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A PROPOSAL FOR A PRESUMED CONSENT ORGAN DONATION POLICY IN NORTH DAKOTA

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North Dakota has long been a social and legal pioneer. Witness the state bank,[1] the state mill and elevator,[2] and the raft of other progressive legislation adopted by the state.[3] Today there is a continuing need for progressive thinking, this time regarding human organ[4] procurement consent laws.[5]

As of June 24, 1992, 27,391 people were on national lists,[6] waiting to receive human organs for transplantation.[7] As of July 8, 1992, North Dakotans, South Dakotans and Minnesotans on this list included 508 for kidneys, 115 for hearts, 10 for hearts and

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1. N.D. CENT. CODE § 6-09-01 (1987) (Bank of North Dakota).

2. N.D. CENT. CODE § 54-18-02 (1987) (North Dakota Mill and Elevator Association).

3. Much of this progressive legislation is the product of the Commissioners on Uniform State Laws. *See, e.g.*, Uniform Adoption Act, N.D. CENT. CODE ch. 14-15 (1991); Uniform Arbitration Act, N.D. CENT. CODE ch. 32-29.2 (Supp. 1991); Uniform Commercial Code, N.D. CENT. CODE ch. 41-01 to 41-09 (1983 & Supp. 1991); Uniform Declaration of Death Act, N.D. CENT. CODE ch. 23-06.3 (1991); Uniform Probate Code, N.D. CENT. CODE ch. 30.1-01 to 30.1-35 (1976 & Supp. 1991). Other entities have also been responsible. *See* Model Penal Code, N.D. CENT. CODE ch. 12.1-01 to 12.1-33 (1985 & Supp. 1991).

4. The term "organ" is used in this article. The Uniform Anatomical Gift Act (UAGA) uses the term "part." Throughout this article the term "organ" means "an organ, tissue, eye, bone, artery, blood, fluid, and any other portion of the human body." UNIF. ANATOMICAL GIFT ACT § 1(7), 8A U.L.A. 8 (West Supp. 1991).

5. North Dakota has taken the forefront in one area of transplantation law by recently establishing a fund to assist organ or tissue transplant patients who are residents of the state. N.D. CENT. CODE § 23-01-05.1 (1991). The fund is administered by a "nonprofit patient-oriented organization" selected by the state health officer. *Id. See also* N.D. ADMIN. CODE § 33-03-26-01 to -02 (1991) (regarding selection of the organization).

6. Computer Inquiry, United Network for Organ Sharing (UNOS) (June 24, 1992). This total was an increase from 24,796 people on the list of December 31, 1991. *Patients Waiting for Transplants*, UNOS UPDATE, Jan. 1992, at 18.

7. *See, e.g.*, Judy E. Boychuk & Jill Feldman Malen, *Lung Transplantation in* SUSAN L. SMITH, TISSUE AND ORGAN TRANSPLANTATION 260-64 (1990). Well-defined guidelines exist for selection of candidates for all transplantation. The guidelines and procedures, while transplantation-center specific, generally include extensive medical workup, psychological and psycho-social workups, and conferences. Decisions then are made to accept, reject or defer acceptance of patients for transplantation. *Id.* If costs of transplantation are not covered by health insurance or other third-party payors, transplant centers usually require pre-payment of most expenses that will be incurred. Roger W. Evans, *Organ Transplantation Costs, Insurance Coverage, and Reimbursement, in* CLINICAL TRANSPLANTS 1990 343, 343-51 (Paul I. Teraski, ed., 1991).

lungs, 63 for lungs, 39 for pancreases, and 38 for livers.[8] Other people originally from the region are on the lists but cannot be directly traced because they have relocated to be closer to transplantation facilities to await receiving organs.

In 1990, the wait was too long for 2,206 people.[9] These people, who were on the waiting list, died hoping to receive organs. For the awaiting recipients and their loved ones, the demand for organs definitely exceeded supply. Even with these statistics, however, one is tempted to ask whether the art and science of transplantation is sufficiently advanced to warrant this attention. Subjectively, recipients and their families believe it is worth the bother. Objectively, we submit that the effort is warranted as well.

The one year survival rate[10] for those fortunate enough to receive organs was extremely high. For example, more than ninety percent of the kidney recipients and more than eighty percent of the heart recipients survived one year or more after transplantation.[11]

With these national and regional figures showing demand for organs and tissue well exceeding the supply, and transplantation being medically successful and statistically significant, the goal becomes one of searching for solutions to the shortage problem.[12] In the authors' opinions, the greatest part of the supply problem is the inadequacy of current methods for obtaining consent for donation.[13] In addition, donation and transplantation needs to be bet-

8. Computer inquiry, United Network for Organ Sharing (UNOS) (July 8, 1992).

9. FRED H. CATE & SUSAN S. LAUDICINA, TRANSPLANTATION WHITE PAPER 3 (1991).

10. The one year survival rate is the standard used by the medical profession. Patient survival for one year or more is considered a medically successful procedure.

11. CATE & LAUDICINA, *supra* note 9 at 3. The actual one year survival rates are as follows: kidney (related living donor) 97%, kidney (cadaveric donor) 92%, pancreas 89%, hearts 83%, liver 76%, heart-lung 57%, and lung 48%. *Id.*

12. Virtually all who are writing about organ and tissue donation and transplantation agree there is a shortage, and some authors recognize that deficient supply is causing continuing medical costs for some and death before organs can be located for others. *See, e.g.*, Thomas G. Peters, *Life or Death: The Issue of Payment in Cadaveric Organ Donations*, 265 JAMA 1302 (1991) (1878 individuals died in 1989 while on lists waiting for organs); Eric C. Sutton, *Giving the Gift of Life: A Survey of Texas Law Facilitating Organ Donation*, 22 ST. MARY'S L.J. 959, 960-61 (1991); Roger D. Blair and David L. Kaserman, *The Economics and Ethics of Alternative Cadaveric Organ Procurement Policies*, 8 YALE J. ON REG. 403, 405-06 (1991); and Beverly Merz, *The Organ Procurement Problem: Many Causes No Easy Solutions*, 254 JAMA 3285 (1985).

13. Those writing on the general topic of increasing the availability of organs for donation, of course, disagree on the principal cause and, therefore, the best solution to the shortage problem. Most commentators recommend modification of consent requirements or procedures. *See* UNIF. ANATOMICAL GIFT ACT (1987) prefatory note, 8A U.L.A. 2-3 (Supp. 1991). Others suggest altruistic donation of organs will not provide significantly greater numbers of transplantable organs and that a "for pay," "market system" must be established. *See* Blair & Kaserman, *supra* note 12, at 420-31. Sale of organs is prohibited under United States law and the UAGA of 1987. 42 U.S.C. § 274e (1988) and UNIF. ANATOMICAL GIFT ACT (1987) § 10, 8A U.L.A. 26 (West Supp. 1991).

ter explained and understood so that social and legal impediments are reduced and a closer balance can be struck between supply and demand. Concomitantly, we, as a society, must address and decide the allocation of resources to all facets of health care and the demands realized by our aging population.[14] With these goals, we begin the discussion by reviewing the history of organ donation laws and subsequently propose several options for increasing donations while protecting the interests of donors.

