

# GIVING VIRGINIA'S ANATOMICAL GIFT CODE LIFE: CREATING LIABILITY FOR A HOSPITAL'S FAILURE TO DETERMINE INDIVIDUAL DONATIVE INTENT

Today, the demand for organs in the United States exceeds supply.<sup>1</sup> Each year there are almost twice as many people on waiting lists for organs as there are available organs.<sup>2</sup> The United States currently relies on altruistically donated anatomical gifts to procure organs for transplantation.<sup>3</sup> To regulate this voluntary system, the Uniform Anatomical Gift Act (UAGA),<sup>4</sup> which is a

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1. See Eric C. Sutton, *Giving the Gift of Life: A Survey of Texas Law Facilitating Organ Donation*, 22 ST. MARY'S L.J. 959, 960 (1991) (discussing the number of people on waiting lists for organs); Daniel G. Jardine, Comment, *Liability Issues Arising Out of Hospitals' and Organ Procurement Organizations' Rejection of Valid Anatomical Gifts: The Truth and Consequences*, 1990 WIS. L. REV. 1655 (1990) (discussing the shortage of transplant organs); Ann McIntosh, Comment, *Regulating the "Gift of Life" — The 1987 Uniform Anatomical Gift Act*, 65 WASH. L. REV. 171 (1990) (discussing the shortage of transplant organs).

2. On January 26, 1994, there were 33,586 people waiting for transplant organs. In 1992, approximately 16,603 people donated organs at the time of death. Telephone Interview with Donna Johnston, Office Assistant, United Network of Organ Sharing (Feb. 3, 1994).

3. A.H. Barnett & David L. Kaserman, *The Shortage of Organs for Transplantation: Exploring the Alternatives*, 9 ISSUES L. & MED. 117 (1993). See *infra* notes 28-29 and accompanying text (discussing proposed alternatives to the United States' voluntary organ donation system).

Donated cadaveric organs are also used for research. An organ donor may specifically donate his or her organs for research purposes. This Note only discusses organ donation for transplantation purposes. For a detailed discussion of organ donation for research purposes, see generally Gregory Gelfand & Toby R. Levin, *Fetal Tissue Research: Legal Regulation of Human Fetal Tissue Transplantation*, 50 WASH. & LEE L. REV. 647 (1993); Thomas P. Dillon, Note, *Source Compensation for Tissues and Cells Used in Biotechnical Research: Why a Source Shouldn't Share in the Profits*, 64 NOTRE DAME L. REV. 628 (1989); Sigrid Fry, Note, *Experimentation on Prisoners' Remains*, 24 AM. CRIM. L. REV. 165 (1986); Brian G. Hannemann, Note, *Body Parts and Property Rights: A New Commodity for the 1990s*, 22 SW. U. L. REV. 399 (1993).

4. UNIF. ANATOMICAL GIFT ACT (1987) 8A U.L.A. 19 (1993). Unless

template for state organ donation laws, suggests donor designation and procurement procedures.<sup>5</sup> Although most states substantially follow the UAGA,<sup>6</sup> not all provisions are followed in totality.<sup>7</sup> Recent amendments to Virginia Code sections concerning anatomical gifts (VAGA) expand the scope of the UAGA by changing procedures relating to donor designation and access to donor information.<sup>8</sup>

As amended, the VAGA constitutes an attempt by the Virginia legislature to strengthen the state's voluntary organ donation

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otherwise indicated, UAGA references in this Note refer to the 1987 version of the UAGA because it contains provisions which are relevant to the proposal in Part III that were not included in the 1968 version. See *infra* note 43 (discussing the revision of the 1968 UAGA).

5. UNIF. ANATOMICAL GIFT ACT §§ 2 & 9, 8A U.L.A. 33-34, 58 (1993). See McIntosh, *supra* note 1, at 171-74 (discussing the 1968 UAGA and the 1987 UAGA).

6. By 1972, all fifty states adopted the main provisions in the 1968 UAGA. This was the quickest nationwide adoption of a uniform law. See Jardine, *supra* note 1, at 1656. See ALA. CODE §§ 22-19-40 to -47 (1969); ALASKA STAT. §§ 13.50.010 -090 (1972); ARIZ. REV. STAT. ANN. §§ 36-841 to -849 (1970); COLO. REV. STAT. ANN. §§ 12-34-101 to -109 (West 1969); DEL. CODE ANN. tit. 16, §§ 27103.4(b)-2719 (1970); D.C. CODE ANN. §§ 2-1501 to -1511 (1970); FLA. STAT. ANN. §§ 732.910-.922 (West 1969); GA. CODE ANN. §§ 44-5-140 to -151 (1969); ILL. ANN. STAT. ch. 755, para. 50/1 to /11 (Smith-Hurd 1969); IND. CODE ANN. §§ 29-2-16-1 to -12 (West 1969); IOWA CODE ANN. §§ 142A.1 et seq. (West 1969); KAN. STAT. ANN. §§ 65-3209 to -3218 (1969); KY. REV. STAT. ANN. §§ 311.165-.235 (Michie/Bobbs-Merrill 1970); LA. REV. STAT. ANN. §§ 17:2351 to :2359 (West 1968); ME. REV. STAT. ANN. tit. 22, § 2901-2910 (West 1969); MD. CODE ANN., EST. & TRUSTS § 4-501 to -512 (1968); MASS. GEN. LAWS ANN. ch. 113, § 7-14 (West 1971); MICH. COMP. LAWS ANN. §§ 333.10101-.10109 (West 1969); MISS. CODE ANN. §§ 411-39-11, 41-39-31 to -53 (1970); MO. ANN. STAT. §§ 194.210-.290 (Vernon 1969); NEB. REV. STAT. §§ 71-4801 to -4821 (1971); N.H. REV. STAT. ANN. §§ 291-A:1 to -A:9 (1969); N.J. STAT. ANN. §§ 26:6-57 to -65 (West 1969); N.M. STAT. ANN. §§ 24-6-1 to -11 (Michie 1969); N.Y. PUB. HEALTH LAW § 4300-4308 (McKinney 1970); N.C. GEN. STAT. §§ 130A-402 to -412.1 (1969); OHIO REV. CODE ANN. §§ 2108.01-.10 (Anderson 1969); OKLA. STAT. ANN. tit. 63, §§ 2201-2209 (West 1969); OR. REV. STAT. §§ 97.250-.295 (1969); 20 PA. CONS. STAT. ANN. §§ 8601-8607 (1972); S.C. CODE ANN. §§ 44-43-310 to -400 (Law. Co-op. 1969); S.D. CODIFIED LAWS ANN. §§ 34-26-20 to -47 (1969); TENN. CODE ANN. §§ 68-30-101 to -111 (1969); TEX. HEALTH & SAFETY CODE ANN. §§ 692.001-.016 (West 1969); W. VA. CODE §§ 16-19-1 to -9 (1969); WYO. STAT. §§ 35-5-101 to -117 (1969).

States were not as quick to adopt the revised 1987 UAGA. McIntosh, *supra* note 1, at 176. The most controversial portions of the 1987 UAGA were the consent provisions and the routine inquiry requirement. *Id.* For further discussion see *infra* part II.A.1. See also *infra* note 54 (discussing the 1987 UAGA routine inquiry requirement and consent provisions).

7. See Jardine, *supra* note 1, at 1665 (noting that specific provisions of the UAGA vary from jurisdiction to jurisdiction).

8. VA. CODE ANN. §§ 32.1-289 to -297.1 (Michie 1992 & Supp. 1994). See *infra* part II.B (discussing VAGA and the 1993 amendments).

system.<sup>9</sup> The VAGA makes it easier for health care workers to determine whether an individual intended to donate his or her organs. In this respect, the 1993 VAGA amendments comport with the UAGA goal of increasing organ donation. This Note, however, questions whether the recent VAGA amendments sufficiently advance the UAGA goal of increasing organ donation. Concluding that, as amended, the VAGA does not go far enough in achieving increased organ donations, this Note proposes further changes to the VAGA.<sup>10</sup> The proposed changes would increase the supply of organs for transplantation by improving hospital access to donor information and encouraging hospitals to discover donors' intent. Finally, this Note suggests that states adopting the 1987 UAGA consider adopting provisions similar to the VAGA provisions as amended by this Note.

Part I of this Note examines the cause of the organ donor shortage and legislative attempts to increase organ supply. Part II analyzes relevant UAGA provisions and the VAGA amendments. Part III proposes VAGA amendments that would increase the number of available organs by allowing hospitals to access donor information and by creating potential hospital liability for failure to verify donor status. Part IV addresses some policy concerns that this Note's proposed amendments may raise.

## I. THE ORGAN SHORTAGE

Factors contributing to the significant dearth of organs available for transplantation range from advances in medical technology, which increases the feasibility of organ transplantation,<sup>11</sup> to human inability to fully accept the recycling of organs. State and federal governments enacted legislation that promotes organ donation for transplantation.<sup>12</sup> Given the ever growing demand for organs, however, states cannot view the UAGA's donation guidelines as the most they can do to encourage organ donation. State legislatures can better achieve the UAGA's goal of increasing voluntary organ donations by expanding the UAGA.

### A. *The Extent of the Organ Shortage*

Organ transplantation became medically possible less than thirty-five years ago.<sup>13</sup> Today, a patient may, in some cases,

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9. See *infra* note 68 and accompanying text.

10. The Virginia legislature provided no written legislative history for the VAGA. According to the prefatory note of the 1987 UAGA, however, the purpose of provisions regulating anatomical gifts is to encourage the voluntary donation of organs. UNIF. ANATOMICAL GIFT ACT Prefatory Note (1987), 8A U.L.A. 20 (1993).

