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INTRODUCTION

For five years, Robert Colavito suffered from end-stage renal disease for which he was placed on a kidney transplant waiting list.¹ On August 21, 2002, Colavito’s longtime friend, Peter Lucia, died of intracranial bleeding. Lucia’s widow decided to donate both of his kidneys to Colavito. Lucia’s left kidney was air-lifted to a Miami hospital. But contrary to his widow’s wishes, the right kidney remained in New York, in the custody of the New York Organ Donor Network (NYODN).² On August 23, 2002, Colavito was fully prepared for surgery³ when Dr. George Burke, his surgeon, discovered that the donated left kidney was irreparably damaged, and therefore useless for transplantation. When a member of Burke’s staff called the NYODN to request the second kidney for Colavito’s use, he was told that it already had been transplanted into another patient.⁴ Subsequent tests indicated that both of Lucia’s kidneys were incompatible with Colavito’s antibodies, so neither could have been transplanted successfully.⁵

Colavito filed suit in federal court against the NYODN and individual doctors involved in the kidney disposition. He claimed the defendants were liable for fraud, conversion, and violation of New York Public Health Law. The district court granted the defendants’ motion for summary judgment, dismissing Colavito’s fraud claim on the merits, and finding that he could not sustain a common law action for conversion or a claim based on New York Public Health Law.⁶ Colavito appealed, and the Second Circuit affirmed with respect

¹ Yale Law School, J.D. expected 2009; Harvard University, A.B. 2006. The author wishes to thank Professor Robert Ellickson, Professor Henry Hansmann, and Professor Peter Schuck for advice on sources, as well as Benjamin Shultz and Wally Adeyemo for insightful comments and editing.
² Collavito v. N.Y. Organ Donor Network, Inc., 438 F.3d 214, 216 (2d Cir. 2006).
⁴ Collavito, 438 F.3d at 218.
⁵ Id. at 219.
⁶ Collavito, 356 F. Supp. 2d at 246.
to Colavito’s fraud claim. However, the court reserved judgment on the conversion and Public Health Law claims, determining that both raised novel and important questions of New York law. As a result, the Second Circuit certified several questions to the New York Court of Appeals, including:

1. Do the applicable provisions of the New York Public Health Law vest the intended recipient of a directed organ donation with rights that can be vindicated in a private party’s lawsuit sounding in the common law tort of conversion or through a private right of action inferred from the New York Public Health Law?

2. Does New York Public Health Law immunize either negligent or grossly negligent misconduct?

The New York Court of Appeals responded, concluding that “a specified donee of an incompatible kidney... has no common law right to the organ” because, under New York law, “there is no common law property right in a dead body.” The court also determined that Colavito could not recover under New York Public Health Law because section 4302(4) only authorizes donors to make a gift to “any specified donee, for therapy or transplantation needed by him.” While “he was in need of a functioning kidney, both of Peter’s kidneys were of no use to [Colavito].” The court thus found that Colavito had no cause of action because Lucia’s kidney was medically incompatible. But the Court of Appeals left open the possibility that, when a donated organ is medically compatible, New York Public Health Law might define a cause of action for the intended organ recipient (donee) for its improper disposition.

This Comment argues that there are sound policy justifications for allowing an intended organ donee to have a cause of action if several caveats are accounted for. Part I briefly outlines the scientific and legal background regarding human organ transplants. Part II explains that a donee’s cause of action could be superior to a donor’s cause of action under narrowly defined circumstances, because the donee’s greater material stake in the organ’s proper disposition makes her more likely to effectively enforce that outcome. The conclusion proposes several liability exceptions, and discussing why a donee’s cause of action is of growing importance, based on current trends in organ transplantation.

7. Colavito, 438 F.3d at 216.
8. Id. at 216-17. The Second Circuit certified a third question as well: “If a donee can bring a private action to enforce the rights referred to in question I, may the plaintiff recover nominal or punitive damages without demonstrating pecuniary loss or other actual injury?” Id. at 217.
10. Id. at *14-15.
11. Id. at *24 (emphasis added).
12. Id. at *25.
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I. BACKGROUND

Donated organs include vital organs (e.g., the heart, the stomach) and nonvital organs that can be removed from the donor without causing death by their absence (e.g., one kidney, a section of the liver). Human organ donation can be accomplished through cadaveric donors of either vital or nonvital organs, or living donors, who are only permitted to donate nonvital organs. Organs are donated to anonymous recipients through the national waiting list or to recipients specified by the donor or her next-of-kin in a process known as "directed donation."

