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A Unified Approach to Organ Donor Recruitment, Organ Procurement, and Distribution

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A UNIFIED APPROACH TO ORGAN DONOR RECRUITMENT, ORGAN
PROCUREMENT, AND DISTRIBUTION

DAVID A. PETERS*

ABSTRACT

The practices of organ procurement and organ donor recruitment in the United States rest upon two significant but incorrect assumptions. The first is that validly signed donor cards have merely advisory function; that is, that their purpose is simply to communicate the supposedly nonbinding desires of deceased or incompetent potential donors to serve as sources of lifesaving organs and tissues after death. Procurement personnel do not accord these documents the legal force of wills. Hence, they invariably ask families of all potential donors — declared and undeclared — for permission to remove organs and tissues from deceased kin. This practice is, however, (a) inconsistent with both the spirit and the letter of nearly all state Uniform Anatomical Gift Acts; (b) inconsistent with the defensible claim that the majority of interests bound up with ownership apply to the relation of a person to his or her body during life and after death; and (c) almost unanimously judged to be morally unacceptable by respondents in two recent empirical surveys. The paper proposes an appropriate revised procedure for use by procurement staff in counseling with families of deceased declared donors.

A second incorrect assumption lies at the heart of donor recruitment campaigns. This is the assumption that consenting to the posthumous removal of organs from one's own body is an act of charity, a work of supererogation. The author argues to the contrary that consenting to the removal and transfer of one's own organs after death is a moral duty. The duty to consent is derivative from a more general moral duty variously called the duty of mutual aid or the duty to attempt an easy rescue of an endangered person (or persons). So, while it is true that every individual has first authority, i.e., paramount right over all others, to control the posthumous disposition of his or her own body parts after death, the author argues that this right is overridden by the more weighty moral duty to consent to the removal and transfer of personal organs after death.

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This last claim has implications for a policy of fair distribution of cadaveric organs under conditions of scarcity. In such circumstances justice demands that those who have consented to be posthumous organ providers, i.e., those who have fulfilled the moral duty to consent, be given first priority access to the cadaver organ pool in the event of need. Nonconsenters are to be given second priority access. This distribution principle is embodied in recent legislation passed by the Parliament of Singapore — the *Human Organ Transplant Act of 1986*. A variety of practical problems connected with instituting in the United States this fair distribution policy are considered and some solutions proposed.

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Professionals engaged in the practices of organ procurement and organ donor recruitment in the United States appear to be guided by two important but fallacious assumptions. First, the standard manner in which procurement personnel approach families of hospitalized potential donors indicates that such personnel view validly signed donor cards simply as nonbinding expressions of their signers' willingness to have usable organs removed from their bodies after death. Retrieval staff clearly proceed on the assumption that such declarations must be validated by the families of declared donors, and that written directives by the latter concerning the posthumous disposition of their body parts are in principle subject to veto by declarants' survivors. Second, those involved in donor recruitment typically characterize a person's consent to the posthumous taking of his or her own organs, or consent to the taking of organs from a deceased relative, as an act of charity, a work of supererogation lying beyond the call of moral duty.

This Article initially demonstrates the falsity of each of these assumptions. Policy alternatives are then proposed to govern donor recruitment and the activities of organ procurement and distribution. These alternatives are consistent with the correct assumptions on the issues mentioned, and appear to be politically feasible in the light of available empirical evidence.

I. INCORRECT ASSUMPTIONS UNDERLYING ORGAN PROCUREMENT AND DONOR RECRUITMENT IN THE UNITED STATES; GENERAL RECOMMENDATIONS FOR POLICY REVISION

A. *The Assumption that Validly Signed Donor Cards Have Merely an Advisory or Expressive Function*

1. Analysis

Organ procurement personnel typically consult with families of brain dead or near brain dead potential donors to obtain family consent for the removal and transfer of usable organs from their hospitalized relatives. This policy is followed even if a potential donor has signed an organ donor card like that attached to state drivers' licenses.¹ Nationally, the number

¹ Prottas, *Encouraging Altruism: Public Attitudes and the Marketing of Organ Donation*, 61 MILBANK Q. 278, 284-85 (1983); Overcast, Evans, Bowen, Hoe & Livak, *Problems in the Identification of Potential Organ Donors*, 251 J.A.M.A. 1559, 1561 (1984).

of "declared donors" is on the rise.² The practice of asking survivors of all potential donors (declared and undeclared) for permission to recover organs from deceased kin conveys to these families the message that they (the families) have final legal control over the disposition of the bodies of their loved ones, irrespective of the latter's stated antemortem wishes concerning posthumous organ donation.

A variety of reasons explain, but fail to justify on either legal or moral grounds, this practice of procurement staff. A principal reason offered in defense of the policy is that if procurement staff proceeded otherwise, i.e., if they initiated organ removal and transfer from a deceased declared donor purely on the strength of the latter's written consent (without asking his or her family), such a policy might ultimately jeopardize the long term success of organ procurement efforts. The worry seems to be that if families are not given the opportunity to decide whether organs will be taken from the body of a deceased relative — irrespective of whether the latter has given express prior consent to this procedure — procurement personnel will quickly gain the reputation of being "organ vultures" who care little about the feelings of grieving family members.³ Surviving kin typically believe that they have a right of some kind, moral or legal, to determine whether invasions of the body of their loved one will be permitted.

The doctrine that a family has a "quasi-property" interest in the body of a dead relative pursuant to discharging its duty to provide the body with a decent burial has long been accepted in American common law.⁴ At least since the turn of the century, however, this doctrine has stood in tension with a competing principle which courts have affirmed at least

² Aggressive efforts to apprise individuals of the opportunity to become posthumous organ donors have met with marked recruitment success in numerous cases. In 1984, sixty percent of the licensed drivers in Colorado were designated donors. Overcast, Evans, Bowen, Hoe & Livak, *supra* note 1, at 1560; in Washington, D.C., the number of people signing donor cards appended to driver's licenses rose from 25 a month in 1982 to approximately 600 a month in 1985. Levine, *Why Blacks Need More Kidneys But Donate Fewer*, 15 HASTINGS CENTER REP. 3 (1985); The Living Bank of Houston, Texas, reports that each time columnist Abigail Van Buren publishes a moving essay by Robert Test (*To Remember Me*), which clarifies the manner in which a person's body can after death serve as a reservoir for lifesaving or debility-assisting organs and tissues for needy others, that the Bank is "inundated" with requests for donor-registration forms. Abigail Van Buren, *Organ Donors' Gifts Precious Legacy to Living*, St. Paul Pioneer Press-Dispatch, Apr. 24, 1989, at 8D; summarizing the results of a 1987 study, Evans & Manninen report that "more people have received information on organ donation than ever before and are carrying donor cards in increasing numbers." Evans & Manninen, *U.S. Public Opinion Concerning the Procurement and Distribution of Donor Organs*, 20 TRANSPLANTATION PROCEEDINGS 781 (No. 5, Oct.) (1988).

³ Overcast, Evans, Brown, Hoe & Livak, *supra* note 1, at 1562.

⁴ See Vestal, Taber & Shoemaker, *Medico-Legal Aspects of Tissue Homotransplantation*, 18 U. DET. L.J. 271 (1955); Wasmuth & Stewart, *Medical and Legal Aspects of Human Organ Transplantation*, 14 CLEVELAND-MARSHALL L. REV. 442 (1965); Marshall, *Testamentary Rights of Bodily Disposition*, 18 A.B.A.J. 31 (1982).

rhetorically. The principle is that a person's antemortem declarations concerning the disposition of his or her corpse (concerning the place or manner of burial) should be respected if at all possible.⁵ Where statute has explicitly stated that the antemortem wishes of the deceased take precedence over opposing views of relatives, courts have decided in favor of the deceased.⁶ Where statute has been silent about how such conflicts should be resolved, courts have tended to find some reason, however strained, for siding with the wishes of the dissenting family.⁷

The model Uniform Anatomical Gift Act (UAGA) of 1968,⁸ on which most state anatomical gift acts are patterned, unequivocally grants primary authority to determine what shall be done with the body or parts of a decedent to the person to whom the body belongs. If a person signs a donation instrument (it need not be a will, it can be a card carried on the person⁹), that individual's family, according to the UAGA, is *not* vested with power to veto the declaration, nor is the family's express agreement with the decedent's wishes legally required to affect the removal and transfer of organs from his or her body.¹⁰ If, however, the decedent has not made a declaration concerning the posthumous disposition of his or her body or parts, yet has not objected to such taking, then the UAGA gives authority to individuals in other categories (e.g., kin by blood or marriage), and in a descending order of priority, to provide such consent.¹¹

Despite the first authority granted by the UAGA to individuals to control the disposition of their own bodies or body parts after death, organ procurement personnel in the United States routinely ask families of dead or medically hopeless incompetent declared consenters for permission to remove organs from these individuals.¹² Subjecting the written and duly

⁵ *Pettigrew v. Pettigrew*, 207 Pa. 313, 56 A. 878 (1904); *Wood v. Butterworth & Sons*, 65 Wash. 344, 118 P. 212 (1911); *Estate of Henderson*, 13 Cal. App.2d 449, 57 P.2d 212 (1936); *In re Johnson's Estate*, 169 Misc. 215, 7 N.Y.S.2d 81 (1938).

⁶ *In re Eichner's Estate*, 173 Misc. 644, 18 N.Y.S.2d 573 (1940).

⁷ *Enos v. Snyder*, 131 Cal. 68, 63 P. 170 (1900); *Fidelity Union Trust Co. v. Heller*, 16 N.J. Super. 285, 84 A.2d 485 (1951); *In re Estate of Angela C. Kaufman*, 158 N.Y.S.2d 376 (1956); *Holland v. Metalious*, 105 N.H. 290, 198 A.2d 654 (1964).

⁸ UNIFORM ANATOMICAL GIFT ACT, 8A U.L.A. 15 (1983) (See Supp. 1990 for 1987 amendments to the Act) [hereinafter UAGA].

⁹ UAGA § 4(b) (1983).

