1988

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A Scarcity of Organs
Judith Areen

Samuel Richardson, writing in 1740, describes one of the bloodier riots at Tyburn gallows, where London hung its criminals:

As soon as the poor creatures were half-dead, I was much surprised before such a number of peace-officers, to see the populace fall to hauling and pulling the carcasses with so much earnestness, as to occasion several warm rencounters, and broken heads. These were the friends of the persons executed . . . and some persons sent by private surgeons to obtain bodies for dissection. The contests between these were fierce and bloody, and frightful to look at.¹

Tyburn thus not only served the demands of justice, it was a steady, though contested, source of corpses for the fledgling science of anatomy.

Medical science still has a need for body parts, although today the parts are needed for transplantation rather than dissection. As in the eighteenth century, many relatives of the dead and dying resist the entreaties of the surgeons. The conflicts, however, now occur in hospitals and are more legal than physical. In Strachan v. John F. Kennedy Memorial Hospital,² for example, the parents of twenty-year-old Jeffrey Strachan were informed that their son was brain dead and were asked to donate his organs for transplant purposes. Although they informed the hospital on Saturday morning that they would not agree to the donation, life-support systems kept their son “pumped up” and “frothing at the mouth” until Monday afternoon, apparently because hospital personnel did not have a procedure to follow when organ donation was refused.³

What is the role of law in organ transplantation in the face of the continuing shortage of organs?

I. Overview of the Shortage

Almost from the beginning, the field of organ transplantation has faced a shortage of organs. Although the first successful kidney transplant was not performed until 1954,⁴ by early 1970 the supply of organs available for

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2. 209 N.J. Super. 300, 507 A.2d 718 (App. Div. 1986) (suit by parents alleging that hospital and transplant program inflicted emotional distress by failing to remove their brain-dead son from life-support systems when asked to do so), recovery denied.
4. Joseph E. Murray, John P. Merrill & J. Hartwell Harrison, Renal Homotransplantation in Identical Twins, 6 Surgical Forum 432, 434 (1955). The transplant, which was performed at Peter Bent Brigham Hospital in Boston, involved the donation of a kidney
transplant—particularly kidneys—was already insufficient. The scarcity, if anything, has only become worse. Although some 7,000 kidneys were obtained for transplant in 1986, another 10,000 patients were on waiting lists for a kidney transplant.\(^5\)

Scarcity has remained a problem despite increases in the size of the pool of potential donors. The development of immunosuppressive drugs, particularly cyclosporine, has made it possible to rely on cadaveric donors for many patients.\(^6\) In 1967, approximately forty-six percent of all kidneys transplanted came from living donors; by 1984, only twenty-four percent did.\(^7\)

There are fewer individuals waiting for organs other than kidneys only because there are no practical artificial alternatives analogous to hemodialysis. Thus, it was reported in 1984 that:

Eighty-four adults and 27 children died over the past two years waiting for liver transplants at the University of Pittsburgh School of Medicine. . . . At New York City's Montefiore Medical Center, 25 out of 30 patients have died over the past two years waiting for a new lung. At Stanford University Medical Center, one out of three candidates for heart transplant dies before a suitable donor is found.\(^8\)

Nonetheless, in 1986 there were a reported 300 people listed as waiting for donor hearts and 400 for livers.\(^9\)

II. Four Approaches to Organ Acquisition

   A. The Uniform Anatomical Gift Act: Voluntary Giving

Four different approaches to organ retrieval have been proposed in the United States. The oldest, a system founded on voluntary donations, is exemplified by the Uniform Anatomical Gift Act (UAGA).\(^10\) UAGA was drafted in 1968 just after the first heart transplants occurred, when it

by a twenty-four-year-old male to his identical twin who was dying of renal failure. Bones were transplanted as early as 1878; cornea transplants became common in the 1940s. Russell Scott, The Body As Property 19, 25 (New York, 1981).

