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NOTES

THE WASHINGTON HOSPITAL CENTER EXAMPLE: A HOSPITAL'S GUIDE TO IMPLEMENTING THE RAPID ORGAN RECOVERY PROGRAM

Karen Edelman Clarke[*]

PROLOGUE

On October 9, 1994, Theresa "Terri" Lynn Kiser was sitting in the bed of a Ford Ranger truck between two friends holding a two-year-old boy in her lap when the driver lost control. Terri curled her body around the young boy just before the truck veered off the road, plowing into a tree. Terri's friends and the two-year-old boy sustained minor injuries, but Terri did not fare as well. She was flown, unconscious, to the Washington Hospital Center's MedSTAR trauma center.[1]

Upon arrival, Terri's prognosis was grim. Her parents quickly learned that she was close to death. At the Washington Hospital Center, a family advocate asked if they would consider Terri as an organ donor. Terri's parents gave the doctors permission to take whatever organs they needed from Terri. On October 10, 1994, at 11:05 a.m., Terri was pronounced dead.[2]

Doctors from Washington Hospital Center's Rapid Organ Recovery

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* B.S., Radford University, 1995; J.D., The Catholic University of America, Columbus School of Law, 1999. Special thanks to the family of Terri Lynn Kiser for trusting life does not have to end at death. Thanks to William O. Ritchie, Ph.D., Director of Decedent Affairs, Washington Hospital Center for making this Note possible. Thanks to the editorial board for their constant support and substantive suggestions throughout the evolution of this Note.

1. *See* Brian Reilly, *Giving the Gift of New Life*, WASH. TIMES, Dec. 26, 1994, at 5.

2. *See id.*

team had to work quickly. They had only thirty minutes from the time Terri's heart stopped beating to preserve her kidneys for donation.[3] If they took too long, the kidneys would not be viable and two of the nearly 800 District of Columbia residents desperately biding time on the waiting list for donated kidneys would have to keep waiting.[4]

The Rapid Organ Recovery team used a new method of organ preservation with Terri. They made an incision in her leg, inserted a catheter into her femoral artery, and flushed her abdominal cavity with chilled preservation fluid.[5] By noon, one hour after Terri's death, the doctors removed Terri's kidneys. The organs were recovered in a preserved state, chilled and "viable." Two people were taken off the organ transplant waiting list and given a second chance at life when they received Terri's kidneys.[6] Terri was the first Rapid Organ Recovery Donor at the Washington Hospital Center.[7]

INTRODUCTION

In 1996, the District of Columbia responded to residents' increasing needs for viable organs suitable for transplant, particularly kidneys,[8] by enacting the Organ Preservation Amendment[9] to the Anatomical Gift Act.[10] The Amendment specifically allows a hospital to initiate invasive organ preservation methods[11] prior to obtaining family consent. This, in effect, buys hospitals more time to speak with family members about organ donation and to obtain consent from the family for an anatomical gift.[12]

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3. *See id.*

4. *See* Council of the District of Columbia, Report (Draft) on Bill 11-317, the "District of Columbia Anatomical Gift Amendments Act of 1995," at 2 (1995).

5. *See* Reilly, *supra* note 1, at 5.

6. *See id.*

7. *See id.* at 4.

8. *See* Bruce R. Braun & Dane A. Drobny, *Life, Death, and Organ Donation*, 24 J. SEC. LIT. 3 (1998); *see also* Reilly, *supra* note 1, at 2.

9. D.C. CODE ANN. § 2-1509.1 (1998).

10. *Id.* at § 2-1501 *et seq.* (1998).

11. *See id.* at § 2-1509.1.

12. An anatomical gift can be organ, tissues, eyes, bones, arteries, blood, other fluids, and any other parts of the human body. *See id.* at § 2-

The Organ Preservation Amendment validated Washington Hospital Center's Rapid Organ Recovery Program (RORP).[13] The RORP began in 1994[14] as a private response to District of Columbia residents' transplant needs.[15] The RORP procedure is designed to prolong the time transplant teams have to gain the next of kin's consent for organ donation. This extra time is important especially for the preservation of kidneys.[16] Because kidneys become unsuitable for transplantation thirty minutes after death,[17] developing a program to increase the viability time of organs from non-heart-beating donors is extremely important.[18] The RORP process mimics heart-beating circulation to accomplish this goal.[19]

The procedure begins at the time of death, certified by the trauma (or intensive care) team.[20] The RORP team, which includes a trans-

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10509.1(a). Further, "the hospital may use organ preservation equipment and techniques, including ventilators and *in situ* flushing and cooling equipment, to maintain the viability of the decedent's organs in order to preserve the option of family members and other authorized persons to consider donation." *Id.*

13. *See* Council of the District of Columbia, *supra* note 4, at 2.

14. *See* Washington Hospital Center, Rapid Organ Recovery Program (visited Nov. 3, 1998) <http://www.whc.mhg.edu/rapid_organ_recovery_program/process.html>

15. *See* J.A. Light, et al., *A Rapid Organ Recovery Program for Non-Heart-Beating Donors*, 29 TRANSPLANTATION PROC. 3553 (1997).

16. *See id.*

17. *See* Council of the District of Columbia, *supra*, note 4 at 2; *see also* Braun & Drobny, *supra* note 8, at 4.

18. *See* A.E. Kowalski, et al., *A New Approach for Increasing the Organ Supply*, 10 CLIN. TRANSPLANTATION 653 (1996). A pivotal distinction is made between non-heart-beating donors and brain-dead donors. Prior to the development of the RORP process, organs were only recovered from brain-dead, heart-beating donors. This was largely due to the fact that the decedent's cardiovascular system continues to operate, thus keeping organs preserved, and viable, inside the decedent's body. *See id.* "If the heart stops beating, the organs rapidly become unsuitable for transplantation, unless *in situ* preservation can be initiated to slow the deterioration and/or organ recovery is rapidly carried out." *Id.* at 654.

19. *See* Light, *supra* note 15, at 3555.

20. *See id.* at 3553.

plant surgeon, makes a small incision in the right groin to insert catheters in the vascular system.[21] Two small incisions are made in the abdomen to insert catheters in the peritoneal cavity. The catheters are connected to a machine circulating preservation fluid[22] for *in situ* (inside the body)[23] organ preservation.[24] The preservation fluid is circulated through the body cavity by closed-circuit refrigeration equipment.[25] This process is extraordinary in that *in situ* preservation may be performed prior to gaining the consent of the next of kin.[26]

Thus far, only Virginia,[27] Florida,[28] and the District of Columbia[29] have amended their Anatomical Gift Acts to allow for *in situ* preservation of organs.[30] The District of Columbia's Washington Hospital Center, however, is the only facility utilizing this legislation as a part of its RORP.[31]

Prior to the Organ Preservation Amendment's enactment, the Washington Hospital Center used the RORP procedure under a protocol developed at the Consensus Conference on Trauma Victims and Organ Donation (Consensus Conference).[32] The Consensus Confer-

21. *See id.*

22. *See* Kowalski, *supra* note 18, at 654. "[E]ach pair of kidneys [is] placed on pulsatile preservation for 24 [hours] using Belzer's preservation solution augmented with TFP (7)." *Id.*

23. *See id.* "The organs to be transplanted are maintained in working order (*in situ*) by the body's own cardiovascular system until consent is obtained. . . ." *Id.*

24. *See* Rick Weiss, *Demand for Organs Fosters Aggressive Collection Methods*, WASH. POST, Nov. 24, 1997, at A16.

25. *See* Kowalski, *supra* note 18, at 653-54.

26. *See* D.C. CODE ANN. § 2-1509.1 (1998); *see also* Washington Hospital Center, *The Rapid Organ Recovery* Process, *supra* note 14.

27. *See* VA. CODE ANN. § 32.1-295 (Michie 1996).

28. *See* FLA. STAT. ch. 732.917 (1998).

29. *See* D.C. CODE ANN. § 2-1509.1 (1998).

30. *See* Braun & Drobny, *supra* note 8, at 4.