A. REVIEW OF THE HISTORY AND DEVELOPMENT OF CURRENT CONSENT LAWS

Currently, most organ donation laws in the United States are based on the concept that donors or their next-of-kin must affirmatively consent to procurement, except in limited circumstances. North Dakota's current consent law is the Uniform Anatomical Gift Act (UAGA) of 1987.[15] North Dakota and twelve other states adopted the UAGA of 1987 as the replacement to the UAGA of 1968.[16] At least eight other states have considered, but not adopted the 1987 Act.[17] The 1968 UAGA provided a general framework for obtaining the consent and donation of organs.[18] A

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14. *See* Norman G. Levinsky, *Age As A Criterion for Rationing Health Care*, 322 NEW ENG. J. MED. 1813 (1990).

This article regarding presumed consent in organ donation does not explicitly deal with the allocation of financial resources. That issue is part of a broader discussion, and is left for another day. However, implicitly the authors endorsed organ and tissue transplantation in cases where recipients have a substantial chance to recover and enjoy a meaningful quality of life. Without such a chance for recovery, procedures are experiments, which must be evaluated and justified on some other basis.

15. 1989 N.D. LAWS 303, § 2. The 1987 UAGA repealed and replaced the UAGA of 1968. N.D. CENT. CODE ch. 23-06.1 (1991), repealed 1989 N.D. LAWS 303, §§ 1-5.

16. UNIF. ANATOMICAL GIFT ACT (1987), 8A U.L.A. 2 (Supp. 1991); ARK. CODE ANN. §§ 20-17-601 to -617 (Michie 1991); CAL. HEALTH & SAFETY CODE §§ 7155 to -7156.5 (West Supp. 1991); CONN. GEN. STAT. ANN. §§ 19a-279a to -280a (West Supp. 1991); HAW. REV. STAT. § 327-1 to -14 (Supp. 1990); IDAHO CODE §§ 39-3401 to -3417 (Supp. 1991); MONT. CODE ANN. §§ 72-17-101 to -312 (1991); NEV. REV. STAT. ANN. §§ 451.500 to -.590 (Michie 1991); N.D. CENT. CODE §§ 23-06.2-01 to -11.1 (1991); R.I. GEN. LAWS §§ 23-18.6-1 to -15 (1989); UTAH CODE ANN. §§ 26-28-1 to -12 (Supp. 1991); VT. STAT. ANN. tit. 18, §§ 5238-5247 (Supp. 1990); VA. CODE ANN. § 32.1-289 to -297.1 (Michie 1985 and Supp. 1991); and WIS. STAT. ANN. § 157.06 (West 1989 & Supp. 1991). For a thorough comparison of the 1968 and 1987 Acts, see Daphne D. Sipes, *Legislative Update on the State Adoption of the 1987 Revision to the Uniform Anatomical Gift Act of 1968*, 4 B.Y.U. J. PUB. L. 395 (1990).

17. The states that considered the 1987 Act but initially failed to adopt it include Georgia, Illinois, Iowa, Minnesota, Oklahoma, Ohio, Virginia, Wisconsin and Wyoming. Sipes, *supra* note 16, at 398 n.27. Virginia and Wisconsin have since adopted the 1987 Act. *See supra* note 16.

18. States adopting the 1968 act are as follows: ALA. CODE §§ 22-19-40 to -47, -60 (1990); ALASKA STAT. §§ 13.50.010-.090 (1991); ARIZ. REV. STAT. ANN. § 36-841 to -849 (1986 & Supp. 1991); COLO. REV. STAT. § 12-34-101 to -109 (1991); DEL. CODE ANN., tit. 16, § 2710-2719 (Supp. 1990); D.C. CODE ANN. § 2-1501 to -1511 (1988); FLA. STAT. ANN. §§ 732.910 to .921 (West 1976 & Supp. 1991); GA. CODE ANN. §§ 44-5-140 to -151 (Harrison 1990); ILL. ANN. STAT. ch. 110 1/2 §§ 301-311 (Smith-Hurd 1978 & Supp. 1991); IND. CODE ANN. §§ 29-2-16-1 to -11 (Burns 1989 & Supp. 1991); IOWA CODE ANN. §§ 142 A.1 to A.10

brief historical tracing of donation consent laws and the Uniform Acts will provide a useful perspective for discussion of current consent needs.

1. *The "Unclaimed Body" Acts as Precursors to Modern Anatomical Gift Acts*

Modern presumed consent laws have been traced to English "unclaimed body" laws.[19] The unclaimed body statutes originated in the eighteenth century when medical science faced shortages of corpses for study and training.[20] The supply often was filled by grave robbers.[21] In response to this problem, the English Anatomy Act of 1832, which gave bodies of the unclaimed dead and deceased paupers to medical schools, was enacted.[22] The statutes were eventually adopted in the United States, where medical examiners or coroners were vested with authority to donate unclaimed bodies to science.[23]

Unclaimed body statutes were laws authorizing or requiring coroners to take charge of bodies for determination of cause of death under certain circumstances.[24] These laws sometimes permitted coroner consent to organ donation, as well as to donation of

(West 1989); KAN. STAT. ANN. §§ 65-3209 to -3218 (1985 & Supp. 1990); KY. REV. STAT. ANN. §§ 311.165 to .235 (Michie/Bobbs-Merrill 1990); LA. REV. STAT. ANN. §§ 17:2351 to :2359 (West 1982 & Supp. 1991); ME. REV. STAT. ANN. tit. 22, §§ 2901-2910 (West 1980 & Supp. 1990); MD. CODE ANN., Est. & Trusts §§ 4-501 to 512 (1991); MASS. GEN. LAWS ANN. ch. 113, §§ 7-14 (West 1983 & Supp. 1991); MICH. COMP. LAWS ANN. §§ 333.10101 to .10109 (West 1980 & Supp. 1991); MINN. STAT. ANN. §§ 525.921 to .93 (West 1975 & Supp. 1991); MISS. CODE ANN. §§ 41-39-11, -31 to -53 (1981 & Supp. 1991); MO. ANN. STAT. §§ 194.210 to .290 (Vernon 1983 & Supp. 1992); NEB. REV. STAT. §§ 71-4801 to -4818 (1990); N.H. REV. STAT. ANN. §§ 291-A:1 -A:9 (1987 & Supp. 1991); N.J. STAT. ANN. §§ 26:6-57 to -65 (West 1987 & Supp. 1991); N.M. STAT. ANN. §§ 24-6-1 to -11 (Michie 1978 & Supp. 1990); N.Y. PUB. HEALTH LAW §§ 4300-4308 (McKinney 1985 & Supp. 1991); N.C. GEN. STAT. §§ 130A - 402 to 412.1 (1990 & Supp. 1991); OHIO REV. CODE ANN. §§ 2108.01 to .10 (Anderson 1990 & Supp. 1991); OKLA. STAT. ANN. tit. 63, §§ 2201 -2209 (West 1984 & Supp. 1992); OR. REV. STAT. §§ 97.250 to .295 (1989); 20 PA. CONS. STAT. ANN. §§ 8601-8607 (1975 & Supp. 1991); S.C. CODE ANN. §§ 44-43-310 to -400 (Law. Co-op. 1985 & Supp. 1990); S.D. CODIFIED LAWS ANN. §§ 34-26-20 to -41 (1986 & Supp. 1991); TENN. CODE ANN. §§ 68-30-101 to -111 (1987 & Supp. 1991); TEX. HEALTH & SAFETY CODE ANN. §§ 692.001 to .016 (West 1992); WASH. REV. CODE ANN. §§ 68.50.340 to .510 (West Supp. 1991); W. VA. CODE §§ 16-19-1 to -9 (1991); WYO. STAT. §§ 35-5-101 to -112 (1988 & Supp. 1991).

