Presumed Donative Consent

Organ donor management in Canada: recommendations of the forum on Medical Management to Optimize Donor Organ Potential

Consent for Organ Donation — Balancing Conflicting Ethical Obligations

Attitudes toward death criteria
and organ donation among healthcare personnel and the general public

The Subtle Politics of Organ Donation: A Proposal

Presumed Consent to Organ Donation: A Reevaluation

Attitudes toward Financial Incentives, Donor Authorization, and Presumed Consent among Next-of-Kin

Consent Systems for Post Mortem Organ Donation in Europe

Presumed Consent, Autonomy, and Organ Donation

Policy Forum: Do Defaults Really Save Lives

The Case For “Presumed Consent” in Organ Donation

Organ Donation Members Statement

Organ Donation Poll

Letter from Len Webber, Federal MP 1/2

Letter from Len Webber, Federal MP 2/2

Letter From Ziad Aboultaif, Federal MP

Parliament of Canada 2011 Report

E-Statictics Report

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Letter from Len Webber, Federal MP 1/2

Letter from Len Webber, Federal MP 2/2

Letter From Ziad Aboultaif, Federal MP

Parliament of Canada 2011 Report

E-Statistics Report

Exhibit 12

Some media examples

Manitoba

Manitoba government rejects call to change how organs donated

Independent MLA Steven Fletcher tabled bill in March on presumed consent he said would cut waiting lists

Steve Lambert · The Canadian Press · Posted: Oct 31, 2017 12:20 PM CT | Last Updated: October 31, 2017

Tory MLA Steven Fletcher tabled a private member's bill in the Manitoba Legislature in March that would've changed the organ donation system in the province. It's since been shot down, the Canadian Press reports. (Fred Chartrand/Canadian Press)

The Manitoba government has rejected a proposal that would have made all people in the province organ donors unless they specifically requested not to be.

Members of the Progressive Conservative government caucus voted Tuesday against a private member's bill from Independent legislature member Steven Fletcher that would have set up presumed consent.

Fletcher proposed the idea as a way to cut long waiting lists for organ transplants.

The bill is to come to a final vote Thursday and Tory caucus spokesman Reg Helwer said his colleagues prefer to promote voluntary registration on the existing donor registry.

"We see the education side as the proper route to take," Helwer said.

"There are implications for particular religions that want to see their loved ones buried whole. There's all kinds of things that have to be covered off on this."

- **Quadriplegic Manitoba politician wants presumed consent for organ donation**
- **Steven Fletcher expelled from Manitoba PC caucus**
- **Province votes down Steven Fletcher's appeal to make legislature more accessible**

Premier Brian Pallister said he is willing to look at the issue at a later date — perhaps as a joint effort with other political parties — but he did not offer details.

"There could be ... an all-party type of mechanism and I'm exploring the options of possibly going that route," the premier said.

"I'm hopeful that we can come up with something even better than what has been initially proposed."

Premier Brian Pallister said he'd be willing to look into the issue of presumed consent more, potentially with in a joint effort with other parties. (CBC News)

Manitoba, like other provinces, currently has an opt-in model under which people choose to be organ donors by signing up on a provincial website.

Fletcher's bill, introduced last spring, would have presumed people to be organ donors unless they opted out by registering their desire not to donate.

There is no presumed consent anywhere in North America, Fletcher said, but some European countries have it.

The Saskatchewan government is examining the idea of presumed consent for organ donations as well. Last week, it said it would focus on ways to expand the pool of donors, but will also focus on other ways to expand the donor pool.

Potential problems: NDP

Fletcher, who has been paralyzed from the neck down since hitting a moose with his vehicle in 1996, said Tuesday he remembers being close to death in hospital, unable to talk and not having registered as an organ donor.

"If I had passed on, it would have been a real shame had my family — not knowing what my intentions were — decided to err on doing nothing," Fletcher told the legislature.

NDP Leader Wab Kinew said his party is "open and willing" to work with the government, but would have to see what sort of bipartisan process the government is proposing before signing

on.

"At the end of the day, if we can come together and serve the people of Manitoba, ensure that these life-saving procedures can take place, but in a way that respects the sanctity of an individual's right to exercise self-determination over their own body, then I think that we'd be prepared to participate," he said.

Opposition New Democrat Andrew Swan said Fletcher's bill warranted more examination, and suggested it could be passed into law with some changes following consultations with experts.

He pointed out there are potential problems with presumed consent, because people may be unaware of how to opt out or English may be a second language.