31. *See id.*; *see also* Craig S. Hunt, *Organ Transplant Consent Debate Endures*, MONTGOMERY COUNTY J., Mar. 1, 1998, at A1; Rick Weiss, *supra* note 24, at A1; Avis Thomas-Lester, *A Helping Hand at the Hardest Moment*, WASH. POST, Nov. 10, 1996, at B4.

32. *See generally* The Washington Hospital Center, Medlantic Research Institute, & Washington Regional Transplant Consortium, *Consensus Con-*

ence consisted of transplant physicians, other health care professionals, organ recipients, government officials, attorneys, members of the community, and clergy.[33] These individuals came together specifically to discuss RORP as an answer to the severe shortage of kidney donors in the District of Columbia.[34]

The Consensus Conference concluded a donor program like the RORP could be successful in the District of Columbia without a legislative amendment as long as: (1) a written protocol was developed and implemented following their proposed guidelines, (2) the community lent its active approval, and (3) the medical examiner determined whether the recently deceased person was an appropriate candidate[35] for organ preservation (and later, recovery).[36] In addition, the RORP could be successful if Washington Hospital Center adhered to the mandates of the Anatomical Gift Act[37] already enacted by the District of Columbia.[38]

The Consensus Conference's proposed protocol contains the four key elements. First, every admission to Washington Hospital Center's MedSTAR Trauma Unit must receive appropriate lifesaving support until the trauma team physicians make a determination and certification of death.[39] Second, upon such determination, notification of the death must be directed to the District of Columbia Medical Examiner, who has the sole authority to approve further action for the preservation and recovery of organs.[40] Third, if approved by the Medical Examiner, the transplant team will begin preserving the organ by *in situ*

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ference on Trauma Victims and Organ Donation, Consensus Report, Oct. 7-8, 1993 [hereinafter Consensus Report].

33. *See id.*

34. *See id.* at Executive Summary.

35. A strong factor in determining whether a given patient is an appropriate candidate for RORP is whether the RORP procedure would adversely affect the ability of the Medical Examiner to determine cause and manner of death. *See id.*

36. *See id.*

37. *See* D.C. CODE ANN. § 2-1501 *et seq.* (1998).

38. *See id.*

39. *See* Unif. Determination of Death Act § 1 (1998); *see also* Consensus Report, *supra* note 32, at 7.

40. *See* Washington Hospital Center, *The Rapid Organ Recovery Process*, *supra* note 14; *see also* Consensus Report, *supra* note 32 at 7.

flushing.[41] The actions of the transplant team are governed by the Anatomical Gift Act.[42] Specifically, the physician that certifies the death of the patient cannot participate on the transplant team in order to eliminate ethical conflicts between the physician treating to save the life of the patient, and the physician operating post-mortem.[43] Fourth, counselors from the Family Advocacy Program[44] are called upon to help the family accept the death of their loved one and to make a decision about organ donation.[45]

The protocol recommended by the Consensus Conference is essentially the same procedure followed by the Washington Hospital Center today.[46] Washington Hospital Center's protocol allows the transplant team to begin invasive techniques on the deceased for the purpose of organ preservation prior to receiving consent from the next of kin.[47] Prior to enacting the Organ Preservation Amendment, the Consensus Conference protocol, in effect, side-stepped the Anatomical Gift Act by permitting invasive organ preservation procedures prior to receiving the consent from the decedent's next of kin.[48] The RORP justified its actions and authority by reference to an overwhelming kidney donor shortage[49] and community approval.[50] Washington Hospital Center, as of today, however, will not initiate RORP preservation tech-

41. *See* Washington Hospital Center, *The Rapid Organ Recovery Process*, *supra* note 14; *see also* Consensus Report, *supra* note 32, at 7.

42. *See* Consensus Report, *supra* note 32, at 7.

43. *See id.*; *see also* D.C. CODE ANN. § 2-1507(b) (1998).

44. *See* Washington Hospital Center, *Family Advocacy Program* (1998).

45. *See id.*; *see also* Consensus Report, *supra* note 32, at 8.

46. *See* Washington Hospital Center, *The Rapid Organ Recovery Process*, *supra* note 14; *see also* Consensus Report, *supra* note 32, at 7-8.

47. *See* Washington Hospital Center, *The Rapid Organ Recovery Process*, *supra* note 14.

48. *See* D.C. CODE ANN. § 2-1501 *et seq.* (1998).

49. *See* Braun & Drobny, *supra* note 8, at 73; *see also* Council of the District of Columbia, *supra* note 4, at 2; Consensus Report, *supra* note 32, at Executive Summary; Kowalski, *supra* note 18, at 653.

50. *See* Consensus Report, *supra* note 32, at 8; *see also* Kowalski, *supra* note 18, at 656-57; Council of the District of Columbia, *supra* note 4, at 5; J.A. Light, A.E. Kowalski & W.O. Ritchie et al., *Developing a Rapid Organ Recovery Program: An Innovative Solution to the Organ Donation Crisis*, 10 UNOS UPDATE (Nov. 1994), at 6.

niques prior to receiving the consent from the next of kin, despite the fact that such allowances are built into the protocol.[51]

The RORP presents a novel problem in the analysis of the regulation of organ donation. Essentially, the RORP will allow a hospital trauma center to employ invasive surgical techniques after certification of death, with or without a statute, and with or without the consent of the next of kin.[52] Such activities give rise to several common law, statutory and constitutional questions examined in this Note. Section I explores the origin of anatomical gift statutes and the subtleties of the consent requirements adopted over time.

The constitutional questions will be addressed in Section II. This Section argues that, first, the next of kin have historical rights in relation to the corpse, namely rights of possession, control, custody, and to ensure a proper burial or other disposition of the remains. Second, these historical rights vest in the next of kin at the time of death. Traditionally, courts called this historical right a "quasi-property" right. The use of the term "quasi-property" does not mean to suggest it is somehow property of a constitutional dimension. The term is used to describe the rights the next of kin may claim to the body of their decedent. This Note argues that quasi-property rights in no way rise to the level of constitutional dimensions and do not grant the next of kin due process guarantees that normally attach to property. The RORP does not violate any due process rights the family may possess when the transplant team invades the body cavity to preserve organs without the next of kin's consent. This Section also argues that because the rights of the next of kin to the decedent's body are not constitutional, a taking does not occur when the RORP team invades the body cavity of the decedent pursuant to the regulatory Organ Preservation statute.[53]

If an Organ Preservation statute is not in effect in the jurisdiction where the RORP process is implemented, the invasion of the body cavity may be evaluated as tort actions of mutilation and/or intentional infliction of emotional distress inflicted against the next of kin. Sec-

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51. *See* Telephone Interview with William O. Ritchie, Jr., Ph.D., Director of Decedent Affairs, Washington Hospital Center (Nov. 10, 1998).

52. *See* Washington Hospital Center, *The Rapid Organ Recovery Process*, *supra* note 14; *see also* Light, *supra* note 15, at 3553; Braun & Drobny, *supra* note 8, at 3-4; Kowalski, *supra* note 18, at 656; J.A. Light et al., *supra* note 50, at 8.

53. *See* D.C. CODE ANN. § 2-1509.1.

tion III evaluates both of these tort actions. This Note posits that because the RORP procedure requires such a minimal invasion of the body cavity, claims on these grounds will most likely fail to reach the standard required by these tort actions.

This Note concludes that the RORP, whether utilized through a legislative mechanism or private hospital program, does not violate the constitutional rights of the next of kin when the process is implemented without their consent. Further, the RORP process is benign in nature and will not give rise to a successful tort action in mutilation or intentional infliction of emotional distress.

