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THE GIFT OF LIFE: ETHICAL AND SOCIAL CONSEQUENCES OF ORGAN DONATION

Michelle Wong*

It is not a conscious concern of many. Until tragedy strikes, it is not likely given any more than a few moments' discussion or contemplation. After all, other than the one brief question to answer when renewing one's driver's license every several years, who really sits down to think about what will be done with their body after they die? Who stops to consider whether or not they want to be organ donors?

Though perhaps not necessarily considered one of the "hot topics" in medical ethics, such as cloning or abortion, the shortage of transplant organs is a serious problem facing medicine today. In 1996, about 4,000 people in the United States died waiting for organ transplants.⁶⁸² In addition, an estimated 55,000⁶⁸³ more were left on waiting lists for kidneys, livers, hearts, lungs, pancreases or bone marrow donors.⁶⁸⁴ Approximately 75% of patients on waiting lists need a new kidney.⁶⁸⁵ Until a donor is found, kidney patients can live for several years on dialysis machines.⁶⁸⁶ However, those in need of a liver, heart, or lung do not have such an option. Tragically, "for at least one-third of these patients, death comes before a new organ."⁶⁸⁷

Unfortunately, the scarcity of organ donors only grows worse every year. Though polls indicate high support for organ transplantation, the number of willing donors has barely grown in recent years.⁶⁸⁸ Regrettably, the number of individuals or families who refuse their

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⁶⁸² See Alissa J. Rubin, *U.S. Plan Addresses Shortage of Organ Donors*, L.A. TIMES, Dec. 16, 1997, at A26.

⁶⁸³ See *id.*

⁶⁸⁴ See Max Jennings, *Organ Transplants—Lives are Lost for Lack of Donors*, DAYTON DAILY NEWS, Nov. 23, 1997, at 6B.

⁶⁸⁵ See Mark F. Anderson, *The Future of Organ Transplantation: From Where Will New Donors Come, To Whom Will Their Organs Go?*, 5 HEALTH MATRIX 249, 253 (1995).

⁶⁸⁶ See *id.*

⁶⁸⁷ *Id.* at 254.

⁶⁸⁸ See Arthur L. Caplan, *Current Ethical Issues in Organ Procurement and Transplantation*, 272 JAMA 1708, 1708 (1994).

consent to donate certainly do not reflect this "high" support.⁶⁸⁹ The potential reasons for the lack of willing donors include religious and personal beliefs concerning donation, as well as ignorance and lack of information regarding donor options. Ironically though, even if there were more people enrolled in donor programs, increased automotive preventative safety measures and "laws governing the use of helmets, seat belts, speed limits and alcohol" have reduced the number of traffic-related fatalities, "where organ donation might have been a possibility."⁶⁹⁰ Finally, as most organ donation takes place after the donor has died, the crucial and highly controversial effort to define "death" (e.g., by cardiopulmonary or neurological criteria) also heavily influences the size of the available organ pool.⁶⁹¹

Growing in tandem with the dearth of organ donors is the overwhelming need for them. Certainly, we must hail advancements in medical technology; however, the improved success rates of organ transplantation have greatly widened the pool of transplant candidates and is partly to blame for the ever-increasing need for donors. Those who were once ineligible for transplant due to age-- at both ends of the spectrum --or who had contraindicative conditions such as diabetes can now be put on the waiting list for transplants.⁶⁹² Also, the lengthening of the average life span in general means a greater elder population and ultimately more people who need transplants.⁶⁹³

Organ transplantation is a comprehensive subject covering many different issues: medical, social, political and economic. This paper focuses on the ethical and social implications of organ donation. Also presented are the different policy and program options attempting to meet the immense demand for donors. Part I addresses an initial obstacle to organ transplantation-- consent. Part II describes the ethical conflicts related to donor sources. Part III examines possible transplant policy solutions and the potential ramifications of their implementation. Part IV concludes with suggestions for future solutions and a recommendation for an effective policy which can increase the organ donor supply, while accounting for consent and respecting individual personal beliefs and wishes.

