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Opt-In or Opt-Out?

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INTRODUCTION

109,931 people nationwide were on the United Network for Organ Sharing waiting list at 3:20pm on Wednesday, December 1, 2010.¹ There were 8,477 donors from January until July, 2010.² This discrepancy leaves tens of thousands of people to die while awaiting a transplant. However, in 1999 and 2000 combined, an estimated 260,000 people died in Pennsylvania alone.³ These deaths would seemingly leave more than enough presumptive donors⁴ to cover the demand for vital organs created throughout the entire country.⁵ Moreover, a single donor⁶ is capable of saving the lives of four individuals and improving the lives of more than five additional individuals.⁷ Consequently, the number of presumptive organ donors far exceeds the number of donors actually needed to meet the

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¹ UNITED NETWORK FOR ORGAN SHARING, <http://www.unos.org/> (last visited Dec. 1, 2010). This list coordinates the country's organ transplant system through a contractual agreement with the federal government. *Id.*

² *Id.*

³ Samantha A. Wilcox, *Presumed Consent Organ Donation in Pennsylvania: One Small Step for Pennsylvania, One Giant Leap for Organ Donation*, 107 DICK. L. REV. 935, 936 (2003).

⁴ The term "presumptive donors" refers to either living individuals who are healthy enough to be capable of donating organs upon their death, or decedents who were healthy enough while alive such that their organs would have been capable of being transplanted at the time of their death, assuming their cause of death did not subsequently prevent the possibility of donation. "Presumptive donors" are not necessarily legally acknowledged as having consented to organ donation. They are, or were, merely *capable* of donating organs. Alternatively, those who are legally acknowledged as having consented to donation are referred to as "donors" within this Article, regardless of whether they have already physically donated an organ to a donee.

⁵ Wilcox, *supra* note 3, at 936.

⁶ "Donors," within this Article, refers only to cadaver donors and not to living donors.

⁷ Wilcox, *supra* note 3, at 936. Each single donor is capable of saving four lives through his or her ability to, ideally, donate one heart, two lungs, and one liver. Additionally, the same single donor is capable of significantly improving the quality of life of several more people through his or her potential to donate two kidneys, one pancreas, two corneas, as well as bones, skin, and other tissue. *Id.*

demand.⁸ This demand is not being met as a direct result of presumptive donors neglecting to declare donative intent prior to death.

Legislative attempts to minimize the gap between the number of presumptive donors and the supply of organs actually donated have been widespread at the international level.⁹ A key variable within legislative attempts is the level of consent required to turn a presumptive donor into an actual donor. The majority of states in the United States require that an individual “opt-in” to be recognized as a donor. Opt-in requirements oblige each individual to specific, affirmative action indicating their unambiguous intent to donate.¹⁰ If an individual chooses not to do so, the default rule states that the presumptive donor will *not* be recognized as an actual donor. Recently, however, a minority of states in the United States moved toward the other extreme by adopting an “opt-out” approach in particular circumstances.¹¹ The default rule in an opt-out approach considers everyone to be a willing donor. Therefore, inaction demonstrates an individual’s consent to donate. Where a given jurisdiction falls upon the spectrum between the two extremes is directly related to the percentage of consenting individuals within the given locale. Specifically, the countries that follow strong opt-out laws have the highest number of donors per capita while countries that follow strong opt-in laws tend to have the lowest.¹²

The United States enacted the federal Uniform Anatomical Gift Act of 1968 (UAGA) which follows the opt-in approach.¹³ If a presumptive donor fails to take an affirmative step declaring donative intent, it is assumed he or she does not want to be an organ donor. Every state, as well as Washington, D.C., has adopted the UAGA or a close variation.¹⁴

Nevertheless, several states have adopted statutes at the state level that require an opt-out approach for particular donations. For example, fifteen states, including Pennsylvania, use an opt-out approach for corneal

⁸ Patrick D. Carlson, *The 2004 Organ Donation Recovery and Improvement Act: How Congress Missed an Opportunity to Say “Yes” to Financial Incentives for Organ Donation*, 23 J. CONTEMP. HEALTH L. & POL’Y 136, 136-37 (2006).

⁹ Abena Richards, *Don’t Take Your Organs to Heaven... Heaven Knows We Need Them Here: Another Look at the Required Response System*, 26 N. ILL. U. L. REV. 365, 388-89 (2006).

¹⁰ Cass R. Sunstein & Richard H. Thaler, *Libertarian Paternalism is Not an Oxymoron*, 70 U. Chi. L. Rev. 1159, 1192 (2003).

¹¹ The “opt-out” approach is commonly referred to in literature as the “presumed consent” approach. However, for purposes of parallelism and clarity in this Paper, I have chosen to use the phrase “opt-out” to signify the idea of “presumed consent.”

¹² See Erica Teagarden, *Human Trafficking: Legal Issues in Presumed Consent Laws*, 30 N.C. J. INT’L L. & COM. REG. 685, 698-700 (2005).

¹³ Wilcox, *supra* note 3, at 937.

¹⁴ Teagarden, *supra* note 12, at 694.

tissue donation.¹⁵ The minimally invasive nature of corneal tissue extraction has influenced states' decisions to utilize the opt-out approach for this specific donation.¹⁶ As a result of the procedure being only minimally invasive, those who see the decedent after the extraction will never know that anything was removed from the decedent's body.¹⁷ While somewhat controversial, this approach avoids particular religious objections and prevents families from having to make donative decisions on behalf of the decedent shortly after death. Furthermore, the high degree of perishability of corneal tissue¹⁸ makes it imperative for a medical examiner to know whether to extract corneal tissue from a decedent immediately following the time of death in order for the tissue to be usable in repairing a donee's vision.

Of course, permitting a medical examiner to extract tissue without consent permits tissue to be extracted from all decedents, including decedents who believed that extraction of tissue violates religious ideals. In addition, it may be unethical to allow organ or tissue extraction to be performed absent the knowledge of the decedent's family. Denying the family knowledge of the procedure simultaneously denies them the opportunity to object to it on the basis of religious or moral ideals that may have been important to the decedent.¹⁹ Together, the challenges faced by states that have adopted the opt-out approach for corneal tissue donation indicate the challenges our country would likely face if it were to switch from an opt-in approach to an opt-out approach for donations of all organs and tissues.

Nonetheless, an opt-out approach, rather than an opt-in approach, has the greatest impact on the number of preventable deaths that occur due to the lack of donated organs. While significant religious and moral concerns exist regarding opt-out procedures, apprehension toward the opt-out approach could subside if education surrounding opt-out procedures is increased. Opt-out laws do not take away an individual's right to refrain from being considered an organ donor. Instead, the opt-out approach merely requires each individual to make one minor action in declaring his or her desire to refrain from donating. If it is truly important to an

¹⁵ Maryellen Liddy, *The "New Body Snatchers": Analyzing the Effect of Presumed Consent Organ Donation Laws on Privacy, Autonomy, and Liberty*, 28 FORDHAM URB. L.J. 815, 828 (2001).

¹⁶ Michele Goodwin, *Formalism and the Legal Status of Body Parts*, 2006 U. CHI. LEGAL F. 317, 330 (2006).

¹⁷ *Id.*

¹⁸ Ronald Smith, *Doheny Eye Bank*, L.A. TIMES, November 10, 1977, available at <http://articles.latimes.com/1997/nov/10/local/me-52250>.

¹⁹ Goodwin, *supra* note 16.

individual *not* to donate, it should be insignificant for the individual to take a moment, once in his or her lifetime, to legally declare intent not to donate.

This Paper looks to increase readers' awareness of the organ shortage while highlighting the stark reality that available cadaver organs and tissues exceed the demand for them. Part I discusses the opt-in approach currently utilized in the United States as enacted through the UAGA. Part II looks at the opt-out approach, the variations in which it has been adopted, and the corresponding influences it has had on helping to meet the demand for organ donations. This Part also explores the critical responses to the opt-out approach, including moral, procedural, religious, and ethical concerns. Lastly, Part III explains how each criticism of the opt-out approach can be addressed through increasing education surrounding opt-out procedures.