11. McIntosh, *supra* note 1, at 171 n.2.

12. See *infra* notes 33-36 and 41-43 and accompanying text.

13. Dr. David Hume performed the first organ transplant in 1951. *Devel-*

have a ninety percent chance of surviving for at least two years after an organ transplant.<sup>14</sup> Organ procurement, however, is an area of controversy in spite of the medical feasibility and success of transplantation.<sup>15</sup> The controversy surrounding the procurement of organs is exacerbated by the shortage of organs available for transplantation.

Despite public support for organ donations,<sup>16</sup> a burgeoning demand for transplant organs exists in the United States. Over the past four years, the number of people awaiting organ transplants increased from 13,000 to 33,000.<sup>17</sup> Although up to seven vascular organs can be harvested from a single donor,<sup>18</sup> cadaveric organ donation satisfies only half of the yearly demand.<sup>19</sup> One explanation for the shortage of organs in spite of

*opments in the Law — Medical Technology and the Law*, 103 HARV. L. REV. 1519, 1614 (1990). However, cadaveric organ transplantation did not become commonplace until the development of cyclosporine, an immunosuppressant agent. Thomas E. Starzl, *Transplantation*, 256 JAMA 2110, 2110 (1986).

14. The one-year survival rates after a cadaveric organ transplant are as follows: kidney, 93%; liver, 73.9%; pancreas, 89.2%; heart, 81.6%; heart-lung, 55.4%. The two-year survival rates after a cadaveric organ transplant are as follows: kidney, 90%; liver, 69.4%; pancreas, 84.1%; heart, 77.0%; heart-lung, 48.8%; lung, 57.7%. Telephone Interview with Donna Johnston, Office Assistant, United Network of Organ Sharing (Feb. 3, 1994).

15. See *infra* notes 25-27 and accompanying text (discussing criticisms of the existing organ procurement policy in the United States).

16. Prior to the first draft of the 1968 UAGA, a Gallup poll reported that 7 out of 10 Americans were willing to donate their organs. A 1985 survey conducted by Gallup concluded that Americans' attitudes about organ donation remained substantially unchanged. According to the 1985 survey, 27% of those surveyed indicated that they were "very likely" to donate organs at death. 73% were "very likely" to give permission to donate a loved one's organs, and 62% "would not mind" if their organs were donated even if they had not made a donative gift prior to death. AMERICAN COUNCIL ON TRANSPLANTATION, ACTION 7 (1985). See also Dr. John A. Morris, Jr., et al., *Pediatric Organ Donation: The Paradox of Organ Shortage Despite the Remarkable Willingness of Families to Donate*, 89 PEDIATRICS 411 (1992); Daphne D. Sipes, *State, Federal Statutes Guide Organ Donation Procedures*, HEALTH PROGRESS, June 1987, at 46, 49.

17. Telephone Interview with Donna Johnston, Office Assistant, United Network of Organ Sharing (Feb. 3, 1994). See also Fact Sheet published by the United Network of Organ Sharing (February 2, 1994); NATIONAL KIDNEY FOUNDATION, KIDNEY (1989) (citing the number of people on waiting lists for organ transplants as of 1989).

18. A donor can provide two kidneys, two lungs, a heart, a liver, and a pancreas. Telephone Interview with Dr. Richard L. Hurwitz, Director, Virginia Vascular Associates (Jan. 13, 1994). See also Jardine, *supra* note 1, at 1656.

19. See *supra* note 14 and accompanying text (discussing the number of organs donated each year). Even though only 16,603 organs were donated in 1992, up to 25,000 people who die each year are suitable organ donors. See Jardine, *supra* note 1, at 1655 n.1; Jeffrey M. Prottas, *The Rules for Asking and Answering: The Role of Law in Organ Donation*, 63 U. DET. L. REV.

broad public support for organ transplantation is that cadaveric organs are rarely harvested pursuant to an individually executed document of gift.<sup>20</sup>

### B. *The Current Organ Procurement System: Express Donation*

The organ procurement system in the United States relies on express donation.<sup>21</sup> Under this system, individuals may make voluntary donative gifts only for altruistic purposes.<sup>22</sup> One who buys or sells organs for "valuable consideration for use in human transplantation" commits a felony under the National Organ Transplant Act of 1984.<sup>23</sup> The Act also prohibits health care providers from receiving monetary incentives when they request that individuals make donative gifts.<sup>24</sup> Thus, under the current system, organs for transplantation come only from donors who expressly make a gift of their organs.

Critics of express donation cite three main reasons why it is an inadequate system for procuring organs. First, critics note

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183, 183 (1985) (distinguishing between the estimated number of organs available for transplantation and the number of organs transplanted); Elizabeth S. Spencer, *Maximizing Use of a Scarce National Resource: An Analysis of Alternatives for Establishing Uniform Standards of Conduct for Organ Procurement Agencies*, 42 FOOD DRUG COSM. L.J. 430, 431 (1987).

Cadaveric organs are used for most organ transplants. Judith Areen, *A Scarcity of Organs*, 38 J. LEGAL EDUC. 555, 556 (1988). See also *Developments in the Law — Medical Technology and the Law*, *supra* note 13, at 1616; Thomas E. Starzl, *Will Live Organ Donations No Longer Be Justified?*, HASTINGS CENTER REP., Apr. 1985, at 5.

20. "[O]nly three percent of those who serve as organ donors are carrying a signed donor card at the time they are pronounced dead, . . . " *Developments in the Law — Medical Technology and the Law*, *supra* note 13, at 1619.

21. Express donation became the "de facto policy" that emerged following the first organ transplants. See Barnett & Kaserman, *supra* note 3, at 120.

22. See Barnett & Kaserman, *supra* note 3, at 121.

23. Pub. L. No. 98-507, 98 Stat. 2339, 2344-47 (1984) (codified at 42 U.S.C. §§ 273-274e (1988)). The statute provides: "It shall be unlawful for any person to knowingly acquire, receive, or otherwise transfer any human organ for valuable consideration for use in human transplantation if the transfer affects interstate commerce." 42 U.S.C. § 274e(a) (1988). Only "reasonable payments associated with the removal, transportation, implantation, processing, preservation, quality control, and storage of a human organ or the expenses of travel, housing, and lost wages" for a donor are permitted. 42 U.S.C. § 274e(c)(2) (1988). Penalties for violating the act include a fine of no more than \$50,000 and/or imprisonment for not than five years. 42 U.S.C. § 274e(b) (1988).

Most states also prohibit commercial transactions involving organs. See, e.g., VA. CODE ANN. § 32.1-289.1 (Michie 1992).

24. Barnett & Kaserman, *supra* note 3, at 121 n.16 (noting that organ procurement officers are an exception to this general prohibition).

that psychological barriers such as a reluctance to confront one's mortality may prevent individuals from considering organ donation.<sup>25</sup> Second, an individual who is ambivalent about donating his or her organs may be further dissuaded because the current system allows no monetary compensation.<sup>26</sup> Finally, physicians or hospital representatives may be unwilling to request a family's permission to harvest the organs of a recently deceased individual who has not made a donative gift.<sup>27</sup>

Although other methods of organ procurement, such as a system relying on presumed consent, might alleviate the shortage of cadaveric organs available for transplantation,<sup>28</sup> improving

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25. See Lloyd R. Cohen, *Increasing the Supply of Transplant Organs: The Virtues of a Futures Market*, 58 GEO. WASH. L. REV. 1, 13 (1989) (arguing that consent to organ donation is the equivalent of assenting to an individual's "own dismemberment"); *Developments in the Law — Medical Technology and the Law*, *supra* note 16, at 1618 (noting that the barriers are largely the same as the barriers that make 80% of people die intestate).

26. See *supra* notes 21-24 and accompanying text (discussing statutes that prohibit receiving "valuable consideration" for organs).

27. The reluctance of physicians to confront families to request organ donation may be due to:

[U]nwarranted fears of legal liability, a legitimate concern that negative publicity might damage further organ procurement efforts, a desire to respect the family's wishes, an unwillingness to cause the grieving family any more stress, physicians' reluctance to ask something of the family when they were unable to save the patient, and physicians' and nurses' uncertainty about the concept of brain death or how to identify a potential donor.

*Developments in the Law — Medical Technology and the Law*, *supra* note 16, at 1619. See also TASK FORCE ON ORGAN TRANSPLANTATION, U.S. DEP'T OF HEALTH AND HUMAN SVCS., ORGAN TRANSPLANTATION: ISSUES AND RECOMMENDATIONS 35-36 (1986); Jardine, *supra* note 1, at 1658-59 (noting that "mere silence" often defeats a donor's intent because of hospitals' fear of liability and concern for families' well being).

28. Presumed consent is one alternative to express donation. Presumed consent assumes that, absent an affirmative statement to the contrary, a donor does not object to post-mortem organ removal. See Barnett & Kaseman, *supra* note 3, at 121-23. A review of the literature on organ procurement policy yields five alternative policies to the current system of express donation. These include: presumed consent, conscription (or an organ draft), routine request, compensation, and a market system. A discussion of these alternatives is beyond the scope of this paper. See generally *id.* at 119-27 (discussing these alternative systems). See also Marvin Brams, *Transplantable Human Organs: Should Their Sale Be Authorized by State Statutes?*, 3 AM. J.L. & MED. 183 (1977) (proposing a combined altruistic and market driven system); Jesse Dukeminier, Jr., *Supplying Organs for Transplantation*, 68 MICH. L. REV. 811 (1970) (proposing statutes to avoid market pressure on organ procurement); Jesse Dukeminier, Jr. & David Sanders, *Organ Transplantation: A Proposal for Routine Salvaging of Cadaver Organs*, 279 NEW ENG. J. MED. 413 (1968); David L. Kaserman & A.H. Barnett, *An Economics Analysis of Transplant Organs: A Comment and Extension*, 19 ATLANTIC ECON. J. 57 (1991); L.

the express donation system remains the most viable method for increasing the supply of transplant organs.<sup>29</sup> Existing statutes that govern organ procurement generally follow the UAGA's system of express or voluntary donation.<sup>30</sup> Even though express donation is widely accepted, the contours and limits of the UAGA's express donation system remain unknown. Despite this uncertainty, legislatures have adhered to the express donation system.<sup>31</sup> Additionally, few people have challenged express donation laws.<sup>32</sup> Thus, changing the current system, rather than adopting a completely new system, seems most likely to succeed.

