

Modern Models of Organ Donation: Challenging Increases of Federal Power to Save Lives

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Introduction

Signed into law in 2010 by President Barack Obama, the Patient Protection and Affordable Care Act (“ACA”) represented the largest amendment to the United States healthcare system since the introduction of Medicare in 1965.¹ The ACA mandates that all Americans, excluding those with religious and financial exceptions, purchase a form of health insurance—either public or private—if they are not already subscribed to a plan by 2014.² Although Congress claimed it enacted the ACA under its power stemming from the Commerce Clause, by arguing that the health insurance industry is a unique interstate market in need of federal interference to prevent insolvency, the Supreme Court upheld the law on taxation grounds.³ While both the merits and constitutionality of the ACA have been debated by scholars and the public alike, the fact that this expansive bill was declared constitutional raises a broader legal question: If Congress can enact this kind of law, how far can it go in extending the power of the federal government into the realm of healthcare?

Aside from the crisis surrounding health insurance, another significant issue in modern healthcare has been the search for

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1. Patient Protection and Affordable Care Act, Pub. L. 111–148 (2010).
2. *Id.*
3. *Thomas More Law Center v. Obama*, 651 F.3d 529, 544 (6th Cir. 2011); *see also National Federation of Independent Business v. Sebelius*, 2012 WL 2427810.

solutions regarding the dangerously low rate of organ donations. Currently, although just over forty percent of United States residents are registered organ donors, in the first ten months of 2011 only 11,716 donors were actually involved in procedures.⁴ Section I of this note will briefly review the current majority model of organ donation in the United States and the reasons why donor rates remain low as a result. Section II then discusses the prevailing views on the constitutionality of changing United States organ donation law to a system of presumed consent. Section III assesses the underpinnings, statistics, and potential First Amendment challenge to altering organ donation law to the model of mandated choice, as has been in place in Illinois since 2006. Section IV analyzes the history, likely results, and potential constitutional challenge related to a preferred donation system in which Americans who register to be live donors would receive preference as recipients, similar to the model passed in Israel in 2008.⁵ Section V discusses alternate forms of incentivizing donations including financial compensation, creating a market for organs, and private exchange networks. Lastly, Section VI discusses which model is likely to not only provide the highest increase in donor rates, but also why each model can survive a constitutionally-based challenge if crafted wisely.

I. The Current Majority Model: Informed Consent

A. History

In 1968, the National Conference of Commissioners on Uniform State Laws (“NCCUSL”) passed the Uniform Anatomical Gift Act (“UAGA”).⁶ UAGA is a model law, yet all fifty states and the District of Columbia have adopted some variation of the act.⁷ Key provisions in UAGA include who is eligible to donate organs,⁸ the

4. *National Donor Designation Report Card*, Donate Life America (April 2011), <http://donatelifenet/wpcontent/uploads/2011/04/DLARReportBKLT307332.pdf>; *Transplant Trends*, United Network for Organ Sharing, <http://www.unos.org> (last visited Jan. 22, 2012).

5. Organ Implementation Law, 5768–2008, SH No. 2144 p. 394 (Isr.).

6. Unif. Anatomical Gift Act § 1, 8A U.L.A. 70 (1968).

7. Alicia Markmann, *Organ Donation: Increasing Donations While Honoring Our Longstanding Values*, 24 TEMP. J. SCI. TECH. & ENVTL. L. 499, 505 (2005). As of Jan. 27, 2012, 44 states, the District of Columbia, and the United States Virgin Islands have adopted the revised version of the UAGA. The remaining six states currently use the 1968 version of the Act.

8. Revised Unif. Anatomical Gift Act §§ 4, 9, 8A U.L.A. 70 (2006).

rights and duties of donees, physicians, and donors,⁹ and who may receive anatomical gifts.¹⁰ UAGA was further amended in 1987 to forbid persons from “knowingly, for valuable consideration, purchas[ing] or sell[ing] a part for transplantation or therapy, if removal of the part is intended to occur after the death of the decedent.”¹¹

One of the primary goals of UAGA was to make organ donation a system based on altruism and voluntarism.¹² As a result, for any person in the United States to make an anatomical gift, the donor must give their consent, or “opt in.”¹³ Consent may be given in a variety of forms, the most common of which are either a preference indicated on the decedent’s driver’s license or permission from a decedent’s family members in a hospital soon after the moment of death.¹⁴ Other means of acquiring consent from donors include approval in a decedent’s will,¹⁵ verbal communication by a terminally ill patient made in the presence of two adults (at least one of whom is disinterested),¹⁶ or through a written and signed statement.¹⁷ If an individual does not give consent for a living donation or indicate a preference to donate their organs after death, it is illegal to harvest any of their organs.¹⁸

To further effectuate the intent of UAGA, Congress created the Health Care Financing Administration (“HFCA”), now known as the Centers for Medicare and Medicaid Services (“CMS”), in 1977.¹⁹ Despite UAGA’s ratification across the country, Congress recognized the unwillingness of hospitals to attempt to secure organ donations, and in response it mandated eligibility requirements for Medicare reimbursement. One such requirement is that hospitals must ask all

9. *Id.* at §§ 5, 6.

10. *Id.* at § 11.

11. Unif. Anatomical Gift Act § 10, 8A U.L.A. 70 (1987).

12. Howard M. Nathan et al., *Organ donation in the United States*, AM. J. TRANS. 2003; 3 (Supp. 4): 29, 31 (2003).

13. Sean R. Fitzgibbons, *Cadaveric Organ Donation and Consent: A Comparative Analysis of the United States, Japan, Singapore, and China*, 6 ILSA J. INT’L & COMP. L. 73 (1999).

14. Nathan, *supra* note 12 at 31.

15. Revised Unif. Anatomical Gift Act § 5(a)(2), 8A U.L.A. 70 (2006).

16. *Id.* at § 5(a)(3).

17. *Id.* at § 5(b).

18. *Id.* at § 5.

19. *Historical Highlights*, Department of Health and Human Services, <http://www.hhs.gov/about/hhshist.html> (last visited Jan. 26, 2012).

donor-eligible patients and their families if they would like to donate.²⁰ These “required request” laws were also developed under the belief that asking patients, and their families, for organ donations would make them more willing to make a gift.²¹

B. Organ donation rates under informed consent

Since the promulgation of UAGA and ratification of required request laws, organ donation rates in the United States have remained in the middle when compared to the rest of the world. As of November 2012, there were 116,482 active waitlist candidates for organ donations in the United States, yet the total number of transplant procedures done in the first ten months of 2011 was only 23,749.²² While just over forty percent of all Americans are registered organ donors,²³ and organ donation rates in the United States have very recently seen a slight upward trend, many states have failed to meet the goals set for them by leading organ donation groups.²⁴ Despite this shortfall, the United States has higher organ donation rates than foreign countries that also employ informed consent—including the United Kingdom, Germany, and Australia, which all have donor rates of fifteen per million population (“pmp”) or lower.²⁵

What is particularly startling about the case of the United States is that surveys indicate the cadaveric organ donation rate should be significantly higher. Numerous polls have shown that nearly all Americans are aware of organ transplantation and a vast majority of individuals say they would donate their organs if asked.²⁶ In reality, less than half of families ever consent to donating their own or a

20. Nathan, *supra* note 12, at 31; 42 C.F.R. § 482.45 (1998).

21. Nathan, *supra* note 12, at 32.

22. Data, OPTN, <http://optn.transplant.hrsa.gov/> (last visited Nov. 13, 2012).

23. *Supra* Introduction.

24. *Id.* The Donor Designation Collaborative (DDC), launched in 2006, is a joint effort with the goals of increasing organ donation rates and developing more efficient donor registries. As of November 2010, only 36 states and the District of Columbia have met the requirements for effective donor registries, while only 24 states have donor rates above fifty percent for residents 18 years and older.

25. Frank Van Gelder, et al., *2009 International Donation And Transplantation Activity. IRODaT Preliminary Data*, International Registry of Organ Donation and Transplant (IRODaT) (2010), <http://www.europeantransplantcoordinators.org/uploads/pdfs/Irodat/01%20Irodat%202009.pdf>.