19. Daphne D. Sipes, *Does It Matter Whether There Is Public Policy for Presumed Consent in Organ Transplantation?*, 12 WHITTIER L. REV. 505, 518 (1991).

20. *Id.* at 519; Jesse Dukeminier, Jr., *Supplying Organs for Transplant*, 68 MICH. L. REV. 811, 811 n.2 (1970).

21. B. Joan Krauskopf, Comment, *The Law of Dead Bodies*, 19 OHIO ST. L.J. 455 (1958).

22. Dukeminier, *supra* note 20, at 811.

23. Sipes, *supra* note 19, at 519.

24. *Id.* Circumstances include suspicious cause of death. *Id. See* N.D. CENT. CODE § 11-19.1-01 to -17 (1985).

the bodies to science.[25] Such laws were inconsistent, however, and did not provide a meaningful vehicle for organ donation at a time when organ transplantation was a medical science coming into its own right.[26] This inconsistency led to development of the Uniform Anatomical Gift Acts (UAGAs) in the 1960s .

2. *The Anatomical Gift Acts*

The UAGAs are the product of the National Conference of Commissioners on Uniform State Laws.[27] The 1968 Act was approved by the American Bar Association in August of 1968.[28] The 1968 Act requires consent by a donor, or by family members in the order of priority provided by statute, in the event the donor had not consented prior to death.[29] The decedent's survivors also could veto a prospective donor's wishes to make an anatomical gift.[30] In the words of the statute, "[i]f the donee[31] has actual notice of contrary indications by the decedent, or that a gift by a member of a class is opposed by a member of the same or a prior class, the donee shall not accept the gift."[32]

The 1968 Act relaxed the requirements for becoming a donor, thus one could donate by will or drivers license endorsement, rather than documents notarized or witnessed by two independent witnesses.[33] The 1968 Act similarly relaxed the method for revocation of consent to donation,[34] and protected persons who

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25. Dukeminier, *supra* note 20, at 843.

26. *See* UNIF. ANATOMICAL GIFT ACT (1968) prefatory note, 8A U.L.A. 17 (West 1983). The Commissioners stated as follows:

> The laws now on the statute books do not, in general, deal with these legal questions [competing interests in organ donation and transplantation] in a complete or adequate manner. The laws are a confusing mixture of old common law dating back to the seventeenth century and state statutes that have been enacted from time to time. Some 39 states and the District of Columbia have donation statutes that deal in a variety of ways with some, but by no means all, of the above listed legal questions. Four other states have statutes providing for the gift of eyes only.

Id.

27. UNIF. ANATOMICAL GIFT ACT (1968), 8A U.L.A. 16 (West 1983); UNIF. ANATOMICAL GIFT ACT (1987), 8A U.L.A. 2-3 (West Supp. 1991).

28. UNIF. ANATOMICAL GIFT ACT (1968), 8A U.L.A. 16 (West 1983).

29. *Id.* § 2. Priority of survivors are (a) the spouse; (b) an adult son or daughter; (c) either parent; (d) an adult brother or sister; (e) a guardian of the decedent at the time of death; or (f) any other person authorized or under obligation to dispose of the body. *Id.* § 2(b).

30. *Id.* § 2(c).

31. *Id.* § 3. Donees are hospitals; individual physicians; medical, dental and other educational programs; as well as specific individuals needing therapy or transplantation. *Id.*

32. *Id.* § 2(c).

33. *Id.* §§ 4-6. *Cf.* UNIF. ANATOMICAL GIFT ACT (1987) prefatory note, §§ 2, 3, 8A U.L.A. 3, 10-11, 14-15 (West Supp. 1991).

34. UNIF. ANATOMICAL GIFT ACT (1968) § 6, 8A U.L.A. 57 (West 1983).

acted in good faith in accordance with the anatomical gift act of the forum state, or the applicable laws of another state or foreign country, by granting civil and criminal immunity.[35]

One of the most important aspects of the Acts, the "good faith" immunity provisions, have been judicially tested and explained. In *Williams v. Hofmann,*[36] the surviving spouse and special administrator of Lucinda Williams brought an action for damages allegedly caused by the wrongful removal of kidneys for transplantation.[37] Plaintiff specifically alleged that the "good faith" limitation of liability section unconstitutionally deprived him of due process and equal protection.[38] The court held that the liability limiting sections, by their own terms, did not apply to medical treatment prior to death, nor to treatment of the organ recipient.[39]

Regarding the organ donor and her survivors, the court held that the term "good faith" was not unconstitutionally vague; that the state, through the organ donation laws, exercised a valid public purpose by encouraging doctors to participate in removal of organs and increasing the supply for transplantation; and that the statute was not an unlawful delegation of legislative authority.[40] In so holding, the court affirmed the plain language of the UAGA and made it easier for medical providers and their counsel to rely on the Act as written. Even so, doctors and their lawyers are reluctant to rely on these written provisions and instead require consent well in addition to that which is required by law. This

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35. *Id.* § 7(c).

36. 223 N.W.2d 844 (Wis. 1974). The court considered and construed Wisconsin's adoption of the 1968 Act, the principles of which were not substantially changed in section 11(c) of the 1987 Act. *Id. See* UNIF. ANATOMICAL GIFT ACT (1987) § 11, 8A U.L.A. 27 (West Supp. 1991).

37. Williams v. Hofmann, 223 N.W.2d 844, 845 (Wis. 1974).

38. *Id.* The limitation of liability section at issue in *Williams* provided as follows:

> (c) A person who acts in good faith in accord with the terms of this section or with the anatomical gift laws of another state (or foreign country) is not liable for damages in any civil action or subject to prosecution in any criminal proceeding for his act.

Id. at 846 (citing WIS. STAT. ANN. § 155.-06(7)(c)).

39. *Id.* at 846.

40. *Id.* at 848-49. In so ruling, the court recognized the need for legal certainty in the organ procurement field and noted as follows:

> Of far greater import, the physicians must labor under the shadow of civil and even criminal liability. This threat, which no doubt impedes the successful development of homotransplantation, presents a striking similarity to the legal problems faced by the eighteenth and early nineteenth century anatomists. Now, as then, the answer must come from statutes, not decisions; and until there are sufficient statutes, doctors will be forced to work not only at the edge of medical knowledge but also at the edge of the law.