I. INITIAL OBSTACLES TO ORGAN TRANSPLANT: CONSENT ISSUES

⁶⁸⁹ See *id.*

⁶⁹⁰ *Id.*

⁶⁹¹ See Stuart J. Youngner, M.D. & Robert M. Arnold, M.D., *Ethical, Psychosocial, and Public Policy Implications of Procuring Organs From Non-Heart-Beating Cadaver Donors*, 269 JAMA 2769, 2771 (1993).

⁶⁹² See Caplan, *supra* note 7, at 1708.

⁶⁹³ See *id.*

The current system for organ procurement is governed in all states by each one's adopted version of the Uniform Anatomical Gift Act,⁶⁹⁴ which essentially provides that "if an individual makes a decision during her lifetime to donate her organs, and that decision remains unrevoked at the time of her death, her decision does not also require the approval of her family."⁶⁹⁵ However, it has traditionally been the practice of medical personnel to attempt to obtain family consent, even if the patient has filled out a donor card.⁶⁹⁶ Usually, if the family denies consent, or cannot be found, the organs are not taken.⁶⁹⁷

One of the main barriers to increasing the organ supply is the failure or refusal of individuals and/or their families to give consent to donate. Even though people take the time to write their wills to designate what is to be done with their property after they die, seldom do they consider what should be done with their body. Some say that it is too "macabre" to even think of dying, let alone to plan post-mortem arrangements. But however morbid such thoughts may be, individuals have a responsibility as members of society to at least take the time to think about whether or not they would want their organs donated, and then to make their decision known.

Among those who have made the choice not to donate, religious and other personal beliefs are often the greatest influence on their decision. Many Christians believe that the body is sacred, "a gift 'on loan' from God,"⁶⁹⁸ and that it is "necessary to preserve [that which] God created in his own image in anticipation of resurrection."⁶⁹⁹ Organ donation, then, is viewed as desecration of the body or sacrilege. On the other hand, the Christian Science religion holds that its followers shall "den[y] all medical intervention" completely, the "pursuit of spirituality" being deemed more important than "wellness of the body."⁷⁰⁰ In contrast, there are other religions that believe "self-donation sacrifice allows them to give entirely of themselves as Christ did."⁷⁰¹

Our society in general also culturally views the body as sacred and demands it be kept free from invasive procedures, even (and perhaps especially) in death.⁷⁰² Out of respect for the deceased and the desire to

⁶⁹⁴ See UNIF. ANATOMICAL GIFT ACT, 8A U.L.A. 15 (1987).

⁶⁹⁵ Anderson, *supra* note 4, at 264.

⁶⁹⁶ See *id.*

⁶⁹⁷ See *id.*

⁶⁹⁸ Alice Fleury Kerns, *Better to Lay It Out on the Table Rather Than To Do It Behind the Curtain: Hospitals Need to Obtain Consent Before Using Newly Deceased Patients to Teach Resuscitation Procedures*, 13 J. CONTEMP. HEALTH L. & POL'Y 581, 609 (1997).

⁶⁹⁹ *Id.* at 610.

⁷⁰⁰ *Id.*

⁷⁰¹ *Id.*

⁷⁰² *Id.* at 609–10.

maintain dignity in death, some families refuse to subject their loved ones' bodies to what they feel is "mutilation." Further, some individuals fear an encroachment on their personal rights of autonomy and self-determination.⁷⁰³

A family's "quasi property right" interest has been recognized in some states: "a right of possession for purposes of burial and other lawful disposition."⁷⁰⁴ But in other states, the courts have declared that "there are no property rights in the body of a deceased family member."⁷⁰⁵ In one Florida case, a family tried to argue that "their right to control the remains of their deceased child constitute[d] a 'fundamental right of personal liberty protected against unreasonable government intrusion by the due process clause.'"⁷⁰⁶ The court did not accept this argument, "emphasiz[ing] that in the area of public health, some government intrusion on individual privacy will be tolerated."⁷⁰⁷ Vociferous objection to even the non-disfiguring, non-altering donative procedure of cornea removal⁷⁰⁸ is example enough of the strong feelings people have regarding rights of possession over their body-- even after death --and why they refuse to be organ donors.

