# ORGAN DONOR TRUSTS AND DURABLE POWERS OF ATTORNEY FOR ORGAN DONATION: NEW TWISTS ON THE LIVING TRUST AND LIVING WILL*

## I. INTRODUCTION

In the three decades since organ transplantation first became possible, the demand for transplantable organs has far outstripped supply. The Uniform Anatomical Gift Act (UAGA), designed to facilitate organ donation through simplifying and harmonizing state law, has had a negligible influence on organ donation. Perhaps the UAGA's foremost weakness is that, despite language to the contrary, decedents' wishes regarding organ donation are often overruled by family members.

This Note discusses two possible mechanisms for facilitating organ donation. The first of these is a proposal to create a revocable *inter vivos* organ trust, analogous either to a nominally-funded trust with a pour-over provision or an unfunded life insurance trust. Such a trust seeks to allow the principal to appoint a trustee, thereby ensuring that the principal's wishes regarding organ donation are respected.

In the alternative, this Note discusses utilizing the durable power of attorney for health care as a mechanism for facilitating organ donation. Currently, only a small minority of states allow an agent to make organ donation decisions under a durable power of attorney for health care. While powers of attorneys cease in the vast majority of states, a small minority of jurisdictions allow an agent to make organ donation decisions following the principal's death.**

## II. BACKGROUND ON ORGAN DONATION

### A. *History*

Since the first successful kidney transplant in 1954, organ transplantation has saved the lives of thousands of critically-ill people.[1] Prior to this

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** *See infra* p. 59 and note 164.

[1] Transplantation is defined as "implanting in one part a tissue or organ taken from another part or another individual." STEDMAN'S MEDICAL DICTIONARY 1624 (25th ed. 1990). For a discussion of many of the issues surrounding organ donation, see generally Symposium, *Organ Donation*, 20 J. CORP. L. 1 (1995).

time, organ rejection had been an insurmountable obstacle.[2] The successful use of immunosuppressant drugs made transplantation feasible for recipients who previously would have been too ill to undergo such procedures.[3] Methods of combating organ rejection continue to evolve rapidly,[4] potentially obviating the need for most, or perhaps all, matching procedures. Due to the high number of illnesses that cannot be adequately treated by any procedure other than organ transplantation, the demand for transplantable organs remains high. As medical technology and immunosuppressant drugs become increasingly more sophisticated and reliable, the demand for transplantable organs will concomitantly increase, as will the number of organs capable of successful transplantation.[5]

Unfortunately, the harsh reality is that the number of organs available for donation has consistently lagged further and further behind medical advances and the demand for transplantable organs.[6] In 1968, the first significant legislative attempt was made to address the dearth of available organs when the National Conference of Commissioners on Uniform Law approved the Uniform Anatomical Gift Act (UAGA)[7]. All fifty states have subsequently adopted it with some degree of variation.[8] In

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[2] Organ rejection occurs when the recipient's body begins an immune response to the transplanted tissue, rejecting it as an invasive foreign object. For discussion of the mechanism of organ rejection, see generally IVAN ROITT ET AL., IMMUNOLOGY § 24.8 (1985); Charles Chandler & Edward Passaro, Jr., *Transplant Rejection: Mechanisms and Treatment*, 128 ARCH. SURG. 279 (1993).

[3] Immunosuppressant drugs bind with immune response cells, thereby preventing them from recognizing the transplanted tissue as having originated outside the donee's body. *See generally* John C. McDonald, *The National Organ Procurement and Transplantation Network*, 259 JAMA 725 (1988).

[4] *See, e.g.*, Sandra Blakeslee, *Doctors Test Radiation to Combat Rejection in Organ Transplants*, N.Y. TIMES, Nov. 1, 1988, at C3.

[5] At present there are at least twenty-five different body parts capable of transplantation, including "parts of the inner ear, a variety of glands (pancreas, pituitary, thyroid, parathyroid and adrenal), blood vessels, tendons, cartilage, muscles (including the heart), testicles, ovaries, fallopian tubes, nerves, skin, fat, bone marrow, blood, livers, kidneys and corneas." Lloyd Cohen, *Increasing the Supply of Transplant Organs: The Virtues of a Futures Market*, 58 GEO. WASH. L. REV. 1, 3 (1989) (citing SCOTT, THE BODY AS PROPERTY 19 (1981)).

[6] *See, e.g.,* Fred H. Cate, *Human Organ Transplantation: The Role of Law*, 20 J. CORP. L. 69 (1995); Teri Randall, *Too Few Human Organs For Transplantation, Too Many in Need . . . and the Gap Widens*, 265 JAMA 1223 (1991) [hereinafter *Too Few Organs*].

[7] 8A U.L.A. 65 (Supp. 1993) [hereinafter UAGA].

[8] For a list of the state statutes adopting the UAGA, see Barbara J. Katz, *Increasing The Supply Of Human Organs For Transplantation: A Proposal For A System Of Mandated Choice*, 18 BEV. HILLS. B.J. 152, 153 n.4 (1984).

1987, the UAGA was amended to address many of its intrinsic shortcomings.[9] The 1987 version eliminated the requirement that an organ donation document signed by the donee be witnessed by two individuals in addition to the donor. The witness requirement, however, still exists if the donee is unable to sign the document.[10] Furthermore, the 1987 version requires all hospitals to inquire whether a patient is an organ donor and to place a copy of documentation in the donor's medical record.[11] It also requires emergency personnel to attempt to locate organ donation documents when a patient is dead or near death.[12] Most interestingly, this version prevents family members from overriding the expressed wishes of the decedent.[13] The current version of the UAGA reads, in pertinent part:

> 1. An individual at least eighteen years of age may (i) make an anatomical gift for any of the purposes stated [in the UAGA] . . . (ii) limit an anatomical gift to one or more of those purposes, or (iii) refuse to make an anatomical gift.[14]
> 2. An anatomical gift may be made only by a document of gift signed by the donor. If the donor cannot sign, the document of gift must be signed by another individual and by two witnesses, all of whom have signed at the direction and in the presence of the donor and of each other, and state that it has been so signed.[15]
> 3. An anatomical gift by will takes effect upon death of the testator, whether or not the will is probated. If, after death, the will is declared invalid for testamentary purposes, the validity of the anatomical gift is unaffected.[16]
> 4. Any member of the following clases of persons, in the order of priority listed, may make an anatomical gift of all or a part of the decedent's body for an authorized purpose, unless the decedent, at the time of death, has made an unrevoked refusal to make that anatomical gift: (1) the spouse of the decedent; (2) an adult son or daughter of the decedent; (3) either parent of the decedent; (4) an adult brother or sister of the

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9 UAGA §§ 1-8.

10 *See infra* text accompanying note 15.

11 UAGA § 5(a).

12 UAGA § 5(c)(1)-(2).

13 UAGA § 2(h). As of 1983, only California, Colorado, Wyoming, and Florida had taken advantage of this provision, merely informing the family as a courtesy that the decedent wished to donate her organs. *See* Thomas D. Overcast et al., *Problems in the Identification of Potential Organ Donors: Misconceptions and Fallacies Associated With Donor Cards*, 251 JAMA 1559, 1562 (1984) (citing NATIONAL HEART TRANSPLANT STUDY, UPDATE NO. 31: DONOR ORGAN PROCUREMENT POLICIES AND PROCEDURES THROUGHOUT THE UNITED STATES: A STATE BY STATE ANALYSIS, at 18 (1983)).

14 UAGA § 2(a).

15 UAGA § 2(b).

16 UAGA § 2(e).

decedent; (5) a grandparent of the decedent; and (6) a guardian of the person of the decedent at the time of death.[17]

5. The following persons may become donees of anatomical gifts for the purposes stated: (1) a hospital, physician, surgeon, or procurement organization, for transplantation, therapy, medical or dental school, college or university for education, research, advancement or medical or dental science; or (3) a designated individual for transplantation or therapy needed by that individual.[18]

In a further attempt to ameliorate the chronic shortage of available organs, Congress passed the National Organ Transplant Act (NOTA) in 1987,[19] which established organ procurement organizations and a transplantation network. An organ procurement organization (OPO)[20] performs the function of locating and delivering an organ for transplant. The transplantation network, known as the United Network for Organ Sharing (UNOS), maintains a national computerized database containing information on potential recipients and donors. This Congressional action largely resulted from public appeals by families for financial support and organ donations for their sick children,[21] as well as the emergence of a potential commercial market for organs.[22]

Under NOTA,[23] the OPO procures all useable organs from potential donors, preserves the organs, and transports the organs to local transplant centers. In reality, neither the UAGA nor the NOTA has significantly alleviated chronic organ shortages, in part because the 1987

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17 UAGA § 3(a).

18 UAGA § 6(a).

19 National Organ Transplant Act, Pub. L. No. 98-507, 98 Stat. 2339, 2344 (1987) (codified as amended at 42 U.S.C. §§ 273-274 (1988)) [hereinafter NOTA].

20 An OPO is a non-profit organization, either independently incorporated or associated with a hospital. OPO's are linked by the Organ Procurement and Transplantation Network, which consists of transplant hospitals, OPO's, and other public agencies. *See* JEFFREY PROTTAS, THE MOST USEFUL GIFT 16-19 (1994)[hereinafter PROTTAS].

21 *See, e.g.,* Phil Gunby, *Media-Abetted Liver Transplants Raise Questions of 'Equity and Decency'*, 249 JAMA 1973 (1983).

22 Dr. Jacobs, a physician whose license had been revoked for mail fraud, established the International Kidney Exchange Limited with the purpose of selling kidneys purchased from healthy donors. Many of these donors were to be solicited from underdeveloped nations. The kidneys were to be sold for cost plus a service fee of $2000-$5000 per kidney. *See, e.g.,* Margaret Engel, *Virginia Doctor Plans Company To Arrange Sale Of Human Kidneys*, WASH. POST, Sept. 19, 1983, at A9; Ann McIntosh, Note, *Regulating the "Gift Of Life": The 1987 Uniform Anatomical Gift Act*, 65 WASH. L. REV. 171, 174 n.30 (1990); Note, *Regulating the Sale of Human Organs*, 71 VA. L. REV. 1015, 1026-27 (1985).

23 NOTA, *supra* note 19, at § 273(b)(2).

version of the UAGA was met with considerable opposition from state legislatures.[24] Currently, there are nearly 40,000 potential recipients awaiting transplants,[25] with evidence pointing to a continuous and disheartening increase in the number of people awaiting transplants.[26]

Even waiting lists do not fully capture the enormity of the problem. Thousands who could benefit by appropriate transplants continue to endure suboptimal living conditions, forced to avail themselves of procedures such as dialysis.[27] Furthermore, waiting list statistics are deceptive because many potential recipients are never placed on waiting lists due to factors such as financial restraints, alcoholism, or the patient's own decision.[28] Whatever the actual number of people who could benefit from organ transplants, it is indisputable that many organs suitable for trans-

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24 As of early 1994, only fourteen states had adopted the 1987 version of the UAGA: Arkansas, California, Connecticut, Hawaii, Idaho, Minnesota, Montana, Nevada, North Dakota, Rhode Island, Utah, Vermont, Virginia, and Wisconsin. *See* David English, *Gift of Life: The Lawyer's Role in Organ and Tissue Donation*, PROB. & PROP., Mar.-Apr. 1994, at 10, 11; *see also* Brian Hannemann, Comment, *Body Parts and Property Rights: A New Commodity for the 1990s,* 22 S.W. U. L. REV. 399, 409 n.66 (1993).