Id. at 849 n.11 (citing Richard J. Sideman & Eric D. Rosenfeld, *Legal Aspects of Tissue Donations from Cadavers*, 21 SYRACUSE L. REV. 825, 828 (1970)).

reluctance to trust provisions of the Act, however, contributes to the continued inadequate supply of transplantable organs.

The decision in *Nicoletta v. Rochester Eye and Human Parts Bank, Inc.*[41] further supports the purposes of the UAGA and a plain reading of its provisions. In *Nicoletta,* the court dismissed an action brought by a donor's father for the alleged unlawful removal for transplantation of his deceased son's eyes. The action was premised upon contentions that the woman who signed consents for removal was not the decedent's wife and, therefore, consent was not valid under the UAGA.[42] The court ruled that the defendants had acted in good faith as a matter of law because, among other things, the woman signing the consent form had represented herself as the decedent's wife, even though she was not.[43] The court also reached its ruling based on policy considerations, including the following:

> To require further action on the part of the defendant [in addition to the hospital's inquiry whether the woman providing consent was married to the decedent and why she used a different last name] would not only impose an unreasonable duty upon the Hospital, but would also run afoul of public policy consideration, as such a decision would tend to jeopardize the whole process of organ donation by causing unnecessary delays, thereby frustrating the entire intent of the Uniform Anatomical Gift Act.[44]

The holdings and discussions in *Nicoletta* and *Williams* support the conclusion that the UAGAs are generally well-drafted pieces of legislation. These court rulings are encouraging evidence that plain terms of the Acts can be relied upon by medical practitioners and their counsel. These conclusions will be important as the article continues and proposals for change are made.

The 1968 Act was adopted by all fifty states and the District of Columbia.[45] In fact, adoption of the 1968 Act occurred rapidly.

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41. 519 N.Y.S.2d 928 (N.Y. App. Div. 1987).
42. Nicoletta v. Rochester Eye and Human Parts Bank, Inc., 519 N.Y.S.2d 928, 930 (N.Y. App. Div. 1987). New York's anatomical gift act permitted consent to donation by next of kin, including the spouse, children, parents, brother or sister 21 years or older, guardian or other person authorized by law. N.Y. PUB. HEALTH LAW § 4301(2)(a)-(f) (McKinney 1985 & Supp. 1991). New York's act is an adaptation of the UAGA of 1968. UNIF. ANATOMICAL GIFT ACT (1968), 8A U.L.A. 15-16 (Table of Jurisdictions Wherein Act Has Been Adopted) (West 1983).
43. *Nicoletta*, 519 N.Y.S.2d at 931.
44. *Id.* at 932-33.
45. UNIF. ANATOMICAL GIFT ACT (1968), 8A U.L.A. 15-16 (Table of Jurisdictions

Twenty-four states adopted the Act within a fourteen month period and forty-one states adopted it within eighteen months.[46] Even so, under the 1968 Act too few transplantable organs were obtained. Chronic shortages continued.[47] One of the principal shortfalls of the 1968 Act was its use as a mechanism for obtaining consent for donation.[48] These and other difficulties with the 1968 UAGA led to several legislative considerations and changes, culminating in adoption of "routine inquiry and required consent" laws and the 1987 UAGA.

Required consent laws mandate that hospital staffs request consent for organ donation under appropriate circumstances. The laws, now embodied in the 1987 UAGA, provide that "[w]hen death occurs, or is deemed imminent, in a hospital to a patient who has not made an anatomical gift, the hospital administrator or a designated representative, other than a person connected with the determination of death, shall request . . . consent to the gift of organs . . . ."[49]

Concomitant with the UAGAs and state efforts, Congress amended the Social Security Act to require that all medical institutions receiving Medicare or Medicaid have in place after October 1, 1987, written policies and practices relating to organ and tissue donation.[50] The institutions are required under the Social Security Act to develop programs for identification of potential donors and for making the family of a decedent aware of options regarding donation.[51]

Required consent laws have increased the number of patients and families approached regarding donation,[52] and in turn, have increased the availability of transplantable organs. However, improvement in medical technology, expansion of transplantation centers, and increased third party payor participation continues to increase the demand for organs. Also, medical professionals generally were not and are not trained in procedures for organ donation requests and they have not had significant success in

Wherein Act Has Been Adopted) (West 1983). See *supra* note 18 (states adopting 1968 UAGA).

46. Sipes, *supra* note 19, at 509 n.21.

47. *See* Eric S. Jaffe, Note, *Assessing The Nonconsensual Removal of Cadaver Organs Under the Takings and Due Process Clauses*, 90 COLUM. L. REV. 528, 535 (1990).

48. *Id.* at 533-35.

49. UNIF. ANATOMICAL GIFT ACT (1987) § 5, 8A U.L.A. 19 (West Supp. 1991).

50. Social Security Act, Pub. L. No. 99-509, § 9318, 100 Stat. 2009 (1986) (codified at 42 U.S.C. § 1320b-8 (1988)).

51. *Id.*

52. *See* UNIF. ANATOMICAL GIFT ACT (1987) prefatory note, § 5 comment, 8A U.L.A. 4, 19-20 (West Supp. 1991).

increasing the number of donors.[53] Therefore, there is still a need to further modify the mechanism for obtaining consent.

The 1987 UAGA was the latest large-scale effort to increase the number of anatomical gifts. In the Prefatory Note to the Act, the Commissioners cite at length to a Hastings Center report regarding problems with the then current donation laws.[54] The inadequacies cited by this independent study group in 1987 are noted below.

> The key problems that hinder organ donation include:
> 1. Failure of persons to sign written directives [i.e. donor cards, drivers license endorsement, or will].
> 2. Failure of police and emergency personnel to locate written directives at accident sites.
> 3. Uncertainty on the part of the public about circumstances and timing of organ recovery.
> 4. Failure on the part of medical personnel to recover organs on the basis of written directives.
> 5. Failure to systemically approach family members concerning donation.
> 6. Inefficiency on the part of some organ procurement agencies in obtaining referrals of donors.
> 7. High wastage rates on the part of some organ procurement agencies in failing to place donated organs.
> 8. Failure to communicate the pronouncement of death to next of kin.
> 9. Failure to obtain adequate informed consent from family members.[55]

Even cursory review of the nine points selected by the Hastings Center points to consent as perhaps the most significant problem facing an increased supply of transplantable organs.

The 1987 UAGA represented a concerted effort to modify and streamline organ procurement. Numerous modifications and improvements to the 1968 Act, such as the required request provisions, have been discussed.[56] Other provisions were added to address problems identified in the Hastings Center report.

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53. *See, e.g.*, Charles Marwick & Teri Randall, *Physician's Attitudes and Approaches are Pivotal in Procuring Organs for Transplantation*, 265 JAMA 1227 (1991).

54. UNIF. ANATOMICAL GIFT ACT (1987) prefatory note, 8A U.L.A. 2-4 (West Supp. 1991) (citing Hastings Center, *Ethical, Legal and Policy Issues Pertaining to Solid Organ Procurement*, Oct. 1985).

55. UNIF. ANATOMICAL GIFT ACT (1987) prefatory note, 8A U.L.A. 3 (West Supp. 1991).

56. *Supra* notes 47-49 and accompanying text.