5. U.S. Dep't Health & Human Serv., Health Care Financing Administration, Proposed Rule on Organ Procurement Organizations and Organ Procurement Protocols, 52 Fed. Reg. 28,666, 28,667 (July 31, 1987) (to be codified at 42 C.F.R. 405, 413, 441, 482, 485, 489). The estimate of need may be low; there are more than 80,000 people now on permanent kidney dialysis in the United States. The estimate of supply, on the other hand, must be reduced because most acts of donation involve two kidneys. Thus, there were fewer than 3500 acts of donation in 1986.


8. Task Force Report, supra note 6, at 27 (citing Emergency Care Research Institute, Issues in Health Care Technology, Organ Transplants: Policy Issues and Donor Organ Procurement § 9.12 (May 1984)).

9. Task Force Report, supra note 6, at 54. Roughly one-third of those waiting were infants or children. Id.

became clear that cadavers could be a source of transplantable organs.\textsuperscript{11} The Act was intended to resolve several difficult legal questions raised by the new procedures, such as whether it was appropriate simply to take organs from brain dead donors, and, if not, who had authority to provide legal consent. Within five years, in a dramatic confirmation of the need for legal guidance in the field, all fifty states and the District of Columbia had adopted versions of the Act.\textsuperscript{12}

UAGA authorizes any competent adult to permit, or to forbid, the posthumous use of his organs for transplantation, research, or teaching. A donation can be embodied in a will or in a nontestamentary document, such as a donor card. If the prospective donor expressed no preference, the next of kin may donate.

Organ donor cards may have seemed a sensible approach in 1968; in practice, however, few people have executed them.\textsuperscript{13} In addition, although signed cards constitute legally effective consent in most states,\textsuperscript{14} physicians will almost never retrieve organs without the consent of the next of kin.\textsuperscript{15} Procurement personnel typically approach surviving families of declared donors in the same way they approach families of potential donors who have not signed donor cards. Three reasons have been offered for the reluctance of the medical community to proceed without family approval. First, many fear legal action by family members and remain unpersuaded that UAGA offers adequate protection. Second, many believe it is morally wrong to proceed when there may be family objections. Finally, many fear the bad press that could result.\textsuperscript{16}

Such practices continue despite their having been widely criticized for undermining the rights of the deceased and for further reducing the supply of organs.\textsuperscript{17} A 1985 Report of the Hastings Center has aptly described the result as a multiple-veto system, in which any of a variety of individuals can stop the retrieval of organs.\textsuperscript{18}

\textbf{B. The Free Market Approach}

In September 1983, H. Barry Jacobs, a physician whose license to practice medicine in Virginia had been revoked after a 1977 conviction for

\begin{itemize}
  \item[12.] 8A U.L.A. at 16.
  \item[13.] See infra text accompanying notes 44–48 for discussion of why so few have executed donor cards.
  \item[14.] Only Florida and New York give family members the right to veto the decision to donate of the deceased. Fla. Stat. Ann. § 732.912(3) (West 1976) (adult son or daughter may veto); N.Y. Pub. Health Law § 4301(3) (McKinney 1985).
  \item[15.] Jeffrey M. Prottas, Obtaining Replacements: The Organizational Framework of Organ Procurement, 8 J. Health Pol., Pol'y & L. 235, 238 (1983); Task Force Report, supra note 6, at 38.
  \item[16.] Raymond D. Cotton & Andrew L. Sandler, The Regulation of Organ Procurement and Transplantation in the United States, 7 J. Legal Med. 55, 65 (1986).
  \item[17.] David A. Peters, Protecting Autonomy in Organ Procurement Procedures: Some Overlooked Issues, 64 Milbank Q. 241 (1986).
  \item[18.] Hastings Center, Ethical, Legal and Policy Issues Pertaining to Solid Organ Procurement: A Report of the Project on Organ Transplantation 11–12 (1985).
\end{itemize}
mail fraud in connection with Medicare billing, established a Virginia company to broker human kidneys.19 Jacobs announced that he intended to solicit healthy individuals to sell one of their kidneys at their chosen price. Some of the kidneys would be purchased from people living in less developed countries. He estimated that donors would charge up to $10,000 for a kidney, and that he would charge another $2000 to $5000 for his services.

