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The Waiting Game: How States Can Solve the Organ-Donation Crisis

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NOTES

The Waiting Game: How States Can Solve the Organ-Donation Crisis

Thousands of patients in the United States live in limbo every day waiting for a lifesaving organ transplant, and the gap between the number of people who need a transplant and the number of available organs widens every year. Every state currently allows individuals to unilaterally indicate their intent to donate their organs upon death, but in practice, family members are frequently allowed to override the express intentions of decedents. In addition, the current U.S. "opt-in" system fails to reach its full potential because many eligible decedents never express their desires to become or not to become organ donors, and family members refuse to consent to donation or cannot be contacted in time. This Note argues that states should again take the lead in organ-donation regulation to solve the organ-shortage crisis and proposes a twofold solution for states to adopt. First, states should switch to a presumed-consent, or opt-out, model. Second, states should implement a monitoring and enforcement mechanism through which state attorneys general and state health departments enforce first-person authorization. Organ procurement organizations should be required to adopt bylaws requiring their strict compliance with decedents' wishes, and a failure to do so would give state attorneys general grounds to sue for breach of 501(c)(3) status obligations. The result would be to increase the supply of viable organs for transplant by interpreting an individual's failure to opt out as a desire to donate and to enforce this choice by not allowing anyone to override it.

INTRODUCTION

"We prayed for a miracle that Curtis would be okay, but when we knew that wasn't going to happen, we prayed that he could be a miracle for someone else."[1] Twenty-nine years ago, Curtis Gano, a sixteen-year-old boy, was riding his bike when a van struck him, leaving him brain dead.[2] His parents did not want his memory to end there, so they donated his organs and saved four other lives.[3] The family had watched a documentary on organ and tissue donation years earlier and knew the impact it would have on other families.[4]

The stories of organ donees, such as Curtis's beneficiaries, may begin long before they get sick, before they are put on the transplant

1. *Donor Dad Reaches 200,000 Students with His Story*, GIFT LIFE DONOR PROGRAM (June 6, 2018), https://www.donors1.org/cherry-hill-nj-resident-reaches-200000-students-with-life-saving-message-2 [https://perma.cc/9L7R-TSLQ].

2. *Id.*

3. *Id.*

4. *Id.*

list, and maybe even before they are born. Their stories begin when a teenager checks "yes" to organ donation at the DMV, when an older man registers to be an organ donor after meeting the donee of an organ transplant, or when a family like the Ganos is struck by tragedy and consents to having its child's organs donated. The stories of the 28,587 people[5] saved by deceased donors in 2017 started when someone was placed in a similar situation.

Every day in the United States, twenty people on the organ-transplant list have their stories cut short while waiting for an available organ.[6] This tragedy is not due to the lack of a cure or even a lack of resources. Although transplant technology has drastically improved over the last twenty years, the number of transplants performed each year has not increased. The organ-donation process in the United States is at a standstill: with deceased-donor transplant operations hovering between twenty-eight and twenty-nine thousand annually in recent years,[7] approximately 114,000 people remain waiting for an organ in 2019.[8] Current legislation and policies fail to address this public health crisis, which only continues to balloon.[9] States led the drive to regulate and promote organ donation at its inception[10] but have since retreated and now fail to effectively monitor and enforce their organ-donation laws.

This Note analyzes the shortcomings of the legal framework for organ donation in the United States and demonstrates that the lack of state regulation and enforcement is at the heart of the problem. Part I provides background information and a brief history of the U.S. organ-donation process. Part II discusses why organ donation has not reached its full potential in the United States and the failures of the present legal framework. Part III proposes a twofold solution: switching to a presumed-consent model and creating a monitoring and enforcement mechanism for states. The Conclusion reiterates the importance of

5. *Deceased Organ Donors in United States Exceeded 10,000 for First Time in 2017*, UNOS (Jan. 9, 2018), https://unos.org/deceased-organ-donors-in-united-states-exceeded-10000-for-first-time-in-2017/ [https://perma.cc/9PKW-KRCE] [hereinafter *Donors Exceeded 10,000*].

6. *Transplant Trends*, UNOS, https://unos.org/data/transplant-trends/ (last visited Feb. 25, 2019) [https://perma.cc/4EM7-WRJB].

7. Sally Satel & David C. Cronin II, *Time to Test Incentives to Increase Organ Donation*, 175 JAMA INTERNAL MED. 1329, 1329 (2015).

8. *Transplant Trends*, *supra* note 6.

9. From 1988 to 2011, the supply of transplantable organs grew by 140 percent, while the number of individuals waiting for a transplant grew by 650 percent. Adelin Levin, The Impact of First-Person Consent Legislation on the Supply of Deceased Organ Donors 2 (Apr. 26, 2014) (unpublished B.A. thesis, Grand Valley State University), https://scholarworks.gvsu.edu/cgi/viewcontent.cgi?article=1302&context=honorsprojects [https://perma.cc/NF8A-6HLG].

10. States started enacting their own organ-donation regulations in the 1960s, whereas the federal government did not enact any legislation on the issue until 1984. *See infra* Section I.B.

states in reclaiming their authority to regulate and enforce organ-donation processes within their jurisdictions.

I. THE NETWORK OF ORGAN-DONATION REGULATION

In 1954, Dr. Joseph Murray, a Boston surgeon, performed the first successful kidney transplant.[11] Surgeons had been researching and experimenting with organ and tissue transplantation since the eighteenth century, but Dr. Murray's operation—transferring a kidney from a living donor to his identical twin brother—was the first to extend a donee's life for a substantial period.[12] In 1962, Dr. Murray performed the first successful deceased-donor kidney transplant, and before the decade's end, various other surgeons had performed the first successful liver, lung, pancreas, and heart transplants, prompting the emergence of transplant centers across the United States and Europe.[13]

This Part begins by detailing the logistics of today's lifesaving organ-donation process. It then proceeds to detail the current U.S. regulatory framework for the organ-transplantation process—discussing state law and the Uniform Anatomical Gift Acts in Section I.B and the applicable federal regulations in Section I.C.

A. The Donation Process

A patient in need of an organ transplant is trapped in a waiting game until she receives the phone call that a donor has matched. An organ procurement organization ("OPO"), the cornerstone of the organ-donation process,[14] is responsible for delivering the good news. OPOs are regional, private nonprofit organizations incorporated under state law that work with organ-transplant facilities and qualifying hospitals to arrange for the acquisition and preservation of donated organs and allocate them to patients on the waiting list.[15] OPOs started developing in the 1960s and were initially intended to each serve the transplant program at just one hospital, but they gradually expanded to serve multiple transplant programs in a given geographical region.[16] The

11. Richard J. Howard et al., *History of Deceased Organ Donation, Transplantation, and Organ Procurement Organizations*, 22 PROGRESS TRANSPLANTATION 6, 7 (2012).

12. *Id.* The donee survived another eight years, and the donor another fifty-six years. Dr. Murray was awarded the Nobel Prize in Medicine in 1990 for his work in transplantation. *Id.*

13. *Id.*

14. DAVID L. KASERMAN & A.H. BARNETT, THE U.S. ORGAN PROCUREMENT SYSTEM: A PRESCRIPTION FOR REFORM 13 (2002).

15. KASERMAN & BARNETT, *supra* note 14, at 13; Howard et al., *supra* note 11, at 10, 14.

16. KASERMAN & BARNETT, *supra* note 14, at 140 n.20; Howard et al., *supra* note 11, at 10, 14.

United States now has fifty-eight OPOs, which serve 248 transplant centers across the country. Each OPO covers a specific geographic region assigned by the U.S. Department of Health and Human Services ("HHS") and is responsible for coordinating donations and allocations within that region and occasionally across the country.[17]

From their inception, OPOs served as the connection between transplant centers and donor hospitals.[18] The Division of Organ Transplantation, an administrative unit under HHS, tasks OPOs to work closely with organ-transplant facilities in their respective regions to identify potential donors, conduct systematic efforts to acquire all usable organs, ensure compliance with standards adopted by the Organ Procurement and Transplantation Network ("OPTN"), and increase public outreach through community awareness.[19] Hospitals enter into contracts with their designated OPO to coordinate the procurement and use of organs as anatomical gifts.[20]

The OPO assigned to the donor's hospital becomes involved when the donor is declared medically and legally brain dead.[21] Under federal regulations, every hospital must notify its local OPO of patients who have died or are nearing death so the OPO can start planning for a potential organ transplantation.[22] Despite this initial notice, a patient will not be evaluated for organ donation until doctors have taken all lifesaving measures.[23] Once a hospital notifies an OPO of a potential donor's death, it must make "a reasonable search of the records of the Department of Public Safety and any donor registry that it knows exists

17. Howard et al., *supra* note 11, at 14. The number of OPOs has fluctuated, with over 128 in 1986, many of which were in the same city and competed for hospital contracts and potential donors. *Id*. OPOs have since consolidated and been assigned exclusive geographic collections regions. KASERMAN & BARNETT, *supra* note 14, at 13. Many smaller OPOs were not economically viable and recovered too few organs, so they eventually merged with larger OPOs to improve effectiveness. Howard et al., *supra* note 11, at 14. To remain solvent, OPOs often competed for hospital contracts with one another. KASERMAN & BARNETT, *supra* note 14, at 13. Because each OPO is now exclusively entitled to a specific geographic region, competition no longer exists among OPOs for organs or to outperform each other.

18. KASERMAN & BARNETT, *supra* note 14, at 13; Howard et al., *supra* note 11, at 14.

19. KASERMAN & BARNETT, *supra* note 14, at 13; Howard et al., *supra* note 11, at 14.

20. Gerry W. Beyer, Controlling Body Disposition: The Law and the Macabre 7 (Oct. 31, 2016) (unpublished manuscript), https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2862112 [https://perma.cc/NTR6-BLAU].

21. *See infra* Section I.A. Donors are those patients who are brain dead but still have healthy, functioning organs suitable for transplantation.

22. 42 C.F.R. § 482.45(a)(1) (2018); U.S. Dep't of Health & Human Servs., *The Deceased Donation Process*, ORGANDONOR.GOV, https://organdonor.gov/about/process/deceased-donation.html (last visited Jan. 12, 2019) [https://perma.cc/WJ4W-BV32] [hereinafter *The Deceased Donation Process*].