I. OPT-IN APPROACH FAILS TO SIGNIFICANTLY MINIMIZE THE DISCREPANCY BETWEEN DONORS AND INDIVIDUALS NEEDING ORGAN DONATIONS

The opt-in approach is one method of responding to the discrepancy between the number of donors and the number of people currently awaiting an organ transplant. The United States follows the opt-in approach, as codified within the UAGA, originally adopted in 1968.²⁰ However, this discrepancy remained minimally effected by the adoption of the UAGA of 1968²¹ and, consequently, changes were made that resulted in the 1987 version which we still follow today.²² The UAGA of 1987 minimizes the discrepancy more so than the UAGA of 1968.²³ However, the discrepancy remains significant in the United States,²⁴ especially relative to countries that follow the opt-out approach instead.²⁵

A. *UAGA of 1968*

²⁰ Unif. Anatomical Gift Act (1968).

²¹ See Teagarden, *supra* note 12, at 694-95 (explains the major obstacles that existed within the 1968 version and how, subsequently, the 1978 version eliminated them, which resulted in an overall increase in the number of organ donations made).

²² Unif. Anatomical Gift Act (1987).

²³ See Teagarden, *supra* note 12, at 694-95.

²⁴ UNITED NETWORK FOR ORGAN SHARING, <http://www.unos.org/> (last visited Dec. 1, 2010).

²⁵ See Andrew Hughes, *You Get What You Pay For?: Rethinking U.S. Organ Procurement Policy in Light of Foreign Models*, 42 VAND. J. TRANSNAT'L L. 351, 364 (2009) (Austria, which uses the strictest form of an opt-out approach, "...has had much more success in procuring organs, supplying kidneys twice as effectively as the United States...").

Technological advances in the medical field have paralleled increasing success rates of organ transplants. Dr. Joseph Murray successfully performed the first invasive transplant in 1954 when he removed a kidney from one identical twin and successfully placed it into the other.²⁶ From then on, as Abena Richards addresses in her law review article discussing the organ shortage, transplantation became commonplace. As a result, states began enacting statutes to regulate donation.²⁷ Forty-two states had their own version of an organ donation statute by 1968.²⁸ Consequently, the National Conference of Commissioners on Uniform State Laws passed the Uniform Anatomical Gift Act (UAGA) of 1968²⁹ in order to unify the forty-two different attempts at regulation statutes at the state level.³⁰ Every state as well as Washington, D.C. had adopted the UAGA or a variation of it by 1973.³¹

The UAGA states that any individual age eighteen or older and of sound mind may donate all or any part of his or her body upon death.³² The acceptable purposes of donative gifts include contributing to medical or dental education, research, and the advancement of medical or dental science³³, as well as contributing to a transplant need of a donee.³⁴ The UAGA requires that presumptive donors “opt-in” by unambiguously declaring donative intent, communicated either by will³⁵ or by a document other than a will, such as a card designed to be carried by the donor.³⁶ If the presumptive donor has not designated his or her donative intent and has not unambiguously indicated intent contrary to donation, then the UAGA provides a hierarchy of third parties close to the decedent who may provide donative consent on the decedent’s behalf.³⁷ The hierarchy increases the

²⁶ Richards, *supra* note 9, 370-71.

²⁷ *Id.* at 371.

²⁸ *Id.*

²⁹ Laurel R. Siegel, *Re-Engineering the Laws of Organ Transplantation*, 49 EMORY L.J. 917, 932 (2000).

³⁰ Richards, *supra* note 9, at 371.

³¹ Siegel, *supra* note 29.

³² Unif. Anatomical Gift Act § 2(a) (1968).

³³ Unif. Anatomical Gift Act § 3(1) (1968).

³⁴ Unif. Anatomical Gift Act § 3(4) (1968).

³⁵ Unif. Anatomical Gift Act § 4(a) (1968).

³⁶ Unif. Anatomical Gift Act § 4(b) (1968). This card must also be signed by the presumptive donor. *Id.*

³⁷ Unif. Anatomical Gift Act § 2(b) (1968). Consent may be provided on behalf of the decedent to donate all or part of the decedent’s body by a third party when the decedent has not acted in a way that expresses contrary donative intent. Unif. Anatomical Gift Act § 2(c) (1968). The third parties capable of providing consent on behalf of the decedent appear in a hierarchy. Unif. Anatomical Gift Act § 2(b) (1968). Therefore, medical personnel are required to attempt to gain consent from the person located at the top of the hierarchical list and only when that person is unreachable after a reasonable attempt has

chance that a decedent will become a donor by increasing the number of people able to provide consent for one single presumptive donor. In this way, the UAGA not only unifies state regulations of organ donation, but it also increases the number of organ donors.

By 1987, however, the hierarchical list of third parties able to provide donative consent on behalf of the decedent was understood to limit the number of donations. It became clear that if the hierarchical list expanded, so would the number of organ donations. This expansion was necessary for two reasons.

First, it was necessary as a response to decedents being legally barred from donating only because hospital personnel were unable to physically locate parties on the hierarchical list within the relevant donative time period. A particular window of time exists between when the presumptive donor is declared dead and when his or her organs are no longer capable of being donated. If consent is not provided by a party on the hierarchical list within this window of time, all of the organs that could have provided life for others, had consent been provided, go unused. Expanding the hierarchical list, therefore, has the ability to increase the number of donations made by increasing the likelihood that medical personnel can physically locate a third party capable of providing consent on behalf of the decedent within the relevant donative window of time.

Second, many people who never objected to being a donor were nonetheless failing to act to become one by completing a will or other document reflective of donative intent. Specifically, a poll conducted in 1985³⁸ indicated that seventy-five percent of the American population approved of the idea of organ donation.³⁹ A 1993 poll⁴⁰ indicated that sixty-nine percent of Americans would like to donate their organs upon their death.⁴¹ However, evidence suggests that the number of adults who would like to donate does not correspond to the number of adults who are registered donors. In fact, only seventeen percent of American adults carry donor cards.⁴²

Presumptive donors may be unaware of their ability to donate, how to become a donor, or the need for donors. Theoretically, providing

been made to contact him or her, is the medical personnel allowed to move on to the next person on the hierarchical list. The hierarchy consists, in order, of the decedent's spouse, adult son or daughter, either parent, adult brother or sister, guardian of the person who died at the time of death of the decedent, and lastly, any other person authorized or under the obligation to dispose of the decedent's body. *Id.*

³⁸ 1985 Gallup Poll.

³⁹ Siegel, *supra* note 29, at 944.

⁴⁰ 1993 Gallup Poll.

⁴¹ Richards, *supra* note 9, at 368.

⁴² Wilcox, *supra* note 3, at 937.

additional education to presumptive donors regarding their ability to donate, and the corresponding procedures required to declare donative intent, could increase the number of donors; however, the additional education would require expending a significant amount of resources. A less costly way of increasing the number of donors, although seemingly less impactful than increasing education, is to expand the list of people who can provide consent on behalf of a decedent. This expansion makes up for the many presumptive donors who want to donate but fail to take the final affirmative step necessary to officially be recognized as donors.

B. UAGA of 1987

The UAGA of 1987 sought to make up for the pitfalls of the 1968 version and its failure to significantly impact the organ shortage.⁴³ It did so in four significant ways, all of which afforded more opportunities for consent to be provided when it otherwise would not have been. The UAGA of 1987: (1) expanded the list of people able to provide consent on behalf of the decedent; (2) expanded the ways in which a person could express donative intent; (3) granted medical personal new express authority to ask for consent from others as well as the presumptive donor him or herself; (4) mandated that individuals be asked whether they are donors upon admittance to a hospital; and (5) authorized the coroner to provide consent on behalf of the decedent in particular scenarios.