Although Jacobs's proposal was legal when originally announced, Senator Gore had already introduced a bill in the United States Congress to prohibit the sale of human organs. Publicity about the Jacobs proposal appears to have hastened legislative action. Within six months of Jacobs's announcement, Virginia passed legislation specifically prohibiting the sale of human organs.20 Several other states have since followed.21 In 1984, Congress passed the Gore legislation. The National Organ Transplant Act makes it a felony "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."22 The only payments excluded from the definition of "valuable consideration" for purposes of applying the Act are "the reasonable payments associated with the removal, transplantation, implantation, processing, preservation, quality control, and storage of a human organ or the expenses of travel, housing and lost wages incurred by the donor or a human organ in connection with the donation of the organ."23 The penalty for violating the Act is a fine of up to $50,000 or five years in prison or both.

The free market approach thus has never really been tried in the United States. A growing chorus of commentators have criticized the federal and state prohibitions on buying and selling organs precisely because reliance on voluntary gifts has not reduced the scarcity of organs.24 Several arguments have been made against a market in organs. There are, first, pragmatic arguments. It is likely that a market approach would discourage voluntary donations and reduce the total number of organs available for transplant. Experience with purchased blood suggests that even if the quantity of supply remained constant, its quality might not.25 The quality of organs acquired for transplantation is a matter of particular importance now that there is evidence that AIDS can be transmitted

23. Id.
through a donated organ. There is also a fairness argument. An unregulated market would almost certainly work to the disadvantage of the poor; they would constitute the majority of sellers but rarely could afford to be buyers. Finally, it is argued that it degrades the human body to permit it—or its parts—to be bought and sold. This argument has a distinguished lineage. Lord Coke, as far back as the sixteenth century, and Blackstone, in the eighteenth century, took the position that dead bodies cannot be a form of commercial property. Their rulings, however, may have been based more on turf battles between civil and ecclesiastical courts (which had jurisdiction over burial) than on legal or moral principles.

The concern that a market approach would have serious drawbacks is reinforced by the concession of most free-market proponents that some regulation may be necessary. Some suggest, for example, that abuses might be avoided if Congress allowed individuals to contract directly with one another but prohibited for-profit third parties to broker organ sales (as Great Britain has done with surrogate mother contracts). Others suggest that Congress should prohibit cash sales and permit remuneration only in the form of free medical care for a period of years or payment to the donor’s family. Congress also might permit income or estate tax deductions for decedents who donated organs for transplantation; or it might give the donor’s relatives transplant priority. It has even been argued recently that the Congressional ban unconstitutionally infringes on an individual’s right of privacy, at least to the extent that it prohibits selling one’s organs after death.

Unless the present system of voluntary giving can be modified to reduce the continuing scarcity, pressure for greater reliance on market mechanisms will probably continue despite the drawbacks of a market approach.

C. Increasing Legal Pressure: The Development of Routine Inquiry and Required Request Legislation

The most recent efforts to increase the supply of transplantable organs without abandoning the principle of voluntary giving focus on those who are in the best position to identify potential donors—the medical profession. Beginning in 1985, a growing number of states have enacted statutes that require asking all patients admitted to hospitals whether they wish to be organ donors (routine inquiry statutes); others require notifying the

next of kin of all potential donors that donation is an option (required request statutes).  

In 1986, Congress mandated that the approximately 6,000 hospitals certified for Medicare reimbursement be required to establish required request policies.  

