A proposed solution to the present organ donation crisis based on a hard look at the past

MELANIE MILLER

The giving and receiving of a gift of enormous value is the most significant meaning of human organ transplantation. This extraordinary gift exchange, moreover, is not a private transaction between the donor and the recipient. Rather, it takes place within a complex network of personal relationships that extend to the families, the physicians, and all the members of the medical team who are involved in the operation. Within the network of these relations, a complex exchange occurs through which considerably more than the organ itself is transferred. . . . The donation of an organ is one of the most dramatic and supreme forms of gift giving extant in contemporary society.

Renee C. Fox and Judith P. Swazey
The Courage to Fail

The sense of a continuation or extension of life, a desire to help others through medicine and science, compensation for a suicide or the unnecessary deaths of others, and even a recycling of human life are all reasons given by donors and their families for the gift of their own organs or those of relatives upon death. Potential organ donors have also implied that participation in the life-giving heritage of organ donation provides a deeper understanding of the meaning of their lives and their place in the larger, cosmic life cycle or as Roberts describes, "the enduring mystery that out of death comes life." One mother expressed the feeling that her son, a multorgan donor, still participates in life: "I wanted the minister to get the message across loud and strong in his sermon at the funeral. My son was an outstanding leader and so there had to be some meaning in why God would take such a boy. . . . [This] transplant was the best substitute for his life."3

Families struggling to comprehend brain death, which defines death as a process and differs from the traditional concept of death as a "moment" in time, are often unwilling to consent to organ donation if no such instant of death has occurred. Organ donation has been called an alternative or solution by some families faced with the decision of whether and when to disconnect a relative from life-support systems or as some have expressed the fear of "playing God."

Organ donation is accepted by all major western religions today. Cwiek states that religion has come to recognize that the process of organ transplantation goes further than the totality of the individual and enhances the totality of mankind through the practices of charity and giving.

A national survey on American attitudes toward organ transplants and donation published in January 1985 revealed that one in three of 1518 individuals surveyed were likely to donate all their organs for transplantation. Three-fourths of those aware of organ transplants said they were likely to donate the organs of a relative, and almost half said they were likely to donate the organs of their own children. An astounding 86% said they had never been asked to contribute an organ.

Of 35 family members interviewed at the University of Minnesota Hospitals whose relatives had served as organ donors, 23 said that they were immediately open to the idea of organ donation when it was presented to them. In another survey, more than half of 264 donor families consented in less than one hour after being approached about the possibility of organ donation. Rarely do these families regret their decisions to permit the removal of transplantable organs of relatives; the majority almost always indicate that organ donation is the only positive aspect of their loss.

Studies and surveys repeatedly have shown a cooperative attitude on the part of the public toward organ donation and transplantation. And yet, in spite of this expressed willingness, the supply of transplantable organs has been grossly inadequate for years, and legislative, institutional, and private-sector attempts to increase their number have been unsuccessful.

This article will review legislative attempts to enhance organ donation by formalizing and legitimizing

From Washington University School of Medicine, St. Louis.
Address for correspondence: Melanie Miller, Managing Editor, Circulation, Washington University School of Medicine, 660 S. Euclid Ave., Box 8055, St. Louis, MO 63110.
Ms. Miller is a member of the Ethics Committee, Council of Biology Editors, Washington, D.C.

*Unpublished data provided by Jeffrey Prottas and Helen Batten, Brandeis University, presented at the Annual Meeting of the American Public Health Association on September 28, 1986.
voluntary donation in the United States and examine current proposals to do the same. An understanding of factors contributing to the success or failure of past efforts should help the community to design a better method of obtaining organ donations in this country and of bringing the supply of donor organs closer to the demand.

Current donation methods

The voluntary system. Before the 1950s, no statute in the United States authorized the removal of organs or tissues from living or deceased persons for transplant into another. Early attempts at organ donation were unsuccessful because delays caused by lengthy and complex legal proceedings deprived the transplantation process of urgency and timeliness. Today, all 50 states plus the District of Columbia have some form of legislation establishing procedures by which a person can donate organs for transplantation. Twenty-six states have enacted various forms of "routine request" legislation, which requires hospital and medical personnel to present families with the opportunity for organ donation upon the death of a relative.