¹⁰ UAGA §§ 2(a) & 2(e) (1983). "Any individual of sound mind and 18 years of age or more may give all or any part of his body for any purpose specified in Section 3, the gift to take effect upon death." UAGA § 2(a) (1983). "The rights of the donee [the person or institution authorized to receive the gift — see Section 3 of the UAGA] created by the gift are paramount to the rights of others except as provided in Section 7(d) [which refers to the preemptive rights of coroners, medical examiners, and other physicians in performing autopsies required by law (and § 2(e))]. UAGA § 2(e) (1983) (In the 1987 amendments, Section 2(e) was moved to Section 8(a). The language was slightly modified and now provides: "Rights of a donee created by anatomical gift are superior to the rights of others except with respect to autopsies under Section 11(b)."). The Commissioners' commentary on Section 2(e) leaves no doubt about their intent: "subsection (e) recognizes and gives legal effect to the right of the individual to dispose of his own body *without subsequent veto by others.*" (emphasis added). UAGA § 2(c) comment (1983).

¹¹ UAGA § 2(b) (1983).

¹² See authorities cited *supra* note 1.

witnessed antemortem consent of a dead or near-death patient to possible veto by his or her family is a violation of both the spirit and the letter of the UAGA.¹³

This point appears to be misunderstood even by professionals involved in the activity of organ procurement. In a 1987 issue of the nationally distributed publication, *RN*, the administrator and coordinator of the organ recovery program at Presbyterian Hospital in New York City advises nurses who may have to ask a family for an organ donation from a deceased loved one:

Remember . . . that any family has the legal right to say 'No' [to donation] even though the patient was carrying a donor card permitting the retrieval of his organs for use in transplants.¹⁴

As a generalization concerning the alleged legal right of a family to veto a loved one's written antemortem consent to posthumous organ donation, this statement is incorrect. Special provisions of the anatomical gift acts of New York State¹⁵ (where the administrator works) and Florida¹⁶ arguably permit such a veto, though the statutory wording is unclear. Legislation governing gifts of body parts in all other states, however, does not grant to families the right of veto over the prior written consent of deceased relatives to the posthumous taking of organs from their own bodies after death.¹⁷

The fact that most families of declared consenters permit the recovery of organs from such patients when apprised of the latter's wishes¹⁸ is irrelevant to assessing the propriety of routinely asking families of all recently deceased donors — declared and undeclared — for permission to remove organs from these individuals. A patient's explicitly stated antemortem wishes concerning the posthumous disposition of his or her body parts is not subject to override by the contrary wishes of kin, except arguably in the two jurisdictions mentioned. According to the provisions of most state UAGAs, a family has neither the legal authority to veto a declared consenter's wishes, nor the legal responsibility to validate such an individual's directives.

Other independent reasons support the controlling legal authority vested by the UAGA in individuals as regards the posthumous disposition of their own body parts. A key buttressing claim is that a person's body is his or her property in an intelligible and important sense. At law, "property" does not refer to a physical object or objects, but rather to a cluster of rights recognized in the object(s).¹⁹ Property is either real or

¹³ See *supra* note 10.

¹⁴ Kiernan, *If You Have to Ask for an Organ Donation*, *RN*, Oct. 1987, at 114.

¹⁵ N.Y. PUB. HEALTH LAW § 430(3) (McKinney 1985).

¹⁶ FLA. STAT. ANN. § 732.912(3) (West Supp. 1989).

¹⁷ See table of provisions of state UAGAs in Lee & Kissner, *Organ Donation and the Uniform Anatomical Gift Act*, 100 *SURGERY* 867, 869 (1986).

¹⁸ Prottas, *supra* note 1, at 287.

¹⁹ 63A AM. JUR. 2d *Property* § 1 (1984); HONORE, *Ownership*, in *OXFORD ESSAYS IN JURISPRUDENCE* 107, 112-24 (Guest ed. 1961).

personal. Personal property is classified further as either corporeal or incorporeal. Corporeal property refers to tangible, physical entities; incorporeal property to various rights in the thing (*res*) recognized and enforced by the courts.²⁰ Among the cluster of overlapping rights bound up with the concept of ownership are the following:

- (1) a right of possession
- (2) a right of exclusion
- (3) a right of disposition
- (4) a right of use
- (5) a right to enjoy fruits or profits
- (6) a right of destruction.²¹

Besides the already mentioned right under the UAGA to decide whether one's own organs will be available for removal and transfer after death, American law currently recognizes a number of other rights connected with the human body as corporeal property. The human body is a material thing.²² Moreover, common law has long accorded individuals, at least rhetorically, the right to determine the place of their own burial, or whether they will be cremated.²³ This right was forthrightly acknowledged by the Utah Supreme Court in *In re Moyer*,²⁴ decided after Utah had passed its version of the UAGA in 1969. The decedent had specified in his will that his body was to be cremated. His mother ignored the declaration and had the body buried. The decedent's personal representative challenged the action and petitioned that the body be exhumed and cremated as the decedent had directed. The *Moyer* court stated that by enacting the UAGA, the Utah legislature had "recognized that a person has property rights in his body" which apply to the disposition of his body after death,²⁵ as long as the directive does not involve the waste of property or offend public sensibilities.²⁶

In medical law, a person's body cannot be invaded or operated upon without that individual's informed consent²⁷ — a protection suggesting

²⁰ 63A AM. JUR. 2d *Property* §§ 1 & 11.

²¹ R. CUNNINGHAM, W. STOEBCUK & D. WHITMAN, *THE LAW OF PROPERTY* § 1.1, at 1 (1984) [hereinafter *THE LAW OF PROPERTY*]; For a slightly different classificatory scheme, see Honore, *supra* note 19; see also 63A AM. JUR. 2d *Property* § 34.

²² 63A AM. JUR. 2d *Property* § 11.

²³ See *supra* notes 5, 6 and accompanying text.

²⁴ *In re Moyer*, 577 P.2d 108 (Utah 1978).

²⁵ *Id.* at 110, n.4.

²⁶ *Id.* at 110.

²⁷ In *Scholendorf v. Society of New York Hosps.*, 211 N.Y. 125, 105 N.E. 92 (1914), Justice Benjamin Cardozo made the following declaration concerning medical care: "Every human being of adult years has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault, for which he is liable in damages." *Id.* at 93. An individual's constitutional privacy right embraces the right to make potentially fatal decisions about his or her own medical treatment. See *In re Quinlan*, 70 N.J. 10, 355 A.2d 647, *cert. denied*, 429 U.S. 922 (1976). See also *In re Storar*, 52 N.Y.2d 363, 420 N.E.2d 64, 438 N.Y.S.2d 266, *cert. denied*, 454 U.S. 858 (1981); *Cobbs v. Grant*, 8 Cal.3d 229, 502 P.2d 1, 104 Cal.Rptr. 505 (1972); *Brophy v. New England Sinai Hosp., Inc.*, 398 Mass. 417, 497 N.E.2d 626 (1986).

the property right of exclusion. Moreover, bodily tissues and fluids such as blood, skin, semen, and saliva have long been bought and sold in the United States.²⁸ Recently, a California appellate court ruled that cells from the surgically removed spleen of a patient that were converted, without the patient's knowledge, into pharmaceutical products of enormous therapeutic and commercial value are the patient's personal property over which he has the ultimate power of disposition.²⁹ Thus, a persuasive case can be marshalled for the claim that the relation of a person to his or her own body exhibits many of the so-called "incidents" of ownership. Under common law it is not necessary that *all* of the relevant indicia of ownership apply for something to qualify as property.³⁰ In sum, the controlling right which the UAGA gives to individuals to decide whether their own body parts will be available for removal and transfer after death can be defended on the ground that a person's body is his or her property in an intelligible and significant sense. In the present writer's view, this claim establishes a substantial burden of proof to show why the family of a deceased declared donor should be asked for permission to remove organs from the individual, thereby in principle subjecting the decedent's prior declaration to possible veto.

It is also worth noting in this connection that all individuals queried in a recent study — both declared consenters and those who had not signed donor cards — agreed that no relative of a deceased declared consenter (or of a deceased declared objector,³¹ for that matter) should

²⁸ R. SCOTT, *THE BODY AS PROPERTY* 190 (1981).

²⁹ *Moore v. Regents of Univ. of Cal.*, 202 Cal. App. 3d 1230, 249 Cal.Rptr. 494 (1988), *reh'g granted*, 763 P.2d 479, 252 Cal. Rptr. 816 (Nov. 10, 1988).

³⁰ *THE LAW OF PROPERTY*, *supra* note 21, § 1.2, at 7; *see also* *First Victoria Nat'l Bank v. United States*, 620 F.2d 1096, 1103-04 (5th Cir. 1980).

³¹ It is hard to imagine procurement staff in possession of a written and witnessed *objection* by a person to the taking of his or her organs after death nevertheless asking that person's family whether they desire to donate their deceased relative's organs. Subjecting a person's prior *objection* to postmortem organ donation to possible family veto would, no doubt, strike most people as morally wrong. Why then should it be less wrong to subject to family veto a person's written prior *consent* to donation?

Many states have recently added so-called "required request" legislation to their respective UAGAs. This legislation places a legal obligation on hospitals to make certain that families of potential donors dying in these institutions are asked about the possibility of organ donation from these patients. It is noteworthy, however, that the wording of many of these required request laws explicitly excepts a hospital from making the request if the decedent has personally authorized, by a valid instrument, the removal and transfer of his or her own organs after death. *See, e.g.*, ALASKA STAT. § 13.50.014(a) (1988); D.C. CODE ANN. § 2-1509(a) (1988); MAINE REV. STAT. ANN. tit. 22, § 2910.1.A (West Supp. 1989); WASH. REV. CODE ANN. § 68.50.500 (1987). It is clear that the required request legislation in these states is fully consistent with the original provisions of their state UAGAs which prohibit family override of a decedent's prior written positive decision to donate.

