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THE CASE FOR A POST-MORTEM ORGAN DRAFT AND A PROPOSED MODEL ORGAN DRAFT ACT

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"The evil that men do lives after them,
The good is oft interred with their bones . . . ."
—Shakespeare[1]

Every year in our nation 200,000 useful organs are consigned to the maggots for ready conversion to swill. The law indulges us in this practice while thousands anguish for want of the buried parts.

In the era of modern transplant surgery, human cadavers are needed. Under prevailing law they are not adequately supplied. While medicine advances at astounding speed, the law does not keep pace, and life-saving surgery is hostage to its wariness.

Existing law looks to procure organs through voluntary donation but fails to answer the need. This Article proposes a Model Organ Draft Act. Subject only to exemption for religious objection, the organ draft would empower the state to conscript every cadaveric organ suitable for transplantation without regard to any contrary wishes expressed by the decedent while he lived or by surviving relatives after he dies.

Section I describes the national shortage of transplantable organs and the supply that might be furnished if all usable organs were in fact salvaged. Section II traces the development of current organ procurement policies. Section III examines the failure of current policies and introduces the proposed Model Organ Draft Act. Section IV compares the proposed organ draft with the procurement policies that now operate and those that have been proposed as alternatives. Section V addresses the constitutionality of the proposed organ draft, and Section VI concerns the draft's compatibility with American traditions of liberty and free will. All of these explorations indicate that the proposed Model Organ Draft Act offers to resolve the national organ shortage in a fashion that is medically, economically, and constitutionally sound.

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[1] Shakespeare, *Julius Caesar*, act III, sc. 2, in THE COMPLETE WORKS OF SHAKESPEARE (W. Craig ed. 1935).

[2] Cadaveric transplantation means implanting in a person a tissue or organ taken from a cadaver. Grafting and transplantation are synonyms. *See* STEDMAN'S MEDICAL DICTIONARY ILLUSTRATED 603, 1475 (24th ed. 1982).

I. TRANSPLANTABLE ORGANS: THE SHORTAGE AND THE POTENTIAL SUPPLY

Thirty years ago, the living had little use for pieces of the dead; cadaveric transplantation[2] always failed.[3] Transplant surgeons began seriously to solicit post-mortem organ donations in 1962 when pharmacologic immunosuppression lifted the curse of prompt, certain rejection.[4] Since then, control of rejection and hence the utility of transplantation have been markedly enhanced by the introduction of HLA tissue typing in 1966[5] and cyclosporin in 1983.[6]

With the matter of rejection better in hand, transplantation is one of medicine's newest miracles. Through surgical graft of kidney, heart, liver, cornea, skin, bone, and lung, thousands now walk the earth successfully[7]

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[3] *See generally* F.D. MOORE, GIVE AND TAKE: THE DEVELOPMENT OF TISSUE TRANSPLANTATION (1964 ed.) (noting that the first successful transplant between unrelated persons did not occur until the spring of 1962).

[4] In January, 1962, a surgeon performing a kidney transplant first introduced immunosuppressive drug therapy in an effort to prevent rejection. The outcome was moderately successful and a number of similar procedures were consequently undertaken in subsequent months. *Id.* at 116-28.

[5] Regarding HLA tissue typing and its significance to the advancement of transplantation, see J. BARRETT, TEXTBOOK OF IMMUNOLOGY: AN INTRODUCTION TO IMMUNOCHEMISTRY AND IMMUNOBIOLOGY 279-82 (5th ed. 1988); F. MOORE, *supra* note 3, at 213-21. The contribution of HLA tissue typing to graft survival has not been evaluated by controlled study since physicians began using Cyclosporin A in immunosuppressive therapy. *See infra* note 6. Nevertheless, organ procurement personnel continue to make immunologic match a priority in pairing donors and recipients. *Cf.* Denny, *How Organs Are Distributed*, 13 HASTINGS CTR. REP. 6, 26-27 (Dec. 1983) (noting that while immunologic matching remains a priority in transplantation techniques, it is often unavailable for heart and liver transplants because of the limited preservation time of these organs).

[6] Regarding cyclosporin and its contributions to the development of transplantation, see U.S. DEP'T OF HEALTH & HUMAN SERVS., PUB. HEALTH SERVS., HEALTH RESOURCES & SERVS. ADMIN., TASK FORCE ON ORGAN TRANSPLANTATION, REPORT TO THE SECRETARY AND THE CONGRESS ON IMMUNOSUPPRESSIVE THERAPIES 10-14 (1985) [hereinafter TASK FORCE 1985 REPORT]; *see also* Starzl, Iwatsuki, Van Thiel, Gartner, Zitelli, Malatack, Schade, Shaw, Hakala, Rosenthal & Porter, *Evolution of Liver Transplantation*, 2 HEPATOLOGY 614-36 (1982) [hereinafter Starzl].

[7] Authorities deem an organ transplant successful if the patient *and* the organ survive for one year. This standard follows from the widespread finding that death attributable to complications of transplantation or rejection of the transplanted organ usually occur within one year of surgery. *See* TASK FORCE 1985 REPORT, *supra* note 6, at 11-12 (finding that the "highest risk of failure occurs in the immediate postoperative period, with relatively few losses occurring beyond one year"). Success rates for cadaveric transplantation of kidney, heart, liver, and heart-lung approximated 90%, 80%, 70%, and 60% respectively. *See* TASK FORCE 1985 REPORT, *supra* note 6, at 12-13. For instance, of 6,968 kidney transplants performed in 1984, at least

disburdened of morbid and debilitating illness. They are sustained by organs from the dead[8] and from the dead organs still must come. But, because so few Americans donate their bodily parts post-mortem, this nation now suffers a profound shortage of transplantable organs.[9]

For example, approximately 12,000 new patients need kidneys annually in

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6,131 resulted in one-year graft and patient survival. *See* U.S. DEP'T OF HEALTH & HUMAN SERVS., PUB. HEALTH SERVS., HEALTH RESOURCES & SERVS. ADMIN., ORGAN TRANSPLANTATION ISSUES AND RECOMMENDATIONS: REPORT OF THE TASK FORCE ON ORGAN TRANSPLANTATION 17 (table I-1) (1986) [hereinafter TASK FORCE 1986 REPORT]. For the purposes of this Article, where transplantation of a particular type of organ is not usually successful, such organ—the pancreas for example—is not considered in short supply and is therefore not included in this discussion.

Pancreatic transplant represents an effort to cure diabetes mellitus type I (also called "juvenile diabetes" or "insulin dependent diabetes"). A pancreatic transplant is deemed successful if, for a full year, the graft functions and allows the patient to be insulin free. Telephone interview with Dr. D. E. Sutherland, International Pancreatic Transplantation Registry, University of Minnesota (Dec. 1986) [hereinafter Sutherland interview]. Between 1966 and 1977, only 60 pancreatic transplants were performed worldwide. *See* Sutherland, *Pancreas and Islet Transplant Registry Data*, 8 WORLD J. SURGERY 270 (1984). Of these, only two functioned for more than one year, and none functions in 1988. *Id.* Of the 189 pancreatic grafts implanted between 1977 and 1983, 39 functioned for more than one year. Thus, as of 1985, one-year pancreatic graft survival was lower than 20%. *Id.; see also* TASK FORCE 1986 REPORT, *supra*, at 17, 19 (reflecting a one-year graft survival rate of 35-40% for pancreas transplants). Since 1983, another 700 transplants have been performed worldwide. About half of these were performed in the United States. These 700 transplants show a one-year graft survival rate of 45%; the success rate is thus improving. *See* Sutherland interview, *supra*.

Despite these improvements in the one-year survival rate for pancreatic transplants, Dr. D. E. Sutherland, the world leader in pancreatic transplant, considers a 45% chance of insulin independence insufficient promise to justify transplantation except in rare situations. *Id.* Therefore, although doctors continue to practice pancreatic transplants, it still results in too little success to warrant the conclusion that a pancreas shortage now obstructs progress. *Id.*

[8] For example, of the 28,020 kidney transplants performed between 1980 and 1984, 20,122 came from cadavers. TASK FORCE 1986 REPORT, *supra* note 7, at 36 (table II-2); *see also* Note, *Regulating the Sale of Human Organs*, 71 VA. L. REV. 1015, 1016 (1985) (noting that "[d]onations made at [the] donor's death . . . are the major source of transplantable organs").

[9] The Task Force on Organ Transplantation, established pursuant to Title I, § 101 of the National Organ Transplant Act (42 U.S.C. §§ 273, 274 (Supp. IV 1986)) concludes, without describing its methodology, that the overall need for transplant organs is three times the supply. TASK FORCE 1986 REPORT, *supra* note 7, at 27. It concludes, also, that the "[c]urrent availability of donor tissue (e.g., corneas, skin, and bone) for transplantation . . . is inadequate to meet the needs of thousands of people who could benefit from the therapeutic use of these resources." *Id.* at 27.

the United States[10] and only 5,000-7,000 get them.[11] The nation thus suffers a shortage of approximately 6,000 kidneys annually.

Hearts too are in short supply. The annual need for useful donor hearts in the United States may be as high as 50,000.[12] Yet in 1985, for example, only

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[10] This is easier stated than proved. The Health Care Financing Administration ("HCFA"), a component of the United States Department of Health and Human Services, has maintained data regarding the need and supply of transplantable kidneys since 1978. *See, e.g.*, U.S. HEALTH CARE FIN. ADMIN., END-STAGE RENAL DISEASE PROGRAM MEDICAL INFORMATION SYSTEM FACILITY SURVEY TABLES 9-10 (1983) [hereinafter RENAL DISEASE SURVEYS]. In assessing the need for kidneys, transplant and dialysis centers are influenced by their knowledge of the limited supply. Many systematically report a need that is roughly equal to their anticipated supply. For example, a dialysis clinic serving 200 patients might anticipate a yearly organ donation to its region of only 80 kidneys. The clinic then identifies only 80 patients as needing these organs, ignoring the 120 who remain dependent on dialysis. The nation's renal transplant centers add to their waiting lists—their lists of those patients officially deemed in need of organs—at rates little greater than those of anticipated donation. Short supply, then, is a principal, and deceptively circular, influence on Health Care Financing Administration data assessing organ need. Telephone interview with Dr. Roger W. Evans, Research Scientist, Battelle Human Affairs Research Center, in Seattle, Washington (Dec. 1986); telephone interview with Dr. Paul Tersaki, Director, UCLA Renal Transplant Center (Dec. 1988). Because of this circular process, HCFA data regarding the need for donor kidneys in fact reflect little more than the supply of donor kidneys.

The number of patients who would receive transplants in the face of unlimited supply represents the true need for kidneys. In 1983, approximately 72,000 United States patients required ongoing dialysis. RENAL DISEASE SURVEYS at 11. Of these roughly half are true transplant candidates from a medical point of view. R. EVANS, THE PRESENT AND FUTURE NEED FOR AND SUPPLY OF ORGANS FOR TRANSPLANTATION, A WORKING PAPER 20-24 (report prepared by the Battelle Human Affairs Research Center in conjunction with the National Heart Transplant Study, 1983) (citing sources indicating that three-eighths of dialysis patients are suitable candidates for kidney transplantation); *see also* Cooper, Abrams & Blagg, *The Potential Supply of Cadaveric Kidneys for Transportation*, 23 TRANSACTIONS OF THE AM. SOC. FOR ARTIFICIAL INTERNAL ORGANS 416, 417 (1977) (assuming that approximately half of the patients diagnosed each year as having treatable end-stage renal disease are potential transplant recipients) [hereinafter Cooper]. The number of patients needing dialysis has been increasing by 6,000 to 7,000 each year. RENAL DISEASE SURVEYS at 11 (reporting data from 1980-1983). Approximately 6,000 transplants are performed annually. *Id.* at 9-10. Thus, on an annual basis approximately twice as many kidneys are needed as are available, and approximately 26,500 more are needed to eliminate the backlog of patients needing kidneys.

[11] *See* TASK FORCE 1986 REPORT, *supra* note 7, at 36 (table II-2).

[12] Research data gathered through the National Heart Transplant Study, conducted by the HCFA, indicate that as many as 50,000 heart transplants would be conducted every year if the supply of donor hearts were unlimited. *See* R. EVANS, *supra* note 10, at 20-24. In 1985, only 719 heart transplants were performed. *See*

719 were donated.[13]

Liver failure kills 50,000 adults and 10,000 children every year in America.[14] Conventional estimates indicate that 5,000 of these patients could benefit from liver transplant each year.[15] There is reason to believe, however, that most of these 60,000 liver disease patients would benefit from new livers, and that the true annual need for donor livers may be close to 70,000.[16] But whether the need for livers is 5,000 or 70,000, only 300-600

Organ Transplants: Hearings on H.R. 4080 Before the Subcomm. on Investigation and Oversight of the House Comm. on Science and Technology, 98th Cong., 1st Sess. 60 (1983) (testimony of Dr. Norman E. Shumway, Surgery Professor, Stanford University School of Medicine) [hereinafter *H.R. 4080 Hearings*]. The HCFA, and all of the nation's transplant centers, impose very restrictive criteria in determining which patients should receive the limited supply of transplantable hearts. *See, e.g.*, Notice, 46 Fed. Reg. 7072-73 (1981) (requiring as prerequisites for heart transplants (1) no more than 25% probability of survival for six months without transplant; (2) exhaustion of all other appropriate medical and surgical therapies; and (3) a finding that "adverse influences," including the advanced age of the patient and the absence of adequate external psychosocial support, do not render transplant success unduly speculative); Jamieson, Oyer & Reitz, *Cardiac Transplantation at Stanford*, 1 HEART TRANSPLANTATION 86, 86 (1981) (stating that Stanford's selection criteria includes irremediable terminal cardiac disease with the outlook for survival not exceeding a few months and a patient of age 50 years or younger, and listing psychological abnormalities, systemic diseases, insulin diabetessis, and absence of adequate external psychosocial support as contraindications of suitability for transplant). In comparing the number of hearts available for cadaveric transplant—approximately 700 in 1985—with the number of kidneys available for cadaveric transplant—approximately 7000 in 1983—it is hard to see why heart donations should be so few. Doctor Norman E. Shumway of the Department of Cardiac Surgery at Stanford University, points out that fewer hearts than kidneys are suitable for donation and that many families donate kidneys but do not donate hearts. Telephone interview with Dr. Shumway, Professor of Surgery, Department of Cardiac Surgery, Stanford University (Dec. 1985). Whether these observations in fact explain this discrepancy merits further study.

[13] *See H.R. 4080 Hearings*, *supra* note 12, at 60.

[14] *H.R. 4080 Hearings*, *supra* note 12, at 20 (testimony of J. W. Williams, Assoc. Professor of Surgery, University of Tennessee College of Medicine) (citing statistics on the number of Americans who die annually of liver disease).

[15] *See* R. EVANS, *supra* note 10, at 38. For a general discussion of the indications and contraindications of the suitability of a potential receiver for liver transplant and for information about the success rates of liver transplants, see Calne, *Liver Grafting*, 35 TRANSPLANTATION 109-11 (1983); Grendell, *Hepatic Transplant and Resection*, in HEPATOLOGY: A TEXTBOOK OF LIVER DISEASE 1274-85 (D. Zakim & T. Boyer eds. 1982).

[16] The American Liver Foundation and the National Heart Transplant Study identify a yearly need for only 5,000 livers. R. EVANS, *supra* note 10, at 38. These 5,000 livers would go to patients with chronic active hepatitis, biliary atresia, primary biliary

livers were available for transplant in 1985.[17]

Lung transplantation represents an innovation whose potential beneficiaries cannot yet be quantified.[18] Although 220,000 patients die each

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cirrhosis, cryptogenic cirrhosis, Budd-Chiari syndrome, secondary biliary cirrhosis, or carcinoma of hepatic ducts, and to alcoholics no longer drinking. Calne, *supra* note 15, at 109; R. EVANS, *supra* note 10, at 38; Grendell, *supra* note 15, at 1274-75.

