SB

112

FISCAL NOTE

STATE OF ALASKA
1991 LEGISLATIVE SESSION

BILL NO. SB 112

Revision Date:
Title: An Act relating to anatomical gifts.
Sponsor: Senator Fahrenkamp
Requestor: Senate HESS

Department Affected: Public Safety
BRU: Alaska State Troopers
Component: Detachments

COMPONENT SERIAL NO. | | 7 | 9 | 9 |

EXPENDITURES/REVENUES: (Thousands of Dollars) (Inflation not Included)

OPERATING	FY 92	FY 93	FY 94	FY 95	FY 96	FY 97
PERSONAL SERVICES						
TRAVEL						
CONTRACTUAL						
SUPPLIES						
EQUIPMENT						
LAND & STRUCTURES						
GRANTS, CLAIMS						
MISCELLANEOUS						
TOTAL OPERATING	-0-	-0-	-0-	-0-	-0-	-0-

CAPITAL	-0-	-0-	-0-	-0-	-0-	-0-

REVENUE	-0-	-0-	-0-	-0-	-0-	-0-

FUNDING: (Thousands of Dollars)

GENERAL FUND						
FEDERAL FUNDS						
OTHER/PROG RCPT						
TOTAL	-0-	-0-	-0-	-0-	-0-	-0-

POSITIONS:

FULL-TIME	0	0	0	0	0	0
PART-TIME	0	0	0	0	0	0
TEMPORARY	0	0	0	0	0	0

Estimate of current year impact None

ANALYSIS: (Attach a separate page if necessary)

No fiscal impact on Alaska State Troopers.

Prepared by: Gayle A. Horetski
Phone: 465-4322
Division: Commissioner's Office
Date: 3/5/91
Approved by Commissioner: Richard L Burton Richard L. Burton
Agency: Department of Public Safety
Date: 3/5/91

Distribution (by preparer): Legislative Finance, Legislative Sponsor, Requestor, OMB, & Impacted Agency(ies).

Rev 10/90

Page 1 of 1

STATE OF ALASKA
1991 LEGISLATIVE SESSION

Bill Version: SENATE BILL 112
Publish Date: 2/11/91

REQUEST: FISCAL NOTE

Revision Date:
Agency Affecte Health & Social Serivces
Title: Anatomical Gifts
BRU: State Health Serivces
Sponsor: Fahrenkamp
Components: Public Health Administration
Requester: Senate HESS

EXPENDITURES/REVENUES: (Thousands of Dollars)

OPERATING	FY 91	FY 92	FY 93	FY 94	FY 95	FY 96
Personal Services						
Travel						
Contractual						
Supplies						
Equipment						
Land & Structures						
Grants, Claims						
Miscellaneous						
TOTAL OPERATINC	0.0	0.0	0.0	0.0	0.0	0.0
CAPITAL	0.0	0.0	0.0	0.0	0.0	0.0
REVENUE	0.0	0.0	0.0	0.0	0.0	0.0

FUNDING: (Thousands of Dollars)

General Funds	0.0	0.0	0.0	0.0	0.0	0.0
Federal Funds						
Other						
TOTAL	0.0	0.0	0.0	0.0	0.0	0.0

POSITIONS

Full-Time		0				
Part-Time		0				
Temporary		0				

ANALYSIS: (attach a separate page if necessary)

No fiscal impact.

Prepared By: Alfred G. Zangri
Division: PUBLIC HEALTH
Phone: 465-3090
Date: 02/27/91

Approved By Commissioner: Theodore Mala, M.D., MPH
Agency: HEALTH & SOCIAL SERVICES
Date: 3-5-91

Distribution (by preparer):
Legislative Finance, Legislative Sponsor, Requestor,
Office of Management & Budget, Impacted Agency(ies)

Alaska State Legislature

SENATOR BETTYE FAHRENKAMP
CHAIRMAN, LEGISLATIVE COUNCIL
CHAIRMAN, ADMINISTRATIVE REGULATION
REVIEW COMMITTEE
119 N. CUSHMAN STREET, SUITE 201
FAIRBANKS, ALASKA 99701
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Senate

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MEMORANDUM

TO: All Senators

FROM: Senator Bettye Fahrenkamp

DATE: April 15, 1991

SUBJECT: CS SB 112 (Judiciary)
An Act relating to anatomical gifts.