However, there are those who feel that since we do not actually "own" our bodies it is no sacrifice "to allow the body of a loved one to be harvested for the immeasurable benefit of numerous other human beings."⁷⁰⁹ Doctors are the ones faced with the often difficult task of telling patients that the only chance they might have to live, a transplant, is just not possible because there are not enough people who are willing to give up their body after they die. Some doctors feel that while respect should be given to the dead, it should not result in "sentimentaliz[ing] the newly dead body as a symbol of the deceased at the expense of real people out there suffering."⁷¹⁰ Those who feel a desire and a duty to society to give something back to their community when they die, to allow others the use of vital organs which will mean nothing to them in death but can give others life, must be sure to inform their families of their decisions so that consent may be obtained and their wish can be carried out upon their deaths.

⁷⁰³ See Council on Ethical and Judicial Affairs, American Medical Association, *Strategies for Cadaveric Organ Procurement: Mandated Choice and Presumed Consent*, 272 JAMA 809, 809 (1994).

⁷⁰⁴ Kerns, *supra* note 17, 588.

⁷⁰⁵ *Id.* at 594.

⁷⁰⁶ *Id.* at 595.

⁷⁰⁷ *Id.*

⁷⁰⁸ See Anderson, *supra* note 4, at 261.

⁷⁰⁹ Mark Bernstein, M.D., Bioethics Discussion Pages, <http://www-hsc.usc.edu/~mbernste/ethics.harvestingorgans.html> (visited Jan. 29, 1998).

⁷¹⁰ Kerns, *supra* note 17, at 604.

Another problem that arises from the failure to ensure knowledge of consent to donate, is the emotional trauma that having to make this decision could cause families at a very difficult time, and the eventual loss of potential donors during the time wasted trying to locate families and obtain their consent. It is difficult enough for doctors to have to report a patient's death to the family. However, it is that much harder to tell a family that their loved one is dead and then in the next breath to ask if the organs can be donated. Time is of the essence and if organs are to be salvaged, they must be removed immediately after death.⁷¹¹ If the patient's intention is not already known or if the family has not already given consent, the doctor will immediately have to speak with the family to request permission to remove organs for donation.⁷¹² It is a traumatic time and doctors "do not want to offend the family or add to their grief"; having to request their consent could "make a bad situation . . . worse."⁷¹³ Also, even when the doctor does ask for consent, "permission to remove organs is denied almost half of the time."⁷¹⁴ The death of a family member or friend is always a tragedy. However, the tragedy is compounded when patients, who wish to donate, fail to inform their families of their donative intent. The potential donor's inaction will often lead to the loss of many other lives because their intent to donate was never clearly communicated.

In order to help doctors and donor organizations respect people's religious or personal beliefs, as well as relieve unnecessary emotional stress on patients' families, the most important responsibility of individuals is to make their wishes known to their families or doctors. Especially if their convictions lead them *toward* donation, individuals must indicate that desire-- either to their caregivers, their next-of-kin, or simply to everyone concerned, by doing something as simple as checking "yes" in the donor box, upon renewal of their driver's license. When the decision regarding organ donation is made well in advance, when the consent barrier is breached, and when family and doctors are notified, not only are all parties given peace of mind that the patient's wishes will be fulfilled, but obtaining consent early on can encourage informed, voluntary donation.⁷¹⁵

II. ETHICAL CONFLICTS RELATED TO DONOR SOURCES

Since the timing and plan of execution of most organ transplantations depend upon the death of the donor, the method of determining when (or

⁷¹¹ See Council, *supra* note 22, at 810.

⁷¹² See *id.*

⁷¹³ Kerns, *supra* note 17, at 607.

⁷¹⁴ Anderson, *supra* note 4, at 257.