I. FROM THE UNIFORM ANATOMICAL GIFT ACT, AROUND THE COUNTRY, AND BACK TO THE DISTRICT OF COLUMBIA

A. The Uniform Anatomical Gift Act

In 1968, the legal community responded to the medical community's rapid advances in transplant technology when the National Conference of Commissioners on Uniform State Laws (NCCUSL) released the Uniform Anatomical Gift Act of 1968 (1968 Act).[54] All fifty states and the District of Columbia enacted the 1968 Act within five years.[55] In 1987, the NCCUSL revised and amended the 1968 Act and released the Uniform Anatomical Gift Act of 1987 (1987 Act).[56] The 1968 Act and the 1987 Act created protocols to govern the giving and accepting of anatomical gifts.[57] Specifically, they provided that the donee[58] may obtain anatomical gifts after obtaining the consent of the

54. Unif. Anatomical Gift Act § 1-6 (1968); *see also* Erik S. Jaffe, *She's Got Bette Davis['s] Eyes: Assessing the Nonconsensual Removal of Cadaver Organs Under the Takings and Due Process Clauses*, 90 COLUM. L. REV. 528, 532 (1990).

55. *See* Unif. Anatomical Gift Act 1968 References & Annotations.

56. Unif. Anatomical Gift Act § 1-6 (1987).

57. *See e.g.*, Unif. Anatomical Gift Act § 1-6 (1968); *see also* Unif. Anatomical Gift Act § 1-6 (1987).

58. *See* Unif. Anatomical Gift Act § 3 (1968); *see also* Unif. Anatomical Gift Act § 6(a) (1987).

> (a) The following persons may become donees of anatomical gifts for the purposes stated:
>
> (1) a hospital, physician, surgeon, or procurement organization, for transplantation, therapy, medical or dental education, research, or advancement of medical or

listed parties able to be donors.[59] The NCCUSL released the 1968 Act to encourage an increase in the current supply of viable, transplantable donated organs.[60] In practice, however, the consent requirement of the 1968 Act was a barrier to obtaining viable, transplantable organs.[61]

The 1987 Act amends the 1968 Act by allowing the coroner or medical examiner (M.E.) to remove parts of a body for transplantation without first obtaining consent.[62] This can be done so long as: (1) there is a request from a donee for the organ; (2) the M.E. weighs the donee's need for the specified organ; (3) the M.E. makes a reasonable effort to contact those able to make the anatomical donation; (4) there is no refusal on the part of the decedent or those able to make the anatomical donation; (5) the removal of the part is performed by a physician, surgeon, or technician; (6) an autopsy or investigation is not hindered by the removal; (7) the recovery is performed according to accepted protocol; and (8) the M.E. ensures that cosmetic restoration will be performed if necessary.[63] This new provision recognizes that the requirements of consent are a barrier to receipt of organs from possible donors.[64]

> dental science;
>
> (2) an accredited medical or dental school, college, or university for education, research, advancement of medical or dental science; or
>
> (3) a designated individual for transplantation or therapy needed by that individual.

Unif. Anatomical Gift Act § 6(a).

59. *See* Unif. Anatomical Gift Act § 2 (1968); *see also* Unif. Anatomical Gift Act § 2-3 (1987).

(a) "An individual . . . who is at least [18] years of age may . . . make an anatomical gift. . . ." Unif. Anatomical Gift Act § 2-3 (1987).

60. *See* Jaffe, *supra* note 54, at 535; *see also* Jesse Dukeminier, *Supplying Organs for Transplantation*, 68 MICH. L. REV. 811, 814-15 (1990).

61. *See* Dukeminier, *supra* note 60, at 825-31.

62. *See* Unif. Anatomical Gift Act § 4(a) (1987).

63. *See id.*

64. *See id.*

> The Task Force on Organ Transplantation reported that the number of potential donors annually is much smaller than the estimated one million deaths that occur each year in hospitals in the United States . . . "Given the available estimates of the size of the donor pool, the current system for procuring organs yields somewhere between nine and twenty percent of the possible pool of donors for various types of organs and tissues."

B. Around the Country

There are two types of statutes that attempt to remedy the "consent as a barrier" problem triggered when a body is in the custody of the M.E. The first type is a statute such as the 1987 Act, which requires an M.E. to exercise a reasonable effort to obtain consent to an anatomical gift from the next of kin.[65] The second type is a statute that presumes consent to an anatomical gift when the body is in the custody of the M.E.[66]

Id. at Comment.

65. States falling into the reasonable effort category include: Arizona, ARIZ. REV. STAT. § 36-844(A)(2) (1998); California, CAL. HEALTH & SAFETY CODE § 7515.5(a)(2) (1998); Hawaii, HAW. REV. STAT. § 327-4(a)(2) (1998); Idaho, IDAHO CODE § 39-3405(1)(b) (1998); Indiana, IND. CODE § 29-2-16-4.5(a)(2) (1998); Iowa, IOWA CODE 142C.4A(1)(b) (1998); Minnesota, MINN. STAT. ANN. § 525.9213(a)(2) (West 1998); Montana, MONT. CODE ANN. § 72-17-215(1)(b) (1998); New Hampshire, N.H. REV. STAT. ANN. § 291-A:5(I)(b) (1998); New Mexico, N.M. STAT. ANN. § 24-6A-4(A)(2) (1998); North Dakota, N.D. CENT. CODE § 23-06.2-04(1)(b) (1998); Oregon, OR. REV. STAT. § 97.956(1)(c) (1998); Pennsylvania, 20 PA. CONS. STAT. ANN. § 8641(a)(2) (1998); Rhode Island, R.I. GEN. LAWS § 23-18.6-4(a)(2) (1998); Tennessee, TENN. CODE ANN. § 68-30-204(3) (1998); Utah, UTAH CODE ANN. § 26-28-5(1)(b) (1998); Wisconsin, WIS. STAT. ANN. § 157.06(4)(a)(2) (1998).

66. *See, e.g.*, Colorado's statute designed to negate the need for reasonable effort.

> (1) Whenever a post-mortem examination is performed pursuant to section 30-10-606(2), the examining physician may remove the pituitary gland from the body of the deceased for the purpose of medical research, education, or therapy if:
> (a) The removal is performed in conjunction with a post-mortem examination performed under the jurisdiction of the county coroner;
> (b) The removal will not impede or interfere with the investigation which gave rise to the post-mortem examination and will not significantly alter post-mortem appearance;
> (c) No prior objection by the decedent is made known or no objection by the decedent's next of kin is expressed at the time of the post-mortem examination and the decedent was not a known member of a religious group with a public position in opposition to tissue removal.

COLO. REV. STAT. § 30-10-621(1) (1998).

Presumed consent statutes generally target a specified body part, such as the pituitary gland or the cornea.[67] The M.E. may then remove only the specified body part(s) if four criteria are met:

> (1) a request for such tissue for the purposes of transplant or therapy is made by an authorized recipient; (2) the removal would not interfere with the course of an autopsy or other investigation; (3) the removal would not alter the deceased's facial appearance; and (4) no objection by the deceased or the next of kin is known by the [M.E.].[68]

C. The District of Columbia

The District of Columbia enacted the 1968 Act[69] in 1970.[70] In addition, the District of Columbia enacted an Anatomical Gift statute providing for the non-consensual removal of the cornea, aortic heart valve, and the pulmonary heart valve.[71] When a body is in the custody of the Chief Medial Examiner of the District of Columbia,[72] he or she may authorize the removal of these parts.[73] Despite the enactment of

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67. *See generally* Colorado, COLO. REV. STAT. ANN. § 30-10-621 (West 1998); Florida, FLA. STAT. ANN. § 732-9185 (West 1998); Kentucky, KY. REV. STAT. ANN. § 311.187 (Michie 1998); Maryland, MD. CODE ANN. EST. & TRUSTS § 4-509.1 (1998); Michigan, MICH. COMP. LAWS ANN. § 333.10202 (West 1998); Minnesota, MINN. STAT. ANN. § 390.36 (West 1998); Mississippi, MISS. CODE ANN. § 41-61-71 (1998); Nebraska, NEB. REV. ST. § 71-4813 (1998); New Hampshire, N.H. REV. STAT. ANN. § 291-A:7-b (1998); New York, N.Y. PUB. HEALTH LAW § 4222 (McKinney 1998); Ohio, OHIO REV. CODE ANN. § 2108.60 (Anderson 1998); Oklahoma, OKL. STAT. ANN. TIT. 63 § 944.1 (West 1998); Tennessee, TENN. CODE ANN. § 68-30-204 (1998) & TENN. CODE ANN. § 68-30-301 (1998); Washington, WASH. REV. CODE ANN. § 68.50.630 (West 1998); West Virginia, W. VA. CODE § 16-19-3a (1998).