25 UNITED NETWORK FOR ORGAN SHARING, FACTS ABOUT TRANSPLANTATION IN THE UNITED STATES (1995) (39,285 people on waiting lists as of April 6, 1995).

26 THE PATNERSHIP FOR ORGAN DONATION, THE AMERICAN PUBLIC'S ATTITUDES TOWARD ORGAN DONATION AND TRANSPLANTATION, at *i* (1993) (presenting evidence that the waiting list may grow to 50,000 by 1995) [hereinafter PUBLIC ATTITUDES]; Sheldon F. Kurtz, *Forward: Organ Donation Symposium*, 20 J. CORP. L. 1, 1 (1995) (indicating 150% growth in the number of people on waiting lists between 1987 and 1994). The growth in the number of registrants on the National Transplant Waiting List can also be discerned in just the past few years alone. *See, e.g.,* Roger W. Evans et al., *The Potential Supply of Organ Donors, An Assessment of the Efficiency of Organ Procurement Efforts in the United States*, 267 JAMA 239 (1992) (estimating waiting list at 23,000 as of January 1992) [hereinafter *Potential Supply*]; Melissa N. Kurnit, Note, *Organ Donation in the United States: Can We Learn From Successes Abroad?*, 17 B.C. INT'L. & COMP. L. REV. 405 n.1 (1994) (citing UNOS as reporting 33,728 people on waiting list as of February 2, 1994); English, *supra* note 24, at 11 (citing figure of 33,520 people on waiting list as of December 22, 1993). Further exacerbating the situation, some studies indicate that organ donor rates have actually decreased in recent years. *See, e.g.*, Randall, *Too Few Organs, supra* note 6, at 1223 (citing 3,975 cadaveric donors in 1988 and 3,898 in 1989).

27 *See* Roger W. Evans, *supra* note 26, at 239 (estimating 60,000 people die or endure suboptimal living conditions that could benefit from liver, heart, heart-lung, lung, kidney, or pancreas transplants).

28 The patient's own decision may be based on a variety of different reasons. *See, e.g.*, PARTNERSHIP FOR ORGAN DONATION, SOLVING THE ORGAN DONOR SHORTAGE, at 3 (1993) ("tens of thousands more would be added to the [waiting]

plant are interred with their owners,[29] and are followed shortly thereafter by persons who could have benefitted from transplants.[30] Of these, a significant percentage are children.[31]

### B. *Physical Impediments to Organ Donation*

Approximately two million people die per year in the United States.[32] Fully one-half of these deceased persons are unavailable for organ donation because they do not die in hospitals or are unsuitable donors due to factors such as age or the nature of their illness.[33] Thus, the majority of organs are procured from donors who have lost all brain function and are being maintained on respirators,[34] which further limits the potential donor pool to an estimated two percent of all hospital deaths.[35] Time remains the single greatest obstacle because organs have extremely limited

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list were it not for the apparent hopelessness of obtaining an organ") [hereinafter DONOR SHORTAGE]; Randall, *Too Few Organs*, *supra* note 6, at 1223.

[29] *See, e.g.*, Theodore Silver, *The Case For a Post-Mortem Organ Draft and a Proposed Model Organ Draft Act*, 68 B.U. L. REV. 681, 681 (1988) ("Every year in our nation 200,000 useful organs are consigned to the maggots for ready conversion to swill. The law indulges us in this practice while thousands anguish for want of the buried parts.").

[30] *See, e.g.*, English, *supra* note 24, at 11 (citing figure of 2,000 deaths per year of persons on waiting lists); Thomas G. Peters, *Life or Death: The Issue of Payment in Cadaveric Organ Donation*, 265 JAMA 1302 (1991) (citing a figure of 1,878 deaths in 1989 of potential recipients on the waiting list); Randall, *Too Few Organs, supra* note 6, at 1223 (citing 30% mortality rate for persons awaiting heart or liver transplant); Silver, *supra* note 29, at 685 (citing mortality rate of over 50,000 adults per year just due to liver failure). Put in more stark terms, every four hours a person awaiting a transplant dies. *See* Cate, *supra* note 6, at 70 (footnote omitted).

[31] *Is Organ Donation A Moral Obligation?*, WASH. POST, Aug. 28, 1990, at Z20 (claiming that one-half of children awaiting liver or heart transplants die before obtaining a transplant); Silver, *supra* note 29, at 685 (citing 10,000 child mortalities per year from liver failure).

[32] Silver, *supra* note 29, at 687 n.25 (citing BUREAU OF CENSUS, UNITED STATES DEP'T OF COMMERCE, STATISTICAL ABSTRACT OF THE UNITED STATES (Table 81) (1986)); Michelle Yuen, Note, *Letting Daddy Die: Adopting New Standards for Surrogate Decisionmaking*, 39 UCLA L. REV. 581, 589 n.33 (1992).

[33] Silver, *supra* note 29, at 688 n.25 (citing Kenneth J. Bart et al., *Cadaveric Kidneys for Transplantation: A Paradox of Shortage in the Face of Plenty*, 31 TRANSPLANTATION 379 (1982) (claiming approximately 60% of Americans die in hospitals)).

[34] For example, heart-beating cadaver donors (HBCD's).

[35] Silver, *supra* note 29, at 687-88 n.25; *see also* DONOR SHORTAGE, *supra* note 28, at 5 ("using conservative estimates, 12,000 to 15,000 medically suitable potential donors are available each year.").

preservation times.[36] As a result, immunologic matching is often impossible to perform in a timely fashion when an organ suddenly becomes available.[37]

### C. *Social Impediments to Organ Donation*

Gallup polls have consistently shown widespread support for organ donation.[38] The most comprehensive survey to date, conducted by The Gallup Organization for The Partnership For Organ Donation in Boston, indicates that eighty-five percent of the public supports the general idea of organ donation, a percentage that is "positively correlated with higher levels of education."[39]

Despite widespread support for organ donation, less than twenty percent of all Americans carry organ donor cards.[40] The great disparity between the number of people who support organ donation, and those who have actually filled out organ donor cards, may be traced to numerous factors. Among the most common factors are:

(1) a lack of understanding that a donor must be declared brain dead before organs may be salvaged for donation;[41]

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36 While the technology of organ preservation continues to progress, preservation times of organs prior to transplantation remain low, as follows: heart (4-6 hours); liver (8-24 hours); kidney (48-72 hours); heart-lung (4-6 hours); lung (up to 12 hours); pancreas (8-24 hours). *See* Kurnit, *supra* note 26, at 408 n.17.

37 Silver, *supra* note 29, at 682 n.5 (citing Denny, *How Organs Are Distributed*, 13 HASTINGS CNTR. REP. 6, 26-27 (Dec. 1983)).

38 *See generally* PUBLIC ATTITUDES, *supra* note 26; *see also* Randall, *supra* note 6, at 1223 (citing 1990 Gallup poll showing 85% of those polled were in favor of organ donation by a relative, and 60% of those polled would consent to donating organs themselves).

39 *Public Attitudes*, *supra* note 26, at 3 (showing 80% approval among persons with high school education or less, 90% approval among persons with some college education, and 95% approval among college graduates).

40 Dianne L. Manninen & Roger W. Evans, *Public Attitudes and Behavior Regarding Organ Donation*, 253 JAMA 3111, 3115 (1985) (citing a figure of 19%); TASK FORCE ON ORGAN TRANSPLANTATION: ISSUES AND RECOMMENDATIONS, *prefatory note in* Uniform Anatomical Gift Act (1987), 8A U.L.A. 2 (Supp. 1987) (citing approval rate of 75% but only 17% completion of organ donor cards).

41 *See* Teri Randall & Charles Marwick, *Physicians' Attitudes and Approaches Are Pivotal In Procuring Organs For Transplantation*, 265 JAMA 1227, 1227 (1991) (citing research that 53 out of 93 families consented to donation if prior to the request they clearly understood their relative was deceased, but when the request accompanied notification of death, the number of families consenting decreased to 11 out of 62); PUBLIC ATTITUDES, *supra* note 26, at 34 (indicating that 21% of people feel there is hope of recovery by people declared brain dead, with a further 16% unsure).

(2) the fear among potential donors that doctors would not utilize appropriate life-saving medical procedures, so as to obtain the donors' organs for transplantation;[42]

(3) physicians' reluctance to make routine inquiries of family members following death of a potential donor;[43]

(4) physicians' reluctance to remove organs when the decedent has consented but relatives object;[44]

(5) the perception among potential donors that organ donation remains inequitable, with wealthier potential recipients having more opportunity to undergo transplants;[45]

(6) potential donors' reluctance to contemplate their own mortality;[46]

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[42] *See, e.g.*, Deborah Mathieu, *Introduction* to ORGAN SUBSTITUTION TECHNOLOGY: ETHICAL, LEGAL AND PUBLIC POLICY ISSUES 34 (Mathieu ed. 1988). *But see* PUBLIC ATTITUDES, *supra* note 26, at 33 (showing that 89% of respondents believe doctors will take all means to save life before removing organs). Under the UAGA, a physician with an interest in organ retrieval may not make a determination of death. As Prottas writes, "[t]he normal division of labor in medicine ensures this practice in any case—neurophysicians are usually involved in brain death determinations, transplant surgeons in organ procurement. The latter lack the expertise to make the death determination, and the former have no occasion to transplant organs." PROTTAS, *supra* note 20, at 13-14.

[43] *See, e.g.*, Cate, *supra* note 6, at 82 (citing study finding that 30% of families of potential organ donors are never asked to approve donation). Many states require doctors to ask relatives if they would consent to donating the decedent's organs. Most evidence indicates this has had no significant impact on organ donation rates. Physicians are often reluctant to make such inquiries out fear they will appear callous to the sensitivities of the grieving family, or simply that time constraints prevent physicians from making inquiries. *See* Jeffrey M. Prottas & Henry Levine Batten, *Health Professionals and Hospital Administrators In Organ Procurement: Attitudes, Reservations, and Their Resolution*, 78 AM. J. PUB. HEALTH 642, 644 (1988).

[44] *See, e.g.*, Cate, *supra* note 6, at 82:

> [e]ven if a valid donor card is found and presented to the physician in charge of the patient's care, doctors and hospitals fear professional criticism and legal liability if they procure organs against the wishes of next-of-kin. Donor cards are legally binding in forty-eight states and health professionals who act on them are immune from liability under the UAGA in every state, but the cards have proven to be useless unless next-of-kin approve the donation.

(footnotes omitted); *see also* McIntosh, *supra* note 22, at 184.

[45] *See, e.g.*, PUBLIC ATTITUDES, *supra* note 26, at 39 (indicating that 58% of respondents feel a poor person does not have an equal chance of receiving a needed transplant as does a wealthy person).

