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INTRODUCTION

Until the early 1980s, there were not enough successful organ transplantations to create an organ shortage,[1] and "[t]he issue of transplantation remained quiescent for many years."[2] With the introduction of new immunosuppressive drugs, however, organ transplantation therapy became much more viable and the demand for organs began to increase.[3] As a result, in the United States today, there is an inadequate supply of organs available for transplant; in fact, for every available organ, there are approximately three people waiting for transplantation.[4]

At the same time, there are many more cadavers suitable for use as organ donors than are currently being used.[5] The Council of Scientific Affairs estimates that if all usable organs could be retrieved, there would be few shortages, if any, in the supply of organs for transplant.[6] From the beginning of serious transplantation efforts, the problem has been trying to find ethically and morally acceptable ways to retrieve all usable organs,[7] while at the same time respecting the cadaver donors, their families and other social values.

The primary social values involved in cadaveric organ procurement include saving the lives of organ recipients,[8] protecting the potential donor from

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1. Merz, *The Organ Procurement Problem: Many Causes, No Easy Solutions,* 254 J. A.M.A. 3285 (1985).

2. *Ethical, Legal and Policy Issues Pertaining to Solid Organ Procurement: A Report of the Project on Organ Transplantation,* HASTINGS CENTER REP., Oct. 1985, at i [hereinafter *Ethical, Legal and Policy Issues*].

3. Merz, *supra* note 1, at 3285.

4. OFFICE OF ORGAN PROCUREMENT, U.S. DEPT. OF HEALTH & HUMAN SERVICES, REPORT OF THE TASK FORCE ON ORGAN TRANSPLANTATION: ISSUES AND RECOMMENDATIONS 27 (1986) [hereinafter TASK FORCE].

5. *Id.* at 35.

6. Council on Scientific Affairs, *Organ Donor Recruitment,* 246 J. A.M.A. 2157 (1981). *But see* TASK FORCE, *supra* note 4, at 34-35 (discussing the difficulty of accurately estimating the potential cadaveric donor pool).

7. *See Ethical, Legal and Policy Issues, supra* note 2, at 9 (discussing the ethical problems of more efficient alternatives to organ procurement).

8. TASK FORCE, *supra* note 4, at 28.

what some people believe to be over-zealous organ procurers,[9] respecting individual autonomy,[10] "[p]romoting a sense of community through acts of generosity,"[11] showing respect for the decedent,[12] avoiding aggravating the grief caused by the sudden death of a loved one,[13] and respecting religious rights or preferences.[14] Because several of these social values directly involve the family, the family of the potential organ donor has traditionally had a very important role in the procurement of organs.[15]

According to common law, the family has certain rights to the remains of deceased relatives and can control the disposition of the body.[16] While sometimes limiting the family's role, most modern statutes continue to recognize some familial rights and require medical examiners and health officials, where individual consent is absent, to get the family's consent before removing any organs.[17] Finally, medical practitioners also look to the family for consent, even when they are not legally required to do so.[18] These factors combine to create an important role for the family.

The problem with the familial role in organ procurement arises when the family becomes an impediment to the efficient procurement of organs. When this occurs, the goal of saving lives comes into conflict with the goal of protecting familial interests.[19] Requiring familial consent can burden organ procurement in several ways. Doctors hesitate to ask families whether they want to donate the deceased's organs because the doctors are afraid of aggravating the families' grief.[20] Doctors also fear potential tort litigation instituted by the family.[21] Finally, families seldom think about organ donation on their own.[22] Therefore, under statutes, common law doctrine and medical practices that require the family's consent, many organs suitable for transplantation may go unused.

When the family becomes an impediment to the retrieval of organs, lawmakers must decide whether to eliminate or reduce the family's role in

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9. *Id.* at 38; *see also* THE GALLUP ORGANIZATION, INC., GALLUP SURVEY: THE U.S. PUBLIC'S ATTITUDES TOWARD ORGAN TRANSPLANTS/ORGAN DONATION 26 (1985) [hereinafter GALLUP SURVEY].

10. TASK FORCE, *supra* note 4, at 28.

11. *Id.; see also* P. RAMSEY, THE PATIENT AS PERSON 210 (1970).

12. TASK FORCE, *supra* note 4, at 28.

13. Dukeminier & Sanders, *Organ Transplantation: A Proposal for Routine Salvaging of Cadaver Organs,* 279 NEW ENG. J. MED. 413, 416 (1968); *see also* R.G. SIMMONS, S. KLEIN & R.L. SIMMONS, GIFT OF LIFE 338, 355-60 (1977) (discussing the trauma and anguish felt by the family during the organ procurement process).

14. Dukeminier & Sanders, *supra* note 13, at 416-17.

15. *Ethical, Legal and Policy Issues, supra* note 2, at 9.

16. *Id.*

17. *See, e.g.,* UNIF. ANATOMICAL GIFT ACT § 4, 8A U.L.A. 30 (1987 & Supp. 1989).

18. TASK FORCE, *supra* note 4, at 29.

19. *See Ethical, Legal and Policy Issues, supra* note 2, at 9.

20. TASK FORCE, *supra* note 4, at 32.

21. *Id.* at 44.

22. *Id.* at 32.

an effort to procure more organs, or to recognize a familial role in order to protect various social values.[23] As organ transplantation therapy becomes more and more feasible, the demand for organs will increase and the issue of the family's appropriate role will become even more important.

In order to evaluate what the family's role in cadaveric organ procurement should be, it is necessary to examine the family's historical role, its modern role, alternatives to the modern role and the social values involved in cadaveric organ procurement. Part I of this Note discusses the development of the family's role in organ procurement (and the disposition of dead bodies generally) and articulates some of the social values surrounding the family in the context of death, dying and the disposal of corpses. This discussion not only helps to explain some of the reasons for the family's modern role, but also underscores the venerability and magnitude of the values at stake in the general area of cadavers. Part II examines the family's modern role in its various forms and alternatives to this role. Finally, Part III summarizes the relevant social values and evaluates the family's modern role and its alternatives in light of those values. This Note concludes that the family should continue to have a prominent and legally recognized role in cadaveric organ procurement.

I. HISTORICAL DEVELOPMENT OF THE FAMILY'S ROLE

While the phenomenon of organ transplantation is very recent, the values that surround cadaveric organ procurement are much older and are closely related to values involving the disposal of cadavers in general.[24] In fact, some of the first legal requirements for the removal of cadaveric organs evolved out of the family's rights to dead bodies.[25] A brief survey of the historical development of the family's rights and duties in the context of dead body disposal is thus necessary to illuminate some of the reasons for the family's current role in organ procurement.

A. Early Historical Developments

For centuries people have buried, cremated, or otherwise carefully and respectfully disposed of human remains.[26] There is even evidence that the

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23. *See supra* notes 8-14 and accompanying text for a description of the relevant social values.