"It may be people ... who are not empowered, who may not know or who may not have the ability to truly consider this and make their own choices."

More from CBC Manitoba:

- **Councillors rewrite Sterling Lyon Parkway plan to avoid residential properties**
- **Guido Amsel bombing trial hears of crater, 70-metre debris field**
- **'Shocking' comments show Manitoba judicial justices of the peace need domestic violence training, MLA says**

With files from CBC News

Organ donation a life-and-death matter

PRESUMED CONSENT SHOULD BE ABOVE POLITICAL GAMES

By: **Dan Lett**
Posted: **3:00 AM CST Monday, Nov. 13, 2017**
Last Modified: 7:26 AM CST Monday, Nov. 13, 2017

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Aaron Vincent Elkaim / Canadian Press files

Toronto Police Chief Mark Saunders received a kidney transplant last month.

OPINION

Late last month, Toronto police Chief Mark Saunders underwent a kidney transplant.

Any time a prominent person undergoes an organ transplant, you can bet it will be news. However, in this case, there was more to the story than a medical procedure involving Toronto's top cop.

Turns out that Saunders, who was born with only one kidney, got a new one from his wife Stacey, who, remarkably, was a perfect match to be a donor.

It seems fair to conclude that if Saunders had an option other than his wife, he would have gone that way.

The reality is that hundreds of Canadians die every year waiting for organ transplants that never come. At present, nearly 5,000 Canadians linger anxiously on waiting lists in a country with all of the technology and resources to do a transplant, but not enough organs to make it a reality.

The sad fact is that Canada, along with other countries as well, does a pathetic job of marshaling the prior approval of its citizens to donate organs.

This sets up a painful, tragic dichotomy in public policy. Despite the fact that opinion polls show between 70 and 90 per cent of Canadians support organ donation, only 20 per cent of us have registered to be organ donors.

Why? For some, it's a religious concern about the desecration of human remains. Still others see it as an intrusion by the state in a deeply personal matter. Procrastination probably accounts for many others.

There are solutions. The countries with the highest rates of organ donation have instituted legal regimes which presume that we are all organ donors until we opt out.

It's a fascinating and elegant solution which creates a much greater pool of potential donors while still giving all conscientious objectors the right to refuse.

Unfortunately, this approach has not been embraced by Canada. Even when lawmakers are given the opportunity to deal with an issue that could save hundreds if not thousands of lives, we balk.

Such was the case recently in Manitoba when a private member's bill sponsored by MLA Steven Fletcher that would have instituted Canada's first presumed consent policy for organ donation suffered its own untimely death.

The bill died when it failed to get the support of the Progressive Conservative caucus. With a commanding Tory majority in the legislature, no private member's bill can move forward without the support of a strong majority of those MLAs. And for a variety of

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Fred Chartrand / Canadian Press files
Steven Fletcher sponsored a bill that would have made everyone in the province an organ donor unless they asked not to be.

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reasons, that support was not to be.

Tory caucus chairman Reg Helwer told reporters that his party would not support the bill and believed that public education was "the proper route to take." Then, Premier Brian Pallister announced that the issue would be studied by an all-party task force.

This laid-back response is completely unacceptable when you consider the gravity of the issue. However, there were complicating factors.

First off, let it be said that there was no way the Tories were going to allow any bill sponsored by Fletcher to become law. The renegade MLA was kicked out of the PC

caucus for frequent acts of mutiny. Any private member's bill with his name on it is destined to become a litter-box liner.

However, the Tories can't admit that spite drove them to discard Fletcher's bill. So, via Helwer, they spouted some nonsense about religious concerns that are, to some extent, a red herring.

There certainly are religious sentiments that associate organ donation with desecration of remains. However, even in those religions where the debate is most vigorous — such as Judaism — there is support significant for organ donation.

In Israel, for example, advocates of medical necessity found a solution: priority for available organs would be given to people who had provided prior consent to donate their own organs. One of the architects of this policy, a cardiologist, said he pressed for changes after he had been told by several Orthodox Haredi Jews that although they would never donate organs, they saw nothing wrong in accepting a donated organ.

And that, in a nutshell, is the problem we face in Canada. Faced with the imminent demise of a loved one who needed a new heart or lung or kidney, most of us would strike any deal necessary to secure a new organ. And we would do that even if we had no intention of actually donating our own organs.

The current system has relied almost entirely on our willingness to step up and do the right thing. And to this point, we've failed spectacularly in that challenge. For all the right reasons, it's certainly time to give presumed consent a test drive.