³² Corlett, *Public Attitudes Toward Human Organ Donation*, 17 *TRANSPLANTATION PROCEEDINGS* 103 (No. 6, Supp. 3) (1985), at 106; *see also* Manninen & Evans, *Public Attitudes and Behavior Regarding Organ Donation*, 253 *J.A.M.A.* 3111 (1985); Robinette & Stiller, *Summary of Task Force Proceedings*, 17 *TRANSPLANTATION PROCEEDINGS* 9 (Supp. 3) (1985).

have the right to countermand the express antemortem directives of an individual concerning the disposition of his or her organs after death.³² Also, the majority of respondents in a survey conducted in connection with the National Heart Transplantation Study stated that if someone signs an organ donor card, this decision should not need to be approved by his or her family after death.³³

2. Recommendations

The foregoing considerations provide strong grounds for demanding a revision in the standard approach used by organ procurement personnel in counseling the family of a deceased or near-death declared consentor. Procurement staff should tactfully and sensitively *inform* the family of their loved one's explicitly stated and legally binding declaration to serve as a posthumous organ provider. They should also convey to the family the assurance that hospital staff will do everything possible to affect the transfer to needy others of their relative's life-saving organs as the latter has directed. In other words, the family of a declared donor should not be *asked* for permission to remove organs from such an individual. Rather,

³³ Evans, Manninen, Overcast, Garrison, Yagi, Jonsen, *et al.*, THE NATIONAL HEART TRANSPLANTATION STUDY: FINAL REPORT, *Executive Summary* 33-34 (Seattle, Wash.: Battelle Human Affairs Research Centers, 1984) [hereinafter TRANSPLANTATION STUDY].

³⁴ It is instructive to compare the responsibilities of the person or institution occupying the position of "donee" as defined by the UAGA (i.e., the person or institution authorized to *receive* the body or body parts of a deceased declared donor) to that of a coroner or medical examiner in circumstances where: (a) in the case of a donee, the decedent's family objects to the taking of organs from their loved one or (b) in the case of a coroner, the decedent's family objects to the performance of an autopsy required by law. Rho reports that "direct challenges to the legal right of medical examiners to perform autopsies have invoked one or more of the following arguments: religious tenets forbidding autopsies, mental anguish and grief to the next of kin, and the right of the next of kin to possession of the decedent's body." Rho, *Medical Examiner's Authority*, 81 NEW YORK STATE J. MED. 1687 (1981). Nevertheless, Rho avers, "the private right of a deceased person's family to prevent an autopsy is subservient to governmental interest as far as is deemed necessary." *Id.* (citing R. LONG, THE PHYSICIAN AND THE LAW (3d ed. 1968)). In the circumstance where a decedent's family objects to a legally required autopsy for any of the reasons cited, Rho says that the medical examiner "or his office should undertake an effort to explain to the family why the autopsy has to be done. This requires a high degree of understanding and sensitivity on the part of the medical examiner. More often than not, the family will comply with the medical examiner's decision for an autopsy after an explanatory session. It is only after all such efforts fail that the law must intervene. A blunt and bureaucratic approach will only aggravate the hostility of the family and the public." *Id.*

In the organ donation context, the most accessible person authorized to function as donee will typically be the attending physician of the deceased declared donor. See UAGA *supra* note 8, at §§ 3, 4(c). And, as indicated in note 10 *supra*, prior to amendment, Section 2(e) of the UAGA unequivocally stated that "[t]he rights of the donee created by the gift are paramount to the rights of others except as

they should be considerably informed that retrieval procedures will be implemented in deference to their loved one's prior decision.³⁴ It is noteworthy that, according to a 1984 study, this procedure is already used by procurement staff in four states — California, Colorado, Florida and Wyoming.³⁵ The procedure should be standard whenever procurement personnel counsel families of declared consenters.

That such a procedural change would likely be accepted by the majority of citizens is supported by the empirical evidence noted above, namely, that (a) most families of declared consenters do grant permission when asked and apprised of the decedent's stated desire to be a posthumous organ provider,³⁶ and (b) most people queried in the surveys cited³⁷ believe that survivors should not have veto power over a person's antemortem wishes concerning the disposition of his or her body after death. The recommended procedural change, then, appears to be politically feasible.

provided by § 7(d) [which affirms the pre-emptive rights of coroners and medical examiners to conduct autopsies as mandated by statute]."

Section 7(a) of the UAGA stated that "[t]he donee may accept or reject the gift." § 7(a) (1983) (In the 1987 amendments, Section 7(a) was moved to Section 8(a). The language of this Section now reads: "A donee may accept or reject an anatomical gift.") This raises an important question of interpretation: Is the donee at liberty to reject an anatomical gift, the transplantable body parts of the decedent, for just *any* reason, for example, to avoid the ire of the decedent's family who opposes removal of organs from their loved one? This is unclear. What is clear is that if any of the decedent's body parts are *medically* unacceptable, that is, are malignant or infected, the donee can and will refuse the gift.

On the other hand, where a declared donor's organs are medically acceptable, one must remember that the decedent doubtless gave antemortem consent to posthumous donation because the person wanted his or her body parts to be transferred, if possible, to those facing imminent death or severe disability without them. Hence, if at the moment of a declared donor's death there are in fact individuals who could benefit from the declared donor's organs (over which the physician-donee exercises custody), then the physician arguably has a legal *duty* to begin the process of organ retrieval from the deceased by notifying the nearest organ procurement agency of the availability of the person's body parts. If this interpretation of donees' responsibilities is defensible, then a donee should proceed with respect to a dissenting family in the same manner that Rho recommends that a coroner proceed with a family who objects to an autopsy on a relative who has died of unusual or suspected unlawful causes. The donee should tactfully and sympathetically *inform* the family of what must be done in deference to the legal right of the decedent which is at stake in this case, namely, the decedent's right to control by prior directive the disposition of his or her own body parts after death. Able discussion of the psychological issues connected with counseling survivors and recommended counseling techniques are provided in several sources. See Miles, *The Impact of Sudden Accidental Death on Bereaved Survivors*, in *BEREAVEMENT: HELPING THE SURVIVORS* 152-58 (M.A. Morgan ed. 1987); Weber, *The Human Connection: The Role of the Nurse in Organ Donation*, 17 *J. NEUROLOG. NURS.* 119 (1985); Youngner, Allen, Bartlett, Cascorbi, Hau, Jackson, Mahowald & Martin, *Psychosocial and Ethical Implications of Organ Retrieval*, 313 *NEW ENG. J. MED.* 321 (1985) [hereinafter *Organ Retrieval*].

³⁵ Overcast, Evans, Bowen, Hoe & Livak, *supra* note 1, at 1562.

³⁶ Prottas, *supra* note 1, at 287.

³⁷ Corlett, *supra* note 32, at 106; *TRANSPLANTATION STUDY*, *supra* note 33.

B. The Assumption that Consenting to the Posthumous Taking of One's Own Organs is an Act of Charity, Not a Moral Duty

1. Analysis

Media appeals that encourage people to sign organ donor cards typically speak of a person's consenting to the postmortem removal and transfer of his or her organs/tissues as the making of an anatomical "gift" or "donation." The terms "gift," "donor," and "donee" are also used in all state statutes patterned after the UAGA which govern the removal and transfer of body parts from cadavers.³⁸ These terms are accurate to the extent that those who consent to such procedures neither expect, nor are they legally permitted to receive, money for the excised organs and tissues.³⁹ But the terms also suggest that giving such consent is an act of charity — something that is praiseworthy for people to do, but not something that is clearly required by moral duty such that adequate excusing reasons for nonconsent are thought to be a legitimate expectation. As Arthur Caplan observes: "For many years the rhetoric of public education in the organ procurement field has been that of charity."⁴⁰ Consenting to the posthumous taking of one's own organs, or consenting to the taking of organs from the body of a deceased loved one, has been and still is typically viewed as an act of human kindness. According to Prottas and Batten⁴¹ and a 1985 Gallup poll,⁴² most Americans view organ donors as "loving, generous people who care about others." Commenting on the forces that led to the drafting of the Model Uniform Anatomical Gift Act in 1968 and its quick adoption thereafter by the vast majority of states, Caplan states:

Free choice and voluntarism played key parts in the moral and legal arguments that surrounded the passage of this legislation. Proponents of donor cards, donor statements on drivers' licenses, and other forms of living wills argued that a system of cadaver organ procurement built on voluntarism would promote socially desirable virtues, such as altruism, and at the same time protect the rights of persons who might, for various reasons, oppose the procurement of tissues from cadavers.⁴³

³⁸ See, e.g., DEL. CODE ANN. tit. 16, §§ 2710-2719 (Supp. 1988); N.J. STAT. ANN. §§ 26:6-57-26:6-65 (West 1987 & Supp. 1989); PA. CONS. STAT. ANN. §§ 8601-8607 (Purdon 1975 & Supp. 1989); VT. STAT. ANN. tit. 18, §§ 5231-5237 (1987).

³⁹ National Organ Transplantation Act, 42 U.S.C. § 274(E) (1984) Title III.

⁴⁰ Caplan, *Requests, Gifts, and Obligations: The Ethics of Organ Procurement*, 18 TRANSPLANTATION PROCEEDINGS 49, 55 (No. 3, Supp. 2) (1985).

⁴¹ Prottas & Batten, *Attitudes & Incentives in Organ Procurement, Part II: Attitudes of the American Public* (Report to the Health Care Financing Administration, 1986).

⁴² Gallup Organization, Inc., *The U.S. Public's Attitudes Toward Organ Transplantation/Organ Donation*. Gallup survey, 1985.

⁴³ Caplan, *Ethical and Policy Issues in the Procurement of Cadaver Organs for Transplantation*, 311 NEW ENG. J. MED. 981, 982 (1984).