First, the UAGA of 1987, still in effect today, expanded the hierarchical list of people capable of providing donative consent on behalf of the decedent by adding grandparents.⁴⁴ This theoretically increased the number of people physically available to provide consent during the donative window of time, thus increasing the likelihood that a decedent becomes a donor. In addition, it made make up for the many presumptive donors who wished to donate but who did not act to designate themselves as donors due to a lack of education concerning opt-in procedures.

Second, the UAGA of 1987 expanded the ways in which a person could express donative intent. Now, a person eighteen or older could make an anatomical gift for the purposes expressed in the 1968 version generally, or designate one or more specific purposes listed in the 1968 version.⁴⁵ For example, an individual could decide to donate on the condition that his or her donation would be used only to provide an organ for another living person in need and not for medical research. By allowing a presumptive donor to express donative intent according to specific conditions reflective

⁴³ Siegel, *supra* note 29, at 933.

⁴⁴ Unif. Anatomical Gift Act § 3(a)(5) (1987).

⁴⁵ Unif. Anatomical Gift Act §§ 2(a)(i)-(ii) (1987).

of his or her particular intentions, the hope was that more people would be willing to donate.

Third, the UAGA of 1987 clarified the implications of failing to act affirmatively to express donative intent.⁴⁶ Specifically, the UAGA of 1987 stated that medical personnel was allowed to ask parties on the hierarchical list to provide consent on behalf of the decedent if a decedent failed to act affirmatively to express donative intent and also failed to act affirmatively to express intent contrary to donation.⁴⁷ In the UAGA of 1968, it was understood that medical personnel possessed authority to ask parties on the hierarchical list for consent. In contrast, the UAGA of 1987 used express language to create this authority within medical personnel. The addition of the express language in the 1987 version added clarity to the Act which, in turn, provided additional security for the people affected by the Act.

For example, parties on the hierarchical list were now able to know that the decedent never acted to express intent contrary to donation, if the parties on the hierarchical list were approached by medical personnel for consent. If the decedent had expressed contrary intent, medical personnel were not allowed to ask parties on the hierarchical list for consent. As a result, parties on the hierarchical list would be afforded additional security in their decisions when providing consent on behalf of the decedent. The security came from knowing that the decedent never expressed intent contrary to donation, if the process for obtaining consent from third parties reached the point where the parties were approached by medical personnel to provide consent. This additional security, in turn, allowed more consents to be provided.

Fourth, the UAGA of 1987 mandated that all individuals eighteen and over admitted to a hospital be asked upon admittance whether they were donors.⁴⁸ This therefore targeted a subpopulation that had never before been targeted by organ donation regulation laws in the United States. Moreover, an answer in the affirmative from someone who had never before expressed donative intent, equates to one new donor. As a result of this requirement, the number of donors increased.⁴⁹ The increase is significant due to the large number of people who enter a hospital annually, many of whom likely had never contemplated donating before. What is more, of all presumptive donors who die, many die after being admitted into

⁴⁶ Unif. Anatomical Gift Act § 2(i) (1987).

⁴⁷ Unif. Anatomical Gift Act § 3(a) (1987).

⁴⁸ Unif. Anatomical Gift Act § 5(a) (1987).

⁴⁹ Due to the increased number of individuals who were targeted and subsequently required to affirmatively state their decision regarding organ donation, additional numbers of individuals responded that they would like to be donors, as opposed to the time when this entire subpopulation was not expressly questioned at all.

a hospital. Logistically speaking, it is a logical subpopulation to target when granting medical personnel authority to expressly ask particular individuals whether they are donors.⁵⁰

Fifth, the UAGA of 1987 granted coroners the ability to provide consent on behalf of the decedent.⁵¹ The coroner or medical examiner “may release and permit the removal of a part from a body within that official’s custody, for transplantation or therapy...”⁵² This authorization is allowed only after two requirements have been met. First, a reasonable effort to locate the parties on the hierarchical list must have failed. Case law illustrates the ambiguity within the term “reasonable effort,”⁵³ which has unfortunately permitted some decedents to become donors after coroners made very little, if any, effort to obtain consent from family members who would have objected.⁵⁴ Second, the official must be unaware of any contrary indication or refusal to donate made by the decedent or parties on the hierarchical list.⁵⁵ This expansion of the coroner’s ability to presume consent significantly increases the number of donations made.

Together, the UAGA of 1968 unified many different attempts at regulating organ donations while simultaneously serving as the scaffolding required to support the 1987 version. The latter version, in response to the shortfalls of the 1968 version, increased the number of organ donors, thereby alleviating the organ shortage. However, even after the adoption of the 1987 version, the organ shortage in the United States remains, as illustrated by the monumental discrepancy between the number of organ donors and the number of individuals awaiting donations.⁵⁶ While the discrepancy has lessened through the implementation and subsequent

⁵⁰ In 2009, donations were made from 8,022 decedents. Of those, 3,179 were made by patients who died of a stroke. In addition, 2,669 of the total number of donations were made by patients who died from head trauma. Both of these causes of death tend to bring patients into the confines of a hospital prior to the announcement of death. So long as the patients are legally competent, and age eighteen or older, they are able to provide consent to donate upon admittance. Prior to the UAGA of 1987, this subpopulation of people were not expressly asked whether they intended to donate upon arrival at the hospital. U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES, ORGAN PROCUREMENT AND TRANSPLANTATION NETWORK, <http://optn.transplant.hrsa.gov/latestData/rptData.asp> (last visited Dec. 1, 2010).

⁵¹ Unif. Anatomical Gift Act § 4 (1987).

⁵² Unif. Anatomical Gift Act § 4 (1987).

⁵³ *Georgia Lions Eye Bank, Inc., v. Lavant*, 355 S.E.2d 127, 127 (1985) (the parents of the infant, who served as a donor, had not expressly objected to their infant child serving as a donor; however, “there was no notice of the intended removal, nor any realistic opportunity to object”).

⁵⁴ *Id.*

⁵⁵ Unif. Anatomical Gift Act §§ 4(a)(2)-(3) (1987).

⁵⁶ UNITED NETWORK FOR ORGAN SHARING, <http://www.unos.org/> (last visited Dec. 1, 2010).

revision of the UAGA, the opt-in approach is only capable of going so far. In the end, it permits a significant percentage of the population to avoid ever contemplating the idea of donating. In addition, it permits decedents to never be considered donors only as a result of their inaction to declare donative intent, regardless of their underlying desire to donate. Alternatively, studies of countries abiding by the opt-out approach indicate significantly smaller discrepancies between organ donors and those awaiting donations.

II. OPT-OUT APPROACH SIGNIFICANTLY MINIMIZES DISCREPANCY BETWEEN DONORS AND INDIVIDUALS NEEDING ORGAN DONATIONS

The opt-out approach, thoroughly explained in Samantha Wilcox's law review article discussing the impact of opt-out laws in Pennsylvania⁵⁷, is the opposite of the opt-in approach.⁵⁸ The opt-out approach states that at the time of death, decedents are automatically potential organ donors unless the person has "opted-out" by expressing opposition to donation through a specific affirmative step taken at some point during his or her lifetime.⁵⁹ The opt-out approach successfully increases the number of available organs.⁶⁰ Additionally, countries that use an opt-out approach have a higher proportion of multiorgan donors in comparison with countries that utilize an opt-in approach.⁶¹ The level of success is correlated to the type of opt-out approach that a particular country adopts.⁶² For example, countries such as Austria, France, and Singapore have adopted a strict form of the opt-out approach,⁶³ meaning that no consideration is given to the wishes of family members of the decedent at, or after, the time of death. Alternatively, softer forms of the opt-out approach may consider objections made by family members following a person's death, although no efforts are made to seek out the family members at the time of death in any variation of the opt-out approach.⁶⁴ Because the softer forms require additional opportunities for intent contrary to donation to be considered, they result in fewer donations overall when compared to stricter forms.⁶⁵

⁵⁷ Wilcox, *supra* note 3, at 935.