23. *Donation Process*, CTR. FOR ORGAN RECOVERY & EDUC., https://www.core.org/understanding-donation/donation-process/ (last visited Jan. 12, 2019) [https://perma.cc/XM8T-J2ZR].

for the geographical area in which the individual resides"[24] and must reasonably "search for any person . . . having priority to make an anatomical gift on behalf of a prospective donor."[25] If the decedent has already indicated her intent to donate, such as on a driver's license, the OPO does not have to seek consent from a person with priority.[26]

If the decedent is a registered donor, the registration serves as legal authorization for a transplantation team to procure the organs for donation ("first-person authorization").[27] If the decedent is not registered, the OPO will ask the decedent's next of kin for authorization to remove and use the organs for donation.[28]

Once authorization is received, hospital personnel enter the donor's medical characteristics into the United Network for Organ Sharing ("UNOS"), a national database of all patients awaiting a transplant, which then matches each organ with the best potential donee.[29] The OPTN, a nonprofit organization under contract with the federal government, administers UNOS.[30] Recipients of the organs are usually located proximate to the donor, but UNOS can also share them with waiting patients in other regions.[31] While the matching process is underway, the donor's organs are kept on artificial support and closely monitored.[32] A transplant-surgical team supplants the medical team that was treating the patient before death,[33] as medical personnel trying to save the patient's life can never be involved with the

24. TEX. HEALTH & SAFETY CODE ANN. § 692A.014(a) (West 2017).

25. *Id.* § 692A.014(g). This Texas law is one example of a state statute adopting the Uniform Anatomical Gift Act ("UAGA"). Other states have similar provisions.

26. *See* REVISED UNIF. ANATOMICAL GIFT ACT § 9 cmt. (2006) (UNIF. LAW COMM'N, amended 2009). A person with priority is authorized to make an anatomical gift of a decedent's organs, and the order of priority for whose permission is sought is outlined in section 9 of the latest version of the UAGA ("2006 Revised Act"). *Id.* Many OPOs, however, still will seek consent from a person with priority, even when the decedent has made her intentions clear, and will follow the wishes of the family member instead of the express wishes of the patient. *See infra* Section II.C.

27. *Organ Donation Process*, LIFEGIFT, http://www.lifegift.org/organ-donation-process (last visited Jan. 12, 2019) [https://perma.cc/9ZGP-VRFL]; *The Deceased Donation Process*, *supra* note 22.

28. *The Deceased Donation Process*, *supra* note 22.

29. *Id.*

30. U.S. Dep't of Health & Human Servs., *Glossary of Organ Donation Terms*, ORGANDONOR.GOV, https://www.organdonor.gov/about/facts-terms/terms.html (last visited Jan. 12, 2019) [https://perma.cc/S44R-6QN7].

31. *The Deceased Donation Process*, *supra* note 22.

32. *Id.*

33. *Id.*

transplant process.[34] The donor's organs are removed in an operating room and taken to the donee by air or ambulance.[35]

B. State Law and the Uniform Anatomical Gift Acts

The development of organ-transplant technology provoked legislation to regulate these groundbreaking procedures. State law governs most of the substantive standards, rights, and obligations of hospitals and OPOs, including donor registration, public education, declaration of brain death, and authorization to donate.[36] States took action to regulate and control the organ-donation process in the 1960s,[37] long before the federal government enacted its first legislation on the matter in 1984. In 1968, the Uniform Legal Commission ("ULC")[38] issued the first Uniform Anatomical Gift Act ("UAGA") to promote uniformity among states and simplify the organ-transplantation process in order to increase the number of cadaveric donors.[39] States could and did adopt the UAGA as their own legislation.[40] Organ transplantation is time sensitive and involves coordination among states, especially when donors and donees are located in different states.[41] Thus, having uniform laws across cooperating states is imperative to procuring and allocating organs efficiently as they become available.[42]

34. *Donation Process*, *supra* note 23; *The Deceased Donation Process*, *supra* note 22. Medical personnel responsible for attempting to save the patient's life must be separate from the transplant team to avoid real or perceived conflicts of interest.

35. *The Deceased Donation Process*, *supra* note 22.

36. Sam Crowe & Eric Cohen, *Organ Transplantation Policies and Policy Reforms*, PRESIDENT'S COUNCIL ON BIOETHICS (2006), https://permanent.access.gpo.gov/lps92649/organ_donation.html [https://perma.cc/Z87Q-NRNQ]. Federal law prescribes standards for OPO certification, outcome requirements, and process performance measures. *See* 42 C.F.R. §§ 486.303–.360 (2018).

37. *See* COMM. ON ISSUES IN ORGAN DONOR INTERVENTION RESEARCH, NAT'L ACADS. OF SCIS., ENG'G & MED., OPPORTUNITIES FOR ORGAN DONOR INTERVENTION RESEARCH 73 (2017), https://www.ncbi.nlm.nih.gov/books/NBK470922/ [https://perma.cc/8U8T-UC9V] (explaining that "states began enacting organ donation and procurement legislation in the 1960s when organ transplantation became a viable medical procedure").

38. The ULC, also known as the National Conference of Commissioners on Uniform State Laws, reviews and studies state laws, determines which areas of law should be uniform among the fifty states and District of Columbia, and proposes model legislation for state legislatures to adopt. *Overview*, UNIFORM L. COMMISSION, http://www.uniformlaws.org/aboutulc/overview (last visited Jan. 13, 2019) [https://perma.cc/AF58-RBYM].

39. KASERMAN & BARNETT, *supra* note 14, at 11.

40. *Id.*

41. Levin, *supra* note 9 (manuscript at 4).

42. *Id.*

The UAGA was amended in 1987 specifically to prioritize, for the first time, a donor's wishes above those of her family,[43] but it did not strictly prohibit seeking familial consent before procuring organs, as was the general practice.[44] Only twenty-six states, however, adopted the 1987 UAGA.[45] While some attributed the lack of widespread acceptance to the small number of significant changes, others blamed the provision permitting coroners and medical examiners to make anatomical gifts if no family could be found and a contrary intention was not known ("presumed consent").[46] The UAGA was again amended in 2006 ("2006 Revised Act") and subsequently adopted by forty-six states, the District of Columbia, and the U.S. Virgin Islands.[47] It currently serves as the model act for state regulation of the organ-donation process in hospitals nationwide.[48] The 2006 Revised Act reaffirmed the importance of first-person authorization and maintained a good faith affirmative defense for transplantation professionals, both discussed below in more detail.

Emerging state laws on the topic ignited debate over when a potential donor should be pronounced medically and legally dead and when it becomes ethically acceptable to procure that person's organs for transplantation.[49] In 1981, the ULC adopted the Uniform Determination of Death Act ("UDDA"), which defines death as the irreversible cessation of circulatory and respiratory functions or the

43. UNIF. ANATOMICAL GIFT ACT prefatory note (UNIF. LAW COMM'N 1987), *amended by* REVISED UNIF. ANATOMICAL GIFT ACT (2006) (UNIF. LAW COMM'N, amended 2009); *id.* § 2(h) ("An 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.").

44. Levin, *supra* note 9 (manuscript at 4).

45. REVISED UNIF. ANATOMICAL GIFT ACT prefatory note.

46. Daphne D. Sipes, *Legislative Update on the State Adoption of the 1987 Revision to the Uniform Anatomical Gift Act of 1968*, 4 BYU J. PUB. L. 395, 426–28, 435 (1990). This provision was modeled after states' presumed-consent statutes for corneas, eye tissue, and occasionally organs. *See infra* Section I.B.3.

47. *Anatomical Gift Act*, UNIFORM L. COMMISSION, https://www.uniformlaws.org/committees/community-home?CommunityKey=015e18ad-4806-4dff-b011-8e1ebc0d1d0f (last visited Jan. 13, 2019) [https://perma.cc/F3SE-FJBP].

48. *Id.*

49. Howard et al., *supra* note 11, at 9. For example, states typically chose one of four common models to follow when they enacted brain-death laws in the 1970s: the Kansas model, providing alternative means for determining death; the Capron-Kass model, where death is pronounced while heart and lung functions are artificially maintained; the American Bar Association model, where irreversible cessation of total brain function equals death; or the Uniform Brain Death model, which is similar to American Bar Association model but emphasizes irreversible cessation of brain stem function. Frank P. Stuart et al., *Brain Death Laws and Patterns of Consent to Remove Organs for Transplantation from Cadavers in the United States and 28 Other Countries*, 31 TRANSPLANTATION 238, 242 (1981).

cessation of all functions of the entire brain, including the brain stem.[50] All fifty states and the District of Columbia adopted the UDDA, but guidelines on how to determine brain death as defined in the UDDA currently vary among states and between hospitals.[51]

1. First-Person Authorization

The 2006 Revised Act significantly relaxed the process for becoming an organ donor; individuals are now empowered to consent either by signing a donor card or other official document—such as a driver's license application—or by enrolling in a donor registry.[52] Each of the fifty states and the District of Columbia currently operates its own online donor-consent registry that allows hospitals and OPOs to check donor status.[53] Additionally, fifty-seven of fifty-eight OPOs operate online registries that enable individuals to register online as organ donors.[54]

The 2006 Revised Act stresses the importance of donor autonomy, dedicating an entire section to the preclusive effects of registering as an organ donor.[55] It requires hospitals and OPOs to honor a decedent's express wishes and to ignore family members' attempts to override the donor's decision.[56] Under section 8(a), "[I]n the absence of

50. UNIF. DETERMINATION OF DEATH ACT § 1 (UNIF. LAW COMM'N 1980); Howard et al., *supra* note 11, at 9.

51. Howard et al., *supra* note 11, at 9. For example:

> In some states, 1 physician is required to pronounce brain death, whereas in other states 2 physicians are needed. Furthermore, in some states 2 declarations of brain death have to be separated in time, but in others both declarations can be made at the same time. Some states specify which physicians can diagnose brain death; others do not. Thus, currently an individual can be pronounced dead in 1 state but be considered alive in the state next door. . . . [G]uidelines for determination of brain death vary considerably among US hospitals.

Id. at 9–10. In Texas, a registered nurse or physician's assistant can declare a patient brain dead if allowed by the hospital's written policy, unless the patient is on life support. *What Is the Uniform Declaration of Death Act (UDDA)?*, FINDLAW, https://healthcare.findlaw.com/patient-rights/what-is-the-uniform-declaration-of-death-act-or-udda.html (last visited Jan. 13, 2019) [https://perma.cc/X4XY-YC8U].

52. W.J. Chon et al., *When the Living and the Deceased Cannot Agree on Organ Donation: A Survey of US Organ Procurement Organizations (OPOs)*, 14 AM. J. TRANSPLANTATION 172, 173 (2014).

53. *Id.*

54. *Id.* at 172.