For the Pallister government, it's a potential watershed moment. The previous NDP government never got around to dealing with this issue. Desperate to create contrast between themselves and the evil New Democrats, the Tories can demonstrate some real initiative by making presumed consent a hallmark of their new approach to governing.

The Tories couldn't stomach a solution that was penned by Fletcher. Fine. So let's get on with the business of designing a modern policy to encourage more organ donation that doesn't contain any of his input.

In political hyperbole, politicians too often describe challenges as matters of life and death. This is one of those instances where presumed consent is a life-and-death issue.

Largely because, without a new law, people will most definitely die.

dan.lett@freepress.mb.ca

Dan Lett
Columnist

Born and raised in and around Toronto, Dan Lett came to Winnipeg in 1986, less than a year out of journalism school with a lifelong dream to be a newspaper reporter.

Read full biography
Sign up for Dan Lett's email newsletter, Not for Attribution

Manitoba

Quadriplegic Manitoba politician wants presumed consent for organ donation

Tory MLA Steven Fletcher in favour of 'opt-out' system he says would improve access to transplants

Steve Lambert · The Canadian Press · Posted: Mar 08, 2017 4:21 PM CT | Last Updated: March 8, 2017

Tory MLA Steven Fletcher plans to table a private member's bill in the Manitoba Legislature Thursday that would change the organ donation system in the province. (Fred Chartrand/Canadian Press)

A Manitoba politician left paralyzed from the neck down by a highway collision is pushing for a law that would make all people in the province an organ donor unless they opted out.

Steven Fletcher, who has used a wheelchair since hitting a moose with his vehicle in 1996, said in an interview he remembers being close to death in hospital, unable to talk, and not having registered as an organ donor.

"Organ donation would have been consistent with my wishes, and to think that my organs, if I had passed on, would have been wasted is not a very good thought," he said.

Fletcher is to introduce a private member's bill in the legislature Thursday that would change the way the province registers organ donors. Currently, people opt in as donors by signing up on a provincial website or on certain provincial identity cards.

- **Steven Fletcher frustrated by lack of wheelchair access at Manitoba Legislature**
- **Province votes down Steven Fletcher's appeal to make legislature more accessible**

Fletcher's plan, known as presumed consent, would create an opt-out system. People would be presumed to be organ donors unless they registered their desire not to donate. Donations would only be for surgeries and other therapeutic purposes — not research, Fletcher added.

Fletcher is a backbencher in the Progressive Conservative government elected last year, so there are no guarantees that his bill will become law. Few such bills get passed in the legislature, where they compete with the government's official legislative agenda.

Fletcher has been here before. In 2014, when he was a member of Parliament, he introduced a private member's bill on doctor-assisted death. The bill didn't pass, but it helped spark debate.

- **Doctor-assisted suicide bill shows divide in disabled community**

The following year, the Supreme Court of Canada struck down the law against assisted suicide in cases where a person is competent, enduring endless suffering and in "grievous and irremediable" condition.

"What I learned from that is, you don't need to win to win. You don't need to pass a bill to be successful with that bill," Fletcher told The Canadian Press.

"With things as fundamental as life and death or right and wrong ... bills tend to gain public support before the (politicians) catch up."

Support in Sask.

Saskatchewan Premier Brad Wall said last year he would like to see presumed consent for organ donation. The government was looking at what steps could be taken to protect such legislation from being legally challenged.

- **Sask. organ donation idea gets boost from Man.**

A group called Manitobans for Presumed Consent has been pushing for the change. It points to a presumed-consent law in Wales in 2015 that increased the number of transplants by 24 per cent.

"That means people are living as opposed to dying, because there are literally people that are dying on the organ-transplant waiting list," said spokesman Bryan Dyck.

The organ-donation bill is not the only topic on Fletcher's agenda. He has a number of private bills ready to be introduced this spring, including one that would toughen the conflict-of-interest law that governs legislature members.

Currently, members only have to disclose property they own in the province. His bill would cover all of Canada, including northwestern Ontario where many Manitobans have cottages.

It would not cover international properties such as the home owned by Premier Brian Pallister in Costa Rica.

- **ANALYSIS | Premier Pallister's place in the sun**

The reason, Fletcher said, is that properties in other countries cannot benefit by Manitoba government decisions, whereas cottages across the Ontario boundary can.

"From mining claims to environmental plans to corridors for roads or energy, that all can be important to said assets."