⁵⁸ Richards, *supra* note 9, at 378.

⁵⁹ Wilcox, *supra* note 3, at 938.

⁶⁰ *Id.*

⁶¹ Paul Michielsen, *Presumed Consent to Organ Donations: 10 years' experience in Belgium*, 89 J. ROYAL SOC'Y MED. 665, 665 (Dec., 1996).

⁶² Wilcox, *supra* note 3, at 938.

⁶³ Richards, *supra* note 9, at 389-92.

⁶⁴ Wilcox, *supra* note 3, at 938.

⁶⁵ *Id.* *But see id.* at 939 (suggests that the positive results obtained in countries that utilize the strictest forms of the opt-out approach may be attributable to "alternative

A. *Strict Opt-Out Approach Allows for the Largest Number of Donors Per Capita*

Austria's approach is the strictest among all countries that have adopted an opt-out approach.⁶⁶ In fact, the physician attending to the decedent is under no obligation to discuss the donation with the decedent's family. The only way a decedent would not be considered a donor is if the person, while alive, affirmatively objected to donation in such a way that at the time of death, the attending physician was unequivocally aware of the decedent's prior objection.⁶⁷

This strict approach to opting-out explains why Austria has the highest rate of cadaver donors per year.⁶⁸ Specifically, Austria has the highest mean retrieval rate per million inhabitants for kidneys, hearts, livers, pancreases, and lungs out of all countries that have adopted the opt-out approach.⁶⁹

In countries that adopt the opt-out approach, including Austria, there is minimal, if any, apprehension toward the approach expressed by the public.⁷⁰ The lack of apprehension, combined with the default rule that all citizens are organ donors, has undoubtedly allowed countries with an opt-out approach to significantly surpass the United States in decreasing the gap between the number of organs donated and the demand for organs.

1. *Strict Opt-Out Approach Raises a Range of Concerns*

This gap remains prominent in the United States due to the opposition toward the opt-out approach expressed among particular citizens of our country. Four main concerns have developed among Americans. First, an opt-out approach may raise significant moral concerns if implemented within our country's unique set of ideals. Second, many people remain ignorant about issues relating to organ donation and, as a result, a large number of people who oppose donation may be unaware of their right to opt-out if the United States were to adopt the opt-out approach. Third, the opt-out approach may encroach on the religious freedom promised to Americans through our Constitution. Fourth, concerns have been expressed wherein adopting such a supportive attitude toward donation

sources, such as increased hospital participation, more active transplant teams, and public education campaigns.”).

⁶⁶ Teagarden, *supra* note 12, at 725.

⁶⁷ *Id.*

⁶⁸ Wilcox, *supra* note 3, at 938.

⁶⁹ Michielsen, *supra* note 60.

⁷⁰ *Id.* at 666.

may coincide with premature determinations of death for the purposes of transplanting needed organs into waiting patients. While each concern has its merits, increasing education surrounding the opt-out approach and its corresponding procedures would minimize concerns, as discussed *infra*. This would subsequently allow our country to adopt the opt-out approach which would minimize the discrepancy between donors and needed organs.

a. Moral Concerns

The first concern related to adopting an opt-out approach in our country considers moral challenges. Specifically, the concern states that adopting the opt-out approach would be taking advantage of Americans who are not inclined to act affirmatively one way or another to express their beliefs regarding donation.⁷¹ The numbers taken through polls in 1985 and 1993⁷² indicate that a high percentage of Americans not only support the idea of organ donation, but claim they wish to personally serve as donors. Although, the percentage of Americans that has acted affirmatively in response to their beliefs has been significantly less.⁷³ This discrepancy illustrates that Americans hold beliefs they are unwilling to support through affirmative expression. What is more, it seems immoral to take advantage of Americans' unwillingness to affirmatively support their beliefs.⁷⁴

However, the response to this concern is significant. In fact, the opt-out approach is the perfect solution to Americans' failure to act affirmatively to back up the beliefs that they truly possess. By making organ donation the default rule we are eliminating the requirement that Americans must act affirmatively in order for their desires to donate to be honored. As a result, the opt-out approach makes it easier for Americans to have their desires to donate granted. For those who feel strongly against donating, it follows that a strong desire not to donate would be enough for a person to act affirmatively to opt-out. Thus, the opt-out approach allows the default to be a rule that significantly alleviates the tragedy associated with the high number of deaths of individuals awaiting donations.

Moreover, by adopting an opt-out approach, a corresponding transfer in responsibility from the decedent's family to the attending physician occurs, regarding whether to make an organ donation. In the

⁷¹ Richards, *supra* note 9, at 387.

⁷² 1985 and 1993 Gallup Polls.

⁷³ *Id.*

⁷⁴ Liddy, *supra* note 15, at 844. John Stuart Mill explains that any society that engages in regulating an individual's right of self-determination, is a society wherein the people are not truly free. This freedom is lost to the regulation of individual rights which, as a result, conforms coercive regulation regardless of the form of government in place within the society. The coercive regulation in effect does not respect individual rights. *Id.*

instance wherein a decedent has not acted affirmatively during his or her lifetime to declare donative intent within our current opt-in approach, the decedent's family is forced to make the untimely decision on behalf of the decedent. The pressure of this decision is undeniably difficult for the family members of a decedent. Being forced to make this decision mere moments after a person dies seems nearly inhumane, and thus immoral in its own way. Alternatively, the opt-out approach takes this difficult step out of the family's hands and places it into a physician's hands, leaving the family to mourn the loss of the decedent absent the pressure of having to make such a significant decision.

b. Procedural Concerns

The second major concern regarding adopting an opt-out approach relates to Americans' ignorance in regards to organ donation generally. This ignorance becomes particularly problematic when people in an opt-out approach do not wish to donate but who are nonetheless unaware of the requirement of making an affirmative action to express their decision. This concern has strong ties to the concern listed above. Particularly, if an opt-out approach were adopted in the United States, Americans who do not wish to donate may nonetheless be presumed to be donors only as a result of their failure to act affirmatively to express their decision. However, distinguishable from the concern posed above, this subset of Americans who would fail to act affirmatively would not do so out of laziness, but rather, out of ignorance of the issue of organ donation and specifically ignorance concerning the procedure required to express their decision.

While sympathy would exist for individuals mistakenly believed to be organ donors in an opt-out system only as a result of their procedural ignorance, the sympathy should not be overstated. It is fair to hold people to possess a particular level of awareness in relation to their own health and to the inevitability of death. Particularly in the United States, one's own death seems to be a topic too taboo to discuss. However, this is not a reason sufficient enough to hold that as a result, we should not be held to take a moment to contemplate what we wish to be done with our organs *when* we die (not *if* we die). Furthermore, as discussed below, providing Americans with education surrounding opt-out procedures would minimize this concern altogether.

This moment of contemplation should be expected of us, if not for the sole reason that most Americans expect that, should they ever be in the unfortunate position of needing an organ transplant, there will be someone willing to donate. In fact, it seems as though Americans believe it is their *right* to be considered as an organ donee, should they require an organ. It

follows from this feeling of entitlement to receive, that there should exist a responsibility to both consider being a donor and affirmatively expressing the decision made regarding donation.