68. Jaffe, *supra* note 54, at 535.

69. *See* Unif. Anatomical Gift Act § 1 *et seq.*

70. *See* D.C. CODE ANN. § 2-1501 *et seq.* (1998), Notes, References and Annotations.

71. *See* D.C. CODE ANN. § 2-1605 (1998).

72. *See* Telephone Interview with William O. Ritchie, Jr., Ph.D., Director, Office of Decedent Affairs, Washington Hospital Center (Nov. 10, 1998).

73. *See* D.C. CODE ANN. § 2-1605 (1998). However, the current Chief

these statutes, the District of Columbia continued to suffer from a severe shortage of transplantable organs.[74]

On May 24, 1996, the District of Columbia passed the Organ Preservation amendment to the existing Anatomical Gift Act[75] to "address the current shortage of organs that are acceptable for transplantation while respecting the wishes of the potential donor's family."[76] This amendment follows the more recent trend toward presumed consent anatomical gift statutes[77] by allowing the hospital to begin invasive organ preservation techniques prior to gaining family consent to an anatomical gift.[78] The Organ Preservation amendment provides that

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Medical Examiner of the District of Columbia, Dr. Joye M. Carter, "bars the removal of corneas and heart valves at the morgue. . . ." Frank J. Murray, *Doctor Controls Access to D.C. Body Parts*, WASH. TIMES, Nov. 6, 1995, at A6.

74. *See* Braun & Drobny, *supra* note 8, at 73; *see also* Council of the District of Columbia, *supra* note 4, at 2.

75. *See* D.C. CODE ANN. § 2-1509.1 (1998).

76. *See* Council of the District of Columbia, *supra* note 4, at 2.

77. *See generally* Colorado, COLO. REV. STAT. ANN. § 30-10-621 (1998); Florida, FLA. STAT. ANN. § 732-9185 (1998); Kentucky, KY. REV. STAT. § 311.187 (1998); Maryland, MD. CODE ANN. EST. & TRUSTS § 4-509.1 (1998); Michigan, MICH. CODE L. ANN. § 333.10202 (1998); Minnesota, MINN. STAT. ANN. § 390.36 (1998); Mississippi, MISS. CODE § 41-61-71 (1998); Nebraska, NEB. REV. ST. § 71-4813 (1998); New Hampshire, N.H. REV. STAT. ANN. § 291-A:7-b (1998); New York, N.Y. PUB. HEALTH LAW § 4222 (McKinney 1998); Ohio, OHIO REV. CODE § 2108.60 (1998); Oklahoma, 63 OKL. STAT. ANN. § 944.1 (1998); Tennessee, TENN. CODE ANN. § 68-30-204 (1998) & TENN. CODE ANN. § 68-30-301 (1998); Washington, WA. STAT. 68.50.630 (1998); West Virginia, W. VA. STAT. § 16-19-3a (1998).

78. The Organ Preservation statute states in pertinent part:

> (a) In the event a person authorized by § 2-1502(b) to consent to an anatomical gift of all or part of the decedent's body is not immediately available for a representative of a hospital to make the request required by § 2-1509, the hospital may use organ preservation equipment and techniques, including ventilators and *in situ* flushing and cooling equipment, to maintain the viability of the decedent's organs in order to preserve the option of family members and other authorized person to consider donation.

D.C. CODE ANN. § 2-1509.1 (1998).

when the next of kin is not available to consent to an anatomical gift, "the hospital may use organ preservation equipment and techniques including ventilators and *in situ* flushing and cooling equipment, to maintain the viability of the decedent's organs in order to preserve the option of [next of kin] . . . to consider donation."[79]

There is a significant difference between the District of Columbia's presumed consent statute allowing for the removal of the cornea, aortic heart valve, and the pulmonary heart valve,[80] and the presumed consent statute allowing for the preservation of organs after death.[81] The difference lies in the custody and control of the deceased. Statutes that allow for the removal of corneal tissue specifically call for the deceased to be in the physical and legal custody of the M.E.[82] The new organ preservation statute has no such requirement. The new amendment allows hospitals to begin organ preservation techniques while the decedent is in their custody.[83] Washington Hospital Center's RORP protocol requires notification to, and approval of, the Office of the Medical Examiner, before preservation techniques can be used.[84] The Washington Hospital Center recognizes that whenever a person dies, the body is legally in the custody of the M.E., though not physically, until the Office of the Medical Examiner can certify the cause of death.[85]

II. HANDS OFF! THAT'S MY QUASI-PROPERTY: NEXT OF KIN'S CONSTITUTIONAL RIGHTS IN THE CORPSE OF THEIR DECEDENT

In order for a person to be protected by the United States Constitu-

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79. *Id.*

80. *See id.* at § 2-1605.

81. *See id.* at § 2-1509.1.

82. *See id.* at § 1605(b). "The Chief Medical Examiner of the District of Columbia may allow tissue to be removed from any dead human body in his or her custody or under his or her jurisdiction. . . ." *Id.*

83. *See id.* at § 2-1509.1.

84. *See* Washington Hospital Center, *The Rapid Organ Recovery Process*, *supra* note 14; *see also*, Consensus Report, *supra* note 32, at 7.

85. *See* Telephone Interview with William O. Ritchie, Jr., Ph.D., Director of Decedent Affairs, Washington Hospital Center (Nov. 16, 1998); *see also*, D.C. CODE § 11-2304 (1998).

tion, the person must be alive. Constitutional protections turn on the definition of "person." Life is a bare minimum for personhood, therefore the "person" ceases to exist at death. If there is no "person," the Constitution will no longer apply.[86] The Constitution, however, does protect the interests of living persons with claims regarding the deceased. The rights existing after death, whatever the state declares them to be, belong to the next of kin.[87]

Common law principles recognize that the next of kin has no commercial or material property right to the body of their decedent.[88] Yet, many courts recognize his or her next of kin's "quasi-property rights" in the body, stemming from their obligation to bury the decedent.[89]

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86. *See generally* Roe v. Wade, 410 U.S. 113 (1973).

87. *See id.*

88. *See* Culpepper v. Pearl Street Building, Inc., 877 P.2d 877 (Colo. 1994).

> It is universally recognized that there is no property in a dead body in a commercial or material sense. "[I]t is not part of the assets of the estate (though disposition may be affected by the provision of the will); it is not subject to replevin; it is not property in a sense that will support discovery proceedings; it may not be held as security for funeral costs; it cannot be withheld by an express company, or returned to the sender, where shipped under a contract calling for cash on delivery; it may not be the subject of a gift causa mortis; it is not common law larceny to steal a corpse. Rights in a dead body exist ordinarily only for purposes of burial and, except with statutory authorization, for no other purpose."

Id. (citation omitted); *see also* Daugherty v. Mercantile-Safe Deposit and Trust Co., 387 A.2d 244, 246 n.2 (Md. 1978) (*citing* Snyder v. Holy Cross Hosp., 352 A.2d 334, 340 (*quoting*, P.E. JACKSON, THE LAW OF CADAVERS AND OF BURIAL AND BURIAL PLACES, 2nd ed. 1950)).