BILL SUMMARY

* Reinforces that an individual's decision to donate body organs does not require the consent or concurrence of any individual after the donor's death.

* Requires that a reasonable search must be made for documentation that identifies the individual as a donor or as someone who has refused to make an anatomical gift. Failure to do so may result in administrative sanctions.

* Law enforcement or medical personnel and hospitals located in areas where hospitals don't have the provisions to accept an organ donation, are exempt from being required to make a reasonable search for documentation. But the hospital is required to make an effort to contact a donor bank if they are aware that the individual is a donor.

FISCAL IMPACT: Zero fiscal notes from HESS and Dept. of Public Safety.

PREVIOUS COMMITTEE ACTION:
HESS: DO PASS Sturgulewski, Cotten and Menard.
JUDICIARY: DO PASS Halford, Collins, Adams and Frank.

DEPARTMENT POSITION: Supported by the Department of Public Safety.

ABOUT THE BILL:
Currently hospitals require the consent of the next of kin before accepting an organ donation. SB 112 requires that hospitals and organ procurement centers comply with the wishes of the individual to make a gift upon their death and not require the consent of any other person. Hospitals that are not equipped to accept a donation are required to make a reasonable effort to contact a donor bank if the individual is an organ donor.

POSITION PAPER / DEPARTMENT OF PUBLIC SAFETY

BILL NO: SB 112

DATE: 3/5/91

TITLE: An Act relating to anatomical gifts.

CONTACT: Gayle A. Horetski
Deputy Commissioner
465-4322

SB 112 modifies the existing anatomical gift statute in the following ways:

1. Unless a gift is revoked before death by the donor, the gift becomes irrevocable and does not require the consent or concurrence of any person after the donor's death.

2. Requires hospital administrators and employees to make a reasonable search for a document or other information, identifying the deceased as a donor, or as a person who has refused to make an anatomical gift.

3. Requires law enforcement officers to make a "reasonable search" for a document of gift or other information identifying the bearer as a donor, or as a person who has refused to make an anatomical gift, and to inform hospital personnel of the intended gift.

4. The bill establishes that failure of either hospital administrators or police officers to make a reasonable search may subject the administrator or police office to "appropriate administrative sanctions".

The Department of Public Safety interprets the requirement that law enforcement personnel at the scene of a death make a "reasonable search" for an anatomical gift document to mean that the officer must take an extra moment or two to search the person of the deceased for documents proclaiming him or her as a donor.

The Department of Public Safety supports this bill, as it has the laudable goal of encouraging Alaskans to donate their organs, upon their death, to other persons in dire need of those organs.

The Department proposes one change in the bill. In Section 3, at page 2, line 13, the word "administrative" should be changed to "disciplinary", and a period should be placed after "sanctions", ending the sentence. Line 14 should be omitted entirely. Disciplinary actions against State Troopers are taken under authority of the Department's Operating Procedures Manual (OPM), state personnel rules, bargaining unit contracts, and other applicable provisions. The Department of Public Safety does not have separate regulations regarding this subject.

Richard L Burton

Richard L. Burton
Commissioner

Alaska State Legislature

SENATOR BETTYE FAHRENKAMP
CHAIRMAN, LEGISLATIVE COUNCIL
CHAIRMAN, ADMINISTRATIVE REGULATION
REVIEW COMMITTEE
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WHILE IN JUNEAU
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TO: Senator Arliss Sturgulewski, Chair
Senate Health, Education and Social Services Committee

FROM: Senator Bettye Fahrenkamp

DATE: February 22, 1991

SUBJECT: Senate Bill 112
"An act relating to anatomical gifts."

A constituent of mine, upon renewing his driver's license this summer, decided to become an organ donor. He was then advised that hospital policy still required the consent of next of kin or they would not accept the donation.