The system of organ donation in the early years in the United States was a voluntary one based primarily on the expressed consent of the donors or their families. During the 1960s when organs for the first kidney transplants were obtained from living donors, legal emphasis was on the rights of an individual to make a gift of an organ as long as the donor was fully informed about the risks of the procedure and free from any type of coercion — social, emotional, or monetary. This informed consent approach is the foundation of the voluntary system by which most transplantable organs have been obtained to date in this country.

In 1968, the National Conference of Commissioners on Uniform State Law and the American Bar Association (ABA) drafted the Uniform Anatomical Gift Act (UAGA), an attempt to provide states with a model for recognizing and formalizing methods through which individuals or families could make a gift of their organs or those of a relative. The UAGA authorizes an individual 18 years of age and older, in the presence of two witnesses, to record his wishes regarding organ donation by will, donor card, or other written document before his death and authorizes the next of kin to consent to organ donation in the absence of a decedent’s known objection. The UAGA prohibits a physician from taking part in both the declaration of death and procurement of an organ from the same patient.

Although the voluntary system of donation depends on donor cards, living wills, and drivers’ licenses for recording the wishes of potential organ donors, only 2% of drivers who have the legislative authority to do so actually mark their licenses for these purposes. Only one state (Colorado) requires drivers to choose specifically whether or not they wish to become organ donors. Potential donors identified through other donor documents, such as wallet-size cards distributed by private organizations and institutions, account for a maximum of only 2% to 3% of organ donations at most each year. Very few people make arrangements for organ donation in advance, and even fewer carry donor documents regardless of their expressed willingness concerning organ donation.

Inability of hospital personnel and law enforcement officers to locate donor documents in emergency situations further frustrates the purpose of donor documents under the voluntary system. The National Heart Transplantation study revealed that only 10 states instruct their police officers to attempt to locate organ donor documents under appropriate circumstances.

The psychological difficulty in giving one’s organs away or drafting a living will that includes organ donation and forces a confrontation with one’s own mortality has been offered as one explanation for the disparity between the public’s stated willingness to donate organs and the implementation of these wishes. Stuart et al.7 explain that “the signing of a donor card is much more significant than responding in the affirmative to a pollster’s question about the willingness to donate.” One father who gave consent for his child to become an organ donor at death perceives society’s unfulfilled promises as follows: “Everyone knows about [organ] transplants and supports them but people don’t stop to think about where the organs actually come from.”

Lack of trust by physicians and hospital administrators in the legal validity and authority of donor documents and fear of lawsuits has been well documented. Unfortunately, it is not uncommon for hospitals and physicians to allow the wishes of the next of kin, if opposed to organ donation, to override those of the decedent despite the UAGA’s clear provisions that a relative’s veto of an organ donation is a violation of the Act and that a properly executed donor card is deemed to be a binding and legal document. In defense of the practice of honoring next of kin’s wishes, some experts believe that more aggressive confrontation of relatives opposed to organ donation may have an adverse effect on public attitudes. Although defensible by law, such a “tug of war” with family members could have an impact on the larger and more important issue of the continuing widespread willingness on the part of the public in general to donate in years to come.

Donor documents at best succeed in making known
the wishes of the decedent and help eliminate any doubts the next of kin might have. In addition, campaigns to distribute donor cards and recruit potential donors serve to stimulate public awareness regarding transplantation issues and need for a greater supply of organs. There is little hope, however, that this same voluntary system, even if further strengthened or fine-tuned, could ever deliver the number of donor organs needed in the United States.

The main purpose of the UAGA was to establish the authority of donor documents without the consent of the decedent’s next of kin. It was expected that by clarifying and outlining the procedures and rights of those involved in organ procurement and donation, the number of anatomic gifts would increase. Although all 50 states and the District of Columbia had adopted some form of the UAGA by 1973, the true goals of the Act have never been realized.7 It is now clear that the availability of organs via donor documents depends more on chance than on any defined statutory procedure — the chance that the wishes of a potential donor will be recognized, known, or even investigated at the time of his death; that donor documents will be located in time and that medical personnel will not violate the law by allowing the objection of next of kin to override the decedent’s consent; or that medical personnel will present the opportunity for donation to the potential donor’s family. Medical and hospital personnel, on the whole, have not followed or enforced the UAGA, nor has the UAGA succeeded in motivating the public to take sufficient action to ensure that an expressed desire to become an organ donor will be honored and implemented at death. Evans9 reports that today, “evidence clearly indicates that the UAGA has not succeeded in matching the supply of donor organs to the demand; demand still far exceeds the number of donor organs available.”