89. *See generally* Fuller v. Marx, 724 F.2d 717 (8th Cir. 1984); O'Donnel v. Slack, 55 P. 906 (Cal. 1899); McCoy v. Georgia Baptist Hosp., 306 S.E.2d 746 (Ga. Ct. App. 1983); Orr v. Dayton & M. Traction Co., 96 N.E. 462 (Ind. 1911); Anderson v. Acheson, 110 N.W. 335 (Iowa 1907); Seaton v. Commonwealth, 149 S.W. 871 (Ky. Ct. App. 1912); Radomer Russ-Pol Unterstitzung Verein v. Posner, 4 A.2d 743 (Md. 1939); Burney v. Children's Hosp. in Boston, 47 N.E. 401 (Mass. 1897); Doxtator v. Chicago & W. M. R. Co., 79 N.W. 922 (Mich. 1899); Larson v. Chase, 50 N.W. 238 (Minn. 1891); Strachan v. John F. Kennedy Memorial Hosp., 507 A.2d 718 (N.J. Super. Ct. App. Div. 1986); Barela v. Frank A. Hubbel Co., 355 P.2d 133 (N.M. 1960); Parker v. Quinn-McGowen Co., 138 S.E.2d 214 (N.C.

Prior to this recognition, the next of kin did not have standing to enforce an action if the decedent was not decently buried.[90]

Due to the nature of this quasi-property right, the right vests in the next of kin at the time of death.[91] "Furthermore, the survivor has the legal right to bury the body in the condition it was in when life [ended]."[92] When a third party interferes with these rights, the remedy lies not in the damages done to the decedent's body, but "to the next of kin by infringement of his right to have the body delivered to him for burial without mutilation."[93] Determining in whom these quasi-rights vest is somewhat hierarchical, beginning with the surviving spouse.[94] If there is no spouse, then the rights vest with those closest

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1964); Pettigrew v. Pettigrew, 56 A. 878 (Pa. 1904); Sullivan v. Catholic Cemeteries, Inc., 317 A.2d 430 (R.I. 1974); Simpkins v. Lumbermens Mut. Casualty Co., 20 S.E.2d 733 (S.C. 1942); Terrill v. Harbin, 376 S.W.2d 945 (Tex. Civ. App. 1964); Sanford v. Ware, 60 S.E.2d 10 (Va. 1950); England v. Central Pocahontas Coal Co., 104 S.E. 46 (W.Va. 1920); Koerber v. Patek, 102 N.W. 40 (Wis. 1905) [hereinafter Quasi-Property Rights Cases]. The use of the phrase "quasi-property" is not to indicate an automatic constitutional right as if it were property. The terminology is used as a convenience.

90. *See* Osteen v. Southern R. Co., 86 S.E. 30 (S.C. 1915).

> This court will not commit itself to such a barbarous and savage doctrine as to hold that, when a person dies, no one has such a property interest in the body as to see the body as decently interred, and resting place uninterfered with; and a relative or friend has a right to see that the body is protected, and these feelings in relation thereto protected.

Id. at 31.

91. *See* Quasi-Property Rights Cases, *supra* note 89.

92. Parker v. Quinn-McGowen Co., 138 S.E.2d 214, 216 (N.C. 1964) (citing Kyles v. Southern R.R., 61 S.E. 278 (N.C. 1938)). This is also true with rights such as inheritance rights. Note that inheritance rights are not referred to as "quasi-property," therefore the use of this term is misleading and merely for convenience of the court.

93. Deeg v. City of Detroit, 76 N.W.2d 16 (Mich. 1956); *see also* Larson v. Chase, 50 N.W. 238 (Minn. 1891).

94. *See* Southern Life & Health Ins. Co. v. Morgan, 105 So. 161 (Fla. 1925), *cert. denied.* 105 So. 168 (Fla. 1925); Enos v. Snyder, 63 P. 170 (Cal. 1900); Boyle v. Chandler, 138 A. 273 (1927); Dunahoo v. Bess, 200 So. 541 (Fla. 1941); Louisville & N.R. Co. v. Wilson, 51 S.E. 24 (1905); Anderson v. Acheson, 110 N.W. 335 (1907); Haney v. Stamper, 125 S.W.2d 761 (1939);

in relation to the decedent, such as, children of proper age, parents, or siblings until the closest relation is located.[95]

Anatomical gift statutes have followed the common law approach by recognizing the next of kin has an interest in the family member's corpse. The 1968 Act, 1987 Act, and subsequent state legislation recognize the requirement that the next of kin must give consent to an anatomical gift.[96]

A. Looking at the Due Process Clause of the United States Constitution

The Due Process Clauses of the Fifth and Fourteenth Amendments to the United States Constitution[97] provide that a person shall not be deprived of life, liberty, or property, without due process of law.[98] This guarantee only applies to the actions of government officials or state actors when they seek to deprive a person of life, liberty, or property.[99] State actors include government officials and their agents acting under the color of state law.[100] The nature of due process protections can be divided among two major areas: procedural due proc-

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Bunol v. Bunol, 127 So. 70 (1930); Pulsifer v. Douglass, 48 A. 118 (1901); Messina v. La Rosa, 150 N.E.2d 5 (Mass. 1958); Sacred Heart of Jesus Polish Nat. Catholic Church v. Soklowski, 199 N.W. 81 (Minn. 1924); Holland v. Metalious, 198 A.2d 654 (N.H. 1964); Parker v. Quinn-McGowen Co., 138 S.E.2d 214 (N.C. 1964); McClellan v. Filson, 5 N.E. 861 (Ohio 1886); Hardin v. Ehring (Madison Co.), 155 N.E. 153 (Ohio Ct. App. 1926); Leschey v. Leschey, 97 A.2d 784 (Penn. 1953); Sullivan v. Catholic Cemeteries, Inc., 317 A.2d 430 (R.I. 1974); Simpkins v. Lumbermens Mut. Casualty Co., 20 S.E.2d 733 (1942); Samsel v. Diaz, 659 S.W.2d 143 (Tex. Ct. App. 1983); Flores v. DeGalvan, 127 S.W.2d 305 (Tex. Ct. App. 1939); Nichols v. Central V.R. Co., 109 A. 905 (Vt. 1919); Koerber v. Patek, 102 N.W. 40 (1905).

95. *See* Sullivan v. Catholic Cemeteries, Inc., 317 A.2d 430 (R.I. 1974).

96. *See* Unif. Anatomical Gift Act § 3(a) (1987); *see also* Unif. Anatomical Gift Act § 2 (1968).

97. For purposes of this Note, the analysis of due process protections in terms of property deprivation will be treated as if they are the same under the Fifth and Fourteenth Amendments to the United States Constitution.

98. *See* U.S. CONST. amend. V; *see also* U.S. CONST. amend. XIV, § 1.

99. *See* Daniels v. Williams, 474 U.S. 327, 331 (1986).

100. *See* 42 U.S.C. § 1983 (1998).

ess and substantive due process, though procedural due process analysis is more relevant to organ donation statutes.

1. Procedural Due Process

When the government seeks to deprive an individual of life, liberty, or property, a procedure to effectuate deprivation should be employed. The "[g]overnment must have made an individualized determination about a particular individual, and that individualized determination must impose a burden on or deny a benefit to that individual in a way which infringes that individual's liberty or property (or life) interests."[101] Such a determination may only be made through some type of procedure affording the individual notice of the proceeding and a2n opportunity to be heard on the merits of the claim.[102]

Procedural due process[103] rights are especially important in the case of an anatomical gift. If the gift is made without the next of kin's consent, the only realistic remedy is a monetary award. The nature of an anatomical gift is an overriding concern for the court in evaluating whether making an anatomical gift complies with the procedural due process test. Such concerns will give rise to court scrutiny in the areas of notice to the next of kin and consent requirements.

2. Substantive Due Process

Recent Supreme Court cases have focused their substantive due process analysis on finding personal, "fundamental" privacy rights protections in the due process clause.[104] It is difficult to analyze where the Supreme Court falls today on the subject of substantive due proc-

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101. WILLIAM A. KAPLIN, THE CONCEPTS AND METHODS OF CONSTITUTIONAL LAW 143 (1992).

102. *See id.*

103. Mathews v. Eldridge, 424 U.S. 319 (1976), set the standard to determine how much process is due by performing a three step balancing test. The court must balance "the private interest that will be affected by the official action; . . . the risk of an erroneous deprivation of such interest through the procedures used. . . and; . . . the Government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail." *Id.*; *see also* Jaffe, supra note 54, at 562.