Provisions were added to encourage donation by reducing difficulties connected with obtaining consent. The most dramatic, and probably the most under-utilized, is contained in section 4. Section 4 of the 1987 UAGA permits the coroner, or other designated local public health official, to consent to donation under certain circumstances.[57] This provision is a "quasi-presumed consent" law that, under certain circumstances, allows organ procurement without specific consent by the donor or the donor's next-of-kin.

Section 4 limits presumed consent to situations where the coroner has custody of the body, there is no known objection to donation, reasonable efforts have been made to obtain actual consent from the next-of-kin, and the decedent's medical records have been reviewed regarding consent.[58] In the event there is no evidence that the decedent did not want to donate, and in the event next-of-kin cannot be located, organs may be procured.[59]

Under North Dakota law, and the laws of most other states, coroners are authorized to take custody of bodies when death is believed to have been caused by criminal or violent means, casu-

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57. The full text of UAGA of 1987 section 4 provides:

4. Authorization by [Coroner] [Medical Examiner] OR [Local Public Health Official].
   (a) The [coroner][medical examiner] may release and permit the removal of a part from a body within that official's custody, for transplantation or therapy, if:
      (1) the official has received a request for the part from a hospital, physician, surgeon, or procurement organization;
      (2) the official has made a reasonable effort, taking into account the useful life of the part, to locate and examine the decedent's medical records and inform persons listed in Section 3(a) of their option to make, or object to making, an anatomical gift;
      (3) the official does not know of a refusal or contrary indication by the decedent or objection by a person having priority to act as listed in Section 3(a);
      (4) the removal will be by a physician, surgeon, or technician; but in the case of eyes, by one of them or by an enucleator;
      (5) the removal will not interfere with any autopsy or investigation;
      (6) the removal will be in accordance with accepted medical standards; and
      (7) cosmetic restoration will be done, if appropriate.
   (b) If the body is not within the custody of the [coroner][medical examiner], the [local public health officer] may release and permit the removal of any part from a body in the [local public health officer's] custody for transplantation or therapy if the requirements of subsection (a) are met.
   (c) An official releasing and permitting the removal of a part shall maintain a permanent record of the name or the decedent, the person making the request, the date and purpose of the request, the part requested, and the person to whom it was released.

UNIF. ANATOMICAL GIFT ACT (1987) § 4, 8A U.L.A. 16 (West Supp. 1987).

58. *Id.* § 4 (a)(2).

59. *Id.*

alty, suicide, accidental death, or when the person died suddenly but was in apparent good health, and suspicious or unusual circumstances attend death.[60] This arrangement causes several difficulties in organ procurement and subsequent transplantation. First, with the exception of corneas and tissues like bones and skin, all procurement must be done with the donor on artificial support systems so that vascular organs have a blood and oxygen supply.[61] The coroner's authority, on the other hand, does not exist until a person has died or has been declared dead, which is a time after which most organs will be rendered unusable.[62]

The difficulty with the coroner consent law found in section 4 of the 1987 UAGA and the coroner authorization laws in chapters 11-19 and 11-19.1 of the North Dakota Century Code is that together they are not calculated to produce a significant number of usable, transplantable organs while ensuring protection of the interests of those who do not wish to donate some or all of their organs. A remedy to this conflict is proposed below.

Another significant, but largely unused, provision in the 1987 Act relates to next-of-kin "vetoing" a donor's wishes. The 1968 UAGA provided that body parts[63] could not be accepted if anyone in the same or prior class of next-of-kin opposed donation.[64] The 1987 UAGA sought to reverse this practice by including the provision that "[a]n anatomical gift that is not revoked by the donor before death is irrevocable and does not require the consent or concurrence of any person after the donor's death."[65] Rather than relying on the clear terms of the law, medical facilities routinely,

60. N.D. CENT. CODE §§ 11-19-02, 11-19.1-07 (1985).

61. Danny Hawke et.al., *Tissue and Organ Donation and Recovery in* SUSAN L. SMITH, TISSUE AND ORGAN TRANSPLANTATION 90-91 (1990).

62. *See, e.g.,* N.D. CENT. CODE §§ 11-19.1-07, 11-19.1-01(2) (1985) ("Casualty shall mean death arising out of accidental or unusual means."). Chapter 23-06.3 of the North Dakota Century Code, The Uniform Determination of Death Act, defines a person as dead when there is either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the entire brain, including the brain stem. N.D. CENT. CODE § 23-06.3-01 (1991). Obviously the donor must be "dead" before organ procurement is possible. In the case of the coroner, however, the body often is given over to the coroner when it has been without life for some time and no artificial means of support have been used to preserve the organs.

Sometimes patients are declared dead and are maintained on artificial support systems pending notification of a coroner or while consent for donation is sought from next of kin. Due to costs and fears of potential liability for unconsented procedures, under current law this scenario occurs all too seldom and the chance for donation is lost.

63. "Parts" is defined in the 1968 Act as "organs, tissues, eyes, bones, arteries, blood, other fluids and other portions of a human body." UNIF. ANATOMICAL GIFT ACT (1968) § 1(e), 8A U.L.A. 30 (West 1983); *Cf.* UNIF. ANATOMICAL GIFT ACT § 1(7), 8A U.L.A. 8 (West 1983); *supra* note 4.

64. UNIF. ANATOMICAL GIFT ACT (1968) § 2(c), 8A U.L.A. 34-35 (West 1983).

65. UNIF. ANATOMICAL GIFT ACT (1987) § 2(h), 8A U.L.A. 11 (West Supp. 1991); N.D. CENT. CODE § 23-06.2-02(6) (1991).

and we submit, improperly, require additional consent.[66] This second consent often is not obtained in time, or is refused for any number of reasons, including confusion over the donor's intentions and wishes, disagreement among surviving family members, and inability to make a decision due to grief brought on by the sudden or traumatic death of the potential donor. Both of these problems require a look at alternatives.

B. PROPOSALS FOR CHANGE: THE NEED FOR A PRESUMED CONSENT LAW

From the brief discussion above, one is compelled to conclude that the lack of organ donation is at least part of the reason more transplants cannot be accomplished. If the shortage of organ donations is part of the problem, and the same number of transplants or more are to be contemplated, part of the solution must be to increase donations of transplantable organs and tissue.

The two current[67] principle proposals for increased donations are presumed or quasi-presumed consent for donation[68] and payment for organs.[69] We reject the proposal for procurement of organs by payment. Any payment-for-donation system would result in the grave problems of setting appropriate "market" prices and deciding who can "buy" the organs. In addition, payment for donation may harm the financially disadvantaged, be they the donors from whom organs are purchased or the person who must buy an organ.[70] More subtle concerns are that such a procurement-by-payment system will create a true property interest in a dead body,[71] will lead to a "futures market" for organs,[72] or

66. Sipes, *supra* note 19, at 510-11.

67. The term "current" is used advisedly. Proposals for procurement of organs by payment and by presumed consent have been seriously discussed in the United States for at least 24 years. *See, e.g.*, Dukeminier, *supra* note 20; David Sanders & Jesse Dukeminier, Jr., *Medical Advance and Legal Lag: Hemodialysis and Kidney Transplantation*, 15 UCLA L. REV. 357, 410-13 (1968); and Jesse Dukeminier & David Sanders, *Organ Transplantation: A Proposal for Routine Salvaging of Cadaver Organs*, 279 NEW ENG. J. MED. 413 (1968) [hereinafter Dukeminier & Sanders, *Organ Transplantation*]. The discussion continues today. *See generally* Dilup S. Kittur, et al., *Incentives for Organ Donation?*, UNOS UPDATE, Jan. 1992, at 8.