### C. *Legislative Attempts to Increase Organ Supply*

Congress enacted the National Organ Transplant Act of 1984 to address the shortage of organs available for transplantation.<sup>33</sup> The National Organ Transplant Act provides guidelines for organ procurement organizations,<sup>34</sup> prohibits interstate organ

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Roels et al, *Effect of a Presumed Consent Law on Organ Retrieval in Belgium*, 22 *TRANSPLANTATION PROC.* 2078 (1990); Richard Schwindt & Aidan R. Vining, *Proposal for a Future Delivery Market for Transplant Organs*, 11 *J. HEALTH POL., POL'Y & L.* 483 (1986) (arguing for an organized, public futures market for organs); Theodore Silver, *The Case for a Post-Mortem Organ Draft and a Proposed Model Organ Draft Act*, 68 *B.U. L. REV.* 681 (1988) (proposing that the state be allowed to conscript cadaveric organs); Aaron Spital, *The Shortage of Organs for Transplantation: Where Do We Go From Here?*, 325 *NEW ENG. J. MED.* 1243 (1991); David E. Chapman, Comment, *Retailing Human Organs Under the Uniform Commercial Code*, 16 *J. MARSHALL L. REV.* 393 (1983) (arguing that the UCC would provide adequate controls for the sale of organs).

29. One commentary suggests that the current system of express donation has failed in its entirety. See Barnett & Kaserman, *supra* note 3, at 120-21.

Physicians, however, suggest that the demand for cadaveric organs may diminish as animal organs are successfully transplanted into humans. Telephone Interview with Dr. Richard L. Hurwitz, Director, Virginia Vascular Associates (Jan. 13, 1994).

30. See *infra* notes 33-43 and accompanying text (discussing federal and state statutes concerning organ donation).

31. See McIntosh, *supra* note 1, at 174.

32. See *infra* note 66 and accompanying text (discussing cases that have challenged the UAGA).

33. 42 U.S.C. §§ 273-274e (1988). See generally Sipes, *supra* note 16, at 46 (noting that Congress' intent in enacting the National Organ Transplant Act was also to "assist in improving the network of donors and recipients and in raising public awareness").

34. 42 U.S.C. § 274. The act established the Organ Procurement and Transplant Network to facilitate locating organs for potential recipients. The Organ Procurement and Transplant Network is a not-for-profit entity that matches donated organs with compatible recipients according to tissue type, size of organ, and other factors. The act also requires the Organ Procurement and Transplant Network to publish information concerning organ donation.

sales,<sup>35</sup> and requires the establishment of a National Task Force to study the organ shortage.<sup>36</sup> The first report of the National Task Force recommended that health care professionals take proactive steps to identify potential organ donors.<sup>37</sup> Congress codified this recommendation in the 1987 amendments to the Social Security Act.<sup>38</sup> Under these amendments, hospitals that receive Medicare or Medicaid funding must establish written procedures for informing families of potential donors about the option of organ donation.<sup>39</sup> The recommendations of the National Task Force also led to the creation of a national organ sharing system to assist private organ procurement agencies.<sup>40</sup>

Because the scope of federal legislation addressing the organ shortage is limited, state statutes based on the Uniform Anatomical Gift Act (UAGA) provide most of the law governing organ procurement procedures.<sup>41</sup> Drafted in 1968 by the National Conference of Commissioners on Uniform State Laws (NCCUSL),<sup>42</sup> the UAGA's main purpose was to remove the

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Sipes, *supra* note 16, at 46. *See also* McIntosh, *supra* note 1, at 175.

In addition, the act established guidelines for organ procurement organizations which include: requiring not-for-profit status, designating geographical boundaries, requiring at least fifty potential donors per geographical boundary each year, and requiring that qualified personnel administer transplant programs. 42 U.S.C. § 273(b).

35. 42 U.S.C. § 274e. *See supra* notes 23-24 and accompanying text (discussing the prohibition on the sale of organs codified in the National Transplant Act of 1984).

36. Pub. L. No. 98-507 §§ 101-105. The task force was appointed by the Health and Human Services Secretary to study the organ shortage problem. In 1986, the task force filed a final report analyzing the organ shortage and recommending possible solutions. *See* TASK FORCE ON ORGAN TRANSPLANTATION, *supra* note 27. *See generally* Sipes, *supra* note 16, at 46 (describing the task force's findings).

37. TASK FORCE ON ORGAN TRANSPLANTATION, *supra* note 27, at 23.

38. Social Security Act § 7, 42 U.S.C. § 1320b-8(a)(1)(A) (1988).

39. *See* 42 U.S.C. § 1320b-8(a)(1)(A). Legislative history suggests that familial consent is not required if the individual has already designated his or her intent to make a donative gift. Rather, the familial consent provision is designed to encourage organ donation in cases where an individual has not completed a document of gift. Cf. LEGISLATIVE HISTORY OF THE BUDGET RECONCILIATION ACT OF 1986, Pub. L. No. 99-509 (1986), *reprinted in* 1986 U.S.C.C.A.N. 3607, 3963-65.

40. TASK FORCE ON ORGAN TRANSPLANTATION, *supra* note 25, at 49. *See supra* note 34 (discussing the Organ Procurement and Transplant Network). *See generally* Sipes, *supra* note 16, at 46-47 (explaining that the Network's purpose is to assist organ procurement groups).

41. McIntosh, *supra* note 1, at 172-74.

42. The purpose of the National Conference of Commissioners on Uniform State Laws (NCCUSL) is to promote uniformity of state law. The NCCUSL drafts models for state law. Members of the NCCUSL, which include representatives from all states, then introduce the proposed model to their respective



barriers to organ donation caused by conflicting and incomplete state and common laws.<sup>43</sup>

The UAGA and the National Organ Transplant Act of 1984 responded to a growing demand for cadaveric organs for transplantation.<sup>44</sup> The speed with which states adopted the 1968 UAGA demonstrates that states needed uniform standards governing organ procurement.<sup>45</sup> Today, the demand for cadaveric organs for transplantation continues to outweigh the supply of available organs.<sup>46</sup> In response to the persistent organ shortage, the NCCUSL amended the UAGA in 1987 to more effectively increase the supply of cadaveric organs.<sup>47</sup> As amended, the UAGA may therefore serve as a springboard for states seeking to increase the supply of cadaveric organs.

## II. STATUTORY FRAMEWORK OF THE UAGA AND THE VAGA

### A. *The Uniform Anatomical Gift Act*

As the continued organ shortage demonstrates, current legislation has not solved the problems with the organ procurement system.<sup>48</sup>

#### 1. Documenting Intent to Make an Anatomical Gift

One problem in procuring an adequate number of organs for transplantation is discerning whether individuals intended to donate their organs. To foster uniformity in donor designation procedures, the UAGA establishes procedures for making anatomical gifts.<sup>49</sup> Section 2(b) allows any competent adult<sup>50</sup> to

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state legislatures. McIntosh, *supra* note 1, at 171-72 n.8. See also LAWRENCE M. FRIEDMAN, A HISTORY OF AMERICAN LAW 652 (1985).

43. UNIF. ANATOMICAL GIFT ACT Prefatory Note (1987), 8A U.L.A. 20-22 (1993). Describing the different state laws governing organ donation, the preface to the 1968 UAGA advocated drafting a model law to address common legal questions arising from organ donation. The Prefatory Note stated that due to the recent success of organ transplantation, common law and state laws were ill-equipped to deal with these legal questions. The Prefatory Note of the 1987 UAGA restated the goal of promoting greater uniformity among state laws. According to the Prefatory Note, the 1987 UAGA and NCCUSL drafted revisions and additions to address the inadequacies in the 1968 system.

44. See *supra* notes 31 and 44-47 and accompanying text.

45. See *supra* note 6 (noting that by 1972 all fifty states adopted the main provisions in the 1968 UAGA).

46. See *supra* notes 13-17 and accompanying text.

47. See *infra* part II.A (discussing the 1987 UAGA).

48. See *supra* note 43 (discussing revisions to the UAGA).

49. See *supra* notes 42-43 and accompanying text (discussing the NCCUSL's purpose in drafting uniform acts).

make an anatomical gift by completing a document of gift.<sup>51</sup> People can donate their organs by will or by signed statement.<sup>52</sup> The most common form of donative instrument is a statement imprinted on the back of motor vehicle drivers' licenses, which remains valid even if the license is later suspended, canceled, or expires.<sup>53</sup> Section 2(h) specifies that only express revocation may invalidate an anatomical gift, and once the donor dies, the gift becomes irrevocable.<sup>54</sup>

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Uniform donor designation procedures are crucial to the transplant process because organs remain viable for transplantation for only a short length of time. A heart, lung, or heart-lung combination can be preserved for only as long as 4 to 6 hours. A liver can be preserved only for as long as 12 to 24 hours. A kidney can be preserved only for as long as 48 to 72 hours. UNITED NETWORK FOR ORGAN SHARING, FACTS EVERYONE SHOULD KNOW ABOUT ORGAN DONATION AND TRANSPLANTATION (1993).

50. Under the UAGA, a competent adult is "[a]n individual who is at least 18 years of age." UNIF. ANATOMICAL GIFT ACT § 2(a) (1987), 8A U.L.A. 33 (1993).

51. Section 2(b) provides:

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.

UNIF. ANATOMICAL GIFT ACT § 2(b) (1987), 8A U.L.A. 33 (1993).