⁷¹⁵ See *id.* at 269.

if) death has occurred is crucial in the transplant process. Thirty years ago, the main source of organs for transplant were patients declared dead by traditional cardiopulmonary criteria, also called non-heart-beating cadaver donors (NHBCD's) because their hearts were no longer beating at time of organ procurement.⁷¹⁶ Then in 1968, came the acceptance of "brain death," in the medical community⁷¹⁷ and today, most donor organs come from patients "declared dead by neurological criteria-- i.e., they have irreversibly lost all brain function and their bodies are being maintained on ventilators in intensive care units."⁷¹⁸ Their hearts *are* beating at time of organ procurement, so they are referred to as heart-beating cadaver donors (HBCD's).⁷¹⁹ Both types of cadaver donor sources have advantages, but raise ethical conflicts as well.

A. Heart-Beating Cadaver Donors (HBCD's)

Until recently, donors have been mostly patients who are "declared dead on neurological grounds . . . or 'brain dead.'"⁷²⁰ The organs are removed while the donors are "still on respirator and their hearts are still beating, ensuring that the organs remain healthy until the moment of removal."⁷²¹

Medically speaking, HBCD transplantation is ideal in that there is no delay between cessation of heartbeat and removal of the organs as there is with NHBCD's.⁷²² With NHBCD's, there is a delay between the death of the donor and the harvesting of the organs. During this time, the organs may suffer "warm ischemia, in which cell and tissue damage begin and progress-- sometimes to the point that the organ is irreparably damaged."⁷²³ However, a serious drawback from a psychological standpoint in harvesting organs from HBCD's is that the families of patients who potentially have been terminally ill or were slowly dying over a period of time, cannot be with them in their last moments. This may deny families what many feel is almost a "basic animal need to personally attend to the death of their loved one."⁷²⁴ One doctor, who donated his son's kidneys, felt that he was unable to accept his death

⁷¹⁶ See Younger, *supra* note 10, at 2769.

⁷¹⁷ See Anita Srikameswaran, *When Is It Ethical to Harvest Organs?*, PITT. POST-GAZETTE, Dec. 19, 1997, at A3.

⁷¹⁸ Younger, *supra* note 10, at 2769.

⁷¹⁹ See *id.*

⁷²⁰ Rick Weiss, *Demand for Organs Fosters Aggressive Collection Methods*, WASH. POST., Nov. 24, 1997, at A1.

⁷²¹ *Id.*

⁷²² See Younger, *supra* note 2769.

⁷²³ *Id.* at 2770.

⁷²⁴ Richard A. Kunin, M.D., *Voluntary Organ Donation: Autonomy . . . Tragedy*, 270 JAMA 1930, 1930 (1993).

because he and his wife did not "actually hold him in [their] arms . . . let him die in [their] souls."⁷²⁵

From a less emotional perspective, HBCD transplantation also invokes in some people a disgust or fear that their organs, or those of their family member, might be "snatched while they are still [technically] alive."⁷²⁶ This fear then leads to refusal to give consent to donate.

B. *Non-Heart-Beating Cadaver Donors (NHBCD's)*

After the acceptance of brain death, HBCD's dominated the pool of donors primarily because the problem of warm ischemia could be avoided and more organs successfully salvaged. However, there has been renewed interest in NHBCD's with the advent of two new methods for organ removal which can skirt the ischemia problem: "in situ organ preservation immediately following uncontrolled cardiopulmonary arrest" and "procurement from patients who have died after choosing to forgo life-sustaining treatment."⁷²⁷

In situ preservation of kidneys involves the "infusion or perfusion of kidneys immediately after death has been pronounced in accordance with cardiopulmonary criteria."⁷²⁸ It entails the insertion of catheters with balloons through the femoral artery and into the abdominal aorta.⁷²⁹ Next, an "occluding balloon is inflated above the renal arteries."⁷³⁰ Then, ice-cold preservatives are continuously flushed through the kidneys,⁷³¹ thereby minimizing warm ischemia, and buying time by keeping the organs in "suspended animation" while awaiting family consult.⁷³²

While this process may provide the answer to a great obstacle which has limited the supply of donors in the past, many ethical conflicts arise. The preservation process must be implemented as soon as possible after cardiopulmonary arrest,⁷³³ which allows very little time for attainment of family consent to the procedure. A 1996 Washington, D.C. law allows for "preemptive and invasive organ preservation without family consent,"⁷³⁴ and in one major medical center, patients are infused with a "cocktail of organ-preserving drugs"⁷³⁵ even *before* death occurs. The preemptive surgery is intended to give doctors time to locate patients' families. This

⁷²⁵ *Id.*

⁷²⁶ Weiss, *supra* note 39, at A1.