Alcoholics still drinking are conspicuously absent from the candidate pool. Surgeons tend to exclude alcoholics who still drink from the candidate pool, since these alcoholics are thought to be unreliable regarding medication and follow-up. Calne, *supra* note 15, at 109. Yet, if livers were abundant it would be difficult to justify withholding one from an imminently terminal patient because the patient might fail to cooperate with the post-operative therapy. Unreformed alcoholics are not deprived of other lifesaving treatments on this basis. It would seem that if alcoholic cirrhotics do not "need" livers, it is because livers are a scarce commodity. Prevailing estimates of the "need" for livers, like the HCFA assessments pertaining to kidneys, are influenced by the unavailability of the organ.

If alcoholic cirrhotics are added to the candidate pool, the yearly need for livers would increase drastically, since for every 100,000 people, there are 40 deaths attributable to alcoholic cirrhosis annually. U.S. DEP'T OF HEALTH & HUMAN SERVS., ALCOHOL CONSUMPTION AND RELATED PROBLEMS 164 (1982). With our nation's population in excess of 200,000,000, the number of alcoholic cirrhotics who might benefit from liver transplants exceeds 80,000 annually.

[17] The number of transplants performed is a valid indication of the number of organs available. In 1984, 308 liver transplants were performed; in 1985, 602 transplants were performed. TASK FORCE 1986 REPORT, *supra* note 7, at 107.

[18] Lung grafting is accomplished through either a single lung transplant or as part of a heart-lung transplant, a procedure in which the patient receives a new heart and two new lungs from one donor. Until 1980, single lung transplantation showed little success. *See* Veith, *Lung Transplantation*, 35 TRANSPLANTATION 271 (1983). Since 1980, however, the use of cyclosporin has led to major advances in experimental and clinical lung transplantation. *Id.* Between 1983 and 1986, a University of Toronto team performed eight lung transplants, and as of 1987, at least three of the Toronto patients had survived beyond one year. Telephone interview with Dr. F. Griffith Pearson, Toronto Lung Transplant Group, Toronto, Ontario (Jan. 1987); *see also* Toronto Lung Transplant Group, *Unilateral Lung Transplantation for Pulmonary Fibrosis*, 314 N. ENG. J. MED. 1140, 1140-45 (1986) (reporting the success of two of the single lung transplants performed by the Toronto Lung Transplant Group). There is reason to believe, therefore, that in the future, single lung transplantation will furnish a viable treatment for end-stage pulmonary disease.

As of December 1986, six centers in the United States practiced heart-lung transplantation. TASK FORCE 1986 REPORT, *supra* note 7, at 165. This procedure boasts greater success than single lung transplantation. By December 29, 1986, United States centers had performed 81 heart-lung transplants, with one year survival rates of approximately 60%. Telephone interview with the office of the Registry of the International Society for Heart Transplantation, University of Minnesota (Dec. 1986).

year of pulmonary disease,[19] transplant surgeons do not, at this stage of the technology's development, include all of these patients in the candidate pool.[20] Indeed, authorities hesitate to furnish numerical estimates of the total population that lung transplantation might some day benefit.[21] Nonetheless, as to those patients who are named as candidates, organ supply appears to be the limiting factor.[22] As relevant technologies advance, lung transplantation may well become an important part of surgery's lifesaving resources, and a lung shortage will likely limit its use.[23]

Numerical data on the supply of and demand for transplantable tissues such as cornea, skin, and bone have not been reported. Among professionals in the field (including the Task Force on Organ Transplantation), however, it is noted without question that inadequate donation limits the number of tissue transplants surgeons performed in the United States.[24]

Although the nation is short of transplantable organs, available data indicate that every year it buries 20,000 bodies with 40,000 usable kidneys, 20,000 usable hearts, 20,000 usable livers, and 20,000 usable lung pairs.[25]

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[19] U.S. DEP'T OF HEALTH & HUMAN SERVS., NATIONAL CENTER FOR HEALTH STATISTICS, BIRTHS, MARRIAGES, DIVORCES, AND DEATHS (1986).

[20] The heart-lung transplant candidate pool is largely limited to patients with primary pulmonary hypertension. TASK FORCE 1986 REPORT, *supra* note 7, at 18.

[21] Telephone interview with Dr. Frank Veith, Chief of the Department of Vascular Surgery and Director of the Transplant Program, Montefiore Medical Center-Albert Einstein College of Medicine, New York City (Dec. 1986) [hereinafter Veith interview].

[22] Veith interview, *supra* note 21.

[23] Even with respect to single lung transplantation, still an infant technology, see *supra* note 18, experience foreshadows a lung shortage. Dr. Frank Veith of Montefiore Medical Center in New York, reports that the seven procedures performed under his auspices were delayed by the extreme scarcity of healthy donor lungs. Veith, *Lung Transplantation in Perspective*, 314 N. ENG. J. MED. 1186-87 (1986). Indeed, of 59 candidates he had identified, 49 died while waiting for lungs. *Id.*

[24] On personal questioning, the American Council on Transplantation, the American Association of Tissue Banks, Tissue Bank International, and the Task Force on Organ Transplantation were all unable to report studies or statistics that firmly document a shortage of transplantable tissues. But each of these groups asserts that severe shortages exist with respect to all transplantable tissues. It appears, however, that no person or entity has gathered the data needed to substantiate the widespread assertion.

[25] Although approximately two million people die annually in the United States, most of their cadaveric organs are not suitable for transplant. BUREAU OF CENSUS, U.S. DEP'T OF COMMERCE, STATISTICAL ABSTRACT OF THE UNITED STATES 1986, (table 81) (1986). Transplantable organs must come primarily from brain-dead patients whose breathing and cardiac activity have been artificially maintained. When the heart stops and respiration ceases, oxygen deprivation quickly renders organs unsuitable for transplantation. Telephone conversation with Dr. James Cerilli, Direc-

With respect to hearts, livers, and lungs, the potential supply could go far to reduce the deficit.[26] With respect to kidneys it might fully relieve the shortage.[27]

The discrepancy between potential supply and unmet need is a problem for which the law should offer a solution. It is for the law to resolve conflicts between medical needs of the living and deep-rooted sentiments concerning the dead. To date, the law of organ procurement has favored the sentimental and failed the sick.

II. THE DEVELOPMENT OF PRESENT-DAY ORGAN PROCUREMENT POLICIES

On its face, common law doctrine provides that cadavers are not property and that they create no property rights in the decedent, her surviving family, or anyone else.[28] This "no-property rule" arose in England.[29] Packed with

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tor of Transplantation, University of Rochester School of Medicine (Jan. 1989). Because organs must come from brain-dead bodies whose respiration and circulation have been artificially maintained *after* death, donors must, first of all, die in hospitals. About one-half of Americans do so. Bart, Macon, Whittier, Baldwin & Blount, *Cadaveric Kidneys For Transplantation: A Paradox of Shortage in the Face of Plenty*, 31 TRANSPLANTATION 379-81 (1982) (indicating that 60% of people who die in the United States die in hospitals); Cooper, *supra* note 10, at 417 (noting that in a study in Washington state, nearly half of the recorded deaths occurred in hospitals).

Medical wisdom also dictates that donors must be relatively young and free from disease impinging on the organ to be salvaged. Though estimates vary, it appears that about two percent of the approximately one million patients who die annually in United States hospitals satisfy these criteria. *See, e.g.*, Mertz, *The Organ Procurement Problem: Many Causes, No Easy Solution*, 254 J. A.M.A. 3258 (1985); Russel & Cosimi, *Transplantation*, 301 N. ENG. J. MED. 470-79 (1979); Cooper, *supra* note 10, at 416-20 (estimating the potential kidney donors in Washington as 0.0032% of the population per year); Bart, *Prevalence of Cadaveric Kidneys for Transplantation*, in AMERICAN ASSOCIATION OF TISSUE BANKS: PROCEEDINGS OF THE 1977 ANNUAL MEETING 124-30 (K. Sell, V. Pewy & M. Vincent eds. 1977). If two percent of one million cadavers are suitable donors, then the potential supply of single kidneys, a paired organ, is approximately 40,000. The potential supply of hearts, livers, and lung pairs is approximately 20,000. This estimate is consistent with that of the Task Force on Organ Transplantation which suggests that the potential pool of organ donors is between 17,000 and 26,000 annually, although they recommend further study. TASK FORCE 1986 REPORT, *supra* note 7, at 35.

[26] *See supra* notes 10-23 and accompanying text. The potential supply of hearts and livers would meet approximately half of the estimated need. The need for lungs is unknown, but a supply of this magnitude would dwarf the supply now available for transplant.

[27] *See supra* note 10 and accompanying text.

[28] *See, e.g.*, Cohen v. Gorman Mortuary, 231 Cal. App. 2d 1, 41 Cal. Rptr. 481 (1964) (holding that there is no property right in a corpse but a quasi-property right to possession of a corpse may exist for the limited purpose of determining custody for

the bags and baggage of English jurisprudence, it reached the new world, and in building their judicial systems the new American states adopted it as part of the common law at large.[30] Consequently, throughout its history, American common law has provided that dead bodies are the property of no one.[31]

Despite the no-property rule, American courts also hold that the power of disposition of the dead body rests with the decedent if she issues pertinent instructions during life and with the surviving family if she does not.[32] In reconciling the no-property rule with the individual's right to control her own cadaver, courts have held that, whether or not the body is property, it does give rise to a proprietary interest empowering the decedent to decide, by will, its fate.[33] Notwithstanding the English rule, it is clear that in all American jurisdictions one may by will, or by contract,[34] supervise the disposition of her own remains.[35]

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burial); Pierce v. Swan Point Cemetary, 10 R.I. 227, 238-39 (1872) (noting that while a corpse is not property in the usual sense, it is a kind of property to which certain persons may have non-ownership rights, as in the right of burial). *See generally* P. JACKSON, THE LAW OF CADAVERS AND OF BURIAL AND OF BURIAL PLACES 120-24 (1937).

[29] Until the 1850s, disposition of the dead was, in England, a matter for the ecclesiastical courts; it was not the province of the common law. P. JACKSON, *supra* note 28, at 24-29. The province of English common law courts in the eighteenth century was the enforcement of property rights. *Id.* at 116. In respecting ecclesiastical jurisdiction and acknowledging their own impotence to govern dead bodies, English common law courts determined that the corpse did not represent property of anyone. *See, e.g.*, Foster v. Dodd, 3 L.R.-Q.B. 67, 77 (1867) (holding that a "dead body by law belongs to no one").

[30] P. JACKSON, *supra* note 28, at 28.

[31] *See, e.g., supra* note 28.

[32] *See generally* P. JACKSON, *supra* note 28, at 48-61.

[33] [T]he body of one whose estate is in probate unquestionably forms no part of the property of that estate, [but] it is recognized that the individual has a sufficient proprietary interest in his own body after his death to be able to make valid and binding testamentary disposition of it.

O'Donnel v. Slacks, 123 Cal. 285, 288, 55 P. 906, 907 (1899); *In re* Widening of Beekman Street (unreported), *discussed in* Appendix, *Law of Burial*, 4 Bradford Surr. 503, 509 (N.Y. 1875); *see also* Kuzenski, *Property in Dead Bodies*, 9 MARQ. L. REV. 17 (1924) (reviewing cases discussing property concepts with respect to corpses and finding that cases hold no commercial property rights exist in the corpse, but a right of burial usually persists nonetheless).

[34] *See, e.g.*, Standard Accident Ins. Co. v. Rossi, 35 F.2d 667, 670 (8th Cir. 1929) (holding that where decedent during life undertakes an insurance contract wherein she consents to autopsy after death, the autopsy shall be performed over the objections of the surviving family and despite the absence of any related testamentary instruction).

[35] "It always has been, and will ever continue to be, the duty of courts to see to it

Similarly, in the absence of testamentary directive, the decedent's spouse, children, or surviving next of kin are entitled to supervise burial.[36] In squaring familial rights with the no-property rule, some courts have conceded that surviving relatives are not proprietary owners and have characterized them instead as trustees who hold the corpse for the benefit of those with an interest in its decent disposal.[37] Still other courts have held that the relatives have no property right in the cadaver but that they have instead a "quasi-property" right born of "a duty imposed by the universal feelings of mankind to be discharged by someone towards the dead . . . ."[38] One court

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that the expressed wish of one, as to his final resting place, shall, so far as it is possible, be carried out." Thompson v. Deeds, 93 Iowa 228, 231, 61 N.W. 842, 843 (1895) (determining that where the decedent's daughter had assented to his request to be buried in her cemetery plot, the daughter could not thereafter seek to have the decedent's corpse removed).

[36] While most judicial discourse indicates that the decedent's own wishes take precedence over the survivor's wishes, Wood v. Butterworth, 65 Wash. 344, 118 P. 212 (1911), courts have also ruled that survivors' wishes defeat testamentary instructions that contravene certain natural sentiments of the living. Thus, in New Hampshire, a husband could conduct a funeral though his deceased wife had directed against it, Holland v. Metalious, 105 N.H. 290, 198 A.2d 654 (1964), and the California Supreme Court denied the validity of a testator's command that his body be delivered to a woman other than his widow, Enos v. Snyder, 131 Cal. 68, 69, 63 P. 170, 171 (1900). Any privilege that might belong to the executor in this regard is no greater than the privilege that belongs to the decedent. In the absence of a testamentary directive, therefore, the wishes of the surviving family are superior to those of the executor. Decisions to the contrary have been "properly repudiated." P. JACKSON, *supra* note 28, at 54. While there have been debates about priorities between spouse and next of kin, under the prevailing view the spouse's claim defeats that of other relatives. P. JACKSON, *supra* note 28, at 55-61.

[37] Pettigrew v. Pettigrew, 207 Pa. 313, 315, 56 A. 878, 879 (1904).

[38] That there is no right of property in a dead body, using the word in the ordinary sense, may well be admitted. Yet the burial of the dead is a subject which interests the feelings of mankind to a much greater degree than many matters of actual property. There is a duty imposed by the universal feelings of mankind to be discharged by someone towards the dead; a duty, and we may also say a right, to protect from violation; . . . it may therefore be considered as a sort of *quasi* property.

Pierce v. Swan Point Cemetery, 10 R.I. 227, 238 (1872) (footnote omitted) (emphasis in original); *see also In re* Remains of Johnson, 94 N.M. 491, 494, 612 P.2d 1302, 1305 (1980) (declaring that there is a quasi-property right in a dead body that vests in the nearest relative of the deceased); Snyder v. Holy Cross Hospital, 30 Md. App. 317, 328-29, 352 A.2d 334, 341 (1976) (stating that a parent had a right to the body of his own child, permitting the parent to seek equitable relief from interference with possession of the dead body for purposes of decent burial); Leno v. St. Joseph Hospital, 55 Ill. 2d 114, 117, 302 N.E.2d 58, 59-60 (1973) (reiterating that no property rights exist in a dead body in the ordinary sense, but a right of possession does exist for the next of kin to determine disposition of the body); Thompson v. Deeds, 93

ruled forthrightly that whether or not dead bodies are "property," American common law would be "disgraced" if it failed to recognize that a surviving family has rights in the cadaver.[39]

Hence, while the English no-property rule still walks American soil in some ghostly form, the early common law allowed, and today unquestionably provides, that the decedent has a right by will or contract to avoid the fate of her body, and that if she does not avail herself of this right her spouse and next of kin succeed to it. Statutes in every state invade this power of disposition in one important respect: regardless of what the deceased or surviving family might desire, coroners or medical examiners may examine and dissect a body if the circumstances so warrant.[40] Absent a coroner's statutorily authorized intervention, however, the executor or appropriate survivor is entitled to receive the corpse in a condition unchanged, except by natural processes, from the time of death.[41]

This was the state of the law when cadaveric kidney transplantation became feasible in the early 1960s.[42] Any surgeon who removed transplanta-

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Iowa 228, 231-32, 61 N.W. 842, 842 (1895) (stating that a wife has unquestioned right to properly improve and adorn the grave of her husband, although the wife does not own the burial plot).