In theory, individually executed donative gifts should be the most preferred method of organ donation because once made, these gifts are irrevocable upon the donor's death and no additional consent is required from family members to harvest these organs. Critics note, however, that physicians routinely fail to harvest organs without obtaining familial consent even when the donor has completed a valid document of gift. *See infra* notes 101-103 and accompanying text (explaining why hospitals also obtain familial consent and suggesting that liability should accrue to physicians who require unnecessary additional familial consent). *See also* Kathleen S. Anderson & Daniel M. Fox, *The Impact of Routine Inquiry Laws on Organ Donation*, HEALTH AFF., Winter 1988, at 67 ("No organ procurement agency will remove organs solely on the approval of a signed donor card, although its presence may encourage family members to consent to donation.").

52. UNIF. ANATOMICAL GIFT ACT § 2(b) and (e) (1987), 8A U.L.A. 33-34 (1993).

53. The UAGA provides specifically for imprinting donor documents on motor vehicle licenses. UNIF. ANATOMICAL GIFT ACT § 2(c) (1987), 8A U.L.A. 34 (1993). Section 2(c) provides: "If a document of gift is attached to or imprinted on a donor's motor vehicle operator's or chauffeur's license, the document of gift must comply with subsection (b). Revocation, suspension, expiration, or cancellation of the license does not invalidate the anatomical gift." *Id. Compare* § 2(c) with VA. CODE ANN. § 46.2-342G (Michie 1994) ("The donor designation provided pursuant to subsection D may only be rescinded by appearing in person at a Department branch office. . .").

54. Section 2(h) provides: "An anatomical gift that is not revoked by the donor before death is irrevocable and does not require the consent or concurrence of any person after the donor's death." UNIF. ANATOMICAL GIFT ACT § 2(h) (1987), 8A U.L.A. 34 (1993).

## 2. Liability Limitations

The UAGA does not rely solely on its document of gift provision to ascertain donative intent, but also imposes an affirmative duty on emergency personnel<sup>55</sup> and hospitals to determine an individual's donative intent. Section 5(a), for example, requires that a hospital ask an individual about his or her donative intent upon admission to the hospital.<sup>56</sup> Section 5(c) authorizes emergency personnel and hospitals to perform a "reasonable search" for a document of gift or other information indicating donative intent.<sup>57</sup> The UAGA, however, does not define the scope of this search.<sup>58</sup>

The UAGA recommends minimal liability if designated personnel fail to discover an individual's donative intent. The comment to section 5 of the UAGA notes that section 5(c) was added to create "a minimum level of duty towards persons in

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55. Emergency personnel include law enforcement officers, firefighters, paramedics, or other emergency rescuers finding an individual who the searcher believes is dead or near death. UNIF. ANATOMICAL GIFT ACT § 5(c)(1) (1987), 8A U.L.A. 47 (1993).

56. Section 5(a) provides: "[O]n or before admission to a hospital, or as soon as possible thereafter, a person designated by the hospital [shall] ask each patient who is at least [18] years of age: 'Are you an organ or tissue donor?'" UNIF. ANATOMICAL GIFT ACT § 5(a), 8A U.L.A. 47 (1993).

57. Section 5(c) provides:

The following persons shall make a reasonable search for a document of gift or other information identifying the bearer as a donor or as an individual who has refused to make an anatomical gift:

- (1) a law enforcement officer, fireman, paramedic, or other emergency rescuer finding an individual who the searcher believes is dead or near death; and
- (2) a hospital, upon admission of an individual at or near the time of death, if there is not immediately available any other source of that information.

UNIF. ANATOMICAL GIFT ACT § 5(c) (1987), 8A U.L.A. 47 (1993). Compare § 5(c) with VA. CODE ANN. § 32.1-292.1.A, .B (Michie Supp. 1994). See *infra* notes 67-83 (discussing VAGA provision).

58. Virginia has interpreted § 5(c) to authorize a physical search of the victim to determine donative intent. VA. CODE ANN. § 32.1-292.1.A, .B (Michie Supp. 1994). Section 5(a) provides: "The following persons may make a *reasonable search* for a document of gift or other information identifying the bearer as a donor or as an individual who has refused to make an anatomical gift: . . ." VA. CODE ANN. § 32.1-292.1.A (Michie Supp. 1994) (emphasis added).

Section 32.1-292.1.B clarifies subsection A by specifying the nature of the "reasonable search." Section 32.1-292.1.B provides: "A physical search pursuant to subsection A may be conducted at or near the time of death or hospital admission and shall be limited to those personal effects of the subject where a driver's license may be reasonably stored. . . ." VA. CODE ANN. § 32.1-292.1.B (Michie Supp. 1994).

an unconscious state and toward those who are conscious but otherwise unable to communicate."<sup>59</sup> Section 5(f), which applies to sections 5(a) and 5(c), shields emergency personnel and hospitals from civil and criminal liability but authorizes "appropriate administrative sanctions."<sup>60</sup> The comment to the UAGA recommends that "hospital accrediting agencies, law enforcement, and other state agencies that have existing disciplinary procedures" impose sanctions.<sup>61</sup> The UAGA provides no guidance, however, for determining what constitute "appropriate administrative sanctions."<sup>62</sup>

In addition to the limitation on liability in section 5(f), section 11(c)<sup>63</sup> also limits liability of health care personnel.<sup>64</sup> Under section 11(c), health care personnel are not held liable for

59. UNIF. ANATOMICAL GIFT ACT § 5 cmt. (1987), 8A U.L.A. 48 (1993).

60. Section 5(f) provides: "A person who fails to discharge the duties imposed by this section is not subject to criminal or civil liability but is subject to appropriate administrative sanctions." UNIF. ANATOMICAL GIFT ACT § 5(f) (1987), 8A U.L.A. 47 (1993). The administrative sanctions contained in § 5(f) also apply to a hospital's failure to make these inquiries.

See *infra* note 81 and accompanying text (discussing Virginia's routine inquiry and required request provisions). See generally *Are Michigan Hospitals Complying with the Required Request Law?*, MICHIGAN HOSPITALS, Sept. 1991, at 21 (reporting survey results determining reasons for sharp decrease in donations following implementation of the Required Requests law); Thomas E. Burris et al., *Impact of Routine Inquiry Legislation in Oregon on Eye Donations*, 6 CORNEA 226 (1987) (finding increase of 135% in donor eye procurements in 1984-85); M.F. Mozes et al., *Impediments to Successful Organ Procurement in the "Required Request" Era: An Urban Center Experience*, 23 TRANSPLANTATION PROC. 2545 (1991); M.K. Norris, *Required Request: Why It Has Not Significantly Improved Donor Shortage*, 19 HEART & LUNG 685 (1990) (noting that the anticipated increase in donors was not realized); Robert M. Veatch, *Routine Inquiry About Organ Donation — An Alternative to Presumed Consent*, 325 NEW ENG. J. MED. 1246 (1991) (analyzing presumed consent and alternatives, including required request); B.A. Virnig & A.L. Caplan, *Required Request: What Difference Has it Made?*, 24 TRANSPLANTATION PROC. 2155 (1992) (concluding that required request laws have greater indirect impact than direct impact).

61. UNIF. ANATOMICAL GIFT ACT § 5 cmt. (1987), 8A U.L.A. 48-49 (1993).

62. UNIF. ANATOMICAL GIFT ACT § 5(f) (1987), 8A U.L.A. 47 (1993).

63. Section 11(c) provides:

A hospital, physician, surgeon, [coroner], [medical examiner], [local public health officer], enucleator, technician, or other person, who acts in accordance with this [Act] or with the applicable anatomical gift law of another state [or a foreign country] or attempts in good faith to do so is not liable for that act in a civil action or criminal proceeding.

UNIF. ANATOMICAL GIFT ACT § 11(c) (1987), 8A U.L.A. 59-60 (1993) (brackets in original).

64. Health care personnel may include: hospitals, physicians, surgeons, coroners, medical examiners, local public health officers, enucleators, and technicians. *Id.*

harvesting an individual's organs without ascertaining donative intent if they act in "good faith." Section 11(c), therefore, encourages health care providers to take proactive steps to harvest organs.<sup>65</sup> Absent a clear indication that a health care provider did not act in "good faith," courts generally uphold this limitation on liability as necessary to promote the UAGA's goal of increasing the supply of organs available for transplantation.<sup>66</sup>

## B. *The Virginia Anatomical Gift Code*

### 1. Documenting Intent to Make an Anatomical Gift

The VAGA, Virginia's version of the UAGA, establishes procedures for donating and harvesting anatomical gifts.<sup>67</sup> Enacted in 1970, the VAGA adopts many of the UAGA's provisions.<sup>68</sup> In an attempt to strengthen the state's voluntary organ donation system, the Virginia legislature amended the VAGA in 1993.<sup>69</sup> The amendments, which exceed the scope of the UAGA, are intended to enlarge the pool of potential donors and to increase the supply of available transplant organs.<sup>70</sup> The amend-

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65. These proactive measures are essential because transplant organs remain viable for only a limited time. *See supra* note 49 (discussing the limited viability of organs).

66. *See, e.g.,* Nicoletta v. Rochester Eye & Human Parts Bank, Inc., 519 N.Y.S.2d 928, 931 (Sup. Ct. 1987) (holding that the "good faith" provision applied to defendant procurement agency that harvested deceased patient's eyes after an unauthorized party gave consent); Brown v. Delaware Valley Transplant Program, 615 A.2d 1379, 1382 (Pa. Super. Ct. 1992) (holding the "good faith" provision applied to a hospital's participation in harvesting decedent's heart and kidneys); Hinze v. Baptist Memorial Hosp., 1990 WL 121138, at \*5 (Tenn. App. Aug. 23, 1990) (holding that the "good faith" provision applied to the removal of the eyes of plaintiff's decedent after an unauthorized party gave consent); Williams v. Hofmann, 223 N.W.2d 844, 848 (Wis. 1974) (upholding the UAGA's "good faith" provision as not unduly vague or unconstitutional). *But see* Callsen v. Cheltenham York Nursing Home, 624 A.2d 663, 666 (Pa. Commw. 1993) (holding that there was a triable issue of fact as to whether the "good faith" immunity provision should apply to efforts to locate a patient's family to consent to organ donation).