55. REVISED UNIF. ANATOMICAL GIFT ACT § 8 (2006) (UNIF. LAW COMM'N, amended 2009).

56. The 1987 Act stated in a one-sentence provision that "[a]n anatomical gift that is not revoked by the donor before death is irrevocable and does not require the consent . . . of any person after the donor's death." UNIF. ANATOMICAL GIFT ACT § 2(h) (UNIF. LAW COMM'N 1987), *amended by* REVISED UNIF. ANATOMICAL GIFT ACT. The drafters of the 2006 Revised Act purposefully expanded the provision to draw attention to it and reinforce its intent. Beyer, *supra* note 20 (manuscript at 6).

an express, contrary indication by the donor, a person other than the donor is barred from making, amending, or revoking an anatomical gift of a donor's body or part if the donor made an anatomical gift of the donor's body or part."[57] This addition, known as first-person authorization or first-person consent, forbids families from overriding a decedent's explicit donation of her organs; doctors and hospital personnel are thus required to follow the decedent's directive, not the wishes of the family.[58]

First-person authorization was not a groundbreaking concept when it was included as part of the 2006 Revised Act. States began enacting first-person-authorization laws in 1994[59] "based on the principle that a decision by a person with decision-making capacity should be respected even after he or she dies."[60] These laws are widely supported by empirical evidence that concludes that knowledge of a patient's wishes regarding organ donation both aids families in making their decisions and increases the likelihood they will authorize organ donation and be satisfied with their final decisions.[61] By 2006, nineteen states had first-person-authorization laws in place,[62] and currently all fifty states and the District of Columbia have enacted first-person-authorization laws.[63] The transplant community largely supports this concept, but doctors and OPOs do not always follow it when the next of kin opposes donation.[64]

The disparity between general favor for organ donation and consent rates has historically been and continues to be high.[65] Ninety-five percent of U.S. adults approve of organ donation, yet only fifty-four percent are registered organ donors.[66] First-person-authorization legislation is designed to narrow this gap by ensuring that survivors follow decedents' wishes whenever they are documented.[67] Eliminating the need for familial consent increases the conversion rate—the rate at

57. REVISED UNIF. ANATOMICAL GIFT ACT § 8(a).

58. Chon et al., *supra* note 52, at 172–73.

59. Levin, *supra* note 9 (manuscript at 7).

60. Chon et al., *supra* note 52, at 172.

61. Heather M. Traino & Laura A. Siminoff, *Attitudes and Acceptance of First Person Authorization: A National Comparison of Donor and Nondonor Families*, 74 J. TRAUMA & ACUTE CARE SURGERY 294, 299 (2012).

62. Levin, *supra* note 9 (manuscript at 7).

63. Chon et al., *supra* note 52, at 173.

64. *Id.* at 175.

65. Levin, *supra* note 9 (manuscript at 3).

66. U.S. Dep't of Health & Human Servs., *Organ Donation Statistics*, ORGANDONOR.GOV, https://organdonor.gov/statistics-stories/statistics.html (last visited Jan. 13, 2019) [https://perma.cc/4C2C-662E] [hereinafter *Organ Donation Statistics*].

67. Levin, *supra* note 9 (manuscript at 3).

which eligible donors[68] are "converted" into actual donors—because families, at least theoretically, cannot override the wishes of decedents who have indicated a preference to donate.[69] Thus, introducing first-person authorization increases the number of actual deceased organ donors because there is a higher likelihood that the donor's wish to donate, as opposed to the donor's family's wishes against donation, is respected.[70]

2. Good Faith Defense

Under both the original UAGA and the 2006 Revised Act, doctors and hospital personnel may assert an affirmative defense of good faith.[71] The good faith defense removes criminal and civil liability when doctors and other hospital personnel violate the UAGA but do so while attempting in good faith to act in accordance with the UAGA.[72] "The good-faith immunity provision . . . does not require strict compliance with the [UAGA]'s procedures for obtaining and conveying donative consent; rather, it immunizes good-faith efforts to comply with its mandatory procedures."[73] The widely accepted definition and objective standard adopted is "an honest belief, the absence of malice and the absence of design to defraud or to seek an unconscionable advantage."[74]

Courts have traditionally interpreted the defense's coverage extremely broadly, effectively protecting the medical community.[75] For example, courts found the good faith defense dispositive when a hospital worker mistakenly harvested bones from a decedent whose family had specifically refused consent[76] and when an eye bank harvested corneas from a deceased patient when doctors misread the consent form and mistakenly thought the family had authorized eye

68. Eligible donors are those patients who have been declared medically brain dead and do not have any organs with major diseases or infections. *See* 42 C.F.R. § 486.302 (2018).

69. Levin, *supra* note 9 (manuscript at 5).

70. *Id.*

71. REVISED UNIF. ANATOMICAL GIFT ACT prefatory note (2006) (UNIF. LAW COMM'N, amended 2009); UNIF. ANATOMICAL GIFT ACT § 4(a) (1968) (UNIF. LAW COMM'N, amended 1987).

72. Beyer, *supra* note 20 (manuscript at 7).

73. 22A AM. JUR. 2D *Dead Bodies* § 91 (2013).

74. *See* Sattler v. Nw. Tissue Ctr., 42 P.3d 440, 443 (Wash. Ct. App. 2002) (internal quotation marks omitted) (quoting Nicoletta v. Rochester Eye & Human Parts Bank, Inc., 519 N.Y.S.2d 928, 930 (Sup. Ct. 1987)) (tracking the creation of the definition by a New York court and subsequent adoption by a federal district court and state courts in Arizona, Michigan, Minnesota, and Alabama).

75. Leonard H. Bucklin, *Woe unto Those Who Request Consent: Ethical and Legal Considerations in Rejecting a Deceased's Anatomical Gift Because There Is No Consent by the Survivors*, 78 N.D. L. REV. 323, 334–35 (2002).

76. Ramirez v. Health Partners of S. Ariz., 972 P.2d 658, 662 (Ariz. Ct. App. 1998).

donation.[77] The public policy rationale behind the defense is to encourage medical personnel to move forward with donation and transplantation operations without fear of subsequent liability.[78] Courts consider this rationale when determining whether defendants may successfully invoke the defense.[79] Transplant professionals have only asserted the defense in actions brought by a donor's family, as there are no plaintiffs to sue on behalf of patients on the waiting list to enforce compliance with first-person authorization.[80] Thus, transplant professionals have never had the need to assert the defense in a suit brought by a decedent's estate for failing to retrieve and donate organs when she registered as a donor but the OPO allowed her family to override her decision.

3. A Failed State-Driven Presumed-Consent Model

More than two-thirds of states previously experimented with presumed-consent statutes, beginning in the late 1960s. These statutes allowed for the retrieval of corneas and other eye tissues, pituitary glands, and occasionally organs from deceased individuals in coroners' or medical examiners' custody.[81] The rationale behind presumed consent was that donating an eye tissue or, in rare circumstances, an organ was no more invasive than a full autopsy, and therefore no additional rights were infringed.[82] Coroners and medical examiners could only proceed with the retrieval if they were unaware of any objections by the individuals or family members.[83] As discussed previously, the 1987 UAGA reinforced presumed-consent statutes by recommending provisions for the donation of any organ or tissue from cadavers in coroners' and medical examiners' custody when certain

77. Lyon v. United States, 843 F. Supp. 531, 536 (D. Minn. 1994).

78. *See* Bucklin, *supra* note 75, at 336 (citing Williams v. Hofmann, 223 N.W.2d 844, 848–49 (Wis. 1974)).

79. *See Sattler*, 42 P.3d at 443 ("Affording the good faith defense to procurement organizations effectuates the Legislature's intent. Without the protection from liability provided by the good faith defense, procurement organizations would likely hesitate to seek needed donations."); *Williams*, 223 N.W.2d at 848–49 (stating that "limitation on liability contained in [section 7(c) of the UAGA of 1968] . . . is justified by the legitimate public purpose of encouraging doctors to participate in the removal of organs following death, and therefore increasing their supply").

80. *See* KASERMAN & BARNETT, *supra* note 14, at 45–50, 147 n.20 (concluding that violations of first-person authorization have gone unpunished because there is no plaintiff to enforce compliance).

81. David Orentlicher, *Presumed Consent to Organ Donation: Its Rise and Fall in the United States*, 61 RUTGERS L. REV. 295, 299 (2009).

82. *Id.* at 299–300.

83. *Id.* at 300.

prerequisites were met.[84] After implementation, numerous state courts found no violation of individual rights when individual plaintiffs challenged the statutes.[85]

Two federal appellate court decisions, however, triggered the movement to repeal presumed-consent legislation.[86] In *Brotherton v. Cleveland*,[87] the U.S. Court of Appeals for the Sixth Circuit "recognized a Fourteenth Amendment procedural due process right for family members" when the coroner took the corneas of the plaintiff's spouse after hospital personnel had specifically documented her objection in the medical record.[88] The coroner had a policy "not to obtain a next of kin's consent or to inspect the medical records or hospital documents before removing corneas."[89] The Sixth Circuit never decided what level of process was due to the plaintiff; only that "some process was due to her before the corneas could be taken."[90]

The Ninth Circuit recognized in *Newman v. Sathyavaglswaran*[91] that "family members may claim property rights in the body of a deceased person" and some level of process is due to the family before removing a decedent's corneas.[92] In *Newman*, the coroner—who made approximately $250,000 per year from selling corneas to a for-profit tissue bank—made every effort to avoid speaking with the family to ensure he would not learn about any objections.[93] Soon after, a trend toward abandoning presumed consent emerged, and the 2006 Revised Act essentially eliminated the 1987 provision encouraging it.[94] All but

84. *Id.*; *supra* note 46 and accompanying text. The 2006 Revised Act similarly allows "any other person having the authority to dispose of the decedent's body" (which is often a coroner or medical examiner) to make an anatomical gift after a reasonable search for family members and no knowledge of refusal or objection. REVISED UNIF. ANATOMICAL GIFT ACT § 9(a)(10) & cmt. (2006) (UNIF. LAW COMM'N, amended 2009). But the commentary states that "in that case it is most unlikely that the decedent's organs could be donated as they are not likely to be medically suitable for transplantation or therapy given the amount of time that likely will pass before it can be determined that no one else will claim the body." *Id.* § 9 cmt. Of course, states could have adopted the UAGA without including coroners or medical examiners as persons authorized to dispose of bodies.

85. Orentlicher, *supra* note 81, at 300.

86. *Id.* at 305–08.

87. 923 F.2d 477 (6th Cir. 1991).

88. Orentlicher, *supra* note 81, at 306.

89. *Brotherton*, 923 F.2d at 478.

90. Orentlicher, *supra* note 81, at 306.

91. 287 F.3d 786 (9th Cir. 2002).

92. Orentlicher, *supra* note 81, at 307.

93. *Id.* at 306.