[39] "The dogma of the English ecclesiastical law that a child has no . . . [sacred and inherent right to custody of his parent's dead body] is so utterly inconsistent with every enlightened perception of personal right, so inexpressively repulsive to every proper moral sense, that its adoption would be an eternal disgrace to American jurisprudence." *In re* Widening of Beekman Street (unreported), *discussed in* Appendix, *Law of Burial*, 4 Bradford Surr. 503, 529 (N.Y. 1875).

[40] The most recent compendium of statutes on this subject was published in 1931. *See* WEINMANN, A COMPENDIUM OF THE STATUTE LAWS OF CORONERS AND MEDICAL EXAMINERS IN THE UNITED STATES 111-23 (1931). There is no indication that any state fails to specify by statute the circumstances under which autopsy is mandatory, although a comprehensive survey on this subject may now be warranted. Regarding states rights to perform autopsies, see generally Hassard v. Lehane, 143 A.D. 424, 426, 128 N.Y.S. 161, 163 (1911) (stating that the coroner can dissect a dead body if authority to do so is expressly conferred by law); Kingsley v. Forsyth, 192 Minn. 468, 472, 257 N.W. 95, 97-98 (1934) (declaring that in an action by a spouse for damages for wrongful mutilation of decedent's body, sufficient evidence is needed to prove that the coroner wrongfully ordered an autopsy).

[41] Foley v. Phelps, 1 A.D. 551, 555-56, 37 N.Y.S. 471, 473-74 (1896) (declaring that a surviving spouse is entitled to the possession of the body of the deceased spouse in the same condition as when death occurred, for the purpose of giving it proper care and burial, and the spouse may sue for damages one who unlawfully mutilates the body before burial); Hawthorne v. Delano, 183 Iowa 444, 449, 167 N.W. 196, 198 (1918) (stating that although one has an action for damages for mutilation of a dead body, the defendant must have knowledge of the mutilation).

[42] Though surgeons did not actively seek organ donations from the dead until the 1960s when medicine could meaningfully address the problem of organ rejection,

ble organs was subject to civil suit,[43] and possibly to criminal prosecution,[44] if she proceeded without consent[45] of the decedent or appropriate survivor. Because of this legal restriction and because organ donations were inadequate to meet the medical need, the need arose in the 1960s for legal innovation that would address the demand for cadaveric organs.

By 1968, forty-two states had sponsored "donation" statutes expressly empowering the individual to bequeath all or some of her organs for transplant.[46] These enactments did little more than reiterate the common law.[47] Indeed, they "were a confusing mixture of old common law dating back to seventeenth century and state statutes that had been enacted from time to time."[48] These donation statutes lacked uniformity, differing with respect to donor qualifications, donee qualifications, and permissible uses of the donation.[49] Furthermore, the statutes failed to address interstate transactions; a

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kidney transplantation between identical twins was performed in the 1950s. That competent adults have the legal right to donate their body parts has never been challenged, but whether a minor child has such right and capacity was challenged in Massachusetts in 1957, when a minor child wished to give a kidney to his identical twin in desperate need. *See* Curran, *A Problem of Consent: Kidney Transplant in Minors*, 34 N.Y.U. L. REV. 891, 892 (1959).

[43] *See, e.g.*, Georgia Lions Eye Bank v. Lavant, 255 Ga. 60, 335 S.E.2d 127 (1985) (holding physician liable for removing decedent's cornea for transplant without first obtaining consent of relatives); Tillman v. Detroit Receiving Hosp., 138 Mich. App. 683, 360 N.W.2d 275 (1984) (same).

[44] Comment, *Indecent Treatment of the Corpse as a Common Law Crime*, 4 ARK. L. REV. 480 (1949) (detailing the development of the common-law criminal prohibition of disposing of a dead body in any way that offends ordinary decency or threatens public health); *Recent Decisions—Criminal Law: Mutilation of a Dead Body: Cal. Pen. Code* § 290, 27 CALIF. L. REV. 217, 217-18 (1939) (citing state statutes making mutilation of a dead body punishable by a fine or imprisonment).

[45] Physicians varied in their interpretation of the word "consent." Some removed tissue for transplantation on the strength of mere consent to autopsy. Vestal, Taber & Shoemaker, *Medicolegal Aspects of Tissue Homotransplantation*, 18 U. DET. L. REV. 171, 173 n.7 (1955).

[46] Featherstone, *The Uniform Anatomical Gift Act—The Law's Response to a Human Need*, 110 TR. & EST. 468, 468 (1971) (listing the states in which legislatures had enacted such statutes).

[47] Statutes in four of these 42 states addressed only the cornea. *Id.* These enactments did considerably less than reiterate the common law.

[48] *See* Weissman, *Why The Uniform Anatomical Gift Act Has Failed*, 116 TR. & EST. 264, 264 (1977) (stating that the Act simplified the procedures through which organs were donated); *see also* Stason, *The Uniform Anatomical Gift Act*, 23 BUS. LAW 919, 920-24 (1968) (enumerating the problems of anti-mortem gift statutes that predated the Uniform Anatomical Gift Act).

[49] UNIF. ANATOMICAL GIFT ACT, 8A U.L.A. 16, 17 (1968) (Prefatory Note) (amended 1987) (citing the myriad differences among donation statutes and the difficulties to which they potentially gave rise).

surgeon wishing to remove an organ in State A could not be sure of her right to remove the organ if the donor had executed her will in State B.[50]

It was to these shortcomings that the National Conference of Commissioners on Uniform Law addressed itself in 1965 when it began to draft the Uniform Anatomical Gift Act (the "UAGA").[51] In 1968 the Commissioners approved the UAGA and by 1972 the District of Columbia and all fifty states had enacted it,[52] some with minor variations from the original.[53] The UAGA was amended in 1987 to "simplify the manner of making an anatomical gift."[54]

The UAGA, as amended, provides that a decedent who properly executes a gift while she lives will prevail over her survivors when she dies.[55] It establishes a relatively simple donation procedure involving what is commonly called a "donor card."[56] If the decedent fails to make a gift, her close relatives are empowered to donate her body parts provided they know of no contrary wishes of the decedent or of other relatives standing higher on the statutory hierarchy (spouse, child, parent-guardian).[57] Similarly, if a surviving relative authorizes donation, a recipient must refuse it if she knows of objections by the decedent or a relative higher on the hierarchical ladder than the one authorizing the donation.[58] The UAGA also subordinates itself to statutes that specify circumstances under which the coroner or medical examiner is requested to perform an autopsy.[59]

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[50] *Id.* (noting that state donation statutes did not deal adequately with interstate transactions).

[51] *See id.* at 17.

[52] *See id.* at 15-16 (listing jurisdictions that have adopted the Act and the times at which they did so).

[53] *See id.* at 16-18.

[54] *See* UNIF. ANATOMICAL GIFT ACT, 8A U.L.A. 2 (Supp. 1987) (amending the UAGA).

[55] *Id.* § 2(h). Section 2(h) states that an anatomical gift does not require the consent or concurrence of any person after the donor's death.

[56] UNIF. ANATOMICAL GIFT ACT, 8A U.L.A. at 3 (Supp. 1987) (Prefatory Note). Under the UAGA, one effectively makes an anatomical gift by signing a "document of gift." *Id.* § 2(b). A "document of gift" is simply what is commonly referred to as a "donor's card." *Id.* § 1 (defining a "document of gift" as "a card, a statement attached to or imprinted on a motor vehicle operator's or chauffeur's license, a will or other writing used to make an anatomical gift"). The "document of gift" need not be delivered or filed. *Id.* § 2(b). As originally approved in 1968, the UAGA required that the "document of gift" bear the signature of two witnesses. The 1987 amendments eliminate this requirement. *Id.* § 2 comment (noting that the deletion of this requirement was intended to simplify the donation process).

[57] *Id.* § 3 (establishing (1) a hierarchy among surviving relatives who may have conflicting wishes regarding post-mortem donation; and (2) the procedure through which decedent's relatives may make, revoke, and contest anatomical gifts).

[58] *Id.* § 6(c).

[59] *Id.* § 11(b) comment (emphasizing that concerns for good medical practice and law enforcement are paramount to the policies behind the UAGA).

The authors of the 1968 UAGA describe the competing interests they wish to balance as: (1) the wishes of the decedent during his lifetime; (2) the desires of the surviving spouse or next of kin; (3) the interest of the state in determining by autopsy the cause of death in cases involving crime or violence; (4) the need of autopsy to determine cause of death when private legal rights are dependent on such a determination; and (5) the need of society for bodies, tissues, and organs for medical education, research, therapy, and transplantation.[60] The UAGA definitively resolves the ambiguities surrounding state donation statutes and the common law. It does little, however, directly to foster organ donation. Its chief effect is to define the rights of parties interested in the decedent's remains.

III. THE FAILURE OF ENCOURAGED VOLUNTARISM AND A PROPOSED ORGAN DRAFT

That the UAGA has had any positive impact on the supply of transplantable organs is hard to assert or deny, but the rate of organ donation from donor cards is low.[61] There is no question that since 1972 when the fiftieth state adopted the UAGA, the organ shortage has persisted, and that any relief wrought by the UAGA is small.[62]

Indeed, the Commissioners on Uniform Laws amended the UAGA in 1987 because, according to their research, it was "not producing a sufficient supply of organs."[63] The amendments, however, were designed only to

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[60] UNIF. ANATOMICAL GIFT ACT, 8A U.L.A. at 16 (1968) (Prefatory Note). If this list represents the order of priorities, it is small wonder the organ shortage persists; the need for transplantable tissue finishes fifth out of five.

[61] A 1985 Gallup poll commissioned by the American Council on Transplantation concluded that although 75% of the Americans surveyed approved of transplantation, only 17% of them had actually completed donor cards. *See* UNIF. ANATOMICAL GIFT ACT, 8A U.L.A. at 2 (Supp. 1987) (Prefatory Note) (citing Gallup poll). In Maryland, where the donor card is on the driver's license, a 1981 survey indicated only 1.5% of licensed drivers had completed them. *See* Council on Scientific Affairs, *Organ Donor Recruitment*, 246 J. A.M.A. 2157, 2157 (1981).

[62] *See supra* notes 2-25, 52 and accompanying text; *see also*, Weissman, *supra* note 48, at 265 (citing various sources and concluding that the effect of the Uniform Anatomical Gift Act on the shortage of cadaver parts has been minimal); Dukeminier, *Supplying Organs for Transplantation*, 68 MICH. L. REV. 811, 866 (1970) (stating that "[a]ll evidence indicates that the [Uniform Anatomical Gift] Act will not relieve the shortage of free cadaver organs to any appreciable extent and that . . . [t]he Act is a placebo easily swallowed, but not a remedy").

[63] *See* 8A U.L.A. at 2 (Prefatory Note to amendment) (quoting the prefaces to Hastings Center Report on Organ Transplantation, *Ethical, Legal and Policy Issues Pertaining to Sold Organ Procurement*, published in October of 1985).

"simplify the manner of making an anatomical gift and require that the intentions of a donor be followed."[64]

As an instrument of organ procurement, the UAGA embodies a policy called "encouraged voluntarism."[65] Some argue that this policy ought not to be abandoned and that it should, for many reasons, continue as the basis of national organ procurement. Others regard encouraged voluntarism as a failed policy and suggest alternatives. These include: (1) a commercial market in which transplantable organs would be bought and sold;[66] (2) a "presumed consent" system in which decedents and survivors would be deemed to donate organs unless they affirmatively express an objection;[67] and (3) a "routine inquiry" scheme continuing the prohibition on organ removal without the express consent of donor or survivor but meanwhile requiring that hospital personnel approach surviving families and raise the issue of organ donation.[68]

This Article proposes a straightforward conscription of transplantable organs post-mortem. Subject to religious exemption, the proposed Model Organ Draft Act[69] (the "Act") authorizes physicians and hospital personnel to remove from any cadaver such organs as would be useful to a living patient[70] registered with a central registry.[71] Organs would be evaluated and removed without consent of either the decedent or her survivors.[72] This Article suggests that this proposed organ draft is superior to encouraged voluntarism and to the proposed policies of organ sale, presumed consent, and routine inquiry.

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[64] UNIF. ANATOMICAL GIFT ACT, 8A U.L.A. at 2 (Supp. 1987) (Prefatory Note).

[65] *See, e.g.*, Caplan, *Organ Transplants: The Cost of Success*, 13 HASTINGS CTR. REP. 23, 24 (Dec. 1983) (describing the policy of encouraged voluntarism).

[66] *See infra* notes 89-112 and accompanying text.

[67] *See infra* notes 113-28 and accompanying text; *see also* Caplan, *supra* note 65, at 24; Weissman, *supra* note 48, at 267, 281-82; Dukeminier & Sanders, *Organ Transplantation: A Proposal for Routine Salvaging of Cadaver Organs*, 279 N. ENG. J. MED. 413 (1968).

[68] *See infra* notes 129-39 and accompanying text. As noted in the Prefatory Note to the 1987 version of the Uniform Anatomical Gift Act, a majority of states have now enacted some form of "routine inquiry" statute. UNIF. ANATOMICAL GIFT ACT, 8A U.L.A. at 2-3.

[69] *See infra* Appendix: The Model Organ Draft Act [hereinafter MODA] § 16 (detailing the procedures and standards for the religious exemption to the Act's coverage).

[70] MODA, *supra* note 69, § 13.

[71] MODA, *supra* note 69, § 5.

[72] MODA, *supra* note 69, §§ 9, 11(1) (permitting evaluation and removal without consent of patient or family).

IV. A Comparison of the Organ Draft with Other Procurement Policies

A. *Encouraged Voluntarism*

The policy of encouraged voluntarism has dominated organ procurement since transplantation first began. It is the cornerstone of the UAGA and operates, therefore, throughout the United States.[73] In defense of voluntarism, Professor Paul Ramsey argues that the opportunity affirmatively to give organs does service to potential donors and to the society of which they are a part.

> A society will be a better human community in which giving and receiving is the rule, not taking for the sake of good to come. The civilizing task of mankind is the fostering, the achievement, or the shoring up of consensual community in general, and not only in regard to the advancement of medical science and the availability of cadaver organs in efforts to save the lives of others. Civilization means living our consensual communities, not living in communities in which consent and refusal go on, just as surely as we live our bodies, not in them. The positive consent called for by Gift Acts, answering the need for gifts by encouraging real givers, meets the measure of authentic community among men. The routine of taking organs[74] would deprive individuals of the exercise of the virtue of generosity. The moral sequels that might flow from education and action in line with proposed Gift Acts may be of far more importance than prolonging routinely. The moral history of mankind is of more importance than its medical advancement, unless the latter can be joined with the former in a community of affirmative consent.[75]

With respect to the values Mr. Ramsey propounds, an organ draft is better than the voluntarism he advocates. According to Professor Ramsey, the positive consent that voluntary donation requires fosters "real givers" and furthers the goal of "authentic community."[76] Ramsey writes that "[a] society will be a better human community in which giving and receiving is

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[73] *See supra* notes 51-60 and accompanying text. For arguments in support of encouraged voluntarism, see P. Ramsey, The Patient as Person 198-215 (1970); Sadler, Sadler, Stason & Stickel, *Transplantation: A Case for Consent*, 280 New Eng. J. Med. 862 (1969).

[74] In using the phrase "routine taking" Professor Ramsey refers to the policy of "presumed consent," discussed *infra* notes 113-26 and accompanying text. *Id.* at 210-11 (comparing the policy embodied in the Uniform Anatomical Gift Act to a policy that would give effect only to patients' objection that their organs not be used—i.e. "presumed consent").

[75] P. Ramsey, *supra* note 73, at 209-10.