By accepting next of kin's refusal to honor an organ donor's wishes, hospitals and organ procurement centers may be witholding medical care from transplant recipients. This would hold particularly true in the instance where a recipient is on hand and the next of kin cannot be reached to ask for consent. **No one should interfere with an individual's right to make the final decision on organ donation.**

BILL SUMMARY:

SB 112 clarifies that an individual's decision not revoked by the donor before death does not require the consent or concurrence of any person after the donor's death.

SB 112 also requires that a reasonable search must be made for documentation that identifies the person as either a donor or someone who has declined to donate. Failure to make a reasonable search may be the basis for appropriate sanctions under regulations of the Department of Health and Social Services, the State Medical Board or private hospital accrediting organizations. Any hospital or person acting in good faith or attempting to do so in accordance with this chapter could not be held liable for any damages.

SB 112 is an attempt to put the decision about organ donation back into the donor's hands, while clearly defining the protection against liability to hospital officials and physicians who act on the basis of signed donor cards.

As Joel Swerdlow of the Annenberg Washington Program wrote in **Matching Needs, Saving Lives**, "By letting donors themselves decide, we protect two basic values: First, we protect our right to decide, which is already granted by law. Second, we can save lives: when health-care institutions accept the next of kin's refusal to honor an organ donor's wishes, they may be withholding medical care from transplant candidates."

I urge your early scheduling and favorable consideration of this measure. I would be happy to answer any questions you may have and provide further information upon request.

PUBLIC OPINION MESSAGE

DEAR: SENATOR STURGULEWSKI

NAME: DONALD STEIN/CMTE MEMBER
TITLE: ALASKA LEGISLATIVE AFFAIRS WATCH
ADDRESS: PO BOX 10904
CITY: FAIRBANKS ZIP: 99710
PHONE: 455-6208
BILL NO: SB 112
SUBJECT: ANATOMICAL GIFTS
MESSAGE: ALASKA LEGISLATIVE AFFAIRS WATCH OPPOSES SB 121. THANK YOU. EOM/CLS

POMID: 07124217
DATE: 91/03/15
TIME: 12:42:17
LIONAME: FAIRBANKS LIO

COPIES: REPRESENTATIVES

BOYER
KOPONEN
M.W.MILLER
MOYER
SHARP

SENATORS

FAHRENKAMP
FRANK
SHULTZ
ZHAROFF
HOFFMAN
PEARCE
KERTTULA
POURCHOT
DUNCAN
ADAMS
UEHLING

MATCHING NEEDS, SAVING LIVES

BUILDING A COMPREHENSIVE NETWORK FOR TRANSPLANTATION AND BIOMEDICAL RESEARCH

A REPORT ON POLICY OPTIONS

BY JOEL L. SWERDLOW

THE ANNENBERG
WASHINGTON PROGRAM
Communications Policy Studies
Northwestern University

DEDICATION

About a year ago I read a newspaper story about how a 49-year-old woman in Wisconsin had saved the life of a six-year-old girl in Raleigh, N.C., who was dying of leukemia. The girl needed a bone marrow transplant and had no siblings whose antigens matched hers. But the woman in Wisconsin was a perfect match—a computer search that cost pennies brought the two of them together.

The story made me think of my brother, Paul H. Swerdlow. He was full of life and love, a Ph.D. in nuclear physics and a board-certified radiologist—a man with much to give. In late 1984 he lay dying of leukemia.

Paul's hope for life was that either our sister or I would be a match. Technicians took our blood. We all tried to keep busy with other things while we waited for the results. When the telephone rang, however, the lab reported that neither of us matched Paul. Seven months later, at the age of 42, he died.

Paul lived in Boston. In just that area, according to medical experts, there were about 100 people who might have saved him. In all of America, as many as 25,000 people might have saved my brother's life—if society had set up the necessary communications system. It could have been so simple, but ultimately it was impossible. And, as this report shows, the need goes far beyond my brother's particular illness.