The new law requires hospitals to have written protocols that “assure that each family of a potential organ donor knows of its options to either donate an organ or organs or to decline to donate . . . [and to] require that an organ procurement organization . . . be notified of potential donors.” Unfortunately, the language is directed only to families, which may reinforce the misimpression that family members in all states have a legal right to reject donation even if it was chosen by the donor.  

Surprisingly little data is available on whether the new legislation will help to alleviate the shortage. The National Task Force did report that donations in the Henry Ford Hospital in Detroit, Michigan, increased from an annual rate of six to twenty donors within nine months of the enactment of a policy of routinely requesting that the next of kin of potential donors consider donation.  

**D. The Most Aggressive Policy: Presumed Consent**  

In 1984 more than 24,000 cornea transplants were performed, compared to only 15,000 in 1981. The difference was attributed by the National Task Force to the adoption in a growing number of states of presumed consent laws. The laws permit retrieval of corneas, and sometimes skin and bone, when a body is under the jurisdiction of the medical examiner unless there is knowledge that the person objected while alive, or that the next of kin objects.  

Courts in three states have held such presumed consent statutes constitutional. In *Florida v. Powell*, for example, the Supreme Court of Florida held that the state’s presumed consent statute was constitutional.  


35. Cf. the California statute that provides:  

Each general acute care hospital shall develop a protocol for identifying potential organ and tissue donors. The protocol shall require that any deceased individual’s next of kin . . . at or near the time of notification of death be asked whether the deceased was an organ donor. . . . If not, the family shall be informed of the option to donate organs and tissues.  


36. Task Force Report, supra note 6, at 32.  

37. Id. at 30.  

Court of Florida upheld a Florida statute that authorizes the medical examiner to remove cornea tissue from bodies undergoing autopsy unless the next of kin objects. The Florida statute does not, however, require notification of next of kin.

The opinion in Florida v. Powell began with a discussion of the great need for cornea tissue. The Court emphasized that, in contrast to autopsy, which it characterizes as “massive intrusion into” the body, cornea removal requires only “an infinitesimally small intrusion,” and one that does not affect the appearance of the decedent because the eyes must be capped to maintain a normal appearance with or without cornea removal. The court next rejected the holding of the trial court that the statute deprived the next of kin of a property right. The court invoked the long-established common-law rule that next of kin have no property right to a corpse, although they have a limited right to possess the body for purposes of burial.

Some states have already extended the principle of presumed consent to the organs of the unclaimed dead. Maryland, for example, authorizes the chief medical examiner or his deputy or assistant to retrieve organs when there has been an “unsuccessful search” for next of kin. California has a similar provision, applicable when a “diligent search” has failed to locate any next of kin, although the statute also requires the police to check for relatives. It may be politically acceptable to harvest organs without express consent from individuals without any available next of kin, but it is certainly ethically troubling to appropriate for public use the body parts of only the most vulnerable citizens.

For a time, it appeared that the National Conference of Commissioners on Uniform State Laws was going to recommend revising UAGA to extend the concept of presumed consent, approved in Florida for corneal tissue, to any “parts” from a body undergoing autopsy. The most recent proposal from the Conference, however, requires that a “reasonable effort [be] made...to inform [the next of kin] of the option to make, or object to the making of, an anatomical gift.” The proposed new UAGA thus would permit presumed consent to operate only when no relative can be located. It will be interesting to see whether even this more limited version of presumed consent will be acceptable to most state legislatures. The answer is likely to turn on whether the growing number of routine inquiry or mandatory request statutes generate sufficient organs. The outcome may also tell us something about the value our society attaches to different body parts. Corneas, like hair or fingernails, are more easily accessible than other organs. They also are not basic to life, unlike the heart, liver, and second kidney. Taking such “minor” and accessible parts of the body without explicit permission may not be seen as disrespectful as the harvesting of crucial organs without permission.