[76] *Id.* at 210.

the rule,"[77] and that the "routine taking of organs would deprive individuals of the exercise of the virtue of generosity."[78] Giving is the essence of an organ draft. An organ draft requires the society to express its donative, civilized instincts where retentive and primitive ones might otherwise prevail. The proposed organ draft is not, therefore, inimical to the values of charity and gift. It effectuates these values, directing them toward social progress and the common good.

In support of voluntarism, Ramsey writes that "the civilizing task of mankind is the fostering, the achievement, or the shoring up of consensual community in general."[79] Analyzed closely, two Gallup polls suggest that the proposed organ draft would, indeed, reflect community consensus. In a 1968 Gallup poll, seventy percent of surveyed Americans affirmed their willingness to donate vital organs after death.[80] A 1985 Gallup poll indicated that, although seventy-five percent of the Americans surveyed would be willing to donate their organs, only seventeen percent had actually completed donor cards.[81] That seventy-five percent of the populace should say "yea" to organ donation from an armchair, while eighty-three percent say "nay" from the deathbed, suggests that most people believe they should donate their organs post-mortem but cannot bring themselves to do so. The legitimate role of coercive law in civilized society is to implement common will and wisdom where voluntary incentive is lacking.

Whatever the reason for the ultimate reluctance to donate organs,[82] the decision to give or withhold organs generates what economists have called "externalities." These externalities make compulsory conscription a necessary and advisable means of effectuating the "consensual communities" of which Professor Ramsey thinks so highly. With respect to any private decision, an externality is a consequence favorable or unfavorable, that impinges not on the decisionmaker but on some other party or parties. The

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[77] *Id.*

[78] *Id.*

[79] *Id.*

[80] N.Y. Times, Jan. 17, 1968, at A18, col. 2.

[81] *See* UNIF. ANATOMICAL GIFT ACT, 8A U.L.A. 2 (Supp. 1987).

[82] Some scholars suggest that people hesitate to complete donor cards because they are unwilling to contemplate death openly. *See, e.g., H.R. 4080 Hearings*, *supra* note 12, at 145 (testimony of Donald W. Denny). This explanation is not persuasive. Few adults resist other acts that require as square a meeting with mortality. They execute wills, and they purchase annuity contracts, life insurance, and burial plots.

The reluctance appears to relate more to an aversion to invasion of bodily integrity. People are generally disinclined to suffer dissection except where it is designed as therapy for themselves or a loved one. Surgery offers therapy to the patient herself. Even autopsy may be perceived by bereaved families as a final form of surgery designed to let them know, in the end, precisely why their relative has died. Organ donation does not have this type of benefit for the relatives or the decedent.

decision to be buried intact carries externalities;[83] a person who chooses not to donate harms patients who need organs but are unable to get them. Furthermore, such person is entitled to receive organs from someone who has chosen to donate. Thus, a potential donor has little incentive to give. This constitutes a market failure and damages society by creating inefficient use of resources.[84]

These externalities might be partially internalized if patients who agreed to donate their organs had priority in receiving them. However, even if such a policy would generate more organ donations, it would not prevent the deaths of those who need organs and have not agreed to donate. These deaths are part of the social harm that an organ procurement policy should address.

The government's regulatory power is a well-recognized means of correcting inefficiencies due to externalities.[85] Pollution control provides a good example. In a society of citizens who believe that clean air is worth its economic price, the public interest is best served not by voluntary purchase but by a rule compelling such purchase.[86] If the matter were left to voluntarism, few drivers would purchase the necessary equipment even if they themselves (1) wished to breathe clean air, and (2) believe clean air to be worth the price of the purchase. Why? Because no one citizen will reap the benefit of the investment unless all others also invest. No one citizen, therefore, will have a private incentive to adopt the good measure. One driver's effort to control his own vehicle's emissions does not appreciably affect the quality of the air he breathes.[87]

Environmental regulations, the military draft, and tax laws compel behavior in order to promote the public interest. The sense behind the coercive power of democratic governments is to move society forward by public decree where individuals will not, by private volition, act in their own best interests.

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[83] The decision not to donate organs generates what economists term a *negative* externality, or a harmful effect upon a person who was not a party to the decision that created the harmful effect. G. STIGLER, THE CITIZEN AND THE STATE 104-05 (1975). When one party refuses to donate another suffers. The decision to donate organs generates what economists term a positive externality, or a favorable effect upon a person who is not a party to the decision. When one party donates another benefits.

[84] "Private decisions will not lead to a maximum of satisfaction unless externalities are negligible; or to use essentially equivalent language, resources are not used with maximum efficiency unless all the results, good and bad, of an investment (that is, its marginal social product) accrue to the person making the investment." *Id.* When parties undertake an economic decision without taking into account the costs that fall on others, they may undertake activities that harm society as a whole. *Id.* "[I]f the parties to a decision do not reckon in benefits which accrue to others, they may spurn activities which would be socially advantageous." *Id.*

[85] *See generally* R. COOTER & T. ULEN, LAW AND ECONOMICS 45-49 (1988).

[86] *Id.* at 45-46.

[87] *See* P. SAMUELSON, ECONOMICS 501-05 (1970).

Moreover, the social value that Professor Ramsey attributes to voluntarism is gravely undercut by the fact that it does not work; people do not give enough. The organ shortage persists. Whether this is because of externalities or because the Gallup polls are wrong and the community consensus does not in fact favor organ donation, the organ draft is an appropriate solution. Good law should not necessarily reflect prevailing community consensus on the day it is enacted. Coercive laws can foster social growth. As Rousseau wrote:

> The general will is always right, but the judgment that guides it is not always enlightened. It is therefore necessary to make the people see things as they are . . . to point out to them the right path they are seeking. Some must have their wills made to conform to the reason, and others must be taught what it is they will. From this . . . would result the union of judgment and will in the social body. From that union comes the harmony of the parties and the highest power of the whole. From then is born the necessity of a legislator.[88]

Even in the face of public opposition it is likely the proposed organ draft would ultimately serve society better than voluntarism.

B. *Commercial Organ Market*

In the 1970s, debate and literature on organ donation focused on the notion of a commercial organ market to alleviate the organ shortage.[89] One

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[88] J.J. ROUSSEAU, THE SOCIAL CONTRACT 35 (Hafner Library of Classics 1947) (London ed. 1791).

[89] *See, e.g.*, Brams, *Transplantable Human Organs: Should Their Sale Be Authorized by State Statutes?*, 3 AM. J. L. & MED. 183 (1977) (arguing that state laws should be passed to support a combined altruistic and market system of human organ procurement and distribution); Frier, *Organ Selling For Transplantation*, 38 PROGRESS CLIN. & BIOL. RES. 141, 141-46 (1978-79) (discussing the hypothetical sale of a kidney by a living donor for a large sum of money); Movrodes, *The Morality of Selling Human Organs*, 38 PROGRESS CLIN. & BIOL. RES. 133, 133-39 (1978-79) (noting that purchase and sale arrangements could be made before death and discusing the morality of selling body parts); Note, *Retailing Human Organs Under the Uniform Commercial Code*, 16 J. MARSHALL L. REV. 393, 401-02 (1983) [hereinafter Note, *Retailing Human Organs*] (arguing that "supplementing the [Uniform Anatomical] Gift Act's altruistic principles with a market system would substantially alleviate the shortage of organs by providing a monetary incentive"); Note, *The Sale of Human Body Parts*, 72 MICH. L. REV. 1182 (1974) (exploring the legal and ethical implications of establishing a commercial market system as a means of eliminating the shortage of human organs available for transplant); *see also* J. KATZ & A. CAPRON, CATASTROPHIC DISEASES: WHO DECIDES WHAT? 185-89 (1975) (describing a market system for kidneys and concluding that such a system inaccurately reflects a person's valuation of her life because of inequality in wealth distribution).

commentator even considered its tax implications.[90] Thought was inspired not only by theoretical speculation but also by the fact that during the 1970s such a market began to bud.[91] In 1984, however, Congress felonized the purchase and sale of organs implicated in interstate commerce, essentially ending the debate.[92]

Those who favored an organ market claimed it offered several advantages. Proponents contended that an active market would go far to alleviate the organ shortage.[93] They argued that "common sense—backed by extensive data on the relationship between economics and human behavior"[94] and "analysis of the interaction between economics and human behavior"[95] indicate that many persons who would not donate their organs altruistically might sell them for a price. This greater availability of cadaveric organs, commentators argued, would reduce the need for live donation with its attendant surgical risks.[96] They maintained that the enlarged pool of donors

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[90] Note, *Tax Consequences of Transfers of Bodily Parts*, 73 COLUM. L. REV. 842 (1973) (considering the status of organ transfers under income, estate, and gift tax provisions of the Internal Revenue Code and suggesting tax provisions that might encourage organ donation).

[91] *See* Brams, *supra* note 89, at 189 (noting that blood and sperm may be lawfully sold despite the fact that they are defined as body parts under the Uniform Anatomical Gift Act); Council of the Transplantation Society, *Commercialization in Transplantation: The Problems and Some Guidelines for Practice*, 8457 LANCET 715, 716 (1985) (reporting that, consistent with a climate of commercialization, "instances of brokerage of kidneys from living unrelated donors have begun to emerge"); Note, *Retailing Human Organs*, *supra* note 89, at 401 n.49 (1983) (citing *Kidneys and Eyes for Sale as Well as Pints of Blood*, Evening J. (Wilmington, Del.), Apr. 14, 1975, at 10, col. 1 (arguing that a commercial market system would be successful because evidence indicates that potential donees would be willing to pay for organs)).

[92] National Organ Transplant Act, 42 U.S.C. §274e (Supp. 1986) (imposing a fine of "not more than $50,000 or imprisonment of not more than five years, or both" on persons selling or receiving human organs, if interstate commerce is implicated).

[93] *See, e.g.*, Brams, *supra* note 89, at 187 & n.13 (arguing that financial compensation would "provide a strong incentive for some individuals to relinquish an organ" and help reduce the organ shortage); Note, *Retailing Human Organs*, *supra* note 89, at 403 (arguing that the ability to sell one's organs would substantially increase the supply of organs).

[94] Brams, *supra* note 89, at 189. However, no "extensive data" are cited in Professor Brams's article.

[95] Note, *Retailing Human Organs*, *supra* note 89, at 401. The "analysis," however, is not disclosed in this Note.

[96] *See, e.g.*, Note, *Retailing Human Organs*, *supra* note 89, at 401-03 (arguing that an organ market would substantially alleviate the organ shortage and that this would reduce the need for living kidney donors who face not only the dangers of major surgery but also the possibility that if the remaining kidney suffers future damage, the donor may require a transplant); Brams, *supra* note 89, at 190 (same).

would also improve immunologic matching between donor and recipient, reducing the incidence of rejection.[97]

With regard to the increased organ supply that a commercial organ market might afford, inter vivos sales could be made only of tissues with such reserve, or capacity for regeneration, as would allow the donor to maintain life. This means that inter vivos purchase and sale could not increase the supply of hearts, lungs, or livers. As a workable solution to the organ shortage, therefore, a market mechanism would have to provide for the purchase and sale of post-mortem organs.

Because a potential donor cannot, in advance of her death, guarantee the utility of her organs post-mortem,[98] the value of her organs would be speculative and might therefore bring too low a price to promote significant sales.[99]

In order for a market to function, therefore, sales might have to be made by the donor's estate or surviving family. It does not seem safe to assume that monetary remuneration, whatever the amount might be, would induce families to donate organs in quantities sufficient to alleviate the shortage.[100] Furthermore, a market system might result in distributional inequities, wherein organs would be available only to the wealthy. In response to this observation, one proponent of purchase and sale noted that it would be "absurd" to dismiss a market system capable of helping so many simply because some cannot participate.[101]

An organ draft eliminates all of the price-based uncertainty that attends the market system. Subject only to religious exemption, it will make all usable post-mortem organs available for transplant. Moreover, if the availability of sellers' organs will reduce the need for live donation and improved

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[97] *See* Brams, *supra* note 89, at 190.

[98] *See supra* note 25 and accompanying text.

[99] Brams argues that payment to a donor could be made to that donor's estate after death, or if the organs were removed during life, payment could be made at the time of removal. Brams, *supra* note 89, at 187-88. It is possible that a system of agents, brokers, and speculators could be fashioned which would allow donors and recipients to buy and sell options on post-mortem organs. One who wishes to sell her organs for donation after death might then receive some payment during life, and after death, if her organs were needed, her estate would receive the additional payment. A potential donee would pay for an option when she first became needy. At some point in the future she would pay the full exercise price for delivery.

[100] Of course, cost might be spread among the population via the mechanisms of public subsidy or private insurance. Whether the price of organs is paid by the recipient or by society, we cannot know what that price will be and, consequently, who will be able to pay it. Free-market proponents may argue that organs *should* be committed to the soil if that is where the "invisible hand" directs them. Proponents of an *organ* market have never taken such a position nor even raised the argument. Indeed, it would be inconsistent with their avowed desire to increase the supply of transplantable organs.

[101] Brams, *supra* note 89, at 191.

immunologic matching, then the availability of drafted organs will do so more effectively.

Proponents further contended that an organ market operated pursuant to statute might foster positive change in social attitudes toward donation.[102] If an organ market will improve the public's attitude toward donation, an organ draft will foster even greater and more dramatic improvement.[103]

Proponents of an organ market anticipated certain objections it would likely raise.[104] These included the likelihood that a market system would reduce the rate of organ donation[105] and that sale is in itself immoral or unethical.[106] Professor Brams argued that a decrease in the supply of free organs seems a "reasonable price to pay for an overall increase in the availability of organs."[107] Reasonable or not, an organ draft would occasion no such price.

Cognizant of ethical and moral objections to organ sale, those who advocate an organ market urge that sale is neither unethical nor immoral. They argue that a policy that supplies more needed organs is ethically superior to one that supplies fewer and that "one who relinquishes an organ 'for money' may well have an altruistic motive—specifically to acquire income to provide his family with advantages he could not otherwise obtain."[108]

Furthermore, one author observes, that the transplant surgeons who object on moral grounds to the purchase and sale of organs charge a fee for transplant surgery and that when an organ is transplanted many people other than the donor will be paid for their part in the operation.[109] "If you suggest somehow it's immoral for the donor to get paid, then you have picked him out from among all these other people as being the one whose contribution to that operation is the contribution which should not be paid for."[110]

But many people do believe that humanity is debased when one individual endeavors not to keep, not to give, but to sell certain aspects of his or her

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[102] *Id.* at 189.

[103] *See supra* notes 79-87 and accompanying text.

[104] *See* Brams, *supra* note 89, at 191-93.

[105] *Id.* at 191 (setting forth the argument that persons who otherwise would have donated their organs gratuitously might not do so given the opportunity for financial compensation). In addressing this concern one author notes that although the prospect of future compensation may reduce the number of people who would relinquish organs altruistically, and hence the supply of free organs may decrease, individuals who could not afford to purchase organs could be given the first opportunity to receive organs donated gratuitously.

[106] *Id.* at 192-93 (averring that an organ market policy is ethically *superior* to a gift policy because "it benefits a greater number of persons, while causing little or no harm to a significant minority").

[107] *Id.* at 191.

[108] Brams, *supra* note 89, at 192.

[109] Movrodes, *supra* note 89, at 137.

[110] *Id.*

being.[111] Perhaps this is the reason that under state and federal statutes one may not sell his life, his freedom, his children, or his sexual partnership. And, right or wrong, federal law now proscribes the sale of organs as well.[112] The debate on purchase and sale of organs is and ought to be moot. It is not here contended that an organ market is inherently bad, only that, in comparison with an organ draft, it is an inferior solution to the national organ shortage. It cannot meet our nation's need for organs.