Brain death issues. The understanding, acceptance, and comfort with the concept of brain death by both medical personnel and laymen is essential to a successful organ procurement program.

Before the establishment of any legal or formal definition of brain death and because of increasing concern regarding civil and criminal liability in determining brain death, it was not uncommon for surgeons to turn off life-support systems, pronounce a patient dead, and then turn the system back on while the organ recipient was prepared for transplantation.10 Although physicians have always had the right and responsibility to determine death according to current medical practice in the community under common law, theoretically making a brain death statute unnecessary, uniform legislation would provide physicians, hospital staff, patients, and families with an expectation of compliance with legal standards of protection and an increased comfort level when dealing with brain death cases. Forty-four states now have either statutory recognition of brain death or appellate decisions that establish a diagnosis of brain death as sufficient for a pronouncement of death.

In 1968, the Ad Hoc Committee of the Harvard Medical School made a pioneer attempt to create guidelines for determining brain death in response to mounting pressures from the medical community. The Committee proposed that when use of the traditional definition of death was inconclusive (for example, where circulatory and respiratory functions must be supported by mechanical means), the diagnosis of irreversible coma should be used if all relevant tests and criteria were performed and observed twice within a 24 hour period and with the same results.

The Kansas-Maryland statutes, the first attempts at state legislation on brain death, were enacted in 1970 and 1972, respectively, when organ transplantations were still experimental. The main criticism of this model (the Maryland statute was adopted verbatim from the Kansas law) was that it appeared to favor the interests of organ recipients over those of potential donors.10

In 1972, the Task Force on Death and Dying of the Institute of Society and Ethics and the Life Sciences elaborated by specifying that the Harvard criteria should not replace the traditional means of determining death but instead should be used to complement it.10

The Capron-Kass model, the American Bar Association’s definition of death resolution, the National Conference of Commissioners on Uniform State Laws “Uniform Brain Death Act,” and the American Medical Association’s “Model Determination of Death Act” all attempted to codify conditions and criteria for the determination of brain death.10-12 In May 1980, the Uniform Determination of Death Act (UDODA) was drafted and ratified by the ABA, the AMA, and the National Conference of Commissioners on Uniform State Laws and endorsed by the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research.10-12

The UDODA states, “An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions or (2) irreversible cessation of all functions of the entire brain including the brain stem is dead. A determination of death must be made in accordance with accepted medical standards”10

This model differs from previous attempts by its
emphasis on the physiologic standards of determining brain death rather than operational criteria and medical tests and procedures, although the Commission did include an appendix to the Act summarizing the consensus of 60 nationally prominent physicians regarding currently accepted medical practice on the diagnosis of brain death. The AMA, until the drafting of the UDODA, had opposed any uniform legislation regarding brain death on the basis that criteria and diagnostic tests must constantly change to reflect the most recent advances in biomedical knowledge and technique.

The UDODA stands apart from all other organ donation legislation and decisions to terminate life-support systems. Like the UAGA, the UDODA also prohibits a physician from taking part in both the declaration of death and the procurement of organs from the same patient.

The UDODA was drafted to eliminate confusion, to resolve the ambiguities between and among all previous brain death definitions, and to provide uniformity in the determination of brain death, but because adoption of the uniform law is the prerogative of each state, the Act to date is not being used for its intended purpose. Only 22 states have adopted legislation patterned after the UDODA.

Despite the established validity of brain death with the cessation of life and to some extent its acceptance by society, uniform legal recognition of brain death as offered by the UDODA is crucial to protect medical professionals, donor families, and patients and to support the advancement of organ transplantation.

The National Organ Transplant Act (NOTA), signed into law by President Reagan in 1984, provided for the establishment of grants to existing organ procurement and matching programs and organizations to strengthen and expand their activities in the United States, particularly in the private sector. The NOTA established the Office of Organ Transplantation and a 25 member Task Force comprising physicians, sociologists, economists, theologians, health insurance representatives, attorneys, and the general public to oversee the implementation and enforcement of the Act. The Task Force was directed to make recommendations concerning human organ procurement and donation and did so in its Final Report to Congress in April 1986, thus completing a 15 month review of all related medical, legal, ethical, economic, and social issues concerning organ transplantation. Specifically, in the area of organ donation and procurement, the final report calls for:

(1) All state legislatures to enact the UDODA and for each state medical association to develop model policies available to hospitals for the determination of brain death.