67. VA. CODE ANN. §§ 32.1-289 to -297.1 (Michie 1992 & Supp. 1994).

68. Although the VAGA contains the basic outline of the UAGA, it does not follow all UAGA provisions. According to an anonymous source at the Legislative Services Office, VAGA provisions differ from the UAGA in order to fit UAGA provisions into Virginia's existing statutory framework. Telephone Interview with Uniform Law Commissioner, Virginia Legislative Services Office (Jan. 31, 1994). For example, one UAGA provision, Routine Inquiry and Required Request, UNIF. ANATOMICAL GIFT ACT § 5 (1987), 8A U.L.A. 47 (1993), is not even contained in Virginia's anatomical gifts code section. Rather, the provision is located, in an amended form, in the hospital licensure section of the Virginia code. VA. CODE ANN. § 32.1-127 (Michie Supp. 1994).

69. Telephone Interview with Kenneth V. Geroe, Vice-Chairman of the Virginia Democratic Party (Nov. 11, 1993).

70. *Id.* Amendments to the Virginia Code include: VA. CODE ANN. §§ 32.1-

ments establish procedures to make donor information more accessible at the time of a donor's death by changing existing driver's license donor designation procedures.<sup>71</sup>

Prior to the 1993 amendments, the VAGA, like most state anatomical gift codes, required only that a driver's license include a uniform donor document.<sup>72</sup> As amended, section 46.2-342.D of the Virginia Code requires the Department of Motor Vehicles (DMV) to establish additional procedures whereby a driver's license applicant can specify his or her donative intent.<sup>73</sup> The VAGA's new provision delegates responsibility for recording

290, -290.1, -292.1, -295, and 46.2-342 (Michie 1994 & Supp. 1994). See *infra* notes 71-90 and accompanying text (discussing the 1993 amendments).

71. See *infra* notes 78-87 and accompanying text (discussing the VAGA amendments). Other amendments to the Virginia Code that attempt to promote organ procurement efforts include: 1) authorizing a minor under the age of eighteen to make donative gifts with the written consent of his or her parent or guardian, VA. CODE ANN. § 32.1-290.A (Michie Supp. 1994); and 2) permitting authorized persons to take "medically necessary steps" to maintain organ viability for transplantation pending a search for donor authorization or familial consent, VA. CODE ANN. § 32.1-295.E (Michie Supp. 1994).

72. Section 46.2-342.D provides:

The Department [of Motor Vehicles] shall establish a method by which an applicant for a driver's license or an identification card may designate his willingness to be an organ donor . . . and shall cooperate with the Virginia Transplant Council to ensure that such method is designed to encourage organ donation with a minimum of effort on the part of the donor and the Department.

VA. CODE ANN. § 46.2-342.D (Michie 1994).

73. Section 46.2-342.D previously provided:

Every license shall also bear the following document which the licensee may complete.

[UNIFORM DONOR DOCUMENT] OF —

Print or type name of donor

In the hope that I may help others, I hereby make this anatomical gift without cost to my estate, to take effect upon my death. The words and marks below indicate my desires. I give:

(a) — eyes and any other needed organs or parts

(b) — only the following organs or parts . . .

Specify the organ(s) or part(s) . . . for the purposes of transplantation, therapy, medical research, or education;

Limitations or special wishes, if any:

— Signed by the donor and the following two witnesses in the presence of each other:

Signature of Donor, Date of Birth of Donor

Date Signed, City & State

Witness, Witness

This is a legal document under Article 2 (s. 32.1-289 et seq.) of Chapter 8 of Title 32.1 or similar laws.

VA. CODE ANN. § 46.2-342.D (Michie 1988).

donor designation to the DMV and Virginia Transplant Council.<sup>74</sup> In addition, the amendment requires the DMV and Virginia Transplant Council to revise the Uniform Donor Document.<sup>75</sup>

Prior to the amendments, the VAGA did nothing to ensure that physicians or other qualified authorities would discover a person's anatomical gift even if that person had completed a valid donor document.<sup>76</sup> Physicians and administrators often cannot locate donor documents contained on a driver's license when a potential donor is admitted to the hospital. Therefore, even searches for donor documentation conducted by hospital and emergency personnel pursuant to UAGA section 5(c) may prove fruitless.<sup>77</sup>

The VAGA amendments attempt to address the potential unavailability of donor documents in trauma situations in section 46.2-342.E by authorizing the DMV to designate a donor's status on his or her driving record.<sup>78</sup> To further its objective of discovering donor status, the Virginia legislature added section 32.1-292.1.B, which authorizes law enforcement officials to search a person's driving record to determine his or her donor status if, upon hospital admission, a physical search reveals no relevant documents.<sup>79</sup> Documentation of an anatomical gift in a DMV

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74. VA. CODE ANN. § 46.2-342.D (Michie 1994). *See supra* note 72 (quoting statutory provision).

The Virginia Transplant Council was established “[f]or the purpose of conducting educational and informational activities and coordinating such activities as they relate to organ and tissue procurement and transplantation efforts in the Commonwealth. . . .” The Virginia Transplant Council membership includes representatives from the University of Virginia Medical Center, the Medical College of Virginia, the Virginia Organ Procurement Agency, the Eastern Virginia Renal Transplant Program, the Eastern Virginia Tissue Bank, the Old Dominion Eye Bank, the Lion’s Eye and Research Center of Eastern Virginia, the Eye Bank and Research Foundation. VA. CODE ANN. § 32.1-297.1 (Michie 1992).

75. VA. CODE ANN. § 46.2-342.K (Michie 1994).

76. The UAGA requires that an individual indicate donative intent via a signed organ donor document. UNIF. ANATOMICAL GIFT ACT § 2(b) (1987), 8A U.L.A. 33 (1993). According to some commentators, however, “only three percent of those who serve as organ donors are carrying a signed donor card at the time they are pronounced dead.” *Developments in the Law — Medical Technology and the Law*, *supra* note 13 at 1619. *See also* R. Magreiter, *What Can Be Done About the Insufficient Supply of Grafts?*, 19 *TRANSPLANTATION PROC.* 79, 82 (1987).

77. *See supra* notes 57-59 and accompanying text (discussing section 5(c) of the UAGA).

78. Section 46.2-342.E provides: “If an applicant designates his willingness to be a donor pursuant to subsection D, the Department may make a notation of this designation on card and shall make a notation of this designation on his driver record.” VA. CODE ANN. § 46.2-342.E (Michie 1994).

79. According to a Uniform Law Commissioner, the Virginia legislature

driving record constitutes sufficient authority to harvest an organ.<sup>80</sup>

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added § 32.1-293.1.B to address the concern that an unconscious adult would be unable to signify that he or she had made an anatomical gift. Telephone Interview with Uniform Law Commissioner, Virginia Office of Legislative Services (Jan. 31, 1994). Section 32.1-292.1.B provides:

Any law-enforcement officer may conduct an administrative search of the subject's Department of Motor Vehicles driver record to determine the person's authorization for organ donation or refusal of organ donation. . . . Any information, document, tangible objects or other items discovered during such search shall be used solely for the purpose of ascertaining whether the subject intends to make an anatomical gift, and in no event shall any such discovered material be admissible in any subsequent criminal or civil proceeding.

VA. CODE ANN. § 32.1-292.1.B (Michie 1994).

Only two other states require the Department of Motor Vehicles to designate donative status on more than the driver's license. Florida requires the Department of Motor Vehicles to note donative status in the driver's record. *See* FLA. STAT. ANN. § 732.921 (West Supp. 1994) (creating a donor identification program by providing a method for designating donative status on identification cards, driver licenses, and driver records); FLA. STAT. ANN. § 732.9215 (West Supp. 1994) (creating an educational program relating to anatomical gifts and assessing the program's effectiveness in procuring organs). New Mexico requires the Department of Motor Vehicles to microfilm a copy of a donative gift made pursuant to a driver's license application or renewal and file it in the statewide organ and tissue donor registry. N.M. STAT. ANN. § 24-6-5 (Michie 1994). New Mexico also allows state police to verify donor information on the microfilmed document upon request of an authorized hospital.

The majority of states, however, require only that the Department of Motor Vehicles record a driver's donative status on the license. *See, e.g.*, CONN. GEN. STAT. ANN. § 14-42(b) (West 1987) (requiring that the driver's license provide a conspicuous indication of donative intent to enable immediate identification of organ donors); HAW. REV. STAT. § 286-109.5 (1992) (requiring a system for designating donative intent be imprinted on driver's licenses); LA. REV. STAT. ANN. § 32:410.B (West Supp. 1994) (requiring the DMV, at the time of license renewal, to inquire whether an individual would like to make a donative gift and, if the individual so signifies, requiring the DMV to make an appropriate designation on the driver's license); ME. REV. STAT. ANN. tit. 29, § 540-C (West Supp. 1993) (requiring the Secretary of State to provide, on each driver's license issued, a statement indicating a declaration of an anatomical gift); R.I. GEN. LAWS § 31-10.3-32(9) (Supp. 1993) (requiring the DMV to include organ donor information on a driver's license); TENN. CODE ANN. § 55-50-407(9) (1993) (requiring the DMV to include organ donor information on a driver's license); TEX. REV. CIV. STAT. ANN. art. 6687b (West Supp. 1994) (requiring the DMV to include a method for indicating donative intent on a driver's license, and authorizing an organ or tissue procurement organization to determine if the deceased is a declared donor); VT. STAT. ANN. tit. 18, § 5241(b) (Supp. 1993) (authorizing law enforcement official or designated hospital representative to inspect an individual's driver's license to determine whether that individual has made a donative gift); W. VA. CODE § 17B-1B-1 (1991) (requiring the DMV to provide a method for



## 2. Liability Limitations

In addition to establishing procedures designed to make it easier to determine if a person is an organ donor, the VAGA also provides broader liability limitations than the corresponding UAGA provisions.<sup>81</sup> The VAGA contains the UAGA liability limitation that shields health care providers from liability for harvesting organs in "good faith."<sup>82</sup> The 1993 amendments to the VAGA, however, also grant the DMV civil and criminal immunity for failing to make donor designations in a drivers' records.<sup>83</sup> There is no such corresponding UAGA provision.<sup>84</sup>

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determine whether that individual has made a donative gift); WYO. STAT. § 35-5-112 (1994) (requiring the DMV to provide a method for donor designation on driver's licenses).