Fully consistent with the view that consenting to the removal of one's own organs after death is an act beyond the requirement of strict moral duty is the following claim of David Ogden, past president of the National Kidney Foundation. Ogden argues against a proposal to institute routine removal of cadaver organs based on the legal doctrine of presumed consent. That doctrine holds that unless an individual expressly objects during life to the posthumous taking of organs from his or her body, the person shall be presumed to have consented to such taking:

Presumed consent is not quite the American way. It is relatively coercive, compared to the more classical freedom of choice that characterizes our way of life. Consent should be positive, not implied.⁴⁴

This author maintains, however, that providing such consent is not an act of charity. It is, rather, a moral duty of substantial stringency. The duty to consent is an instance of a more general moral duty variously called the duty of mutual aid,⁴⁵ or the duty to attempt an easy rescue of an endangered person.⁴⁶ This general moral duty is the foundation of laws enacted in two states, Vermont⁴⁷ and Minnesota,⁴⁸ and in fifteen foreign countries,⁴⁹ which place a legal obligation on any citizen (not just medical or law enforcement personnel) who encounters a person in serious danger to assist the imperiled individual in any significantly helpful way that does not involve undue cost or risk to the potential rescuer. Rhode Island⁵⁰ and Massachusetts⁵¹ have imposed on the general public an affirmative

⁴⁴ Ogden, *Another View on Presumed Consent*, 13 HASTINGS CENTER REP. 28 (1983). In 1976, France adopted a presumed consent law governing cadaveric organ retrieval, the so-called "Caillavet Law." The following comment on this law by a recent author is noteworthy in connection with the basic argument to follow in this paper which maintains that consenting to the posthumous taking of one's own organs is a moral duty, a duty derivative from the same general moral duty, that stands at the foundation of so-called "Good Samaritan" laws in the United States and numerous foreign countries: "If the Caillavet Law gives greater weight to the needs of the transplant recipient than to the possibility that the individual will of the donor has been violated . . . such a balancing accords with French legal recognition of the "Good Samaritan" principle. The French penal code mandates punishment of one who voluntarily abstains from aiding someone in peril, without risk to himself. Thus, the potential donor who is deceased and who has failed to object to organ retrieval may be viewed as a Good Samaritan bearing a legal duty to assist those waiting for transplants." Gerson, *Refining the Law of Organ Donation: Lessons from the French Law of Presumed Consent*, 19 N.Y.U. J. INT'L. L. & POL. 1013, 1027 (1987).

⁴⁵ Reeder, *Benevolence, Supererogation, and Role Duty*, in *BENEVOLENCE AND HEALTH CARE* (Shelp ed. 1982).

⁴⁶ Lipkin, *Beyond Good Samaritans and Moral Monsters: An Individualistic Justification of the General Legal Duty to Rescue*, 31 UCLA L. REV. 252 (1983).

⁴⁷ VT. STAT. ANN. tit. 12, § 519 (1973).

⁴⁸ MINN. STAT. ANN. § 604.05 (West 1988).

⁴⁹ Portugal, the Netherlands, Italy, Norway, Russia, Turkey, Denmark, Poland, Germany, Rumania, France, Hungary, Czechoslovakia, Belgium, and various cantons of Switzerland. For a discussion and full citations see Rudzinski, *The Duty to Rescue*, in *THE GOOD SAMARITAN AND THE LAW* 91 (Ratcliffe ed. 1966).

⁵⁰ R.I. GEN. LAWS, §§ 11-37-3.1 to -3.3 (Michie 1989).

⁵¹ MASS. GEN. LAWS Ann. ch. 268, § 40 (West Supp. 1989).

legal duty to assist strangers in emergency situations, though this duty is of a more limited nature than that required under the Vermont and Minnesota statutes.

The conditions under which the legal duty of mutual aid (or easy rescue) arises in the "Good Samaritan" legislation cited above are described by Weinrib.⁵² Weinrib's analysis may conveniently serve as the first approximate specification of the conditions which generate the general *moral* duty of mutual aid upon which these laws are founded.

1. *The emergency condition* - someone is caught in a situation that is likely to get worse unless the victim is assisted (e.g., the victim might die or suffer grave injury absent help).
2. *The convenience condition* - a witness is in a position to render assistance without significant cost or risk to self (e.g., by summoning police, throwing a life preserver, by keeping the victim warm, or by shouting a warning, etc.).

A more detailed analysis of the conditions under which the general moral duty of mutual aid arises is offered by Beauchamp and Childress.⁵³ They refer to the duty as the "duty of beneficence." The following embellishes slightly on their analysis:

Apart from the existence of special moral relationships such as contracts, promises, or roles, X has a duty to assist Y only if all of the following conditions exist:

1. Y is at risk of significant loss or damage,
2. X's action is needed to prevent this loss,
3. X's action would probably prevent it,
4. X's action would not present significant cost or risk to X,
5. The benefit that Y will probably gain far outweighs any harms that X is likely to suffer, and
6. X knows, or a reasonable person in X's position would recognize, that conditions 1-5 exist.

Consider paradigm emergency situations like the 1964 murder of Kitty Genovese in Queens, New York⁵⁴ or the 1983 pool table rape of a woman in a New Bedford, Massachusetts tavern.⁵⁵ Most of us believe that in such circumstances any witness is under a clear moral obligation to assist the victim (or victims) *when such assistance can be provided at zero or minimal cost/risk to the potential provider of aid*. We are abhorred by the inaction of those who just stood by and made no effort to assist these victims by so simple an act as summoning police. We think that very good reasons must be supplied for failing to do anything when something could have been done that would have posed zero or little cost/risk to potential assisters.

⁵² Weinrib, *The Case for a Duty to Rescue*, 90 YALE L.J. 247, 280-81, 285 (1980).

⁵³ T.L. BEAUCHAMP & J.F. CHILDRESS, PRINCIPLES OF BIOMEDICAL ETHICS 153 (2d ed. 1983).

⁵⁴ N.Y. Times, Mar. 27, 1964, at 1, col. 4.

⁵⁵ *The Tavern Rape: Cheers and No Help*, Newsweek, Mar. 21, 1983, at 25.

By analogy, this writer maintains, any relatively healthy individual who understands that as a result of accidental fatal head trauma, he or she would then become a potential resource for organs capable of saving one or more end-stage organ disease (ESOD) victims needing transplants at that moment, is under a moral obligation to *now* explicitly consent to the posthumous taking of his or her own organs for this lifesaving purpose. In other words, the relationship between any living individual (whose body can, at the moment of accidental death, function as a repository of lifesaving organs) to those who at the time of the individual's death are dying of various ESODs, is similar in sufficient relevant respects to the relationship between a potential rescuer and endangered individuals covered by the Good Samaritan laws discussed earlier. Hence, all potential organ providers have a *prima facie* moral duty to take the steps necessary to ensure that their organs will be available for lifesaving use after death.

Several objections may be lodged against the analogy. One might challenge the fundamental assumption on which the entire argument rests, the assumption, namely, that under the conditions enumerated by Beauchamp and Childress,⁵⁶ an individual in a position to assist a seriously imperiled person has a moral *duty* to provide aid when this can be done at zero or minimum cost/risk to the potential rescuer. It might be argued that refraining from aiding an endangered person amounts to withholding a benefit from that person, not inflicting harm upon that person. And while, concededly, there is a general moral duty to refrain from causing harm to others, there is no general moral duty to benefit others. Hence, the so-called moral duty of mutual aid is not really a duty at all. Conferring benefits is always supererogatory, never obligatory. Failing to render aid to a person in serious danger, even easily provided aid, is therefore not a failure of moral duty.

This argument trades on a number of incorrect assumptions concerning omissions (i.e., informed, intentional inactions), causality, and harm-doing. If a father intentionally poisons his infant's food, he is uncontroversially the cause of the child's death. If a father purposely omits feeding his infant who consequently dies of starvation, again he is the cause of the child's death, though his act may properly be described as an omission. (It is implausible to describe his act as "withholding a benefit" from the child). If a father spies his lightly-clad infant lying in the snow and does nothing, and the child contracts pneumonia and dies, then while the cause of death is the pneumonia, the father's inaction is nonetheless a *causal factor* in the death of the infant. While his failure to aid the child is not a *harm-initiating* action, it is a *harm-exacerbating* action in that his failure to supply aid has effectively made the child worse off.⁵⁷ In Weinrib's terminology, the father's inaction is a "but-for cause" of the child's death,⁵⁸ since the child would not have died had the father removed his infant from the snow and procured medical care.

⁵⁶ See *supra* text accompanying note 53.

⁵⁷ The terminology is that of Kleinig, *Good Samaritanism*, 5 PHIL. & PUB. AFF. 382, 393 (1976).

⁵⁸ Weinrib, *supra* note 52, at 253.

The but-for test of factual causation focuses first on situations in which a potential assister has failed to help someone exposed to danger or harm, and then compares the actual course of events to a hypothetical course of events that would have taken place had the potential assister intervened.⁵⁹ Not rendering aid has causal character. Assigning responsibility to potential assisters of vulnerable and helpless persons would be inappropriate if it were never possible to prevent an impending harm from materializing, or to prevent an already initiated harm from worsening. But the latter clearly is not the case. Hence, imputing such responsibility to a potential assister is warranted, and warranted to the strongest degree when the danger to the victim is great and the cost or risk to the potential rescuer is small.

In Anglo-American law a father is liable for failing to provide aid to his endangered child because the law views him as standing in a "special relationship" to the child.⁶⁰ Other special relationships include the relationship of innkeeper to guest, employer to employee, carrier to passenger, and proprietor to customer.⁶¹ The special relationship condition for assigning liability to acts of omission or negligence is not, however, a rationally satisfactory basis for confining the scope of legal liability for inaction. And since it may be initially tempting to believe that the special relationship condition also appropriately delimits the scope of our *moral* duties to others who are vulnerable and helpless, it is pertinent to consider a standard line of argument advanced by critics against the prevailing Anglo-American legal doctrine that there is no general duty resting on all citizens to provide aid to strangers in emergency situations.⁶²

Consider the following examples provided by Bentham:

A woman's head-dress catches fire, water is at hand. A man, instead of assisting to quench the fire, looks on and laughs at it. A drunken man, falling with his face downwards into a puddle, is in danger of suffocation: lifting his head to one side would save him. Another man sees this and lets him die. A quantity of gunpowder lies scattered about a room. A man is going into it with a lighted candle. Another, knowing this, lets him go in without warning. Who is there that in any of these cases would think punishment misapplied?⁶³

In each of these cases assume that the person capable of easily assisting the endangered party stands in no special relationship to the victim; that is, assume that they are strangers. Critics of the tendency of Anglo-

⁵⁹ *Id.*

⁶⁰ See, e.g., *Palmer v. State*, 223 Md. 341, 164 A.2d 467 (1960).

⁶¹ W. PROSSER, *HANDBOOK OF THE LAW OF TORTS* 338-50 (1971).