⁷²⁷ Younger, *supra* note 10, at 2769.

⁷²⁸ *Id.* at 2770.

⁷²⁹ *See id.*

⁷³⁰ *Id.*

⁷³¹ *See id.*

⁷³² *See* Weiss, *supra* note 39, at A1.

⁷³³ *See* Younger, *supra* note 10, at 2770.

⁷³⁴ Weiss, *supra* note 39, at A1.

⁷³⁵ *Id.*

gives the families more time to learn of and cope with their loss while also "putting the decision about donation in the hands of the family."⁷³⁶ Critics of the practice consider the procedure disrespectful, a desecration of the dead. Proponents respond that the intervention surgery is "nondeforming" and "nonmutilating,"⁷³⁷ a small sacrifice for the donor to make.

Aside from the objection to mutilation, however, stands the critical question: how can we ensure that the decision to implement organ preservation measures does not "influence the decision of when to stop resuscitation efforts"?⁷³⁸ In light of this fear, is it possible that families will *not* consent to donation, in order to prevent doctors from "giving up" on saving their loved ones? There may be no simple answer.

The other method for reducing warm ischemia is for patients and families to give consent for organ removal after deciding to forgo life support treatment.⁷³⁹ The consent barrier is overcome with this method because the decision to donate is made by the family, or even the patient, well before death, with more "time for discussion [and] reflection" of the issues surrounding donation.⁷⁴⁰ As a result, both patients and families can feel more at peace and less pressured with their decision to donate. The medical advantage is that the patient is taken to the operating room where a surgical team removes organs immediately after death.⁷⁴¹ Since time and place are controlled, warm ischemia time is minimized.⁷⁴² There have not been many of these procedures performed, however, results of the few cases studied show success rates have been high,⁷⁴³ indicating a possible new source of organ donors for the future.

C. *Living Donors*

Living donors⁷⁴⁴ are also a source of organs for transplant-- most traditionally used in kidney transplants.⁷⁴⁵ Living donors can solve the consent problem almost completely. They are usually family members or sometimes very close family friends who are more than willing to donate an organ to save their loved one's life. Consent is not an issue, and the intent to donate is clear. Although there is a potentially large supply of living donors, doctors face a serious conflict between the desire to save a

⁷³⁶ *Id.*

⁷³⁷ Younger, *supra* note 10, at 2770.

⁷³⁸ *Id.*

⁷³⁹ *See id.*

⁷⁴⁰ *Id.*

⁷⁴¹ *See id.*

⁷⁴² *See id.*

⁷⁴³ *See id.*

⁷⁴⁴ Other potential living donors include anencephalic infants (those born without brains) and animals, however this paper will focus on human donors.

⁷⁴⁵ *See* Anderson, *supra* note 4, at 280.

patient who desperately needs a transplant and the danger of harming a perfectly healthy donor-- a "violation of one of medicine's basic tenets[:] do no harm."⁷⁴⁶ Even though a kidney transplant is a major surgical procedure, success rates are high, and very few people have died as a direct consequence of donating a kidney.⁷⁴⁷

The alleged social drawbacks to living organ donations seem minor in light of the benefits. Some critics are troubled by living donation because it "creates an obligation on the part of the recipient,"⁷⁴⁸ who feels a compelling need to repay the donor. This is then said to cause "an imbalance in the social fabric."⁷⁴⁹ However, the advantages -- both medically and socially -- seem to far outweigh these ethical disadvantages. Living donors, often family members, usually provide a better donor-recipient tissue match, which means reduced risk of rejection.⁷⁵⁰ Also, most living donors are eager to play such an important role in saving someone to whom they are very close. They often report that "the donation was one of the high points of their lives and that they feel better about themselves for having done it."⁷⁵¹