[46] *Id.* at 13 (citing 36% of respondents as uncomfortable with contemplating their own death). As Sigmund Freud wrote:

> Our own death is indeed unimaginable, and whenever we make the attempt to imagine it we can perceive that we really survive as spectators. Hence, . . . no one

(7) religious objections;[47]

(8) the failure of physicians to make routine inquiries in a culturally-aware[48] or sensitive manner;[49]

(9) potential donors' aversion to violation of their bodily integrity caused by organ removal;[50] and

(10) potential donors' belief that family should make organ donation decisions.[51]

Further exacerbating the situation, victims of motor vehicle and other accidents[52] are frequently not utilized as donors because their organ donor cards are not delivered to the hospital expediently enough to allow for organ salvage.[53]

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believes in his own death, or to put the same thing in another way, in the unconscious every one of us is convinced of his own immortality.

SIGMUND FREUD, *Thoughts for the Times on War and Death*, *in* 4 COLLECTED PAPERS 304-05 (1925) *quoted in* Alan S. Wilmit, *Applying the Doctrine of Revocation By Divorce to Life Insurance Policies*, 73 CORNELL L. REV. 653, 654 n.4 (1988). It is also this fear of contemplating one's mortality that accounts for the common failure of people to make wills.

47 *See, e.g.*, PUBLIC ATTITUDES, *supra* note 26, at 31 (citing 4% of white respondents as giving religious objections compared to 13-14% of Hispanic and Afro-Americans); Kurnit, *supra* note 26, at 428-29 n.184.

48 *See, e.g.*, Teri Randall, *Key To Organ Donation May Be Cultural Awareness*, 265 JAMA 176 (1991) [hereinafter *Cultural Awareness*].

49 For further discussion of reasons persons are reluctant to be organ donors, see generally PUBLIC ATTITUDES, *supra* note 26, at 5.

50 *See, e.g.*, PUBLIC ATTITUDES, *supra* note 26, at 5, 37-38; Silver, *supra* note 29, at 697 n.82.

51 Arthur J. Matas et al., *A Proposal For Cadaver Organ Procurement: Routine Removal with Right of Informed Refusal*, 10 J. HEALTH POL. POL'Y & L. 231, 236 (1985). *See generally* Orly Hazony, Note, *Increasing the Supply of Cadaver Organs for Transplantation: Recognizing that the Real Problem is Psychological Not Legal*, 3 HEALTH MATRIX 219 (1993); PUBLIC ATTITUDES, *supra*, note 26, at 17-27.

52 An ironic result of vehicle safety laws, higher legal drinking ages, reduced state speed limits and helmet and seat belt laws has been to reduce the number of potential organ donors. *See, e.g.*, PROTTAS, *supra* note 20, at 42 ("In 1986, perhaps 45 percent of all organ donors died as a result of motor vehicle accidents; in 1990, only 25 percent did."); Evans, *Potential Supply*, *supra* note 26, at 239.

53 Among the difficulties are that donors fail to carry the organ donor documentation with them, and emergency personnel fail to look. As of 1984, Louisiana was the only state in which there was an official police policy of searching for organ donor cards. In nine other states, the police do so sporadically. *See* Thomas D. Overcast et al., *Problems in the Identification of Potential Organ Donors*, 251 JAMA 1559, 1561 (1984); *see also* English, *supra* note 24, at 12 (estimating that only 3% of organ donor cards are retrieved following car accidents); Randall, *Too Few Organs, supra* note 6, at 1227 ("thousands of opportunities are

Clearly, any feasible alternative to the present organ donor system would have to address many of these obstacles to organ donation. Allowing for an organ donor trust or durable power of attorney for organ donation might serve to (a) allay potential donors' fears that doctors would not try all appropriate life-saving medical procedures; (b) obviate the need for doctors to make routine inquiries of family members following brain death of a potential donor; (c) alleviate hospitals' concerns over removing organs when relatives have not consented; and (d) prevent the recurring problem that organ donor cards are not forwarded to the hospital until it is too late for successful organ salvage.

## III. Proposal for Creating a Revocable Inter Vivos Organ Trust

### A. *Introduction and Issues*

Perhaps the greatest limitation of the current organ donor system is that even if a decedent has made known his or her wishes regarding organ donation, hospitals generally will not remove organs if the decedent's relatives object. Even in the fourteen states which have adopted the 1987 version of the UAGA, the decedent's wishes are routinely overruled by relatives.

One possible way of ensuring that a decedent's wishes regarding organ donation are honored is to utilize a trust mechanism. A trust is a fiduciary relationship in which one or more persons hold property, subject to equitable duties to deal with the property for the benefit of the beneficiaries.[54] An express trust is a trust created by the express direction of the settlor, either by declaration, testamentary disposition, or *inter vivos* or living trusts.[55] An express trust must include: (1) an intention by the settlor to create a trust;[56] (2) a present transfer of a trust corpus; (3) a trustee;[57] and (4) a beneficiary of the trust, otherwise known as a cestui

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being lost because we cannot locate the family or the patient's organ donor card.").

54 Restatement (Second) of Trusts § 2 (1959).

55 *See* Eugene F. Scoles & Edward C. Halbach, Jr., Decedent's Trusts and Estates 302 (5th ed. 1993) [hereinafter Scoles & Halbach].

56 *Id.* at 320.

57 But as courts will appoint a trustee when needed, a settlor, trust property, and identifiable beneficiaries are sufficient. *See, e.g.,* Hiles v. Garrison, 62 A. 865 (N.J. 1906) (failure to name a trustee "will not prevent the execution of the trust, for the court will always appoint a trustee wherever necessary to sustain the trust"); *see also* L. Henry Gissel, Jr. & Karen R. Schiller, *Trusts Made Easy: A Simplified Overview Of the Reasons For Creating, Modifying, And Terminating*

que trust.[58] A trust is inherently flexible because it may be established for any purpose not contrary to public policy.[59]

In order for an organ trust to be legally feasible, it must meet the requirements of an *inter vivos* trust. As such, certain issues must be successfully addressed. First, given that a present transfer of a trust corpus or property is necessary, can organs constitute property? Second, if organs can be considered property, can a settlor meet the requirement of present transfer? Third, given that such a trust would be revocable, would the transfer be deemed illusory and testamentary? Fourth, against whom, and by whom, would the trust be enforceable?

## B. *The Requirement of a Present Transfer of a Trust Corpus*

### 1. The Trust Corpus

#### a. Organs as Property

The first issue to be addressed is whether organs may be considered property.[60] Over the past several decades, scholars have debated whether property rights should be recognized in the human body and its constituent parts. This debate had been intensified by such factors as the call for an organ market in the late 1980's,[61] as well as the potential value of human tissues in the rapidly-growing area of biotechnology.

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*Express Trusts*, 10 PROB. L.J. 241 (1991); SCOLES & HALBACH, *supra* note 55, at 320.

58 RESTATEMENT (SECOND) OF TRUSTS § 23 states: "A trust is created only if the settlor properly manifests an intention to create a trust." RESTATEMENT (SECOND) OF TRUSTS § 2, cmt. h, states that "[A] trust involves three elements, namely (1) a trustee. . .; (2) a beneficiary. . .; (3) trust property. . . .Although all three elements are present in a completed trust, one or more of them may be temporarily absent without destroying the trust or even without preventing the creation of the trust." *See, e.g.*, SCOLES & HALBACH, *supra* note 55, at 320.

59 *See* RESTATEMENT (SECOND) OF TRUSTS § 59 (1959).

60 Property is commonly defined as a bundle of rights that an individual or entity enjoys. *See* C.B. MACPHERSON, *The Meaning of Property, in* PROPERTY: MAINSTREAM AND CRITICAL POSITIONS 1, 3-4 (MacPherson ed. 1978). For a discussion of the issue of the body as property, see generally Katz, *supra* note 8; Thomas H. Murray, *On the Human Body As Property: The Meaning of Embodiment, Markets, and the Meaning of Strangers*, 20 U. MICH. J.L. REF. 1055 (1987); Michelle B. Bray, Note, *Personalizing Personalty: Toward A Property Right in Human Bodies*, 69 TEX. L. REV. 209 (1990); Hannemann, *supra* note 24; Roy Hardiman, Comment, *Toward the Right of Commerciality: Recognizing Property Rights in the Commercial Value of Human Tissue*, 34 UCLA L. REV. 207 (1986).

61 Alarmed at the prospects of a free market in human organs, Congress enacted the National Organ Transplant Act in 1984, making it unlawful to purchase livers, kidneys, lungs, hearts, corneas or eyes, bone marrow, pancreas, skin or

Much of the modern American law dealing with property rights in the human body stems from English common law. The English courts traditionally held that there were no property rights in cadavers held by the decedent, next of kin, or anyone at all.[62] Indeed, the Latin root of the word cadaver—*caro data vermibus*—means "flesh given to the worms."[63] The common law, however, did recognize the existence of specific obligations to the bodies of decedents, such as a duty to inter a body lawfully.[64]

Although American courts originally adhered to the stance of the English common law, they generally hold that a cadaver does give rise to a proprietary interest insofar as the decedent or relative provides for the disposal of a cadaver by will or contract.[65] As the court in *Pierce v. Proprietors of Swan Point Cemetery* held, "the person having charge of [the cadaver] . . . holds it only as a sacred trust for the benefit of all who may from family or friendship have an interest in it . . . ."[66] This proprietary right may best be described as a limited, quasi-property right.[67] Prosser and Keeton have stated that:

> [i]n most of these cases the courts have talked of a somewhat dubious "property right" to the body, usually in the next of kin, which did not

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bone for purposes of transplantation. Pub. L. No. 98-507, 98 Stat. 2339 (1984) (codified at 42 U.S.C. §§ 273-274e (1988)).

62 *See, e.g.*, Regina v. Sharpe, 169 Eng. Rep. 959 (Q.B. 1857) (English law "recognizes no property in a corpse."); Foster v. Dodd, 3 L.R.-Q.B. 67, 75 (1867) ("A dead body by law belong to no one . . . ."); Williams v. Williams, 20 Ch.D. 659, 665 (1881) ("there is no property in a dead body"); The Queen v. Price, 12 Q.B.D. 247, 252 (1884) ("a dead body is not the subject of property").

63 *See* PERCIVAL E. JACKSON, THE LAW OF CADAVERS AND OF BURIAL AND BURIAL PLACES 127 (2d ed. 1950) (citing Lord Coke).

64 *See, e.g.*, Regina v. Vann, 169 Eng. Rep. 523 (Q.B. 1851) (father required to pay for child's burial if able to do so); Regina v. Sharpe, 169 Eng. Rep. at 960 (unlawful removal of a cadaver was a misdemeanor offense); The Queen v. Price, 12 Q.B.D. at 247 (recognizing duty of lawful interment).

65 More specifically, these proprietary rights include the right to possession and custody of the cadaver for burial, the right to have the cadaver remain undisturbed in its burial place or to move it to another suitable burial place, and the right to claim damages for any injury or indignity to which the cadaver is subjected. Katz, *supra* note 8, at 157 (citations omitted). For a discussion of the differences between the English and American approaches, see Bray, *supra* note 60, at 225.

66 10 R.I. 227, 243 (1872).