Approximately 96,000 people are on the national waiting list for organ transplantation. Thousands more await tissue transplantation. The demand for transplants far outpaces the supply. Between January and November of 2006, only 28,923 transplants were performed. Each day, an average of seventeen people in the United States die waiting for transplants. Those who survive require expensive treatment.

Under most states’ common law, “next of kin have a ‘quasi-property’ right in the decedent’s body for purposes of burial or other lawful disposition.” But the narrow definition of this quasi-property right has led courts and commentators to suggest that it is actually “a legal fiction created to enable relatives to recover for the tort of mental distress.” Several cases interpret this

14. Id.
19. OPTN, Waiting List Candidates, supra note 17.
20. NYODN, Overview, supra note 18.
21. Leonard H. Bucklin, Woe Unto Those Who Request Consent: Ethical and Legal Considerations in Rejecting a Deceased’s Anatomical Gift Because There is No Consent by the Survivors, 78 N.D. L. REV. 323, 343 (2002) (estimating that replacing dialysis with kidney transplants in one thousand cases would produce taxpayer savings of $500 million over a twenty-year period).
23. See, e.g., Fuller v. Marx, 724 F.2d 717, 719 (8th Cir. 1984) (declining to extend the “quasi-property” interest to “all of the body’s organs”); Snyder v. Holy Cross Hosp., 352 A.2d 334, 341 (Md. Ct. Spec. App. 1976) (finding a property right existed ordinarily only for purposes of burial); Pierce v. Swan Point Cemetery, 10 R.I. 227, 242 (1872) (noting that “certain persons may have rights” (emphasis added)).
right to allow next-of-kin to sue for improper harvesting of a decedent’s organs; some cases even find the right to be of constitutional dimension.25 But these cases all address the right to prevent medical personnel from harvesting organs from dead relatives, not to require such personnel to harvest and allocate them according to the donor’s wishes. Courts have also significantly constrained common law property rights of a person to her own body parts. For example, several courts have decided that common law does not support a tort claim of conversion for the research use of a patient’s tissue without her permission.26

The Uniform Anatomical Gift Act (UAGA) of 1968 and its 1987 revision, which regulate cadaveric donation and have been adopted in some form in all fifty states and the District of Columbia,27 permit a donor’s (or her next-of-kin’s) cause of action when her organs are harvested beyond the scope of consent.28 However, the UAGA’s “good faith” immunity provision often protects medical personnel.29 The UAGA may provide grounds for a donor to sue when physicians cause the donated organ to be used for a purpose other than her specified purpose of transplantation, although, again, physicians may be excused from liability for good faith.30

The donee’s right to sue seems mostly confined to medical malpractice cases in which she experiences harmful treatment at the hands of the transplanting surgeon.31 But a few cases and statutes suggest another donee’s cause of action: for improper disposition of the organ. For example, the UAGA states, “The rights of the donee created by the gift are paramount to the rights of others . . . .”32 Additionally, an Indiana court reserved judgment on the issue of whether an intended donee had a protectable liberty interest in receiving a promised organ.33 And Ohio explicitly defines a donee’s property right in the

25. See Newman v. Sathyavagiswaran, 287 F.3d 786, 796 (9th Cir. 2002); Brotherton, 923 F.2d at 482. But see Georgia Lions Eye Bank, Inc. v. Lavant, 335 S.E.2d 127, 128 (Ga. 1985).
32. UNIF. ANATOMICAL GIFT ACT (UAGA) § 2(e) (1968) (amended 1987).
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anatomical gift, although the only remedy provided is a declaratory judgment. Indeed, the importance of Colavito is that “[no] court has [yet] held that an intended recipient has any right in a donated organ or tissue prior to the completion of the gift,” that is, prior to “actual transplantation into the recipient.”

II. POLICY REASONING SUPPORTING A DONEE’S CAUSE OF ACTION

Colavito illustrates how medical personnel may disregard or even flout a donor’s wishes by transplanting an organ into someone other than the intended donee. Physicians have even transplanted organs into the wrong individuals in other, more appalling instances. Individual states may react to these cases by more closely monitoring or regulating the organ transplantation process or by providing a private cause of action for improper organ disposition. States should consider a donee’s cause of action because it would be more effective than a donor’s cause of action in enforcing proper organ disposition.