68. Sipes, *supra* note 19, at 524-32.

69. *Id.* at 514.

70. For a general discussion of provisions and rationales for prohibiting the sale of organs, see UNIF. ANATOMICAL GIFT ACT (1987) § 10 and comment, 8A U.L.A. 26 (West Supp. 1991).

71. *See infra* notes 87-105 and accompanying text. *Cf.* Moore v. Regents of the Univ. of Cal., 249 Cal. Rptr. 494 (Cal. Ct. App. 1988) (finding that a leukemia patient whose spleen was used to produce a cell line had property right in spleen and could sue for conversion.), *rev'd in part*, 271 Cal. Rptr. 146 (Cal. 1990).

72. Ronald D. Guttmann, *The Meaning of "The Economic and Ethics of Alternative Cadaveric Organ Procurement Policies,"* 8 YALE J. ON REG. 453, 460 (1991).

will lead to involuntary or hastened deaths so that organs can be sold.[73] A presumed consent system, on the other hand, could be implemented to increase the supply of usable organs while protecting the donor's pre-death wishes and the interests of the donor's next-of-kin.

Presumed consent laws are generally defined as those providing for cadaver donation of transplantable organs without specific consent, unless contrary wishes are communicated to appropriate persons.[74] Separate from the UAGA, presumed consent laws already exist in the United States for a limited number of organs, such as eyes and pituitary glands.[75] The states that adopted the UAGA of 1987 also have quasi-presumed consent laws, as discussed above.[76] Additionally, at least sixteen foreign countries have varying degrees of presumed consent laws for general organ and tissue donation.[77] However, nearly all require involvement of a coroner or medical examiner.[78]

Presumed consent laws are in place and currently are widely used for procurement of eyes. Enactment of these laws led to a

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73. *Id.* at 459; Blair & Kaserman, *supra* note 12, at 421.

74. *See* Dukeminier & Sanders, *Organ Transplantation*, *supra* note 67. In 1968, these authors concluded that:

> [T]he great value of cadaver organs in saving human life requires that the burden be shifted from the surgeons to the dead donor or his next of kin. At present the surgeon is told: "You may not remove cadaver organs to save the life of a living person unless you have obtained consent from the deceased or his next of kin." He ought to be told: "You may remove cadaver organs to save the life of a living person unless the deceased notified you that he objected or the next of kin now objects."

Id. at 418. The foregoing is based on four conclusions reached by the authors, namely:

> [1] Removal of useful cadaver organs is routine practice; leaving them to putrefy is unusual.
>
> [2] Removal of organs is performed under conditions that do not burden the bereaved persons with problems.
>
> [3] The donor may object during life to removal of his organs after death, and the objection is controlling. If, however, the donor expressly agrees to the use of his organs after death, his next of kin has no power of veto; and
>
> [4] If the donor neither objects nor expressly assents, his next of kin may object to removal any time before the organs are removed, and the objection is controlling. This principle should be included to obviate any constitutional problems regarding freedom of religion.

Id.

75. Sipes, *supra* note 19, at 524-28.

76. Arkansas and Rhode Island omitted subsection (b) of § 4 regarding the local health officer's authority to permit removal of organs. California expanded § 4 to permit hospitals to authorize removal of organs when efforts have been made to obtain actual consent from the next-of-kin. Connecticut effectively omitted § 4 by modification of the language. Vermont deleted the provision. UNIF. ANATOMICAL GIFT ACT (1987) § 4 comment, 8A U.L.A. 17-18 (West Supp. 1991).

77. Sipes, *supra* note 19, at 515; Donald R. McNeil, Jr., Note, *The Constitutionality of "Presumed Consent" for Organ Donation*, 9 HAMLINE J. PUB. L. & POL. 343, 356 (1987).

78. Sipes, *supra* note 19, at 515.

marked increase in donated corneal tissues.[79] Presumed consent laws also have been judicially tested and found to pass constitutional muster, and courts have given literal enforcement to the challenged anatomical gift acts.[80]

In *State v. Powell,*[81] *Georgia Lion Eye Bank, Inc. v. Lavant,*[82] and *Tillman v. Detroit Receiving Hospital,*[83] actions were commenced to challenge cornea procurement presumed consent laws. In each case, a body had been turned over to the coroner for autopsy and corneal material was procured.[84] Each of the states had laws giving the coroner authority to consent to enucleation as long as no objections to donation were known.[85] In each case survivors sued to recover damages on the ground that the presumed-consent-to-donation laws deprived them of due process of law.[86]

The courts uniformly held that there was no constitutionally protected property right to a dead body.[87] In so holding, the courts recognized the surviving next-of-kin's "quasi-property right" to the possession of a dead body for purposes of mourning, preparation for burial, burial, or other lawful disposition.[88] In these three cases, the courts steadfastly held that this limited "quasi-property right" was, on the balance, a lesser interest to the greater good of providing usable tissue for transplantation.[89] The

79. Georgia's presumed consent law for corneas was enacted in 1978. Georgia Lion Eye Bank, Inc. v. Lavant, 335 S.E.2d 127, 128 (Ga. 1985). Before passage of the law, "approximately 25 corneal transplants were performed each year. In 1984, however, more than 1000 persons regained their sight through transplants." *Id.* Florida's law was enacted in 1977. State v. Powell, 497 So. 2d 1188, 1191 (Fla. 1986). In 1976, five hundred corneas were procured. *Id.* In 1985, more than three thousand corneal transplants were performed in Florida. *Id.*

80. Nicoletta v. Rochester Eye & Human Parts Bank, 519 N.Y.S.2d 928 (N.Y. App. Div. 1987); State v. Powell, 497 So. 2d 1188 (Fla. 1986), *cert. denied* Powell v. Florida, 481 U.S. 1059 (1987); Georgia Lions Eye Bank v. Lavant, 335 S.E.2d 127 (Ga. 1985), *cert. denied* Lavant v. St. Joseph's Hosp., 475 U.S. 1084 (1986); Tillman v. Detroit Receiving Hosp., 360 N.W.2d 275 (Mich. Ct. App. 1984); and Williams v. Hofmann, 223 N.W.2d 844 (Wis. 1974). *Cf.* Brotherton v. Cleveland, 923 F.2d 477 (6th Cir. 1991) (Ohio cornea procurement by coroner under presumed consent law violated surviving spouse's due process rights where surviving spouse had previously specifically refused consent for eye enucleation).

81. 497 So. 2d at 1188.

82. 335 S.E.2d at 127.