24. *Compare supra* notes 8-14 and accompanying text *with* Beatty v. Kurtz, 27 U.S. 566, 585 (1829) (affirming an injunction "to preserve the repose of the ashes of the dead, and the religious sensibilities of the living"); Yome v. Gorman, 242 N.Y. 395, 152 N.E. 126 (1926) (wishes of the deceased's wife and next of kin are not always the same); Pettigrew v. Pettigrew, 207 Pa. 313, 56 A. 878 (1904) (no universal rule as to burial of the dead, and each case must consider the public interest, the wishes of the decedent, and the rights and feelings of relatives); Pierce v. Properties of Swan Point Cemetery, 10 R.I. 227 (1872) (relatives of the deceased have an enforceable quasi-property right over the body of the deceased).

25. *See* Dukeminier & Sanders, *supra* note 13, at 413-15.

26. P. JACKSON, THE LAW OF CADAVERS AND OF BURIAL AND BURIAL PLACES 6-18 (2d. ed. 1950).

Neanderthals provided some sort of funeral services as long ago as 100,000 B.C.[27] Whether for religious reasons, habits of veneration, or moral sentiments, the people of various ages and societies have expressed respect for the sanctity of the remains of the deceased in their methods of disposal.[28]

In western societies, the methods of disposal and the rights and duties of various parties were historically governed by the Christian churches. In fact, early Christian burial practices became the body of canon law.[29] In England, the ecclesiastical courts gained control of churchyards and burials by an ordinance of William the Conqueror.[30] Since the ordinance severed temporal and spiritual jurisdictions, the Church gained exclusive control over burials, took bodies "into their actual, corporeal possession," and decided all disputes involving the possession of bodies or the use of holy places.[31]

The Church's exclusive control over dead bodies makes sense in the context of Christian beliefs. When people believe that the souls of the dead go to a heaven or a hell and further believe that the dead will be resurrected with the second coming of the Savior,[32] then the Church would have a natural interest in controlling dead bodies. What is important in the context of organ procurement, however, are the values and concepts that the association between dead bodies and spiritual matters creates. While the official doctrine of most Christian churches in modern times allows for the removal of organs for transplant, some people still refuse to donate their organs in order to keep their bodies intact for a healthy afterlife.[33] Thus, the historical connection between the Church, religion and the disposition of dead bodies introduced religious and spiritual values into the area of cadaveric organ procurement.

During the Church's era of control over the disposition of dead bodies, it not only infused the area of cadaver disposal with spiritual values, it also established a framework of laws and practices that exists to the present day. Under ecclesiastical laws, "[e]very person except the felon, the heretic, and the suicide was entitled to be buried in the consecrated ground of the parish churchyard."[34] In fact, "by ancient practices under canon law, the taking of any fee for a burial was prohibited, the right to burial being one's religious privilege and the necessity of according it a corresponding

27. M. WEISS & A. MANN, HUMAN BIOLOGY AND BEHAVIOR 380-81 (4th ed. 1985).
28. P. JACKSON, *supra* note 26, at 5.
29. *Id.* at 21; *see also* Sanders & Dukeminier, *Medical Advance and Legal Lag: Hemodialysis and Kidney Transplantation,* 15 UCLA L. REV. 357, 395-403 (1968).
30. P. JACKSON, *supra* note 26, at 22.
31. *Id.* at 23.
32. *John* 6:44.
33. TASK FORCE, *supra* note 4, at 38.
34. P. JACKSON, *supra* note 26, at 24.

duty."[35] Thus, under these laws, people gained some burial rights that were protected by the Church.[36]

Analyzing the early history of cadaver disposal helps to explain the sanctity of cadaveric remains, the presence of religious and spiritual values in the organ procurement area and the emergence of the notion that a person has a right to a proper burial. This analysis also indicates the importance of the values involved with the disposition of dead bodies by providing evidence of both the age and universality of these values.

However, since the Church had exclusive control of dead bodies, looking at this early period does not explain the presence of a familial role in cadaveric organ procurement. For such an explanation, it is necessary to look to later historical developments.

B. Early Historical Developments in America

While the ecclesiastical regulations of dead bodies survived in England until the adoption of the English Burial Acts in the 1850s,[37] they were never controlling in the United States. Americans "have never considered [them]selves bound by the ecclesiastical decisions, many of which were inapplicable to [the American] form of government."[38] Consequently, while still being influenced by the structure and ideas of ecclesiastical law, the American courts found a lack of precedent as to who should control the remains.[39] To fill the vacuum, the courts decided that the family would have the duty to provide the burial and a corresponding right to control the disposition of their relatives' remains.[40]

Exactly why the courts gave such rights and duties to the family instead of some other individual or institution, such as the executor or the courts themselves, is not entirely clear. However, the early cases seem to be concerned with the family's emotions and sensibilities.[41] In addition, since the family members would generally be those people most concerned about the deceased's remains, they would probably be those most likely to be

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35. *Id.*

36. Later under American law, the family replaced the Church as the protector of the decedent's "right" to a decent burial. The point is, however, that while a different entity became the protector of the "right," the "right" persisted into modern times nonetheless. *See infra* note 40 and accompanying text.

37. P. JACKSON, *supra* note 26, at 22.

38. *Id.* at 26.

39. *See id.*; *see also* Cohen v. Congregation Shearith Israel, 99 N.Y.S. 732 (1906), *aff'd*, 189 N.Y. 528, 82 N.E. 1125 (1907).

40. *See Yome*, 242 N.Y. at 395, 152 N.E. at 126; *Pettigrew*, 207 Pa. at 313, 56 A. at 878; *Pierce*, 10 R.I. at 227.

41. *See Beatty*, 27 U.S. at 566; *Yome*, 242 N.Y. at 395, 152 N.E. at 126; *Pettigrew*, 207 Pa. at 313, 56 A. at 878; *Pierce*, 10 R.I. at 227.

willing to protect the remains and bear the burden of providing for the burial.

When the courts adjudicated cadaver disposition cases, they articulated many of the same values that arise today in cadaveric organ procurement. In 1829, Justice Story of the United States Supreme Court thought that the Court of Chancery should use its injunctive power "to preserve the repose of the ashes of the dead, and the religious sensibilities of the living."[42] Later, the highest courts of Rhode Island,[43] New York[44] and Pennsylvania[45] articulated the following similar values as worthy of protection: respecting the wishes of the decedent, the wishes of the decedent's spouse, family and friends, and protecting public health.

Recognizing such values, the common law courts established an important role for the family, especially when the wish of the decedent was "casually or lightly" declared.[46] In some cases the family's wishes could even override the decedent's own wishes as expressed in his or her will.[47] For example, in *Holland v. Metalious*[48] the deceased had willed her remains to a university for medical research.[49] After the university refused to accept the remains, the family decided to hold funeral services even though the deceased specifically requested that there be no funeral services. In a dispute between the family and the executor of the deceased's will, the court found for the family and allowed the funeral services to be performed.[50] Cases such as *Holland* indicate the importance of values other than personal autonomy; courts have recognized the feelings and sensibilities of the living family members as critically important, even to the point of being dispositive.