In total, the opt-out approach does not take advantage of anyone's ignorance because a person's ignorance regarding this topic is, in the first place, unacceptable. Americans know that if we ever need an organ, we have the option of being considered as an organ donee. It follows that we should be held to know our rights concerning opting-out of an organ donation approach that requires an affirmative step to express intent contrary to donation.

c. Religious Concerns

The third concern with the opt-out approach considers the possibility that the approach may stifle religious freedom which, due to its tie to the Constitution, holds significant weight. The First Amendment states that the government is prohibited from interfering with an individual's right to exercise his or her religion.⁷⁵ It follows that any government action that interferes with an individual's religious freedom should be struck down for violating the Constitution. Therefore, the relationship between the protections afforded by the Constitution and the religions that prohibit donation may be problematic in adopting an opt-out approach. Specifically, several religions, including the Gypsy, Shinto, and Jewish religions, either prohibit donation generally or prohibit particular aspects inherent within donation.

For example, the Gypsies disagree with organ donation due to reasons relating to their belief in protecting the afterlife. They believe that a person's soul retraces its steps for one year after death. In order to do so, the body must remain intact so that it has the physical components necessary to make this journey during the afterlife.⁷⁶

Alternatively, the Shinto and Jewish religions view donation as a form of injury and mutilation to the dead. Specifically, the Shinto view donation as a serious crime because they believe it is equivalent to injuring a dead body.⁷⁷ Judaism, on the other hand, honors several specific burial rights that conflict with aspects of donation. The concept of "issur hana'ah"⁷⁸ prohibits deriving any benefit from a cadaver.⁷⁹ A related

⁷⁵ U.S. CONST. art. I.

⁷⁶ U.S. DEPT. OF HEALTH & HUMAN SERVICES, http://organdonor.gov/donation/religious_views.htm (last visited Dec. 1, 2010).

⁷⁷ *Id.*

⁷⁸ Translated, this phrase means "the prohibition against deriving any benefit from a dead body." *Id.*

concept, “kevirat hamet,”⁸⁰ holds that a decedent must be buried with all parts intact.⁸¹ In fact, doing otherwise is essentially mutilation of the dead, according to Judaism.⁸² Thus, due to the potential religious conflict inherent in adopting the opt-out approach in the United States, proponents of its adoption suggest including an express exemption for religious purposes.⁸³ Supplemental to that, increased education surrounding opt-out procedures would help alleviate opposition to the approach based upon protecting religious freedom.⁸⁴

d. Ethical Concerns

Lastly is the concern that the opt-out approach will influence physicians to prematurely announce the death of a presumptive donor so that his or her organs may be removed and transplanted to an awaiting presumptive donee. However, several measures exist to assure this would never happen. First, all fifty states as well as Washington, D. C., have adopted the Uniform Determination of Death Act (UDDA), which recognizes death at the time when the brain irreversibly ceases to function.⁸⁵ Second, the relationship between those who provide medical care for the patient and those who extract organs or tissue from the decedent for transplantation purposes is specifically designed to protect the health and safety of the patient first and foremost.

Advancements in medical technology have allowed for humans to be kept alive using life supporting equipment; however, these advances have blurred the line between life and death. The UDDA states that “an individual who has sustained either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the entire brain, including the brain stem, is dead.”⁸⁶ The UDDA goes on to say that each states’ medical association should develop and adopt hospital policies and protocols that reinforce the definition of death provided in the UDDA.⁸⁷

⁷⁹ Khalil Jaafar Khalil, *A Sight of Relief: Invalidating Cadaveric Corneal Donation Laws Via the Free Exercise Clause*, 6 DEPAUL J. HEALTH CARE L. 159, 161 (2002).

⁸⁰ Translated, this means “the requirement to bury a dead person and all his parts in tact.” U.S. DEPT. OF HEALTH & HUMAN SERVICES, http://organdonor.gov/donation/religious_views.htm (last visited Dec. 1, 2010).

⁸¹ Khalil, *supra* note 78.

⁸² *Id.*

⁸³ Alexander Powhida, *Forced Organ Donation: The Presumed Consent to Organ Donation Laws of the Various States and the United States Constitution*, 9 ALB. L.J. SCI. & TECH. 349, 361 (1999).

⁸⁴ *See infra*, at Part III.C.

⁸⁵ Unif. Determination of Death Act (1981).

⁸⁶ *Dead Bodies*, 22A AM. JUR. 2D § 98 (1988).

⁸⁷ Unif. Anatomical Gift Act § 1 comment (1987).

The concept of brain death relates to studies seeking to determine exactly when a person has entered into an irreversible coma. These studies were first conducted in 1968 by an Ad Hoc Committee of the Harvard Medical School.⁸⁸ The results provided a particular collection of qualities that, when possessed together, signify the moment at which an individual has entered into an irreversible coma. These qualities include unreceptivity, unresponsiveness, and the absence of spontaneous movements, breathing, and reflexes.⁸⁹ Furthermore, these qualities must persist for a twenty-four hour period.⁹⁰ At that time, the cessation of the other organs becomes not only inevitable, but imminent.⁹¹

Cases involving anencephalic infants illustrate that physicians strictly adhere to the UDDA requirements concerning the unequivocal determination of death prior to removing organs for donation purposes.⁹² Anencephalic infants are born without most of their brain; however, the infants are capable of staying alive for a brief period of time after birth because they are born with a portion of their brain stem which allows them to breathe.⁹³ As a result, these infants are able to stay alive for up to a few months,⁹⁴ although because they do not physically possess other portions of their brain, there is no possible way they could ever be capable of higher brain functioning.⁹⁵

Over the course of their lifetime, the infants' respiratory system begins its slow progression toward complete failure.⁹⁶ By the time the infant satisfies the brain-death criteria naturally, the infant's organs have gone a period of time without receiving adequate oxygen such that their organs are incapable of being donated.⁹⁷ Moreover, donating infant organs serves a special purpose in society because 1,500 infants die each year while waiting for a transplant.⁹⁸ What makes this number so significant is that infants are physically capable of receiving organs only from other

⁸⁸ Ralph O. Wallerstein, *Brain Death*, 238 JAMA 1661, 1661-62 (Oct. 10, 1977).

⁸⁹ *Id.*

⁹⁰ *Id.*

⁹¹ *Id.*

⁹² *In re Estates of Perry*, 40 P.3d 492, 497 (Okla. App. Div. 3, 2001); *In re T.A.C.P.*, 609 So.2d 588, 588 (Fla. 1992); 1 HEALTH L. PRAC. GUIDE § 15:10 (2010).

⁹³ Philippe Ducor, *The Legal Status of Human Materials*, 44 DRAKE L. REV. 195, 216 (1995).

⁹⁴ *Id.*

⁹⁵ See Faber ES, *Functional Interplay Between NMDA Receptors, SK Channels and Voltage-Gated Ca²⁺ Channels Regulates Synaptic Excitability in the Medial Prefrontal Cortex*, 588 J. PHYSIOL. 1281, 1281-92 (2010).

⁹⁶ <http://law.jrank.org/pages/8948/Organ-Donation-Law-Should-Dying-Babies-Be-Organ-Donors.html> (last visited Dec. 1, 2010).

⁹⁷ *Id.*

⁹⁸ *Id.*

infants due to the small size of their bodies. Therefore, some individuals argue that, upon parental consent, an anencephalic infant should be able to donate organs prior to complete respiratory failure even though the infant still maintains some functioning of the brain stem.

However, the requirements for being capable of donation are not met by anencephalic infants. Specifically, anencephalic infants maintain the functioning of their brain stem and as a result, cannot be declared completely brain dead.⁹⁹ From a donative standpoint, it is unfortunate that the final declaration of brain death in an anencephalic infant cannot occur until after their slow respiratory decline. By that time, their organs are no longer capable of transplantation due to the time spent without adequate oxygen. However, the UDDA requirement of cessation of the entire brain prior to donation must be strictly enforced. This strict enforcement emphasizes the importance placed upon meeting all requirements of being “dead” prior to donation.