Some states do not require designation of donative intent at all. *See, e.g.*, N.J. STAT. ANN. § 39:3-10 (West Supp. 1994) (requiring individuals to be informed of the procedures for making an anatomical gifts); WIS. STAT. ANN. § 157.06(2) & (5)(C) (West 1989 & Supp. 1993) (requiring the DMV to include a method for designating donative intent on a driver's license and authorizing hospitals to perform a physical search for this information).

80. Section 46.2-342.F provides: "The donor designation authorized in subsection E shall be sufficient legal authority for the removal, following death, of the subject's organs or tissues without additional authority from the donor, or his family or estate." VA. CODE ANN. § 46.2-342.F (Michie 1994). *See supra* note 78 (providing the text of subsection E).

81. VA. CODE ANN. §§ 32.1-289 to -297.1 (Michie 1992 & Supp. 1994). The Virginia Code differs with respect to the administrative sanctions described in the Routine Inquiry and Required Request provision of the UAGA. Although the Virginia Code contains a version of Routine Inquiry and Required Request, the Code does not impose administrative sanctions for a failure to request organ donation from a potential donor or his or her family. Rather, the Code provides for generic sanctions administered by the Virginia Board of Health only if a hospital fails to establish routine *protocols* for routine request. VA. CODE ANN. § 32.1-127.0 (Michie 1992). *See supra* notes 60-62 and accompanying text (discussing the liability sanctions contained in the Routine Inquiry and Required Request provisions of the UAGA).

82. Section 32.1-295.D provides: "A person who acts in good faith in accord with the terms of this article, or under the anatomical gift laws of another state or a foreign country is not liable for damages in any civil action or subject to prosecution in any criminal proceeding for his act." VA. CODE ANN. § 32.1-295.D (Michie Supp. 1994). *See supra* notes 62-65 and accompanying text (discussing Section 11(C) of the UAGA).

83. Section 46.2-342.J provides: "In the absence of gross negligence or willful misconduct, the Department and its employees shall be immune from any civil or criminal liability in connection with the making of or failure to make a notation of donor designation on any license or card or in any person's driver record." VA. CODE ANN. § 46.2-342.J (Michie 1994).

84. Under the UAGA, donor designation in the Department of Motor Vehicles records is not a valid means of making an anatomical gift. *See supra* part II.A.1 (discussing the UAGA provisions that specify procedures for making anatomical gifts).

### III. PROPOSAL FOR CREATING HOSPITAL DUTY AND LIABILITY

Increasing the number of organs available for transplantation under our present organ donor system requires improving access to donor information.<sup>85</sup> Virginia's amendments address some weaknesses in the express voluntary donation system by authorizing donor designation in DMV records and authorizing law enforcement officials to verify donor status.<sup>86</sup> This Note, however, proposes to amend the VAGA in order to more effectively expand the number of available organs, one of the expressed purposes of the UAGA.<sup>87</sup> These changes would improve hospital access to donor information and would help ensure that all organs donated via an individually executed document of gift are harvested.

#### A. Hospital Access to DMV Records

VAGA section 32.1-292.1.B, which authorizes law enforcement officials to search DMV records for the purpose of verifying donor status,<sup>88</sup> is not likely to significantly increase anatomical gifts.<sup>89</sup> By limiting those authorized to search DMV records to law enforcement officials, section 292.1.B prevents the timely and efficient dissemination of donor information. The Virginia legislature enacted section 292.1.B to provide donor information that might otherwise be unavailable at the time of hospital admission.<sup>90</sup> In its original form, section 292.1.B authorized both hospitals and law enforcement officials to search DMV records.<sup>91</sup> As enacted, however, the amendment does not provide this access to hospitals.<sup>92</sup>

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85. See *supra* notes 76-80 and accompanying text (discussing the low probability that a individual will have a document of gift upon hospital admission and detailing legislative attempts to solve this problem by requiring documentation of donative intent on the driver's license).

86. See *supra* part II.B (discussing the amendments to the VAGA).

87. See *supra* note 43 and accompanying text (discussing the purpose of the UAGA).

88. VA. CODE ANN. § 32.1-292.1.B (Michie 1992). See *supra* note 75 and accompanying text (discussing section 32.1-292.1.B).

89. Telephone Interview with Dr. Richard L. Hurwitz, M.D., Director, Virginia Vascular Associates (Jan. 13, 1994).

90. See *supra* notes 76-78 and accompanying text (discussing the problem of locating a document of gift at the time of hospital admission).

91. Letter from Kenneth V. Geroe, Vice-Chairman of the Virginia Democratic Party to Oscar E. Edwards, M.D., Glenn R. Barnhart, M.D., Robert A. Fisher, M.D. & Richard L. Hurwitz, M.D., (Dec. 3, 1992) (on file with the *Journal of Urban and Contemporary Law*).

92. VA. CODE ANN. § 32.1-292.1.B (Michie 1994). See *supra* note 79 (quoting the text of section 32.1-292.1.B as enacted).

Section 292.1.B must also authorize hospital access to DMV records because hospital employees can most efficiently locate donor documentation. Following a donor's death, an organ must be harvested immediately or the donor must be placed on a life support system until the organ can be surgically removed.<sup>93</sup> Requiring a search by law enforcement officials wastes valuable time, time that could be better spent harvesting the organ and transporting it for transplantation in a needy recipient. Section 292.1.B creates unnecessary procedural barriers because hospitals, not law enforcement officials, are the common denominator in the organ procurement process.

The Virginia legislature should remove unnecessary impediments to organ donor identification by amending section 292.1.B to read:<sup>94</sup>

B. Any law enforcement officer *or hospital representative(s)* may conduct an administrative search of the subject's Department of Motor Vehicles driver record to determine the person's authorization for organ donation or refusal of organ donation. *The hospital shall designate the hospital representative(s). The Department of Motor Vehicles shall register each appointed representative and shall be required to verify each representative's authority to search Department of Motor Vehicles records prior to permitting access to the records. . . .*

The proposed addition of a hospital representative as a party who may search DMV records enables a hospital to verify donor status if a law enforcement official is unavailable. Hospitals may appoint representatives based upon assessments of the hospital's transplant program and staffing.<sup>95</sup> The proposed

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93. In the case of brain death, artificial life support systems can sufficiently maintain bodily functions pending harvesting an organ. Physicians have successfully used profusion therapy to maintain organ viability in the case of cardiac death. Profusion therapy allows organs to remain viable by lowering the body temperature, thereby slowing bodily functions, and keeping blood pumping through the body. Telephone Interview with Dr. Richard L. Hurwitz, M.D., Director, Virginia Vascular Associates (Jan. 13, 1994).

94. In the proposed amended VAGA sections, italics indicate textual additions.

95. Hospitals may want to appoint a representative based upon involvement with transplant procedures or according to the hospital's pre-existing hierarchal structure. Appointments should be made keeping in mind that the purpose of designating a representative is to maintain the confidentiality of information contained in DMV records. Physicians are not authorized as representatives in the proposal because all transplant procedures are currently performed in hospitals. Therefore, physicians may always request that an available hospital representative perform the DMV records search.

amendment requires DMV registration of the hospital representative(s) to preserve the confidentiality of information available in driving records.<sup>96</sup> If adopted, this amendment to section 292.1.B would abolish the current bifurcated system and would allow hospitals to directly access donor information.

### B. *Hospital Liability*

Currently all parties who act in "good faith" under section 32.1-295.D, are immune from civil and criminal liability.<sup>97</sup> The purpose of section 295.D is to encourage authorized parties, including medical personnel, to harvest organs without fear of legal reprisal.<sup>98</sup> The liability limitation in section 295.D, however, is contrary to the purpose of organ procurement laws because it does not promote organ procurement efforts in all situations.<sup>99</sup> For example, absent the threat of potential liability, hospital and emergency personnel may fail to conduct a thorough search for an individual's donor documents.<sup>100</sup> To promote proactive efforts to procure organs, the immunity in section 295.D must be limited to those people who actually harvest organs.

One commentator has suggested creating civil liability for health care providers for failing to procure organs by imposing liability on those providers who seek additional familial consent before harvesting organs.<sup>101</sup> This proposal assumes that the physician already possesses information indicating a donor's wish to make an anatomical gift. This approach further assumes that the physician ignores this information and instead seeks

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96. See *infra* note 124 (discussing privacy concerns that access to DMV information may raise).

97. See *supra* notes 63-66 and accompanying text (discussing the "good faith" immunity provisions in the VAGA).

98. See *supra* note 49 and accompanying text (discussing the policy reasons for encouraging expedited organ harvesting).

99. See *supra* note 48 and accompanying text (discussing the purpose of the UAGA). See also UNIF. ANATOMICAL GIFT ACT § 5(f) (1987), 8A U.L.A. 47 (1993), *supra* notes 58-61 (discussing the administrative sanctions in the routine inquiry and required provisions of the UAGA).

100. Cf. *infra* notes 101-103 and accompanying text (discussing an alternative approach that fails to consider the importance of a thorough search for donor documents).