Evolving from early ecclesiastical laws where the Church controlled the disposition of bodies, and religious values predominated in the area, American common law courts established the family as the entity responsible for the body's disposal. By giving some weight to the deceased's own indications of preference for the method of disposal, the courts recognized a form of personal autonomy. However, by allowing the wishes of the family to be heard and, at times, even override the wishes of the deceased, the courts recognized and protected the family's decision and sensibilities. Finally, while no longer allowing the Church to control dead bodies, courts continued

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42. *Beatty*, 27 U.S. at 585.
43. *Pierce*, 10 R.I. at 227.
44. *Yome*, 242 N.Y. at 395, 152 N.E. at 126.
45. *Pettigrew*, 207 Pa. at 313, 56 A. at 878.
46. *Yome*, 242 N.Y. at 404, 152 N.E. at 129 (dictum).
47. Sanders & Dukeminier, *supra* note 29, at 400; *see also infra* notes 48-50 and accompanying text.
48. 105 N.H. 290, 198 A.2d 654 (1964).
49. *Id.* at 292, 198 A.2d at 655.
50. *Id.* at 294, 198 A.2d at 656.

to give due weight to religious values, especially as they were expressed by the decedent.[51]

C. *Early American Statutes on Organ Procurement*

Doctors could not confidently remove organs based on the decedent's consent alone, because the family played such an important role and because the questions of whose consent would control were unsettled at common law.[52] In response to this uncertainty and the inadequacy of the number of organs acquired from family donations, the National Commissioners on Uniform State Laws formulated the first Uniform Anatomical Gift Act (UAGA) in 1968.[53]

With the 1968 UAGA and the statutes modeled after it, legislators attempted to reduce the family's role and use individual consent in order to procure more organs.[54] The first UAGA essentially embodied the doctrine of "encouraged voluntarism" as developed by Sadler and Sadler.[55] Using this doctrine, the Act allowed and encouraged individuals to donate their organs by signing donor cards.[56] Under the Act, if a person completed an organ donor card before he or she died, then hospitals could use the organs without infringing on the decedent's autonomy and without encountering the legal impediments of the traditional common law rights of the family.[57] Accordingly, the Act allowed medical practitioners to remove organs without familial consent when the individual had completed a donor card.[58] However, even where the individual had not completed a donor card, the Act allowed families to donate organs when the deceased had not expressed his or her wishes.[59]

Using such an approach, legislators attempted to promote two important values in the organ procurement area. They tried to increase the supply of organs and they sought to protect individual autonomy.[60] However, by emphasizing individual consent, the Act sacrificed some of the familial

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51. *Yome,* 242 N.Y. at 402-03, 152 N.E. at 128. Justice Cardozo stated that "[t]he wish of the deceased, even though legal compulsion may not attach to it, has at least a large significance. Especially is this so when the wish has its origin in intense religious feeling." *Id.* (citations omitted).

52. Sanders & Dukeminier, *supra* note 29, at 395, 402.

53. Caplan, *Organ Transplants: The Costs of Success,* 13 HASTINGS CENTER REP., Dec. 1983, at 23; *see also* UNIF. ANATOMICAL GIFT ACT (1968) (amended 1987).

54. *Ethical, Legal and Policy Issues, supra* note 2, at 9.

55. Sadler, Sadler, Stason & Stickel, *Transplantation: A Case for Consent,* 280 NEW ENG. J. MED. 862 (1969); *see also* Sadler, Sadler & Stason, *The Uniform Anatomical Gift Act,* 206 J. A.M.A. 2501 (1968).

56. UNIF. ANATOMICAL GIFT ACT § 4 (1968) (amended 1987).

57. *Ethical, Legal and Policy Issues, supra* note 2, at 9.

58. UNIF. ANATOMICAL GIFT ACT § 4 (1968) (amended 1987).

59. *Id.* at § 2.

60. Sadler, Sadler, Stason & Stickel, *supra* note 55, at 862.

values recognized by the common law.[61] Even if the individual had consented, taking the organs without the family's consent might aggravate the family's grief. In addition, allowing the individual to determine the disposition of his or her own remains conflicted with the notion that the family's will could sometimes take precedence over the individual's wishes.[62]

For various reasons, the UAGA of 1968 failed to work as planned. Only seventeen percent of the people surveyed by Gallup in 1985 had signed a donor card.[63] People indicated that their fear of doctors hastening their death to get their organs, distaste for thinking about death, religious objections and other concerns influenced their decision not to sign donor cards.[64] In addition, even when people had signed donor cards, doctors and procurement agencies were reluctant to use the organs without the family's consent.[65] In this instance, the medical profession seemed to be more concerned about the family's grief and the family's right to make the final determination than was the early UAGA. Thus, one of the reasons for the UAGA's failure appears to be its disregard for those social values surrounding the family. Regardless of the reason for the UAGA's failure, its failure caused many people to call for reforms of organ procurement laws. With the introduction of these reforms and the greater need for organs, the family's modern role in cadaveric organ procurement began to develop.

II. Modern Role of the Family and Alternatives

In response to both the values surrounding cadaveric organ procurement and the historical development of the family's role, the courts, legislative bodies and the medical profession all established laws, rules and practices that make up the family's modern role.

A. Court Actions

While legislative acts have reduced the importance of the courts for determining the family's role in organ procurement,[66] the courts continue to help define the family's role in two ways. First, where events surrounding organ donations fall outside the scope of a statute, the family's common law rights to control the disposition of a relative's body re-emerge.[67] Second,

61. *See* P. Ramsey, *supra* note 11, at 199-200.
62. *See supra* notes 46-50 and accompanying text.
63. Gallup Survey, *supra* note 9, at 19.
64. *Id.* at 26.
65. Task Force, *supra* note 4, at 29.
66. *See infra* note 74 and accompanying text.
67. *See* Kirker v. Orange County, 519 So. 2d 682, 684 (Fla. App. 1988); Strachan v. John F. Kennedy Memorial Hosp., 109 N.J. 523, 538 A.2d 346 (1988).

courts decide whether the family has any constitutionally protected rights to the decedent's remains.

1. Common Law Rights

Under the common law, a family has a quasi-property right in the remains of its deceased relatives.[68] Accordingly, the courts will enforce the family's right to have the body for burial "in the condition found when life became extinct."[69] Any infringement of this right may be redressed by an action in damages.[70] While this right has been called a quasi-property right, most modern courts and commentators conclude that it has nothing to do with property. Instead, it "is something evolved out of thin air to meet the occasion, and . . . in reality the personal feelings of the survivors are being protected, under a fiction likely to deceive no one but a lawyer."[71] Even though the family's right to the corpse is now explicitly based on protection from mental distress rather than quasi-property rights,[72] courts continue to protect the right.[73]

Modern organ procurement statutes modeled after the UAGA limit the family's common law rights to the decedent's remains. Section 11 of the UAGA states, "A hospital, [or] physician, . . . who acts in accordance with this [Act] . . . or attempts in good faith to do so is not liable for that act in a civil or criminal proceeding."[74] While section 11 provides protection to doctors and hospitals in most instances, there still exists the possibility that someone could face civil liabilities arising from the family's common law rights.