Though most living organ donations are kidney transplants, partial liver and partial lung transplants are also possible, though not as common. Since the liver can regenerate itself, portions of adult livers can be transplanted to children.⁷⁵² Lungs do not regenerate, but humans can survive (albeit with restricted activity) with just one.⁷⁵³ In both liver and lung transplants, it is usually parents donating part of their organs to their sick children. This situation is ideal ethically -- there are no issues of consent, and certainly no complications of "permanent debt" feelings.

Overall there are quite a few benefits to living donors: medical, psychological and social. Perhaps the most important advantage is that the number of potential living donors is quite large. Informing and educating people about the option to donate is the key to accessing this source, which can make a substantial contribution toward meeting the high demand for donors.

III. POTENTIAL POLICY SOLUTIONS

⁷⁴⁶ *Id.*

⁷⁴⁷ *Id.* at 281.

⁷⁴⁸ *Id.*

⁷⁴⁹ *Id.* at 282.

⁷⁵⁰ *See id.* at 284.

⁷⁵¹ *Id.* at 285.

⁷⁵² *See id.* at 288.

⁷⁵³ *See id.*

Numerous policies have been proposed to solve the problems related to organ donation. Two of the most debated options are presumed consent and mandated choice.

A. *Presumed Consent*

Presumed consent attempts to circumvent the obstacles in obtaining patient or family consent and the failure of people who *do* want to donate to make their preferences known. This policy assumes that "people consent to be cadaveric organ donors unless they or their families register an objection."⁷⁵⁴ Rather than leaving it to potential donors to take the initiative to fill out a donor card, the system uses an "opt-out" approach.⁷⁵⁵

Ideally, if a presumed consent policy could be effectively implemented and well monitored, the benefits could be quite far-reaching. It is estimated that there are at least 11,000 cadaveric donors potentially available each year; yet, because consent is often not attainable (either due to refusal or failure to locate the family), only about 4500 donors are actually obtained.⁷⁵⁶ If donation was the standard procedure, there would be a much larger pool of donors, which not only means that greater numbers of people on waiting lists could be given transplants, but that there might be greater chances for tissue matches with patients from among the pool, and in the end, less chance of rejection. Another possible benefit of presumed consent is sparing the family from having to make a potentially "difficult choice under traumatic circumstances."⁷⁵⁷ They are struggling with the burden of losing a loved one, so they are often not in the frame of mind to make an informed decision, which under this system is taken off their hands.

From a social standpoint, supporters of presumed consent claim that the opting-out system "reflects a more communitarian outlook that respects the needs of the larger community as well as those of the individual."⁷⁵⁸ The communitarian outlook "holds that individuals have a moral duty to help others when the cost to the individual of helping is very low."⁷⁵⁹ In this respect, a presumed consent policy could encourage awareness of the crisis in organ donor supply, and hopefully inspire at least consideration of the idea that perhaps organ donation should be viewed as an obligation to society and a small debt easily paid.

⁷⁵⁴ Council, *supra* note 22, at 810.

⁷⁵⁵ *Id.*

⁷⁵⁶ See Anderson, *supra* note 4, at 258.

⁷⁵⁷ *Id.*

⁷⁵⁸ Council, *supra* note 22, at 811.