A. Competing Interests

In creating a private cause of action, a state is likely to balance the same sort of competing interests underlying the UAGA. Those include “the wishes of the deceased during [her] lifetime concerning the disposition of [her] body... the desires of the surviving spouse or next of kin” and “the need of society for bodies, tissues and organs for medical education, research, therapy and transplantation.” To apply to living as well as cadaveric donors, these interests seem best summarized as “donor’s wishes,” “donor’s agent’s wishes, if donor’s wishes cannot be ascertained,” and “societal and donee’s personal
interest in effective organ use.” In light of those competing interests, providing a narrowly defined donee’s cause of action seems superior to providing a donor’s cause of action.

B. The Donee’s Greater Material Stake in the Organ Makes Her a Superior Enforcer of the Donor’s Wishes

When a donor or her agents specify a transplantation recipient, a donee’s cause of action against medical personnel for improper organ disposition is likely to be a more effective way of enforcing the donor’s or her agents’ wishes while protecting the donee’s reliance interests in the organ. Unlike the donor, the donee has great material stake in the organ’s proper disposition. While the donor may only suffer intangible emotional or dignitary harms by having her wishes ignored, the donee suffers pecuniary harms including medical expenses for prolonged treatment, lost wages due to that prolonged treatment, and lower future wage potential due to ongoing illness. If the donee learns of the organ’s improper disposition after she has been prepared for or perhaps even begun undergoing surgery, such as in *Colavito*, she may also suffer reliance-like damages due to undergoing risky, painful, and expensive procedures without the compensating benefit of the ultimate organ transplantation.

The donee’s greater material stake makes her a better enforcer of the donor’s wishes for three reasons: First, the donee is more likely to sue because she can expect greater monetary recovery. When a statute clearly provides a donee’s cause of action to recover her pecuniary damages due to the lost chance of a fully functioning organ, she may recover more and with greater likelihood than a donor suing for mere emotional distress. Second, the donee
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is more likely to sue because her recovery will more appropriately vindicate her claim. Because the donee’s damages are pecuniary in nature, financial remuneration is an appropriate substitute. In contrast, because the donor’s harms are intangible, she may not see financial compensation as worthwhile enough to merit bringing suit. Third, a donee’s cause of action creates a more credible threat to pressure medical personnel into proper disposition when it is still possible, because the performance the donee seeks would provide her with material, financial benefits that are more fungible with the costs of a lawsuit. Proper organ disposition would not provide any material benefit to the donor that could offset the material costs of initiating a lawsuit, so medical personnel are less likely to be pressured by a donor’s threat of lawsuit than if the same threat were made by a donee.

For cadaveric donors who cannot enforce their own wishes, providing the donee with a cause of action may serve an especially important function: ensuring the transplantation takes place. Five percent of Americans claim they would be unlikely to donate a deceased family member’s organs even if that family member had explicitly expressed the wish to donate. This statistic suggests that a substantial number of people would not sue to enforce their family member’s donation preference if it contradicted their own preferences. This seems particularly true in light of the fact that legal enforcement poses high litigation costs. Especially when the donor’s family members do not approve of the donor’s wishes, “hospitals and doctors . . . often fail to honor a deceased’s directions to donate.” In these cases, a donee’s cause of action could prove necessary for effectively enforcing the donor’s wishes.

In other words, these arguments suggest that absent a donee’s cause of action, medical personnel may be insufficiently deterred from substituting their own judgment and preferences for those of the donor. As a result, the argument for an organ donee’s cause of action is analogous to an argument supporting an estate’s ability to bring a survival claim; in both cases if the substitute party is not granted a cause of action to bring suit, the defendant will be insufficiently deterred from negligent or reckless behavior.