43. Id.
III. The Need for a New Approach: Supported Autonomy

The major cause of the continuing shortage of organs is that so few potential donors have organ donor cards. Although some 20,000 potential donors die in the United States annually, only seventeen percent have completed organ donor cards. The problem is not that potential donors are unaware of the need for organs, or even that they are unwilling to donate. A 1985 Gallup poll found that more than ninety percent of the respondents knew about organ transplantation. Polls indicate that roughly seventy-five percent of those questioned approve of organ donation.

According to the National Task Force, the two most common reasons given for not permitting organ donation were (1) They might do something to me before I am really dead; (2) Doctors might hasten my death. Mistrust of the medical profession rather than opposition to donation itself is apparently the main reason most Americans have not filled out organ donor forms. As a spokesman for the American Council on Transplantation explained, "Some people are concerned that doctors will prematurely declare them brain dead." The explanation is confirmed by data indicating that Americans are more likely to donate the organs of a loved one than to donate their own. One recent poll found that eighty-two percent of the respondents would donate the organ of a loved one, but only forty-eight percent would donate their own. The difference presumably reflects the belief that, because relatives would give permission only after death was unavoidable, physicians would not give up too early in their efforts to treat the donor. The family, in other words, can function as a buffer between the needs of the patient and a medical establishment that many fear will not care for them adequately because of the need for organs.

In the light of the data, it seems foolish for the UAGA to continue to focus primarily on individual donation. But focusing on family donation alone, as the new required-request statutes do, may also be self-defeating. One woman writes of her distress over a request to consider donation of her husband's kidneys:

In my state of acute shock, distress and grief, there suddenly came this totally unexpected question—I was astounded and utterly appalled at such a complete lack of feeling. To make such a decision for oneself is hard enough but to be asked to make it on behalf of another, while one is so shocked and grief stricken is both harrowing and cruel. Never could I want any close relative to suffer as I had done in making such an agonizing decision during the worst moment of a lifetime.

Some use such reactions to argue for dispensing with consent altogether.

44. Task Force Report, supra note 6, at 35, 38. Corneas are excluded from these figures because they are governed by different legal standards. See infra text at IID.
45. Task Force Report, supra note 6, at 38.
46. Id.
48. Id.
50. Arthur J. Matas, John Arras, James Muyskens, Vivian Tellis & Frank J. Veith, A
sensitive fashion, however, can reduce some of the distress relatives experience. Indeed, some families report that their decision to donate organs that provided life to others who might otherwise have died helped them cope with the grief of losing a family member.51

The data on donation, however, suggest that a third voluntary gift procedure should be authorized before we conclude that voluntarism will not work. The procedure would depend not on the individual donor alone or on the donor's family alone, but on an alliance of both. It is clear that many people are unwilling to trust the health care profession to decide when to stop providing medical treatment. They are unlikely ever to sign organ donor cards. They may also want to spare family members the agony of making the decision about donation without knowing their own wishes. Such individuals might well sign a durable power of attorney for organ donation, which grants to the surrogate selected (who might be either a family member or a friend52) the authority to donate organs once the surrogate is persuaded that the donor will not benefit from further medical care. If people were given the option of using such a durable power of attorney for organ donation instead of a donor card, efforts to educate the public about the need for organs might produce more organs.


51. See, e.g., the statement of one mother:

It was horrible for me, just that short time from Friday to Saturday night. A neighbor who worked in the emergency room sort of convinced me that it was better not to try to keep him alive on machines and to donate. . . . All I could think was, "If he's going to die, why not give someone his kidneys? A doctor from the University came and told us that if you could see the difference in these peoples' lives after a transplant . . . well, it really made me feel good."


The policy of one university transplant service is to send a letter to the family of any cadaver-donors shortly after the survey to thank them for the donation. The letter gives general facts about the recipients, such as their sex and age, and reports on the success of the transplants. One widow of a deceased donor states:

When I received the letter, it was about a month and a half after. In my case, I was just feeling so terribly down and I've never been a down person in my whole life. But I would say that was one of the most rewarding things, to hear that something good came out of his death. Just the way it was written and everything. It really pleased me. You don't get very many rewards out of something like this.