(2) Hospitals to design routine inquiry/required request policies that help identify potential organ and tissue donors and to provide next of kin with appropriate opportunities for donation after formulation and enactment of routine request laws by their state legislatures.

(3) Both the Joint Commission on the Accreditation of Hospitals and The Commission for Uniform State Laws to develop standards and model laws that require acute-care hospitals to develop affiliations with organ procurement agencies and to adopt routine request procedures.

(4) The Health Care Financing Administration of the United States to incorporate into the conditions of participation for hospitals receiving Medicare funds, a condition that requires hospitals to have routine inquiry policies.

An important provision of NOTA prohibits the buying and selling of transplantable human organs for “valuable consideration” in the United States. Under this law, the marketing of donor organs is forbidden and persons found in violation can be subject to a fine of $50,000 or imprisonment up to five years. Although the buying and selling of donor organs has been deplored internationally by the transplant community in general, the concept of a regulated market system continues to be proposed as a reasonable solution to the acute shortage of donor organs. Proponents argue that such activities are within the “spirit of free enterprise” and that other necessary commodities are obtained through such a system. Well-publicized instances in which private European hospitals guarantee patients kidney transplants within a specific period and perform the operations for substantial fees are not uncommon. In 1984, as many as 600 kidneys are believed to have been exported from the United States while 20,000 dialysis patients in America awaited transplantation.

A market system set up for the procurement of human organs automatically includes an advantage to those who can afford to pay for the procedure. These people become organ recipients and those who cannot afford the costs automatically become organ donors. Such a system could ultimately create fear and a general distrust of the medical community or even of next of kin that everything possible may not be done to save a life if a profit were to be made from organ donation.

United States Senator Albert Gore, Jr., of Tennessee stated that although “it is true that we live in a free market society that allows the individual the freedom
to choose many things... a person seeking an organ transplant does not do so because they choose to be sick. We must not allow technology to dehumanize people so they are regarded as things to be bought and sold like the parts of an automobile. If this were allowed, it would seriously undermine the values of our society... Therefore, the bill [NOTA] expressly forbids the buying and selling of human organs.15

Although computerized telephone networks such as the United Network of Organ Sharing (UNOS), which matches donor kidneys to recipients, and the 24-Hour Alert system operated by the National Association of Transplant Coordinators Organization (NATCO), which is responsible for matching extrarenal organs to compatible recipients through member hospitals, are already in existence, another major provision of NOTA calls for the design and implementation of a national computerized network that would include transplant centers, procurement agencies, voluntary health organizations, and the public. Access to such a 24-hour national service would identify potential recipients both regionally and nationally, and if well developed and maintained, the network would succeed in enhancing the chances for matching donor organs to patients who have a reduced chance of obtaining organs through usual procedures. This network, designated the Organ Procurement and Transplantation Network (OPTN), would monitor the performance of its members, determine national policy and goals, analyze and publish data regarding organ procurement and transplantation in the United States, and conduct related activities. Funds in the amount of $400,000 in fiscal year 1986 have been appropriated by Congress to support the establishment of the OPTN.17

Realistic alternatives

The UAGA was drafted in an attempt to clarify, legitimize, and streamline the mechanics of the voluntary system of organ donation in this country. The NOTA included provisions to review, strengthen, and expand the organ procurement and donation systems currently in place. Further improvement of this system will not provide the answer to the acute donor organ shortage that exists today. It is the system itself that needs reevaluation and replacement.

Three methods of organ donation will be presented and examined here: (1) presumed consent, (2) mandatory consent, and (3) required request for consent. All three could replace the unproductive voluntary system as the main instrument for the donation of organs.

Presumed consent. A presumed consent law would presume that the deceased had consented to donate his organs for transplantation but would strictly enforce the wishes of those who desire for themselves or family members not to become organ donors. Stuart1 suggests that, similar to the Medical Information System of the End Stage Renal Disease Program conducted under the auspices of the Social Security Administration, objections to donation under the law would be entered into a nationwide computer system or registered with the medical staff of a hospital before or at the time of death.