46. One might argue that even with a donee’s cause of action, medical personnel will be insufficiently deterred because malpractice insurance covers the cost of their liability. But “[i]ndividual physicians may now face higher premiums or even coverage rejection” if they commit malpractice. ROBERT A. BERENSON ET AL., CTR. FOR STUDYING HEALTH SYSTEM CHANGE, MEDICAL MALPRACTICE LIABILITY CRISIS MEETS MARKETS: STRESS IN UNEXPECTED PLACES (2003), available at http://www.hschange.com/CONTENT/605. Moreover, medical groups and hospitals pay higher premiums if their members or employees commit malpractice. Id. Finally, hospitals that self-insure even more directly suffer from their employees’ claims experience. Id.
47. See Smith v. Whitaker, 734 A.2d 243, 252 (N.J. 1999) (arguing that punitive damages should
The reasoning behind providing a donee’s cause of action is also analogous to the reasoning underlying third-party beneficiary theory in contract. According to that theory, which is "generally recognized in modern law," the promisee, and the promisor, may contract for the promisor to provide a benefit to the intended beneficiary. If the promisor does not provide the benefit, the promisee may enforce the promisor's duty by lawsuit. The principles underlying this theory are that "parties to a contract have the power, if they so intend, to create a right in a third person, and for "grounds of simplicity and convenience of remedy the beneficiary is allowed a direct action against the promisor." In the case of organ donation, a physician (the promisor) enters an agreement with a donor (the promisee) to benefit the donee (the intended beneficiary) by transferring the organ to her. If the physician breaks her promise, the donee should have a direct cause of action against her based on the same principles that support a direct cause of action for a third-party beneficiary contract.

C. A Donee’s Cause of Action Might Encourage Organ Supply

Providing a donee’s cause of action could also increase the organ supply. Donors are more comfortable donating organs to familiars (family members or close friends) than to strangers. Because donors would prefer to specify their recipients, they would likely be even more inclined to donate if they could be sure their desires would be respected. The Second Circuit acknowledged as
much in *Colavito*, noting that without statutory rights preserving personal preference and legal remedies to enforce them, families might refuse to donate organs in the first place—as in *Colavito*, Debra Lucia testified that “if she [knew she] could not have directed the second kidney to Colavito, she would have buried it in the ground along with the rest of Mr. Lucia’s body.”

D. Need To Narrowly Define the Donee’s Cause of Action

The policy reasoning discussed in Sections II.B-C justifies only a narrowly defined donee’s cause of action. There are four ways in which the cause of action may need to be constrained: first, the cause of action should exist only against medical personnel assisting in the transplantation process, not against the donor or her agents should they reconsider the choice to donate. Particularly while the organ remains in the donor’s body, threat of suit could exert inappropriate coercive pressure on the donor to go through the risky and invasive transplantation process. Second, the cause of action should be confined to cases in which the organ was intended for transplantation, not research. The arguments in Section II.B regarding the donee’s greater material stake apply with less force to donees receiving the organ for research purposes because an organ’s material value for research is less certain than for transplantation. Third, the cause of action might be better confined to directed donations and not extended to donations through the national organ waiting list. Waiting list donations do not as strongly implicate specific donor wishes. The procedure for determining the list’s order is extremely complex, and a donee is unlikely to be aware if the organ she should have received went to someone lower on the list. As a result, regulation seems a better form of oversight for waiting list donations. Finally, the cause of action should be confined to a statutory definition, rather than implied from common law property or contract rights. Imposing a cause of action from common law rights could upset those who are hesitant to commodify or commercialize body parts. A statutory...
cause of action might be more popular, being less likely to create unsavory precedent for conceptualizing organs as commodities.

CONCLUSION

A. Liability Exceptions

Colavito illustrates the need for states to define liability exceptions to a donee’s cause of action. The first exception should afford “good faith” immunity to medical personnel. Excessive liability could, if unchecked, deter medical personnel from participating in organ transplantations. Colavito, 438 F.3d at 228 (“Encouraging private lawsuits . . . may over-deter doctors and hospitals that need to act quickly to preserve life-saving organs.”); Perry v. St. Francis Hosp. & Med. Ctr., Inc., 886 F.Supp. 1551, 1557 n.3 (D. Kan. 1995) (“Absent a provision which protects them from liability for anything other than ‘bad faith,’ hospital personnel would likely avoid involvement in the donation process in almost all cases.”). For the donor’s cause of action, the UAGA incorporated a good faith immunity provision “to help increase the organ supply by encouraging medical professionals to participate in the organ procurement process.” Colavito v. N.Y. Organ Donor Network, Inc., No. 106, 2006 N.Y. LEXIS 3655, at *20 (N.Y. Dec. 14, 2006).

Additionally, Colavito raises the important issue of medical compatibility of donated organs. For successful organ transplantation, the organ must be compatible with the recipient on several dimensions, but donated organs are frequently incompatible. The donee’s body will reject an incompatible organ, such that it cannot benefit her, and could even cause harm. When the organ would not benefit the donee, permitting doctors to allocate it to a different individual would ensure that it is put to good use.

commodity is morally repugnant to the sanctity of personhood.”); Nancy E. Field, Note, Evolving Conceptualizations of Property: A Proposal To De-Commercialize the Value of Fetal Tissue, 99 YALE L.J. 169, 171 (1989) (“The policy rationale behind [prohibiting organ sales is] . . . that impoverished individuals might be induced to sell their organs for profit.”).