My brother lived in the world of medicine and science; my work involves politics and public policy. "We should write something together," he often said. "The people in your world have to better understand the great advances in mine."

During the past six months I've visited in Paul's world. I've interviewed hundreds of health care providers, read medical journals and transcripts of congressional hearings, and attended conventions of transplant specialists. Although I was sometimes the only nonmedical person at the meetings, few participants seemed surprised to see me. The transplantation community knows the outside world will eventually pay more attention. Some expect the attention to come in the form of scandal, bred by the lack of regulation in tissue recovery and the huge dollar flow in the processing and distribution of organs and tissues. Others expect that the public will some day demand to know why more sick and injured people don't benefit from transplants.

I repeatedly heard one message from professionals who work long hours, receive little recognition and make miracles: To accept the status quo, given today's capabilities, is inexcusable.

This report is dedicated to all the people who would have helped my brother if given the chance, to all who now suffer for lack of a transplant and to those who will make possible the happy endings yet to come.

JOEL L. SWERDLOW

CONTENTS

INTRODUCTION

This report is worthy of attention for its fresh, comprehensive look at the issues in the critical field of human organ and tissue transplantation, and, in particular, for its emphasis on improving communications within the field and coordination of efforts to increase organ and tissue availability.

The shortage of organs and tissues is often the factor that most severely limits physicians' ability to treat patients who need a transplant. The patients' life-or-death situation and the present scarcity of available organs demand the most efficient use of present resources and intensification of efforts to increase supply.

We are making progress in increasing supply through such measures as state required-request laws for organ donation, the Uniform Anatomical Gift Act and federal requirements that hospitals develop written protocols for identification of potential organ donors. Despite these important steps, however, we are still unable to provide lifesaving organs to even a majority of individuals who need transplants.

Innovative means of increasing supply should be both encouraged and subjected to thoughtful scrutiny by patients, physicians and other health care personnel, ethicists, legal experts, hospital administrators and those involved in organ procurement and distribution. Improvements in supply are likely to be achieved by involving all parties concerned with improving patient care.

M. ROY SCHWARZ, M.D.
Assistant Executive Vice President,
Medical Education and Science
American Medical Association

The proposals advanced in this document do not necessarily reflect the policies and positions of the American Medical Association.

propose a comprehensive National Human Organ and Tissue Policy. The task force would both initiate and coordinate demonstration projects in the medical community and propose legislation. It would consider and recommend plans for initiatives such as these, built on existing institutions:

- a comprehensive national computer-based communications network to coordinate the recovery and allocation of donated tissues as well as organs under consistent, equitable ground rules,
- a continuous, intensive public education campaign to promote donation and family discussion of donation options,
- experimentation with a statewide electronic donor registry and other mechanisms that would let donors themselves (instead of their next of kin) make the final decision to donate,
- training and incentives for hospital personnel to increase the recognition of potential donors and improve requests for donation,
- streamlined systems on the local level for more extensive recovery of donated organs and tissues,
- an expanded computer registry of living Americans who volunteer to donate lifesaving bone marrow,
- a 24-hour database of medical literature and a telephone hotline to make available the latest techniques and data to health care providers,
- a coordinated system of national databases, linked with all tissue and organ transplantation centers and procurement organizations, to collect data on treatment, cost and outcomes for evaluation,
- assessment of public attitudes about and the desirability of expanding "presumed-consent" laws, which would increase donation by declaring that everyone has given consent to donation unless they explicitly withhold it (registering their refusal with a national databank), and
- a medical consensus conference on the desirability of beginning kidney recovery from non-heart-beating donors, which would greatly increase the supply of the most frequently transplanted organ.

Many people still think of transplantation as a high-technology luxury. In fact, investing in the measures described above would save money for taxpayers and society as a whole, because transplantation is often less costly than alternative treatments.

More importantly, the lives saved and suffering ended give us tens of thousands of human reasons for action.