94. REVISED UNIF. ANATOMICAL GIFT ACT § 9 cmt. (2006) (UNIF. LAW COMM'N, amended 2009); *see supra* note 84.

a few states repealed their presumed-consent laws, and those who retained them mainly did so for cornea procurement only.[95]

C. Federal Regulation

Federal law prescribes standards for the procurement, allocation, and transplantation of organs; it governs everything that happens to the decedent and donee once the decedent's donor status is confirmed. In 1984, the National Organ Transplant Act ("NOTA") created the Division of Organ Transplantation to oversee the OPTN and Scientific Registry and to assert federal regulation over OPOs and UNOS by exercising its rulemaking authority.[96] The OPTN organizes a national listing of transplant candidates, and the Scientific Registry tracks records of organ donees. OPOs and UNOS predate NOTA, having developed as hospitals and regions gradually cooperated and shared organs. It was necessary for OPOs to produce a uniform list of waiting patients through UNOS to allocate organs as they became available, because the market of donors and donees expanded and hospitals within a given region needed to share information fluidly with each other and their designated OPO.[97] Scholars debate how Congress envisioned the execution of a federal system of transplant regulation under NOTA.[98] The public policy underlying NOTA, however, has never been seriously questioned or evaluated; it is merely a de facto adoption of the policy that justified the system as it existed in 1984.[99] The federal

95. *See, e.g.*, IND. CODE § 36-2-14-19 (2018) (allowing coroners and medical examiners to remove corneas for transplant when they have attempted to contact individuals authorized to make or refuse such a donation and do not know of any objection to the removal and donation of the decedent's corneas); WIS. STAT. § 157.06 (2018) (allowing coroners and medical examiners to retrieve organs when there is no evidence of either making or refusing an anatomical gift and every reasonable effort has been made to locate individuals who would be authorized to make or refuse an anatomical gift on behalf of the decedent); *see also* Orentlicher, *supra* note 81, at 307–08.

96. Howard et al., *supra* note 11, at 11.

97. *Id.*

98. *See* KASERMAN & BARNETT, *supra* note 14, at 8 (noting that Congress passed NOTA in response to a Virginia physician attempting to alleviate the organ shortage by brokering living-donor kidneys); James F. Blumstein, *Government's Role in Organ Transplantation Policy*, 14 J. HEALTH POL. POL'Y & L. 5, 22 (1989) (arguing NOTA had "distinct elements of a market-perfecting orientation . . . compatible with a pluralistic, decentralized, voluntary system" and the resulting network was much more centralized and uniform than intended by drafters); Frank A. Sloan et al., *Is There a Rationale for Regionalizing Organ Transplantation Services?*, 14 J. HEALTH POL. POL'Y & L. 115, 128–34 (1989) (arguing that Congress sought to establish a national procurement and distribution system but was unsuccessful because allocation remains in the hands of local and regional networks).

99. KASERMAN & BARNETT, *supra* note 14, at 8.

Act solidified the system of altruistic donation[100] and established the OPTN and Scientific Registry.[101]

UNOS oversees the national registry of potential donors and the waiting list of potential donees.[102] In 1969, the South-Eastern Organ Procurement Foundation ("SEOPF"), an independent nonprofit organization serving eight transplant centers in four states and the District of Columbia, developed under federal contract a computer system to create an organ-procurement and sharing network.[103] Many transplant centers outside of SEOPF's region sought to use the computer system, and in 1977, it was officially named the United Network for Organ Sharing and became the national computer system for registering transplant candidates and sharing organs across the country.[104] Before NOTA's passage in 1984, some regional sharing occurred outside of states and OPOs that matched using UNOS, but NOTA required that all transplant candidates be listed on UNOS and only permitted organ sharing through the OPTN.[105]

In response to a widening gap between donor-eligible deaths and successful donations, HHS adopted two significant recommendations in its 1998 final rule: (1) routine referral and (2) required request.[106] Routine referral requires hospital personnel to refer all deaths that occur in the hospital to its OPO.[107] Required request obliges hospital personnel to discuss the possibility of organ donation with surviving family members, giving every family the opportunity to donate their family member's organs.[108] Despite this federal mandate, a study analyzing data on organ-donation consent rates between 2008 and 2011

100. By codifying the contemporary system of altruistic donation, Congress prevented the possible formation of any market system for organ donation. *See id.* at 51–54 (arguing for the creation of a market system in the United States).

101. *Id.* at 12.

102. *Id.* at 13.

103. Howard et al., *supra* note 11, at 11.

104. *Id.*

105. *Id.*

106. 42 C.F.R. §§ 486.324, .342 (2018); Identification of Potential Organ, Tissue, and Eye Donors, 63 Fed. Reg. 33,856, 33,869–70 (June 22, 1998) (to be codified at 42 C.F.R. pt. 482). The 1987 UAGA, an update of the original 1968 model statute, included another requirement, called routine inquiry. Routine inquiry requires hospital personnel to ask patients upon admittance if they would consider being organ donors, so the donative intention of every patient who enters the hospital is known. UNIF. ANATOMICAL GIFT ACT § 5(a) (UNIF. LAW COMM'N 1987), *amended by* REVISED UNIF. ANATOMICAL GIFT ACT (2006) (UNIF. LAW COMM'N, amended 2009). But only twenty-four states adopted the 1987 UAGA. Crowe & Cohen, *supra* note 36. HHS did not include the routine-inquiry requirement in any regulation, but 42 C.F.R. § 486.324(b)(12) gives OPO boards the authority to recommend policies to assist "hospitals in establishing and implementing protocols for making routine inquiries about organ donations by potential donors." The 2006 Revised Act also does not include this requirement, but it is unclear why.

107. Identification of Potential Organ, Tissue, and Eye Donors, 63 Fed. Reg. at 33,870.

108. 42 C.F.R. § 486.342(a).

found that in three percent of cases (1,080 deaths), eligible donors' families were not asked to donate the decedent's organs.[109] Even when physicians did discuss organ donation with families, they refused to consent in forty-six to fifty percent of cases.[110] In theory, routine referral and required request should have a significant impact on the number of donors, but in practice, there is no enforcement mechanism to ensure hospitals are following protocol.

II. UNENFORCED RIGHTS AND OBLIGATIONS

Gift law governs organ donations and creates a binding contract between the donor and the respective OPO: the donor intends to have her organs donated for transplantation (or other specified purposes) upon her death, and the OPO will follow her wishes if medically possible.[111] All three elements of an executed gift are present: donative intent, transfer or delivery, and acceptance.[112] When an OPO concedes to family objections and refuses to procure the decedent's organs, that legally binding promise is compromised, which violates both the 2006 Revised Act's first-person-authorization provision and common law gift law.[113] This Part first presents the two areas of law currently governing organ transplantation and then explains why hospitals and OPOs continue to degrade first-person authorization without repercussion. It concludes by positing that OPOs, as private, nonprofit actors, must be held to the same standards as other nonprofits and risk losing tax-exempt status if they breach 501(c)(3) duties to confer a public benefit.

A. Property Rights in Dead Bodies

The "no property" rule—a common law principle that no one has a property right of ownership in a dead body—developed in English

109. *See* David S. Goldberg et al., *Deceased Organ Donation Consent Rates Among Racial and Ethnic Minorities and Older Potential Donors*, 41 CRITICAL CARE MED. 496, 499 (2013).

110. Orentlicher, *supra* note 81, at 309–10.

111. *See* Alexandra K. Glazier, *Organ Donation and the Principles of Gift Law*, 13 CLINICAL J. AM. SOC'Y NEPHROLOGY 1283, 1283 (2018) ("The UAGA establishes gift law as the central legal principle in the United States opt-in system of organ donation."); Daniel G. Jardine, Comment, *Liability Issues Arising out of Hospitals' and Organ Procurement Organizations' Rejection of Valid Anatomical Gifts: The Truth and Consequences*, 1990 WIS. L. REV. 1655, 1657, 1671.

112. *See* Alexandra K. Glazier, *The Principles of Gift Law and the Regulation of Organ Donation*, 24 TRANSPLANT INT'L 368, 368 (2011).

113. *See Adherence to First Person Consent*, NATCO (Nov. 2009), http://www.natco1.org/Advocacy/files/First Person Consent.pdf [https://perma.cc/GDQ3-EW4K] [hereinafter *NATCO Policy Statement*].

common law.[114] English common law, however, did recognize the right of a decedent's executors to custody and possession of the body until its proper burial.[115] Using English common law as a foundation, U.S. courts similarly adopted the no property rule and protected the family's right of proper burial as a "quasi-property" right.[116] This quasi-property right gives next of kin a cause of action against anyone who tortiously interferes with the burial and proper preservation of remains.[117] But once buried, the next of kin loses any constitutionally protected property interest in the body.[118] The phrase "quasi-property" is misleading, as it creates no real property rights and only has vague legal protections for both controlling the body for burial and preventing organ removal.[119]

Some states have modified common law principles to recognize stronger property rights in dead bodies. For example, Texas has modified the common law to prioritize a decedent's properly expressed wishes regarding burial instructions over the wishes of living individuals who have the right to control the disposition of the decedent's remains.[120] But there is no statutory penalty for failing to comply with the decedent's wishes.[121] Other "states recognize a legitimate claim of entitlement by the next of kin to possession of the remains . . . for burial or other lawful disposition" and permit next of kin to bring 42 U.S.C. § 1983 actions arising from an "alleged deprivation of procedural due process with regard to such remains."[122]

To some extent, the UAGA itself morphed common law property principles concerning dead bodies. Although the Act does not grant to any person a property right in the donor's dead body, it recognizes the OPO's superior right to the body over the "limited privilege of the next

114. P.D.G. Skegg, *Medical Uses of Corpses and the 'No Property' Rule*, 32 MED. SCI. & L. 311, 311–12, 314 (1992). It is unclear where this principle originated, with scholars speculating that the rule developed either as a result of dead bodies normally being subject to the control of the ecclesiastical courts or because judges believed that treating corpses as property would devalue them. *Id.* at 314.

115. *Id.* at 312.

116. 25A C.J.S. *Dead Bodies* § 2 (2018).

117. *Id.*

118. 22A AM. JUR. 2D *Dead Bodies* § 5 (2013).

119. Bucklin, *supra* note 75, at 327 ("It seems reasonably obvious that the word 'quasi-property' [was] something evolved out of thin air to meet the occasion, and that in reality the personal feelings of the survivors [were] being protected, under a fiction likely to deceive no one but a lawyer." (alterations in original) (quoting W. PAGE KEETON ET AL., PROSSER AND KEETON ON TORTS § 12 (5th ed. 1984))).

120. Beyer, *supra* note 20 (manuscript at 8).

121. *Id.* (manuscript at 13).

122. 22A AM. JUR. 2D *Dead Bodies* § 4. Section 1983 actions are civil suits for the deprivation of rights. 42 U.S.C. § 1983 (2012).

of kin to later get the body for burial."[123] The law is currently too vague to determine the legal implications of not following this prescribed order of rights. For example, if a person violates the order, it is unclear what entity, if any, is entitled to sue. If the OPO gives up its superior interest, it is disregarding the decisions of both the donor and the potential donee,[124] but neither individual is in a position to sue to enforce her rights. The decedent has no legal representative available to advocate for her rights, and the potential donee has no idea that her potentially lifesaving organ would be available but for the OPO's refusal to procure it in violation of state law.