101. Jardine, *supra* note 1, at 1659. Jardine suggests that if a hospital or physician rejects a decedent organ donor's gifts "on the basis of failure to obtain the legally irrelevant 'consent' from next of kin," a cause of action for negligence against the hospital may accrue. *Id.* at 1669. Similarly, Jardine proposes that causes of action for tortious interference or invasion of privacy against those members of decedent's family who interfered with the transplant may accrue. *Id.* at 1686, 1689.

familial consent.<sup>102</sup> Although this proposal discourages physicians and hospitals from requiring additional familial consent before harvesting organs, it fails to stress the importance of a thorough search for donor documents.<sup>103</sup> Under this proposal, a physician or hospital could conceivably perform a cursory search for donor status and, after finding no such designation, request that the family make an anatomical gift.

To ensure a thorough search for documentation of an anatomical gift, hospital personnel must be authorized to access DMV records, and they must be civilly liable for failing to conduct a physical as well as a DMV record search to determine donor status. To provide incentives for determining donor designation, section 295.D should be amended to include:<sup>104</sup>

*D. A person who acts in good faith in accord with the terms of this article, or under the anatomical gift laws of another state or a foreign country is not liable for damages in any civil action or subject to prosecution in any criminal proceeding for his act. This section shall not affect the sanctions contained in section 292.1.C.*

Section 292.1.C should then be added, and include:

*C. A hospital that fails to discharge the duties imposed by Section 292.1(1) and (2) is not subject to criminal liability but may be subject to civil liability and appropriate administrative sanctions, including, but not limited to, fines and/or revocation of license.*

Section 292.1.D should also be added, and include:

*D. Pursuant to guidelines established by the Virginia State Department of Health and Virginia Transplant Council, hospitals shall be required to prepare written quarterly reports. These written quarterly reports shall include the following:*

*1) A numeric identifier for all persons who have died in the hospital during the relevant quarter.*

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102. *Id.* at 1658-59.

103. See *infra* notes 133-34 and accompanying text (discussing potential causes of action under the proposed amendments to remedy these shortcomings). See also *supra* note 27 and accompanying text (discussing obtaining familial consent).

104. Creating liability for nonfeasance is not a new concept under the UAGA. See *supra* notes 64-66 and accompanying text (explaining the administrative sanctions contained in section 5(f) of the UAGA).

- 2) *A designation of each person in Section 292.1.C(a) medically eligible to make an anatomical gift at the time of death.*
- 3) *A designation of whether donor information was obtained for each of the persons eligible to make an anatomical gift through:*
  - a) *verbal or written consent by the decedent;*
  - b) *a physical search of the decedent;*
  - c) *a Department of Motor Vehicle records search of the decedent;*
  - d) *consent of the next of kin pursuant to Section 32.1-290.1.*
- 4) *In the case of organs harvested pursuant to familial consent, whether an attempt to obtain donor information specified in Section 292.1.D(3)(a)-(c) was conducted by the appropriate personnel.*
- 5) *A designation of which organs were harvested from persons consenting to organ donation pursuant to the methods described in Section 292.1.D(3).*

The additions to sections 292.1.C and 292.1.D would require hospitals to alter organ donor procedures. The proposed addition of liability for a hospital's failure to verify donor status in section 292.1.C would make hospitals accountable to both potential donors and to donees on waiting lists. The proposed amendment imposes a reporting requirement to determine whether hospitals have properly verified a patient's donor status. The reporting requirement in section 292.1.D will ensure that hospitals conduct routine searches for donor information. To avoid liability under section 292.1.D(4), hospitals will be required to perform an exhaustive search for an individual's document of gift, thereby making familial consent a less preferable method of making a donative gift.<sup>105</sup>

#### IV. ANALYSIS OF PROPOSED AMENDMENTS

The proposed amendments to the VAGA would encourage hospitals to determine individual donor status prior to requesting donor gifts from families. The proposal eliminates barriers to obtaining donor information by granting hospitals access to DMV records.<sup>106</sup> Furthermore, the proposal provides an incentive for hospitals to obtain donor information by imposing an affir-

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105. See *supra* note 27 and accompanying text (discussing the problems associated with obtaining familial consent for organ donation).

106. See *supra* part III.A (discussing proposed amendments to the Virginia Code granting hospitals access to DMV records).

mative duty to search for donor status.<sup>107</sup> These additions to the VAGA would enhance organ procurement efforts by expanding hospitals' responsibility.<sup>108</sup>

Requiring hospitals to perform both a physical search and DMV records search creates a uniform standard which all hospitals must observe. The proposal imposes mandatory guidelines that require hospitals to search for donor status in a prescribed manner.<sup>109</sup> Such standards ensure a minimum duty to all individuals who are unable, at the time of hospital admission, to indicate or express their desire to make an anatomical gift.<sup>110</sup> Moreover, this requirement comports with UAGA guidelines that require hospital personnel to establish individual intent prior to requesting that a family make an anatomical gift.<sup>111</sup>

### A. Reporting Requirement

The proposed reporting requirement would enable interested parties to monitor hospitals' compliance with the proposed search guidelines and to track how donative gifts are made. For each person who dies either upon arrival at, or while in, the hospital the proposal requires the hospital to document whether the patient was an eligible donor and whether the hospital performed the prescribed search for individual donative status prior to consulting the family.<sup>112</sup> Requiring hospitals to report such information would allow interested parties to determine

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107. See *supra* part III.B (discussing the proposal for civil liability and administrative sanctions for a hospital's failure to determine individual donative status).

108. See *supra* notes 90-96 and accompanying text (explaining why hospitals, in addition to law enforcement officials, should have access to donor information).

109. See *supra* part III.A (discussing the proposed search protocols).

110. The proposal requires a search of DMV records because in many circumstances, individuals are unconscious at the time of admission to a hospital and are unable to indicate whether they have made a donative gift. The UAGA's routine inquiry and required request provisions address this problem. See *supra* note 58 and accompanying text (discussing the purpose of routine inquiry and required request). See also *supra* notes 56-57 and accompanying text (discussing the physical search provisions in the VAGA).

111. See *supra* notes 50-51 and accompanying text (discussing the UAGA provision requiring hospitals or physicians to attempt to determine the individual's donative intent prior to consulting with the family). But see *supra* notes 108-09 and accompanying text (questioning the effectiveness of UAGA provisions authorizing organ donation solely on the basis of an individually executed gift).

112. See *supra* notes 94-105 (discussing the DMV records search provisions and reporting requirements in the proposed amendments).

the success of the DMV's new donor designation procedures.<sup>113</sup> In addition, the reporting requirement creates liability for hospitals that fail to determine donor status and would give hospitals an incentive to perform prescribed searches in all necessary situations.<sup>114</sup>

Under the proposal, hospitals that report a failure to ascertain donative status are subject to penalties enforced by the Virginia Department of Health or by an interested citizen.<sup>115</sup> The Virginia Department of Health, the direct recipient of donor information reports, for example, could require hospitals to search for donor status as a condition of hospital licensure.<sup>116</sup> Moreover, the Virginia Department of Health or any citizen could bring a civil suit to penalize hospitals for failing to search for donor status.<sup>117</sup>

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113. One of the goals of the 1993 amendments to the VAGA was to encourage more individuals to make donative gifts by using the uniform donor document on the back of their drivers license. *See supra* notes 74-76 and accompanying text. Because the DMV, in cooperation with the Virginia Transplant Council, is responsible for promulgating a new uniform donor document, the document's success or failure in encouraging individuals to make donative gift should be monitored. *See supra* notes 72-75 and accompanying text (discussing the creation of a new uniform donor document).

114. *See supra* part III.B (discussing the proposed amendments creating civil liability and administrative sanctions for hospitals that fail to search for donative status).

115. The proposal gives the Virginia Department of Health specific authority to enforce the search provisions. *See supra* part III.B (granting enforcement authority to the Virginia Department of Health). *See infra* notes 117-18 and accompanying text (explaining how a citizen could sue a hospital for non-compliance with the search provisions).

116. The Virginia code section about hospital licensure provides: "State agencies shall make or cause to be made only such inspections of hospitals as are necessary to carry out the various obligations imposed on each agency by applicable state and federal laws and regulations. . . ." VA. CODE ANN. § 32.1-125.1 (Michie 1992). Because the statute provides for hospital licensure by the Department of Health, the Department of Health could require hospitals to comply with the proposed reporting requirement as an "applicable state law" and as a requisite for licensure. *Id.*

The Virginia code requires licensure to establish or operate hospitals or nursing homes. VA. CODE ANN. § 32.1-125 (Michie 1992). For a detailed discussion of hospital licensure requirements, *see generally* ROBERT D. MILLER, PROBLEMS IN HOSPITAL LAW 295-96 (5th ed. 1988); Terri Finkbine Arnold, *Let Technology Counteract Technology: Protecting the Medical Record in the Computer Age*, 15 HASTINGS COMM. & ENT. L.J. 455 (1993).

117. The proposal provides only for civil suits as a judicial remedy. Criminal actions would be outside the scope of the UAGA and VAGA. Currently, the UAGA has one provision authorizing administrative sanctions, and the VAGA does not impose any penalties. *See supra* notes 60-66, 81-84 and accompanying text (discussing the administrative sanctions and liability limitations in the UAGA and the liability limitations in the VAGA, respectively). This proposal attempts to encourage organ donation by facilitating access to information without discouraging physicians and hospitals from maintaining organ trans-



The potential for a citizen to bring a private attorney general action would give hospitals additional encouragement to comply with the proposal's search provisions and would facilitate the Virginia Department of Health's enforcement of the reporting requirement.<sup>118</sup>

### B. *Administering the Proposals*

Although the proposal's search provision and reporting requirements would require hospitals to implement new procedures, the overriding societal benefit of increased organ donation outweighs this added potential burden.<sup>119</sup> Over 3,000 of the

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plant programs due to liability concerns. Criminal actions — an extreme measure — might be more detrimental to organ procurement efforts than beneficial.