⁶² See, e.g., B. CARDOZO, *THE PARADOXES OF LEGAL SCIENCE* 2526 (1928); J. FEINBERG, *HARM TO OTHERS* 126-86 (1984); Benditt, *Liability for Failing to Rescue*, 1 *LAW & PHIL.* 391 (1982); Woozley, *A Duty to Rescue: Some Thoughts on Criminal Liability*, 69 *VA. L. REV.* 1273 (1983); Lipkin, *supra* note 46; Note, *Bad Samaritanism and the Duty to Render Aid: A Proposal*, 19 *U. MICH. J. L. REF.* 315 (1985).

⁶³ J. BENTHAM, *AN INTRODUCTION TO THE PRINCIPLES OF MORALS AND LEGISLATION* 293 (J.H. Burns & H.L.A. Hart eds. 1970).

American law to refuse to impose on all individuals a general legal duty of easy rescue have asked: Why should potential assisters in cases like those described by Bentham be free of legal responsibility to provide relatively cost and risk-free aid? If the above-described father of the insufficiently clothed child who was exposed to the elements has a legal duty to assist the child in the circumstance, then why shouldn't any stranger who happens upon the child have the same legal obligation?⁶⁴

Common to all those special relationships which at law are thought to impose on some member of the relationship (say, a parent, innkeeper, employer) a duty to render aid to the complementary party in the relationship (e.g., an offspring, guest, employee) is a particular *situational structure*: someone is in a helpless and vulnerable position and dependent upon someone else who is in a position to easily provide help. But this same structure obtains in those situations described by Bentham (and in the Kitty Genovese murder and Massachusetts bar rape cases) in which victims and potential rescuers are strangers. Hence, critics have urged, it is inconsistent to confine the legal duty to aid imperiled individuals to situations in which potential rescuers and victim(s) stand in special relationships to each other.⁶⁵

Now the relationship of any potential organ provider to those histocompatible end-stage organ disease (ESOD) victims who at the moment of that person's death face imminent death themselves absent transplants is, typically, a relationship between strangers. But if the foregoing argument is accepted, the mere lack of a special relationship between potential organ provider and needy organ recipient(s) is not sufficient in itself to defeat the claim that the potential provider has a moral duty to take those steps necessary to ensure that his or her organs will be available for transfer to needy others at death, that is, a moral duty to sign a "donor" card.

The analogy being advanced might be attacked on other grounds,

⁶⁴ Several cases illustrate the principled refusal of American common law to impose legal liability on individuals who could have easily assisted seriously endangered strangers but did not. See, e.g., *Osterlind v. Hill*, 263 Mass. 73, 160 N.E. 301 (1928) (Businessman who rented boat to intoxicated customer violated no legal duty to the deceased, who was not in a helpless condition and was able to take steps to protect himself from drowning); *Handiboe v. McCarthy*, 114 Ga. App. 541, 151 S.E. 2d 905 (1966); *Buch v. Amory Mfg. Co.*, 69 N. H. 257, 44 A. 809, 810-11 (1897) (Giving this example of the absence of a duty to rescue — "Suppose A, standing close by a railroad, sees a two year old babe on the track, and a car approaching. He can easily rescue the child, with entire safety to himself, and the instincts of humanity require him to do so. If he does not, he may, perhaps, justly be styled a ruthless savage and a moral monster; but he is not liable in damages for the child's injury, or indictable under the statute for its death." In fact, the *Buch* court would not recognize any duty to rescue or protect a trespasser.)

Courts later imposed a duty of reasonable care upon property owners, see, e.g., *Ovellette v. Blanchard*, 116 N.H. 552, 364 A.2d 631 (1975), including the duty to take reasonable affirmative action to prevent further injury to trespasser entrapped in a position of peril. *Pridgen v. Boston Hous. Auth.*, 364 Mass. 896, 308 N.E.2d 469 (1974).

⁶⁵ See authorities cited *supra* note 61.

however. It might be contended that the *sources* of threats to endangered individuals which come within the compass of the Good Samaritan legislation cited (e.g., stabbings, shootings, beatings, rapes, etc.) are conspicuously different from the source of threat to those needing transplants, namely, death from an organic disease. But why should the kind of serious threat matter in making the comparison? Suppose a person could easily assist a diabetic in insulin shock or apply CPR to someone just seized by a heart attack? Surely such a person would be under a moral obligation to provide such aid when this can be supplied at minimal or zero cost/risk to the person.

Another objection might be that in the standard types of emergency situations falling within the scope of Good Samaritan laws, the harm to be relieved or prevented is one that is already being sustained by the victim (e.g., physical injuries from a beating) or which will materialize in seconds or minutes (e.g., death from drowning), whereas the death faced by ESOD victims is a harm which will come to pass over an extended period of time, perhaps six to eight months. But here again the alleged significant dissimilarity between the compared cases is problematic. Lefton reports that at any given time in 1985 there were six to eight heart patients that were expected to die in 48 hours or were rejecting an already implanted heart.⁶⁶

The analogy might be attacked in yet another way. One might call attention to the fact that the peril faced by victims in the model emergency situations is clearly visible to or audible by the witnesses owing to their physical proximity to the beating, rape, or stabbing in progress, whereas potential organ donors (i.e., all living individuals who could at any time die from some sort of severe cerebral insult) are spatially removed from those needing transplants, and thus are not directly aware of the danger faced at any given moment by transplant candidates. This objection purports to attach moral significance to an epistemological distinction (bearing upon condition 6 in Beauchamp's and Childress' criteria)⁶⁷ between

⁶⁶ Lefton, *New Worry About Donor Heart Supply*, AM. MED. NEWS, Sept. 13, 1985, at 52.

⁶⁷ An independent issue posed by this particular example is: *How much* of one's income or time is required by the moral duty of mutual aid in the circumstances described? Peter Singer insists that a plausible case can be made for the claim that the level of assistance demanded is to give to the point of marginal utility, to "the level at which, by giving more, I would cause as much suffering to myself or my dependents as I would relieve by my gift." Singer, *Famine, Affluence, and Morality*, 1 PHIL. & PUB. AFF. 229 (1972).

Admittedly, the moral duty of mutual aid as applied to the problem of famine relief raises difficult questions about the quantity of personal resources one is required to provide to meet the minimum demands of the duty. Fortunately, however, questions about the degree or extent of one's duty to assist imperiled person in those model emergency situations covered by Good Samaritan laws are not as intractable as in the famine relief case. If someone is drowning nearby and a life-preserver is within easy reach of a potential rescuer, then clearly the latter should throw the preserver to the victim. Or, in the case of those who witnessed the Kitty Genovese assault, there surely is an obligation to at least summon the police. In such circumstances there obviously is little or no cost

direct and indirect knowledge of an emergency situation. The argument presumes that direct knowledge of an emergency situation imposes a greater responsibility on those in a position to help than does indirect knowledge. But this claim too is suspect. If I visit Ethiopia and encounter first-hand people who are starving, am I, simply because of my direct knowledge of these people's plight, *more* morally obligated to assist them (if I can contribute to this goal by a monetary contribution that places me at no serious financial risk⁶⁸) than I was when I merely knew about their desperate need through news reports and public appeals for donations? This seems doubtful. Admittedly, I may be *psychologically* more inclined to respond to their need because of my personal acquaintance with them. But this is not pertinent to assessing whether my prior indirect knowledge of their plight imposed on me *then* a less strict duty to assist than I now have according to the epistemologically based objection here under consideration.

According to a national survey conducted in 1987, almost 99% of those interviewed said that they had heard about organ transplantation and 84% said that they had received information concerning organ donation.⁶⁹ There is reason to believe, then, that in the United States there is widespread indirect knowledge about the critical need for organs for people dying from ESODs. Such indirect knowledge is *as* pertinent to developing the case for the moral duty to consent as any direct knowledge of the plight of ESOD victims would be. Moreover, if the set of other independent considerations material to establishing this duty are persuasive, the weight of the duty will not vary in accordance with whether the potential assister's knowledge of the emergency situation is direct or indirect.

Another counterargument to the analogy might be this. Dangers faced by others (e.g., imminent death from various ESODs) at the moment of my death are future dangers. Future dangers by definition do not exist. Dangers that do not now exist cannot impose on me now a duty to respond to them. Hence, I do not have a duty to now consent to the posthumous removal and transfer of my organs.

Admittedly, the probability that at the moment of my death there will be needy persons whose blood and tissue-type are sufficiently compatible with mine to benefit from receipt of my body parts is less than 1.0%. Nonetheless, it is *more probable than not* that there will be histo-

involved to potential rescuer(s).

It is far more controversial to insist that one has a further responsibility to pay for the paramedics' service call or the victim's hospital bills if the victim cannot afford it. As this author will argue shortly, a person's consenting to the posthumous taking of his or her own organs for transfer to needy others is as cost and risk free for the typically situated individual as throwing an easily obtainable life preserver to a drowning victim, shouting a warning to someone facing an impending danger, or summoning the police to the scene of a rape or assault. Thus, the argument for the moral duty to consent to the posthumous taking of one's own organs does not face as vexatious an array of questions concerning the boundaries or limits of the duty of mutual aid as is generated by the famine relief problem.

⁶⁸ See *supra* text accompanying note 53.

⁶⁹ Evans & Manninen, *supra* note 2, at 782.

compatible individuals capable of benefiting from one or more of my body parts when I die. Each person's body is a reservoir of transplantable organs and tissues of potential value to many others in need: heart, kidneys, pancreas, liver, bone, skin, marrow, corneas, etc.⁷⁰ Therefore, while the probability is obviously less than 1.0% that at death my body parts will be able to save at least one person from death or serious disability, the probability is high enough to impose on me now the duty to prepare for this eventuality by signing a donor card. (Under the policy revision recommended earlier, such a declaration will not be subject to veto by others).