C. *Presumed Consent*

"Presumed consent," or "routine salvage," is a system in which all decedents are presumed to donate their organs unless the decedent or her survivors expressly state otherwise. The individual and the bereaved family retain a right to withhold organs, but to exercise this right they must act affirmatively. Presumed consent systems operate in fourteen nations: Austria, Czechoslovakia, Denmark, France, Finland, Greece, Israel, Italy, Japan, Norway, Poland, Spain, Sweden, and Switzerland.[113] In the 1970s and early 1980s, several American authorities advocated presumed consent

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[111] It is true, of course, that monetary payment represents an accepted method for the solicitation of blood and various hormonal substances and precursors. The problems that arise in connection with organ sale do not arise in connection with the sale of these substances. Blood, semen, and hormones regenerate; donation wreaks no permanent or fundamental loss upon the donor and for this reason, I think, fails to raise the practical and "moral" objections occasioned by the prospect of an organ market. *See generally* Stewart, *The Battle Over Blood Collection*, 3 AM. J. L. & MED. 77 (1977) (examining both the need for a safe and available blood supply and the effects of government regulation, with the assumption that blood donation is socially desirable); R. TITMUSS, THE GIFT RELATIONSHIP: FROM HUMAN BLOOD TO SOCIAL POLICY 70-89 (1971) (noting that while blood donors give for various reasons, including financial ones, blood donation, even though compensated, is generally seen as desirable for the community); *cf.* Murray, *Who Owns the Body? On the Ethics of Using Human Tissue for Commercial Purposes*, 8 IRB: A REVIEW OF HUMAN SUBJECTS RESEARCH 1, 4 (1986) (noting that although the current system with respect to body fluids and organs has been successful, the system is being threatened by the commercialization of biology and the assertion by individuals of property rights in their removed body parts).

[112] National Organ Transplant Act, 42 U.S.C. § 274(e) (Supp. IV 1986) (stating that it is "unlawful for any person to knowingly acquire, receive, or otherwise transfer any human organ for valuable consideration if the transaction affects interstate commerce").

[113] *See* Caplan, *supra* note 65, at 30 (in half of the countries with a presumed consent policy, doctors ask families whether they object to organ donation; in the others, physicians proceed with organ donation unless a prior objection has been made); *see also* N.Y. Times, Dec. 22, 1986, at A15, col. 1 (reporting that Singapore's government proposed legislation permitting doctors to remove the kidneys from fatal accident victims who have made no prior objection to removal).

as a system that would increase organ supply without unreasonably burdening personal liberty.[114]

In comparison to encouraged voluntarism—and, *sub silento*, mandatory conscription—presumed consent is said to be more humane toward family and society, more practical, and more consonant with the true public will. Encouraged voluntarism often requires that survivors be disturbed in moments of deepest mourning to make the difficult decision of whether to donate. Advocates of presumed consent argue that an express consent system, such as encouraged voluntarism, cannot operate meaningfully at such times. Proponents argue that a presumed consent system would implement society's better judgment—a judgment that is often not reached under a system requiring express consent. As one proponent observes:

> Almost always the potential organ donor has died suddenly and unexpectedly. Relatives or friends are in a state of shock, grief, and confusion.
>
> In such situations it is difficult to see how families can have a real opportunity to make an informed or voluntary choice. Basic factors ordinarily held to be absolutely necessary for any choice to be informed and free—time and suitable decision-making environment—are often absent in a busy hospital corridor or emergency room. The capacity of bereaved family members to comprehend information under such circumstances is highly questionable.[115]

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[114] Butler, *The Law of Human Organ Procurement: A Modest Proposal*, 1 J. CONTEMP. HEALTH L. & POL'Y 195, 203 (1985) (arguing that a presumed consent system would increase the organ supply and be ethically sound so long as it affords presumed consent donors a simple method of registering objection); *see also* Caplan, *Organ Procurement: It's Not In The Cards*, 14 HASTINGS CTR. REP. 9, 12 (1984) (arguing that a policy of weak presumed consent would produce significant social good while accommodating family choice and autonomy in an atmosphere of mutual respect); Caplan, *supra* note 65, at 30; Dukeminier, *supra* note 62, at 837-42 (concluding that the organ supply would increase significantly if usable organs were routinely removed from cadavers except where the potential donor or her family had registered an objection to removal). *See generally* Muyskens, *An Alternative Policy for Obtaining Cadaver Organs for Transplantation*, 8 PHIL. & PUB. AFF. 88 (1978) (proposing a policy of routine organ salvage, with broad exceptions to protect the autonomy of those opposed to it). It is sometimes reported that certain states have adopted presumed consent statutes pertaining to cornea transplantation. TASK FORCE 1986 REPORT, *supra* note 7, at 30. These statements refer to the fact that twelve states have adopted statutes allowing medical examiners to remove corneas from unclaimed cadavers, after reasonable effort to locate surviving relatives and solicit their approval. ETHICAL, LEGAL AND POLICY ISSUES PERTAINING TO SOLID ORGAN PROCUREMENT: A REPORT OF THE PROJECT ON ORGAN TRANSPLANTATION 17 (Hastings Center, October, 1985).

[115] Caplan, *supra* note 65, at 25-26.

Relying on express consent at times like these, the argument runs, denies the decedent or the survivor the chance to reach a decision that conforms to her own better judgment.[116] Professor Arthur L. Caplan observes: "When we find ourselves in 'boundary situations'—when our lives have become unraveled, we need ritual, routine, and automatic procedures. These procedures ought to be those that reflect our collective judgment expressed in more normal times."[117] Citing the 1968 Gallup poll, which purportedly demonstrates that the majority of Americans wish to donate their organs post-mortem,[118] Professor Caplan concludes that a presumed consent policy would implement the society's better judgment automatically.[119]

According to one advocate of presumed consent, a system in which medical personnel request organ donation from bereaved families is "callous and uncivilized."[120] "It is hard to imagine a physician reaching for a telephone and saying: 'Mrs. Smith, I deeply regret having to inform you that your husband Thomas had a car accident on Interstate 5. He was admitted here in a dying condition and he died five minutes ago. We very much need his kidneys for transplantation. Will you give us permission to remove them?' "[121]

Advocates also argue that presumed consent is a less radical departure from traditional humanistic values than is the policy of encouraged voluntarism embodied in the UAGA, because "by making the basic presumption one which favors life, and by thus putting the burden of objecting upon persons who would deny life to another, the policy of saving human life is given first priority . . . ."[122]

Finally, advocates argue that presumed consent would be less costly than encouraged voluntarism. Encouraged voluntarism requires advertising and public education campaigns to remind individuals about the need for organ donation.[123] "Though it is difficult to obtain exact figures, the Red Cross, the

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[116] *See id.*

[117] Muyskens, *supra* note 114, at 96 (commenting that a "giving" policy has the disadvantage of asking for family approval during the time of greatest grief, when they are most likely to refuse, regardless of whether they would generally agree with the procedure).

[118] *See* N.Y. Times, Jan. 17, 1968, at A18, col. 3 (reporting a Gallup poll showing that 70% of persons surveyed said they would be willing to have their organs donated to medical science upon their death).

[119] *See* Caplan, *supra* note 65, at 25-26 (stating that there should be "ritual, routine and automatic procedures" reflecting society's collective judgment during ordinary times).

[120] Dukeminier, *supra* note 62, at 831.

[121] *See id.* at 831; *see also id.* at 838 (discussing the awkwardness of obtaining consent from family members under an express consent policy).

[122] Dukeminier, *supra* note 62, at 837.

[123] Caplan, *supra* note 65, at 30.

National Kidney Foundation, and the numerous eye banks located throughout the United States estimate their advertising and promotional costs to be in the millions of dollars."[124]

Presumed consent, however, insidiously exploits the citizen's regrettable reluctance to dissent, even though dissent is her right. It would depend for its success on the unhappy fact that most human beings are disinclined toward active protest of that which is customary and routine. Exploitation of one's reluctance to assert her rights is not a sound basis for social policy.

Furthermore, presumed consent represents conscription in disguise. It gives citizens the impression that they have the right to refuse donation, when in fact many would not. Because many families might be entirely unaware that organs will be removed unless they object, organs will be removed without their consent or prior knowledge. Surviving relatives might then learn of the removal after the fact or not at all. In either event they have no opportunity to protest the removal, and, in a very meaningful sense, the organs are taken with no account for their wishes. The nation would fare better with conscription plainly clothed.

The argument that presumed consent will spare families the strain of making difficult decisions at the time of death is also spurious. Those who know that organs will be removed unless they protest will need to decide, just as they would need to decide under an express consent system, whether or not to allow donation. A presumed consent system might amplify the anguish by requiring the potential donor or family to protest donation, presumably a less desirable decision from the hospital's perspective, at a time when the hospital's good will is cherished.[125]

Presumed consent would permit society to procure organs without squarely facing the pertinent questions of social priority. By contrast, the proposed draft encourages genuine social growth. It rearranges priorities forthrightly. It commits the populace unequivocally to a course of conduct that promotes salvage instead of waste. Conscription presses upon the society a social advance that conforms to its avowed belief that the living come before the dead.

Finally, presumed consent systems may not effect the most important goal of a donor system—an adequate organ supply. European countries that follow presumed consent schemes[126] continue to experience organ shortages.[127] This fact has dampened enthusiasm for presumed consent in the

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[124] *Id.*

[125] People fearing to express wishes not to have their organs donated might have additional anguish from knowing that their own fear to speak will cause their body to be "violated" after they die.

[126] *See supra* note 113 and accompanying text.

[127] *See* Stuart, Veith & Cranford, *Brain Death Laws and Patterns of Consent to Remove Organs for Transplantation from Cadavers in the United States and 28 Other Countries*, 31 TRANSPLANATION 238, 239 (1981).

United States. According to the Task Force on Organ Transplantation, "there is little support for this mechanism as a way of increasing the availability of donor organs."[128]

D. *Routine Inquiry*

That presumed consent has not taken root in America is of little concern to most procurement authorities, for an emerging wisdom now attributes inadequate organ supply not to a dearth of consents but to a dearth of requests.[129] It has been reported that most hospitals fail to ask for organs when a potential donor is dying or dead.[130] This insight fuels a movement toward the "routine inquiry" policy, the latest in organ procurement proposals.[131]

The routine inquiry scheme provides that, where feasible, designated hospital personnel must ask the survivors of a potential donor whether the deceased's organs might be used for transplantation. Proponents argue that routine inquiry will, at a minimum, salvage the organs of all persons whose survivors are in fact willing to donate.[132] Furthermore, it is urged, the scheme represents a policy option that will "accommodate both individual autonomy and community good."[133]

By 1987, a majority of states had enacted a variety of routine inquiry laws that "require hospital administrators to discuss with next of kin the option of donating, or requesting the donation of, organs of a decedent."[134] In addition, some hospitals have, on their own, initiated routine inquiry policies.[135]

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[128] TASK FORCE 1986 REPORT, *supra* note 7, at 31.

[129] *See, e.g., id.* at 12 (arguing in favor of a required request policy); Muyskens, *supra* note 114, at 90 (noting that although 70% of adult Americans profess a willingness to donate organs post-mortem, few take steps to do so).

[130] *See, e.g.*, Caplan, *Requests, Gifts, and Obligations: The Ethics of Organ Procurement* 18 TRANSPLANTATION PROC. 49 (Supp. 2 1986) (noting that if the request were made most families would willingly donate organs of a deceased relative, but that in most instances hospitals do not make the request); Caplan, *Organ Procurement: It's Not In The Cards*, *supra* note 114, at 12 (noting that even if a deceased person has signed a donor card, American physicians are unwilling to remove organs without the family's consent and that this is an indication of their reluctance to disturb bereaved families).

[131] *See, e.g.*, Caplan, *Organ Procurement: It's Not in the Cards*, *supra* note 114, at 9.

[132] *See id.*

[133] *Id; see also* Muyskens, *supra* note 114, at 95 (arguing that a policy of routine salvage would save lives and, at the same time, allow for nonparticipation by those who object).

[134] UNIF. ANATOMICAL GIFT ACT, 8A U.L.A. at 3 (Supp. 1987) (Prefatory Note).

[135] *See* Oh & Uniewski, *Enhancing Organ Recovery by Initiation of Required Request Within a Major Medical Center*, 18 TRANSPLANTATION PROC. 426-28 (1986) (reporting that Henry Ford Hospital in Detroit initiated a program of routine inquiry).

Since October of 1987, the federal government has denied Medicare participation to hospitals that fail to "assure that families of potential organ donors are made aware of the option of organ or tissue donation and their option to decline."[136]

Preliminary data suggest that routine inquiry may increase organ donation. The Henry Ford Hospital in Detroit initiated its own routine inquiry system in 1985 and between January and September received twenty-nine consents. During the same nine-month period in 1984, the hospital received only nine donations.[137] This report indicates that routine inquiry might be effective.

Other data, however, suggest that the routine inquiry policy will never fully alleviate the organ shortage. Where required request systems operate, approximately sixty percent of those who are asked agree to donate organs.[138] Even if, under a required request plan, all families of decedents with usable organs were asked to donate the organs of dead or dying patients and even if sixty percent of these families consented to removal of every transplantable organ, some organ shortages would persist.[139]

As an organ procurement device, a routine inquiry scheme with a sixty percent consent rate is inferior to a draft which exploits 100% of the available organ pool. Nevertheless, in comparing routine inquiry to the proposed organ draft, one might suggest that the nation should first experiment with routine inquiry, evaluate its efficacy and, if it fails to alleviate the shortage, *then* consider a measure so extreme as the draft.

The trouble is, though, that adults and children will die while this experiment proceeds. Why then should the nation not first enact a draft? One who

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[136] 42 U.S.C. § 1320b-8 provides, in part:

(1) The Secretary shall provide that a hospital meeting the requirements of subchapter XVIII or XIX . . . [is eligible for certain types of federal funding and reimbursement programs] only if—

(A) the hospital establishes written protocols for the identification of potential organ donors that—

(i) assure that families of potential organ donors are made aware of the option of organ or tissue donation and their option to decline,

(ii) encourage discretion and sensitivity with respect to the circumstances, views, and beliefs of such families . . . .

Id.

[137] Oh & Uniewski, *supra* note 135, at 426 (reporting the number of organ donations at Henry Ford Hospital during 1984 and 1985).

[138] Caplan, *Requests, Gifts, and Obligations: The Ethics of Organ Procurement*, *supra* note 130, at 53 (noting that when families are asked to donate, over 60% consent, and concluding that the level of altruism is high both in theory and in deed).

[139] There are 20,000 potential organ donors each year in the United States. *See supra* note 25 and accompanying text. If 60% of these potential donors gave all of their usable organs for transplantation, the kidney shortage might well disappear. The heart and liver shortage, however, might not. *See supra* notes 10-17 and accompanying text.

rejects this suggestion must believe that an organ draft poses so extreme a threat to personal liberty as to make it an unacceptable step now—or perhaps at any time—even though it will almost certainly better promote health than any procurement system yet proposed or extant. Indeed, all objections to the organ draft would probably relate to the matter of personal rights and liberty. "Personal liberty" denotes matters of constitutional and non-constitutional dimension.

V. CHALLENGES TO THE CONSTITUTIONALITY OF AN ORGAN DRAFT

The constitutionality of an organ draft might be challenged under the first amendment right to free exercise of religion,[140] the fifth amendment right to "just compensation,"[141] and the constitutional right to privacy.[142]

A. *First Amendment Challenges*

The first amendment forbids the government to prohibit free exercise of religion.[143] The proposed Model Organ Draft Act exempts from participation any person who objects to organ donation on religious grounds and does not, therefore, conflict with the first amendment.

It is not clear that an organ draft act would violate the first amendment without such an exemption. The United States Supreme Court has not yet ruled on a first amendment free exercise challenge to legislation requiring the individual to submit to medical treatment or procedures.[144] Several federal

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[140] The first amendment states that "Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof. . . ." U.S. CONST. amend. I, cl. 1. Federal and state governments are equally constrained by the first amendment. *See* Cantwell v. Connecticut, 310 U.S. 296, 307 (1940).