67 A quasi-property right may be viewed as not having all the elements of the bundle of property rights. It is essentially the right of the family to dispose of the cadaver but little else. *See, e.g.*, Smialek v. Begay, 721 P.2d 1306, 1307 (N.M. 1986), *cert. denied*, 479 U.S. 1021 (1986) ("a quasi-property right in a dead body vested in the 'nearest relatives' of the deceased") (quoting Barela v. Frank A. Hubbell Co., 355 P.2d 133, 136 (N.M. 1960)).

> exist while the decedent was living, cannot be conveyed, can be used only for one purpose of burial, and not only has no pecuniary value but is a source of liability for funeral expenses. It seems reasonably obvious that such "property" is something evolved out of thin air to meet the occasion, and that in reality the personal feelings of the survivors are being protected, under a fiction likely to deceive no one but a lawyer.[68]

Historically, legal institutions have been much more amenable towards recognizing property rights in living bodies than in cadavers.[69] For instance, the institution of slavery illustrates "the ease with which the human body may be treated as property."[70] Under the common law, a debtor could be personally attached to pay debts and thrown into debtor's prison.[71] In addition, both the crimes of rape[72] or the more general common law crime of ravishment[73] were largely considered a property crime against the husband.[74] Recognizing a property right in the human body, however, need not have the unsavory connotations of these historical examples. Slavery, debt, and common law ravishment all reflect a proprietary right in the body which vests in another person. In contrast, the gradual yet perceptible movement in the American courts towards recognizing property rights in the human body seeks only to establish individual property rights in one's *own* body.

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68 W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS § 12, at 63 (5th ed. 1984); *see also* Bray, *supra* note 60, at 227.

69 *See* Bernard M. Dickens, *The Control of Living Body Materials*, 27 U. TORONTO L. J. 142 (1977); Stephen A. Mortinger, Comment, *Spleen for Sale: Moore v. Regents of the University of California and the Right to Sell Parts of Your Body*, 51 OHIO ST. L.J. 499, 503 (1990).

70 Hardiman, *supra* note 60, at 224. The case of Gregson v. Gilbert, 3 Dougl. 232, 233 (1783), amply illustrates this. The case involved the crew of a slave-trading vessel who pushed slaves overboard in order to alleviate a shortage of drinking water on board the ship. The court observed that "it has been decided, whether wisely or unwisely. . .that a portion of our fellow-creatures may become the subject of property. This, therefore, was a throwing overboard of goods."

71 *See* Dickens, *supra* note 70, at 144; Hardiman, *supra* note 60, at 224.

72 *See* SUSAN BROWNMILLER, AGAINST OUR WILL: MEN, WOMEN, AND RAPE 16 (1975); Hardiman, *supra* note 60, at 223; Mortinger, *supra* note 69, at 503.

73 *See* J.H. BAKER, AN INTRODUCTION TO ENGLISH LEGAL HISTORY 518-19 (1990) (stating that in ravishment or adultery cases, the wife's consent was considered void and therefore the husband could recover for the loss of the wife's personal belongings, which in law belonged to the husband, or for his loss of consortium).

74 Professor Seipp, however, has shown that in the early history of the common law, lawyers commonly used the word "property" only to refer to "interests in domestic animals and goods." *See* David J. Seipp, *The Concept of Property in the Early Common Law*, 12 LAW & HIST. REV. 29, 33 (1994). As such, the term "seisin" was used to denote possessory interests in land, wives and servants.

Individual property rights in the human body are reflected by such cases as *Venner v. Maryland*,[75] in which the Maryland Court of Special Appeals held that a property right may vest in "excrement, fluid waste, secretions, hair, fingernails, toenails, blood, and organs or other parts of the body."[76] In the case of *In re Moyer*, the Utah Supreme Court conceded that under the UAGA a person has a:

> [property] interest in his body, and the organs thereof. . .[and] should be able to make a disposition thereof, which should be recognized and be held to be binding after his death, so long as that is done within the limits of reason and decency as related to the accepted customs of mankind.[77]

Furthermore, in the landmark biotechnology case of *Diamond v. Chakrabarty*,[78] the Supreme Court upheld a patent granted for an oil-devouring bacterium, labeled a live, genetically engineered micro-organism, which had its origins in a human cell-line.[79]

One of the most influential, albeit controversial, cases was *Moore v. Regents of the University of California*.[80] The plaintiff Moore was treated at the Medical Center of the University of California at Los Angeles for an extremely rare form of leukemia, known as hairy-cell leukemia. After Moore's spleen expanded to life-threatening proportions, his treating physician, Dr. Golde, removed it. Dr. Golde further discovered that Moore's spleen cells were a very valuable item.[81] Using genetic engineering, Dr. Golde developed a cell-line potentially valued at three billion

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[75] Venner v. Maryland, 354 A.2d 483 (Md. Ct. Spec. App. 1976), *aff'd* 367 A.2d 949 (Md. 1977), *cert. denied*, 431 U.S. 932 (1977).

[76] Venner, 354 A.2d at 498.

[77] *In re* Moyer, 577 P.2d 108, 110 and n.4. (Utah 1978); *see also* Katz, *supra* note 8, at 159:

> Both the Uniform Anatomical Gift Act and the state statutes modeled upon it give support to the idea that a person has property rights in his dead body. The Act does so by giving an individual the power to dispose of 'all or any part of his body' for organ donation purposes, and permits the power to descend to his statutory heirs if not exercised by the individual himself.(footnotes omitted).

The *Moyer* court also pointed out that the majority of courts "recognize that there is a property right of some nature, sometimes referred to as a quasi-property right. Those courts that do not so recognize hark back to the time when such matters were under the jurisdiction of the ecclesiastical courts and human remains were not regarded as property." Moyer, 577 P.2d at 110 n.5.

[78] 447 U.S. 303 (1980).

[79] *Id.* at 318.

[80] 249 Cal. Rptr. 494 (Cal. Ct. App. 1988), *rev'd*, 793 P.2d 479 (Cal. 1990). *See generally* Mortinger, *supra* note 69; Helen R. Bergman, Note, *Case Comment:* Moore v. Regents of the University of California, 18 AM. J.L. & MED. 127 (1992).

[81] Moore, 249 Cal. Rptr. at 498.

dollars.[82] He induced Moore to continue visiting over the span of seven years for sample removal,[83] telling Moore that it was necessary for his treatment. Moore largely bore the cost of the treatments. Following dismissal of Moore's suit, the California Court of Appeals reversed, holding that Moore had an "unrestricted right to use, control and disposition [sic]" of his spleen, and therefore his spleen met the traditional tests of property.[84] While the California Supreme Court reversed the decision of the Court of Appeals, its holding reflected a desire by the court to circumvent the property issue and leave such public policy issues to the California legislature.[85]

In *U.S. v. Garber,*[86] the Fifth Circuit reviewed a claim of willful tax evasion by the Internal Revenue Service based on the defendant's receipt of approximately $80,000 per year from the sale of her blood plasma, which contained a rare antibody. The court analogized the sale of blood plasma both to the sale of "tangible property"[87] and to the performance of a service. The court did not indicate which of the two it more closely resembled.[88] In his dissent, Justice Ainsworth argued that the proceeds

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82 *Id.*

83 These samples included blood, blood serum, bone marrow aspirate, and sperm. Moore, 793 P.2d at 481.

84 Moore, 249 Cal. Rptr. at 505.

85 The court stated, however, that "[W]e do not purport to hold that excised cells can never be property. . . ." Moore, 793 P.2d at 493. The California Supreme Court reversal held that Moore could not sustain a cause of action for conversion of his spleen but that he had a cause of action for breach of Dr. Golde's duty of disclosure. The majority opinion chose not to address the property issue through legal analysis, instead citing policy considerations supporting its decision. For a comprehensive discussion of the *Moore* decision, see generally Benjamin Appelbaum, Comment, Moore v. Regents of the University of California*: Now That the California Supreme Court Has Spoken, What Has It Really Said?*, 9 N.Y.L. SCH. J. HUM. RTS. 495 (1992).

86 607 F.2d 92 (5th Cir. 1979).

87 *Id.* at 97.

88 As the court stated:

> In some ways, Garber's activity does resemble work: artificial stimulation, which is not a necessary prerequisite to plasma extraction, causes nausea and dizziness; the ordeal of plasmapheresis can be extremely painful if a nerve is struck, can cause nausea, blackouts, dizziness and scarring, and increases the risks of blood clotting and hepatitis. These efforts of production may logically compare to the performance of a service. On the other hand, blood plasma. . .like any salable part of the human body, is tangible property which in this case commanded a selling price dependent on its value. The amount of Garber's compensation for any given pint of plasma was directly related to the strength of the desired antibodies.

*Id.*

from the sale of plasma should be considered taxable income insofar as it was the sale of property.[89]

In *Brotherton v. Cleveland*,[90] the decedent's wife filed suit alleging that the coroner's office had unconstitutionally deprived her of her property right in her husband's corneas by removing them without her consent. The United States Court of Appeals for the Sixth Circuit, after analyzing Ohio law, held that the wife had a constitutionally-protected property right in her husband's corneas.[91]

As medical technology progresses, proprietary issues involving human tissue continue to evolve as well. In *York v. Jones*,[92] the federal court grappled with the issue of property rights in preembryos.[93] The Yorks, the gamete providers, wished to transfer their frozen embryos from a clinic in Virginia (where they resided) to another clinic in California. The Virginia clinic, however, refused to release the preembryos. The Yorks filed suit, claiming conversion of their property. The court concluded that the frozen preembryos were the Yorks' property, and that the Virginia clinic was holding the preembryos as a bailee for the Yorks despite the fact that the Yorks had signed a restrictive covenant limiting their rights.[94]

While these cases indicate that some courts have been willing to recognize a property right in the human body, there may indeed be salient policy reasons behind recognizing a quasi-property right in the human body. As Michelle Bray writes:

> Recognizing a quasi-property right—the use of and control, but a limited right of disposition—in both dead and living bodies is a coherent approach to according individuals the necessary control over their own bodies while protecting against the risk of commodification. Such an

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89 *Id.* at 103; *see also* Note, *Tax Consequences of Transfers of Bodily Parts*, 73 COLUM. L. REV. 842, 845 n.21 (1973) (noting that a graduate student at the University of Pennsylvania received $150 for ten grams of non-regenerative thigh muscle).

90 923 F.2d 477 (6th Cir. 1991).

91 *Id.* at 482.

92 717 F.Supp. 421 (E.D. Va. 1989).

93 For a discussion of preembryos as property, see Jean Voutsinas, *In Vitro Fertilization*, 12 PROB. L.J. 47, 59-66 (1994).

94 717 F.Supp. at 426-427. *See also* Voutsinas, *supra* note 93, at 60. As Voutsinas points out, the limited use of a bailment theory does not indicate whether the court would have been willing to recognize the Yorks' full ownership rights. However, given that property is commonly a bundle of rights, granting gamete providers quasi-property rights would be entirely appropriate, as it may be with respect to organs in general. Voutsinas, however, argues that preembryos should not be classified as property or as people, but rather are deserving of their own classification. *Id.* at 64-66.