By definition, if someone does not act in accordance with the UAGA or make a good faith effort to do so, he or she would not be protected by section 11.[75] For example, a doctor could remove an organ without making a good faith effort to obtain consent as required by sections 4 and 11.[76] Since the doctor would have infringed upon the family's right to have the

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68. Pierce v. Proprietors of Swan Point Cemetery, 10 R.I. 227 (1872); *see also* Fuller v. Marx, 724 F.2d 717, 719 (8th Cir. 1984); *Strachan,* 109 N.J. at 531, 538 A.2d at 350.

69. *Kirker,* 519 So. 2d at 684; *see also Strachan,* 109 N.J. at 531, 538 A.2d at 350.

70. *Strachan,* 109 N.J. at 531, 538 A.2d at 350 (quoting Spiegel v. Evergreen Cemetery Co., 117 N.J.L. 90, 93, 186 A. 585 (1936)).

71. W. KEETON, D. DOBBS, R. KEETON & D. OWEN, PROSSER & KEETON ON THE LAW OF TORTS § 12 at 63 (5th ed. 1984) [hereinafter PROSSER & KEETON]; *see also Strachan,* 109 N.J. at 531, 538 A.2d at 350; State v. Powell, 497 So. 2d 1188, 1192 (Fla. 1986), *cert. denied,* 481 U.S. 1089 (1986).

72. *Strachan,* 109 N.J. at 531, 538 A.2d at 350.

73. *See id.; see also Kirker,* 519 So. 2d at 682.

74. UNIF. ANATOMICAL GIFT ACT § 11 (1987 & Supp. 1989).

75. *Id.*

76. UNIF. ANATOMICAL GIFT ACT §§ 4, 11 (1987 & Supp. 1989).

body "in the condition found when life became extinct,"[77] the doctor would be liable under the common law.

Just such a case occurred recently in Florida. A medical examiner removed the eyes and corneas of a deceased infant after the mother had expressly objected to the procedure.[78] The court held that the immunity provision in the state's organ procurement statute did not apply to the defendant's actions because the mother had expressly objected to the procedures.[79] Thus, when the action of removing organs is beyond the scope of the organ procurement statute or when the removal is not performed in good faith, the family's common law right to the remains of their deceased relatives can re-emerge.

The re-emergence of the family's right in these situations creates a "watchdog" role for the family. Since they have the power to sue medical practitioners for non-compliance with the statute, families ensure that those dealing with corpses will comply with the appropriate statutory provisions. By creating such a right for the family, courts not only recognize the family's own interests in controlling the deceased's remains (*e.g.*, avoiding aggravation of the family's grief), they also make the family the primary mechanism for protecting both the donor's interests (safety and autonomy) and society's interests (*e.g.*, decent burials).[80]

2. Constitutional Rights

As interpreted to date, the family has no constitutional right to control the disposition of its relative's remains.[81] When arguing for such rights, plaintiffs and commentators typically assert constitutional rights to property, privacy or religious freedom.[82]

The Georgia Supreme Court, in *Georgia Lions Eye Bank v. Lavant*,[83] has stated that there is no property right to the remains of a deceased's body. Neither the United States Constitution, nor the common law predating the Constitution recognizes any sort of property right in corpses.[84] Instead, the quasi-property right recognized at common law is simply court-made doc-

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77. *Kirker*, 519 So. 2d at 684.

78. *Id.*

79. *Id.*

80. *See Ethical, Legal and Policy Issues, supra* note 2, at 2 for an indication of the use of informed consent as a mechanism for protecting various social values.

81. The United States Supreme Court has not addressed this issue, *but see Powell*, 497 So. 2d at 1188; Georgia Lions Eye Bank v. Lavant, 255 Ga. 60, 335 S.E.2d 127 (1985).

82. *See Powell*, 497 So. 2d at 1192-93; *Lavant*, 255 Ga. at 60, 335 S.E.2d at 127; *see also* Johnson, *Sale of Human Organs: Implicating A Privacy Right*, 21 VAL. U.L. REV. 741 (1987); Merriken & Overcast, *Governmental Regulation of Heart Transplantation and the Right to Privacy*, 11 J. CONTEMP. L. 481 (1985).

83. 255 Ga. at 60, 335 S.E.2d at 127.

84. *Id.* at 61, 335 S.E.2d at 128.

trine that seeks to assuage the family's emotional grief.[85] Accordingly, so-called property rights do not impose any sort of limitation on the legislature when it enacts laws concerning the disposition of corpses, including organ removal.[86]

While the *Lavant* court discusses the legislature's important purpose in creating organ procurement statutes,[87] and thereby implies a balancing test, there is really no need for any balancing. Since the family never had any real property rights in the corpse, organ procurement statutes take nothing actually belonging to the family. This is so even where the statutes allow for the removal of organs without consent. Consequently, no matter what the legislature's purpose for creating the statute, a court-made quasi-property right should in no way limit the legislature's actions. Justice Weltner, writing for the majority in *Lavant,* echoes this argument: "A person has no property, no vested interest, in any rule of the common law . . . [therefore] the law itself, as a rule of conduct, may be changed at the will, or even at the whim, of the legislature . . . ."[88]

One year after *Lavant,* the Florida Supreme Court rejected a similar claim to a constitutionally protected property right in corpses.[89] The court also distinguished constitutional rights to privacy, stating that right to privacy cases all involve relationships among living persons.[90] Since the removal of organs from cadavers occurs only after the donor is dead, there is no relationship among living persons.[91] Once again, under this analysis, the legislature is free to enact organ procurement statutes for any reason whatsoever.

The only constitutionally-based challenge to organ procurement statutes left open by the courts is a first amendment religious objection. The *Powell* court acknowledged this argument, but left the question open since the plaintiff failed to raise it.[92] This issue, however, is beyond the scope of this Note because no court has ruled on the challenge and the issue involves speculation.

As mentioned above, the courts do influence and enhance the family's role in the organ procurement area. In the absence of relevant statutory prohibitions, the courts still allow family members to recover for their emotional pain and suffering.[93] By doing so, the courts implicitly recognize those social values that respect the family's emotions in reaction to death

85. *Id.*
86. *Id.* at 61-62, 355 S.E.2d at 128-29.
87. *Id.* at 62, 355 S.E.2d at 129.
88. *Id.* at 61, 355 S.E.2d at 128 (quoting Munn v. Illinois, 94 U.S. 113, 134 (1876)).
89. *Powell,* 497 So. 2d at 1193.
90. *Id.*
91. *See id.*
92. *Id.*
93. *See supra* notes 78-79 and accompanying text.

and dying. In addition, the courts establish the family as the primary mechanism for protecting various social values. While these judicial decisions are relevant to any analysis of the family's role in cadaveric organ procurement, the courts do not define the essence of the family's modern role. Since the courts have refused to recognize any constitutional rights in the area of organ procurement and every state legislature has enacted relevant statutes,[94] legislatures are more important in defining the modern family role in organ procurement.

B. Legislative Actions

Modern organ procurement statutes typically try to respond to the 1968 UAGA's failure to procure sufficient organs to meet the demand.[95] In doing so, the statutes follow one of two approaches. In most cases, legislators attempt to procure more organs by increasing the role of familial consent. However, legislators sometimes try to procure organs by reducing *both* the individual's and the family's role.