In West Germany, a similar presumed consent law provides that an individual's objection to presumed donation of his organs is recorded on his state identification card. In France, when admitted to a hospital, a patient is given an opportunity to state an objection, which is then recorded in the hospital records. But in America, no state has enacted a policy of presumed consent for solid transplantable organs.* Although several European countries practice variations of presumed consent, physicians in six of 13 of these countries still seek concurrence of the next of kin.18

A presumed consent law in this country could meet objection under the First Amendment of the United States Constitution providing citizens with free exercise of speech and religion and under the Fifth Amendment granting the government the right under certain circumstances to invoke eminent domain or to take private property with compensation for public use. Other legal issues, such as establishing ownership to a decedent's body and its disposition at death, would need to be resolved for a presumed consent policy to be enforceable.

Mandatory consent. A mandatory consent law would require all individuals over a specified age to register their written consent or objection to organ donation coincident with the recording of other routine information, such as acquisition or renewal of a state driver's license. Responses to the question, "Do you wish to donate organs or tissues for transplantation upon your death?" could be recorded with little effort, for example, when state income tax returns are filed. Changes in an individual's recorded response could be made and would be noted officially at any time during the person's life.

This information would be filed with an appropriate agency or entered in a national system and recovered at the time of death. Strict enforcement of both compliance and objection to donation under this system would be of paramount importance for such a law to be constitutional. Under a mandatory consent law, no one

---

*Twelve states currently have presumed consent laws for removal of corneal tissue for transplantation purposes.
would be forced to make a predetermined statement but instead would be required only to answer a yes or no question.16 Unlike presumed consent, mandatory consent avoids the issue of the “taking” of one’s property because individuals would still ultimately be consenting to donate organs as anatomic gifts. As Katz15 points out, “The requirement that one make a choice and state it, carries only slight intrusiveness compared to the potential benefit to society. Even if the system of mandated choice burdens one’s privacy to some small extent, the law often permits minor burdens when the benefit to be procured thereby is great.”

Opponents of presumed and mandatory consent laws argue that either or both might produce a “backlash” wherein the public would perceive these laws as being compulsory in nature and those who are likely to donate organs voluntarily would withdraw their consent in protest. However, the number of organs “lost” to such circumstances would not be significant compared with the increased number of organs made available by an enforced and socially acceptable policy of mandatory or presumed consent.

Cwiek2 states that with systems of presumed and mandatory consent, “few cadavers would actually be needed for organ donation.” For example, according to current estimates, a mere 2% of hospital deaths resulting in potential donors would provide 25,000 kidneys per year.

**Required request for consent.** Required request (or routine inquiry) for consent legislation, first passed in New York and Oregon in 1985, requires that organ donation be requested of next of kin as part of the protocol for the discontinuation of life-support measures or at the time of death of any potential donor. The official request and the family’s response are documented on the patient’s medical records and/or death certificate. The organ donation request is made by attending or emergency room physicians, procurement agency representatives, or hospital-designated and trained professionals who by law can take no part in the process of determination of death.

Required request laws unequivocally honor a decedent’s or next of kin’s objections to organ donation. If the objections are known in advance, the request for donation need not be made at all; the circumstances are simply recorded in the patient’s medical records.

Required request legislation targets general, acute-care hospitals and is typically implemented as a state-mandated program. A required request law is “hospital specific” in that each hospital is allowed to determine its own criteria for organ donor candidacy. These criteria can be extremely broad and include all patients regardless of age as donor candidates for bachelor organs in addition to skin, bones, tendons, corneas, and tissue, or they can be restrictively narrow. Once criteria have been established by the hospitals, required request legislation calls upon hospitals to establish procedures and designate trained personnel to carry out the routine requests of the families whose relatives fall within the hospital’s criteria for donor candidacy.

The New York State Health Department is responsible under the state’s new required request law for preparing guidelines for use by hospitals in requesting organ donations from patients and their families and recording the outcome of these requests. One New York state legislative aid who lobbied for the passage of required request stated, “We do not have a shortage of donors in New York. We have a shortage of askers.”19 Although this type of law absolutely honors a refusal to consent, its great advantage lies in the asking. It requires someone in authority to ask for the donation, whereas other systems and laws allow the question to go unasked but more importantly, unanswered.

Few of the states that have enacted required request legislation include penalty clauses in their statutes. The New York statute sets fines of up to $1000 for hospitals found in violation of the law.19 Those who support required request bills without penalty clauses, or “teeth,” wish to retain the concept of voluntarism in organ donation and emphasize that such laws are asking for as opposed to requiring acceptance of responsibility on everyone’s behalf to make routine request policies effective.