[141] The fifth amendment states that private property shall not "be taken for public use without just compensation." U.S. CONST. amend. V.

[142] *See infra* notes 178-93 and accompanying text.

[143] Freedom to act in the exercise of religion is subject to regulation by the state for the protection of society. Such regulation, however, must be in furtherance of a permissible end and must not unduly infringe the protected freedom. *Cantwell*, 310 U.S. at 307-08.

[144] Although some courts cite *Jacobson v. Massachusetts* as authority for the proposition that public health and safety may justify government intrusion on religious freedom, *Jacobson* arose when the first amendment was not yet applicable to the states; and, the Court did not refer to religious freedom or the first amendment. 197 U.S. 11 (1905) (sustaining regulation requiring all adult citizens of Cambridge, Massachusetts, to receive smallpox vaccinations, notwithstanding that exposure to vaccination carried statistical possibility of serious illness and even death); *cf.* Kurland, *Of Church and State and the Supreme Court*, 29 U. CHI. L. REV. 1, 24 (1961) (noting that in free exercise challenges, California and Maryland courts have relied upon dicta of the Supreme Court in *Jacobson*).

district courts, however, have ruled on first amendment challenges to medically oriented legislation.[145] One, for example, ruled that the state may mandate blood transfusions for minor children despite the parents' religious objections.[146] According to this district court, the "right to practice religion freely does not include liberty to expose . . . the child . . . to ill health or death."[147] Similarly, a state appellate court held that compulsory vaccination and quarantine laws are constitutional notwithstanding religious objections, on the grounds that free exercise of religion does not embody a right to "hurt or harm the overwhelming majority of the community."[148] These decisions lend support to the argument that an organ draft is viable under the free exercise clause because the individual's refusal to donate organs exposes others to ill health or death.[149]

On the other hand, several Supreme Court decisions suggest that an organ draft would violate the first amendment if it did not exempt those who opposed organ donation on religious grounds. Looking to the first amendment, the Supreme Court has invalidated statutes that burden religious practice when the state advances "no compelling state interest as justification."[150] The Court has further indicated that, in relation to the secular

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[145] *See, e.g.*, Staelens v. Yake, 432 F. Supp. 834, 834-39 (N.D. Ill. 1977) (holding that a court order removing son from parents' custody and appointing guardian to consent to medical treatment did not deprive parents of their religious freedom); Sconiers v. Jarvis, 458 F. Supp. 37, 40 (D. Kan. 1978) (holding that defendants did not act in arbitrary or capricious manner by administering psychotropic drugs against plaintiff's will where plaintiff articulated vague religious objections); Jehovah's Witnesses v. King County Hosp. 278 F. Supp. 488, 504-05 (W.D. Wash. 1967), *aff'd*, 390 U.S. 598 (1968) (stating that Washington statutes empowering superior court judges to authorize blood transfusions of children, against the objections of their parents, are not invalid under the United States Constitution).

[146] *Jehovah's Witnesses*, 278 F. Supp. at 504-05.

[147] *Id.* at 504 (noting that the Supreme Court has held that "the family is not beyond regulation in the public interest, as against a claim of religious liberty") (quoting Prince v. Massachusetts, 321 U.S. 158, 166 (1944)).

[148] *See In re* Whitmore, 47 N.Y.S.2d 143, 144 (N.Y. Dom. Rel. Ct. 1944).

[149] With respect to the federal and state decisions just cited, those supporting the organ draft would undoubtedly note the draft's status as promoter of health and welfare. Opponents, on the other hand, might draw the dubious distinction between law that prohibits the citizen from generating disease, and law that affirmatively requires one to cure it. It is difficult to imagine a logical constitutional argument that would render such a distinction relevant.

[150] Sherbert v.Verner, 374 U.S. 398, 403 (1964). In *Sherbert v. Verner*, an employer discharged a Seventh Day Adventist employee because she refused to work on Saturday, the Sabbath Day of her faith. *Id.* at 399. A state statute denied unemployment benefits to any person who resigned employment without good cause; the state determined that religious faith was not "good cause." *Id.* at 399-401. The Court held the statute invalid because it violated the petitioner's right to exercise her religion freely and advanced no compelling state interest as justification. *Id.* at 403;

purposes for which they are designed, such statutes must impose as small a burden on religious practice as is possible.[151] As Professor Jesse Dukeminier writes, an organ draft that places an indirect burden on religion would not be constitutional if other methods of obtaining an adequate organ supply were available.[152] Faced with a first amendment challenge to the proposed organ draft, the Court would likely require the state to show that it had no available legal device that would procure needed organs without burdening religious practice. It would be "plainly incumbent" upon the state to "demonstrate that no alternative forms of regulation" would serve its purpose "without infringing on First Amendment rights."[153]

A simple exemption from the organ draft for those opposed to donation on religious grounds would not likely frustrate procurement to any significant degree[154] and is probably essential to its constitutionality. Therefore, the

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see also Thomas v. Review Bd., 450 U.S. 707, 719-20 (1980) (refusing to overrule *Sherbert v. Verner*, and holding that a state's asserted concern over widespread unemployment and fraudulent claims on its treasury do not permit the state to withhold unemployment compensation from Mr. Thomas, who resigned his employment on religious grounds when directed to manufacture military equipment). In 1972 the Supreme Court held that the state's interest in mandating public education through tenth grade was not so "compelling" as to justify the attending burden on the Amish who opposed high school education on religious grounds. Wisconsin v. Yoder, 406 U.S. 205, 216-19, 234-35 (1972).

[151] For example, the Supreme Court found in *Sherbert v. Verner* that the state advanced no compelling state interest that could not be fulfilled by some means less burdensome upon the free exercise of religion and that the state failed to demonstrate that "no alternative forms of regulation would combat such abuses without infringing on First Amendment rights." *Sherbert*, 374 U.S. at 403-07. Similarly, in *Wisconsin v. Yoder*, the Supreme Court ruled that an exemption for the Amish would not destroy the state's ability to fulfill its objective and that the state's interests could be served by means other than denial of religious exemptions. *Yoder*, 406 U.S. at 216-19, 234-35; *see also* West Virginia Bd. of Educ. v. Barnette, 319 U.S. 624, 639 (1943) (holding that the right to perform religious acts, although not absolute, is susceptible of restriction by the state "only to prevent grave and immediate danger to interests which the state may lawfully protect").

[152] Dukeminier, *supra* note 62, at 836.

[153] *Sherbert*, 374 U.S. at 407.

[154] Most lines of theological authority in the Judeo-Christian tradition deem voluntary cadaveric organ donation by an individual to be permissible. For arguments supporting this statement, see *H.R. 4080 Hearings*, *supra* note 12, at 343 (testimony of Robert Veatch). *See also* Rosner, *Organ Transplants: The Jewish Viewpoint*, 3 J. THANATOLOGY 1, 233, 237-41 (1975); Rabinovitch, *What is the Halakhah for Organ Transplants*, in JEWISH BIOETHICS 351-57 (F. Rosner & J. Bleitch 1979); Pope Pius XII, Allocation to a Group of Eye Specialists (May 14, 1965), *reprinted in* B. ASHLEY & K. O'ROURKE, HEALTH CARE ETHICS: A THEOLOGICAL ANALYSIS 311 (1978). *But see* I. JAKOBOVITZ, JEWISH MEDICAL ETHICS 152 (1959) (noting that organs can be removed but not transplanted, since the Judaic rule requires that all parts of the body be buried).

proposed Act exempts from participation any "person who . . . has a religious objection to conscription of her own organs or those of her minor child . . . ."[155] The Act is thus compatible with the first amendment.

B. *Fifth Amendment Challenges*

The fifth amendment forbids the government to take private property for public use without just compensation.[156] If post-mortem removal amounts to a "taking" and if organs are "property," then the proposed draft would occasion compensation and would be permissible only if the taking is "for a public use."[157]

Legal literature features sophisticated debate on the question of whether given governmental interferences constitute fifth amendment takings.[158] There is no question, however, that a thing is "taken" under the fifth amendment when it is physically invaded, occupied, or appropriated in the ordinary sense of those words.[159] Post-mortem removal of organs would

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[155] *See* MODA, *supra* note 69, § 16. Dukeminier states that '[d]etermining what is a 'religious belief' is clearly a matter that everyone would be wise to avoid" and he seeks to avoid this determination by suggesting that an organ draft statute should permit a person to refuse organ removal for any reason. *See* Dukeminier, *supra* note 62, at 836-37. Such a broad exemption goes too far and is not necessary to avoid constitutional implications.

[156] The fifth amendment to the United States Constitution provides "nor shall private property be taken for public use, without just compensation." U.S. CONST. amend. V. State governments, like the federal government, are bound by this provision. *See* Chicago, B&Q R.R. v. Chicago, 166 U.S. 226, 239 (1897) (holding that the fourteenth amendment protects the right to compensation for private property taken by a state).

[157] The Supreme Court has repeatedly stated that "one person's property may not be taken for the benefit of another private person without a justifying public purpose, even though compensation be paid." Hawaii Hous. Auth. v. Midkiff, 467 U.S. 229, 241 (quoting Thompson v. Consolidated Gas Corp., 300 U.S. 55, 80 (1937)). "Public use" is broadly interpreted; as the Court states in *Midkiff*, the "public use" requirement is "coterminus with the scope of a sovereign's police powers." *Id.* at 240.

[158] Regarding the meaning of "taking" and "property" under the fifth amendment's takings clause, see R. EPSTEIN, TAKINGS (1985); J. GELIN & D. MILLER, THE FEDERAL LAW OF EMINENT DOMAIN ch. 2 (1982); Michelman, *Property, Utility, and Fairness: Comments on the Ethical Foundations of "Just Compensation" Law*, 80 HARV. L. REV. 1165 (1967).

[159] The modern significance of physical occupation is that courts, while they sometimes do hold nontrespassory injuries compensable, *never* deny compensation for a physical takeover. The one incontestable case for compensation (short of formal expropriation) seems to occur when the government deliberately brings it about that its agents, or the public at large, "regularly" use, or "permanently" occupy, space or a thing which theretofore was understood to be under private ownership.

Michelman, *supra* note 158, at 1184 (emphasis in original).

therefore constitute a "taking" under the fifth amendment. Considerable doubt remains, however, on the characterization of cadaveric organs as "property."

Property is perhaps the most basic principle of social order; it is to the universe of law what "existence" and "being" are to the universe. Because no philosopher has yet reduced the words "existence" and "being" to more fundamental terms,[160] it is not surprising that a constitutional definition of "property" is not readily at hand.

Hobbesian thought holds that private property is whatever the state proclaims it to be and that property exists at the suffrance of the sovereign.[161] This thought has held some sway in fifth amendment interpretation. As the Supreme Court has written: "[N]ot all economic interests are 'property rights'; only those economic advantages are 'rights' which have the law [in] back of them, and only when they are so recognized may courts compel others to forbear from interfering with them or to compensate for their invasion."[162]

On the other hand, scholars and judges have urged that the word "property" as used in the fifth amendment cannot be subject to final interpretation by state and federal legislatures. Realty and personalty held in traditional

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[160] There have, of course, been heroic efforts in this regard. *See generally* J.P. SARTRE, BEING AND NOTHINGNESS (H. Barnes trans. 1970); R. DESCARTES, *The Second Meditation*, in MEDITATIONS ON FIRST PHILOSOPHY (E. Haldane & G. Ross trans. 1955) (2d ed. 1642).

[161] Hobbes avers that when individuals band together to form a governed society, they give up all rights to self-government. It is "as if every man should say to every man, *I authorize and give up my right of governing myself, to this man, or to this assembly of men, on this condition, that thou give up thy rights to him, and authorize all his actions in like manner.*" T. HOBBES, LEVIATHAN 132 (Collier ed. 1962) (originally published in 1651) (emphasis in original).

[162] United States v. Willow River Co., 324 U.S. 499, 502 (1945); *see also* Monongahela Navigation Co. v. United States, 148 U.S. 312, 341 (1893) (ruling that the federal government must compensate state-created property rights, in this case a franchise to exact tolls and complete certain construction along the Monongahela River. The Court states:

> The franchise is a vested right. The State has power to grant it. It may retake it, as it may take other private property, for public uses, upon the payment of just compensation. A like, though a superior, power exists in the national government. It may take it for public purposes, and take it even against the will of the State; but it can no more take the franchise which the State has given than it can any private property belonging to an individual.

Id.

Similarly, in *Fox River Paper Co. v. Railroad Commission*, the Court looked to Wisconsin state law to decide whether a riparian proprietor acquires property rights over navigable areas of the river: "If the state chooses to resign to the riparian proprietor sovereign rights over navigable rivers which it acquired upon assuming statehood, it is not for others to raise objections." 274 U.S. 651, 655 (1927).

forms, for example, seem certain to qualify as private property under the fifth and fourteenth amendments apart from any state notions to the contrary.[163] In its nature, some argue, the Constitution rejects the "crude Hobbesian conception" that property has only such dimension as the state may give it. The fifth amendment would be meaningless if it delegated to the state the task of defining "private property."[164] In limiting the state's power over private property, it is said, the Constitution endorses the Lockean notion[165] that private property has a meaning independent of the sovereign. As Justice Marshall has written:

> The constitutional terms 'life, liberty, and property' do not derive their meaning solely from the provisions of positive law. They have a normative dimension as well, establishing a sphere of private autonomy which government is bound to respect. Quite serious constitutional questions might be raised if a legislature attempted to abolish certain categories of common-law rights in some general way.[166]

Whether "property" under the fifth amendment is defined according to positive law or "the sphere of private autonomy which government is bound to respect,"[167] it is evident that post-mortem organs do not qualify. First, the common law expressly rejects the notion that dead bodies are the surviving family's property, at most conferring upon them the status of "quasi-property."[168] Regarding the donor himself, it might be argued that one's organs are his own property during life. Clearly, his testamentary powers of disposal, however, are not. The power to make a will is, in all common-law jurisdictions (except, perhaps, Wisconsin[169]), "in no sense a property right

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[163] J. NOWACK, R. ROTUNDA & J. YOUNG, CONSTITUTIONAL LAW § 13.5, at 473 (noting that "[t]he most difficult issues relate to the definition of property" and that "[c]ertainly all of the traditional forms of real and personal property fall within this definition").

[164] R. EPSTEIN, TAKINGS: PRIVATE PROPERTY AND THE POWER OF EMINENT DOMAIN 65 (1985).

[165] Lockean theory holds that "natural" individuals gave up to the sovereign only as much of their "natural liberty" as was necessary to assure public safety and order. Thus, unlike Hobbes, whose social contract posits the relinquishment of *all* rights and the supremacy of positive law, *see supra* note 161, "Locke searched for the *tertiam quid*, that is, for a set of institutional arrangements that would allow individuals to escape the uncertainties and risks of social disorder without having to surrender to the sovereign the full complement of individual rights." R. EPSTEIN, *supra* note 164, at 9-10 (1985).

[166] *Id.* (footnote omitted).

[167] Pruneyard Shopping Center v. Robins, 447 U.S. 74, 93 (1980).

[168] *See supra* note 38 and accompanying text.