26. Nathan, *supra* note 12, at 32. The Gallup poll from 1993 used in the article indicates that ninety-nine percent of Americans are aware of transplantation. Three polls from 1991, 1993, and 2001 show that about seventy-five percent of those surveyed would agree to donate their organs.

loved one's organs.²⁷ This disparity between those who say they want to donate and the actual registration rate stems from numerous flaws with the informed consent system.²⁸ These flaws include doctors following the wishes of the decedent's family instead of the wishes of the decedent, the failure of emergency personnel to locate written directives at accident sites, and the inefficiency of organ procurement services in obtaining referrals from donors.²⁹ One of the leading factors contributing to a lower-than-expected organ donation rate under the informed consent model is the reluctance of potential donors to contemplate and plan for their inevitable deaths.³⁰ Despite the United States maintaining one of the highest rates of organ donation for informed consent countries at over twenty-one pmp, polling suggests the disparity between registered donors and actual transplants should be far less than it is.³¹

The growing need for organ donations and apparent failure of the informed consent system to match the increased demand generates the question: What other models exist, would they increase organ donation rates, and can they be successfully implemented in the United States?

II. The Common Alternative: Presumed Consent

A. Background

The most frequently used alternative model of organ donation to informed consent is the presumed consent system. Broadly construed, the presumed consent, or "opt out," system statutorily mandates that the organs of a decedent are available for donation because the decedent has tacitly given his or her consent unless otherwise indicated.³² Practically, there are two forms of presumed consent: strong and weak.³³ *Strong presumed consent* systems prohibit a decedent's family from interfering with the donation process,

27. *Id.* When families were actually asked to provide consent to donate a deceased's organs, only forty-eight percent agreed to donate.

28. Unif. Anatomical Gift Act, Refs. & Annos., 8A U.L.A. 70 (1987).

29. *Id.*

30. Andrew C. MacDonald, *Organ Donation: The Time has Come to Refocus the Ethical Spotlight*, 8 STAN. L. & POL'Y. REV. 177, 180 (1997).

31. Van Gelder, *supra* note 25.

32. Michele Goodwin, *Formalism and the Legal Structure of Body Parts*, 2006 U. CHI. LEGAL F. 317, 330-31.

33. Lori Hartwell, *Global Organ Donation Policies Around the World*, Contemporary Dialysis & Nephrology (Dec. 1999)

whereas *weak presumed consent* systems require permission from the decedent's family before any organs can be harvested.³⁴ The weak model, used in Spain and Belgium, is far more common, and on its face appears similar to the informed consent model used throughout the majority of the United States.³⁵

A recent study from Johns Hopkins University concluded that in most countries with presumed consent, donation was discussed with the decedent's family at the time of death despite doctors having the legal right to harvest the organs.³⁶ Furthermore, in the thirteen European nations studied that have presumed consent laws, six legally require doctors to speak with the relatives of the deceased.³⁷ One of the crucial considerations of weak presumed consent is the respect for the decedent's relatives who are grieving and the notion that strong presumed consent laws could impose even further psychological damage upon those family members.³⁸

B. Organ donation rates under presumed consent

On the whole, countries that employ a presumed consent model for organ donation have higher donation rates than countries using alternate methods. Spain, which as previously mentioned operates a weak presumed consent system, currently leads the world in number of deceased organ donations at over thirty-four organs donated pmp.³⁹ Other European nations, including France, Belgium, Austria, Italy, and Latvia, also use a presumed consent donation model and have donor rates above twenty pmp.⁴⁰

Whether organ donation rates would rise as a result of changing United States donation law to a presumed consent model is still a matter of significant debate. The Johns Hopkins study from January 2012 indicates that while presumed consent may slightly increase

34. *Id.*

35. Brian Boyarsky et al., *Potential Limitations of Presumed Consent Legislation*, 93 *Transplantation* 136 (2012); Amber Rithalia et al., *A Systemic Review of Presumed Consent Systems for Deceased Organ Donation*, 13 *HEALTH TECH. ASSESSMENT* 1 (2009).

36. Boyarsky, *supra* note 35.

37. *Id.*

38. *Id.*

39. Van Gelder, *supra* note 25, at 7.

40. *Solutions*, Presumed Consent Foundation (last visited Jan. 26, 2012), <http://www.presumedconsent.org/solutions.htm>; *Organ Donation and Transplantation: Policy Options at EU Level*, European Commission (June 27, 2006), http://ec.europa.eu/health/ph_threats/human_substance/oc_organs/consultation_paper.pdf. The European Commission report uses the 2005 annual statistics from IRODaT.

donation rates, the effect is not significant.⁴¹ Researchers conducted interviews with leading European transplant experts concluding there is too much heterogeneity across the presumed and informed consent organ donation models, and that the differences in donor rates are attributable to country-specific factors.⁴²

Conversely, other organ donation experts and economists believe that a presumed consent model will lead to a statistically significant increase in donation rates, or at least establish a framework where donation rates can increase faster.⁴³ A 2006 econometric study found that when controlling for outside factors, presumed consent can increase organ donation rates as much as twenty-five percent to thirty percent.⁴⁴ Similarly, the Centre for Reviews and Dissemination at the University of York determined that countries with presumed consent models have higher donation rates, although the increased rates were not solely attributable to the presumed consent system.⁴⁵

While the debate continues about the potential benefits and harms of presumed consent organ donation—from both practical and psychological standpoints—the larger question is whether this model could legally be implemented in the United States at a national level.

C. Limited current use of presumed consent laws in the United States

Although informed consent is the traditional organ donation model in the United States, numerous states have implemented presumed consent laws on a limited basis.⁴⁶ As of 1995, twenty-one states had some form of presumed consent law for posthumous donation of corneas.⁴⁷ The extent of presumed consent laws in the United States is severely restricted, however, and is traditionally limited to corneas or John Doe homicide victims.⁴⁸ Since their

41. Boyarsky, *supra* note 35.

42. *Id.*

43. Alberto Abadie and Sebastien Gey, *The Impact of Presumed Consent Legislation on Cadaveric Organ Donation: A Cross Country Study*, 25 J. HEALTH ECON. 599 (2006); Rithalia, *supra* note 35.

44. Abadie, *supra* note 43, at 619.

45. Rithalia, *supra* note 35, at 35.

46. See Fla. Stat. Ann. §765.5185. See also Mich. C.L.A. 333.10203; but see Tex. Transp. Code Ann. §521.405(b) (repealed Sept. 2005).

47. Fred H. Cate, *Human Organ Transplant: The Role of Law*, 20 J. CORP. L. 69, 84 (1995).

48. *Id.*

inception, these laws have come under scrutiny, but courts have rarely found them to violate either state or federal law.⁴⁹

Traditional challenges to presumed consent laws are based in property and personal rights.⁵⁰ In Michigan, a mother challenged the state's presumed consent law for cornea extraction, complaining that the act of removing her deceased daughter's corneas constituted an unconstitutional invasion of privacy.⁵¹ The Michigan Court of Appeals upheld the law, stating that the right of privacy is entirely personal and "ends with the death of the person to whom it is of value. It may not be claimed by his estate or his next of kin."⁵² Although the court recognized an interference tort cause of action for family members entitled to possession of a decedent without mutilation for burial purposes, the court held that cornea removal without facial appearance alteration was insufficient evidence to support an individual claim.⁵³

Other courts outside of Michigan have come to similar results regarding the property rights of next of kin and their decedents in presumed consent situations.⁵⁴ The Supreme Court's pronouncement in *Roe v. Wade* that a person's property rights over their own body end at death has become the cornerstone of presumed consent jurisprudence and has made it significantly harder for next of kin to claim ownership over a decedent.⁵⁵ The NCCUSL also recognized the desire of legislatures to impose limited presumed consent models and explicitly included such provisions in its 1987 and 2006 versions of UAGA.⁵⁶

49. See *infra* notes 51, 54.

50. Fitzgibbons, *supra* note 13, at 99.

51. *Tillman v. Detroit Receiving Hosp.*, 360 N.W.2d 275, 277 (1984).