B. Gift Law

Gift law governs all anatomical donations in the United States[125] and derives from property law.[126] "A 'gift' is a voluntary transfer of property by one person to another without any consideration or compensation therefor."[127] A "perfected," or executed, gift has the same legal status as an executed contract if "founded upon the consent of the parties."[128] That is, the gift becomes legally enforceable. Three elements must be satisfied to constitute a legally enforceable gift: (1) donative intent, (2) transfer or delivery, and (3) acceptance.[129]

Donative intent requires that the donee make the gift voluntarily and form "an affirmative objective to donate."[130] This legal requirement is satisfied through the "document of gift," which is documentation that indicates the individual would like to consent to donate.[131] Under the current U.S. "opt-in" or "explicit-consent" donor-registration and donation system, an individual may document her consent to donate by signing a donor card—indicating such intent when she renews her license or registers online through her local OPO's or state's internet-based donor registry.[132]

123. Bucklin, *supra* note 75, at 333.

124. *Id.* at 342.

125. *Legal Aspects of a Registered Donor: What You Need to Know*, ALLIANCE (2017), https://organdonationalliance.org/wp-content/uploads/2017/10/CSuite-Snapshot-Fall-2017-FINAL.pdf [https://perma.cc/NRQ3-LYK6].

126. Glazier, *supra* note 112, at 368.

127. 38 AM. JUR. 2D *Gifts* § 1 (2010).

128. *Id.* § 2.

129. Glazier, *supra* note 112, at 368.

130. *Id.* at 369.

131. *Id.*

132. *Id.*

Transfer or delivery is the second step in perfecting a gift.[133] Delivery in the context of gift law may include manual delivery (physically transferring the property),[134] constructive delivery (transferring a physical object that will give access to the property),[135] or symbolic delivery (transferring a symbol of the property to eventually be transferred, such as a written instrument).[136] In the context of organ donation, symbolic delivery is satisfied when the OPO receives the electronic transmission or physical form indicating the donor's intent to donate organs upon death.[137]

Acceptance by the OPO is the final requirement to complete the legally enforceable gift, and the OPO accepts the gift by allowing the donor on the registry. The OPO, not the eventual donee, must accept the gift because under the UAGA, the OPO is the legal donee.[138] Therefore, the gifting of organs is completed before death and is legally enforceable upon the donor's death, as long as she does not change her mind before being declared medically brain dead.[139] OPOs that refuse to procure organs from a donor until the family consents are in the legal position of rejecting the gift and requesting the same gift again from the next of kin.[140]

Symbolic delivery is the most appropriate delivery paradigm in the context of organ donations. One scholar has suggested the transfer element is satisfied through manual delivery when doctors transplant the organ into the body of the donee.[141] This theory is incorrect; if transferring the organ into the donee's body were the only way to satisfy the transfer requirement, the anatomical gift would not be legally

133. 38 AM. JUR. 2D *Gifts* § 2, at 762 n.5 ("[D]elivery is the adrenaline that makes it a contract executed.").

134. *Id.* § 19 (actual delivery is given when it is shown that the "owner parted with dominion and control over the gift").

135. *Id.* § 21 (constructive delivery is given when, "in place of actual manual transfer, the donor delivers to the donee the means of obtaining possession and control of the subject matter or, in some other manner, relinquishes to the donee power and dominion over it").

136. *Id.* (symbolic delivery is given when, "instead of the thing itself, some other object is handed over in its name and stead").

137. Symbolic delivery is permitted when manual or constructive delivery is impossible. *Id.*

138. REVISED UNIF. ANATOMICAL GIFT ACT § 11(c)(3) (2006) (UNIF. LAW COMM'N, amended 2009) ("If the part is an organ and the gift is for the purpose of transplantation or therapy, the gift passes to the appropriate organ procurement organization as custodian of the organ.").

139. *Id.* § 6(a) (describing the process of amending and revoking an anatomical gift as done before a donor's death).

140. Bucklin, *supra* note 75, at 337–38.

141. Glazier, *supra* note 112, at 370 (identifying the transfer element of a gift as one that "involves the recovery of the donated organ and the delivery of the organ to the recipient"). Alexandra Glazier is the president and CEO of New England Donor Services, an affiliation between two OPOs. *See* Alexandra Glazier, LINKEDIN, https://www.linkedin.com/in/alexandra-glazier-914677 (last visited Jan. 13, 2019) [https://perma.cc/42M3-JWVQ].

binding until after such a transfer. Thus, an OPO (and eventual transplant donee) would not have legal title to the organ until it had already been transplanted. This framework risks not fulfilling the donor's wishes if the family is allowed to intervene and disrupt the donor's intent. A manual delivery theory is incorrect also because it designates acceptance by the donee or donee's surgeon as fulfilling the legal requirement of acceptance,[142] whereas the UAGA states explicitly that the OPO is the legal donee of the organ.[143]

C. The Current Lack of Enforcement of First-Person Authorization

OPOs have employed diverse tactics to implement first-person-authorization statutes—such as communicating to families their desire to honor the patient's wishes rather than asking for consent[144]—but a significant number of registered donors' wishes are still not followed. Not executing a donor's gift is a violation of first-person-authorization statutes in every state; as of 2013, however, twenty percent of OPOs still had not procured an organ when the next of kin objected, and thirty-five percent reported they had yet to "proceed with organ procurement from a registered organ donor whose family objected to donation."[145] Fifteen percent of OPOs had not been presented with the dilemma and may still refuse to procure organs when confronted with family objections.[146]

The acts of OPOs that refuse to honor first-person authorization are not only unethical[147] but in express violation of section 8(a) of the 2006 Revised Act. The ULC added section 8(a) in response to OPOs not

142. Glazier, *supra* note 112, at 370 (highlighting that the donee or the donee's surgeon may accept the gift).

143. *See* REVISED UNIF. ANATOMICAL GIFT ACT § 11(c)(3) (designating organ procurement organizations as custodians of the gifted organ); *see also* Bucklin, *supra* note 75, at 329 (declaring the OPO "the 'donee' of the gift from the donor").

144. Chon et al., *supra* note 52, at 173.

145. *Id.* at 172–73; *see also* Casey Leins, *Should the Government Decide if You're an Organ Donor?*, U.S. NEWS & WORLD REP. (Feb. 12, 2016, 1:37 PM), www.usnews.com/news/articles/2016-02-12/presumed-consent-and-americas-organ-donor-shortage [https://perma.cc/5FHL-KVSW] ("[H]ealth care workers still don't want to take organs without the family's consent and don't follow [first-person-authorization laws] in practice, says Arthur Caplan, director of the Division of Medical Ethics at the New York University Langone Medical Center.").

146. Fifty-one OPOs reported that a registered donor's family objects in less than ten percent of cases, six OPOs reported that a registered donor's family objects in eleven to twenty-five percent of cases, and one OPO did not respond. Chon et al., *supra* note 52, at 172–74; *see also* Traino & Siminoff, *supra* note 61, at 296 (noting that while "some OPOs will uphold decedents' wishes in the face of family dissent, others choose not to procure out of habit and/or to prevent negative publicity").

147. *See* Chon et al., *supra* note 52, at 175.

in compliance with the 1987 UAGA,[148] and the drafters specifically intended to clarify and address this problem.[149] The ULC included in its notes to the 2006 Revised Act that seeking affirmation of a gift from the donor's family could result in not only unnecessary delays in recovering the organs but also the reversal of the donor's donation decision:

> Section 8 intentionally disempowers families from making or revoking anatomical gifts in contravention of a donor's wishes. Thus, under the strengthened language of this [Act], if a donor had made an anatomical gift, there is no reason to seek consent from the donor's family as they have no right to give it legally.[150]

Involving families in the organ transplantation process is permissible,[151] but allowing them to override the decedent's wishes is not.

NATCO, a trade group for transplant professionals, has announced its support for first-person authorization and the 2006 Revised Act.[152] But it mischaracterized the legal issue: NATCO recognized that "not accepting the donation from a clinically suitable donor is a violation" of the UAGA, but transplant professionals' "[f]ears about litigation should be mitigated by" the good faith defense when they proceed with organ and tissue donations in the face of family objections.[153] This statement correctly notes that transplant professionals should feel confident that they will be insulated from litigation when they act in good faith, but it fails to address OPOs' legal obligations to procure donated organs. No OPO, transplant center, or doctor has been penalized to date for refusing to honor first-person authorization, which, in turn, creates a perverse incentive for OPOs and others involved in the donation process to keep discarding the express wishes of the decedent in exchange for the grieving family's approval.[154]

OPOs that do not procure organs over family objections cite potential lawsuits and negative publicity as the primary motivating

148. The 1987 UAGA included one provision that mandated OPOs follow first-person authorization. *See* UNIF. ANATOMICAL GIFT ACT § 2(h) (UNIF. LAW COMM'N 1987), *amended by* REVISED UNIF. ANATOMICAL GIFT ACT.

149. REVISED UNIF. ANATOMICAL GIFT ACT prefatory note.

150. *Id.*

151. Chon et al., *supra* note 52, at 175.

152. *NATCO Policy Statement*, *supra* note 113.

153. *Id.*

154. KASERMAN & BARNETT, *supra* note 14, at 147 n.20:

> After death, the rights of the intended recipient (if one exists) are to dominate the claims of all others under this law. Nonetheless, attending physicians routinely require permission from the patient's family before removing the organs. . . . Such violations have gone unpunished to date, apparently because there is no identifiable plaintiff to enforce compliance.

factors in neglecting the donor's wishes.[155] Transplant professionals' fear of potential lawsuits is based on a misinterpretation of the law, as *not* following the decedent's wishes violates the 2006 Revised Act. Fear of negative publicity, however, may not be misplaced. Only once has an OPO filed suit to retrieve organs from a registered donor when the family vehemently objected,[156] and the move came with significant backlash. Although the OPO won and procured the registered donor's organs, the local media focused on the family's grief and disbelief that doctors could take its son's organs over its wishes.[157] Given that OPOs are responsible for registering and educating the public in their regions and maintaining close working relationships with transplant centers,[158] it is unsurprising some will trade UAGA compliance for positive relationships with communities and hospitals. Thus, OPOs need stronger incentives to comply with first-person authorization while preserving positive relationships with health-care providers.