Perhaps the most important question connected with the acceptability of the analogy is this: Are there in fact significant costs/risks connected with expressly consenting to serve as a posthumous organ provider which defeat the obligation to consent on the ground that condition (4) in Beauchamp's and Childress' criteria remains unsatisfied? Someone might claim, for example, that explicitly consenting to the postmortem removal of his or her body parts does indeed generate significant cost or risk because:⁷¹

- (a) he or she is revulsed by the idea of being cut up after death;
- (b) postmortem removal of body parts jeopardizes the possibility or quality of the afterlife;
- (c) posthumous removal of organs violates ritual or ethical rules of his or her religious tradition;
- (d) known consenters are likely to receive suboptimal care from medical staff when they are hospitalized and in critical condition;
- (e) organ removal disfigures the corpse and precludes the possibility of an open casket funeral.

On a purely rational assessment, however, none of these beliefs stands up to critical scrutiny:

- belief (a) reflects an irrational fear, given the other things we already know will happen to our bodies after death (e.g., its inevitable decomposition over time, the intravenous draining of blood during embalming procedures along with tying off the penis, plugging the bodily orifices, etc);⁷²
- belief (b) is inconsistent with traditional views concerning divine omnipotence and the nature of the general resurrection;⁷³

⁷⁰ Department of Health and Human Services, *Organ Transplantation: Issues and Recommendations, Report of the Task Force on Organ Transplantation* 160-98 (Appendix C, Location of Transplant Centers and Tissue Banks) (Health Resources and Services Admin. 1986).

⁷¹ The following reasons have been offered for not signing donor cards by individuals interviewed in polls and formal studies. See, e.g., Schulman, *Getting Organ. . . ized*, 20 *TRANSPLANTATION PROCEEDINGS* 1025 (No. 1, Supp. 1) (1988); Parisi & Katz, *Attitudes Toward Posthumous Organ Donation and Commitment to Donate*, 5 *HEALTH PSYCH.* 565 (1986).

⁷² C. STRUB, *THE PRINCIPLES AND PRACTICES OF EMBALMING* 334-51 (L.G. Fredrick ed. 1959).

⁷³ Gapen, *Minority Organ Donors Encouraged*, *AM. MED. NEWS*, Nov. 9, 1984, at 19 (quoting C. Callendar).

- belief (c) is valid only for orthodox Jews, according to some but not all rabbinic interpretations,⁷⁴ and possibly for Jehovah's Witnesses,⁷⁵
- belief (d) is false since medical personnel typically view the loss of a patient as a professional failure,⁷⁶ and no physician receives any financial benefit by apprising organ procurement agencies of potential donors under his or her care or supervision;⁷⁷
- belief (e) is false because removal of organs and post-surgical repair of the corpse leave no scars visible to viewers of the body lying in state.

Except, then, for Orthodox Jews and possibly Jehovah's Witnesses, who are able to legitimately advance claim (c), this writer contends that the remainder of us are bound by the moral duty to consent; that is, for all but the two cited groups, claims (a) - (e) above do not identify true and significant costs/risks which defeat condition (4) in the set of criteria specifying the conditions under which the duty to consent obtains.

2. Recommendations

Media appeals aimed at recruiting consenters should, then, acknowledge that consenting is a moral duty, not charity. Such appeals should also provide prospective consenters with accurate information concerning issues (a) - (e). Correct information *is* capable of changing people's false beliefs. There is evidence that those who object to or who are reticent about donating organs from deceased kin because they believe that post-mortem removal of body parts jeopardizes the possibility or quality of the afterlife, can be persuaded of the unreasonableness of this belief by rational argument.⁷⁸ Another study indicates that the belief that known consenters risk receiving suboptimal critical care, or that organ removal disfigures the corpse, are amenable to change through receipt of accurate information.⁷⁹ Apprising people of the moral duty to consent, and disseminating correct information on issues (a) - (e), for example, can be accomplished through those means now used for consenter recruitment; brochures supplied by the National Kidney Foundation, the American Council on Transplantation, and eye banks, and continuous-play video

⁷⁴ Rosner, *The Traditionalist Jewish Physician and Modern Biomedical Ethical Problems*, 8 J. MED. & PHIL. 236 (1983).

⁷⁵ Corlett, *supra* note 32, at 104.

⁷⁶ Sophie, *Intensive Care Nurses' Perceptions of Cadaver Organ Procurement*, 12 HEART & LUNG 266 (1983); *Organ Retrieval*, *supra* note 34, at 322.

⁷⁷ Caplan, *Professional Arrogance and Public Misunderstanding*, 18 HASTINGS CENTER REP. 34, 36 (1988).

⁷⁸ Gapen, *supra* note 73.

⁷⁹ See Winkel, *Public Communication on Donorcards: A Comparison of Persuasive Styles*, 19 SOC. SCI. & MED. 957 (1984).

tapes concerning posthumous organ removal and transfer available in some state Department of Motor Vehicle offices.

II. THE DUTY TO CONSENT AND PRINCIPLES FOR FAIRLY ALLOCATING ORGANS UNDER CONDITIONS OF SCARCITY

It bears noting, however, that if consenting *is* a moral duty, then that duty clearly rests in the first instance upon the person whose body can serve as a posthumous saving resource. The primary "obligee," in other words, is the person himself or herself - *not* the person's *family*. As indicated above, the provisions of the UAGA which give first authority to the individual to control the disposition of his or her own body or body parts after death can be morally defended by appeal to the plausible claim that a person's body is his or her property in a significant sense.⁸⁰ The argument of the preceding section, however, was that for typically situated individuals, this right is overridden by the moral *duty* to consent. Hence, if a person is apprised of the duty to consent through an informationally adequate recruitment appeal, and if he or she fails to make an explicit yes or no decision concerning the posthumous taking of his or her organs (thus passing this decision on to survivors), then that person is shirking a moral responsibility incumbent upon him or her in the first instance. This judgment of moral failure holds even if his or her family happens to consent to the release of organs from the person's body after death.

This analysis raises an important issue concerning the fair distribution of organs under conditions of scarcity: why should needy individuals who have been solicited by an informationally adequate consentor recruitment appeal, but who have not personally agreed to the posthumous taking and transfer of their own organs (i.e., who have not fulfilled their moral duty to consent), be given equal access to the pool of cadaver organs with those who have agreed to the taking of their body parts after death? Assuming equal need and prospect of transplant success for two individuals, A and B, if A is a declared consentor and B is not, then A's prior fulfillment of moral duty arguably stands as a morally acceptable reason for providing A with a histocompatible available organ ahead of B.

A law passed by the Parliament of Singapore in 1986 — *The Human Organ Transplant Act* — adopts this principle for allocating cadaver kidneys in conjunction with a kidney retrieval practice based on the legal theory of presumed consent.⁸¹ The premise of the Singapore law is that unless an individual expressly objects to the posthumous taking of his or her organs, he or she shall be presumed to have consented to such taking. Under the Singapore law, those who object to serving as posthumous kidney providers are given second-priority access to the cadaver kidney

⁸⁰ See *supra* notes 19-29 and accompanying text.

⁸¹ See Iyer, *Kidneys for Transplant — "Opting Out" Law in Singapore*, 35 FORENSIC SCI. INT'L 131 (1987).

pool in the event of need; that is, only if an available kidney is not able to be used by a needy non-objector (i.e., a presumed consentor), will it be offered to a needy objector. This priority principle for distributing scarce kidneys is, however, theoretically independent of the policy of presumed consent. It applies as well to a retrieval policy based on explicit consent, or "opting in," as it is frequently called. Under the latter policy — the one operative in the United States — the Singapore priority principle would dictate that only if an individual explicitly *agrees* to the taking of his or her organs after death shall he or she be given first priority access to the cadaver organ pool in the event of need.

The current United States policy of opting in is, as I argued above, tied to and colored by the incorrect assumption that opting in is a charitable act, a work of supererogation. But if (i) opting in is a moral duty resting in the first instance upon each individual (not upon his or her family), and (ii) it is neither morally nor legally defensible to permit families to veto the antemortem decisions of dead relatives regarding the posthumous disposition of their organs, then it seems eminently fair to conjoin to our "opt in" retrieval policy, a distribution policy giving first priority access to the cadaver organ pool to those who have consented and thus have *personally* made possible the lifesaving organ pool itself. Needy nonconsenters would be given second priority access as in the Singapore law.

The revised policy I recommend offers at least two incentives to provide express antemortem consent: (a) the recognition that consenting is a moral duty; and/or (b) the fear that one might go without a needed organ because of the second-priority status accorded nonconsenters. It is plausible to believe that more people might respond to the appeal to duty than to the appeal to charity since duty provides a more morally stringent reason for acting than does charity. The fear of going without a needed organ is of course a prudential rather than a moral reason. But a distribution policy does not become morally suspect merely because some people may act only in accordance with duty rather than from duty (to use a Kantian distinction).⁸²

In the remainder of this essay an attempt will be made to fill in some of the details of how such a unified approach to consentor recruitment and organ procurement and distribution might operate to demonstrate its practical and political feasibility.

III. OPERATIONALIZING THE PROPOSED PROCUREMENT-DISTRIBUTION SYSTEM: PRACTICAL PROBLEMS AND SUGGESTED SOLUTIONS

A. Procedural Mechanisms for Allaying Fears of Dying Prematurely from Medical Neglect

As previously discussed,⁸³ one of the risks some people believe to be connected with giving express antemortem consent to the posthumous

⁸² I. KANT, FOUNDATIONS OF THE METAPHYSICS OF MORALS § 1 (1785).

⁸³ See *supra* note 71 and accompanying text.

taking of their own organs is the risk of receiving suboptimal critical care if they are hospitalized and medical staff know that they are declared consenters. This worry has no basis in fact, as already indicated.⁸⁴ It must be addressed, nevertheless, in consentor recruitment appeals. This goal can be accomplished partly through disseminating correct information on this matter. The fear in question can be further reduced if one or both of the following safeguards are mandated in connection with organ procurement procedures, and the public is apprised of these protective mechanisms in consentor recruitment messages.

1. Increase the secrecy or privacy of consent by recording an individual's consent in a computer registry⁸⁵ that can be tapped only by authorized medical personnel after the person has been declared brain dead. This procedure would keep medical professionals ignorant of a person's donor status while they are caring for the patient. If people want to carry cards that openly declare their desire to be posthumous sources of organs and tissues, they would of course be free to do so.