OPTIONS: TO INCREASE DONATION

In the Dan Smith scenario, Dan was able to donate because he and his wife had talked about donation long before his fatal accident and because hospital personnel were prepared to respond to his wish. These things seem simple, but they are not the norm in the United States today. As long as patients are waiting for organ transplants, the failure to recover a single suitable donated organ is tantamount to withholding medical care. A concerted effort is needed, including any or all of the following policy options, before we can expect more people to give or receive "the gift of life."

FULLY IMPLEMENT THE "REQUIRED-REQUEST" LAWS

In the mid- to late 1980s, public policymakers took what they hoped would be a major step to increase donation: federal regulations and "required-request" laws in 41 states and the District of Columbia obligate hospitals to ask next of kin whether they wish to donate the organs and tissues of a recently deceased family member.[33]

In practice, however, state agencies make little effort (or have little authority) to enforce required-request laws, and many hospitals—including major transplant centers—have done nothing to implement them, according to hospital officials. Short-staffed hospitals frequently lack the resources to perform the time-consuming, demanding tasks necessary to acquire donated tissue and organs.

The first task is for physicians to identify medically eligible donors and alert the appropriate hospital personnel. This is not so likely to be done as one might expect. A recent sample of 195 physicians and nurses found that only 35 percent "correctly identified the legal and medical criteria for determining" brain-death.[34] The leader of one of the nation's most successful organ procurement organizations says the hospitals in his area often do not call when they have potential donors because they do not properly identify them. "We sit around and wait far more than we should," he says.

Second, a hospital or organ procurement worker must approach the family to request donation—a delicate task. When the health-care worker assigned to request donation doesn't want to do it or doesn't know how, says University of Minnesota ethicist Arthur Caplan, "the consent rate is . . . zero."[35] In some states, furthermore, the required-request laws do not apply to tissue donation and do nothing to encourage donation of human material for medical research.[36]

It is too soon to know how well required-request laws work. Caplan, their principal proponent, remains optimistic that "the supply of organs and tissues will significantly increase once all protocols are in place and people are more comfortable with required request."[37] However, evidence about the effects of the laws is conflicting. Tissue bank officials indicate that tissue donations have increased, perhaps by as much as 300 percent.[38] The Eye Bank Association of America reports only a 4 percent increase in 1988.[39] A recent UNOS study reveals "a marked upturn trend for the 15-month period ending in December 1988,"[40] although some transplant surgeons question this finding.

Experience indicates that donations surge in hospitals where trained professionals have adequate time to communicate with donor families.[41] At the same time, reports from some localities, including a statewide Ohio survey, show no change in the donation rate after passage of required-request laws.[42] Whatever the success of required-request laws, experts agree that there is little reason to believe that these laws alone will produce an adequate supply.

INCENTIVES AND TRAINING TO PROMOTE REQUIRED-REQUEST

Requesting donations is a difficult, labor-intensive task that demands sensitivity and special skills. Yet it often falls upon hospital personnel who are already overworked and underpaid. Thus, money for training and incentives is needed: public/private-sector mechanisms could pay for training of personnel to implement required-request. Hospitals could be motivated by more consistent enforcement of existing required-request statutes and by linking their accreditation or tax-exempt status to effective donor-recruitment efforts.

When the House of Representatives was considering transplantation legislation in 1984, then-Congressman Albert Gore predicted that the bill would inspire "educational and training programs in every hospital and medical community throughout this country in order to greatly increase the rate of organ donation."[43] But no organization received the mandate or the money necessary to conduct such an effective nationwide training program. Training has been sporadic, and varies significantly from hospital to hospital.

BUILD A CONTINUING PUBLIC EDUCATION CAMPAIGN

Despite extraordinary dedication of the OPOs and voluntary organizations, current efforts to spread the word about donation have been underfunded.[44] For various reasons the health community has not yet fully enlisted the communications media in this cause as effectively as it has put out messages about smoking, seat belts, drunk driving, illegal drugs and AIDS.

By not volunteering to donate their own or their relatives' organs and tissues, too many people opt to permit avoidable suffering and death without knowing they are making the choice.