1. "Required Request"

In 1983 and 1984, Arthur Caplan argued strenuously for reform of donation laws.[96] He contended that, in order to take advantage of the willingness of families to donate their relatives' organs, society needed laws requiring that someone in hospitals ask families for the organs.[97] Caplan argued that these laws would compensate for the public's reluctance to fill out donor cards and the doctors' reluctance to ask families for donations.[98] He compared organ donations to blood donations and concluded that "requests" were needed to stimulate altruism.[99]

"Required request" laws take a variety of forms. Typically, however, they either force hospitals to inform the "appropriate parties" of the opportunity to give organs, or they require that hospitals actually ask for organs whenever the cadaver is in suitable condition.[100] These laws have a

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94. UNIF. ANATOMICAL GIFT ACT (1987 & Supp. 1989).

95. Caplan, *supra* note 53, at 24; *see also* UNIF. ANATOMICAL GIFT ACT (1987 & Supp. 1989); TASK FORCE, *supra* note 4.

96. Caplan, *supra* note 53; Caplan, *Organ Procurement: It's Not in the Cards,* 14 HASTINGS CENTER REP., Oct. 1984, at 9 [hereinafter *Organ Procurement*].

97. *Organ Procurement, supra* note 96, at 12.

98. *Id.*

99. *Id.*

100. *See, e.g.,* UNIF. ANATOMICAL GIFT ACT § 5 (1987 & Supp. 1989); *see also* TASK FORCE, *supra* note 4, at 31-34.

great impact on the role of the family because the family is usually the "appropriate party."[101]

As the shortages of organs continued to grow under the old laws, the federal government passed the National Organ Transplant Act establishing the Task Force on Organ Transplantation.[102] After a detailed study, the Task Force strongly recommended that "required request" policies and statutes be adopted on both state and federal levels.[103]

Recognizing the failure of the 1968 UAGA, the National Conference of Commissioners on Uniform State Laws reacted by amending the UAGA in 1987.[104] While in form the amended Act appears to preserve the 1968 UAGA's preference for individual consent, in practice it elevates the family's role to that of the primary agent of consent.

The Act does retain those provisions that allow people to donate their organs before they die by filling out organ donation cards.[105] However, when enacting the amendments, the commissioners were aware of the problems with voluntary organ donation. Specifically, they knew that few people signed organ donor cards and that, even when the cards were signed and available, doctors would not retrieve the organs without the additional consent of a family member.[106] Accordingly, the commissioners must have realized that simply continuing to allow voluntary individual donations would do little to increase the supply of organs. Therefore, the provisions relating to familial consent and "required request" are the essence of the amended Act.

Section 3 of the 1987 UAGA[107] establishes the family's role by allowing family members to donate the organs of deceased relatives. It also establishes a hierarchy within the family, thereby increasing the efficiency of the familial consent mechanism by indicating levels of authority in case of disagreement among family members.[108] Section 3, however, is relatively unchanged from the 1968 version of the Act.[109] More important to the family's role is the

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101. In cadaveric organ procurement, the patient is by definition dead. In addition, many cadaver donors died suddenly, so that the hospital would never have a chance to ask the organ donor about donation. R.G. SIMMONS, S. KLEIN & R.L. SIMMONS, *supra* note 13, at 339-42. Therefore, the family will often be the only available party from whom consent can be acquired.

102. TASK FORCE, *supra* note 4, at 1; National Organ Transplant Act, Pub. L. No. 98-507, 98 Stat. 2339 (1984) (codified at 42 U.S.C. §§ 201, 273-274 (Supp. 1987)).

103. *Id.* at 31-34. Over the last couple of years a majority of states have adopted "required request" or similar statutes. Martyn, Wright & Clark, *Required Request for Organ Donation: Moral, Clinical and Legal Problems,* 18 HASTINGS CENTER REP., Apr.-May 1988, at 27, 33 n.2.

104. UNIF. ANATOMICAL GIFT ACT (prefatory note) (1987 & Supp. 1989).

105. *Id.* at § 2.

106. *Id.* at prefatory note.

107. *Id.* at § 3.

108. *Id.*

109. UNIF. ANATOMICAL GIFT ACT § 2 (1968) (amended 1987).

addition of Section 5: "Routine Inquiry and Required Request, Search and Notification."[110]

Section 5 requires that a representative of the hospital discuss the option of making an anatomical gift with the patient while alive or with the family at the time of death.[111] As a practical matter, the addition of section 5 places the family at the forefront of the procurement effort. Since the dying or deceased individual is usually unable to talk to hospital representatives,[112] the family becomes the practical focus of the "routine inquiry" or "required requests."[113] Accordingly, "required request" laws at least maintain and will probably increase the family's role in cadaveric organ procurement.

2. "Presumed Consent"

A few states have enacted "presumed consent" laws.[114] These statutes presume that dying individuals would consent to organ donation if they had the opportunity.[115] Pursuant to this presumption, these statutes typically allow medical examiners to remove organs without giving notice or obtaining anyone's consent.[116] Under this scheme, the burden for objecting to organ donation rests on the individual before death or on the family. Since there is no notice requirement, families are sometimes unaware that organ removal will occur and have no real opportunity to refuse.[117]

Using presumptions of consent, "presumed consent" laws attempt to reduce both the individual's and the family's roles in order to maximize the number of organs retrieved.[118] Overall, however, these laws are not very important in the United States. They exist in only a few states and typically apply only to such organs as corneas.[119] "Presumed consent" does, however, provide an important model of reform.

In 1968, when the policies of "encouraged voluntarism" were adopted by the UAGA, the most significant alternative model was "presumed consent."[120] As recently as 1983, Arthur Caplan supported "presumed consent" as a method of addressing the failures of the 1968 UAGA.[121]

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110. UNIF. ANATOMICAL GIFT ACT § 5 (1987 & Supp. 1989).
111. *Id.*
112. R.G. SIMMONS, S. KLEIN & R.L. SIMMONS, *supra* note 13, at 339-42.
113. *See supra* note 101 and accompanying text.
114. *Ethical, Legal and Policy Issues, supra* note 2, at 20.
115. Dukeminier & Sanders, *supra* note 13, at 418; *see also Lavant,* 255 Ga. at 60, 355 S.E.2d at 128.
116. Dukeminier & Sanders, *supra* note 13, at 418; *see also Powell,* 497 So. 2d at 1193.
117. *Lavant,* 255 Ga. at 60, 355 S.E.2d at 128.
118. *See* Sanders & Dukeminier, *supra* note 29, at 395-403; *see also* Caplan, *supra* note 53, at 27-28.
119. *Ethical, Legal and Policy Issues, supra* note 2, at 20.
120. Sanders & Dukeminier, *supra* note 29, at 410-13; *see also* Caplan, *supra* note 53, at 23.
121. Caplan, *supra* note 53, at 27-32.