2. Permit participants in the program who have recorded their express consent in the private registry to make the actual posthumous *taking* of their organs/tissues contingent upon a validating consent given by someone whom they specifically designate to authorize this release.⁸⁶ The appointed validator of the person's original registered consent would be in a position to monitor the care given to the incompetent declared consentor and would be empowered to withhold or refuse validation if he or she believed that the medical staff were fudging or had fudged on their professional responsibility to provide beneficial medical care up to the limit specified by the patient in oral conversations with the validator, or in a living will or durable power of attorney for health care document. The assumption is that the person picked to be the validator will be someone whom the consentor trusts and who will be well aware that the consentor does strongly desire to have his or her usable organs transferred to others upon death. The only contingency is that the consentor be given at least the expected level of medical care when incompetent and in critical condition.

If both of these protective devices were available to consentors, the worries concerning suboptimal treatment now harbored by many current nonconsentors should be significantly reduced.

⁸⁴ See *supra* note 76.

⁸⁵ Technical details for operating such a registry are discussed in Dewhurst, *A Computerized Kidney Donorship Register*, 11 *JOURNAL OF MED. SYS.* 381 (1987); see also Ross, Dewhurst & Salaman, *A Computerized Kidney Donor Register — One Year Review*, 20 *TRANSPLANTATION PROCEEDINGS* 816 (No. 5, Oct.) (1988)

⁸⁶ This idea is suggested by Childress in a different context. See Childress, *Some Moral Connections Between Organ Procurement and Organ Distribution*, 3 *J. CONTEMP. HEALTH, L. & POLY* 85, 93 (1987).

*B. Issues of Justice in Granting/Denying First-Priority
Access to the Cadaver Organ Pool*

1. The Problem of the "Procrastinating Nonconsenter"

Another problem likely to arise is that of people putting off registering consent until they discover that they either have, or are at high risk for acquiring, some medical problem that might require an organ or tissue transplant in the future. By hypothesis, such an individual could not, or would likely be unable to serve as a posthumous provider to others of the specific organ/tissue which he or she might eventually need.

One way of addressing this problem might be to establish the following connection between registering consent and eligibility to receive organs/tissues. Since from a medical point of view, younger healthy individuals who die of accidents are generally the best sources for cadaver transplants,⁸⁷ the distribution policy could require that all persons 18 years of age or older at the time the policy is officially established have three years in which to register. During this initial sign-up period, no distinction would be made between registrants and non-registrants as regards first- and second-priority access to the pool in the event of need. After this initial three year period, however, anyone who was 18 or older when the policy was inaugurated, but who did not enroll during this period, would automatically be granted second-priority access to the pool. Should any of these people choose to register later, they would still retain second-priority status for some period of time thereafter (perhaps two years). Individuals below the age of 18 at the time the policy is instituted might be automatically granted first-priority status until the age of 21, even without registering. If they registered after their 21st birthday, however, they would be assigned second-priority status for at least two years, with a conversion to first-priority status thereafter. This policy should provide sufficient incentive to register at a young age when the probability of imminently needing an organ or tissue is low.

2. Accommodating Nonconsent for Religious Reasons

There is an important difficulty connected with granting first-priority access to the organ/tissue pool to those who decline to consent for religious reasons: How does one distinguish between valid and invalid religious objections? The latter will no doubt embrace beliefs that will be judged as superstitious by adherents of or sympathizers with a specific religious persuasion who have seriously considered the beliefs in question. Howard University surgeon Clive Callendar calls attention to this problem among blacks. Members of certain black churches, according to Callendar, are often reluctant to consent to the taking of kidneys from dead relatives

⁸⁷ Somerville, "Procurement" vs. "Donation" — Access to Tissues and Organs for Transplantation: Should "Contracting Out" Legislation Be Adopted?, 17 TRANSPLANTATION PROCEEDINGS 53, 55 (No. 6, Supp. 4) (1985).

because of unexamined religious worries that postmortem organ excision might jeopardize the possibility or quality of resurrection life. Callendar, himself a black, frequently persuades hesitant families to permit kidney retrieval from a deceased loved one by using the following approach: "If God is capable of getting you together, it doesn't matter whether there's almost nothing left or not. If He's going to create the resurrection miracle, He doesn't need your kidneys to do it."⁸⁸

Presumably, then, it is not impossible to distinguish between religious objections to consenting that are considered and those that are unreflective. The religious objection of, say, an orthodox Jew to the posthumous removal of his or her organs and tissues would probably be defensible.⁸⁹ The major religious groups have, however, explicitly endorsed the posthumous taking and use of human organs for transplantation.⁹⁰ If the distribution of lifesaving body parts under the proposed revised policy is to accommodate religious objectors on a first-priority basis, there needs to be some means of distinguishing between valid and invalid religious objections.

One procedure for doing this might be the following. To be eligible for first-priority access to the organ/tissue pool, those who decline to consent on religious grounds would have to show that (a) they are members of an organization that is recognized by the state as a "religious" group (e.g., this designation might be the basis of the group's tax exempt status) and (b) that the organization's formally stated articles of faith or rules of ritual assert or imply the impermissibility of postmortem removal of organs/tissues from its members. The circumstance of such objectors would be analogous to those who for religious reasons objected to bearing arms during the era of military conscription. The burden of proof would be borne by those who claim religious reasons for nonconsent, yet desire to be eligible to receive organs/tissues on a first-priority basis along with consenters. Presenting evidence for a religious exception to the organ allocation priority rule should be no more onerous than presenting evidence for the status of conscientious objector to bearing arms in combat. Requiring that the burden be met is reasonable and can be salutary. Individuals who think that consenting to provide their own organs/tissues after death is inconsistent with their religious beliefs will be required to examine this view under pressure of the principal ethical claim justifying the revised distribution policy itself, namely, that consenting is a moral *duty*. It is expected that the critical examination of those beliefs that supposedly preclude consent will be conducted among authorities within religious organizations and in consultations of lay persons with such authorities. It is plausible to believe that the result of such critical reflection will be the recognition that the supposed inconsistency between

⁸⁸ Gapen, *supra* note 73.

⁸⁹ Rosner, *supra* note 74; see also Dukeminier & Sanders, *Organ Transplantation: A Proposal for Routine Salvaging of Cadaver Organs*, 279 NEW ENG. J. MED. 413, 416 (1968).

⁹⁰ Pittsburgh Transplant Foundation, *Postmortem Organ Procurement Protocol* (1984).

religious beliefs and the act of consenting is ill-founded. People may even discover that their religious beliefs positively require giving such consent.⁹¹

IV. SUMMARY

The practices of donor recruitment and organ procurement and distribution in the United States are currently informed by two significant but nonetheless mistaken assumptions. The first incorrect assumption, typically embraced by organ procurement personnel, is that a validly signed donor card functions merely as a nonbinding expression of the signer's willingness to have usable organs removed from his or her body after death. The second fallacious assumption, discernible in standard donor recruitment appeals, is that consenting to the posthumous taking of one's own organs is an act of charity, not a matter of moral duty. This Article has presented ample evidence to show the falsity of each of these assumptions.

An alternative, theoretically unified policy was proposed to govern the distinguishable activities of consentor recruitment, organ procurement, and distribution; this proposed policy is consistent with the correct assumptions on the issues cited. Under the revised policy, consentor recruitment messages would inform the public that consenting is a moral duty, an instance of the more general moral duty to assist an endangered individual (or individuals) when this can be done at minimal or zero cost/risk to self. Organ distribution would proceed on the principle that, under conditions of scarcity, those who have given prior consent to the posthumous taking of their own organs shall have first-priority access to the cadaver organ pool in the event of need.

Various special problems connected with operationalizing the proposed system were considered and strategies suggested for addressing them. Throughout, reasons were offered for believing that the revised approach is politically feasible and hence merits serious consideration by law- and policy-makers.

V. APPENDIX

A. A Revised Approach for Counseling Families of Deceased Declared Organ "Donors"

Section 1.A of the present Article sought to demonstrate that asking the family of a deceased declared donor for permission to remove body parts from such an individual is a violation of both the spirit and the letter of the UAGA. The correct approach is simply to inform the family that appropriate procedures will be initiated to make the decedent's organs available for those lifesaving purposes he or she previously endorsed.

⁹¹ See May, *Religious Justifications for Donating Body Parts*, 15 HASTINGS CENTER REP. 38 (1985).

The conclusion of Section 1.B was that, for a typically situated individual, consenting to the posthumous taking of his or her own organs is not an act of charity, but rather the fulfillment of the general moral duty to assist persons in peril when this can be done at zero or minimal cost or risk to a potential rescuer. Characterizing such consent as an act of kindness lying beyond the call of moral duty is therefore unjustified.

If these two conclusions are accepted, then the substance of what organ procurement personnel say to the family of a deceased consentor will have to be revised accordingly. Procurement staff must avoid leading such a family to believe that they (the family) have a legal responsibility to validate the prior decision of their deceased loved one to serve as posthumous provider of organs. Otherwise, the family is given the impression that they have a legal or moral right to veto the prior authorization of their relative to have useful organs removed from his or her body after death. Beyond this, a deceased person's agreement to serve as a posthumous organ provider must not be characterized as a work of supererogation. Given the analysis presented in 1.B., providing such consent is the fulfillment of the general moral duty of mutual aid. The language of charity is neither appropriate nor necessary. As Kant has taught us, a person is hardly demeaned by doing his or her duty out of respect for duty. Kant says of such a good will that it "sparkles like a jewel in its own right."⁹² Procurement staff should therefore have no misgivings about speaking of a decedent's antemortem consent as a response to a moral duty incumbent upon us all.

Now it must be recognized that if the approach to families of deceased declared consentors is revised in the manner indicated, psychological problems for the survivors may be exacerbated. Substantial evidence exists that families of deceased potential donors who have been asked about and who have consented to organ recovery from brain dead relatives derive significant therapeutic value from this action. Being offered the opportunity to authorize organ retrieval from loved ones provides families with a sense of being able to do something to bring some good out of the senseless deaths with which they are trying to cope.⁹³ Moreover, it is also reasonable to assume that most survivors of declared consentors have probably heard or read about families who have donated organs from deceased kin. Hence, there is reason to expect that if the physician, nurse, or transplant coordinator approaches the family of a declared consentor and simply informs them about what the hospital will be doing to give effect to their loved one's wishes to serve as a posthumous organ provider — rather than asking the family's permission to do this — the family may find this approach both unorthodox and stress-increasing. The approach directly challenges an important (though incorrect) assumption shared by most families in this type of situation, namely, that at least until interment or cremation, they have legitimate and final authority concerning the disposition of the body of their loved one. The challenge

⁹² I. KANT, *supra* note 82.