104. *See e.g.*, Griswold v. Connecticut, 381 U.S. 479 (1965).

ess and fundamental rights. For purposes of this Note, be aware that privacy rights exist by application of the due process clause and that only the rights that are found to be "fundamental" are included in a guarantee of the right to personal privacy.[105]

B. Recent Case Law Regarding the Quasi-Property Interest

If the next of kin possess a quasi-property right at the time of the decedent's death, certain due process rights may attach. Recently, individuals have attacked the constitutional validity of presumed consent statutes[106] on the grounds of violations of procedural and substantive due process.[107]

1. Attacking Presumed Consent Statutes on Procedural Due Process Grounds

In *Georgia Lions Eye Bank, Inc. v. Lavant*,[108] a mother sued a hospital for removing the corneal tissue of her child who died of sudden infant death syndrome.[109] The removal was pursuant to a Georgia statute.[110] The law allows for the removal, so long as the decedent is in the custody of the M.E. and, *inter alia*, the decedent does not object to such a procedure during his or her life.[111] The hospital knew of no

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105. *See e.g.*, Roe v. Wade, 410 U.S. 113 (1973); *see also* Griswold v. Connecticut, 381 U.S. 479 (1965).

106. *See e.g.*, State v. Powell, 497 So.2d 1188 (Fla. 1986); Georgia Lions Eye Bank, Inc. v. Lavant, 335 S.E.2d 127 (Ga. 1985); Tillman v. Detroit Receiving Hosp., 360 N.W.2d 275 (Mich. 1984); Mansaw v. Midwest Organ Bank, 1998 WL 386327 (W.D.Mo. 1998); Perry v. Saint Francis Hosp. and Medical Ctr., Inc., 886 F. Supp. 1551 (D. Kansas 1995); Brotherton, et al. v. Cleveland, et al., 733 F. Supp. 56 (S.D. Ohio 1989).

107. *See e.g.*, State v. Powell, 497 So.2d 1188 (Fla. 1986); Georgia Lions Eye Bank, Inc. v. Lavant, 335 S.E.2d 127 (Ga. 1985); Tillman v. Detroit Receiving Hosp., 360 N.W.2d 275 (Mich. 1984); Mansaw v. Midwest Organ Bank, 1998 WL 386327 (W.D. Mo. 1998); Perry v. Saint Francis Hosp. and Medical Ctr., Inc., 886 F. Supp. 1551 (D. Kansas 1995); Brotherton, et al. v. Cleveland, et al., 733 F. Supp. 56 (S.D. Ohio 1989).

108. 335 S.E.2d 127 (Ga. 1985).

109. *See id.*

110. *See* GA. CODE ANN. § 31-23-6(b)(1) (1996).

111. *See id.* which states in pertinent part:

objections made by the decedent during life since the decedent was an infant, however, Lavant argued that the corneal tissue was wrongly removed because she received no notice that the procedure would be performed.[112]

The lower court agreed with Lavant holding the removal of corneal tissue after death, without notice and an opportunity to object, deprives the next of kin of a quasi-property right in the corpse of the decedent.[113] The Supreme Court of Georgia agreed with the lower court, holding "the courts have evolved the concept of quasi property in recognition of the interests of surviving relatives in the possession and control of the decedents' bodies."[114] The court then went on to overturn the lower court by stating that such a creation of the courts does not rise to the level of constitutional dimension.[115]

The *Lavant* court stopped short of declaring that the next of kin's interest in this common law right could not be protected. But because the court refused to recognize a due process right in the next of kin's interest in the decedent, the state and its courts could continue to define the nature of the interests. In this case, the state defined its interest in a decedent to include authority to remove corneal tissue without the consent of the next of kin.

> (b)(1) Upon a request from an authorized official of an approved eye bank for corneal tissue to be used for transplants or research, a coroner, a medical examiner, hospital, funeral director, or an authorized official acting for the coroner may permit the removal of the corneal tissue of a decedent by individuals designated by the eye bank for delivery to the eye bank for such purposes if all of the following conditions are met:
> (A) the decedent from whom the tissue is to be taken is under the jurisdiction of a coroner or medical examiner pursuant to Code Section 45-16-27;
> (B) no objection by the decedent during his lifetime or, after his death, by the appropriate person listed in paragraph (2) of this subsection is known to the coroner, medical examiner, or authorized official acting for the coroner at the time the tissue is removed; and
> (C) the person designated by the eye bank to remove the tissue is a person authorized to do so under Code Section 31-23-5.

Id.

112. *See Georgia Lions Eye Bank*, 335 S.E.2d at 128.

113. *See id.*

114. *Id.*

115. *See id.*

2. *Attacking Presumed Consent Statutes on Substantive Due Process Grounds*

In *Tillman v. Detroit Receiving Hospital*,[116] the decedent's mother brought an action against the hospital for removing her daughter's eyes without consent in violation of state law.[117] Mrs. Tillman argued that because she was the next of kin to the decedent, she "ha[d] an inherent, fundamental right to bury her decedent's body without mutilation."[118]

Michigan common law recognizes that the next of kin have a cause of action in tort for the interference with their right to the "possession, control, or burial" of their decedent.[119] The *Tillman* court, however, found this right did not rise to the level of constitutional dimensions.[120] The court did not agree that a quasi-property right was in fact a due process property right with all of the constitutional protections that followed. The *Tillman* court clarified that the use of the term "quasi-property" does not mean that the court intended for the interest to be a property interest. Further, because the court found no procedural due process right, there was no constitutional tort. The court further stated that the fundamental privacy right applies only to a person's right to make decisions about his or her own body[121] and that right dies when the person dies.[122]

The Florida Supreme Court addressed a similar issue in *State v. Powell*,[123] where the families of two young boys sued for damages as a result of the wrongful removal of their sons' corneal tissue.[124] The families claimed, among other things, that the statute allowing the M. E. to remove corneal tissue without consent violated the fundamental due process right of families to make personal choices and decisions

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116. 360 N.W.2d 275 (Mich. 1984).

117. *See id.* at 276-77.

118. *Id.* at 277.

119. *Id.* (*citing* Deeg v. Detroit, 76 N.W.2d 16 (Mich. 1956)).

120. *See id.*

121. *See id.*

122. *See Tillman*, 360 N.W.2d at 277 (*citing* Hubenschmidt v. Shears, 270 N.W.2d 2 (Mich. 1978) and McLean v. Rogers, 300 N.W.2d 389 (Mich. 1980)).

123. 497 So.2d 1188 (Fla. 1986).

124. *See id.* at 1190.

affecting the family.[125] This argument proved to be unsuccessful since substantive due process rights are directed at the living person and pertain to liberty of the person. The next of kin are the living persons to which the substantive due process rights are directed, not the decedent. To argue for family substantive due process rights, where the family member in question is no longer recognized as possessing these rights, is unfounded.

The *Powell* court stated the right to personal freedom of choice exists between family members now living.[126] It held the next of kin may not bring a tort action for interference with their right to effect a proper burial because it does not rise to the level of constitutional protections.[127] The court ruled the family is free to pursue other tort remedies, such as mutilation, which would require proof that the decedent's body was so affected by an intrusion that the body is unfit for burial.[128]

C. The District of Columbia Organ Preservation Amendment and Due Process

The Organ Preservation Amendment to the Anatomical Gift Act in the District of Columbia[129] is similar to the presumed consent statute that allows the Chief M.E. to remove the cornea, aortic heart valve, and pulmonary heart valve without the consent of the next of kin.[130] The statute allows the intrusive techniques to be performed on the deceased for purposes of organ donation. There are, however, two notable differences between the statutes. First, the Organ Preservation Amendment does not allow the actual removal or mutilation of any part of the deceased; the allowed intrusion is exclusively for the preservation of organs, pending consent by the next of kin for recovery of organs.[131] The intrusion is carefully calculated to buy the hospital more time to gain consent from the next of kin.[132]

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125. *See id.* at 1193.
126. *See id.*
127. *See id.*
128. *See infra* part III.A.
129. *See* D.C. CODE ANN. § 2-1509 (1998).
130. *See id.* at § 2-1605.
131. *See id.* at § 2-1509.1.
132. *See id.* at § 2-1509.1(a) which states in pertinent part, "the hospital

Second, the Organ Preservation Amendment does not presume the M.E. has custody of the decedent's body prior to beginning the invasive preservation techniques.[133] However, the RORP targets non-heart-beating donors that die of traumatic injuries.[134] As long as RORP donors consist of this group of individuals, it is arguable the decedent, when donating under this program, is in the legal custody of the M.E.[135] This is because the Chief M.E. is required by statute to investigate, violent deaths,[136] sudden deaths where the cause is not readily ascertainable,[137] deaths that occur under suspicious circumstances,[138] and deaths that result from a disease suspected to be a threat to public health.[139]

Currently, District of Columbia law, like many other jurisdictions, recognizes the rights of the next of kin to "possess, preserve and bury, or otherwise to dispose of, a dead body."[140] Existing case law recognizing this right recognizes remedies only in tort.[141] This recognition is aligned with the decisions of neighboring jurisdictions discussed above[142] by refusing to recognize a constitutional property right in the next of kin.