52. *Id.*

53. *Id.* at 277–78.

54. *State v. Powell*, 497 So. 2d 1188, 1190–91 (1986) (Supreme Court of Florida holding that Florida's presumed consent cornea donation law has a permissible legislative objective of providing sight and that next-of-kin have no fundamental property right in a decedent); see *Lawyer v. Kernodle*, 721 F.2d 632, 634 (8th Cir. 1983) (noting that next-of-kin only have a quasi-property right in a decedent for the sole purpose of burial (citing *Rosenblum v. New Mt. Sinai Cemetery Ass'n*, 481 S.W.2d 593, 594–95 (Mo. App. 1972))).

55. See *Roe v. Wade*, 410 U.S. 113, 152 (1973).

56. Revised Unif. Anatomical Gift Act § 22, 8A U.L.A. 70 (2006); Unif. Anatomical Gift Act § 4, 8A U.L.A. 70 (1987).

Recently, presumed consent laws have come under scrutiny for violating the First Amendment's Free Exercise Clause.⁵⁷ Critics theorize that because courts recognize a quasi-property right for next of kin with regard to burial rights, presumed consent infringes upon what is traditionally a religious service.⁵⁸ A further proposed challenge to presumed consent laws stems from the Due Process Clause of the Fourteenth Amendment.⁵⁹ It is hypothesized that the recognition of a quasi-property right for burial satisfies both the property and liberty interest components of the Fourteenth Amendment's due process protection.⁶⁰ If true, the crucial issue becomes whether or not the simple act of taking an organ without the consent of next-of-kin violates that kin's procedural due process.⁶¹

Despite these proposed challenges, presumed consent laws in the United States have almost unanimously been found constitutional. Although these laws have been found constitutional in their limited nature, it has been suggested that Americans generally—and some doctors—will not accept a broader version of presumed consent.⁶² Personal autonomy has long been a hallmark of American society and the notion of an opt-out model for organ donation appears morally repugnant to many.

If presumed consent is not an option for psychological, constitutional, or practical reasons, unconventional models of organ donation may prove successful in increasing donation rates while also alleviating concerns of personal autonomy.

57. See generally Carrie Parsons O'Keeffe, *When An Anatomical "Gift" Isn't A Gift: Presumed Consent Laws As An Affront To Religious Liberty*, 7 TEX. F. ON C.L. & C.R. 287 (2002).

58. *Id.* at n.84.

59. Alexander Powhida, *Forced Organ Donation: The Presumed Consent to Organ Donation Laws of the Various States and the United States Constitution*, 9 ALB. L.J. SCI. & TECH. 349, 364 (1999).

60. *Id.*

61. See *Brotherton v. Cleveland*, 923 F.2d 477, 481–82 (1991); but see *Tillman*, 360 N.W.2d at 278 (holding that the taking of a person's body parts for a criminal investigation without the consent of next of kin is constitutional).

62. See Robert M. Veatch & Jonathan B. Pitt, *The Myth of Presumed Consent: Ethical Problems in New Organ Procurement Strategies*, 27 TRANSPLANTATION PROC. 1888 (1995); see also Lloyd R. Cohen, *Increasing the Supply of Transplant Organs: The Virtues of a Futures Market*, 58 GEO. WASH. L. REV 1, 19 (1989) (noting most doctors find it unethical to take organs without the consent of the decedent or next of kin).

III. Coercing the Opt-in Process: Mandated Choice

A. Background

In 2006, Illinois enacted the First-Person Consent Act (“FPCA”) requiring all citizens over age eighteen to inform the state, when acquiring or renewing their driver’s licenses, whether they consent to being an organ donor after death.⁶³ The FPCA further dictates that this decision is legally binding and cannot be changed by family members or witnesses upon death of the intended donor.⁶⁴ Along with convincing passage from the Illinois legislature, the American Medical Association (“AMA”) advocated for the ratification of the FPCA, one of the first bills of its kind in the United States.⁶⁵ The AMA stressed, however, that the mandated choice model is only appropriate if there is a “meaningful exchange of information” at the time the choice is made thereby ensuring the system is in accordance with the principles of informed consent.⁶⁶

B. Prior Attempts at Mandated Choice

Illinois’ implementation of the FPCA is not the first iteration of a mandated choice bill in United States history. Two other states in the last twenty years have had laws on the books attempting to establish a mandated choice system with the goal of increasing donation rates.⁶⁷

In 1991, Texas enacted a statute requiring citizens applying for, or renewing, driver’s licenses to indicate either “yes” or “no” as to whether they would enter the state’s organ donation registry.⁶⁸ The law specifically stated that, “[a] statement of gift must be executed each time a driver’s license or personal identification card is renewed, reinstated, or replaced.”⁶⁹ Despite the text of the statute employing the word “must,” individuals were not denied licenses if they failed to

63. 625 ILL. COMP. STAT. 5/6117 (2006) (amended 2009).

64. 755 ILL. COMP. STAT. 50/520 (2006) (amended 2007).

65. *Opinion 2.155 – Presumed Consent and Mandated Choice for Organs from Deceased Donors*, American Medical Association (Nov. 2005), <http://www.ama-assn.org/ama/pub/physician-resources/medical-ethics/code-medical-ethics/opinion2155>. page.

66. *Id.*

67. 1991 Tex. Gen. Laws 1204–05; Board on Health Sciences Policy, *Organ Donation: Opportunities for Action 178* (James F. Childress & Catherine T. Liverman eds., 2006).

68. Board on Health Sciences Policy, *supra* note 67.

69. Haley Cotter, *Increasing Consent for Organ Donation: Mandated Choice, Individual Autonomy, and Informed Consent*, 21 HEALTH MATRIX 599, 618 (2011).

answer the question.⁷⁰ Furthermore, a refusal to answer the question or a failure on the part of registry employees to ask the question yielded an automatic “no” to organ donation.⁷¹ This law was eventually repealed in 1997 based on the legislature’s concerns surrounding a general lack of public education on organ donation.⁷²

Two years prior to the implementation of the Texas program, Virginia instituted its own form of limited mandated choice.⁷³ Unlike the Texas form that required a firm “yes” or “no” response, the Virginia form allowed for “yes,” “no,” or “undecided.”⁷⁴ The ability to choose “undecided” or simply abstain from answering the question altogether makes this version of mandated choice a *partial* system. Although donors were given the option to opt in or not, the organ donor registry was not established in Virginia until 2000.⁷⁵ However, in a similar fashion to Texas, all non-“yes” responses were registered as “no” due to the fact that Virginia initially used computers operating on a binary system.⁷⁶ Today, Virginians may still register to donate their organs when renewing or applying for a driver’s license, but a web-based opt-in registry and changes to the binary computer system have alleviated many of the former issues and taken the system out of the realm of mandated choice.⁷⁷

C. The First Amendment and the Right To Not Speak

Assuming the federal government amended its organ donation policy and enacted a national statute following the mandated choice model currently employed in Illinois, the issue immediately raised is whether the law implicates First Amendment protections. Specifically, the constitutional question presented is whether a mandated choice model violates a person’s right to remain silent on any particular issue.

In 1943, the Supreme Court recognized that the First Amendment right of freedom of speech implicates both the right to

70. *Id.*

71. *Id.*

72. Susan Herz, *Two Steps to Three Choices: A New Approach to Mandated Choice*, 8 CAMBRIDGE QUARTERLY OF HEALTHCARE ETHICS 340 (1999).

73. Va. Code Ann. § 46.2-342 (West 1989).

74. Ann C. Klassen & David K. Klassen, *Who Are the Donors in Organ Donation? The Family’s Perspective in Mandated Choice*, 125 ANNALS OF INTERNAL MED. 70, 72 (1996).