57. See Colavito, 438 F.3d at 228 (“Encouraging private lawsuits . . . may over-deter doctors and hospitals that need to act quickly to preserve life-saving organs.”); Perry v. St. Francis Hosp. & Med. Ctr., Inc., 886 F.Supp. 1551, 1557 n.3 (D. Kan. 1995) (“Absent a provision which protects them from liability for anything other than ‘bad faith,’ hospital personnel would likely avoid involvement in the donation process in almost all cases.”).


59. Brief of Am. Ass’n of Tissue Banks et al., supra note 35, at 20 n.2 (listing blood type, histocompatibility, and organ size as a few of the necessary dimensions of compatibility). Organs must also be generally viable. See id.

60. See Michael T. Morley, Note, Proxy Consent to Organ Donation by Incompetents, 111 YALE L.J. 1215, 1216 (2002); Brief of Am. Ass’n of Tissue Banks et al., supra note 35, at 13 (“In fact, from 2000 to 2005 in the designated service area for the New York Organ Donor Network, there were a total of 147 directed donation requests that resulted in only 28 transplants into intended recipients due to clinical compatibility factors.”).

61. Emma Young, Healing Rays, NEW SCIENTIST, May 16, 2001, available at http://www.newscientist.com/article.ns?id=dn739 (explaining that anti-rejection drugs “dampen[] the patient’s immune system and increase[] their risk of infection. In extreme cases, rejection can lead to death.”).
Finally, states should provide liability exceptions for important state interests. The UAGA and several cases suggest that a coroner should be exempt from liability to the deceased or her agents if their preferred organ disposition would interfere with an effective autopsy in cases of suspected homicide. The same reasoning justifies a coroner’s exemption from liability to a donee. Public health concerns also justify precluding the donee’s recovery of the organ or corresponding damages. A number of diseases may be transmitted from donor to donee along with the organ, physically harming the donee and risking contagion to others. The importance of preventing the spread of disease necessitates a liability exemption for physicians who decline to transplant diseased organs.

B. Growing Importance of a Donee’s Cause of Action

Organ donations for transplantation are generally increasing and that trend includes directed donations. Donors are now capable of donating organs or parts thereof that were impossible to donate before, such as liver sections from living patients. As living donation becomes even safer and public awareness increases, the number of directed donations can be expected to grow. Paired organ exchanges comprise another growing source of directed donations. The success of early paired exchanges has led scholars and physicians to

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64. Medical personnel should not be held liable for complying with federal regulations that prohibit the transplantation of diseased organs. See, e.g., 21 C.F.R. § 1270.21(b) (2007).

65. See OPTN, Living Donor Transplants by Donor Relation, supra note 53.


promote their use.\textsuperscript{71} These directed donations comprise situations meriting a donee's cause of action, as described in Part II.\textsuperscript{72}

As a result of these trends in organ transplantation, a donee's cause of action is increasingly relevant. As the number of directed donations rises, it becomes even more important to ensure that organs are allocated as donors specify, both to respect donor wishes and to sustain their willingness to donate. Given the policy reasoning in Part II, a donee's cause of action is likely to be more effective at enforcing proper organ disposition than a donor's cause of action, and so states should consider statutorily creating a cause of action for the donee. However, for reasons discussed in Part II and this Conclusion, legislatures should narrowly define the cause of action, and provide certain liability exceptions. In so doing, states can transform the troubling facts of \textit{Colavito} into a positive scheme that protects the interests of organ donors, donees, and society in proper and effective organ transplantation.


\textsuperscript{72} Some organ technology developments, such as transplantation of animal body parts or mechanical organ prostheses, could slightly offset the growing need for a donee's cause of action. However, these technologies are expensive and have lower success rates than human organ donation, so they are unlikely to comprise many organ transplantations in the near future. See, e.g., MassGeneral Hospital for Children, Organ Donation, http://www.massgeneral.org/children/adolescenthealth/articles/aa_organ_donation.aspx (last visited Mar. 26, 2007) ("[T]he xenotransplantation [of animal body parts] success rate has been dismal.").