Today, the major effort to educate the donation decision-maker occurs immediately after the death of a relative, when a health-care worker sits down with the grieving next of kin. It is not the ideal time for either one. A concerted public education program would at least lay the groundwork for such sensitive discussions.

Teaching people about donation when they are in a learning setting can be very effective; therefore, donor-awareness programs could well be expanded in schools, churches, synagogues and civic organizations. Other mechanisms, some already in use, are also appropriate—among them, public service advertisements and dramatizations of the donation theme in popular television programs.[45]

Other health-related campaigns have shown that sustained effort can change behavior, particularly when the message taps into preexisting public support. According to public opinion polls, transplantation has such support. If campaigns are to promote complex changes in behavior, however, they must be continuous. Sporadic campaigns yield sporadic results.

The ideal campaign would encourage people to consider universal donation—all tissues and organs for medical research as well as transplantation. As a complement to in-depth efforts, it would also offer a 24-hour "800" Human Organ and Tissue (HOT) hotline, similar to the service the OPTN now operates (dial 800-24-DONOR), that anyone could call to ask questions.

In-depth research on Americans' current knowledge and attitudes about donation would help in fine-tuning the donor-options message, perhaps building on the familiar "Give the Gift of Life" theme now employed. Surveys and anecdotal evidence suggest, for instance, that many fear that organ and tissue donation disfigures the body before burial and in the afterlife. (Polls show that a vast majority of the American people believes in an afterlife.[46]) Outreach could reassure people that the major religions in this country encourage donation and could clarify the poorly understood concept of brain-death.

LET DONORS DECIDE FOR THEMSELVES

Federal and state laws give adults the right to decide whether to donate their tissues and organs.

Indeed, many people carry signed consent forms or fill in pledges on their drivers' licenses. Many assume that their wishes will be automatically respected, but often they are wrong. Hospitals contend that family values must be protected and fear negative publicity and legal challenges by displeased survivors. Therefore, they almost always let the next of kin make the final decision, regardless of the wishes of the deceased.

ONLY ABOUT 5% OF ELIGIBLE ADULTS DONATE BLOOD. IF THE SAME PERCENTAGE DONATED TISSUE, THE NATION'S TISSUE NEEDS COULD BE MET.

By letting donors themselves decide, we protect two basic values: First, we protect our right to decide, which is already granted by law. Second, we can save lives: when health-care institutions accept the next of kin's refusal to honor an organ donor's wishes, they may be withholding medical care from transplant candidates. This is particularly true in cases when a potential organ donor has just died, a recipient is at hand and the next of kin cannot be reached to be asked for consent.

Letting the donor decide would also clarify in the public mind who is making the decision and give donors a measure of personal satisfaction while they are still living.

Various kinds of legislation could put the decision back in donors' own hands. New laws could, for example, strengthen and more clearly define the protection against liability afforded hospital officials and physicians who act on the basis of signed donor cards. States could obligate hospitals and OPOs to recover organs and tissues for which there is a donor card and a demonstrated need. States could also more diligently enforce existing administrative penalties or allow civil liability to be imposed against institutions that fail to act on the basis of donor cards.

A DONOR REGISTRY

A communications option that would help return the donation decision to the donor is a computerized donor registry,[47] which medical personnel would consult shortly before or after the death of a person medically eligible to donate. With information from the registry, personnel could act promptly to recover organs and tissues during the brief period of time in which they are most useful for transplantation and research. For people who register as donors and then change their minds, the registry would permit easy updates.

In 1984, the Senate committee responsible for the National Organ Transplant Act reported its belief "that one important and appropriate new activity to include in the national computer registry is to provide a centralized list of individuals who have voluntarily agreed to donate organs. . . ."[48]

To avoid pitting the health care community against the family, donor registries (and nonelectronic alternatives such as consent forms and living wills) could include certification that the donor had discussed the decision with family members and, as appropriate, that the family had endorsed the decision. The registry could also bring in medical history data vital for screening for AIDS, hepatitis and other infectious diseases (and helpful in locating particular types of diseased tissues needed for research).