75. Va. Code Ann. § 32.1-292.2 (West 2000).

76. Board on Health Sciences Policy, *supra* note 67.

77. *Id.*

speak freely and the right to refrain from speaking at all.⁷⁸ The only limitation placed on this rule was that a person could not claim the protection if essential operations of government to maintain an orderly society required an individual to speak even if they otherwise would refrain from doing so.⁷⁹ In *West Virginia State Board of Education v. Barnette*, the Supreme Court held that students could not be forced to salute the American flag or recite the Pledge of Allegiance in school.⁸⁰ A decision upholding the requirement would be inherently antithetical to the spirit of the First Amendment by allowing officials to set a standard on a matter of personal opinion.⁸¹

This holding was later reaffirmed in the Court's decision granting relief to a Jehovah's Witness seeking to declare unconstitutional a New Hampshire statute mandating that the state's motto, "Live Free or Die," be written on every issued license plate.⁸² The petitioners in *Wooley v. Maynard* claimed that the motto conflicted with their religious and moral beliefs and therefore infringed their First Amendment rights. In particular, the Court clarified the language of *Barnette* by holding that "[a] system which secures the right to proselytize religious, political, and ideological causes must also guarantee the concomitant right to decline to foster such concepts."⁸³

D. What Right Does Compelling an Answer Abridge?

What is particularly intriguing about the possibility of a First Amendment challenge to mandated choice based on the right to not speak is that it is somewhat unclear as to the type of speech right upon which the government is actually infringing. Although mandated choice questions compel some sort of speech act, such an act does not easily fall into one of the traditional categories of speech enumerated by the Court.⁸⁴

78. *West Virginia State Board of Education v. Barnette*, 319 U.S. 624, 645 (1943) (Murphy, J. concurring).

79. *Id.*

80. *Id.* at 642 (majority opinion).

81. *Id.*

82. *Wooley v. Maynard*, 430 U.S. 705, 714–15 (1977).

83. *Id.* at 714.

84. False statements of fact (*see, e.g.*, *Gertz v. Robert Welch, Inc.*, 418 U.S. 323 (1974); *see also* *New York Times v. Sullivan*, 376 U.S. 254 (1964)); threats (*see, e.g.*, *Virginia v. Black*, 538 U.S. 343 (2003)); obscenity (*see, e.g.*, *Miller v. California*, 413 U.S. 15 (1973)); and fighting words (*see, e.g.*, *Chaplinsky v. New Hampshire*, 315 U.S. 568 (1942); *see also*, *R.A.V. v. City of St. Paul*, 505 U.S. 377 (1992)).

More importantly, unlike the cases of *Barnette* and *Wooley*, the state in adopting a mandated choice model is not belligerently attempting to impart a particular viewpoint upon an individual. In *Barnette* the issue was that saluting the flag was a deliberate attempt to instill a sense of nationalistic pride, while in *Wooley*, New Hampshire was imparting its state credo on every moving vehicle registered in the state. Here, the state in its attempt to increase organ donation rates is only requiring people to express their own views on the subject, and is not endorsing one particular answer over another.

Contrary to the notion that the state is merely acting as a neutral party in a mandated choice system, it has been argued that simply requiring an answer to the question can serve as tacit coercion.⁸⁵ While mandated choice certainly respects individual autonomy more than a system of presumed consent—by allowing a party to opt in to the organ donation database rather than force that party to opt out—“there is a bit of high-handedness in ordering people to record publicly their choice for or against organ donation.”⁸⁶

With these competing beliefs on the role of the state, the next crucial question to be asked is, ironically, “how is the question asked?”

E. The Form of the Question Matters

Looking at the language the Court has used in its prior precedent on compelling speech acts, it is likely that the constitutionality of any mandated choice law enacted at the federal or state level will be largely determined by the language of the question used to compel the choice. The systems employed by Illinois, Texas, Virginia, and most recently California in 2010, offer a broad sampling of the possible ways to ask citizens to become donors and how those responses are subsequently reported in the states’ donor registries.

As previously described in Section III(b), the systems of Texas and Virginia asked the question in two different forms, with Virginia specifically allowing for a third option of “undecided,” to potential registrants.⁸⁷ The Illinois model, in turn, more closely mimics the older system Texas employed in the 1990s by requiring citizens to

85. Amitai Etzioni, *Organ Donation: A Communitarian Approach*, 13 KENNEDY INST. OF ETHICS 1, 3 (2003).

86. *Id.*

87. *Supra* Part III.b.

answer either “yes” or “no.”⁸⁸ Unlike the Virginia and Texas systems, the Illinois version of mandated choice does not place those who answer “no” into a separate non-donor database. Illinois thus leaves open the door for a next of kin to be asked upon a person’s death if they would like to make a donative gift.⁸⁹ Furthermore, the Illinois system has the added legal bonus that all registrants who answer “yes” are immediately entered into the database and that decision becomes permanently binding so that family members may not alter that choice at the time of death.⁹⁰

In October 2010, California passed its own form of mandated choice that is similar in nearly every respect to the FPCA.⁹¹ The language of the bill requires that “an application for an original or renewal driver’s license or identification card shall . . . include check boxes for an applicant to mark either (A) Yes, add my name to the donor registry or (B) I do not wish to register at this time.”⁹² Additionally, regardless of what a registrant marks on his or her form, a department of motor vehicles employee is required to vocally ask the registrant if they wish to join the registry.⁹³ Like Illinois, a response of “no” will not automatically put donors on a non-donor registry, and a registrant’s “yes” response is made legally binding regardless of the desires of family members.⁹⁴

As Amitai Etzioni remarks, the simple asking of a question regarding donative intent can be perceived as governmental browbeating in an attempt to coerce parties to join the donor registry.⁹⁵ This potential government coercion implicates the same conflict in *Barnette* and *Wooley* wherein the government attempts to assert its particular viewpoint—here, that one should donate their organs—over others in what is a deeply personal and private decision. Following the Court’s opinion in *Wooley*, if the government attempts to impart its views upon its citizens, those same citizens must have the ability to reject those beliefs.⁹⁶ More importantly, however, if a

88. *How Required Choice for Organ Donation Actually Works in Practice*, Nudge (Oct. 10, 2010), <http://nudges.org/2010/10/10/how-required-choice-for-organ-donation-actually-works-in-practice>.

89. *Id.*

90. Richard Thaler, *Opting in vs. Opting out*, N.Y. TIMES, Sept. 29, 2009, at BU6.

91. Cal. Veh. Code § 12811(b) (West 2011).

92. *Id.*

93. *Id.*

94. *Id.*; Nudge, *supra* note 88.

95. Etzioni, *supra* note 85.

96. *Wooley v. Maynard*, 430 U.S. 705, 714 (1977).

citizen declines to join the registry or is unsure of his or her beliefs on becoming an organ donor, the state's categorization of that response could violate the principle in *Barnette* that a person has the right to remain silent.

If the mandated choice system adopted by a state or the federal government is similar to that of Texas or Virginia, where individuals are placed on either a donor or non-donor list, the state effectively coerces an answer to a question on which a person may wish to remain silent. Such a designation is problematic unless being placed on a non-donor list puts an individual in the position of a standard citizen in a generic opt-in system at the time of his or her death. Unlike Texas and Virginia, the Illinois and California models avoid this potential pitfall altogether because there is no non-donor list, only a donor registry. In those states, because the content of the speech act recorded is unclear—declining to join the registry could be either a “no” or an “unsure”—it is likely that the government's intentional avoidance of coercing a definitive answer avoids entangling the principle outlined in *Barnette*.

Still, the courts could find that the mandated choice question implicates First Amendment protections. Therefore, a discussion of state interests is necessary.⁹⁷

F. Does the Mandated Choice System Work?

The entire purpose of moving to a mandated choice model for organ donation is to increase the donation rate of citizens. Importantly, the mandated choice system retains the principle of opting in to the registry, while also bringing to the attention of nearly every citizen, before the time of death, that the ability to donate one's organs exists. As previously examined, the ability to make decisions about one's own body is crucial to the constitutionality of any organ donation system in the United States.⁹⁸ Furthermore, a public opinion survey in 1992 indicated that ninety percent of respondents believed adopting a mandated choice program is an acceptable option.⁹⁹ Despite the seemingly overwhelming approval for such a model, empirical results have been inconclusive.