⁹³ Batten & Protas, *Kind Strangers: The Families of Organ Donors*, 6 HEALTH AFF. 35, 37-38, 44-45 (1987).

may itself intensify the family's distress. In addition, telling the family, rather than asking them about what will be done with the decedent's body parts, deprives the family of those therapeutic benefits just mentioned which are typically gained by families who are asked to consent to organ recovery from their loved ones and who authorize this procedure.

In the view of the present writer, however, the value of protecting the decedent's right to control the disposition of his or her body after death and the value of saving lives threatened by ESODs take precedence over protecting the psychic welfare of dissenting families *when these values are in irresolvable conflict*. Though this rank ordering of the competing values is justified in this author's judgment, we must still consider *how* an organ procurement staffperson should proceed in informing the family of a declared consentor concerning what the hospital will be doing to give effect to the decedent's express desire to have his or her organs made available to needy others after death. We need, in other words, to develop a protocol for approaching families of declared consentors that is sensitive to the needs of these families, but which at the same time openly and forthrightly acknowledges and protects the important values of preserving donors' control over the disposition of their bodies and saving the lives of transplant candidates. To be adequate, any proposed protocol must be informed by and responsive to a number of problems typically connected with counseling survivors in this type of circumstance.

First, from a medical standpoint, the most acceptable donors are usually young, otherwise healthy individuals who suffer some type of fatal head trauma (e.g., an aneurism). The vital organs of these brain dead individuals usually remain unaffected by the cerebral insult, and heart-beat and respiration can be maintained artificially through the use of respirators and other critical care devices. While these victims are dead according to conservative and accepted medical and legal criteria, i.e., while they are unequivocally "cadavers," they do not *appear* dead to either professional medical staff or laypersons.

[T]hey remind us in many ways of living patients. They are warm and retain a healthy color, which is no surprise, because their hearts continue to pump oxygenated blood throughout their bodies. Digestion, metabolism, and elimination continue . . . [T]hese dead patients do not appear to be very different from . . . usual patients, who are under general anesthesia.⁹⁴

Convincing the decedent's family that their loved one is dead, visual appearances notwithstanding, is an additional special hurdle that must be overcome in the unique circumstance of organ retrieval here under consideration. In cases of unexpected deaths generally, getting the family to accept the fact that their relative has indeed died is difficult enough because the unprepared survivors are in a state of acute distress, typically harbor a sense of unreality, and frequently hold to the possibility that their loved one might still be alive.⁹⁵ The seemingly healthy appearance

⁹⁴ *Organ Retrieval*, *supra* note 34, at 321-22.

⁹⁵ Miles, *supra* note 34, at 154.

of artificially maintained cadavers thus complicates further the task of persuading the family that their relative is in fact dead.

Second, some of the survivors may view the process of organ recovery as itself a disrespectful manner of treating the dead.⁹⁶ Also, family members may believe that organ removal from the deceased will preclude, or negatively affect, the possibility or quality of the afterlife for their loved one.⁹⁷ Mindful of these considerations, the following guidelines are proposed for informing families of deceased declared donors of the death of these individuals and of the process of organ recovery that medical staff will be initiating in deference to the decedent's stated desires to serve as a posthumous organ provider.

B. Protocol Recommendations

1. An appropriate physical setting should be located. Ideally it should be informal, quiet, and private.⁹⁸
2. If the attending physician is to inform the family of their relative's death, then ideally he or she should be accompanied by a nurse to whom the family feels close.⁹⁹
3. Once the family is seated, the physician should announce death briefly and straightforwardly. Equivocation in informing of death, perhaps to soften the blow, is both dishonest and counterproductive since it may contribute to the family's maintaining false hopes for a miraculous recovery.¹⁰⁰

[E]uphemism and ambiguity confuse families, whose comprehension often suffers in such stressful situations. 'Preparing' the expectant listeners with a narrative only torments them. A straightforward 'Mrs. Brown, I'm sorry to tell you that your husband has died' conveys fact and sympathy. Once death has been disclosed, time can be taken to review the illness and mode of death. Silence helps some families most of all. The physician should include any personal recollections - ideally nonmedical - of the patient while talking with the family. Anecdotes embodying concern for the patient's comfort may be consoling. The physician should offer support with statements such as 'He died without pain,' 'She will not suffer any more,' or 'I spoke with the nurse who was with her and . . .'. Precise wording makes little difference; family members clearly perceive honesty and kindness — or lack of concern, for that matter.¹⁰¹

⁹⁶ *Organ Retrieval*, *supra* note 34, at 321-32.

⁹⁷ See Gapen, *supra* note 73.

⁹⁸ Perkins, *The Shortage of Cadaver Organs for Transplantation: Can Psychology Help?*, 42 AM. PSYCH. 921, 925-26 (1987); Schneiderman & Gruhn, *How — and Why — to Request an Autopsy*, 77 POSTGRAD. MED. 153, 156 (1985).

⁹⁹ Schneiderman & Gruhn, *supra* note 98, at 156.

¹⁰⁰ Perkins, *supra* note 98, at 925.

¹⁰¹ Schneiderman & Gruhn, *supra* note 98, at 156.

4. The physician or other appropriate staffperson must explain the concept of brain death and convey to the family that neurologic death is a terminal event; hence, nothing more can be done for the patient.¹⁰²
5. Time should be allotted for the family to absorb the announcement of death and to assimilate the unfamiliar notion of brain death. Some families grasp this idea quickly, others may take hours, or overnight. The family will probably want to see the (artificially maintained) body of their loved one during this period. This should be permitted.
6. When the person who is to inform the family about organ retrieval from their loved one judges that sufficient time has elapsed for the family to ponder and accept the difficult announcement of death, the person should approach the family realizing that the information he or she is about to convey will make it unequivocally clear that there is no basis for continuing hope for a miraculous recovery. The following is an example of the manner in which the needed information might be communicated to a family in this circumstance:

Mrs. Jones (or the Jones family), I know that this is an extraordinarily difficult time for you. As I indicated earlier, we did everything we could for John. I want, however, to relay some information which I hope may bring some measure of consolation to you. Are you aware that in October, 1985, John signed what is called an "organ donor card?" While he was alive, did he ever speak with you about his desire to have his organs made available after death to help save the lives of those waiting to receive transplants? John obviously was a person of moral sensitivity who had a clear perception of a responsibility resting upon us all, namely, to help, where convenient and possible, those whose health and very lives are in serious jeopardy. John's recognizing and responding to this obligation, like the famous Good Samaritan, expresses the best of which any of us are capable. His formally completing a legal donor card is a model for us all. I trust, then, that you will be pleased to learn that this hospital, honoring John's wishes, will shortly begin the process of making John's organs available for transfer to needy individuals some of whom may be saved from death itself by receiving them.

7. The person speaking with the family should hasten to clarify that the required surgery will in no way delay or complicate funeral arrangements, and that the decedent's body will show no scars or disfigurement should it lie in state. If the family asks about which organs are to be taken, and the staffperson has information about this matter, he or she should disclose it.

¹⁰² Weber, *The Human Connection: The Role of the Nurse in Organ Donation*, 17 J. NEUROSURG. NURS. 119, 121 (1985).

8. Should the family express concern that organ removal from their loved one might jeopardize the possibility or quality of the afterlife for the deceased, the following type of reply used by Howard University surgeon Clive Callendar in such situations should in most cases be both appropriate and persuasive: "If God is capable of getting you together, it doesn't matter whether there's almost nothing left or not. If He's going to create the resurrection miracle, He doesn't need your kidneys [or heart, liver, or pancreas, etc.] to do it."¹⁰³
9. The staffperson should also tell the family that following organ retrieval they will have an opportunity to see their loved one again before his or her body is released from the hospital for funeral proceedings. It has been found that "when such an opportunity has been offered, families have chosen it without hesitation."¹⁰⁴ Family members will then be able "to see their loved one after the organs have been taken, the machines have been disconnected, all life functions have ceased, and the loved one seems at peace. The body of the deceased can be appropriately cleaned and covered. Such an arrangement allows for a more traditional farewell and could take place in the recovery room or in an unoccupied operating room."¹⁰⁵
10. The staffperson should also tell the family that he or she will contact them as soon as information is available concerning the types of individuals who have become recipients of their loved one's organs. The organ procurement agency involved typically makes such general information available to the notifying hospital, though the names of recipients and other highly specific information concerning their circumstances are sometimes withheld.

The preceding protocol is consistent with the recommendations made in Parts I and II of this essay. It avoids possible family veto of the stated antemortem consent of the deceased to be a posthumous provider of needed organs. Also, it does not falsely characterize such consent as an act of charity but rather as the fulfillment of a basic moral obligation to assist our vulnerable and helpless brethren in circumstances where such aid can be provided at zero or minimal cost/risk to self. In addition, the protocol remains sensitive to the psychological needs of the grieving family without jeopardizing the paramount values of protecting the declared consentor's right to control the posthumous disposition of his or her body and the saving of human lives through organ transplantation.

Acknowledgement

Brief portions of this article overlap with the text of two prior articles, *Protecting Autonomy in Organ Procurement Procedures: Some Overlooked Issues*, 64 *Milbank Q.* 241-70 (No. 2) (1986) and *Rationales for Organ Donation: Charity or Duty?*, 7 *J. of Medical Humanities and Bioethics* 106-21 (No. 2) (1986). References to prior articles are used with permission of the *Milbank Quarterly* and the *Journal of Medical Humanities and Bioethics*, respectively.

¹⁰³ Reported in Gapen, *supra* note 73.

¹⁰⁴ *Organ Retrieval*, *supra* note 34, at 323.

¹⁰⁵ *Id.*