> approach is also consistent with much of existing jurisprudence. The benefit of employing personhood analysis in arriving at the quasi-property right is the utilization of a philosophy that can adapt to address new legal issues as they arise, instead of simply attempting to force new dilemmas into existing legal parameters.[95]

This fear that granting organs full property status will result in the development of a brisk commodities market in transplantable organs is one of the most often cited arguments against recognizing a property right in the human body.[96] However, as Hardiman points out, the human body already meets most of the elements of property:

> [H]uman tissue possesses characteristics that satisfy many of the criteria for establishing rights in tangible property. The human body is material in nature. An individual can control, exercise domain over, and dispose of his or her body. The policy against waste of one's estate is analogous to criminal laws governing the human body. Mistreating or wrongfully disposing of a dead body may constitute a criminal offense. Under the law of mayhem, criminal liability extends to the intentional and malicious maiming or disfigurement of a person, even when that person consents. Attempted suicide was originally a criminal offense, even though it no longer constitutes a crime in the majority of American states.[97]

Recognizing property interests in human organs, however, could have tangible and beneficial results. As Cate argues, "if human organs and tissues were treated with the same official respect as real property—which, for instance, the police will act immediately and forcefully to protect upon the death of the owner—a far greater supply of transplantable body parts would result."[98] Failing to recognize such property rights results in a lack of protection for the interests of those seeking transplants, with the end result being the anomalous result that while people "die for lack of those organs. . .the legal system treats those organs as having no value."[99]

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95 Bray, *supra* note 60, at 244.

96 *See generally* James F. Blumstein, *The Use of Financial Incentives in Medical Care: The Case of Commerce in Transplantable Organs*, 3 HEALTH MATRIX 1 (1993); Mary T. Danforth, *Cells, Sales and Royalties: The Patient's Right to a Portion of the Profits*, 6 YALE L. & POL'Y REV. 179 (1988).

97 Hardiman, *supra* note 62, at 218; *see also* Katz, *supra* note 8, at 160:

> [T]here are enough incidents to substantiate the idea that one has *some* property interest in one's body. One does, for example, have the right to use one's body, the right to the income it achieves, and the right to exclude others from its use. It is not particularly strange, therefore, to speak of one's having a property right in one's body, even if it is a lesser right than ownership. (emphasis in text).

98 Cate, *supra* note 6, at 86.

99 *Id.*

As Hardiman correctly points out, organs already meet many of the requisite elements inherent in property. The reluctance of courts and legal scholars to recognize a full property right in the human body results from a well-intentioned and understandable fear that it would debase the human body. As long as this concern exists, recognizing a quasi-property right in the human body is a coherent approach that respects the individual's right to donate his or her organs, while preempting the possibility of the commercial exploitation of the body.[100]

Given that a limited right of disposition of one's body already exists, it is not a tortured extension of current law to allow for a trust mechanism promoting disposition of one's organs for transplant in a non-commercial manner. An *inter vivos* organ trust simply seeks to facilitate observance of a decedent's right to donate organs, which is already customarily recognized.

b. Alternatives to the Notion of Organs as Property

An *inter vivos* organ trust need not hinge on the existence of a full or even quasi-property right in human organs, however. For instance, a useful analogy may be drawn from unfunded life insurance trusts. In such a trust, the trust corpus consists of the insurance proceeds to be distributed to the beneficiary of the policy following the death of the insured settlor. The proceeds of the policy go into an unfunded receptacle trust, along with an attached pour-over provision in a written will instrument. The vast majority of states have statutorily provided for unfunded life insurance trusts.[101]

As the designated beneficiary of the life insurance policy, the trustee has a contract right to collect the life insurance proceeds upon death of the settlor. This contract right is commonly deemed to constitute the trust corpus.[102] Indeed, naming an appropriate Organ Procurement Or-

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100 Katz notes some interesting potential repercussions of recognizing a full property right in the human body. For instance, it could "reinforce powerful social arguments against wastage." Katz, *supra* note 8, at 158 (footnote omitted). In addition, organs could conceivably be subject to eminent domain. *Id.* at 160-63.

101 *See, e.g.,* ALASKA STAT. § 13.11.200 (1994); CAL. PROB. CODE § 6300 (Deering 1993); D.C. CODE ANN. § 18-306 (1993); MASS. ANN. LAWS ch. 203, § 3B (Law. Co-op. 1994); N.J. REV. STAT. § 3B: 4-2 (1994). *See generally* Robert Lynn, *Problems With Pour-Over Wills*, 47 OHIO ST. L.J. 47 (1986); Lawrence W. Waggoner, *The Multiple-Marriage Society and Spousal Rights Under the Revised Uniform Probate Code*, 76 IOWA L. REV. 223 (1991).

102 *See, e.g.,* Gurnett v. Mutual Life Ins. Co., 191 N.E. 250 (Ill. 1934); Bose v. Meury, 163 A. 276 (N.J. 1932); Gordon v. Portland Trust Bank, 271 P.2d 653 (Or. 1954); RESTATEMENT (SECOND) OF TRUSTS § 57 cmt. f; § 82 cmt. b; § 84 cmt. b (1959); *see also* Waggoner, *supra* note 101, at 227 n.11.

ganization as both the trustee and beneficiary may suffice to grant a contract right to the trustee-beneficiary to collect the stipulated organs for transplantation.

Furthermore, the *inter vivos* organ trust need not be an unfunded trust. To ensure the existence of a trust corpus, the organ trust could be nominally funded. Under such a trust, attachment of a single dollar bill to the trustee's copy of the trust instrument would be sufficient to constitute the trust corpus.[103] Such nominally funded trusts may be funded at the death of the beneficiary, as through a pour-over provision.

2. Present Transfer

The settlor must overtly manifest an intention to create a trust, by intending to impose enforceable duties on a trustee to deal with the property for another's benefit. Intent may be manifested by words, conduct, or both.[104]

The trust corpus must normally be in existence and be definite or definitely ascertainable, both at the time of creation and throughout the existence of the trust.[105] The trust corpus may consist of virtually any interests in property—tangible, intangible, real, or personal[106]—and usually must be effectively transferred to the trustee.[107] An effective transfer of the trust corpus consists of physically giving the trustee a deed to land, stock certificates, money, or some other instrument which has the effect of putting the trust corpus into the trustee's hands.

Clearly, the law cannot reasonably expect the settlor of an organ trust to part prematurely with vital organs, rather than merely enunciating the terms of the gift.[108] Fortunately, the law, however, recognizes that manifestation of a clearly articulated, present intention to create a trust may

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103 *See* Gissel & Schiller, *supra* note 57, at 244 n.12.

104 *See, e.g.*, Jimenez v. Lee, 547 P.2d 126 (Or. 1976); *see also* SCOLES & HALBACH, *supra* note 55, at 320.

105 *See, e.g.,* McKee v. Paradise, 299 U.S. 119 (1936); Kavanaugh v. Estate of Dobrowolski, 407 N.E.2d 856 (Ill. Ct. App. 1980); Sussman v. Sussman, 392 N.E.2d 881 (N.Y. 1979); Cahill v. Monahan, 155 A.2d 282, 288 (N.J. Super. Ct. App. Div. 1959) ("where there is no specific res, there can be no trust"); *see also* SCOLES & HALBACH, *supra* note 55, at 326.

106 *See, e.g.,* Burke v. Burke, 102 N.E. 293, 295 (Ill. 1913) ("In general, any right, interest, or thing which may be the subject of property may be granted in trust. Every kind of vested right which the law recognizes as valuable may be transferred in trust."); *see also* SCOLES & HALBACH, *supra* note 55, at 325.

107 *See, e.g.,* Dahlgren v. First Nat'l Bank of Nevada, 580 P.2d 478 (Nev. 1978); WILLIAM M. MCGOVERN, JR. ET AL., WILLS, TRUSTS AND ESTATES 191 (1988).

108 *But see Live Organ Transplants*, *in* THE MEANING OF LIFE (The Monty Python Partnership and Universal Pictures 1983).

override the issue of whether there is an adequate trust corpus.[109] A mere promise to create a trust, however, will not satisfy the requisite intention unless the declaration is presently effective and enforceable.[110] For instance, the Massachusetts Appeals Court in *Edinburgh v. Edinburgh*, ruled that the labeling of paintings constituted "symbolic delivery" of a trust corpus although the settlor retained possession of the paintings.[111] Similarly, in *Golleher v. Horton,* the Arizona Court of Appeals held that a trust of land was valid if the settlor merely delivered the deed to the trustee.[112] The Court stated that "[w]e find no authority for the proposition that the physical control of real property must be relinquished in order to transfer an interest in it in trust to a third party."[113] Therefore, precedent establishes that the lack of a present transfer of a trust corpus will not necessarily result in the failure of a trust.

### C. *Would a Revocable Trust Constitute an Illusory Transfer?*

A special problem posed by the existence of revocable trusts is whether the property transfer is deemed illusory. The Second Restatement of Trusts states:

> A disposition is not testamentary and invalid merely because the settlor reserves a beneficial life interest or because he reserves in addition a power to revoke the trust in whole or part, and a power to modify the trust, and a power to control the trustee as to the administration of the trust.[114]

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109 RESTATEMENT (SECOND) OF TRUSTS, § 26 cmt. g (1959); *see also* SCOLES & HALBACH, *supra* note 55, at 326, 356-57; Gissel & Schiller, *supra* note 57, at 251 ("Under a declaration of trust, a transfer of assets, recordation, and consideration are not required.").

110 *See* Bingen v. First Trust Co. of St. Paul, 103 F.2d 260 (8th Cir. 1939) (stating that specificity with which settlor identified mortgages subject to the trust evidenced intent to create a trust); Hamer v. Sidway, 27 N.E. 256 (N.Y. 1891) (stating that court assumes trust property put aside as testator so stated); Ex Parte Pye, 18 Ves. Jr. 140 (Ch. 1811) (stating that creation of an *inter vivos* trust ordinarily requires a present transfer of the res, but actual transfer need not occur if the settlor makes a declaration which is intended to be presently effective); *see also* AUTIN W. SCOTT, WILLIAM F. FRATCHER, THE LAW OF TRUSTS § 17.1 at 226-27 (4th ed. 1987) (transfering property unnecessary as "owner of property can, by a declaration of trust, make himself trustee of the property for others.").

111 492 N.E.2d 1164 (Mass. App. Ct. 1986).

112 715 P.2d 1225 (Ariz. Ct. App. 1985).

113 *Id.* at 1232 *See also* Adams v. Adams, 88 U.S. 185 (1874) (recording of deed to land constituted sufficient delivery to trustee); Mahoney v. Leddy, 223 A.2d 456 (Vt. 1966) (transfering title to trustee sufficient evidence of intent to create a trust); RESTATEMENT (SECOND) OF TRUSTS § 78 (1959).

114 RESTATEMENT (SECOND) OF TRUSTS § 57 (1959).

Generally, the revocable nature of a trust does not lead to a *per se* illusory transfer.[115] In *National Shawmut Bank v. Joy*, the Massachusetts Supreme Judicial Court held that the power of appointment over the trustee, coupled with the power to revoke the trust and to retain a life interest, did not result in the disposition being illusory and testamentary.[116] Since courts wish to allow settlors considerable latitude in disposing of their property, *National Shawmut Bank* is commonly followed as long as there is a beneficiary in existence. As such, a claim that a trust is invalid due to its revocable nature is unlikely to succeed.