[169] *See* W. PAGE, PAGE OF THE LAW OF WILLS § 3.1, at 64-66 (1960) (citing, among others, Will of Schaefer, 207 Wis. 404, 241 N.W. 382, for the proposition that there is an absolute, as opposed to merely a statutory, right to dispose of property as one chooses).

or a so-called natural right."[170] The power to make a will "is therefore not a right protected by any of the constitutional provisions whereby property is protected . . . it is purely a statutory right, subject to the complete control of the legislature."[171] Because the surviving family has no property right in the cadaveric organs and the potential donor has no property right in disposing of them by will, there remains only the possibility that the donor has some property right in his organs after he is dead. It is unlikely that dead bodies have constitutional rights:[172]

Second, at least one attribute is necessary to qualify a thing as property under the fifth amendment; it must have value susceptible to exchange between the owner and some other party.[173] As Justice Frankfurter states: "The value compensable under the Fifth Amendment . . . is only that value which is capable of transfer from owner to owner and thus of exchange for some equivalent."[174] Since federal law now forbids any person to acquire or transfer a human organ for valuable consideration,[175] post-mortem human organs are not susceptible to exchange for value.[176] For this reason alone, post-mortem organs would seem not to qualify as property under the fifth and fourteenth amendments; the Constitution, therefore, would seem not to require any compensation to donors or their survivors when post-mortem organs are conscripted to service.[177]

C. *Right to Privacy Challenges*

From the first, third, fourth, fifth, ninth, and fourteenth amendments to

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[170] W. PAGE, *supra* note 169, § 3.1, at 62-63.

[171] *Id.*

[172] *See infra* note 181 and accompanying text.

[173] As Professor Michelman explains, "[l]et us here stipulate that the word 'thing' signifies any discrete, identifiable (even if incorporeal) vehicle of *economic* at 1184 n.37 (emphasis added).

[174] Kimball Laundry Co. v. United States, 338 U.S. 1, 5 (1949).

[175] National Organ Transplant Act, 42 U.S.C. § 274(e) (Supp. 1986); *see also supra* notes 92 & 112 and accompanying text.

[176] I am unaware of any case in which it was alleged that the federal ban on organ sales was unconstitutional on the grounds that there is a fundamental right to buy or sell organs. Indeed, such an argument would probably not carry much weight in a country that has, to date, been more concerned with the rights of cadavers than with the needs of live potential donees. As to when and whether a proscription on sale or disposition itself constitutes a taking of property in other contexts, see R. EPSTEIN, *supra* note 158, at 126-45; J. GELIN & D. MILLER, *supra* note 158; J. NOWACK, R. ROTUNDA, J. YOUNG, *supra* note 163, § 11.12.

[177] *But cf.* Note, *Compulsory Removal of Cadaver Organs*, 69 COLUM. L. REV. 692, 697 (1969) (concluding that cadaver organs constitute property under the fifth amendment, apparently because the common law recognizes in survivors a "quasi-property" interest in the cadaver). The conclusions of this Note are persuasively refuted by Dukeminier. *See* Dukeminier, *supra* note 62, at 831-37.

the United States Constitution, there emerges a right of personal privacy.[178] It embodies a "promise that a certain private sphere of individual liberty will be kept largely beyond the reach of government"[179] and "the interest in independence in making certain kinds of important decisions."[180]

To begin, the issue of organ donation arises only after an individual has died, and it is unlikely that a corpse is a "person" as that term is used in relation to the fourteenth amendment and to all rights to which it gives rise.[181] The constitutional right to privacy threatens the organ draft only if it protects a living person's decisions regarding the disposition of her cadaver. The class of decisions to which the right of privacy extends represents a matter of no small controversy.[182] The most recent pronouncements from the Supreme Court, however, indicate that it extends only to decisions relating to child rearing, education, family relationships, procreation, contraception, and abortion[183] and, furthermore, that the Court will construe these words narrowly. In *Bowers v. Hardwick*,[184] for example, the Court ruled—albeit over vigorous dissent[185]—that the concepts of family, marriage, and procreation bear no connection to one's decision to engage in homosexual behavior[186] and, consequently, that such a decision is not pro-

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[178] *See, e.g.*, Roe v. Wade, 410 U.S. 113, 152 (1973) (stating that "[t]he Constitution does not explicitly mention any right of privacy" but that such a right is inherent in "areas or zones of privacy" to which various constitutional provisions give rise); *id.* at 153 (finding a right to privacy in the fourteenth amendment's concept of personal liberty and attending restrictions upon state action); Stanley v. Georgia, 394 U.S. 557, 584 (1969) (finding a right to privacy in the first amendment); Terry v. Ohio, 392 U.S. 1, 8-9 (1968) (finding right to privacy in the fourth and fifth amendments); Griswold v. Connecticut, 381 U.S. 479, 484 (1965) (finding a right to privacy in penumbras of the Bill of Rights); *Griswold*, 381 U.S. at 486 (Goldberg, J., concurring) (finding a right to privacy in the ninth amendment).

[179] Thornburgh v. American College of Obstetricians, 476 U.S. 747, 772 (1986) (holding unconstitutional portions of a state statute relating to the regulation of abortion).

[180] Whalen v. Roe, 429 U.S. 589, 599-600 (1977) (characterizing past Supreme Court decisions relating to marriage, procreation, contraception, family relationships, and child rearing and educating as generally limiting the state's powers to regulate certain kinds of fundamental decisions).

[181] *See* Roe v. Wade, 410 U.S. at 157. The term "person" is used in such a matter as to apply "only post-natally." No usage suggests prenatal application. *Id.* Since the word "person . . . does not include the unborn," *id.*, it is logical to conclude that it also does not include the deceased.

[182] *See, e.g.*, Bowers v. Hardwick, 478 U.S. 186 (1986) (demonstrating through powerfully worded plurality, concurring, and dissenting opinions the range of positions on these issues).

[183] *See id.* at 190.

[184] 478 U.S. 186 (1986).

[185] *Id.* at 199-214 (Blackmun, J., dissenting), 214-20 (Stevens, J., dissenting).

[186] *Id.* at 191.

tected by the right of privacy.[187]

Whether the plurality and concurring opinions in *Bowers* represent honest interpretation of precedent or a prostitution of jurisprudence, there is now little reason to believe that the decision to withhold post-mortem organs would fall within the sphere of constitutionally protected decisionmaking recognized by the Supreme Court.

Even if the Court were to conclude that an individual's decision regarding the disposition of her dead body is protected by the right of privacy, it would likely uphold the proposed organ draft on the ground that it promotes a state interest of sufficient importance to warrant an intrusion into constitutionally protected decisionmaking. State interests in obtaining evidence and in public health already override the individual's "liberty" to be disposed of as she pleases. Surely, state interests in preserving life are more important than these other state interests and the invasion no more severe. In the celebrated privacy decision *Roe v. Wade*,[188] the Court acknowledged that the right of privacy is subordinate to statutes that serve "compelling" state interests if they are "narrowly drawn to express only the legitimate state interests at stake."[189] Specifically, it ruled that the physical well-being of an independently viable fetus constituted an interest so compelling as to justify the state in proscribing a woman's choice of abortion, except where necessary to the life or health of the mother.[190]

It appears, therefore, that the state's interest in preserving a viable fetus overrides the individual's interest in deciding to procure an abortion. Furthermore, it seems that the state's interest in preserving the health of an adult woman is stronger even than its interest in the viable fetus. With all of this in mind, it is hard to imagine that the state's interest in promoting life through organ transplantation would be insufficient to prevail over the individual's wish to be buried with his organs in place.

It should be observed, perhaps, that according to some state and federal district courts a constitutional right of privacy protects the morbidly ill patient who chooses—sometimes through a representative—to terminate life-sustaining medical treatment. Moreover, in weighing the patient's interest in privacy against the state's asserted interest in preserving his life, these courts have found more weight on the side of the privacy.[191] These deci-

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[187] *Id.*

[188] 410 U.S. 113 (1973).

[189] *See id.* at 155.

[190] *See id.* at 164.

[191] *See* Gray v. Romeo, 697 F. Supp. 580, 590-91 (1988) (authorizing guardian to order the termination of life support for a patient who was morbidly and hopelessly ill); *In re* Guardianship of Grant, 109 Wash. 2d 545, 565, 747 P.2d 445, 455 (1987) (finding that terminally ill patients have a right to refuse artificial means of nutrition and hydration); *In re* Peter, 108 N.J. 365, 383, 529 A.2d 419, 428 (1987) (finding no objective distinction between withholding of artificial feeding and withholding any other medical treatment); Brophy v. New England Sinai Hosp., 398 Mass. 417, 430,

sions, however, are not dispositive of the constitutionality of the proposed organ draft because an individual's interest in preserving his bodily integrity while alive is not equivalent to the interest in bodily integrity after death. The individual's decision to have his body buried intact involves far less significant a privacy interest than his decision to free his living body of unwanted medical treatment. Similarly, the state's interest in preserving the life of a morbidly ill patient who wishes to forego medical treatment is far less significant than its interest in aiding potentially healthy persons who wish to have their lives prolonged through organ transplantation.

In *In re Conroy*,[192] the Supreme Court of New Jersey wrote that the state's interest in preserving a patient's life did not override the patient's right to terminate life-sustaining treatment precisely "because the life that the state is seeking to protect in such a situation is the life of the same person who has competently decided to forego the medical intervention; it is not some other actual or potential life . . . ."[193] With an organ draft, the state would seek to preserve the life of the organ recipient. Any invasion of privacy, therefore, would be made in order to protect an "other actual . . . life." The state's interest in this regard should be paramount.

VI. Consistency with the Notions of Free Will

Constitutional questions aside, some will find an organ draft contrary to American notions of free will. Such persons would protest the draft simply on the ground that Americans should not be forced to do that which they do not wish to do. David A. Ogden, then president of the National Kidney Foundation, expressed similar concerns in opposition to a presumed consent system:

> Most of the people I've spoken to, including the Health and Scientific Affairs Committee of the National Kidney Foundation, feel that pre-

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497 N.E.2d 626, 634 (1986) (holding that a right to refuse treatment arises both from common law and the unwritten penumbral constitutional right to privacy); Bouvia v. Superior Court, 179 Cal. App. 3d 1127, 1143-46, 225 Cal. Rptr. 297, 305-07 (1986) (authorizing a morbidly and hopelessly ill patient to order the termination of life support); *In re* Conroy, 98 N.J. 321, 374, 486 A.2d 1209, 1236 (1985) (holding that the patient had the right to decline any medical treatment, including artificial feeding); Bartling v. Superior Court, 163 Cal. App. 3d 186, 195, 209 Cal. Rptr. 220, 225 (1984) (holding that the right of a competent adult patient to refuse medical treatment is a constitutionally guaranteed privacy right that must not be abridged); *In re* Quinlan, 70 N.J. 10, 40, 355 A.2d 647, 663 (1970) (holding that the right of privacy is broad enough to encompass an incompetent patient's decision to decline medical treatment even if that decision might lead to death); *cf. In re* Eichner, 438 N.Y.S.2d 266, 271-72, 420 N.E.2d 64, 70 (1981) (holding that the right to privacy gives rise to the right of a guardian to apply to court for authority to have life support systems removed).

[192] *In re* Conroy, 98 N.J. 321, 486 A.2d 1209 (1985).

[193] *Id.* at 349, 486 A.2d at 1223.

> sumed consent is not quite the American way. It is relatively coercive, compared to the more classical freedom of choice that characterizes our way of life. Consent should be positive, not implied.[194]

It is doubtful, however, that these objections are truly related to incompatibilities between the American way and coercion per se. The American way, after all, permits military draft and compulsory gifts to the poor through social "welfare" laws. Indeed, as to the very question of dead bodies, every state in this republic mandates autopsy in cases of suspicious death without regard to the wishes of the decedent or her family, and many order autopsy to furnish evidence in civil cases.[195]

If the American way does not permit an organ draft it must be for some reason other than the impairment of free will. It cannot be that an organ draft of dead bodies is objectionable as a violation of free will but that a military draft of living bodies is not. It cannot be that the need for evidence in criminal and civil cases is more vital than the need for organs in cases of suffering and impending death.

Rather, the opposition to an organ draft would probably relate to this unfortunate phenomenon: Americans deplore the idea that any individual should be required to give even the smallest gift of good or service to any other individual, no matter how great the need. It is a sturdy, common-law principle that a citizen has no duty to offer aid to another in peril, no matter how safe and easy a helping gesture might be.[196] An expert swimmer equipped with boat and rope may sit, smoke, and sunbathe while a fellow citizen drowns before her eyes.[197] Even if one coaxes another into the water, she need give no aid when the latter starts to drown.[198] One need not help a stranger who is bleeding to death[199] or stop a small child from hammering a

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[194] Ogden, *Another View on Presumed Consent*, 13 HASTINGS CTR. REP. 28 (Dec. 1983).

[195] *See supra* note 40.

[196] *See, e.g.*, RESTATEMENT (SECOND) OF TORTS § 314 (1965) (summarizing that "[t]he fact that the actor realizes or should realize that action on his part is necessary for another's aid or protection does not of itself impose on him a duty to take such action"); W. PROSSER & W. KEETON, THE LAW OF TORTS 375 (5th ed. 1984) (noting that "the law has persistently refused to impose on a stranger the moral obligation of common humanity to go to the aid of another human being who is in danger, even if the other is in danger of losing his life").

[197] Osterlind v. Hill, 263 Mass. 73, 76, 160 N.E. 301, 302 (1928) (stating that failure to respond to deceased's cries infringed no legal right of the decedent).

[198] Yania v. Bigan, 397 Pa. 316, 321-22, 155 A.2d 343, 346 (1959) (stating that the mere fact that another person is in a position of peril imposes no legal duty on the potential rescuer).

[199] Allen v. Hixson, 111 Ga. 460, 463, 36 S.E. 810, 810 (1900) (stating that no cause of action arises from a failure to perform an act of humanity, if such failure involves no breach of duty imposed by law); Riley v. Gulf, C.&S.F. Ry., 160 S.W. 595, 597 (Tex. Civ. App. 1913) (declaring that the law does not impose an affirmative duty to assist another in distress).

dangerous explosive.[200] One has no duty to move her vehicle from the path of a fire engine en route to a burning home[201] or to cry warning to one unwittingly headed for the jaws of a dangerous machine.[202]

Although many writers have denounced the no-duty-to-rescue rule,[203] it is slow to weaken.[204] It has been suggested that state legislatures override the common law by enacting statutes that create a duty to rescue.[205] Only two states have taken the suggestion.[206] In all other states the no-duty-to-rescue

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[200] Sidwell v. McVay, 282 P.2d 756, 759 (Okla. 1955) (declaring that where a 16 year-old boy was playing with explosives at the home of a companion and the latter's parents, none was under a duty to prevent the boy from hammering a pipe which contained explosives).

[201] Louisville & N. R.R. v. Scruggs, 161 Ala. 97, 49 So. 399, 400 (Ala. 1909) (stating that there is no duty to aid in preservation of another's property).

[202] Buch v. Armory Mfg. Co., 69 N.H. 257, 261, 44 A. 809, 811 (1897) (stating that there is a great difference between causing an injury and preventing it; the duty to protect against wrong is a moral obligation only and is not recognized or enforced by law).

[203] Rudolph, *The Duty to Act: A Proposed Rule*, 44 NEB. L. REV. 499, 499-503, 509 (1965) (proposing adoption of a duty to act rule in order to promote morality in the community).

[204] The common law does recognize a duty to give affirmative aid where parties manifest a "special relationship" such as common carrier-passenger, and inn-keeper-guest. RESTATEMENT (SECOND) TORTS § 314A (1965); W. PROSSER & W. KEETON, *supra* note 196, at 376-77. The definition of such special relationships has expanded over the course of the century to include (a) owners and invitees, (b) social hosts and social guests, and (c) companions engaged in a common undertaking. *See, e.g.*, Depue v. Flateau, 100 Minn. 299, 303, 111 N.W. 1, 2 (1907) (finding a duty of rescue between a property owner and her invitee); Huthinson v. Dickie, 162 F.2d 103, 106-07 (6th Cir. 1947) (finding a duty of rescue between social host and social guest); Farwell v. Keaton, 396 Mich. 281, 292, 240 N.W.2d 217, 222 (1976) (finding a duty of rescue between companions engaged in a common undertaking).

[205] One scholar has suggested that the states adopt a statute with the following text:

> Whoever, witnessing an obvious and imminent danger threatening the life of another person, fails to come to his aid either through his personal intervention or by providing aid by others or does not notify immediately the proper public officer or institution, although he could do one of those things without reasonable fear of danger to his person or to others, shall be punished by imprisonment of up to . . . , or a fine of up to . . . , or both.