A private attorney general "is someone who sues 'to vindicate the public interest' by representing collectively those who individually could not afford the costs of litigation; . . ." John C. Coffee, Jr., *Rescuing the Private Attorney General: Why the Model of Lawyer as Bounty Hunter is Not Working*, 42 MD. L. REV. 215, 216 (1983). For a more detailed discussion about private attorney generals, see generally Bryant Garth, et al., *The Institution of the Private Attorney General: Perspectives from an Empirical Study of Class Action Litigation*, 61 S. CAL. L. REV. 353 (1988); Carl Cheng, Comment, *Important Rights and the Private Attorney General Doctrine*, 73 CAL. L. REV. 1929 (1985); David Shub, Note, *Private Attorneys General, Prevailing Parties, and Public Benefit: Attorney's Fees Awards for Civil Rights Plaintiffs*, 42 DUKE L.J. 706 (1992).

Private citizens who wished to bring citizens' suits would also be required to meet standing requirements which include: 1) the citizens must prove "injury in fact"; 2) there must be a causal connection between the injury and the conduct complained of; and 3) it must be "likely" as opposed to merely "speculative" that injury will be redressable by a favorable decision. *Lujan v. Defenders of Wildlife*, 112 S. Ct. 2130, 2136 (1992). See generally William A. Fletcher, *The Structure of Standing*, 98 YALE L.J. 221 (1988); John Treangen, Note, *Standing: Closing the Doors of Judicial Review Lujan v. National Wildlife Federation*, 36 S.D. L. REV. 136 (1991); David R. Dow, Essay, *Standing and Rights*, 36 EMORY L.J. 1195 (1987).

118. Those people on waiting lists for organs would have the greatest incentive to monitor hospital compliance with the proposed statutory search requirements. The proposed requirement that hospitals submit quarterly reports would facilitate such monitoring. Under the Freedom of Information Act, individuals would have access to hospital reports. Virginia's Freedom of Information Act allows any interested party to access "records in the custody of public officials." VA. CODE ANN. § 2.1-340.1 (Michie Supp. 1994). Under this act, "[a]ny exception and exemption from applicability shall be narrowly construed in order that no thing which should be public may be hidden from any person." *Id.* Because any individual may access reported information, he or she could determine whether a hospital had followed the statutory requirements.

119. Most individuals support organ procurement. See *supra* note 16 and accompanying text (discussing Gallup poll findings regarding organ donation).

4,942 hospitals in the United States are not-for-profit<sup>120</sup> and exist to improve the health status of their communities.<sup>121</sup> This community service mission accords with the purpose of organ procurement programs.<sup>122</sup>

Minimal changes in hospital procedures would be necessary for hospitals to comply with the proposal's reporting requirements. Hospitals already have comprehensive record-keeping abilities that could be easily modified to accommodate the proposal's reporting requirements. In addition to creating medical records for each patient, hospitals must typically prepare reports for quality review boards. Because the UAGA requires hospitals to inquire about donative status, reporting the requisite information about each patient and generating quarterly reports would entail procedural rather than substantive alterations in organ procurement policies.<sup>123</sup>

### C. Confidentiality

Maintaining a patient's confidentiality may be the most formidable concern caused by allowing hospital access to DMV records.<sup>124</sup> The proposal allows persons other than law enforcement officials to access DMV records.<sup>125</sup> In addition to donor information, DMV records contain personal information and

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120. There are 3,042 nongovernment not-for-profit hospitals in the United States. 590 hospitals are investor owned (for profit), and 1,310 hospitals are run by the state or local government. AMERICAN HOSPITAL ASSOCIATION, HOSPITAL STATISTICS Table 12A, at 206 (1993).

121. Interview with Dr. Wayne Lerner, Chief Executive Officer, Jewish Hospital, in St. Louis, Mo. (Jan. 12, 1994).

122. See *supra* note 43 and accompanying text (discussing the NCCUSL's purpose in drafting the UAGA).

123. Under the UAGA, for example, hospitals are already required to perform physical searches and consult with family members about organ donation. See *supra* notes 55-57 and accompanying text (discussing the search requirements). Under the proposed reporting requirement, hospitals assume only the added responsibility of recording these results. See *supra* part III.B. Moreover, in order to receive medicare funding, the Social Security Act requires hospitals to have organ procurement protocols. See *supra* notes 38-39 and accompanying text (discussing the requirements under the Social Security Act).

124. According to a Uniform Law Commissioner for Virginia, hospitals may not access DMV records because there is a countervailing interest in maintaining patient confidentiality. The commissioner noted that one reason that the Virginia legislature excluded hospital personnel from the list of persons authorized under VAGA to conduct a DMV records search is that there is the potential for abuse. Telephone Interview with Uniform Law Commissioner, Virginia Office of Legislative Services (Jan. 31, 1994).

125. See *supra* part III.A (discussing hospital access to DMV records under the proposed amendment).

list driving infractions.<sup>126</sup> The proposed amendment, therefore, grants hospital personnel access to information that a hospital would not normally acquire about a patient.<sup>127</sup> Access by hospital personnel to a donor's driving record, however, poses a minimum threat of abuse because the proposal limits the number of persons who may access DMV records.<sup>128</sup> Moreover, a search for donor information occurs only if the patient is near death and a physical search fails to produce evidence of donor status.<sup>129</sup> These limitations would ensure that hospital access to DMV records occurs only under controlled, narrow circumstances.<sup>130</sup>

Because hospitals must preserve patient confidentiality,<sup>131</sup> any private information obtained through a DMV records search should not be used for nonmedical purposes.<sup>132</sup> Patient confidentiality protects any information that is not a matter of public record.<sup>133</sup> Thus, a patient could sue for invasion of privacy and

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126. *Doe v. Registrar of Motor Vehicles*, CIV.A. No. 85-3449, 1993 WL 496590, \*1 (Mass. Super. June 8, 1993) (noting that DMV records contain information about motor vehicle infractions in addition to personal information).

127. Upon admission, hospitals require information about health insurance, medical background, cases, and personal data. BARRY R. FURROW ET AL., *HEALTH LAW: CASES, MATERIALS, AND PROBLEMS* 308 (1991).

128. See *supra* part III.A (discussing persons are who authorized to access DMV records under the proposed amendments).

129. See *supra* part III.A (describing search procedures under the proposals).

130. Because the proposal limits the circumstances when a search for donor information may be conducted, hospital representatives could not arbitrarily search DMV records for information about any person. Furthermore, the proposal requires the DMV to utilize security measures to ensure that only hospital representatives access information to determine donative status in emergency situations. See proposed amendment to section 292.1.B, *supra* part III.A.

131. The Virginia code protects the confidentiality of patient records. See VA. CODE ANN. § 32.1-116:2 (Michie 1992) (requiring state Health Commissioner and all other persons to whom data is submitted to maintain the confidentiality of patient information); VA. CODE ANN. § 38.2-5307 (Michie 1992) (requiring private review agents maintain the confidentiality of medical records).

132. Courts have categorized a person's age and height as private information with respect to a DMV record because they "can be readily associated with a particular individual." *Doe v. Registrar of Motor Vehicles*, No. CIV.A. 85-3449, 1993 WL 496590, at \*5 (Mass. Super. June 8, 1993). The court also categorized other items of information, including organ donor information, license, number, name, address, gender, class of license, restrictions on license and the date of expiration, as public information. *Id.* at \*3.

133. In *Geisberger v. Willuhn*, 390 N.E.2d 945, 946 (Ill. App. Ct. 1979), for example, a patient sued his physician for breach of confidential relationship, breach of contract, and invasion of privacy after the physician disclosed the patient's name to law enforcement officers. The court held that disclosing a patient's name did not violate patient confidentiality because names are

breach of a confidential relationship if a health professional discloses private patient information.<sup>134</sup> Patient confidentiality would, therefore, prevent a hospital representative who accessed DMV records from disclosing any private information.<sup>135</sup>

### CONCLUSION

The proposed amendments to the VAGA would ensure that more individual donative gifts are honored. The current express donation system provides inadequate safeguards for hospitals to determine individual donative intent. Not only must hospitals have access to donor information in the most efficient manner, but hospitals must also verify donative intent. Imposing an affirmative duty on hospitals to determine individual donor status, or face potential liability, would achieve these objectives. Moreover, the benefit from increasing the number of donated organs outweighs the minimal loss of patient confidentiality and added responsibility of the reporting requirement. States that adopt the VAGA provisions as amended by these proposals would take an affirmative step toward alleviating the shortage of organs for transplantation.

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public information. *Id.* at 948. The court categorized private information as that information relating to a person's private life that, if made public, would "be offensive and objectionable to a reasonable man of ordinary sensibilities." *Id.*

Critics note, however, that many parties may access donor information. These critics contend that patients do not have a great privacy interest in patient records. *See generally* Terri Finkbine Arnold, *Let Technology Counteract Technology: Protecting the Medical Record in the Computer Age*, 15 HASTINGS COMM. & ENT. L.J. 455 (1993).

134. *See, e.g., Geisberger*, 390 N.E.2d 945, 945 (discussing plaintiff's claims of breach of confidential relationship, breach of contract and invasion of privacy); *Humphers v. First Interstate Bank of Oregon*, 696 P.2d 527 (Or. 1985) (*en banc*) (discussing plaintiff's claims of breach of privacy and invasion of confidence).

135. Although a professional may not disclose confidential patient information, this does not guarantee that confidentiality will extend to other parties who have access to patient information. A variety of parties routinely access patient's medical information. For many of these parties, consent to access medical records is presumed. FURROW ET AL., *supra* note 127, at 309. *See also* Bernard R. Adams, *Medical Research and Personal Privacy*, 30 VILL. L. REV. 1077 (1985) (examining the right to privacy for information contained in medical records).

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