In the six years that Texas had its mandated choice program in place, the program generated a distinctly negative reaction from the

97. See *infra* Part III.g.

98. See *supra* Part I.

99. Aaron Spital, *Mandated Choice: The Preferred Solution to the Organ Shortage?*, 152 ARCH. INTERNAL MED. 2421 (1992).

public. After the statute's enactment, the percentage of citizens declining to register to be organ donors rose to eighty percent.¹⁰⁰ In Virginia, a similar result occurred after the state began asking the organ donation question when residents registered for driver's licenses. Although the actual rate of donors in Virginia was higher than in Texas at thirty-one percent, forty-five percent specifically registered as non-donors and twenty-four percent were undecided.¹⁰¹

The results in Illinois, however, indicate that a partial mandated choice might indeed be the most successful system for registering more organ donors. Since its adoption in 2006, Donate Life Illinois reports that sixty percent of adults in the state are now registered as organ and tissue donors, while eighty-seven percent of adults agree that registering as an organ donor is "the right thing to do."¹⁰² Compared to the national average of forty-percent registration, Illinois' partial mandated choice system has significantly outpaced organ donor rates in other states. Furthermore, while Illinois has experienced growth in terms of its absolute number and percentage of donors, the national donor rate has remained relatively stagnant between 2004 and 2010—increasing alongside, but not in proportion to—the country's enlarged population.¹⁰³

When comparing the results of Texas and Virginia to Illinois, it is unclear what has caused the increase in Illinois's donor rate. Factors such as state culture and increased public education may be determinative, but there is no actual data to support this conclusion. Additionally, since California's new partial mandated choice model is too new, there are no figures to allow conclusions about its effectiveness. Future studies on donor rates in the state should be conducted to determine whether mandated choice has a positive impact on donor rates, or if Illinois is merely a statistical outlier.

100. Laura A. Siminoff & Mary Beth Mercer, *Public Policy, Public Opinion, and Consent for Organ Donation*, 10 CAMBRIDGE Q. HEALTHCARE ETHICS 377, 380 (2001).

101. Steve Libowitz, *Rethinking Mandated Choice*, JOHNS HOPKINS GAZETTE, July 8, 1996.

102. *Organ Donation Information – Stats and Facts*, Donate Life Illinois, http://www.donatelifellinois.org/donatelife/get_the_facts.htm (last visited Mar. 25, 2011).

103. Michael Hentrich, *Health Matters: Human Organ Donation, Sales, and the Black Market* (Mar. 21, 2012), (unpublished paper, on file with the Cornell University arXiv) <http://arxiv.org/ftp/arxiv/papers/1203/1203.4289.pdf>.

G. Increasing Donation Rates as a Compelling or Substantial State Interest

Statutes that implicate First Amendment protections are not automatically deemed unconstitutional. Depending on the level of scrutiny used by the court, if the state can provide a compelling or substantial reason why First Amendment protections should be rendered secondary to that particular interest, the law may stand.¹⁰⁴

Mandated choice laws are not likely to trigger strict scrutiny analysis from the courts because compelling a party to answer a question about future organ donor plans can be viewed as content neutral, not content-based.¹⁰⁵ The assertion that mandated choice models are content neutral, however, is not a full proof argument. Since the purpose of asking the question is to register more donors, and one can only do that by targeting current non-donors, it is plausible to contend that the regulation is based on “the specific motivating ideology or the opinion or perspective of the speaker.”¹⁰⁶ As such, these regulations could be deemed to be content-based restrictions.

Only fifteen years after *Wooley*, the Court recognized in *Burson v. Freeman*, that a statute prohibiting the display of campaign materials within one hundred feet of a polling place was constitutional, even though it was a facially content-based restriction on speech, limiting only certain kinds of political speech.¹⁰⁷ To save the statute from being declared unconstitutional, Tennessee showed that the regulation was necessary to serve the compelling state interests of protecting voters from intimidation and election fraud and that it was narrowly tailored to achieve those particular goals.¹⁰⁸ This case represents one of the few situations in which the Court has allowed such a speech restriction to withstand the strict scrutiny test.¹⁰⁹

In *Wooley*, however, New Hampshire’s two purported state interests of easily identifying vehicles and promoting state history,

104. *Wooley v. Maynard*, 430 U.S. 705, 706, 716 (1977); see *United States v. O’Brien*, 391 U.S. 367, 377 (1968) (for restrictions that are content neutral, the government interest stated must only be substantial and unrelated to the suppression of free expression).

105. See *R.A.V.*, 505 U.S. at 382.

106. *Rosenberger v. Rector & Visitors of the Univ. of Va.*, 515 U.S. 819, 829 (1995).

107. 504 U.S. 191, 197 (1992).

108. *Id.* at 198.

109. *Id.* at 211 (“simple common sense show[s] that some restricted zone around polling places is necessary”).

individualism, and state pride were inadequate to meet even the lower substantial interest bar.¹¹⁰ As to the first stated interest of identifying vehicles, the Court reasoned there were ways to accomplish the same goal through narrower means than requiring the placement of the motto on the plates.¹¹¹ The second asserted interest of promoting state pride was not ideologically neutral, and therefore any restriction on speech attempting to promote that viewpoint was invalid.¹¹²

Since it is unclear what test the government's stated interest in increasing organ donation rates must pass—either a compelling or a substantial interest test—a discussion of both is required. Should the courts determine a mandated choice law is a content-based restriction, it is probable that acquiring more organ donors does not qualify as a compelling state interest, nor that the government's intended means are narrowly tailored to that end. Compelling interests in the past have included national security,¹¹³ preserving human life, and protecting the mentally ill from medical malpractice or coercion.¹¹⁴ The Supreme Court has further limited the notion of what constitutes an interest in preserving human life, despite its use of broad facial language. In *Washington v. Glucksberg*, a Washington-state ban on assisted suicides was deemed constitutional because it helped preserve human life, rather than end it voluntarily.¹¹⁵ In the case of mandated choice, there is no imminent threat of another party affirmatively taking the life of a transplant waitlist patient. Without this qualifying factor, the government's intention to generally preserve human life appears to fail the *Glucksberg* standard.¹¹⁶ Even if the courts recognize increasing organ donor rates as a compelling interest, the availability of less intrusive models such as the standard opt-in system likely dooms the law's fate.

In the far more likely case that the Court recognizes mandated choice laws as content-neutral, however, the state's asserted interest of compelling organ donor registration becomes increasingly

110. *Wooley v. Maynard*, 430 U.S. 705, 716–17 (1977); *see also, supra*, notes 82–84.

111. *Id.* at 716.

112. *Id.* at 717.

113. *Haig v. Agee*, 453 U.S. 280, 307 (1981); *but compare* *Kent v. Dulles*, 357 U.S. 116 (1958).

114. *Washington v. Glucksberg*, 521 U.S. 702, 703 (1997).

115. *Id.* at 735.

116. *Id.* at 732.

palatable. Interests such as protecting societal order and morality,¹¹⁷ protecting citizens from unwanted noise,¹¹⁸ promoting the tranquility of the home,¹¹⁹ and maintaining parks in an attractive and intact condition¹²⁰ have all been deemed substantial governmental interests. Given the life-and-death nature of organ donation and government's general concern for the wellbeing of its citizens, the interest of compelling organ donor registration to save lives appears to easily qualify under the Court's prior precedent.

The easiest way to ensure First Amendment protections are not placed in jeopardy is for legislatures to craft intelligent mandated choice statutes. Even in the case that a legislature fails to heed the warning, however, the law will likely survive a constitutional challenge.

IV. Incentivizing the Gift of Life: Preferred Donation

A. Background

In 2008, Israel recognized it had a severe organ transplant problem and one of the lowest organ donation rates in the developed world.¹²¹ As a result, a radical new policy was developed to increase the donation rate based on the policy of reciprocal altruism.¹²² Upon the advice of concerned doctors, the Knesset passed a law that utilizes a non-medical factor in determining which patients should receive an organ off the transplant waiting list.¹²³ Specifically, the nonmedical criterion used is that if an eligible adult signs up to be an organ donor prior to the time when he or she needs an organ, that individual is given priority status over another adult in need of the same organ who had not previously signed up to be a donor.¹²⁴

117. *Barnes v. Glen Theatre, Inc.*, 501 U.S. 560, 567 (1991).