While this model has now been overshadowed by the "required request" model,[122] legislators may be tempted to adopt "presumed consent" statutes and to eliminate the family's role entirely should current reforms fail to produce a sufficient supply of organs.[123]

C. *Medical Profession*

While legislators try to define the family's precise role with statutory provisions, the medical profession often refuses to follow the applicable laws. By doing so, doctors create a role for the family that may differ from the theoretical legal role. Both the 1968 and 1987 UAGAs allow doctors to remove organs with the donor's consent alone. For example, section 2(h) of the 1987 UAGA provides that "[a]n anatomical gift that is not revoked by the donor before death is irrevocable and does not require the consent or concurrence of any person after the donor's death."[124] In addition, doctors are immune from civil and criminal liability to the extent that they comply with the statute.[125] However, doctors and organ procurement agencies rarely attempt to remove organs without first obtaining the consent of the deceased's family, even when the deceased has signed an organ donor card.[126]

This phenomenon also occurs in countries that have adopted "presumed consent" laws.[127] In France, for example, where doctors do not even need a signed donor card in order to remove organs,[128] "French physicians find it psychologically intolerable to remove tissues from a body without obtaining the permission of next-of-kin."[129]

Several reasons exist to explain this reluctance. First, as previously indicated, there seems to be a psychological unwillingness on the part of doctors to remove organs without the family's consent. Second, organ procurement agencies and hospitals are naturally hesitant to become embroiled in disputes and litigation about their rights to take organs since they rely on the public's good will for support. Finally, as suggested by Caplan, "[p]hysician noncompliance appears to be primarily a result of the resentment held by

122. The National Task Force on Organ Transplantation, for instance, has recommended "required request" legislation. TASK FORCE, *supra* note 4, at 31-34. In addition, several states have already adopted "required request" laws. *See supra* note 102.

123. Caplan indicates the possibility of failure when he alludes to the reluctance of physicians to conform to the new "required request" laws. Caplan, *Professional Arrogance and Public Misunderstanding*, 18 HASTINGS CENTER REP., Apr.-May 1988, at 34-35.

124. UNIF. ANATOMICAL GIFT ACT § 2(h) (1987 & Supp. 1989).

125. *Id.* at § 11.

126. TASK FORCE, *supra* note 4, at 29.

127. *Organ Procurement, supra* note 96, at 10-11.

128. *Id.* at 11.

129. *Id.*

physicians against nonphysicians, most specifically legislators and bureaucrats, about being told what they *must* do."[130]

Through their attitudes and practices, doctors can significantly affect the family's role. When legislators adopted the "encouraged voluntarism" approach of the 1968 UAGA, they intended to reduce the family's role and encourage organ donations by looking to the individual for consent.[131] Doctors, however, resisted the change and continued to require familial consent. Consequently, doctors ensured the continuance of the family's traditional role as developed by the courts.[132] Since legislators are now beginning to re-emphasize the family's role by adopting "required request" laws, the family's legal role will again correspond to its practical role as preserved by doctors.[133] However, should legislators attempt to reduce the family's role by enacting "presumed consent" laws, they will find a significant barrier in the medical profession's unwillingness to comply.

III. Evaluation of the Family's Role

In order to evaluate the family's proper role in cadaveric organ procurement, it is necessary to articulate the primary values surrounding organ procurement, death, dying and the disposition of dead bodies.

A. Value of Organ Transplants for Saving Lives and Improving Health

Improving health, enhancing comfort and preserving life are some of our society's most important values. These values motivate people to spend vast amounts of time and resources to procure and transplant organs.[134] Dukeminier and Sanders state that "[s]aving life is a central ethical principle of medicine, law and religion. Applied to homotransplantation, this principle means that cadaver organs should be used to save the life of some living person."[135]

While the concept of saving lives and improving health through organ transplantation seems very noble, our society may not be as committed to this type of medical procedure as Dukeminier and Sanders suggest. Certain

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130. Caplan, *supra* note 123, at 35 (referring to physician noncompliance with "required request" laws).

131. *See supra* note 54 and accompanying text.

132. *See supra* notes 66-80 and accompanying text.

133. *But see* Caplan, *supra* note 123, at 35 (indicating that doctors are not completely complying with "required request" laws).

134. Task Force, *supra* note 4, at 28. For a particularly poignant illustration of the emotional force of these values, see Squadron, *Two Lives on Hold,* N.Y. Times, Dec. 19, 1988, (Magazine) at 39 (describing the turmoil of a couple waiting for an organ donation).

135. Dukeminier & Sanders, *supra* note 13, at 416.

portions of society, especially older generations, sometimes believe that what a person receives in the form of original organs is fate.[136] Accordingly, some people view the opportunity to obtain a transplanted organ as a matter of luck for which society should not spend vast resources. The great majority of Americans, however, support organ transplantation, and even consider it praiseworthy.[137] In addition, as the feasibility of organ transplantation improves and the frequency of the procedure increases, it is plausible that societal acceptance will improve.

Even if society values organ transplantation as a means of prolonging life and improving health, people must still decide whether they are willing to bear the extraordinarily high costs of this medical procedure. Martyn, Wright and Clark estimate that the average kidney transplantation costs $30,000, heart transplantation, $110,000 and liver transplantation, $240,000.[138] In 1986, the federal government alone spent two billion dollars on dialysis and kidney transplantations through its End Stage Renal Disease program.[139] If the federal government decides to adopt the recommendations of the National Task Force on Organ Transplantation and assume the costs of liver and heart transplantations,[140] the costs of transplantation therapy to the government will be much higher.[141]

Martyn, Wright and Clark argue that "[i]t is an inescapable fact that we do not have an unlimited ability to pay for any and all health care. Our health care budget has limits . . . ."[142] The reality of this conclusion is illustrated by the recent decisions of some states to refrain from developing "formal policies regarding payment for heart and liver transplants . . . in the absence of more definitive information regarding long-term costs."[143] In France (where organ transplantation therapy has been encouraged through "presumed consent" laws), doctors and nurses recognize the high costs of organ transplantation: "Given the growing concern in France over the rising costs of health care there is a reluctance to devote scarce medical resources to organ procurement."[144]

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136. Surveys indicate "that older persons are less positive toward organ transplantation and toward nontraditional methods of handling death . . . . One respondent said, 'My mother had absolute fits. She is extremely religious and she feels you are given one set of organs and if something goes wrong with them, that's it.'" R.G. SIMMONS, S. KLEIN & R.L. SIMMONS, *supra* note 13, at 346.

137. TASK FORCE, *supra* note 4, at 37-38; *see also* GALLUP SURVEY, *supra* note 9, at 23 ("A high proportion (74%) of the respondents disagree with the statement that it is wrong to prolong life through the use of human transplants, but one in four have some reservations.").

138. Martyn, Wright & Clark, *supra* note 103, at 30-31.

139. *Id.* at 34 n.28 (The End Stage Renal Disease program is a medicare program designed to pay for the costs of dialysis and kidney transplantations.).

140. TASK FORCE, *supra* note 4, at 105.

141. Martyn, Wright & Clark, *supra* note 103, at 31. *Compare* TASK FORCE, *supra* note 4, at 105, 225-27 (indicating much lower costs than those estimated by Martyn, Wright & Clark).