83. 360 N.W.2d at 275.

84. *Powell*, 497 So. 2d at 1189; *Georgia Lions*, 335 S.E.2d at 128; and *Tillman*, 360 N.W.2d at 276.

85. *Powell*, 497 So. 2d at 1189; *Georgia Lions*, 335 S.E.2d at 127-28; *Tillman*, 360 N.W.2d at 277.

86. *Powell*, 497 So. 2d at 1190; *Georgia Lions*, 335 S.E.2d at 128; and *Tillman*, 360 N.W.2d at 276-77.

87. *Powell*, 497 So. 2d at 1192; *Georgia Lions*, 335 S.E. 2d at 128; and *Tillman*, 360 N.W.2d at 277.

88. *Powell*, 497 So. 2d at 1190; *Georgia Lions*, 335 S.E.2d at 128; and *Tillman*, 360 N.W.2d at 276-77.

89. *Powell*, 497 So. 2d 1188; *Georgia Lions*, 335 S.E. 2d 127; and *Tillman*, 360 N.W.2d 275.

presumed consent laws, therefore, were constitutionally permissible.

A recent decision from the United States Court of Appeals for the Sixth Circuit is the only ruling that is at odds with the trio of decisions cited above. However, when that decision is reviewed, one is compelled to conclude that procedures with which the court had difficulty could be cured with minimal modification to the notice and communication provisions of anatomical gift acts. One is also compelled to conclude that the result was dictated by the panel's disdain for the coroner's indifferent treatment of the wishes of the decedent's next-of-kin.

In *Brotherton v. Cleveland*[90] the surviving spouse and children brought an action under section 1983 of title 42 of the United States Code for damages allegedly sustained due to deprivation of constitutional rights under color of state law.[91] Factually, the case is simple. Plaintiffs' husband and father was taken to a hospital after being found unconscious.[92] He was pronounced dead on arrival, whereupon the hospital staff sought consent for organ donation.[93] Mrs. Brotherton specifically declined consent, and the declination was recorded in the hospital's "Report of Death."[94]

Because the death was considered a possible suicide, the body was delivered to the county coroner for autopsy in accordance with Ohio law.[95] Ohio law permitted the coroner to consent to eye enucleation as long as the coroner had no knowledge of objection to donation by the decedent or his next- of-kin.[96] In this case,

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90. 923 F.2d 477 (6th Cir. 1991).
91. Brotherton v. Cleveland, 923 F.2d 477, 478-79 (6th Cir. 1991).
92. *Id.* at 478.
93. *Id.*
94. *Id.*
95. *Id. See* OHIO REV. CODE ANN. § 313.13 (Anderson 1990).
96. OHIO REV. CODE ANN. § 2108.60(B)(4) (Anderson 1990). Authority for this procedure is found in the Ohio statute, which provides, in pertinent part, as follows:

> (B) A county coroner who performs an autopsy pursuant to section 313.13 of the Revised Code, may remove one or both Corneas of the decedent, or a coroner may authorize a deputy coroner, physician or surgeon licensed pursuant to section 4731.14 of the Revised Code, embalmer authorized under section 2108.071 [2108.071] of the Revised Code to enucleate eyes, or eye technician to remove one or both corneas of a decedent whose body is the subject of an autopsy performed pursuant to section 313.13 of the Revised Code, if all of the following apply:
> (1) The corneas are not necessary for the successful completion of the autopsy or for evidence;
> (2) An eye bank official has requested the removal of corneas and certified to the coroner in writing that the corneas will be used only for corneal transplants or other medical or medical research purposes;
> (3) The removal of the corneas and gift to the eye bank do not alter a gift made by the decedent or any other person authorized under this chapter to an agency or organization other than the eye bank;

the decedent's corneas were donated pursuant to the statutory procedure and plaintiffs later learned of donation from the autopsy report.[97] Before making the donation, the coroner was not told by the hospital that Mrs. Brotherton had refused to consent to organ donation, that the coroner did not review hospital records, and that the coroner did not otherwise inquire whether there was an objection to donation.[98]

The Federal District Court dismissed Brothertons' action for failure to state a federal claim[99] upon which relief could be granted.[100] The dismissal was specifically based on Ohio judicial decisions providing that the widow and her children had no consti-

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> (4) The coroner, at the time he removes or authorizes the removal of the corneas, has no knowledge of an objection to the removal by any of the following:
> (a) The decedent, as evidenced in a written document executed during his lifetime;
> (b) The decedent's spouse;
> (c) If there is no spouse, the decedent's adult children;
> (d) If there is no spouse and no adult children, the decedent's parents;
> (e) If there is no spouse, no adult children, and no parents, the decedent's brothers or sisters;
> (f) If there is no spouse, no adult children, no parents, and no brothers or sisters, the guardian of the person of the decedent at the time of death;
> (g) If there is no spouse, no adult children, no parents, no brothers or sisters, no guardian of the person of the decedent at the time of death, any other person authorized or under obligation to dispose of the body.
>
> (C) Any person who acts in good faith under this section and without knowledge of an objection, as described in division (B)(4) of this section, to the removal of corneas is not liable in any civil or criminal action based on the removal.

Id. § 2108.60 (B), (C).

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

98. *Id.*

99. *Id.* at 479. Neither the court nor the authors of this article suggest that plaintiffs still did not have an action under state law for severe infliction of emotional distress. *See* Brotherton v. Cleveland, 733 F. Supp. 56 (S.D. Ohio 1989). The district court wrote as follows:

> Despite our sympathy for the plaintiffs and our concern at the Coroner's arbitrary and insensitive actions, we reluctantly conclude that plaintiffs' federal claims must be dismissed.
>
> ....
>
> This Court is disturbed by the defendants' callous actions in this case. Permitting the disfigurement of a loved one's body, even for the noble purpose of donating organs or tissues to others, is a personal decision that should be left to the decedent during life or the next-of-kin after death. Mutilation of a decedent's remains despite expressed instructions to the contrary is certain to intensify the grief, shock, and horror normally experienced by the family at the time of such loss. An action for the infliction of this severe emotional distress is the proper remedy for actions, such as those of the defendants here, which magnify the anguish felt by a decedent's family.

Id. at 57, 60.

100. *Brotherton*, 733 F. Supp. at 57.

tutionally protected property right in a dead body.[101] On appeal, the court, in what can only be described as a tautological mission, and over a well-reasoned dissent supported by Ohio case law, defined plaintiffs' interest in the dead body as sufficient to conclude that the coroner had violated due process protection afforded by the United States Constitution.[102] The court of appeals reached this result on the theory that plaintiffs' interest in a dead body, although not a property right, did constitute " 'a legitimate claim of entitlement'. . . protected by the due process clause . . . ."[103] The case was therefore remanded for consideration of plaintiffs' damage claims.[104]

But for the holding, the lesson in *Brotherton* may be a good one. The result in *Brotherton* requires any type of presumed consent legislation involving state action to contain requirements for communication or registration of the donor's or the next-of-kin's wishes so that egregious conduct such as that present in *Brotherton* will not be repeated. This system and procedure for communication and registration of "no donor" wishes will ensure that necessary "predeprivation process"[105] is provided so that due process requirements are satisfied.