In addition to the incapability of anencephalic infants to serve as donors, the relationship between the physicians who declare a patient dead and the physicians who extract organs from a patient, also illustrates measures taken to assure premature death announcements, for donative purposes, do not occur. Specifically, the UAGA of 1987 requires that the physicians in charge of caring for the patient until the time of death are not allowed to participate in any decisions or procedures involved in organ donations, and vice-versa.¹⁰⁰ By requiring that the announcement of death and the subsequent removal of organs or tissues be conducted by two different groups of individuals, the Act insures that physicians will not prematurely declare death for the purpose of harvesting a patient’s organs.

B. Soft Version of the Opt-Out Approach Produces Fewer Donors but also Fewer Concerns than Strict Version and More Donors than Opt-In Approach

Pennsylvania pioneered a soft approach to opt-out legislation that concerns donations of particular parts of the body. It is considered a “soft approach” rather than a “strict approach” because the coroner must take specific steps prior to assuming donative intent that are not required from the strict approach. These steps serve as a condition precedent to the coroner’s ability to remove anything from the decedent’s body in a soft approach model. Pennsylvania Consolidated Statutes § 8641 of Title 20 states that

⁹⁹ Ducor, *supra* note 92.

¹⁰⁰ Unif. Anatomical Gift Act § 8(b) (1987).

On request from an authorized official of an eye bank for corneal tissue, a coroner or medical examiner may permit the removal of corneal tissue if all of the following apply:

(1) The decedent from whom the tissue is to be removed died under circumstances requiring an inquest.

(2) The coroner or medical examiner has made a reasonable effort to contact persons listed in section 8611 (relating to persons who may execute anatomical gift).

(3) No objection by a person listed in section 8611 is known by the coroner or medical examiner.

(4) The removal of the corneal tissue will not interfere with the subsequent course of an investigation or autopsy or alter the decedent's postmortem facial appearance.¹⁰¹

The first element requires that a cadaver be subject to an autopsy prior to a coroner or medical examiner presuming donative intent.¹⁰² Although autopsy rates are difficult to calculate due to a lack of systematic reporting, it has been estimated that autopsies were performed on only 8.3% of cadavers in 2003.¹⁰³ Therefore, the first requirement of the Pennsylvania Statute significantly decreases the number of decedents, not already legally recognized as donors, capable of being considered for corneal tissue donation.

The second element of the Pennsylvania Statute requires that a reasonable effort be made to contact individuals listed in section 8611 who are able to provide donative consent on behalf of the decedent.¹⁰⁴ These individuals include the decedent's spouse, guardian at time of death, adult son or daughter, adult brother or sister, either parent of the decedent, or any other person with authority or obligation to dispose of the body.¹⁰⁵ The list of individuals is rather extensive, affording the coroner or medical examiner ample opportunity to be able to contact at least one individual on the list. However, section 8641 fails to expressly state the purpose behind the coroner or medical examiner making an effort to contact the individuals listed in section 8611. Consequently, two different interpretations of section 8641 exist, each of which could potentially result in a significantly different outcome than the other. On the one hand, a coroner could understand the purpose of contacting the individuals listed in section 8611 as being to gain consent on behalf of the decedent to donate corneal tissue.

¹⁰¹ 20 Pa.C.S.A. § 8641 (1994).

¹⁰² 20 Pa.C.S.A. § 8641(1) (1994).

¹⁰³ Elizabeth C. Burton, *Autopsy Rate and Physician Attitudes Toward Autopsy*, EMEDICINE, <http://emedicine.medscape.com/article/1705948-overview> (last updated Apr. 8, 2010).

¹⁰⁴ 20 Pa.C.S.A. § 8641(2) (1994).

¹⁰⁵ 20 Pa.C.S.A. § 8611(b) (1999).

Therefore, the “reasonable effort” could be understood to be sufficient as soon as one individual provides consent, meaning there would be no purpose to continue trying to contact other individuals on the list. Alternatively, and in conjunction with the third element of the statute, the coroner could understand the purpose of contacting the individuals as being to determine that no one listed in section 8611 objects to the decedent serving as a corneal tissue donor. This understanding would seem to imply that a reasonable effort be deemed sufficient only after every person on the list is attempted to be located, since any one individual could provide an objection. Furthermore, section 8641 does not address whether the coroner must attempt to contact the individuals listed in section 8611 in any particular order, which adds more ambiguity to the coroner’s responsibility provided in the second element of section 8641.

In addition, exactly what conforms a “reasonable effort” has been subject to debate, not only in Pennsylvania, but in other states that have adopted similar soft approaches to corneal tissue donation as well, such as California. For example, in *Newman v. Sathyavaglswaran*, the California Supreme Court ruled that further consideration should be afforded to the appropriateness of allowing a coroner to remove corneal tissue from a child decedent, when the parents are not notified beforehand.¹⁰⁶ An amendment was made to the applicable California law in 1998, requiring the coroner to obtain written or verbal consent from the next of kin before removing corneal tissue from the decedent.¹⁰⁷

It is likely that the attempts made are required merely to be “reasonable,” rather than “successful,” due to the fact that corneal tissue is particularly perishable. As a result, a decision regarding removal of the tissue must be made very soon after the decedent’s death in order for there to exist an opportunity to transplant the tissue prior to the point wherein it is no longer transplantable. Thus, the “reasonable effort” standard honors the next of kin’s property right in the decedent’s body,¹⁰⁸ while simultaneously honoring presumptive donees whose vision can be restored through corneal donations.¹⁰⁹

The third element of the Pennsylvania Statute requires that neither the coroner nor medical examiner know of any objection made by an

¹⁰⁶ *Newman v. Sathyavaglswaran*, 287 F.3d 786, 786 (9th Cir. 2002). Interestingly, prior to the decision in this case, the practice of removing corneal tissue without consent was discontinued due to associated studies that revealed that the practice was having a disproportionate impact on non-Caucasian people. *Id.*

¹⁰⁷ *Id.*

¹⁰⁸ *Georgia Lions Eye Bank, Inc., v. Lavant*, 355 S.E.2d 127, 127-29 (1985) (Georgia Supreme Court held that eye bank officials did not violate the parents’ property interests when they removed the corneal tissue of the parents’ deceased infant).

¹⁰⁹ Khalil, *supra* note 78, at 162.

individual capable of providing donative consent on behalf of the decedent.¹¹⁰ This element appears to further limit the opportunity for a coroner to provide donative consent on behalf of the decedent. Typically, the individuals on this list are capable of providing donative consent on behalf of the decedent; however, in this particular statute, their authority is expressly provided as relating to their ability to make objections to donations on behalf of the decedent. While this seems to protect the decedent from being mistakenly assumed to be a corneal tissue donor, ambiguity within the clause appears to dilute this protection. Specifically, the clause does not address the objection itself. It therefore remains unknown whether it is sufficient for the third party to object to donation generally, or rather, whether the third party must object specifically to corneal tissue donation.

The fourth element of the Pennsylvania Statute requires two things. First, the removal of the corneal tissue cannot interfere with the autopsy.¹¹¹ However, due to the minimal invasion into the body that corneal tissue removal requires,¹¹² it is unlikely that the procedure would interfere with an autopsy. Second, the removal cannot alter the decedent's facial appearance.¹¹³ Again, the minimal invasion into the decedent's body likely does not result in an alteration of the facial appearance of the decedent. However, speculation may surround the purpose of this element. For example, it could be argued that the purpose of this element is essentially to hide the fact from the decedent's family that the decedent's corneal tissue has been removed.¹¹⁴

Responses to this criticism, however, seem to provide a legitimate reason behind requiring that the procedure maintain the facial appearance of the decedent. For example, perhaps the coroner or medical examiner is in the best position to ensure that the family does not have to contemplate undertaking this decision during a fraught time. Moreover, it is not "hiding" anything from the family, because the family has the preemptive

¹¹⁰ 20 Pa.C.S.A. § 8641(3) (1994).

¹¹¹ 20 Pa.C.S.A. § 8641(4) (1994).