Although the neighboring jurisdictions evaluated in this Note analyzed only presumed consent laws, there are similarities between presumed consent anatomical gift laws and the Organ Preservation amendment. An analysis of the procedure utilized to preserve organs for transplantation under the presumed consent statute versus proce-

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may use organ preservation equipment and techniques, including ventilators and *in situ* flushing and cooling equipment, to maintain the viability of the decedent's organs in order to preserve the option of family members and other authorized persons to consider donation." *Id.*

133. *Cf.*, D.C. CODE ANN. §§ 2-1509.1, 2-1605.

134. *See* Light, *supra* note 15, at 3553.

135. *See* D.C. CODE ANN. § 11-2304 (1998).

136. *See id.* § 11-2304(a)(1).

137. *See id.* § 11-2304(a)(2).

138. *See id.* § 11-2304(a)(3).

139. *See id.* § 11-2304(a)(6).

140. Steagall et al. v. Doctors Hospital, Inc., et al., 171 F.2d 352, 353 (D.C. Cir. 1948). *See also, e.g.*, Quasi-Property Rights Cases, *supra* note 89.

141. *See Steagall*, 171 F.2d at 353.

142. *See Powell*, 497 So.2d at 1188; *see also Georgia Lions Eye Bank*, Inc., 335 S.E.2d at 127; *Tillman*, 360 N.W.2d at 275.

dures used under the Organ Preservation Amendment showed that the procedure to preserve organs is much more benign than the procedures permitted by the presumed consent statutes.[143]

The presumed consent statute in the District of Columbia allows the Chief M.E. to remove the aortic and pulmonary heart valves.[144] To effectuate the removal of these organs, the chest must be surgically cracked and opened, similar to heart surgery.[145] In comparison, during the procedure utilized by the RORP,[146] small incisions are made and catheters are inserted into the arteries carrying chilled preservation fluid through the abdominal cavity, proving to be much less invasive.[147]

The differences between the two procedures are drastic in both description and practice. Yet, presumed consent statutes have been upheld as not violating the due process rights of the next of kin.[148] The Organ Preservation amendment allows a procedure which is much more benign and nothing is removed from the body.

The current trend of case law decisions on the issue of quasi-property rights under presumed consent statutes compared to the benign intrusion allowed by the Organ Preservation Amendment leads to one probable conclusion. A District of Columbia court considering an action arising from the Washington Hospital Center's use of the RORP would most likely determine that the right of the next of kin in overseeing a proper burial is not a constitutionally protected property right. The next of kin likely will not be entitled to procedural or substantive due process protections when the coroner or M.E. is acting within his or her statutory prescription. Hence, there would be no need to analyze the removal of statutorily prescribed organs as a taking under the Constitution. It would also be unnecessary to answer whether, when

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143. Evaluations of each procedure will become increasingly relevant to arguments made by the next of kin. Because family members will not have avenues of remedies in constitutional tort, they will be forced to pursue tort actions alleging mutilation and intentional infliction of emotional distress.

144. *See* D.C. CODE ANN. § 2-1605 (1998).

145. *See* Murray, *supra* note 73, at A6.

146. *See* Washington Hospital Center, *Rapid Organ Recovery Program*, *supra* note 14.

147. *See* Weiss, *supra* note 24, at A16.

148. *See Powell*, 497 So.2d at 1188; *Georgia Lions Eye Bank*, 335 S.E.2d at 127; *Tillman*, 360 N.W.2d at 275.

Washington Hospital Center uses its Rapid Organ Recovery Program, it is an agent of the M.E. acting under the color of state law.

III. REMEDIES IN TORT

A. The Tort of Mutilation

As long as the procedure under the RORP does not rise to the level of a constitutional tort, the next of kin must pursue another avenue of recovery – the tort of mutilation.[149] This is good news for Organ Procurement consortia, hospitals, and organ donation advocates. The tort of mutilation places a much higher burden on the next of kin in terms of proving how the medical procedure rises to the level of mutilation.[150] Where a violation of due process rights requires a mere showing of the state's failure to abide by basic procedural or fundamental constitutional safeguards,[151] the tort of mutilation requires proof that the decedent's body was so affected by an intrusion that it is unfit for burial.[152]

Many jurisdictions recognize the tort of mutilation where one willfully, recklessly, wantonly, unlawfully, or negligently defaces the body of a dead person.[153] Mutilation of a dead body occurs when one effects a disturbance upon the body so as to render it unfit for purposes of burial.[154] Many cases that address the tort of mutilation have a factual basis of wrongful autopsy,[155] negligent handling of the

149. *See e.g.*, *Steagall*, 171 F.2d at 353.

150. *See* RESTATEMENT (SECOND) OF TORTS § 868 (1996).

151. *See* U.S. CONST. amend. V, XIV, § 1; *see also* Daniels v. Williams, 474 U.S. 327, 331 (1986); 42 U.S.C. § 1983 (1998).

152. *See* Farley v. Carson, 8 Ohio Dec. Rep. 119.

153. *See* Plamquist v. Standard Acc. Ins. Co., 3 F. Supp. 358 (S.D. Cal. 1933); see also Streipe v. Liberty Mut. Life Ins. Co., 47 S.W.2d 1004 (Ky. Ct. App. 1932); Burney v. Children's Hosp. in Boston, 47 N.E. 401 (Mass. 1897); Larson v. Chase, 50 N.W. 238; Finley v. Atlantic Transport Co., 115 N.E. 715 (N.Y. Ct. App. 1917); Parker v. Quinn-McGowen Co., 138 S.E.2d 214 (N.C. 1964); Love v. Aetna Casualty & Surety Co. 121 S.W.2d 986 (Tex. 1938); Awtrey v. Norfolk & W.R. Co., 93 S.E. 570 (Va. 1917); Koerber v. Patek, 102 N.W. 40 (1905).

154. *See Farley*, 8 Ohio Dec. Rep. at 119.

155. *See e.g.*, Streipe v. Liberty Mut. Ins. Co., 47 S.W.2d 1004 (Ky.

body,[156] or unauthorized embalming procedures.[157] While wrongful autopsy and negligent handling of the body of a dead person generally have been found sufficient to constitute mutilation,[158] unauthorized embalming has not.[159]

Whether a court is willing to recognize the tort of mutilation turns on the end effect of the action upon the corpse. Two possible questions for the court include (1) whether the body is fit for an open casket burial and if so, (2) whether the actor invaded the body so as to render it unfit for burial.

The RORP can be easily compared to the process of embalming for purposes of evaluating whether the RORP process rises to the level of mutilation. The goals for embalming are to disinfect, preserve, and restore the body.[160] Embalming requires the technician to make an incision in the clavicle and access the corotid artery and jugular vein.[161] The technician then inserts catheters and initiates the embalming machine,[162] which pumps formaldehyde into the corotid artery and drains blood from the jugular vein,[163] until the extremities of the body become hydrated with formaldehyde.[164]

Ct. App. 1932). (Widow sued to recover damages for wrongful autopsy of husband who did not die under suspicious circumstances.)