D. 501(c)(3) Status and Obligations

OPOs incorporate as nonprofit organizations in the state in which they are headquartered. A nonprofit, or 501(c)(3), organization enjoys tax-exempt status[159] but must be organized and operated exclusively for religious, charitable, scientific, testing for public safety, literary, or educational purposes, among others inapplicable in the organ-donation context.[160] State nonprofit law governs nonprofits, which the state attorney general enforces. Typically, the state attorney general alone has the power to bring lawsuits to enforce compliance

155. Chon et al., *supra* note 52, at 176; *NATCO Policy Statement*, *supra* note 113. Some organ-donation advocates argue that

> [s]ince most Americans approve of organ donation, it is difficult to imagine a newspaper's editor siding with a next of kin who wants to prevent his deceased relative's decision to make an organ donation. It is more likely that the newspaper would paint the next of kin as a person trying to frustrate a decedent's dying wish and call the OPO a hero for implementing the moral act of the decedent.

Bucklin, *supra* note 75, at 339–40 (footnote omitted).

156. Chon et al., *supra* note 52, at 173; Allison Manning, *Family Loses Fight to Keep Son's Organs from Donation*, COLUMBUS DISPATCH (July 11, 2013, 12:01 AM), http://www.dispatch.com/content/stories/local/2013/07/11/Judge-ordered-family-to-let-brain-dead-son-donate-organs.html [https://perma.cc/EMJ3-EVLE] (describing the first time that Lifeline of Ohio, an organ procurement organization, went to court over a donation).

157. *See Court: Man's Organs Donated Despite Mom's Plea*, TIMESREPORTER.COM (July 12, 2013, 12:01 PM), http://www.timesreporter.com/article/20130712/NEWS/307129861 [https://perma.cc/AJ6K-WKAY]; Manning, *supra* note 156.

158. KASERMAN & BARNETT, *supra* note 14, at 13; Howard et al., *supra* note 11, at 14.

159. 26 U.S.C. § 501(c)(3) (2012).

160. *Id.*

with 501(c)(3) because she "is the representative of the public in compelling the trustees to perform their duties properly."[161]

Section 501(c)(3) also requires that no part of the net earnings of the organization benefit any private shareholder or individual, no substantial part of the organization's activities be devoted to attempts to influence legislation, and no part of the organization's activities include participating in a political campaign on behalf of a candidate for public office.[162] The U.S. Supreme Court has imposed another requirement for organizations to obtain and maintain tax-exempt status: they must serve a valid public purpose and confer a public benefit.[163] A single substantial nonexempt purpose or payment will "destroy the exemption regardless of the number or importance of [the] truly [exempt] purposes" of the organization.[164] In *Bob Jones University v. United States*, the Supreme Court held that the IRS properly denied tax-exempt status to a nonprofit private school because its racially discriminatory admissions standards were "so at odds with the common community conscience as to undermine any public benefit that might otherwise be conferred."[165]

Federal law requires OPOs to operate as nonprofit organizations that advance a scientific purpose.[166] Specifically, they must identify potential organ donors within their service areas; conduct systematic efforts to acquire all usable organs from potential donors; arrange for the acquisition and preservation of donated organs and set quality standards for such a process; allocate donated organs equitably among transplant patients; provide or arrange for the transportation of donated organs to transplant centers; assist hospitals in establishing and implementing protocols for routine request; and fulfill other duties set forth by federal regulation.[167] OPOs confer a public benefit by managing organ-procurement and allocation systems to facilitate organ donation within their geographic areas and by conducting public outreach to increase the number of registered donors and thus the number of lifesaving organ transplants performed each year.

When an OPO does not comply with first-person-authorization legislation, it undermines the public benefit it purports to confer—and thus puts its nonprofit status in jeopardy. If the IRS were to revoke

161. MARILYN E. PHELAN, NONPROFIT ORGANIZATIONS: LAW AND TAXATION § 14:6 (2d ed. 2018).

162. 26 U.S.C. § 501(c)(3); PHELAN, *supra* note 161, § 12:1.

163. Bob Jones Univ. v. United States, 461 U.S. 574, 589–91 (1983).

164. Better Bus. Bureau of Wash., D.C., Inc. v. United States, 326 U.S. 279, 283 (1945).

165. 461 U.S. at 592.

166. 42 U.S.C. § 273(b)(1)(A) (2012).

167. *Id.* § 273(b)(3).

nonprofit status, the OPO would face several consequences: losing eligibility to receive tax-deductible contributions, losing exempt status from federal income tax, becoming obligated to pay corporate income tax on annual revenue, and potentially being subjected to back taxes.[168] More importantly, the population the OPO serves would have to be absorbed by other OPOs. Even if the added population and donor numbers were proportional after absorption, other OPO responsibilities—such as educating the public in order to increase donor rates—would be spread more thinly, and at least in the interim, the same number of personnel would become responsible for coordinating more transplants.[169] For example, the Iowa Donor Network, the OPO that serves the state of Iowa, is responsible for more than three million people.[170] If it were to shut down, more than three million people would have to be absorbed by other OPOs, who would have to take on the responsibility for education efforts and coordination of transplants among this additional population. Also, the dissolution of an OPO could send a negative message to the public about the stability and importance of the organ-donation system—if the OPO in the area does not operate according to law, how can we trust other OPOs to follow the law?

III. AMENDING THE UAGA ONCE MORE

States spearheaded the movement toward improved coordination and regulation of the organ-donation process with the 1968 UAGA; they should endeavor to regain their roles as the true regulators and enforcers in an effort to drive up the organ supply. Although the federal government largely regulates OPOs, they are incorporated under state law and should be held accountable to serve the taxpayers of the states that grant them 501(c)(3) status. State policies implemented during the past two decades to increase organ

168. *See Revocation of Tax Exemption*, NAT'L COUNCIL NONPROFITS, https://www.councilofnonprofits.org/tools-resources/revocation-of-tax-exemption (last visited Jan. 13, 2019) [https://perma.cc/49N2-D75F]; *Revoked? Reinstated? Learn More*, IRS, https://www.irs.gov/charities-non-profits/automatic-revocation-of-exemption (last updated Dec. 13, 2018) [https://perma.cc/35JZ-HVQB].

169. *See* Howard et al., *supra* note 11, at 14 (describing the federal regulation imposed upon OPO operations that requires the use of "systematic efforts, including professional education, to acquire all usable organs from potential donors," while noting that the decrease in the number of OPOs has been met with an increase in transplant centers).

170. SCI. REGISTRY OF TRANSPLANT RECIPIENTS, IOWA DONOR NETWORK 7 (2018), https://www.srtr.org/document/pdf?fileName=%5C102018_release%5CpdfOSR%5CIAOPOP1XX201805P.pdf [https://perma.cc/M6LT-KYDB].

donation have had little to no effect.[171] The first-person-authorization component of the 2006 Revised Act has made no significant impact on donation rates,[172] and states must enforce their laws and closely monitor the organizations that are responsible for the transplant process—which involves life-and-death matters—within their jurisdictions.

Even if state attorneys general strictly enforced first-person authorization, they would not substantially close the gap between the numbers of organs available and patients on the waiting list.[173] Federal regulation currently requires OPOs to meet specific performance standards,[174] but simply raising such standards will not supply OPOs with adequate resources to increase the organ-donor pool. Thus, to significantly resolve the organ shortage, states should adopt a twofold solution by amending the UAGA to (1) switch the donation system to "presumed consent" but allow individuals to opt out of being an organ donor, either through online registries or while renewing their driver's licenses, and (2) create a monitoring and enforcement mechanism for the new system within state health departments and offices of attorneys general. These amendments would essentially create a state statutory scheme that requires OPOs to procure organs of a decedent unless the individual expressed her wishes not to donate during her lifetime and excludes the next of kin from the process entirely. This type

171. *See* Paula Chatterjee et al., *The Effect of State Policies on Organ Donation and Transplantation in the United States*, 175 JAMA INTERNAL MED. 1323, 1327 (2015) (finding that the passage of revenue policies, "contributing to an additional 6.5 deceased donors and 8 transplants from deceased donors per year for an average state," had only a small effect); Satel & Cronin, *supra* note 7, at 1329 (examining six state-level policies from 1988 to 2010 and concluding that only a dedicated revenue stream for donor recruitment and promotion activities caused a "modest rise in the rate of transplants").

172. Chatterjee et al., *supra* note 171, at 1326–27 (noting that "[f]irst-person consent laws," among other efforts, "had no robust, significant association with either donation rates or number of transplants").

173. *See* KASERMAN & BARNETT, *supra* note 14, at 4 (stating that between thirteen thousand and twenty-nine thousand deaths occurred under circumstances that would allow for organ donation); Chon et al., *supra* note 52, at 172 (reporting that family objections only occur between ten and twenty-five percent of the time); *Donors Exceeded 10,000*, *supra* note 5 (stating that there were 10,281 deceased organ donors in 2017).

174. 42 C.F.R. § 486.318 (2018). Only nine to fourteen percent of OPOs 2009–11, however, were meeting the review criteria of the Scientific Registry, which bases its standards on observed yield and expected yield. Therefore, between eighty-six and ninety-one percent of OPOs were failing in all three areas of criteria: observed yield is at least ten percent lower than expected yield, observed yield per one hundred donors is at least ten less than expected yield per one hundred donors, and the observed yield is statistically significantly different than expected yield. David A. Zaun et al., *Monitoring Performance of Organ Procurement Organization in the United States: Observed and Expected Donor Yield*, SCI. REGISTRY TRANSPLANT RECIPIENTS (2011), https://www.srtr.org/media/1103/atc2012_zaun.pdf [https://perma.cc/T6CF-N575].

of system, termed a "hard opt-out" system, increased donation rates by twenty-five percent in Austria and Singapore.[175]

A. A Presumed-Consent Model

Enforcing first-person authorization in the current opt-in system will not be enough to combat the organ-donation shortage. In the last thirty years, the waiting list for an organ transplant has grown nearly eight-fold, from 15,029 people in 1988 to 113,737 as of February 2019,[176] while the number of donors has increased less than three-fold, from 5,909 in 1988 to 16,473 in 2017.[177] To address this disparity, individual states should adopt a presumed-consent model similar to those currently used in over twenty countries.[178] This model could be termed, as one scholar suggested, "default to donation" rather than "presumed consent" to achieve greater public acceptance and not be viewed as the taking of individual rights.[179]

1. Framing the Issue in Favor of Donation: Not So Radical After All?

Switching to an "opt-out," or presumed-consent model of donation, is not as radical or detrimental as some commentators suggest. In a study analyzing organ-recovery rates from twenty-two countries that do not require explicit consent, researchers found that these countries had approximately twenty-five to thirty percent higher recovery rates for deceased organ donors than countries with opt-in systems.[180] There has been remarkably high and long-standing support

175. *Organ Donation: Does an Opt-Out System Increase Transplants?*, BBC NEWS (Sept. 10, 2017), http://www.bbc.com/news/health-41199918 [https://perma.cc/33A9-58RN]; *see also What Is HOTA All About?*, SING. GOV'T (Aug. 21, 2013), https://www.gov.sg/factually/content/what-is-hota-all-about [https://perma.cc/7GNX-Z4Y9] (explaining Singapore's organ-donation system).