Id. at 369.

The praise and support of other people may be a significant ancillary gain from the decision to donate. Another mother reports:

I got [the letter] from the University saying that two people in their thirties had received them, and I took it to a wedding and I let 'em all read it and they thought it was just great that you could do something like that in the circumstances where he was, to help two people.

Id. at 370.

52. The option of designating a non-family member makes the durable power of attorney for organ donation an important alternative for individuals who do not want family members to have the authority to decide whether or not to donate their organs.
A comparable legal procedure has evolved for decisions to withdraw or withhold treatment for patients who are terminally ill or irreversibly comatose. Durable powers of attorney are increasingly used instead of (or in addition to) living wills to govern treatment decisions for patients who have become unable to make their own treatment decisions. Although a growing number of states have authorized families to make such decisions in the absence of advance directives from the patient, the creation of such a directive can relieve family members from some of the burden of making difficult choices. Similarly, an individual who prepares a durable power of attorney that transfers power to authorize organ donation will be able to inform the surrogate in advance as to his own wishes on the subject and relieve the surrogate of the burden of trying to ascertain what the donor might have wanted. At the same time, the donor will have the comfort of knowing that organs cannot be retrieved without the approval of the surrogate.

IV. Beyond Scarcity

Even if the proposed durable power of attorney for organ donation is widely adopted, the scarcity of organs will be eliminated only if significantly more people agree to donate their own organs and those of close family members. For this, a more fundamental rethinking of the present system of organ retrieval may be required. Such a revision would begin by placing the debate between supporters of a system based on voluntary giving and those who favor either a market system or one based on expropriation (presumed consent) in the larger context of debate about the kind of society we favor.

Much of our political and philosophic tradition rests on the celebration of the autonomous individual. As Alasdair Mcintyre observes, it is "as though we had been shipwrecked on an uninhabited island with a group of other individuals, each of whom is a stranger to me and to all others." Market theory also rests on this model of autonomous strangers. In the market, moreover, self-interested behavior is not only acceptable, it is believed to be of benefit to society in general. Market supporters are thus understandably skeptical of any system that rests on the concept of giving.

The model of autonomous strangers has been subject to mounting criticism in both moral philosophy and political theory because it fails to grapple with how autonomous, rational adults come to be; that is, it ignores the way parents care for (and about) children. It also ignores the continuing...
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importance of caring human relationships in sustaining personal autonomy.

Significantly, one of the few studies conducted of families who have donated organs of deceased family members found that "they wished some knowledge about the person to whom the organs were given." The finding suggests that the present system of voluntary organ donation could be improved if more attention were paid to the importance of human relationships. The proposed durable power of attorney for health care is such a step because it acknowledges the importance of the relationship between the donor and his family (or surrogate decision maker). Perhaps the newly fashionable required-request legislation could be improved by acknowledging the value of fostering some relationship between donor families and recipients of organs. At a minimum, information should routinely be provided to donor families, as some hospitals now do, about the results of transplants and even about the recipients.59

More is at stake in the ongoing debate over the best system for retrieving organs than the scarcity of organs. As Thomas Murray observes:

Gifts to strangers affirm the solidarity of the community over and above the depersonalizing, alienating forces of mass society and market relations. They signal that self-interest is not the only significant human motivation. And they express the moral belief that it is good to minister to fundamental human needs, needs for food, health care, and shelter, but also needs for beauty and knowledge. These universal needs irrevocably tie us together in a community of needs, with a shared desire to satisfy them, and see them satisfied in others.60

Organ donation is one way to extend caring for others beyond the family to friends—and to the larger community.

58. Gift of Life, supra note 51, at 341.
59. The information provided should not include the identity of the recipient unless the recipient agrees.