Of the 26 states that have enacted required request legislation, 22 did so in 1986. Since the majority of these statutes are in the early stages of implementation, there are to date no published reports of the effects of the legislation. However, according to Tracy Miller, Executive Director of the New York State Task Force on Life and the Law, the number of available donor organs has increased substantially in New York, one of the first states in 1985 to pass required request legislation. This increase will be confirmed and the data published upon completion of a study currently being conducted by the New York Center for Assessing Health Services and the New York State Task Force on Life and the Law.

**The solution: A shared responsibility**

As of August 1986, 475 heart transplants had been performed in the United States, 200 patients were still waiting for donor hearts, and an estimated 15,000 more would have benefited from cardiac transplantation. The Center for Disease Control estimates that

---

Vol. 75, No. 1, January 1987
anywhere from 12,000 to 27,000 deaths that could yield transplantable organs depending on selection criteria occur each year in the United States.20 Moreover, according to Safar,21 close to 20,000 potential organ donors exist each year in the United States, but viable organs are obtained from only approximately 2500.

The impact on donor organs of more strict automobile seatbelt and child restraint laws, the 55 mile per hour speed limit, aggressive drunken driving campaigns, motorcycle helmet laws, improved trauma care, and more accessible mental health care, potentially resulting in fewer suicides, remains to be seen. On the other hand, use of xenografts, advances in long-term preservation of organs, and further development of the total artificial heart along with other mechanical forms of circulatory assistance may help reduce the demand for donor organs in the near future.

No single theory or piece of legislation alone will solve the organ donor shortage in this country, nor will placing the responsibility for its resolution on one profession, one institution, or one state-supported agency. The answer will be found in a combination of better laws, comprehensive and continuing education of the public, acceptance of the responsibility for organ donation by both the medical community and the public, and fine-tuning and integration of the mechanisms that facilitate organ procurement and donation.

Estimates of the donor heart supply have been based exclusively on the number of in-hospital deaths each year. Since a sufficient number of people die in hospitals each year under conditions that would allow them to become donors and theoretically meet the estimated need, some experts anticipate that supply could exceed demand in the United States. Although many factors contribute to the imbalance between donor organ supply and demand, the lack of information on these issues reaching those in a position to solve the problem — the public — is of major importance.

Willingness to participate in organ donation by the American public can be predicted on the basis of demographic characteristics. Individuals who have expressed a desire to participate in or who have actually consented to donation have usually completed higher education levels and are in a higher income bracket. These people are found to be “less conservative and less committed religiously; less likely to hold conventional and secular attitudes toward death and life.”1,6 Minority groups exhibit a special need for education regarding organ transplantation. The black population, for example, has four times the risk of the white population for renal disease and hypertension and yet few blacks become organ donors.6,9 Lack of knowledge of transplantation issues, distrust of the medical community, and religious or cultural beliefs help explain the low donation rate among nonwhites. Manninen and Evans22 demonstrated that a very small percentage of the public is decidedly opposed to organ donation and that a large number of people remain undecided. The latter group, if targeted for education on organ donation issues, may become willing potential donors.

Dr. James F. Childress of the Task Force on Organ Transplantation recently discussed the need for education of the public: “Focused education efforts should be undertaken through health education curricula in schools to help inform family decision making and to encourage organ and tissue donation among cultural and ethnic minorities who have not historically participated.”23 Education should be both public and professional in scope, systematic in order to reach all segments of society, and coordinated on a national level using federal funding incentives as a “hammer.”

Transplant centers should educate and work with community medical professionals. Grants should be provided to independent organ procurement agencies and groups such as the National Association for Transplant Coordinators for the development of educational programs. Medical and nursing schools and residency training programs should include organ procurement and donation curricula as well. Church and parent-teacher associations should sponsor special programs in affiliated schools and districts.

A comprehensive system of education should replace the limited education provided by media blitzes launched to help obtain donor organs for specific individuals. This method plays down the larger and continuing problem of organ shortage and incorrectly leaves the public with a feeling of resolution and satisfaction once an organ is donated for the media’s celebrity patient.