118. *Ward v. Rock Against Racism*, 491 U.S. 781, 796 (1989).

119. *Frisby v. Schultz*, 487 U.S. 474, 484 (1988).

120. *Clark v. Community for Creative Non-Violence*, 468 U.S. 288, 296 (1989).

121. Jacob Lavee et al., *A New Law for Allocation of Donor Organs in Israel*, *The Lancet* (Dec. 17, 2009) <http://www.hods.org/pdf/Lancet%20-%20December%2017,%202009.pdf>. In January 2008, only forty-five percent of eligible brain-dead patients in Israel had either previously given, or had their next-of-kin give, consent to donate their organs. Furthermore, only ten percent of eligible Israeli adults had signed up to be organ donors.

122. *Id.*

123. *Id.*

124. Organ Implementation Law, 5768–2008, SH No. 2144 p. 394 (Isr.).

Further complicating the process is the intricate point system based on the particular organ at stake, a candidate's medical condition, and whether or not family members are also involved in the donor program. For example, a kidney transplant waitlistee can have a score range of zero to eighteen points, with candidates who signed up as donors receiving two points.¹²⁵ If a candidate's first-degree relative has signed an organ donor card, but the candidate has not, an allocation of one point is given.¹²⁶ If, however, the candidate's first-degree relative has donated an organ after death or the candidate or first-degree relative was a live nondesignated donor, the candidate receives three and a half points.¹²⁷ Similar points-based systems exist for lung, heart, and liver candidates.¹²⁸

Israel believes this system not only ensures patients with serious medical conditions are granted priority over others in the organ donation waitlist, but that the program also avoids an uncomfortable paradox. Dr. Jacob Lavee first developed the program after having patients confide in him that they would never be willing to donate an organ, but would gladly accept one.¹²⁹ That people would actively accept such a gift, yet were in turn unwilling to sacrifice a piece of themselves, caused Dr. Lavee to design a system that guarantees that those willing to donate receive priority. Those who sign up for the program prior to April 2012 will be granted immediate access to the priority program, whereas those who sign up after that time will have to wait for three years to gain priority eligibility.¹³⁰

B. Does It Work?

Early indications are that the new Israeli organ donation program is a successful way to achieve a higher rate of donations. After the law's passage in 2008, a large publicity campaign touting the benefits of the new program and organ donation in general was launched utilizing radio, television, billboards, and newspapers.¹³¹ Prior to passage of the new law and its advertising campaign, Israel

125. Lavee, *supra* note 121.

126. *Id.*

127. *Id.*

128. *Id.*

129. Danielle Ofri, *In Israel, a New Approach to Organ Donation*, N.Y. TIMES (Feb. 16, 2012) <http://well.blogs.nytimes.com/2012/02/16/in-israel-a-new-approach-to-organ-donation>.

130. Dan Even, *Dramatic Increase in Organ Transplants Recorded in Israel in 2011*, Haaretz, Jan. 12, 2012.

131. Ofri, *supra* note 129.

saw around 3,000 new donor registrants per month.¹³² During the ten weeks of the promotion program, the department responsible for issuing new donation cards saw a substantial increase of seventy thousand new registrants, raising the total number of Israelis registered to over 632,000.¹³³

While the priority program has certainly played a part in increasing the number of willing organ donors, Israel has taken other dramatic steps that might have a much larger impact on donations. Part of the law passed in 2008 also provides for a form of financial compensation for live donors.¹³⁴ Exclusively for live organ donors, the Israeli government will provide forty days of lost wages and up to 30,000 shekels for proven medical expenses for five years after the donation.¹³⁵ On January 19, 2010, Israel passed a further modification to its Public Health Law, whereby anyone making a gift in accordance with the Organ Implementation Law would also be exempted from paying insurance premiums for a temporary period as determined by the Minister of the Health in consultation with the Minister of the Treasury.¹³⁶ Lastly, in 2011, Israel adopted the “chain of living donors” program, which makes it legal for relatives of kidney waitlistees to donate an organ to another waitlistee in exchange for a kidney for their own sick relative.¹³⁷

With these supplementary programs, 2011 saw the single largest increase in organ donations in Israel’s history. A total of 348 transplants were conducted over the course of the year, a sixty-eight percent increase over the total from 2010.¹³⁸ Kidney, liver, and heart transplants saw increases of over one hundred percent in the number of total transplants.¹³⁹

C. An Equal Protection Problem for Preferred Donation Laws

Despite these laws appearing to have a profound effect on organ donation rates in Israel, enacting similar systems in the United States could run afoul of the Constitution. The most obvious issue that appears is a possible equal protection violation when the government

132. *Id.*

133. *Id.*; Even, *supra* note 130.

134. Even, *supra* note 130.

135. *Id.*

136. Public Health (Amendment No. 47) Law, 5770-2010 (Isr.).

137. *Id.*

138. Even, *supra* note 130.

139. *Id.*

provides an organ to one individual over another based on non-medical factors.

The primary rule stemming from the Equal Protection Clause is that “[s]tates must treat like cases alike but may treat unlike cases accordingly.”¹⁴⁰ As long as a legislative classification or distinction does not burden a fundamental right nor target a suspect class, a strong presumption of legality exists and the law will stand so long as it is rationally related to some legitimate state interest.¹⁴¹

The definition of a suspect class was articulated in footnote four of *United States v. Carolene Products Co.* There, Justice Stone declared that certain groups are “discrete and insular minorities” and that laws discriminating against such groups “may call for a more searching judicial inquiry.”¹⁴² Using this standard, the Court has recognized multiple legislative classifications that meet the definition of a suspect class, including race,¹⁴³ religion,¹⁴⁴ national origin,¹⁴⁵ and in certain cases, alienage.¹⁴⁶ Legislation that discriminates against such classes must be narrowly tailored and must further a compelling government interest in order to survive strict scrutiny analysis.¹⁴⁷

In addition to suspect classes, the Court has recognized two types of quasi-suspect classes—gender and illegitimacy—that only need to pass intermediate scrutiny.¹⁴⁸ Unlike strict scrutiny, intermediate scrutiny requires that if a legislative classification on its face discriminates against either of those two groups, the legislation must be substantially related to an important governmental interest.¹⁴⁹ All other facial classifications in legislation need only pass rational basis review, meaning the law need only be rationally related to a legitimate state interest.¹⁵⁰

140. *Vacco v. Quill*, 521 U.S. 793, 799 (1997); *see also Plyler v. Doe*, 457 U.S. 202, 216 (1982).

141. *Romer v. Evans*, 517 U.S. 620, 631 (1996).

142. *United States v. Carolene Products Co.*, 304 U.S. 144, 152 at n.4 (1938).

143. *Adarand Constructors v. Peña*, 515 U.S. 200 (1995); *see, e.g., Hernandez v. Texas*, 347 U.S. 475 (1954); *see also Bolling v. Sharpe*, 347 U.S. 497 (1954).

144. *City of New Orleans v. Dukes*, 427 U.S. 297, 303 (1976).

145. *City of Cleburne, Tex. v. Cleburne Living Center*, 473 U.S. 432, 440 (1985).

146. *Dukes*, 427 U.S. at 303.

147. *Adarand Constructors*, 515 U.S. at 227.

148. *Massachusetts Bd. of Retirement v. Murgia*, 427 U.S. 307, 325 (1976); *see also Miss. Univ. for Women v. Hogan*, 458 U.S. 718, 723–24 (1982).

149. *Clark v. Jeter*, 486 U.S. 456, 461 (1988).

150. *City of Cleburne*, 473 U.S. at 440.