Rudzinski, *The Duty to Rescue: A Comparative Analysis*, in THE GOOD SAMARITAN AND THE LAW 91, 123 (Ratcliffe ed. 1981).

[206] The Minnesota "Good Samaritan law" requires:

> Any person at the scene of an emergency who knows that another person is exposed to or has suffered grave physical harm shall, to the extent that the person can do so without danger or peril to self or others, give reasonable assistance to the exposed person. Reasonable assistance may include obtaining

rule persists.[207] One explanation for its persistence is that legislators would have difficulty creating statutory language that would set ascertainable limits on one's obligation to undertake risk on behalf of another.[208] The difficulty in reducing rights and duties to statutory language is not unique to the problem of rescue, however, and this explanation is not particularly persuasive.[209]

A more persuasive explanation for the states' steadfast refusal to create a private duty to rescue and the reluctance to define its limits in the usual fashion with words of degree is that the idea of compelling one person to serve another private person is fundamentally offensive. Whether or not it is acknowledged, it is this phenomenon that will likely generate the central objection to the proposed organ draft. The subtle power of Americans' aversion to compulsory service among private persons is evidenced in an unreported Pennsylvania chancery decision that approaches the question of compulsory organ donation. The case involved a patient who required a bone marrow transplant. He was well-matched immunologically to his cousin who refused, however, to cooperate with transplantation. The patient sought an injunction ordering his cousin to donate. In response, the court stated that

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> or attempting to obtain aid from law enforcement or medical personnel. Any person who violates this section is guilty of a petty misdemeanor.

MINN. STAT. ANN. § 604.5 (1988). Vermont's "Emergency medical care" statute is similar. *See* VT. STAT. ANN., tit. 12, § 519 (1973).

[207] Approximately thirteen European nations, however, have imposed upon their citizens a duty to rescue one another from danger. *See* Rudzinski, *supra* note 205, at 91-92. The Dutch Penal Code, for example, provides that one who, witnessing the danger of death with which another is suddenly threatened, neglects to give or furnish him such assistance as he can give or procure without reasonable fear of danger to himself or others, shall be punished, if the person in distress dies, by a detention of three months at most and a fine of 300 florins at most. *Id.* at 126.

[208] *See, e.g.*, W. PROSSER & W. KEETON, *supra* note 196, at 376.

> [T]hus far the difficulties of setting any standards of unselfish service to fellow men, and of making any workable rule to cover possible situations where fifty people might fail to rescue one, has limited any tendency to depart from the rule to cases where some special relation has offended a justification for the creation of a duty, without any question of setting up a rule of universal application.

Id.

[209] Courts and legislatures often announce rules, new rights, and new liabilities, many of which depend for their existence on manners of degree. Indeed, as Justice Holmes observed, there ought to be no special worry over legal distinctions that turn upon "differences of degree":

> The whole law does so as soon as it is civilized . . . Negligence is all degree . . . and between the variations according to distance that I suppose to exist and the simple universality of the rules in the Twelve Tables or the Leges Barbarorum, there lies the culture of two thousand years.

LeRoy Fibre Co. v. Chicago, M. & St.P. Ry., 232 U.S. 340, 354 (1914) (Holmes, J., concurring in part).

> the common law has consistently held to a rule which provides that one human being is under no legal compulsion to give aid or to rescue or to take action to save another. . . . [T]he rule is founded upon the very essence of our free society. . . . For our law to compel the Defendant to submit to an intrusion of his body would change the very concept and principle upon which our society is founded. To do so would defeat the sanctity of the individual and would impose a rule which would know no limits, and one could not imagine where the line would be drawn.[210]

The case involved a *living* donor, but it nonetheless indicates that the strongest resistance to an organ draft would derive from the deep-rooted American objection to coerced individual giving.

On the other hand, Americans do not object very strenuously when they are required to give payment or service to the "government" to solve a "public" problem or answer a "public" need. Perhaps the distinction between these two ostensibly antithetical positions—compelled aid to the poor through tax supported assistance programs and no compulsion to rescue—is that aiding the poor is understood generally as contributing to a public need, while rescue is viewed as compelled aid in response to a private need. For example, a citizen would likely find abusive a statute requiring contribution to a specific college student who needs help with tuition. The benefit to the citizen is not readily apparent. Yet the citizen will not protest paying taxes each year so that her government might use the proceeds to address the "public" issue of higher education and the "public" problem of tuition costs by subsidizing the same college student. If the citizen perceives the contribution as serving the public, of which she is a part, she will not likely feel abused. The proposed Model Organ Draft Act is best characterized not as coerced private donation but as a measure related to the public welfare. Under its provisions, the government takes organs from cadavers as it now takes taxes from the paycheck.

CONCLUSION

The Model Organ Draft Act is intended as a sensible and sensitive solution to a serious national problem. Its passage will signify that the United States forbids its citizens to bury human organs when they are needed above ground to serve the cause of national health. All citizens will know that they stand to benefit from the organ draft should they themselves someday need organs. Those who object on religious grounds will be exempt from donation but will stand to benefit nonetheless. All others will participate fully. Such a scheme promises to answer a pressing American need and, when properly understood, comports fully with American notions of liberty, charity, and socialized life.

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[210] McFall v. Shimp, 127 PITTSBURGH LEGAL J. 14, 14-15 (1978).

APPENDIX:
THE MODEL ORGAN DRAFT ACT

§ 1. Statement of Purpose

The purpose of this Model Organ Draft Act is to increase the number of human organs and tissues available for transplantation and thus to improve the prospects for health and longevity of any and all citizens in need of organ or tissue transplantation.

§ 2. Definitions

(1) "Board" means the Transplant Organ Conscription Board hereinafter created.

(2) "Conscriptable organ" means kidney, heart, lung, liver, cornea, skin, or such other bodily parts as the Board may so categorize under Section 4(2)(d) of this Act.

(3) "Hospital" means a facility licensed, accredited, or approved as a hospital under the law of any state or a facility operated as a hospital by the United States government, a state, or a subdivision of a state.

(4) "Donor hospital" means qualified hospital performing the functions under this Act relating to the removal of conscriptable organs.

(5) "Recipient hospital" means qualified hospital performing the functions under this Act relating to receipt and transplantation of conscriptable organs.

(6) "Qualified hospital" means any hospital accorded such status under Section 7(1)(b) of this Act.

(7) "Qualified physician" means physician affiliated with a qualified hospital.

(8) "Prospective donor" means any person so identified pursuant to Section 11(1) of this Act.

(9) "Prospective recipient" means any permanent resident of this state who provides the Transplant Organ Registry with the information described in Section 8(1) of this Act.

(10) "Intended recipient" means a person so identified under Section 12 of this Act.

(11) "Physician" means any person licensed or otherwise authorized to practice medicine, surgery, or osteopathy under the laws of any state.

(12) "State" means any state, territory, or possession of the United States, the District of Columbia, or the Commonwealth of Puerto Rico.

§ 3. Creation of the Transplant Organ Conscription Board

(1) There shall be created within the Department of Health and Human Services a Transplant Organ Conscription Board.

(2) The Board shall consist of eight members appointed by the Governor. The members shall include:

(a) a physician with expertise in the field of renal transplant;

(b) a physician with expertise in the field of liver transplant;

(c) a physician with expertise in the field of heart and lung transplant;

(d) a physician with expertise in the field of corneal transplant;

(e) a physician with expertise in the field of internal medicine;

(f) a physician with expertise in the field of transplantation immunology;

(g) a religious scholar; and

(h) a permanent resident of this state holding a degree from a four-year college.

(3) Each member shall serve for so long as she is less than seventy years of age and willingly fulfills her duties.

(4) The Governor shall appoint the members of the Board by July 1, 19__ and, thereafter, as vacancies occur. The Board shall begin its existence on July 1, 19__.

§ 4 Operation of the Transplant Organ Conscription Board

(1) The Board shall meet once during the first week of July to select a chairperson and secretary from its membership and shall meet at such other times as may be necessary for the performance of its duties. The Board may take action only on the concurrence of five of its members. Seven members shall constitute a quorum.

(2) The Board shall:

(a) make such regulations as are necessary for its operation consistent with the purposes of this Act;

(b) by regulation interpret the provisions of this Act;

(c) conduct hearings to acquire information necessary to execute its functions under this Act; and

(d) conduct hearings each year to assess the status of all reported organ transplant procedures in order to determine, once each year, which organs to add or remove from the category of conscriptable organs.

(3) The Department of Health and Human Services shall:

(a) administer the Board's fiscal duties; and

(b) provide the Board with staff and support services as are necessary and feasible.

§ 5. Creation of the Transplant Organ Registry

The Board shall:

(1) establish and maintain a Transplant Organ Registry (hereinafter the "Registry"); or

(2) arrange for participation in organ procurement registry systems or networks now existing or hereafter created, provided such systems or networks function, as to citizens of this state, in a manner consistent with this Act.

(3) The Department of Health and Human Services shall provide the Registry with such staff and support services as are reasonably necessary to its operation.

§ 6. Operation of the Registry

The Registry shall:

(1) be equipped at all times to furnish and shall furnish any qualified hospital or qualified physician with such information as shall be determined by the Board under Section 9(1)(a) of this Act.

(2) record information relating to all organ transplants performed under this Act, including the identity of the donor, recipient, donor hospital, and recipient hospital.

(3) share its information with other organ procurement registries, agencies, and networks where such sharing will facilitate organ procurement for residents of this state and of other states.

§ 7. Qualified Hospitals

(1) The Board shall:

(a) by regulation establish standards by which to accord the status of qualified hospital; and

(b) accord such status to any hospital conforming thereto.

(2) Standards established pursuant to Subsection (a)(1) shall relate to:

(a) the capability of such hospital competently to perform the medical tasks relevant to provisions of this Act; and

(b) requirements for demonstration by such hospital that guidelines provided by this Act will be followed.

§ 8. Identification of Prospective Recipients

(1) Any permanent resident of this state will be accorded the status of prospective recipient if she provides the Registry with:

(a) her name, date of birth, residence address, and telephone number;

(b) certification from a physician that she is in need of a conscriptable organ for transplant;

(c) certification from a qualified hospital and physician that they will perform necessary medical functions on behalf of such person when a transplant organ becomes available; and

(d) medical data prescribed by the Board pursuant to Section 9(1)(a) of this Act, certified by a physician as correct and complete under this Act.

(2) Information provided pursuant to Subsections (1)(a), (b), (c), and (d) shall be recorded in the Registry.

§ 9 Standards Relating to Suitability of Organs for Transplantation

(1) The Board shall prescribe:

(a) the nature of medical data concerning the prospective recipient necessary to enable a physician knowledgeable in the area of organ transplant to determine whether such recipient is suited to any conscriptable organ available for transplant; and

(b) medical testing techniques whereby such data can be competently acquired.

(2) The Board shall establish guidelines suggesting:

(a) such medical testing and the acquisition of such medical data concerning a prospective donor necessary for determining whether such donor's organ is suitable for a particular prospective recipient; and

(b) means of evaluating such medical data and data prescribed under Subsection (1)(a) of this Section in order to determine whether transplant between a particular prospective donor and prospective recipient offers a reasonable medical likelihood of success.

§ 10. Precautions Regarding Death of a Prospective Donor

The Board shall prescribe procedures and precautions designed to ensure that the declaration of death of any person shall be unrelated to the usability of such person's organs for transplant.

§ 11. Identification of Prospective Donors

(1) When a patient in a qualified hospital dies, and, under prevailing medical standards, the attending physician determines that such patient's organs are likely to be useful for transplant, and such physician has no knowledge that such patient is not a permanent resident of the United States, such physician shall:

(a) take such steps as are necessary to preserve the patient's organs for transplantation (including the mechanical maintenance of respiration and circulation) without regard for the knowledge or consent of the patient's family or of the patient during his lifetime; and

(b) contact the Registry to give and receive information as provided in Subsections (1) and (2).

(2) If the attending physician knows the patient to be a resident of a state other than this one, he or his representative shall so inform the Registry, and the Registry shall determine whether such state provides for compulsory conscription of transplant organs subject only to exemption for contrary religious belief. If such state does provide for such conscription, the Registry shall ascertain whether, in such state, the patient is exempted from compul-

sory organ conscription. If the patient is so exempted or if the attending physician knows the patient not to be a permanent resident of the United States, the patient's organs shall not be used for transplant under this Act, and her cadaver shall be treated and disposed of pursuant to custom and law that would operate in the absence of this Act.

(3) If the attending physician does not know the patient to be a resident of a state other than this one, he shall inquire whether the patient is an exempted donor under Section 16 of this Act and the Registry shall respond to this inquiry.

(4) If on contacting the Registry under Subsection (1)(b) the qualified physician learns that the patient is an exempted donor under Section 16 of this Act, the patient's organs shall not be taken for transplantation under this Act, and the cadaver shall then be treated and disposed of pursuant to custom and law that would operate in the absence of this Act.

(5) If on contacting the Registry under Subsection (1)(b) the qualified physician learns that the patient is not an exempted donor, he shall identify the patient as a prospective donor and conduct upon her cadaver the medical and laboratory testing prescribed under Section 9(2)(a) of this Act with or without the knowledge or consent of the patient's family or of the patient during her lifetime.

(6) If on evaluating the results of testing conducted under Section 11(5) of this Act, the attending physician concludes that one or more of the prospective donor's conscriptable organs are suitable for transplant, such physician or his authorized representative shall contact the Registry and furnish the Registry with the results of such medical testing.

§ 12. Identification of Intended Recipient

(1) On being contacted by an attending physician pursuant to Section 11(6) of this Act, the Registry shall provide the physician or his representative with the information described in Section 6 of this Act.

(2) If on evaluating relevant data pursuant to Section 9(2)(b) of this Act the attending physician determines that a particular prospective recipient is suited to an organ of the prospective donor, he shall contact the prospective donor's physician or other physician affiliated with the qualified hospital identified with the prospective donor and inform the physician that an organ is available for use by the prospective recipient. If such physician agrees that the prospective recipient is suited to the prospective donor's organ or if such qualified physician is unavailable, the prospective recipient may be identified as an intended recipient.

(3) If the attending physician concludes that more than one person or prospective recipient is suited to an organ of the prospective donor he shall select, on the basis of medical need, one such person or prospective recipient to be identified as intended recipient, except that he must first prefer in

such identification, a resident of a state that provides for mandatory conscription of transplant organs subject only to religious objection.

§ 13. Removal of Conscriptable Organs

If an intended recipient has been identified and all relevant requirements of this Act have been observed, a qualified physician shall remove from a prospective donor's dead body such conscriptable organ or organs as have been determined under Section 11(6) of this Act to be suitable for transplant.

§ 14. Transportation of Organs

The donor hospital shall make arrangements in accordance with procedures established by the Board for the transport of the transplant organ or organs to the recipient hospital or hospitals.

§ 15. Expenses of Transplant

Expenses incurred in connection with removal and transport of the transplant organ shall be charged to the intended recipient who shall be liable therefore.

§ 16. Religious Exemption

(1) Any permanent resident of this state who notifies the Board in writing that she has a religious objection to conscription of her own organs or those of her minor child shall be accorded a hearing for the purpose of determining whether such person or child will receive a certificate of religious exemption.

(2) If at such hearing such person establishes her religious objection, the Board shall furnish such person a certificate of religious objection and record, in the Registry, her status as exempted donor.

(3) For purposes of this Section, a religious objection is one that arises from a person's beliefs regarding the duties and obligations imposed on her by her god.

(4) Any person aggrieved by a decision of the Board under this Section may appeal to the _____ Court of the county in which she resides.

§ 17. Application of this Act

This Act shall not apply to a person who is not a permanent resident of the United States and such person's organs shall not be used for transplant under this Act.

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