156. *See e.g.*, Johnson v. Ruark Obstetrics & Gynecology Associates, P.A., 395 S.E.2d 85, 105 (N.C. 1990).

157. *See e.g.*, Parker v. Quinn-McGowen, Co., 138 S.E.2d 214 (N.C. 1964) (an unauthorized embalming of dead body, without more, did not constitute mutilation of a body).

158. *See e.g.*, Streipe v. Liberty Mut. Ins. Co., 47 S.W.2d 1004 (Ky. Ct. App. 1932); *see also* Johnson v. Ruark Obstetrics & Gynecology Associates, P.A., 395 S.E.2d 85, 105 (N.C. 1990).

159. *See id.*

160. *See* Telephone Interview with Tim Smith, Demaine Funeral Home (Nov. 20, 1998).

161. *See id.*

162. *See id.*

163. *See id.*

164. *See id.* The machine flushes through the carotid artery and jugular vein until naturally occurring blood pools are no longer detectable. If blood continues to pool, usually in the extremities, the technician will move to the femoral arteries in the legs and the auxiliary and radial arteries in the arms to effectuate hydration. *Id.*

If conducted pursuant to the Organ Preservation Amendment,[165] the RORP process is very similar to the embalming process. Due to the similarity of procedure and intrusion into the decedent's body, it would be difficult for the next of kin to prove that the RORP process rises to the level of mutilation.[166] Thus far, embalming has not, when performed properly, been found to rise to the level of tortious mutilation. It is, therefore, unlikely that the RORP process would rise to such a level.

B. The Tort of Intentional Infliction of Emotional Distress

Many jurisdictions allow those suffering emotional anguish to recover damages where one acts willfully, wantonly or maliciously and thus injures a dead body.[167] The nature of the tort requires the injured party to prove the tortfeasor acted purposefully and such actions would reasonably result in the injured party suffering emotional anguish.[168]

The RORP process necessitates a family claiming mental anguish to sue under the rubric of intentional infliction of emotional distress. RORP involves the purposeful placement of preservation equipment inside the body cavity of the decedent.[169] To prove the tort of intentional infliction of emotional distress, the injured must show that (1) extreme and outrageous conduct occurred that, (2) intentionally or

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165. *See* D.C. CODE ANN. § 2-1509.1 (1998).

166. *See e.g.*, Streipe v. Liberty Mut. Ins. Co., 47 S.W.2d 1004 (Ky. Ct. App. 1932); *see also* Johnson v. Ruark Obstetrics & Gynecology Associates, P.A., 395 S.E.2d 85, 105 (N.C. 1990).

167. *See generally*, Fuller v. Marx, 724 F.2d 717 (8th Cir. 1983); Sherer v. Rubin Mem'l Chapel, Ltd., 452 So.2d 574 (Fla. Dist. Ct. App. 1984); Burgess v. Perfue, 721 P.2d 239 (Kan. 1986); Weingast v. State, 254 N.Y.S.2d 952 (N.Y. Ct. Cl. 1946); Brownlee v. Pratt (Huron Co.), 68 N.E.2d 798 (Ohio Ct. App. 1946); Nail v. McCullough & Lee, 212 P. 981 (1923); Papieves v. Lawrence, 263 A.2d 118 (Penn. 1970); Hackett v. United Airlines, 528 A.2d 971 (Pa. Super. 1987); Awtrey v. Norfolk & W.R. Co., 93 S.E. 570 (Va. 1917); Kneass v. Cremation Soc. of Washington, 175 P. 172 (Wash. 1918).

168. *See* Dean v. Chapman, 556 P.2d 257 (Okla. 1976).

169. *See* Weiss, *supra* note 24, at A16; see also Light, *supra* note 15, at 3553; A.E. Kowalski, *supra* note 18, at 656.

recklessly caused, (3) severe emotional distress to another.[170]

In order to prove the first element, the conduct must be "so outrageous in character, and so extreme in degree, as to go beyond all possible bounds of decency, and to be regarded as atrocious, and utterly intolerable in a civilized community."[171] If a family member claimed intentional infliction of emotional distress as a result of witnessing the catheters and equipment used by the RORP team, it would be difficult to show this rises to the level of egregious conduct required by the first element. This is because District of Columbia residents are overwhelmingly in favor of the RORP.[172] Though public opinion cannot drive the reasonableness of conduct, it is relevant to the determination of whether or not the act is, "so outrageous in character, and so extreme in degree, as to go beyond all possible bounds of decency, and to be regarded as atrocious, and utterly intolerable in [the] civilized community."[173]

Therefore, it would behoove any hospital administrator to survey and study the population within which it works. It is likely their findings would be similar to the Council of the District of Columbia, thereby providing one more element in defense of possible litigation.

C. Liability of the Hospital in a Tort Action

Washington Hospital Center utilizes the RORP pursuant to the Organ Preservation Amendment. This statute specifically immunizes the hospital from liability, "in the absence of gross negligence or willful misconduct."[174] Similarly, under the presumed consent statute in the

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170. *See* Cooke-Seals v. District of Columbia et al., 973 F. Supp 184 (D.C. Dist. 1997).

171. *See id.* at 188.

172. *See* Council of the District of Columbia, *supra* note 4. William O. Ritchie, Jr., Ph.D., Director, Office of Decedent Affairs, Washington Hospital Center, testified in support of the legislation and noted that he made presentations throughout the city to survey community response. He found overwhelming support for the proposed Organ Preservation amendment to the Anatomical Gift Act. *See id.* at 4-5.

173. Cooke-Seals v. District of Columbia, et al., 973 F. Supp 184, 188 (D.C.Dist. 1997).

174. D.C. CODE ANN. § 2-1509.1(d) (1998).

District of Columbia,[175] if a person performing the procedure "acts in good faith," he or she is not subject to any civil liability.[176] This immunity clause only protects against negligent action. The tort of intentional infliction of emotional distress is a specific intent action not covered by this immunity clause.

The Organ Preservation Amendment immunity clause is a bit less protective than the M.E. immunity clause. The Organ Preservation immunity clause protects the hospital utilizing organ preservation techniques specified in the statute from the tort of mutilation. While the RORP process likely will not rise to the level of mutilation, even if it did, the hospital would be immune from liability if it followed the statutory provisions.

Though it is unlikely the RORP process could rise to the level of atrocious and intolerable action, the hospital may be liable if it did. This is because the immunity provision of the Organ Preservation statute only immunizes the hospital from negligent action. The tort of intentional infliction of emotional distress results from, by definition, grossly negligent or willful misconduct. Either tort action places a tremendous burden upon the plaintiff.

IV. CONCLUSION

The RORP is essential to increasing the supply of available transplant organs. The nature of the RORP process requires that the time of death be called prior to implementation, thus triggering the end of the decedent's personal constitutional rights. The next of kin's rights to custody and decent burial of the decedent, though deserving of protection, do not rise to the level of procedural or substantive due process evidencing a constitutional tort. Therefore, any remedy a family seeks in reaction to unconsented RORP procedures would be through tortious mutilation or intentional infliction of emotional distress.

Neither of these claims are likely to be successful given the nature of the RORP process. The tort of mutilation requires the body of the decedent to be unfit for burial. This standard requires severe intrusions into the body cavity by hospital personnel. Such intrusions are not required by the RORP process. Therefore, if the RORP process is performed per the Consensus Conference protocol and Washington Hos-

175. *See id.* at § 2-1605(c)(1).

176. *Id.* at § 2-1605(c)(6).

pital Center procedures, mutilation will not occur. The tort of intentional infliction of emotional distress places an extremely high burden on the plaintiff to prove the first element: the RORP process shocks the conscience of those in the community. This standard is almost impossible to reach where the hospital can present evidence of a community survey in majority support of the RORP.

Because a hospital faces little or no liability to the family of the decedent in implementing the RORP process, without removing the organs, each hospital in the nation has an obligation to the health and care of patients in its geographical area to implement the RORP program. It would be unjust to do otherwise.