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101. *Id.* at 59. In order for the plaintiff to recover in her § 1983 action she had to prove (1) deprivation of a right secured by the United States Constitution, and (2) that deprivation was caused under color of state law. *Id.* at 58.

102. *Brotherton*, 923 F.2d at 482. Ohio appellate courts had ruled that survivors do not have a property right in a dead body. *See* Everman v. Davis, 561 N.E.2d 547, 550 (Ohio Ct. App.), *appeal dismissed*, 539 N.E.2d 163 (Ohio 1989) (holding that survivors had a qualified, quasi-property right which extended to preparation, mourning and burial); Carney v. Knollwood Cemetery Ass'n, 514 N.E.2d 430 (Ohio Ct. App. 1986); and Hadsel v. Hadsel, 3 Ohio C.C. Dec. 725 (1893).

103. *Brotherton*, 923 F.2d at 482.

104. *Id.*

105. *Id.* The Sixth Circuit panel in *Brotherton* refused to define the necessary process due under circumstances attendant with organ donation. *Id.* In so stating, the court commented as follows:

> It is the policy and custom of the Hamilton County coroner's office not to review medical records or paperwork pertaining to a corpse prior to the removal of corneas. This intentional ignorance is induced by OHIO REV. CODE § 2108.60 which allows the office to take corneas from the bodies of deceased without considering the interest of any other parties, as long as they have no knowledge of any objection to such a removal. After the cornea is removed, it is not returned and the corpse is permanently diminished. The only governmental interest enhanced by the removal of the corneas is the interest in implementing the organ/tissue donation program; this interest is not substantial enough to allow the state to consciously disregard those property rights which it has granted. Moreover, predeprivation process undertaken by the state would be a minimal burden to this interest. This Court does not at this time need to establish the type or extent of predeprivation process required by the due process clause; we merely hold that the policy and custom of the Hamilton County coroner's office is an established state procedure necessitating predeprivation process.

Id.

C. A PROPOSAL FOR MODIFICATION OF NORTH DAKOTA'S CONSENT LAW

Section 4 of the 1987 UAGA has been discussed above. The shortcomings of the provision have been noted. Detailed below are suggested amendments to section 4 which, if implemented, are calculated to increase the supply of transplantable organs while protecting the interests of donors and their next-of-kin. The amended statute should read, in substance, as follows:

23-06.2-04. Authorization by coroner or local public health official.

1. The coroner may permit the removal and release of any part from a body within the coroner's custody, for transplant or therapeutic purposes, if the following requirements are met:
   a. A request has been received from a person specified in subsection 1 of section 23-06.2-06;
   b. A reasonable effort has been made to locate and inform persons specified in subsection 1 of section 23-06.2-03 of the option to make or object to the making of an anatomical gift. Except in the case of corneal material obtained for transplantation, and taking into account the useful life of any other part procured for transplantation, a reasonable effort is deemed to be made when a search for the persons has been underway for at least 24 hours and the search has included checking state, national and international donor registries, to the extent that they have been established, and examination of hospital and medical records;
   c. That official does not know of a contrary indication by the decedent or objection by a person having priority to act as specified in subsection 1 of section 23-06.2-03;
   d. The removal will be by a physician, surgeon, or technician; but in the case of eyes, by one of them or an enucleator;
   e. The removal will not interfere with an autopsy or investigation; and
   f. The removal will be in accordance with accepted medical standards and cosmetic restoration will be done if appropriate.

2. If the body is not in the custody of the coroner, a hospital may release and permit the removal of a part from a body if the hospital, after a reasonable effort has been made to locate and inform persons listed in subsection 1 of section 23-06.2-03 of their option to make, or object to the making of an anatomical gift, determines and certifies that the persons are not available. A search for the persons listed in subsection 1 of section 23-06.2-03 may be initiated in anticipation of death, but except in the case of corneal material to be used for transplantation or where the useful life of the part does not permit, the determination may not be made until the search has been underway for at least 24 hours, and has included checking state, national and international donor registries, to the extent that they have been established, local police missing persons and other appropriate records, examination of hospital and medical records, examination of personal effects, and the questioning of any persons visiting the decedent before death or in the hospital, accompanying the decedent's body, or reporting the death, to obtain information that might lead to identification or location of persons listed in subsection 1 of section 23-06.2-03.
3. If the body is not within the custody of the coroner, the local public health officer may permit removal and release of any part from a body within the local public health officer's custody for transplantation or therapeutic purposes if the requirements of subsection 1, above, are met.
4. An official or hospital permitting the removal and release of any part shall maintain a permanent record of the name of the decedent, the person making the request, the date and purpose of the request, the part requested, and the person to whom it was released.

The statute proposed above has two significant departures from current law. First, hospitals, in addition to coroners and local public health officers, are given authority to permit organ and tissue procurement. This is a necessary development in light of the fact that many potential donors are lost because the coroner or the local public health official was not involved.

Second, the proposed law presumes the establishment of

"state, national or international donor registries." With the focus of law on presumed consent for donation, the registry would be used for non-donors to record their wishes.[106] In North Dakota, the Department of Health and Consolidated Laboratories could maintain a list accessible by computer. Although significantly different in effect and operation, the concept would be similar to the central filing system in place in the Secretary of State's Office for lien filings.[107]

Ultimately we expect that trends in organ donation, procurement, and transplantation will lead to a national, if not international, public attitude that donation is presumed.[108] In such an event, UNOS would be the logical place to establish a national and international registry of those who do not want to be donors. These procedures, coupled with modifications to existing laws, such as changing drivers license endorsements from "donor" to "no donor," would protect an individual's choice while encouraging and effecting public policy toward preserving the significant resource of life and the ability to give and renew life.

CONCLUSION

This article and the materials cited give an overview of developments experienced in the medical and legal fields relating to organ and tissue procurement and transplantation. We hope the article also provides insight into the needs for continued legal growth in this field. By proposing a type of presumed consent legislation, we also hope to stimulate discussion about how that legal growth will be accomplished so that others, and, someday, perhaps we, can be and will be permitted to live longer and better lives through the miracle of donation of life.

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106. UNIF. ANATOMICAL GIFT ACT (1987) § 2(i), 8A U.L.A. 11 (West Supp. 1991) already provides for provisions to protect the wishes of "non-donors." That section provides as follows:

> (i) An individual may refuse to make an anatomical gift of the individual's body or part by (i) a writing signed in the same manner as a document of gift, (ii) a statement attached to or imprinted on a donor's motor vehicle operator's or chauffeur's license, or (iii) any other writing used to identify the individual as refusing to make an anatomical gift. During a terminal illness or injury, the refusal may be an oral statement or other form of communication.

Id.

In keeping with the concept of central registry of "no-donor" wishes, this portion of the Act needs to be modified to include reference to such a registry, or to expand the definition of a "writing" to include entry of information upon such central registries.

107. N.D. CENT. CODE § 41-09-40 (Supp. 1991).

108. *See* Williams v. Hofmann, 223 N.W.2d 844 (Wis. 1974); *supra* note 67.