⁷⁵⁹ *Id.*

In spite of these potential benefits, however, many are opposed to presumed consent.⁷⁶⁰ One of the main problems is the inability to ensure the creation and maintenance of an effective system in which a key element is full information.⁷⁶¹ Everyone must understand how the system works, otherwise they cannot register an objection even if that is what they wish. Because there is a good chance the family might be unaware of its options, it is too great a risk "to relieve the medical profession of the duty of ensuring specific informed consent."⁷⁶² There is the fear that in light of the dire need for organs, doctors will bypass discussion of donation options with families so as to avoid refusal of consent.⁷⁶³ Also, excluding the family might, in some cases, prevent discovery of "the family's knowledge of the decedent's preferences [which] the physicians may lack."⁷⁶⁴ Again, the absence of an objection does not necessarily equal consent. Only if the system was widely publicized and very efficient, providing for full information, might such a conclusion be drawn.⁷⁶⁵

Some states already have presumed consent statutes allowing coroners to remove corneas, pituitary glands and certain other tissues, as long as there is no knowledge of objection from the deceased or the family.⁷⁶⁶ People have challenged these statutes on constitutional grounds, claiming a "viola[tion of] the Fifth Amendment's prohibition on the taking of private property without due process and just compensation."⁷⁶⁷ Most courts have upheld the constitutionality of the corneal transplant statutes,⁷⁶⁸ however, the rulings "suggest that the constitutionality of presumed consent may be in doubt when there is not an effective system for documenting and honoring objections to donation."⁷⁶⁹

B. *Mandated Choice*

The main objection to the presumed consent method centers on the risk that the deceased's wishes or those of the family will not be respected.⁷⁷⁰ Rather than making assumptions for patients or their families and potentially forcing them to accept unwanted consequences, the policy of mandated choice requires individuals to "state their preferences regarding organ donation when they renew their driver's licenses, file income tax forms, or perform some other task mandated by

⁷⁶⁰ *See id.*

⁷⁶¹ *See id.*

⁷⁶² Kerns, *supra* note 17, at 601.

⁷⁶³ *See Council, supra* note 22, at 811.

⁷⁶⁴ *Id.*

⁷⁶⁵ *See id.*

⁷⁶⁶ *See id.* at 810.

⁷⁶⁷ *Id.*

⁷⁶⁸ *See Anderson, supra* note 4, at 261.

⁷⁶⁹ *Council, supra* note 22, at 810.

⁷⁷⁰ *See id.* at 811.

the state."⁷⁷¹ No one makes the decision to donate other than the donor himself, so rights of autonomy and self-determination are protected.

A recognized obstacle to organ donation is often just the reluctance to consider one's own death. The policy of mandated choice forces people to face this fact of life, and make a decision which may not truly ever affect them, but which ultimately can benefit others. It can encourage "the highest level of voluntary, informed organ donation with full cooperation of all concerned."⁷⁷² Since the donor makes his own choice, which is documented well in advance of medical crisis, his family will not have the burden of making the decision. Moreover, unlike with presumed consent, the family can rest assured that their loved one's wishes were fulfilled.

Critics consider mandated choice to be "coercive" and also an "invasion of privacy."⁷⁷³ However, in light of the fact that lives could be saved by answering one small question, the real cost to the donor is insignificant. Also, there is no coercion as there may be with presumed consent, because the only requirement is that a response be given. Hence, the answer to the question of consent can always be "No, I choose not to donate." The obstacles in organ donation are overcome when the choice to donate is made and also made known.

IV. CONCLUSION

The low supply of organ donors today has created a medical crisis which must be addressed by education, policy implementation, and most importantly, by recognition of the role each member of society can play in helping others. The choice to donate is not for everyone; people's religious convictions must be respected. At the same time, the failure to consider donation simply because of reluctance to "think about death" must be overcome in light of the lives at stake. *Both* donors and recipients have rights-- this is a fact which cannot be forgotten when in pursuit of protection of only one group. Many policies have been offered to alleviate the organ shortage at all stages of transplant. While ethical conflicts in transplant procedures for cadaveric and living donations must be addressed, if we take the time to weigh their costs and benefits, and consider the means to fine-tune them so as to advance beyond the conflicts, we are already one step closer to expanding donor sources. Ethical issues also arise with living donors and policies to garner consent. At the same time, the debate over them encourages the search for a

⁷⁷¹ *Id.* at 809.

⁷⁷² Anderson, *supra* note 4, at 269.

⁷⁷³ Council, *supra* note 22, at 809.

compromise, and ultimately increases the awareness of the gravity of the situation, but also of the power one individual has to make a difference.