142. Martyn, Wright & Clark, *supra* note 103, at 30.

143. TASK FORCE, *supra* note 4, at 100.

144. Caplan, *supra* note 96, at 11.

The implication of this cost analysis is that our society will have to sacrifice other important medical procedures if it pursues organ transplantation. Therefore, legislators should first determine the total number of organs they will attempt to procure before they decide the extent of the family's role in individual cases. If legislators decide that health care dollars are better spent on other medical procedures, then it will no longer be necessary to enlist the family in an attempt to procure more organs. The relative value of organ procurement is open to debate; however, this Note's scope is not broad enough to allow for a detailed analysis of the ultimate worth of devoting vast medical resources to organ transplantation.[145]

B. The Family as an Impediment to Organ Procurement

Even assuming that society is willing to bear the cost of transplantations, there is no reason to eliminate the family's role unless the family significantly interferes with the procurement of organs. In the past, commentators have argued that the family does become an obstacle to organ retrieval when laws require familial consent.[146] This can occur in two ways. First, the family's exercise of its right to refuse a donation will preclude the retrieval of an organ. Second, the family will not often think of donating on its own.[147]

Concededly, no doctor or organ procurement agency will take organs from a deceased individual if the family vetoes the decedent's organ donation.[148] Accordingly, frequent familial denials would result in fewer available organs. However, a 1985 Gallup Survey indicates that "a substantial majority (71%) of those aware of organ transplants say they are very likely to give permission to have the organs of a loved one donated after that person's death."[149] An additional 14% indicate that they are "[s]omewhat [l]ikely" to give permission.[150] Given these findings, it is unlikely that the family's ability to deny organ removal significantly impedes procurement.

The family's willingness notwithstanding, it is common for families to forget about the organ donation option when they are beset with grief.[151]

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145. *See* Martyn, Wright & Clark, *supra* note 103, at 31.

> [I]t is plausible to assume that increased costs in one area of the health care budget will have an impact on overall expenditures for health care. The voiceless and under-represented groups in our society, the poor, racial minorities, and the elderly, are most likely to suffer the burden of cutbacks in the provision of other forms of health care.

Id.

146. *See* Sanders & Dukeminier, *supra* note 29, at 395, 399; *see also Ethical, Legal and Policy Issues, supra* note 2, at 9.

147. TASK FORCE, *supra* note 4, at 31-32.

148. *Id.* at 29.

149. GALLUP SURVEY, *supra* note 9, at 12.

150. *Id.*

151. TASK FORCE, *supra* note 4, at 32.

Compounding this problem is doctors' reluctance to approach families about donations.[152] Doctors believe that asking family members to donate will cause them to experience more stress.[153] In addition, doctors sometimes feel that they have failed the family by letting the patient die, and are thus reluctant to ask anything of the family.[154]

However, switching to a system of "presumed consent" will not greatly increase the supply of organs. As reported by some, "presumed consent" laws do help to increase the supply of organs; they do not, however, completely solve the problem.[155] In countries that have adopted "presumed consent" laws, waiting lists for organs remain.[156] Doctors in France still seek familial approval of organ removal, even though the law allows them to remove organs without anyone's consent.[157] In this country, doctors are reluctant to remove organs without familial consent even when the donor has filled out an organ donor card.[158] This reluctance suggests that doctors would continue to seek familial consent even if "presumed consent" laws became widespread in the United States.

Since physicians are the primary obstacle to efficient organ procurement, legislators should focus on the role and activities of medical practitioners.[159] For example, more professional education concerning death and dying situations should reduce doctors' reluctance to discuss organ donation with grieving families.[160] In addition, restructuring the role of the medical profession, as opposed to attempting to reduce the family's role, will not infringe on those social values that dictate familial involvement in organ procurement.[161]

C. Values Involving the Family and Cadaver Donors

Assuming, arguendo, that society values organ transplantation, that society is willing to bear the costs of this procedure, and that the family is an actual impediment to organ procurement, several reasons exist for maintaining the family's role in cadaveric organ procurement. Most impor-

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152. *Id.* at 44.

153. "Physicians and nurses may be reluctant to discuss organ donation with potential donor families, fearing that this will cause the families more stress." *Id.* (citation omitted).

154. *Id.*

155. *Organ Procurement, supra* note 96, at 11 (reporting on French and other European "presumed consent" laws).

156. *Id.*

157. *Id.*

158. *See supra* note 126 and accompanying text.

159. *See* Caplan, *supra* note 123, at 37 (recommending education for health care professionals about their duties concerning organ and tissue procurement).

160. *See* Sadler & Sadler, *A Community of Givers, Not Takers,* 14 HASTINGS CENTER REP., Oct. 1984, at 6, 8-9; *see also* Caplan, *supra* note 123, at 34.

161. *See infra* note 163 and accompanying text.

tantly, several social values necessitate familial involvement. These values include protecting the potential donor from what some people believe to be over-zealous organ procurers, respecting individual autonomy, "promoting a sense of community through acts of generosity," showing respect for the decedent, avoiding the aggravation of the grief caused by the sudden death of a loved one, and respecting religious rights or preferences.[162] These values involve the family in three discrete ways. The family's consent can be used as a mechanism to protect social values; the family's consent can be used to promote community; and the family is important in its own right.

1. Familial Consent Mechanism

Familial consent is used as a mechanism to protect the donor's autonomy before and after death.[163] Justified or not, many people fear that a doctor will falsely pronounce them dead in order to get their organs.[164] One way to protect people from such an event, or at least to address their fears, is to require familial consent for organ donations. Assuming that family members care about their dying relatives, they would be the ones most likely to try to protect the donor from over-zealous doctors. Society could look to the courts to protect these donors by requiring courts to make a declaration of death before any organ removals were allowed; however, the severe time limitations on organ procurement require someone who can be at the hospital immediately.[165] In addition, requiring court supervision would further encumber the legal system.

A requirement of familial consent can also protect the donor's autonomy.[166] To a great extent, society would like to recognize an individual's own wishes regarding his or her remains.[167] As recognized by the first UAGA of 1968,[168] the best way to protect this value is to obtain the individual's consent before death. However, some commentators consider the 1968 UAGA's approach a failure because (1) few people fill out donor cards, (2) the cards are not used by hospitals and (3) the number of organs retrieved under state statutes based on the 1968 UAGA is insufficient.[169]

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162. *See supra* notes 8-14 and accompanying text.

163. *See Ethical, Legal and Policy Issues, supra* note 2, at 2 ("Informed consent is the primary mechanism for protecting the dignity and autonomy of both donors and their families in making organ donations.").

164. *See* GALLUP SURVEY, *supra* note 9, at 26 (Twenty-three percent of those surveyed indicated that a fear of doctors doing something to them before they were really dead was a very important reason for not wanting to give permission for their own organs to be donated.).

165. *See* Caplan, *supra* note 53, at 26-27 (describing the distribution of organs and the time constraints inherent in that process).

166. *See Ethical, Legal and Policy Issues, supra* note 2, at 2.