D. Does Donative Intent Make Patients Not Similarly Situated?

Under any claim of an equal protection violation, the courts first must consider whether or not the groups being compared are similarly situated. If the groups are not similarly situated, the government has the ability to apply different standards to them so long as those standards are not discriminatory.

The specific question of whether individual intent is sufficient to distinguish between two otherwise equal persons has not yet been decided by the Supreme Court. Recently, however, the Court articulated that terminally ill patients requesting assistance to commit suicide are distinguishable from patients refusing life-saving treatment.¹⁵¹ *Vacco v. Quill* dealt with a New York statute that prohibited doctors from actively assisting terminally ill patients to kill themselves, yet permitted doctors to respect the decision of patients to refuse treatment thereby resulting in severe pain and death by natural causes.¹⁵² The Court reasoned the law did not discriminate against any particular group because it applied to every patient equally and that New York could properly distinguish between the types of patients because they are not similarly situated, as indicated through former Court precedent and the opinions of numerous medical organizations.¹⁵³

In the case of incentivized donation, however, the situation is not nearly as clear-cut. The notion of providing a benefit to patients on a transplant list simply because at one point the patient signaled an intent to donate could lead the Court down a slippery slope, requiring it to make determinations about the intent of the parties in a host of other scenarios and whether such intent makes a particular group distinguishable. One argument that can be extracted from *Vacco* in favor of such a distinction between groups is that the Court actively recognized the fact that a patient's wishes make a difference in how society should treat them. The simple counter to this line of reasoning, though, is that the Court had already accepted preventing suicide in any form as a legitimate state interest, so a person therefore cannot wish to commit such an act no matter how merciful it may be.¹⁵⁴ Therefore, a more compelling explanation of the principle guiding the Court in *Vacco* is not recognition of differentiating

151. *Vacco v. Quill*, 521 U.S. 793, 800 (1997).

152. *Id.* at 797.

153. *Id.* at 800–01.

154. *Washington v. Glucksberg*, 521 U.S. 702, 730 (1997).

between a patient's wishes, but instead abiding by the overarching public policy of preventing suicides.

Further complicating the question is that under Israel's version of the law, a person can extract a benefit from the state without having signaled any intent to donate. The Organ Implementation Law grants a partial benefit to patients who are first-degree relatives of persons who have signed up for the program.¹⁵⁵ If adopted in the United States, this provides a far more hazardous case for the courts because, even if they can find a distinction between patients who intend to donate and those who do not, certifying the granting of a benefit to someone simply on the basis of whom they are related to appears murky at best. Without any evidence of intent to donate, two patients in the same medical condition on a transplant waitlist appear, in all meanings of the term, similarly situated.

E. Incentivizing Donation Is Not Facially Discriminatory

In the unlikely case where the courts determine that the donative intent of patients is sufficient to categorize them as dissimilar, the next step under an equal protection analysis is to determine if the statute is actually discriminatory. In Israel's Organ Implementation Law, there is nothing that suggests a legislative attempt to treat classes of persons differently. Everyone in Israel is allowed to join the program, give consent at the time of death to be an organ donor, and receive the benefits of the incentive system without other qualification.¹⁵⁶

Since the law does not appear on its face to create any classification, if it were enacted in the United States it would be presumed constitutional under an equal protection challenge so long as it is rationally related to some government interest. On this point, it is clear the law is related to the interest of acquiring more organs to preserve the lives of waitlisted patients. This concern qualifies as a legitimate state interest in light of the Court's previous recognition that preserving life, preventing suicide, preventing harm to third parties, and protecting medical ethics are all legitimate state interests.¹⁵⁷

155. Organ Implementation Law, 5768–2008, SH No. 2144 p. 394 (Isr.).

156. *Id.*

157. Philip G. Peters, Jr., *The State's Interest in the Preservation of Life: From Quinlan to Cruzan*, 50 OHIO ST. L.J. 891, 891 at n.3 (1989).

F. Incentivizing Donation May Have a Discriminatory Impact

Although the Organ Implementation Law is not facially discriminatory, there is the possibility that, if enacted in the United States, it could still come under challenge for discriminating against certain religions. Currently, the United States employs a transplant waitlist system that only considers the medical criteria of the waitlistees.¹⁵⁸ When only medical criteria are considered, the theory is that every patient—regardless of status, wealth, religion, or race—is equally eligible to get an organ. Should the federal government adopt a measure similar to Israel's, it would be incorporating new non-medical criteria that could disadvantage certain persons who believe it is appropriate to accept an organ transplant, yet believe donating their organs to another violates their religious principles.

Unlike facial equal protection challenges, discrimination challenges concerning facially neutral laws require courts to clear additional hurdles to declare the acts unconstitutional. For any non-facial discriminatory challenge to be considered by the courts, there must first be a disproportionate impact on a suspect or quasi-suspect class.¹⁵⁹ If a disproportionate impact can be shown, the party alleging the violation must also prove the legislature had a discriminatory intent in passing the law.¹⁶⁰ In determining whether or not a discriminatory intent exists, however, the disproportionate impact carries only evidentiary value and is not conclusive.¹⁶¹

Even when a facially neutral law has a clearly disproportionate impact on a quasi-suspect class that is known to legislators, the Supreme Court has upheld such a law under siege from an equal protection challenge so long as no discriminatory intent could be found.¹⁶² In *Personnel Administrator of Massachusetts v. Feeney*, Massachusetts passed a statute that required all veterans who qualified for civil service positions to be considered before any qualifying nonveterans.¹⁶³ Since an overwhelming number of veterans are males, the law was challenged on the notion that it inherently

158. *Understanding the Organ Transplant Waiting List*, Gift of Life Donor Program, <http://www.donors1.org/patients/waitinglist/#1> (last visited Mar. 28, 2012).

159. See *Arlington Heights v. Metropolitan Housing Corp.*, 429 U.S. 252 (1977); see also *Washington v. Davis*, 426 U.S. 229 (1976).

160. *Arlington Heights*, 429 U.S. at 265.

161. *Davis*, 426 U.S. at 242 (“Necessarily, an invidious discriminatory purpose may often be inferred from the totality of the relevant facts, including the fact, if it is true, that the law bears more heavily on one race than another.”).

162. *Personnel Adm’r of Massachusetts v. Feeney*, 442 U.S. 256 (1979).

163. *Id.* at 259.

preferred men for civil service jobs and denied otherwise qualified women an opportunity to obtain these positions.¹⁶⁴ The Court held that despite the vast evidence showing a disparate impact on women in acquiring civil service jobs as a result of the law, a discriminatory intent is only found when it is a factor that influenced the legislative choice.¹⁶⁵ Here, the Court found a legitimate state interest in wanting to favor veterans, not men, in gender-neutral terms and therefore the law was deemed nondiscriminatory under rational basis review.¹⁶⁶

The real impact of the Court's opinion in *Feeney* was that even showing legislative volition and awareness of the consequences of passing such a statute is insufficient to prove discriminatory intent.¹⁶⁷ This has made success much more difficult for plaintiffs in equal protection cases, as legislators are generally intelligent enough to avoid using words in a statute or in the law's legislative history that tip courts off to an underlying nefarious intent.¹⁶⁸ If proof of discriminatory intent and disparate impact is found, however, an analysis under strict scrutiny or intermediate scrutiny is required, subject to the particular class being discriminated against.¹⁶⁹

The Equal Protection claim that might be asserted against the passage of an Israeli-style Organ Implementation Law in the United States would closely parallel the facts of *Feeney*. For persons whose religious beliefs bar the donation of organs yet allow them to accept such donative gifts, the law has a clearly disparate impact on their ability to move up the transplant waiting list. The harder barrier to clear is proof of a discriminatory intent. As *Feeney* makes clear, intent is not proven just by showing the consequences of the law were known to legislators; intent is only proven when such consequences are a reason for passing the law. While the facts surrounding the law's passage will be crucial to determining intent, it is highly doubtful that a legislature will pass a version of the preferred

164. *Id.*

165. *Id.* at 277.

166. *Id.* at 275 (“Just as there are cases in which impact alone can unmask an invidious classification . . . there are others, in which—notwithstanding impact—the legitimate noninvidious purposes of a law cannot be missed. This is one.”).