### D. *The Trustee*

Every trust must be administered by a trustee, but the failure of the settlor to select a trustee,[117] or to select a trustee willing or capable[118] of acting in such capacity is not fatal. The Restatement stipulates that a trust will not fail because the instrument does not name a trustee, or the trustee is dead or otherwise incapable of administrating the trust.[119]

Any natural person or corporation capable of taking title to property may be a trustee.[120] The private corporations which most commonly are trustees are trust companies and banks.[121] It is unlikely that any trust company or bank would agree to act as trustee for an organ donor trust in light of the possibility of family controversy and the distinctive nature of such a trust. As such, the settlor of such a trust would likely have to choose a natural person to serve as trustee.

While trust creation does not require that the trustee be given prior notice of the trust,[122] due to the time constraints inherent in salvaging an organ, it would be essential that the trustee be aware of his or her role. Furthermore, as a practical matter the trustee would have to be cognizant

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115 *See, e.g.,* Exchange Nat'l Bank v. Sparkman, 554 P.2d 1090 (Colo. 1976); Farkas v. Williams, 125 N.E.2d 600 (Ill. 1955); Westerfeld v. Huckaby, 474 S.W.2d 189 (Tex. 1971).

116 53 N.E.2d 113 (Mass. 1944).

117 *See, e.g.*, Hiles v. Garrison, 62 A. 865, 865 (N.J. Ch. 1906) (failure to name a trustee "will not prevent the execution of the trust, for the court will always appoint a trustee whenever necessary to sustain the trust.").

118 *See, e.g., In re* Schouler, 134 Mass. 426 (1883) (trustee died before trust took effect); Ogilby v. Hickok, 128 N.Y.S. 860 (N.Y. App. Div. 1911) (trustee disqualified from serving in such capacity).

119 RESTATEMENT (SECOND) OF TRUSTS, § 32(2) (1959).

120 *Id.* at §§ 89, 96.

121 *See* GEORGE G. BOGERT & GEORGE T. BOGERT, THE LAW OF TRUSTS AND TRUSTEES 94 (5th ed. 1973) [hereinafter BOGERT & BOGERT].

122 *See, e.g.,* Thatcher v. Warden of St. Andrew's Church of Ann Arbor, 37 Mich. 263 (1877).

of the death of the settlor almost immediately to effectuate organ transfer.

Should the original trustee die, resign, or otherwise become unable or unwilling to perform the trustee function, the courts will normally appoint a successor trustee. Should the settlor provide no instructions as to specific successors or method of appointment, courts have exclusive jurisdiction to appoint successor trustees.[123]

### E. *Against Whom, and By Whom, Would the Trust Be Enforceable?*

Every private trust must have a specifically named beneficiary, or a reasonably ascertainable beneficiary, whose identity can be ascertained when the trust is created during the period in which the Rule Against Perpetuities applies, and who concomitantly has the power to enforce the trust. Without a beneficiary to enforce the trust, there can be no trust. This raises two possible issues: who would be the beneficiary of such a trust for enforcement purposes, and how would the trust be enforced?

#### 1. Who Would Be the Trust Beneficiary?

The beneficiaries of a trust may be individuals, or, under some circumstances, corporations. Because the ultimate recipient of the donated organs or tissues is unknown, the beneficiary of an *inter vivos* organ donor trust cannot be an individual. This leaves the possibility that the organ procurement organization ("OPO") itself may be considered a beneficiary. The possibility of an OPO acting as beneficiary raises further concerns: a trust beneficiary must generally be able to take and hold title to property. Under the laws of some jurisdictions and under certain circumstances, a corporation may be ineligible to be a trust beneficiary.[124] Such circumstances may include situations wherein a trust is created by will and the corporation could not be granted property directly through de-

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[123] *See, e.g.,* Thompson v. Hale, 51 S.E. 383 (Ga. 1905); Sawtelle v. Witham, 69 N.W. 72 (Wis. 1896); *see also* SCOLES & HALBACH, *supra* note 55, at 324-25. It may be suggested that the settlor should provide for successor trustees because the possibility exists that the court could appoint a member of the settlor's family that would not agree to organ salvage. However, because courts scrutinize trustee appointments to ensure that the trustee is willing and capable of carrying out the purposes of the trust, the risk seems minimal. Conversely, if the settlor's family members consent to organ donation then there would be no need for the creation of such a trust.

[124] *See, e.g.,* Adams v. Perry, 43 N.Y. 487 (N.Y. 1871) (corporation can be trustee but not beneficiary); Frazier v. Rector of St. Luke's Church, 23 A. 442 (Pa. 1892) (charitable use valid even if devised to university association).

vise or bequest. Unincorporated associations generally can be trust beneficiaries.[125]

If the issue of whether an OPO can be a beneficiary does not present an obstacle, the theoretical questions remains as to who actually benefits. The beneficiary is the one intended by the settlor to receive the benefit of the trust property from the trustee—not one who incidentally receives advantage.[126] While the OPO, on one level, is not the direct beneficiary,[127] nothing in the nature of a trust prevents one OPO from benefiting another as long as the final recipient receives the ultimate benefit.

Declaring an organ procurement agency as a beneficiary should suffice to ensure that the trust is enforceable. In the alternative, an organ trust may possibly be viewed as a charitable trust. According to the Restatement, a trust is charitable if "its accomplishment is of such social interest to the community as to justify permitting the property to be devoted to the [designated] purpose in perpetuity."[128] Such charitable purposes are deemed to include, inter alia, "the promotion of health."[129] Given that facilitating organ donations for transplantation is clearly a health-promotion objective, an *inter vivos* organ trust could arguably be considered charitable. Charitable trusts operate as an exception to the general requirement of beneficiaries because charitable trusts are enforceable by the Attorney General.[130] If deemed to be a charitable trust, the trust

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125 SCOLES & HALBACH, *supra* note 55, at 327; *see also* RESTATEMENT (SECOND) OF TRUSTS § 397 (1959), cmt. f, which provides:

> If the owner of property devises or bequeaths it to an unincorporated charitable association, a charitable trust may be created although the purposes of the trust are not mentioned in the will. If the association is incapable of taking title to the property and administering the trust, the court will appoint a trustee to take the title and administer the trust for the purposes of the association.

126 *See, e.g.,* Brennan v. Vogler, 54 N.E. 556 (Mass. 1899); *see also* BOGERT & BOGERT, *supra* note 121, at 127-28.

127 Note that as the continued existence of an OPO depends on retrieving a specific minimum number of organs—at least theoretically—it can be argued that they do directly benefit. *But see* PROTTAS, *supra* note 20, at 47 (stating that evidence indicates that no OPO has lost certification from failure to meet minimum organ salvage requirement).

128 RESTATEMENT (SECOND OF TRUSTS § 368, cmt. b (1959).

129 *Id.* at § 368.

130 *See, e.g.,* Nichols v. Allen, 130 Mass. 211, 218 (1881) ("the beneficiaries not being described by name or by class, the trust cannot be upheld unless its purposes are such as the law deems charitable"); Morice v. Bishop of Durham, 10 Ves. 522, Eng. Rep. 451 (1805) (trust fails because purpose was too broad to be enforceable as charitable trust); *see also* SCOLES & HALBACH, *supra* note 55, at 326-29.

could list as beneficiaries the general class of persons who are awaiting organ transplants.[131]

### F. *The Mechanics Behind the Organ Trust*

This proposal assumes a basic trust form. Ideally, the trust form would be federally mandated, so as not to necessitate the consultation of an attorney, and would operate to replace or compliment the present organ donor cards available in all fifty states. Such a trust would allow a donor to donate unambiguously any organs he or she desires, allow physicians to transplant organs without seeking approval of next-of-kin or other parties, and allow the potential donor to undergo histocompatibility typing through a routine blood test, thus making such information available to the central reference bank. At the same time, the presence of a trustee chosen by the principal alleviates the common concern of many potential donors that their wishes will not be respected, or that physicians will act to 'pull the plug' on them with the knowledge that they are a potential source of organs.

In an ideal situation, organ trust forms would be given with income tax forms and driver licenses. In addition, this policy could potentially be coupled with a system designed to replace the present "routine inquiry" approach,[132] such as mandated choice[133] or presumed consent.[134]

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131 *See, e.g.*, SCOLES & HALBACH, *supra* note 55, at 326 ("Except for charitable trusts and what are sometimes called 'honorary trusts', a valid trust requires a beneficiary or beneficiaries who have a right to enforce it."); *see also In re* Freshour's Estate, 345 P.2d 689, 695 (Kan. 1959) (a donor may select "some particular class of the public and limit[ ] his benefaction to that class, provided the class is composed of an indefinite number of persons rather than certain designated and named individuals.") (citations omitted).

132 *See generally* Prottas & Batten, *supra* note 43. *But see* Caplan, *Requests, Gifts and Obligations: The Ethics of Organ Procurement*, 18 TRANSPLANTATION PROC. 49, 53 (Supp. 2 1986) (indicating a 60% consent rate when family members are asked permission to donate).

133 Mandated choice seeks to have all competent adults decide whether to consent to organ donation, with their articulated preference considered controlling. *See generally* Aaron Spital, *Mandated Choice, The Preferred Solution to the Organ Shortage?*, 152 ARCH. INTERNAL MED. 2421 (1992); *see also* Katz, *supra* note 8, at 154; Kurtz, *supra* note 26, at 2-3. While no state requires outright that residents indicate whether or not they wish to donate organs, Colorado does require this when obtaining or renewing a driver's license. As a result, nearly one million drivers in Colorado, or 60% of all drivers, designated themselves as potential organ donors. *See* Howard S. Schwartz, *Bioethical and Legal Consideration in Increasing the Supply of Transplantable Organs: From UAGA to 'Baby Fae'*, 10 AM. J.L. & MED. 397, 406 (1985) (citing Overcast et al., *Problems in the Identification of Potential Organ Donors*, 251 JAMA 1559, 1560 (1984)). The in-

While the notion of an organ trust raises many intriguing possibilities and helps to clarify many of the issues which currently surround organ donation in the United States, from a practical standpoint such a proposal has serious limitations. Not only do organ trusts entail a significant expansion of existing law, but the time limitations inherent in organ salvage pose difficulties in utilizing such a mechanism. As such, it may be more fruitful to expand other areas of law which are better suited to incorporating organ donation, such as the area of advance directives.

## IV. ADVANCE DIRECTIVES

An alternative to formulating formal *inter vivos* organ trusts is the expansion of advance directives for health care to allow for organ donation. Advance directives are directives made by a principal to ensure that his or her wishes regarding medical care are respected, in the event the principal becomes incompetent or is diagnosed with a terminal illness.[135] Advance directives could feasibly allow a principal to grant a chosen agent the authority to ensure that the principal's wishes concerning organ dona-

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convenience to residents seems, in my opinion, to be clearly outweighed by the social good.