167. TASK FORCE, *supra* note 4, at 28; *see also* Dukeminier & Sanders, *supra* note 13, at 416.

168. UNIF. ANATOMICAL GIFT ACT (1968) (amended 1987).

169. Caplan, *supra* note 53, at 24.

Consequently, barring a total ban on the use of cadaveric organs, the only way to protect the donor's autonomy is to develop some form of substituted consent; familial consent is one such form and is used by both the old UAGA and more modern procurement statutes.[170]

Familial consent is, after individual consent, the best mechanism for protecting individual autonomy. Family members probably know the deceased's wishes concerning organ donation better than anyone.[171] If the family does not know, the deceased would probably prefer that the family decide rather than some unknown doctor, bureaucrat or judge.[172] Finally, the only real alternative to familial consent is "presumed consent," which does not protect individual autonomy as well as familial consent.

Under "presumed consent" laws, doctors can simply take organs as needed.[173] Therefore, this substantially undermines individual autonomy.[174] The Gallup survey indicates that a significant portion of the American public objects to doctors removing organs without first obtaining consent.[175] In order to protect the autonomy of this group, a "presumed consent" law must create some way for individuals to register their objections.[176] However, it would be nearly impossible to create such a mechanism that could respond to the strict time limitations of organ removal situations.[177] Thus, familial consent is the only viable mechanism for protecting individual autonomy.

2. Familial Consent and the Community

Requiring some form of consent in the organ procurement process can also promote a sense of community.[178] As Paul Ramsey states, "A society will be a better human community in which giving and receiving is the rule, not taking for the sake of good to come."[179] Since would-be donors do not

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170. *See* UNIF. ANATOMICAL GIFT ACT (1968); UNIF. ANATOMICAL GIFT ACT (1987).

171. GALLUP SURVEY, *supra* note 9, at 18 (indicating that those people who are likely to donate tell family members of their intentions concerning donation more often than they tell others).

172. *See id.* Why would people tell family members of their intentions to donate more often than others if they did not want the family involved in the donation process? In light of the public's reluctance to fill out donor cards, it is plausible that the act of telling family members shows the individual's willingness to have the family decide.

173. *See supra* notes 114-17 and accompanying text.

174. For the advocated advantages of the "presumed consent" approach, see *supra* notes 114-17, 155 and accompanying text. However, there are other arguments that the "presumed consent" advantages are illusory. *But see supra* notes 155-61 and accompanying text.

175. While 62% of those surveyed by Gallup "would not mind if, upon death, their organs were donated even if they had never given permission," that still leaves up to 38% who would mind. GALLUP SURVEY, *supra* note 9, at 23.

176. Sadler & Sadler, *supra* note 160, at 8.

177. *Id.*

178. P. RAMSEY, *supra* note 11, at 210.

179. *Id.*

or are unable to consent to donation, the only means left for promoting community in organ donation is to ask the family to consent to the donation.

3. The Family in its Own Right

Finally, social values necessitate familial involvement in order to protect the family members themselves. When organ donation opportunities arise, the family will be in great emotional distress. This is especially true because most people leaving bodies suitable for organ donation died unexpectedly.[180] In such circumstances, "[s]alvaging cadaver organs should be done in such a way as to minimize the traumatic effect of the practice on the bereaved relatives."[181] Giving family members a consenting role will alleviate their grief and provide a means of protecting their sensibilities and emotions.[182]

D. Informed Consent

One of the main reasons for including family members in the organ procurement process is to obtain their informed consent.[183] With such consent, the family can serve as a mechanism for protecting the donor while alive, protecting the donor's autonomy, and for promoting community through generosity.[184] However, if the consent is not truly informed, then the mechanism will fail to protect those values.

Two basic factors can undermine the validity of the family's consent in cadaveric organ procurement: (1) psychological pressures inherent in the organ procurement area and (2) over-aggressive organ procurement efforts.[185] In the wake of death, the potential donor's family faces significant psychological burdens.[186] "It is difficult for the survivors to cease thinking of a body as a person—to whom they have strong emotional ties . . . and to think of the body as a cadaver."[187] Martyn, Wright and Clark argue that these circumstances make the family vulnerable to undue influence and manipulation.[188] These authors further contend that the family cannot be expected to understand the information provided about organ donation at

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180. R.G. SIMMONS, S. KLEIN & R.L. SIMMONS, *supra* note 13, at 339-40.

181. Dukeminier & Sanders, *supra* note 13, at 416.

182. *See, e.g.*, Kirker v. Orange County, 519 So. 2d 682, 684 (Fla. App. 1988) (The fact that the mother sued when her objections to the organ removal were ignored tends to indicate increased aggravation of grief when family members cannot control the disposition of their loved-ones' remains.).

183. *Ethical, Legal and Policy Issues, supra* note 2, at 2.

184. *See supra* notes 163-79 and accompanying text.

185. Caplan, *supra* note 53, at 25-27; *see also* Martyn, Wright & Clark, *supra* note 102, at 29-30.

186. Martyn, Wright & Clark, *supra* note 103, at 29.

187. Sanders & Dukeminier, *supra* note 29, at 359.

188. Martyn, Wright & Clark, *supra* note 103, at 29.

this time.[189] Thus, any "consent" would not be informed in a true sense.

However, Martyn, Wright and Clark offer no evidence, either statistical or anecdotal, of any actual incidence of manipulation or uninformed consent.[190] In contrast, Simmons, Klein and Simmons undertook a study of families who had donated the organs of deceased relatives and found little or no evidence of coercion or uninformed consent.[191]

In fact, they found that most of their subjects were able to make rational decisions and felt positive about making the donation, even as much as one year later.[192] The Task Force on Organ Transplantation confirms the Simmons' findings, stating, "[o]rgan donation and tissue donation is [sic] almost always a profound source of consolation to the families of patients suffering unexpected and premature death."[193]

While families do face difficult circumstances when they decide whether to donate a cadaveric organ, their consent appears to be well-informed and volitional. With such consent, families provide the best available mechanism for protecting the essential values of organ donation while, at the same time, allowing for efficient organ procurement.

CONCLUSION

As transplantation therapy becomes more refined and successful, reformers and legislators may be tempted to reduce the role of the family. In other countries and in some portions of the United States, these attempts have taken the form of "presumed consent" laws. The advantages of these laws, however, are illusory and the risks to other social values are enormous. "Presumed consent" laws ignore those values served by the family's historical role in the disposition of dead bodies. These laws also impair the family's ability to protect the donor while alive and the donor's autonomy generally. The family's traditional role in organ procurement is a role that is finely tuned to both its own needs and the needs of donors. The need for more organs does not justify the losses that would result if the family's role were significantly reduced. Therefore, lawmakers should focus on the role of medical practitioners and attempt to increase the number of available organs by requiring proper professional education.

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189. *Id.*
190. *See id.*
191. *See* R.G. SIMMONS, S. KLEIN & R.L. SIMMONS, *supra* note 13, at 374-75.
192. *Id.*
193. TASK FORCE, *supra* note 4, at 32.