167. *Id.* at 279.

168. Kenji Yoshino, *The New Equal Protection*, 124 HARV. L. REV. 747, 764 (2011).

169. *Feeney*, 442 U.S. at 282 (Marshall, J., dissenting) (claiming the law is purposefully discriminatory based on gender and, because there is no substantial relationship to a legitimate government interest, the law violates intermediate scrutiny required for quasi-suspect classes).

donation law to discriminate against a particular religion, as the goal of the policy is to acquire more organs for all citizens.

If evidence of discriminatory intent behind the law were to surface, it would almost certainly doom the law's constitutionality because, unlike the class distinction in *Feeney*, religion is a suspect class and laws rarely pass muster under strict scrutiny analysis. It is probable that the Court would accept the government's purpose of procuring organs as being legitimate and find that the law is substantially related to that purpose. That the law is narrowly tailored to serve that purpose would be a much more difficult claim for the government to make, given the myriad of other organ procurement policies already enacted across the country.

G. Preferred Donation Laws Create a Perverse Incentive

Dr. Levee, who formed the initial idea of incentivizing donation by providing registrants preferred status, did so because of the paradox of patients accepting organs and at the same time refusing to donate. While the policy has seen positive effects in Israel, it also creates its own perverse incentive of defrauding the system for personal gain.

If an individual knows he or she is likely to need an organ in the future, it is possible to enter the program simply for the benefit of being given priority status on the waitlist and later, once an organ is procured and transplanted, drop out of the program entirely. This fraudulent intent is especially problematic considering the continually increasing number of patients being placed on transplant waitlists. Furthermore, it is unlikely that the law could prohibit a person from leaving the program once he or she has received a transplant, as donating an organ under the program is considered a gift and a current waitlistee cannot claim reliance on an unknown donor's property. Before any state legislature passes a preferred donation law, careful consideration of the perverse incentive of fraud is required to make sure the harm to society is outweighed by the law's benefits.

V. Alternate Incentives

Along with the preferred status given to registered organ donors in Israel, the Organ Implementation Law grants transplant patients monetary benefits as a result of the surgery.¹⁷⁰ Given the success of

170. Even, *supra* note 130.

the program attributed to these alternate benefits, a brief examination of the other incentives and how they would be treated in the United States is necessary.

Congress and the NCCUSL have specifically mandated that it is unlawful to acquire, receive, or transfer any human organ for valuable consideration.¹⁷¹ Like the Israeli law, valuable consideration does not consider lost wages and these are fully recoverable.¹⁷² Another aspect of the Israeli system regarding payments for future care is not clearly defined as being within the ambit of Congress' prohibition against compensation. While it is socially responsible to make sure organ transplant donors are given the care necessary to address any negative side effects of donation, it is unclear if such compensation fits within the ban on valuable consideration. Additionally, despite a current lack of post-transplant financial support for live donors, a majority of American Society of Transplant Surgeons approve of providing non-living donors with funeral costs or a charitable organization donation made in their name.¹⁷³ The most troubling incentive in Israel's program, however, is providing a health insurance premium exemption for donors. In the United States, given that such a provision is likely not considered in the same breath as a tax incentive, the health insurance premium incentive would probably be classified as a separate financial gain that runs counter to the express intentions of Congress.

Although the idea of financially incentivizing organ donations in the United States has been floated as a means of increasing donation rates, it is simply a political non-starter.¹⁷⁴ Nonetheless, private citizens in the United States have established a similar version of the "chain of living donors" program utilized in Israel.¹⁷⁵ Lifesharers, a nonprofit voluntary organization, allows its members to designate a preference in providing fellow members with their organs over non-members.¹⁷⁶ The network uses the Organ Procurement and Transplantation Network's ("OPTN") waitlist rankings, and if the

171. 42 U.S.C. § 274E (1984); Unif. Anatomical Gift Act §16 (amended 1987).

172. 42 U.S.C. § 274E(c)(2) (1984).

173. Robert Arnold et al., *Financial Incentives for Cadaver Organ Donation: An Ethical Reappraisal*, 73 *TRANSPLANTATION* 1361 (2002).

174. Stephen J. Dubner, *Is America Ready for an Organ-Donor Market?*, Freakonomics, <http://www.freakonomics.com/2006/05/15/is-america-ready-for-an-organ-donor-market> (last visited May 15, 2006).

175. *How Lifesharers Works*, Lifesharers, <http://www.lifesharers.org/howitworks.aspx> (last visited Mar. 29, 2012).

176. *Id.*

donor is a member of Lifesharers, the organ can be assigned first to the highest-matching Lifesharers member.¹⁷⁷ Unlike the Israeli system that allows for live donor transfers, Lifesharers only takes donor organs from deceased members of the network.¹⁷⁸ The Lifesharers system allows any registered donor to join the program, and because the system does not provide any form of financial compensation to members for organ donations, it is perfectly legal in the United States.¹⁷⁹

VI. Conclusion

Organ donation is a popular and highly effective medical practice that saves thousands of lives each year. In spite of its popularity and an increase in public education on the subject, the number of individuals throughout the world signing up to give the gift of life still remains quite low. Increasing the number of organ donors is becoming a prevalent topic of discussion for legislatures, but there is no consensus on the best means of achieving this noble goal. Comparing the primary European alternative of presumed consent, the mandated choice system, and Israel's Organ Implementation Law, what is certain is that the form any future law takes has a significant impact on its constitutionality.

Presumed consent eliminates much of the altruistic nature that comes when an individual makes a donative gift. With many citizens today wary of the government compelling actions regarding their bodies, particularly after death, implementing such a program nationally would come with heavy public scrutiny. When the California legislature and former Governor Schwarzenegger enacted the state's mandated choice law in 2010, they specifically rejected passing a presumed consent model out of fear it may be unconstitutional.¹⁸⁰ Despite the overtly compelling nature of the program and legislative wariness of the system, courts across the country have held limited versions of the model constitutional. The very narrow circumstances of current presumed consent systems in the United States make for intriguing test cases, but with the recent

177. *Id.*

178. *Id.*

179. *Id.*

180. Judd Kessler, *Organ Donation Legislation in California*, Market Design, <http://marketdesigner.blogspot.com/2010/10/organ-donation-legislation-in.html> (Oct. 8, 2010).

uproar over the Affordable Care Act, an expansion of the model is unlikely to happen in the near future.

Mandated choice, on the other hand, preserves the altruistic opt-in nature of organ donation while also requiring the topic be brought to the attention of individuals. Unlike presumed consent, which takes control of the decision for persons regarding their bodies after death, mandated choice merely compels a response about one's future wishes. By providing an actual choice not to oblige the government's potentially subtle opinion that donating organs is a social benefit, a well-crafted version of the law likely survives a First Amendment challenge. While the system might be a success legally, what is troubling for mandated choice generally is that it is unclear whether the model actually raises donation rates—or even worse, lowers them.

Although the concept of incentives to increase donations has long been discussed, Israel's new program is the first to give citizens a truly wide variety of offerings in an attempt to raise the country's precipitously low donor rate. The set of financial incentives being offered by the Israeli government, beginning with workers' compensation and medical expenses and ending with health insurance exemptions, range from the perfectly legal to the potentially forbidden under United States law. Most intriguing, however, is the preferred donor program that provides an unguaranteed but significant benefit to registrants. Although there is a host of requirements and regulations, the model offers a unique legal question under the Equal Protection Clause surrounding potential discrimination based solely on the declared status of individuals. Declared status, without other action, should not be sufficient to find that the government created distinct classes, while a challenge based on religious discrimination should likewise fall because the law would be neutral on its face and in its statutory history. Furthermore, enacting a modified version of the incentive system in the United States could yield strongly positive results, as it has in Israel.

With the recent debate over the constitutionality of the Affordable Care Act, United States citizens have never been more attuned to healthcare issues. Organ donation is a problem that continues to plague society. Given the likely constitutionality of these new models for donation, legislatures should begin earnestly discussing these solutions without fear.