¹¹² *State v. Powell*, 497 So. 2d 1188, 1190-91 (Fla. 1986). This court described the procedure of removing corneal tissue as requiring an "infinitesimally small intrusion" into the body of the decedent. *Id.*

¹¹³ 20 Pa.C.S.A. § 8641(4) (1994).

¹¹⁴ However, certain groups of people may value that a decedent's donation is not visible to other people. In particular, religious objections concern beliefs that a body should be buried "whole." The element of the Pennsylvania statute that requires maintenance of facial appearance allows those who see the decedent after death to have the impression that the decedent's body is, in fact, left "whole." For some, the *appearance* of "wholeness" will be a sufficient solution to religious objections. See Goodwin, *supra* note 16, at 331.

right to know and understand the donation laws of their respective state. Every family should understand that, if they reside in a state that follows an opt-out approach to any type of organ or tissue donation, a decedent's body may be used for transplant purposes unless the decedent him or herself objected to donation during his or her lifetime. Furthermore, family members of the decedent are welcome to inquire about donations made by the decedent, should they wish to know.

III. INCREASED EDUCATION ADDRESSES A RANGE OF CONCERNS REGARDING THE OPT-OUT APPROACH

Each moral, procedural, and religious concern could be addressed by incorporating increased education surrounding the opt-out approach itself, as well as the corresponding procedures. While other countries currently utilizing the opt-out approach do not highlight this educational requirement, this is a requirement our country will need to adhere to as a result of the additional freedoms we afford our citizens.

In particular, Americans pride themselves in living within a country that affords each individual specific rights. Assuming each individual is a donor may be viewed as simultaneously taking away the right each individual possesses in determining how they want their remains handled after they die.¹¹⁵ As a result, a default rule designating each individual as a donor may impede on important rights such that adopting an opt-out approach would be immoral. Additional morality concerns relate to Americans' ignorance regarding the procedure required to opt-out. It is possible that this ignorance may be taken advantage of in order to create more donors. Another right we afford Americans is the right of religious freedom. This right correlates with particular concerns related to the opt-out approach, as discussed supra¹¹⁶. However, if the United States wishes to take after the countries that have obtained the results we strive for regarding decreasing the discrepancy between donors and individuals needing organs, the United States must adopt some form of the opt-out approach.

Increased education must continually stress exactly what an opt-out approach is, as well as exactly what it is not. The opt-out approach establishes donative intent in every individual through a default rule that works in conjunction with an opt-out option. Thus, each person is

¹¹⁵Karen Edelman Clarke, *The Washington Hospital Center Example: A Hospital's Guide to Implementing the Rapid Organ Recovery Program*, 16 J. CONTEMP. HEALTH L. & POLY 501, 515 (2000). *See also*, WISCONSIN – ADVANCE DIRECTIVE FORM, available at <http://www.caringinfo.org/UserFiles/File/Wisconsin.pdf>.

¹¹⁶*See generally*, Part II.A(1)(c).

essentially given the choice between choosing to be a donor and choosing not to be a donor. The opt-out approach merely requires those who do not wish to be a donor to complete a simple affirmative act reflective of their contrary intent to donation. What the opt-out approach is not, is an approach that forces everyone to be an organ donor. Additionally, the opt-out approach is not an approach that takes away an individual's ability to freely express his or her religion or to hold moral and ethical viewpoints that are contrary to organ donation. Rather, for the approach to work in a way that respects autonomous decisions regarding donative intent, all that must be emphasized is education surrounding the simple opt-out procedures. This would guarantee that moral, procedural, and ethical concerns be minimized while religious freedom remains protected.

A. Increased Education Responds to Moral Concerns

Forming educational programs surrounding the opt-out approach can work to minimize moral concerns presented in Part II.A(1)(a). These concerns relate to Americans' current failure in expressing donative intent.¹¹⁷ As a result, it is possible that Americans who do not wish to donate will also fail to act affirmatively to express intent contrary to donation, required in the opt-out approach. Failure to act affirmatively to express contrary intent in an opt-out approach, in contrast to an opt-in approach, results in an individual becoming a donor. This result could be viewed as taking advantage of Americans not inclined to act affirmatively one way or another. Of course, some might argue that it is particularly immoral to take advantage of these Americans in a way that infringes upon their right to keep their body "whole" after death. Whereas it is one thing to presume an individual who has not acted affirmatively is *not* a donor, as in the opt-in approach, it is a whole other story to presume that an individual who has not acted affirmatively *is* a donor. This difference rests upon the invasion into the decedent's body that occurs only when we presume donation, rather than when we presume intent contrary to donation. Therefore, legally permitting inaction to signify consent to this invasion into a decedent's body may be viewed as immoral.

However, this Article argues that allowing inaction to signify consent is not immoral, but rather, is a necessity in decreasing the number of preventable deaths which are, in their own way, immoral. The immorality connected to the idea of excusing preventable deaths, should be of utmost concern when establishing an approach to organ donation. Specifically, the primary goal of adopting an approach to organ donation

¹¹⁷ 1985 and 1993 Gallup Polls.

should be to decrease the discrepancy between donors and individuals needing organs. The secondary goal should be to accomplish this in a way that respects individual rights. Adopting an opt-out approach accomplishes the primary goal more so than the opt-in approach. Furthermore, with increased education surrounding the opt-out approach and its corresponding procedures, the secondary goal is met as well.

If it is important enough to an individual to refrain from being an organ donor, it should be just as important to that individual to take the initiative to opt-out. If each individual is educated regarding the opt-out approach and its corresponding opt-out procedure, the only reason an individual would be recognized as a donor against their genuine desire not to donate would be because that individual willingly chose not to opt-out. Keeping the primary goal of adopting a particular approach to organ donation in mind, if an individual willingly chooses not to act affirmatively to express their underlying intent, the particular approach should not be expected to nonetheless respect the individual's underlying intent.. Just as humans cannot read the minds of other humans, it should not be expected that an approach to organ donation be able to read the minds of the individuals it effects. With such minimal steps required to express intent contrary to donation, an individual should be held to the requirement of acting affirmatively in an opt-out approach if he or she wishes to have his or her underlying desire against donation honored. Educating each individual on the opt-out procedure transfers the responsibility to the *individual* to opt-out if he or she so chooses, such that failure to do so may still morally allow for the assumption that the individual consents to donation.

A crucial aspect of this theory, however, is that education surrounding the opt-out approach and its corresponding procedures be provided to every single individual. This way, failure to affirmatively act to express intent contrary to donation can fairly be understood to signify an individual's donative intent, or conscious decision, not to opt-out, rather than ignorance of the requirement to opt-out. Of course, educating every individual about the opt-out approach may be too lofty of a goal. To accomplish this goal, education would have to come in nearly an infinite amount of formats. It would have to be understood by each individual, regardless of the language he or she speaks, his or her age, intellect, and level of comprehension. Furthermore, it would have to be presented to individuals everywhere, whether they reside in the heart of Manhattan or in the extreme isolation of the Rocky Mountains. To claim that this is possible would be failing to take into consideration all that is required to accomplish the goal of providing education to each and every individual.

However, while failing to educate each individual would simultaneously be infringing on their right to determine what they wish to

have done with their body after they die, this Article maintains that forfeiting that right for some individuals is balanced by the right of other individuals to receive organs necessary for their survival. After all, the most isolated or incompetent individuals are incapable of knowing other rights as well. In this situation, their ignorance is indirectly capable of saving lives.

B. Increased Education Responds to Procedural Concerns

Currently, our opt-in procedures do not allow all of those who support organ donation to become organ donors, as reflected in statistics collected through the 1993 Gallup polls.¹¹⁸ This idea reflects the lack of education put out into the community surrounding the opt-in procedures. Alternatively, if we switch to an opt-out approach, those who currently support donation but have not acted affirmatively to do so would become donors by default. Simultaneously increasing the amount and frequency of education provided to the community would also allow current non-donors to be forced to consider donation, many of whom would consider it for the first time. Overall, the switch to the opt-out approach, as well as the increased education provided to the community, would work to create an overall increase in the number of donors within our country.