176. *Transplant Trends*, *supra* note 6; U.S. Dep't of Health & Human Servs., *Ethics of Deceased Organ Donor Recovery*, ORGAN PROCUREMENT & TRANSPLANTATION NETWORK, https://optn.transplant.hrsa.gov/resources/ethics/ethics-of-deceased-organ-donor-recovery (last visited Jan. 13, 2019) [https://perma.cc/3GVV-3R8X] [hereinafter *Ethics of Deceased Organ Donor Recovery*].

177. *Total Number of Organ Donors in the United States from 1988 to 2018*, STATISTA, https://www.statista.com/statistics/398384/total-number-of-us-organ-donors/ (last visited Jan. 31, 2019) [https://perma.cc/25MN-E2TG].

178. *See Ethics of Deceased Organ Donor Recovery*, *supra* note 176.

179. *See* Leins, *supra* note 145.

180. *Ethics of Deceased Organ Donor Recovery*, *supra* note 176; *see also* Shai Davidai et al., *The Meaning of Default Options for Potential Organ Donors*, 109 PROC. NAT'L ACAD. SCI. U.S. 15201, 15201 (2012) (noting the difference in average organ-donation rates between opt-in countries (less than fifteen-percent participation) and opt-out countries (more than ninety-percent participation) and attributing it to "the difference in relative effort and initiative required for participation"); Lee Shepherd et al., *An International Comparison of Deceased and Living Organ Donation/Transplant Rates in Opt-In and Opt-Out Systems: A Panel Study*, 12 BMC MED. 131

for organ donation by the general public, but the rate of organ-donor registration has remained low.[181] In one survey, HHS found that about half of Americans explicitly stated they would support an opt-out system.[182] Instead of drivers being asked to check a box to become an organ donor, they would be asked to check a box if they would prefer *not* to become an organ donor. This model returns higher rates of donation, social psychologists have theorized, because when faced with difficult decisions, people tend to avoid making a choice and instead prefer to follow the default option.[183]

Another study found that the type of system (opt in or opt out) causes large differences in the meaning that individuals attach to participation.[184] Participants asked to think about a country with an opt-in policy judged organ donation to be on par with highly meaningful and significant prosocial behaviors, such as giving away half of one's wealth to charity upon death, and almost equivalent to going on a hunger strike to advocate for a cause.[185] In contrast, participants asked to think about a country with an opt-out policy judged organ donation to be on par with prosocial behaviors that were relatively lower in meaningfulness and significance, such as letting others go ahead in line and volunteering to help the poor.[186] The study ultimately concluded not only that procrastination and laziness are factors contributing to individuals' failures to register in opt-in countries but also that

(2014) (analyzing data from forty-eight countries, including opt-in countries, and finding similar results and that higher rates are a direct cause of the opt-out systems).

181. Chon et al., *supra* note 52, at 172. As of 2016, ninety-five percent of Americans support organ donation, and sixty percent who have not signed up to be an organ donor would be willing to do so. *See* Leins, *supra* note 145. This is an increase from the eighty-five percent of Americans who supported organ donation in 1993 and the seventy-five percent who supported the practice in 1985. Identification of Potential Organ, Tissue, and Eye Donors, 63 Fed. Reg. 33,856, 33,857 (June 22, 1998) (to be codified at 42 C.F.R. pt. 482) (citing a 1993 Gallup poll); UNIF. ANATOMICAL GIFT ACT prefatory note (UNIF. LAW COMM'N 1987), *amended by* REVISED UNIF. ANATOMICAL GIFT ACT (2006) (UNIF. LAW COMM'N, amended 2009) (citing a 1985 Gallup poll).

182. Leins, *supra* note 145. *Contra Ethics of Deceased Organ Donor Recovery*, *supra* note 176 ("A deceased organ recovery model that does not require explicit consent would not gain sufficient support in the US to merit a policy change.").

183. *See* Dan Ariely, *Are We in Control of Our Own Decisions?*, TED (Dec. 2008), https://www.ted.com/talks/dan_ariely_asks_are_we_in_control_of_our_own_decisions [https://perma.cc/E3JZ-KHS7] (asserting that the reason countries with default organ-donation systems have higher rates of organ donation is that individuals tend to choose the default option when confronted with complicated decisions). This study is supported by data finding that mandatory-consent systems return much lower registration rates than expected. A mandatory-consent system forces individuals to choose, "Yes, I want to be a donor," or, "No, not at this time." A popular theory explains that this behavior is due to people feeling uncomfortable thinking about the ends of their lives and, when forced to make a choice, picking whichever choice does not force them to consider their demise. Levin, *supra* note 9 (manuscript at 13–14).

184. Davidai et al., *supra* note 180, at 15203.

185. *Id.*

186. *Id.*

"[p]articipation or nonparticipation . . . is heavily influenced by the meaning that people individually and collectively attach to the opt-in or opt-out choice in question."[187]

2. An Answer to the Question of Donative Intent

Families often claim a lack of knowledge of the decedent's donation preferences as a significant reason for refusing donation. Some families report that they interpret an undesignated donation status on a driver's license or lack of registration as a clear indication that the decedent had previously declined donation rather than an indication that the decedent was undecided.[188] Operating in a presumed-consent system would put families on notice that unless the decedent made the express choice to opt out, she intended to donate her organs. There would be no question regarding whether the decedent would have been okay with donating; if the idea of donation ran counter to her religious beliefs or morals or otherwise concerned her, she would have opted out.

The presumed-consent model would also more fully honor decedents' quasi-property rights than the current model. Gift law[189] currently infers donative intent from the affirmative decision to register to be an organ donor. Under a presumed-consent model, the donative intent is suddenly murkier: Did the decedent affirmatively intend to donate her organs, or did she forget to opt out? If she merely forgot to opt out, are her quasi-property rights in her own body now violated?[190] This potential violation of rights is the same issue that occurs in the current system when OPOs refuse to follow first-person authorization; individual preferences on how a body is used posthumously are discarded in place of the family's or doctor's judgment of what the individual *should* have wanted. Often, in situations when a family objects and overrides a decedent's preference for organ donation, it is not thinking about what the decedent wanted but what it wants in its immense time of grief.[191]

Ninety-five percent of adults in the United States currently support organ donation,[192] and sixty percent of those who have not registered are willing to do so.[193] While fifty-four percent of the adult

187. *Id.*

188. Levin, *supra* note 9 (manuscript at 13).

189. *See supra* Section II.B.

190. *See Ethics of Deceased Organ Donor Recovery*, *supra* note 176 (explaining a major criticism of the presumed-consent model is that if the decedent forgot to opt out, her individual rights would be violated).

191. Orentlicher, *supra* note 81, at 311–12.

192. *Organ Donation Statistics*, *supra* note 66.

193. Leins, *supra* note 145.

population is already registered, approximately another twenty-seven percent of the population would also prefer to donate.[194] This means that 81.6 percent of the adult population in the United States likely wants to become organ donors.[195] Ethicists have argued that this is not nearly high enough to justify a presumed-consent model—this would indeed not be high enough if every person, regardless of preferences, had to donate and there was no ability to opt out.[196] But under the presumed-consent model this Note proposes, the ability to opt out is kept intact. Thus, by presuming consent, more decedents would have their quasi-property rights honored than in an opt-in model.

Moreover, OPOs and transplant centers could institute the routine inquiry requirement proposed in the 1987 UAGA[197]—asking every patient during admittance to the hospital whether she would or would not like to be an organ donor—which would serve as another filter to document objections long before either the hospital or patient must make the donation decision.

3. The United States' Previous Brush with Presumed Consent: Why This Time Is Different

A new presumed-consent system would address the problems that triggered the Sixth and Ninth Circuit cases that led to the dissolution of the state-driven opt-out system in the United States, discussed in Section I.B.3. Under the new system, a consolidated, online registry would hold objections—the same type currently used, but with the names of individuals who opt out of donating their organs. There would be no ability for hospital or OPO personnel to blind themselves to a patient's objection, as in *Brotherton* and *Newman*. Instead, to retrieve and transplant organs, the system would have to be checked, and whether the patient had registered her preference not to donate would have to appear on the death certificate. With technological advances, a phone call or fax has become a click of a button, making for a much more streamlined and easy-to-access objections database. Besides, procurements would occur in hospitals where patients die, providing more oversight than remote, disconnected locations run by

194. Forty-six percent of the adult population is not registered to donate, but sixty percent of that population would like to register. *See Organ Donation Statistics*, *supra* note 66 (stating fifty-four percent of the U.S. adult population is registered to donate). Thus, the percentage of the population that is unregistered but wishes to donate is 27.6 percent (46% × 60% = 27.6%).

195. This estimate comes from the sum of the registered donor population (fifty-four percent) and the population of unregistered donors who would like to donate (27.6 percent).

196. Chon et al., *supra* note 52, at 176.

197. UNIF. ANATOMICAL GIFT ACT § 5(a) (UNIF. LAW COMM'N 1987), *amended by* REVISED UNIF. ANATOMICAL GIFT ACT (2006) (UNIF. LAW COMM'N, amended 2009); *see supra* note 106.

individual doctors. Most importantly, no financial incentive to procure more organs would exist, because all organs would be directly gifted to an OPO and used for transplantation. Organs could only be sold if doctors successfully harvested them in the hospital without detection, smuggled them out of the hospital, and auctioned them on the black market—the same extreme (but unlikely) threat that exists in the current opt-in system.

Most significantly, the presumed-consent system this Note proposes would create a hard opt-out policy[198] rather than the soft opt-out policy[199] previously implemented. Empowering state attorneys general to sue OPOs that do not follow first-person authorization for breaching 501(c)(3) status creates a hard opt-out policy and is necessary because "a key reason why organs are not obtained after a person's death is the unwillingness of family members to give consent"[200] when donative intentions are unknown. This failure to follow first-person authorization was a central flaw in the implementation of the brief, ill-regulated presumed-consent system used by states in the 1960s.[201]

B. A Monitoring and Enforcement Mechanism

Transitioning from an opt-in to opt-out presumption in favor of donation will not eradicate the issue of OPOs' failure to follow first-person authorization. Individual autonomy to choose organ donation is at the centerpiece of state organ-donation legislation yet is not consistently followed—OPOs have neither the motivation nor tools to enforce a decedent's wishes, and a presumed-consent policy will not necessarily change this. The first-person-authorization problem presents itself differently in a presumed-consent system: an individual chooses not to opt out and fails to communicate her intentions,[202] and the family objects to the procurement of her organs when she dies.