Great Britain briefly tested in-hospital donor registries with some success in the mid-1980s.[49] Twenty-one hospitals were connected in a system listing more than a quarter-million donation volunteers. Britain is now considering a system that would allow people to sign up as donors through a computer network with terminals in every physician's office. This would have the dual advantage of placing the discussion of donation in the context of the patient-physician relationship and removing it from the family's time of grief.

Georgetown University bioethicist Robert Veatch suggests that the government could increase the percentage of Americans making the donation decision themselves, and encourage family discussion of the decision, by adding donation questions to income tax forms.[50] For example, the forms could ask the taxpayer, "Do you wish to be an organ/tissue donor? With any limitations?" If a central registry were created, those who consented would have their names entered.

Opponents argue that donor registries are too expensive and difficult to keep up to date, that registries cannot guarantee confidentiality,[51] and that reliance on a registry might inadvertently contradict family wishes. Furthermore, critics say, hospitals might still leave the actual decision to next of kin, disregarding a donor registry just as they now ignore notations on donor drivers' licenses.

A MEDICAL ARGUMENT FOR LETTING DONORS DECIDE

Changing medical practice may increase the number of cases when doctors must determine quickly whether they have consent for donation. Kidneys recovered as late as one hour after coronary death can be transplanted, if certain medical steps are taken.[52] American transplant teams now almost always take kidneys only from brain-dead donors whose hearts are beating with support from ventilators, but recovering from non-heart-beating donors in addition would greatly increase the supply of kidneys—by far the most frequently transplanted organ. By the end of the century, says transplant surgeon David Anaise of the State University of New York at Stony Brook, livers and other organs may also be recovered from non-heart-beating donors.

Anaise estimates this the practice would increase the supply of kidneys tenfold if proper medical procedures are followed. It is, he says, "the only solution to the supply problem."[53]

Although the practice arouses opposition from parts of the medical community, many surgeons argue that "non-heart-beating donors can be a reasonable approach to help alleviate the shortage of kidneys."[54] Animal studies and advances in drugs that inhibit tissue death also suggest the practice may be productive.[55]

Each year, tens of thousands of Americans medically eligible to donate organs suffer coronary death from some form of heart attack or trauma.[56] Use of a donor registry, for rapid identification of those patients who have already consented to donate, would enable hospitals to coordinate rescue squads, emergency room personnel and organ recovery teams to recover the kidneys without delay.

States could adopt laws making it unnecessary to seek permission from next of kin before taking medical steps to protect the transplantability of organs from the deceased, thereby keeping their options open for later donation.[57] (Hospitals already perform a number of routine nondeforming procedures on cadavers for which permission is not requested.[58])

EXAMINE THE DESIRABILITY OF EXPANDING PRESUMED-CONSENT

More than a dozen countries—including France, Israel and Italy—have adopted "presumed-consent" laws, under which everyone is designated a donor unless they register their refusal.[59] These laws may not have had much effect, however, because most physicians still seek family permission.

The prevailing view among U.S. health care professionals is that presumed consent would never attract public support. However, given the new capability of computer/communications systems to register declinations, presumed-consent laws may be consistent with our basic values.[60]

Such a suggestion may seem startling, but limited presumed-consent laws are already on the books. Twenty-one states—double the number of only a few years ago—have such laws for corneas obtained from bodies under the jurisdiction of a medical examiner; unless the next of kin object, the medical examiner may remove the corneas of the deceased during autopsy. Seventeen states have similar provisions for pituitary glands.[61] Various states also have presumed-consent laws for unclaimed bodies. These laws could be expanded to provide tissues for research.

Presumed consent seems to be attracting support within the medical community for use in areas other than transplantation. Medical leaders, for example, are discussing mandatory autopsies and application of presumed consent to "intubation training" for physicians, which does not disfigure the corpse and is necessary for sound medical training.[62]

In Britain, furthermore, there is reportedly substantial public support for laws under which "doctors [can] remove organs from dead people for transplant unless they had specifically 'opted out' before death."[63]