Although some believe that the voluntary and altruistic system of organ donation should be preserved, it is impossible to overlook the failure of this system to supply an adequate number of organs. Routine salvaging of transplantable organs in the absence of a specific objection by the donor or his family is necessary to accomplish this goal. As long ago as 1970, Dukeminier24 wrote in the Michigan Law Review that “society must face the fact that cadaver organs can be used to save human life, perhaps their own, and that a hard choice must now be made. It [society] must decide whether to advance the policy of preserving life or to stand paralyzed by its taboos.” Sixteen years later, we are still struggling with this issue.

Required request legislation honors the wishes of
society’s members yet is aggressive in targeting circumstances most likely to yield donor organs. It forces hospitals and medical personnel to constantly consider the need for and availability of transplantable organs and requires those who are in the best position to effect organ donation — medical professionals who can best identify these candidates — to do so. It further gives all such families the opportunity to choose, when they might otherwise remain unaware of the need. It distributes the burden of obtaining organs equally on all such families and it removes the difficulty of making such a request by qualifying the issue as one of “law.” Previous donation laws have been deficient by failing to specifically direct physicians or medical professionals to initiate donation questions, thus preserving the option to avoid approaching the family even if consent is suspected or known. Required request laws require the best qualified and trained professionals, whether physicians, transplant coordinators, or procurement agency representatives, to present the organ donation question to the family.

Most importantly, the required request law operates on the same premise as that of the voluntary system of organ donation — that a potential donor or his family still makes the final decision regarding organ donation — but it goes one step further by providing a complete professional, medical, and legal support system to ensure that all the options are considered and that the choice is made while the opportunity still exists. Required request is a good compromise between the systems based on voluntarism and those of presumed or mandatory consent.

Baruch A. Brody, Ph.D., a Leon Jaworski Professor of Biomedical Ethics at Baylor College of Medicine, challenges the public and medical profession to solve the problem of organ shortage: “It is morally outrageous that the problem of choice should exist at all. The suggestion that we can choose [to ask or not to ask] on a rational basis is offensive. Where we have failed is in the acquisition of organs.”

Although we can continue to pass legislation on organ donation in an attempt to give a "boost" to society's natural inertia, the support and enforcement of all medical professionals is critical to success.

Fox and Swazey write:

The final gatekeeper in organ exchange is the physician. Acting on behalf of the transplant team, the patient, and possible donors and their relatives, as well as for himself, he makes the ultimate judgment. He acts as mediator and interpreter in the complex social system called into play by the transplantation situation. . . .the physician is not free to abnegate his responsibility nor may he exercise it arbitrarily or coercively. . . . In certain respects, the physician is under pressure to decide in favor of organ transplantation. He is propelled toward it by his own professional and personal motivation to do everything possible to save the life of a dying patient.

Willingness to participate in the solution to the donor organ shortage crisis has been consistently expressed by the public. A combination of intense educational efforts and improved legislation that will clarify and provide legal protection for both patient and medical professional will convert willingness into action and prepare the way for physicians and all medical professionals to step up and take their place in the cycle — of life.

References

17. Minutes of the Task Force on Organ Transplantation, United States Department of Health and Human Services, Office of Organ Transplantation, Rockville, MD, November 18, 1985

Vol. 75, No. 1, January 1987
21. Statement of Peter Safar, M.D. (Director of Resuscitation Research Center, University of Pittsburgh) at Organ Transplants: Hearings before the Subcommittee on Investigations and Oversight of the House Committee on Science and Technology, 98th Congress, 1st Session, 1983


23. Minutes of the Task Force on Organ Transplantation, United States Department of Health and Human Services, Office of Organ Transplantation, Dallas, October 1, 1985


A proposed solution to the present organ donation crisis based on a hard look at the past.

M Miller

Circulation. 1987;75:20-28
doi: 10.1161/01.CIR.75.1.20

The online version of this article, along with updated information and services, is located on the World Wide Web at:

http://circ.ahajournals.org/content/75/1/20.citation

Permissions: Requests for permissions to reproduce figures, tables, or portions of articles originally published in Circulation can be obtained via RightsLink, a service of the Copyright Clearance Center, not the Editorial Office. Once the online version of the published article for which permission is being requested is located, click Request Permissions in the middle column of the Web page under Services. Further information about this process is available in the Permissions and Rights Question and Answer document.

Reprints: Information about reprints can be found online at:
http://www.lww.com/reprints

Subscriptions: Information about subscribing to Circulation is online at:
http://circ.ahajournals.org//subscriptions/