134 Presumed consent, also known as routine salvage or mandatory organ conscription, requires that the donor have previously objected or that the donor's relatives affirmatively object in order to prevent automatic organ removal. *See generally* A. Cantaluppi et al., *Legal Aspects of Organ Procurement in Different Countries*, 16 TRANSPLANTATION PROC. 102, 102 (1984); *see also* Katz, *supra* note 8, at 154; Kurtz, *supra* note 26, at 2-3. While it is used successfully throughout Europe, the day is probably far removed in which Americans would support such an approach. *See, e.g.*, A. H. Barnett & David L. Kaserman, *The Shortage of Organs for Transplantation: Exploring the Alternatives*, 9 ISSUES L. & MED. 117, 122-123 (1993) (citing UNOS survey indicating 52% of those polled opposed presumed consent) (*cited in* Dilip S. Kittur et al, *Incentives for Organ Donation*, 338 LANCET 1441, 1443 (1991)). *But see* Spital, *supra* note 133, at 2422-23 (indicating approval rate of 62% among college students). Furthermore, it may cause more problems than it solves. *See, e.g.*, DONOR SHORTAGE, *supra* note 28, at 9 ("Drastic legal changes. . .could conceivably reduce the organ shortage in the long run. But they also could make matters worse, since national polls indicate the general public is solidly opposed to [cash incentives and presumed consent laws].") This is a point well taken, but I shy away from discussions of presumed consent and similar proposals as being outside the scope of this Note. Such concerns do not apply to the alternatives that I have proposed because organ donor trusts and durable powers of attorney for health care merely seek to ensure that the principal's wishes are carried out, not to impose organ donation against the principal's wishes.

135 *See* Michael R. Schuster, *Protective Services Training Module*, *in* Estate Planning and Administration 1995, at 83 (PLI Tax Law and Estate Planning Course Handbook Series No. O4-5256, 1995).

tion are fulfilled. This section will discuss two advance directives—the living will and the durable power of attorney for health care—and analyze their applicability to the realm of organ donation.

### A. *Living Wills*

A living will is a document, written by a legally competent adult, which directs medical personnel to withhold life support systems in certain specified instances, following his or her incompetency.[136]

The notion of personal autonomy in making medical decisions is not a recent development. English common law has recognized the right of people to make their own medical decisions since the eighteenth century.[137] Moreover, evidence exists that medieval common law several centuries earlier allowed for a writ of trespass to be brought against a medical practitioner.[138]

Law in the United States followed the English model, holding that the right to make medical decisions (or, by extension, the right not to make medical decisions) is fundamental to human autonomy.[139] Medical consent falls within the ambit of the right to privacy.[140] Although not an absolute right,[141] this right receives paramount recognition, unless a

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136 *See* PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, MAKING HEALTH CARE DECISIONS at 139 (1982) [hereinafter PRESIDENT'S COMMISSION].

137 *See, e.g.,* Slater v. Baker & Stapleton, 95 Eng. Rep. 860 (K.B. 1767).

138 *See, e.g.,* Stratton v. Swanlond, B and M. 360, 362 (1374) *cited in* Baker, *supra* note 73, at 374-76.

139 *See, e.g.,* Union Pacific Ry. v. Botsford, 141 U.S. 250, 251 (1891) ("No right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others . . . ."); Canterbury v. Spence, 464 F.2d 772 (D.C. Cir. 1972) (beginning the movement towards grounding informed consent in medical cases in a negligence theory rather than battery); Mohr v. Williams, 104 N.W. 12, 16 (Minn. 1905) (operation without consent is at least a "technical assault and battery"); Schloenderf v. Soc'y of New York Hosp., 105 N.E. 92, 93 (N.Y. 1914) ("Every human being of adult years and sound mind has a right to determine what shall be done with his own body . . . ."); *see also* Susan R. Martyn & Lynn Balshone Jacobs, *Legislating Advance Directives For the Terminally Ill: The Living Will and Durable Power of Attorney*, 63 NEB. L. REV. 779, 781 n.12 (1984).

140 *See, e.g.,* Roe v. Wade, 410 U.S. 113 (1973) (constitutional right of privacy includes decision as to whether to have an abortion); *In re* Quinlan, 355 A.2d 647 (N.J. 1976), *cert. denied*, 429 U.S. 922 (1979) (right to refuse treatment covered under the umbrella of right to privacy).

141 *See* Raleigh Fitkin-Paul Morgan Memorial Hosp. v. Anderson, 201 A.2d 537 (N.J. 1964), *cert. denied*, 377 U.S. 985 (1964) (allowing blood transfusion for pregnant woman against her objections); *see also* Mark Fowler, Note, *Appointing*

countervailing state interest, such as preventing the orphaning of young children, outweighs it.[142]

The *Quinlan* case[143] was the first to inspire a concerted effort to devise a method whereby a person's wishes regarding medical care would be respected if the person became incompetent.[144] The *Quinlan* court held that Karen Quinlan's life support could not be discontinued while she was hospitalized in an irreversible comatose state unless her guardian and family first obtained the consent of the hospital's Ethics Committee.[145] Within two years of *Quinlan*, a movement emerged to enact state statutory provisions allowing written statements that requested the discontinuation of life-sustaining medical care.[146] These written manifestations became known as living wills. The *Quinlan*-inspired movement culminated with more than forty states adopting some version of living will legislation.[147] Most of these living will statutes were modeled after the 1979 Uniform Durable Power of Attorney Act.[148] Living wills, however, are generally relied upon as evidence of the patient's desires rather than as statutorily recognized documents requiring specific treatment.[149]

Courts have also recognized statements made prior to the advent of illness, as long as the statements indicate thoughtful decision-making and were made in the course of "formal discussions."[150] Living wills have become increasingly more common, usually indicating the person's wishes not to receive heroic life-sustaining treatment.[151] This principle

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*An Agent to Make Medical Treatment Choices*, 84 COLUM. L. REV. 985, 990 (1984).

142 *In re* Presidents and Directors of Georgetown College Inc., 331 F.2d 1000, 1008 (D.C. Cir. 1964), *reh'g en banc denied*, 331 F.2d 1010 (D.C. Cir. 1964), *cert. denied*, 377 U.S. 978 (1964).

143 355 A.2d 647 (N.J. 1976), *cert. denied*, 429 U.S. 922 (1979).

144 *See* BARRY R. FURROW ET AL., HEALTH LAW: CASES, MATERIALS AND PROBLEMS 1112 (2d ed. 1991)[hereinafter FURROW].

145 *See* Chen Kornreich, Note, *Who Will Decide Whether to Withhold or Withdraw Extraordinary Medical Treatment? The Constitutional Right To A 'Living Will'*, 6 PROB. L.J. 33, 36 n.11 (1984).

146 FURROW, *supra* note 144, at 1112. For a discussion of living will legislation as well as case law, see Shari Lobe, Note, *The Will to Die: Survey of State Living Will Legislation and Case Law*, 9 PROB. L.J. 47 (1989); Martyn & Jacobs, *supra* note 139.

147 FURROW, *supra* note 144, at 1112.

148 PRESIDENT'S COMMISSION, *supra* note 136, at 391-92.

149 *Id.* at 1123.

150 *See In re* Storar, 420 N.E.2d 64, 68 (N.Y. 1981), *cert. denied*, 454 U.S. 858 (1981).

151 For a discussion of legislative activity in the area of living wills, see Gregory Gelfand, *Living Wills Statutes: The First Decade*, 1987 WIS. L. REV. 737.

could easily be extended to ensure the fulfillment of a person's wishes regarding organ donation.[152]

A living will has been analogized to a trust relationship:

> [T]he patient's body is the res, the patient is the grantor-beneficiary, and the hospital and physicians are the trustees. The physician is given authority to function as the trustee of the patient's body by virtue of the patient's consent to treatment. But the patient, as grantor, may at any time revoke the trust relationship he has created with the physician.[153]

Because living wills seek to specify the individual's wishes should he or she become comatose or succumb to a terminal condition, they are indeed trust relationships. Extending living wills to cover organ donation will take the existing trust relationship and extend it to include fulfillment of the principal's wishes regarding organ donation following his or her death.

In light of the fact that living wills are often taken as a mere indication of the principal's intentions, the preferential approach would be to extend the durable power of attorney for health care to encompass the disposition of organs. This proposal has additional advantages, since a small minority of states have already explicitly expanded durable powers of attorney for health care to provide for organ donation. Furthermore, unlike the living will, the durable power of attorney for health care allows for delegation of decisions about all health care issues, not merely the issue of continuation of life support when the principal is in a persistent vegetative state or in the final stages of a terminal illness.[154]

### B. *Durable Powers of Attorney for Health Care*

#### 1. Introduction and Issues

Traditionally, when a principal is no longer able to make medical decisions on his or her own behalf, the principal's spouse, next of kin, legal guardian, or doctor has authority to make such decisions.[155] Unlike liv-

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152 *See, e.g.*, Fowler, *supra* note 141, at 998 ("[t]here is no inherent reason why [prior written expressions] could not be used to prescribe or proscribe ordinary treatments as well.").

153 Lobe, *supra* note 146, at 47 n.6 (citing Kutner, *The Living Will: The Epitome of Human Dignity in Coping with the Historical Event of Death,* 64 U. DET. L. REV. 661, 665 (1987)).

154 Sally Wagley, *After Cruzan: The Changing Art of Drafting Living Wills and Durable Powers of Attorney*, 7 ME. B.J. 160, 161 (1992).

155 *See, e.g.*, Canterbury v. Spence, 464 F.2d 772, 788-89 (D.C. Cir. 1972) (except in emergencies, doctors must obtain consent from relative); Younts v. St. Francis Hospital and School of Nursing, Inc., 469 P.2d 330, 336 (Kan. 1970) (in the absence of an emergency, consent must be obtained from someone "legally

ing wills, a durable power of attorney for health care is an instrument whereby a principal may appoint a proxy to make medical decisions for her. Originating as an extension of a power of attorney which pertains to the management of financial matters, the durable power of attorney was extended beyond the incapacity of the principal in the 1970's.[156] The durable power of attorney for health care has since become common in statutory provisions.[157] This section analyzes the extension of durable powers of attorney for health care beyond the death of the principal in order to allow the attorney-in-fact to provide for the disposition of the principal's organs in accordance with the principal's wishes.

Utilizing durable powers of attorney for health care to facilitate organ donation presents several issues. First, are there any logical grounds for holding that durable powers of attorney expire along with the patient? Second, would a durable power of attorney adequately ensure that the principal's wishes are carried out?

2. Discussion

The reasons why individuals grant durable powers of attorney for health care vary. Durable powers of attorney traditionally take effect upon the principal's becoming incompetent, or less commonly, when he or she is diagnosed with a terminal illness. An individual, however, may simply wish to delegate such authority to her agent because making specific treatment decisions may exact too great a psychic toll. She may simply prefer to have a trusted agent make her medical decisions. Others may feel that they lack the requisite level of expertise to make an informed or objective decision.[158]

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authorized to give it."); Wilson v. Lehman, 379 S.W.2d 478, 479-80 (Ky. 1964) (consent for surgery comes from "near relative capable of giving consent") (citing Tabor v. Scobee, 254 S.W.2d 474 (Ky. 1951)); *see also* Fowler, *supra* note 140 at 985.

156 *Furrow*, *supra* note 144, at 1124-25.