Additionally, it is our responsibility as American citizens to know our rights and to know the laws. Just as not knowing a criminal law is not an accepted excuse for not abiding by it, not knowing the laws and procedures surrounding an opt-out approach should not be a reason to label it procedurally unjust.

C. Increased Education Responds to Religious Concerns

If the United States were to adopt an opt-out approach, the country would be forced to supplement the adoption with increased education surrounding opt-out procedures due to the religious freedom our country promises its citizens and the possibility of the opt-out approach infringing on this freedom. The increased education should therefore be focused particularly at religious communities. In turn, overall resistance from the public regarding an opt-out approach may be decreased. Minimizing resistance may allow the opt-out approach to function more efficiently, as countries that currently use the opt-out approach are conformed of communities that do not express apprehension or negative attitudes toward the approach.¹¹⁹

¹¹⁸ 1993 Gallup Poll.

¹¹⁹ Michielsen, *supra* note 60, at 666.

Criticisms of this technique include its inability to reach every individual who may have a potential religious objection to donation. Specifically, not every religious individual belongs to a religious organization or establishment and therefore, those who do not may not be targeted by this technique. Hopefully, however, increased education to the population in general would reach individuals that do not belong to a religious organization or establishment.

D. Increased Education is Essential Regardless of Which Approach is Used

Increasing education relating to affirmative actions required to express either donative intent, in an opt-in approach,¹²⁰ or intent contrary to donation, in an opt-out approach,¹²¹ would help assure that individuals' underlying desires are honored upon death. Two approaches illustrate how to provide more educational opportunities. First, an individual approach can seek to provide education through creating educational requirements that must be met in order for an individual to obtain particular goals. Second, an institutional approach can seek to increase education among all individuals belonging to an institution by requiring the institution as a whole to receive and provide education to its members.

1. Education Provided Through an Individual Approach

An individual approach would be able to, ideally, require that education serve as a condition precedent to reaching particular events that individuals in our country value. For example, obtaining a minimum amount of education surrounding the opt-out approach and its corresponding procedures could serve as a condition precedent to obtaining a high school degree, receiving tax returns, passing a driver's test, visiting a doctor, or applying for health insurance. In particular, it seems logical to require health care applicants to receive a minimum level of education relating to organ donation upon adhering to new health care laws. Because these health care laws require applicants to apply for health care coverage annually, individuals could be kept up to date with current trends and changes in organ donation laws and approaches by being required to meet educational requirements each year. Although this educational requirement would utilize various resources and create additional costs, it must be made available in order for our country to effectively adopt an opt-out approach

¹²⁰ Bernard T. Kwitowski, *Learning From Each Other: Combining Strategies to End the Organ Shortage*, 9 J. MED. & L. 141, 144 (2005).

¹²¹ Teagarden, *supra* note 12, at 699.

while simultaneously continue to respect the unique freedoms our country affords its citizens.

2. Education Provided Through an Institutional Approach

Distinct from the approach that seeks to target individuals, the institutional approach seeks to target individuals on a larger scale. Specifically, by creating educational requirements at an institutional level, costs of providing education may be decreased. This can be accomplished by targeting entire groups of individuals, such as individuals who belong to religious organizations or establishments, as well as through adopting state statutes that create minimum education requirements for all state residents.

Institutions, especially religious communities that may have a particularly high interest in opting-out, can be targeted as a whole in regards to educational requirements through specific avenues unique to the institution. For example, religious organizations and establishments have a unique status in American society that incorporates distinctive treatment under tax law.¹²² To receive this special treatment, religious organizations and establishments must follow specific tax filing procedures. Therefore, by creating a condition precedent, in the form of a completed educational requirement, to receiving tax breaks, it can be assured that religious organizations and establishments will receive education regarding opt-out procedures. Using the avenue of tax procedures to provide education to religious organizations and establishments can increase the likelihood that religious populations, likely to possess intentions contrary to donation, become educated regarding their right to opt-out and exactly how to express this intent.

In addition to targeting institutions specifically, states may adopt statutes that create educational requirements that target residents of an entire state. Delaware state law currently utilizes the institutional approach while illustrating the importance behind educating the public about organ donation and corresponding procedures. The state law reveals that regardless of whether an opt-in or opt-out approach is used, education surrounding procedures to act affirmatively either way must be increased. Delaware currently requires that the state create a board to be in charge of particular duties related to meeting educational requirements.¹²³ These

¹²² INTERNAL REVENUE SERVICE, *Tax Guide for Churches and Religious Organizations*, <http://www.irs.gov/pub/irs-pdf/p1828.pdf> (2009).

¹²³ 16 Del.C.S.A. § 2730(a). This law requires that an Organ and Tissue Donor Awareness Board be created. Furthermore, the law states that

The members of the board shall include a representative of the

duties include developing donor awareness programs to educate Delaware residents on donor registration procedures.¹²⁴ Additionally, the law establishes a fund to be utilized to increase education surrounding organ donation awareness among Delaware residents and particularly among secondary school students.¹²⁵

Over time, studies of this law can reveal how it has impacted the number of organ donors in the state. However, regardless of the success the Delaware law will have on increasing the number of organ donors, unfortunately, the law is not capable of reaching the level of success our country could achieve if the United States were to switch to an opt-out approach.¹²⁶

CONCLUSION

Our country must make drastic changes to the approach used to deal with organ donations. Our current opt-in approach clearly fails to significantly minimize the discrepancy between donors and individuals needing organs.¹²⁷ Therefore, the solution to addressing this discrepancy lies within determining how to switch to an opt-out approach. Doing so would require considering the many moral, procedural, religious, and ethical concerns related to an opt-out approach; however, incorporating increased education surrounding the opt-out approach would sufficiently address these concerns. The disheartening reality is that there exist far more cadaver organs at any given time, than organs that are needed by individuals on the organ waitlist. Therefore, changes must be made such that these cadaver organs are made available to those in need. While requiring an organ for survival may seem like a scenario far removed from our daily lives, we ought to pay it great attention because in the time it took you to read this Article, approximately five individuals were added to the Organ Procurement and Transplantation Network's waitlist.¹²⁸ This is in addition

federally certified organ procurement organization serving Delaware, a representative of an eye bank located in Delaware, a transplant recipient, a donor family member, a physician having special interest in area of transplantation, a current officer, employee or board member of a Delaware acute care general hospital, 1 representative each from the Department of Health and Social Services, the Department of Education and the Division of Motor Vehicles.

Id.

¹²⁴ 16 Del.C.S.A. § 2730(b)(1).

¹²⁵ 16 Del.C.S.A § 2730(b)(1)-(2).

¹²⁶ Vanreterghern et al., *Effect of a Presumed Consent Law on Organ Retrieval in Belgium*, 22 TRANS. PROC. 2078, 2078-79 (1990). See Michielsen, *supra* note 60.

¹²⁷ Kwitowski, *supra* note 118, at 146.

¹²⁸ This estimation assumes it took the reader one hour to read this article. The estimation

to the more than 100,000 individuals already on the waitlist.¹²⁹ In total, as time progresses and the waitlist continues to grow, it becomes more likely that you will personally know someone on the waitlist, whether it be an acquaintance, a friend, a family member, or even yourself.

* * *

was made using a mathematical formula that incorporated numerical values taken from <http://optn.transplant.hrsa.gov/latestData/rptData.asp> (last visited Dec. 1, 2010). This website states that in 2009, 50,320 candidates were added to the Organ Procurement and Transplantation Network's waiting list. Therefore, on average, 5.74 candidates were added to the list each hour in 2009. *See id.*

¹²⁹ UNITED NETWORK FOR ORGAN SHARING, <http://www.unos.org/> (last visited Dec. 1, 2010).