Section 12(c) of the 2006 Revised Act allows for administrative sanctions for failing to abide by the statute, but there is no record of any OPO official receiving administrative sanctions for failing to follow first-person authorization. OPOs impose the administrative sanctions themselves, and states do not monitor or oversee OPOs' compliance with the UAGA on a case-by-case basis.[203] The only evidence that OPOs

198. *Consent for Organ Donation*, IR. DEP'T HEALTH, http://health.gov.ie/wp-content/uploads/2014/04/consentoptions.pdf (last visited Jan. 13, 2019) [https://perma.cc/9MPA-AVAY].

199. *Id.*

200. Orentlicher, *supra* note 81, at 309.

201. *Id.* at 309–10.

202. *Id.* at 311.

203. REVISED UNIF. ANATOMICAL GIFT ACT § 12(c) (2006) (UNIF. LAW COMM'N, amended 2009).

do not follow first-person authorization is anecdotal[204] and by anonymous self-reporting.[205] States need to create a monitoring and enforcement mechanism to remedy this oversight. This can be accomplished efficiently by amending the UAGA to require OPO bylaws to include a provision mandating that the OPO always follow first-person authorization. Any violation of such a provision would constitute a breach of the OPO's purpose to confer a public benefit,[206] thus providing grounds for revoking its 501(c)(3) status under state law. The new provision would delegate the task of monitoring OPOs' compliance to state health departments and empower state attorneys general to sue OPOs in breach of their 501(c)(3) statuses, the current enforcement mechanism for nearly all breaches of nonprofit status.[207]

1. State Attorneys General Enforce OPOs' 501(c)(3) Statuses

Currently, there appears to be no standard set of bylaws for OPOs mandated by federal regulation or state law. OPOs must meet performance standards set by federal regulation[208] and abide by applicable state laws as incorporated nonprofits, which includes first-person authorization statutes. But OPOs may currently ignore first-person authorization without repercussion. The UAGA should be amended to include a provision requiring a mandatory bylaw for all OPOs, such as the following: "The OPO shall abide by all provisions of the [name of the state statute adopting the UAGA], including first-person authorization, which forbids OPO personnel to allow next of kin to override the decedent's decision to donate." Another provision should address the effect of the earlier provision, such as this example: "An OPO's failure to strictly follow all bylaws of the OPO will be considered a breach of the nonprofit's duty to confer a public benefit." The second provision is necessary to give state attorneys general sufficient grounds to argue that even one breach of first-person authorization provides a sufficient basis to sue. Most litigation regarding breaches of purpose and revocation of 501(c)(3) status is based on a substantial deviation from an organization's broader stated purpose,[209] so courts may decide one breach is not sufficient to consider revocation of 501(c)(3) status. To avoid this problem, this proposed provision makes clear that one breach is sufficient for OPOs to lose their nonprofit statuses or face other

204. *See* Leins, *supra* note 145.

205. Chon et al., *supra* note 52, at 173.

206. *See* Bob Jones Univ. v. United States, 461 U.S. 574, 592 (1983).

207. PHELAN, *supra* note 161, § 14:6.

208. 42 C.F.R. § 486.318 (2018).

209. PHELAN, *supra* note 161, § 12:1.

sanctions. Also, this interpretation of a breach for purposes of revocation of nonprofit status would be limited narrowly to the organ-donation and OPO context and thus is inapplicable to other types of nonprofits. These amendments to the UAGA would therefore not disrupt the operations and expectations of other nonprofits.

Under these amendments, an OPO could not invoke the good faith defense in response to such a suit, because a conscious decision not to follow the law cannot be considered an attempt to act in good faith. The good faith defense is designed for situations in which transplant professionals mistakenly remove an organ without consent[210] but were acting in good faith "in accordance" with the law. Under the amended statute, refusing to procure organs over family objections would not be acting "in accordance" with the law, and the good faith defense would not apply. This is arguably already true under the 2006 Revised Act,[211] but because no plaintiff exists to represent the rights of potential donees, no situation has ever arisen in which a plaintiff could rebut the defense in this manner.[212] Additionally, the good faith defense only immunizes medical professionals from suits by donors' next of kin, not suits brought by another party on behalf of potential donees—the attorney general under the amended statute.[213]

A breach of 501(c)(3) status is the best theory of liability under which to sue OPOs, as the law tasks the state attorney general with representing *all* citizens, and nonprofits receive benefits from taxpayers. A noncompliant OPO is detrimental not just to patients on the waiting list but also to the general public. The existence of a well-functioning and successful OPO is a public health concern that affects not only those in need of a transplant but their families, employers, and insurance companies, as well as taxpayers who may contribute to their treatment until an organ is available.[214]

Multiple sources have advocated for class actions on behalf of individuals on the transplant list, which would sue OPOs under negligence, tortious interference with contract, breach of contract, and

210. *See* Ramirez v. Health Partners of S. Ariz., 972 P.2d 658, 668–69 (Ariz. Ct. App. 1998) (upholding good faith defense against liability when bone was harvested mistakenly).

211. *See* Bucklin, *supra* note 75, at 338 (arguing that UAGA does not intend for OPOs to decline valid gifts due to family objections).

212. KASERMAN & BARNETT, *supra* note 14, at 45–50, 147 n.20.

213. Jardine, *supra* note 111, at 1664.

214. For example, "the net welfare gain for society over the lifetime of a kidney recipient" is $1,132,000 per patient. P.J. Held et al., *A Cost-Benefit Analysis of Government Compensation of Kidney Donors*, 16 AM. J. TRANSPLANTATION 877, 880 (2016) (analyzing the net costs to society when patients receive a kidney transplant rather than stay on dialysis).

violation of civil rights theories of liability.[215] These strategies are impractical and perhaps impossible. First, the public does not and should not have adequate access to information that would support these theories of liability.[216] Second, although the fifty-eight OPOs have exclusive jurisdiction and responsibility for their territories, not all patients in need of an organ will receive one from their region's OPO.[217] UNOS allocates organs based on many factors, and organs can be procured within one OPO's jurisdiction and transported to another's.[218]

In assessing which plaintiffs are eligible to join a suit against an OPO in violation of first-person authorization, would it be only those patients within the OPO's jurisdiction? Patients in the region who could have received an organ from the OPO? All patients on the national waiting list, exposing a single OPO to liability so large as to cover every patient that died while waiting for a transplant? Additionally, an OPO's failure to follow state law does not technically wrong patients still waiting for a transplant—the estates of those who died while waiting for a transplant are entitled to a remedy. Under the new presumed-consent model, it is imperative that a party representing the rights of all citizens has standing to sue. A doctor or OPO that procures organs over a decedent's documented objection (registration on the opt-out list) should also be held accountable by the state attorney general for violating first-person authorization.

2. State Health Departments Monitor OPOs

The UAGA should also be amended to task the state health department with monitoring the OPO that serves its population and require that the state health department refer all potential violations to the state attorney general for investigation. State governments usually task their respective health departments with monitoring health-care services provided by the private sector and improving the adequacy and availability of health-care resources within the state.[219] The adequacy and availability of organs for transplants within the state

215. *See* Bucklin, *supra* note 75, at 339, 342–48 (addressing possible causes of action); Jardine, *supra* note 111, at 1667–80 (analyzing a potential negligence action).

216. *See infra* Section III.B.2.

217. A recipient's distance from the donor hospital is a consideration for all types of organ transplants, but some organs (e.g., the pancreas and kidneys) can be preserved outside the human body longer than others, and thus those organs can travel longer distances. Other factors are also considered when UNOS determines allocation. *How Organs Are Matched*, UNOS, https://unos.org/transplantation/matching-organs/ (last visited Jan. 13, 2019) [https://perma.cc/L2EC-UZEA].

218. *Id.*

219. Eileen Salinsky, *Governmental Public Health: An Overview of State and Local Public Health Agencies*, NAT'L HEALTH POL'Y F. 13–14 (Aug. 18, 2010), https://www.nhpf.org/library/background-papers/BP77_GovPublicHealth_08-18-2010.pdf [https://perma.cc/3LHZ-GC7V].

is a critical public health concern, and state health agencies have the experience and expertise to monitor and improve OPO performance. Donor registries are managed at the state level,[220] and states already collect death certificates from patients who are declared dead at hospitals.[221] State health departments can compare these two lists with data from OPOs and hospitals on the organs that were procured for transplants and determine whether OPOs followed first-person authorization by procuring organs from each person not on the opt-out list (and those with organs unsuitable for transplantation). Such a case-by-case comparison requires access to both the donor registry and death certificates, and therefore it would be impossible for a class of plaintiffs representing patients on the waiting list to prove an OPO refused anatomical gifts.

State health departments have the expertise to assist OPOs when families object to organ procurement and can assist in training OPOs and hospital personnel regarding their legal responsibilities.[222] In difficult cases, a state health-department official can speak with the family and explain the importance of the donation and the legal ramifications for the OPO if it refuses to comply with the law. This counseling would also ease relations with the OPO and the hospital in the wake of enacting an amended UAGA; decedents' families would view the state health department's lawyers as distinct from the hospital and their loved one's care. It is important to separate the appearance of conflicting interests,[223] and separating the interests of attorneys (the hospital's versus the health department's) could further reinforce the family's faith that the decedent is being declared dead not to procure her organs but because she is medically deceased.[224]

CONCLUSION

Increasingly sophisticated organ-transplantation technology brings with it the ability to save thousands of lives in the United States

220. U.S. Dept. of Health & Human Servs., *Organ Donation FAQs*, ORGANDONOR.GOV, https://www.organdonor.gov/about/facts-terms/donation-faqs.html (last visited Jan. 13, 2019) [https://perma.cc/W8U3-99ZF].

221. *See Documenting Death—The Certificate*, PBS (Feb. 1, 2011), https://www.pbs.org/wgbh/pages/frontline/post-mortem/things-to-know/death-certificates.html [https://perma.cc/7J8B-GMCW] (stating that most states utilize the U.S. Standard Death Certificate).

222. *See* Salinsky, *supra* note 219, at 11–15 (describing the array of regulatory and administrative functions performed by state health agencies).

223. *See Donation Process*, *supra* note 23 (noting that hospital staff is completely separate from transplant team).

224. Orentlicher, *supra* note 81, at 296–97 (noting a popular fear that doctors will declare patients dead just to harvest their organs).

each year, but absent significant changes in legislation, the public will never benefit from this improvement. States initially led the movement to regulate the organ-donation process and should now reemerge as the leaders in organ-donation policy reform. Current law gives states the ability to both monitor and enforce the organizations responsible for the success of organ donation within their jurisdictions, and a policy switch to presumed consent would further ensure that hospitals and OPOs follow donative intent. States should adopt a twofold solution by amending the UAGA: first, changing the default presumption of donative intent to presumed consent, and second, requiring state health departments to monitor their respective OPOs and refer breaches of nonprofit obligations to state attorneys general for enforcement. Now is the time for states to give waiting patients another chance at life before the game is over.

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