157 *See, e.g.*, ILL. REV. STAT. ch. 110.5, para. 804-10 (Smith-Hurd Supp. 1990); N.M. STAT. ANN. § 45-5-502 (Michie Supp. 1990); R.I. GEN. LAWS § 23-410-1 (1990). The durable power of attorney for health care is currently recognized in approximately forty states. *See* Michael Schmitt & Steven Hatfield, *The Durable Power of Attorney: Applications and Limitations*, 132 MIL. L. REV. 203, 220 (1991).

158 *See, e.g.*, MODEL HEALTH CARE CONSENT ACTS § 6(a), 9 U.L.A. 339 (Supp. 1984) (recognizing that competent patients may also choose to make use of agents in medical decisions); N.Y. PUB. HEALTH LAW § 2805-d(4)(b) (McKinney 1977) (allowing a person the right to not be informed about his or her treatment); *see also* PRESIDENT'S COMMISSION, *supra* note 136, at 50-51; Fowler, *supra* note 141, at 985 and 1010 n.164; Alan Meisel, *The "Exceptions" to the In-*

Perhaps the first judicial mention of a durable power of attorney for health care originated in the case of *Cruzan v. Missouri Department of Health*,[159] wherein Justice O'Connor wrote in a concurring opinion that:

> [I wish] to emphasize that the Court does not today decide the issue whether a State must also give effect to the decisions of a surrogate decision-maker. In my view, such a duty may well be constitutionally required to protect the patient's liberty interest in refusing medical treatment. . . . [A health care proxy] may be a valuable additional safeguard of the patient's interest in directing his care.[160]

Although durable powers of attorney for health care have become common, some precedent also exists to suggest that a general durable power of attorney under the Uniform Probate Code might be extended to health care decision-making in the absence of statutory provisions. The New Jersey Supreme Court stated in the case of *In re Peter* that "[a]lthough the [Uniform Probate Code] does not specifically authorize conveyance of durable authority to make medical decisions, it should be interpreted that way."[161] Further, the New York Court of Appeals has noted in dicta that:

> Although powers of attorney have traditionally been limited to delegation of financial powers as opposed to personal decisions this limitation has been eroded by court recognition of the ability of third parties to express the wishes of incompetent patients without written authority. There is therefore no longer any reason in principle why those wishing to appoint another to express their specific or general desires with respect to medical treatment, in the event they become incompetent, may not do so formally through a power of attorney.[162]

In order for a durable power of attorney to apply to organ donation, it must survive the death of the principal. Normally, the power of attorney ceases at the principal's death, perhaps because wills and trusts are sufficient to govern the affairs of decedents. More likely, the principle echoes the common law presumption that it would be imprudent to allow an agent to act unhampered by the principal's oversight. Under existing law, acts of an attorney-in-fact done under the authority of a durable power of attorney, without knowledge that the principal has died, may be bind-

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*formed Consent Doctrine: Striking a Balance Between Competing Values in Medical Decisionmaking*, 1979 WIS. L. REV. 413, 453-60.

159 497 U.S. 261 (1990).

160 *Id.* at 289-92 (O'Connor, J., concurring).

161 529 A.2d 419, 426 (N.J. 1987) (holding that the New Jersey statue governing durable powers of attorney should be construed so as to provide for medical decisions).

162 *In re* Westchester Medical Center (O'Connor), 531 N.E.2d 607, 612 n.2 (N.Y. 1988).

ing.[163] Allowing an attorney-in-fact to make decisions regarding organ donation, where there is clear evidence that the principal would have so desired, is but a small step. Even more promising, a small but growing minority of states, have statutorily expanded the durable power of attorney for health care to encompass disposition of the principal's body following death, including disposition of organs under the UAGA. As of early 1994, seven states had enacted statutes that explicitly allow an attorney-in-fact to authorize organ donation.[164]

This discernable trend in the evolution of durable powers of attorney should be encouraged. An attorney-in-fact who is entrusted to make medical decisions on behalf of the principal while she is still alive is certainly able to make responsible decisions regarding organ disposition following the principal's death. Extending a durable power of attorney for health care is a practical way of respecting the individual's decision to be an organ donor, without entailing a significant expansion of current law.

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163 *See, e.g.*, UNIF. PROB. CODE § 5-504(b) (1990).

164 These statutory provisions are: CAL. PROB. CODE § 4720(b)(1) (West 1995) ("Subject to any limitations in the durable power of attorney, the attorney-in-fact designated in a durable power of attorney for health care may make . . . a disposition under the Uniform Anatomical Gift Act . . . ."); GA. CODE ANN. § 31-36-7(4)(A) (1994) ("If and to the extent a health care agency empowers the agent to . . . [m]ake an anatomical gift on behalf of the principal . . . the anatomical gift . . . shall be deemed the act of the principal or of the person who has priority under the law to make the necessary decisions. . . ."); IDAHO CODE § 39-4505(5)(d) (Michie 1994) ("Subject to any limitations in this document, my agent has the power and authority to . . . [c]onsent to the donation of any of my organs for medical purposes."); ILL. ANN. STAT. ch. 755, para. 45/4-7(d)(1) (Smith-Hurd 1995) ("If and to the extent a health care agency empowers the agent to . . . make an anatomical gift on behalf of the principal under the Uniform Anatomical Gift Act . . . the decision by an authorized agent as to anatomical gift . . . shall be deemed the act of the principal and shall control over the decision of other persons who might otherwise have priority . . . ."); KAN. STAT. ANN. § 58-629(a)(1) (1993) ("A durable power of attorney for health care decisions may convey to the agent the authority to . . . make decisions about organ donation . . . ."); N.C. GEN. STAT. § 32A-19(b) (1994) ("A health care power of attorney may authorize the health care agent to exercise any and all rights the principal may have with respect to anatomical gifts . . ."); W. VA. CODE § 16-30A-4(d)(7) (1994) ("A representative shall have the authority to give, withhold or withdraw informed consent to the health care of the principal, which authority shall include, but not be limited to . . . [m]aking decisions about the gift or donation of a body organ or tissue . . .").

## V. Conclusion

This proposal calls for the creation of an *inter vivos* organ trust or extending advance directives to include organ donation. Either approach would empower an agent chosen by the principal to carry out her wishes regarding organ donation.

The language of the UAGA itself may be compatible with the incorporation of such an *inter vivos* organ trust. The UAGA states that an anatomical gift is initiated through a "document of gift," defined as a "card, a statement attached to or imprinted on a motor vehicle operator's or chauffeur's license, a will or other writing used to make an anatomical gift."[165] In 1987, the UAGA removed the requirement that two witnesses sign the instrument and thus simplified the process. My proposal might reinstate a certain degree of formality, yet, because no evidence indicates that this amendment has resulted in greater numbers of donors, the increased reliability of this requirement would outweigh the inconvenience.

To be maximally effective, the trust must develop with a minimum of paperwork, ideally a single page form allowing the donor to check off the appropriate boxes. This system could also incorporate a mandated choice system, wherein a donor is required to make a decision regarding organ donation. This decision would require a routine physical exam for typing blood and tissue, that the physician note the desired organs for donation, that the form indicate a trustee, and that the trustee sign the form. For successful implementation, the trust form should be readily available at the physical exam. Furthermore, each person could receive a bracelet or 'dogtag' with coded symbols indicating that she is an organ donor.[166]

Advantages of this proposal include the following:

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165 9 U.L.A. § 7 (1994).

166 The principal could be given a bracelet similar to medical alert tags coded for her tissue type, what organs are to be donated, and the name of the trustee. This would alleviate the common problem of misplaced organ donor cards and dramatically reduce the burden on physicians to inquire of a decedent's next of kin whether they would consent to organ donation, thus sparing the considerable psychic trauma this imposes on both doctor and relatives. Many possible donors, however, may find this intrusive. It also may not alleviate potential donors' fears that doctors would not take all steps to save them if they are known to be potential donors. Should a health system, such as that proposed by the Clinton administration ever be put into place, the proposed "health security card" could efficiently store all such information. A simple code embossed on the card itself could also allay concerns that a card might incorrectly identify an individual as an organ donor.

(1) the trustee would provide peace of mind for the large percentage of people who abstain from organ donation because they fear that doctors would 'pull the plug' on them in order to harvest their organs;

(2) the proposals may act to replace the largely ineffectual and unpleasant "routine inquiry" approach;

(3) the trust form would spell out the list of organs that people may donate, thus informing them that donations include such items as skin and corneas, and increasing the number of people willing to donate such organs;

(4) decreased controversy over whether a decedent did (or would) consent to organ donation;

(5) enhanced cross-referencing of potential donors and recipients for organ banks, thus assisting in decreasing the burden of arranging potential matches when faced with extreme time constraints; and

(6) decedents' relatives could not override decedents' preferences regarding organ donation.

In order for an organ donor trust to be practicable on a tangible level, the current law would require substantial revision. There are also severe time limitations involved in notifying the trustee following the principal's death. One may also wonder whether physicians would be comfortable salvaging organs based on the word of an organ donor trustee if the principal's relatives vehemently oppose it. Given such difficulties, extending advance directives to include organ donation is the more feasible of the two proposals, particularly in light of the existing statutory provisions which allow an attorney-in-fact, under the authority of a durable power of attorney for health care, to dispose of the principal's organs.

Given the enormous number of people who can benefit from organ donation, as well as the chronic shortage of salvageable organs, the law should evolve to promote organ donation. Likewise, attorneys must recognize their responsibility to ensure that this necessary evolution occurs. Recognizing this, the American Bar Association passed a resolution in 1992 sponsored by the Real Property, Probate and Trust Law section, stating that:

> RESOLVED, that the American Bar Association supports efforts to educate the public about the critical need for organ and tissue donations, and supports efforts to inform the legal community and clients of the opportunities to make these donations.
>
> BE IT FURTHER RESOLVED that the American Bar Association urges all attorneys to raise with their clients, when appropriate, the topic of organ and tissue donations and to provide donation forms to those clients who indicate an interest in making a donation.

> BE IT FURTHER RESOLVED that the American Bar Association urges the legal community to coordinate its efforts with respect to organ and tissue donations with the efforts of the medical community . . . and others involved in organ and tissue transplantation.
>
> BE IT FURTHER RESOLVED that the American Bar Association supports efforts to bring uniformity, comity, and universality to the law and practice of organ . . . donations and encourages all states to enact the 1987 version of the Uniform Anatomical Gift Act.
>
> BE IT FURTHER RESOLVED that the American Bar Association recommends that the Uniform Anatomical Gift Act be revised to expressly provide that an agent under a durable power of attorney may be granted authority to make organ and/or tissue donations.[167]

Given the importance of promoting organ donation, this Note will achieve its primary goal if it serves to inform members of the legal community of the critical shortage of organs and promotes dialogue of possible solutions—whether through expansion of existing laws to create an organ trust, encouraging states to adopt the 1987 version of the UAGA, or through expanding durable powers of attorney for health care to encompass the disposition of organs. The thousands of people who die needlessly for want of transplantable organs deserve no less.

IAN C. PILARCZYK

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167 1992 A.B.A. SEC. REAL PROP. PROB. & TR. L. REP. (adopted by the House of Delegates in 1992), *reprinted in* English, *supra* note 24, at 14.