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THE IMPACT OF ROUTINE INQUIRY LAWS ON ORGAN DONATION

by Kathleen S. Andersen and Daniel M. Fox

Prologue: Health policy making regarding the emotionally charged issue of organ donation has evolved quickly, attempting to keep up with new developments in medical technology. A key policy problem has been how to increase the supply of organs to satisfy the burgeoning demand. One proposal to which U.S. policymakers have been attracted is that of routine inquiry (also called required request). This policy requires hospitals or their designees to ask families of patients and/or potential donors about their wishes concerning organ donation. Routine inquiry laws were enacted first in the states. The federal government, running close behind, adopted the policy in its 1986 Omnibus Budget Reconciliation Act, which supersedes state law. This paper reports survey data that assess the impact of these new state and federal routine inquiry laws on organ donation. Kathleen Andersen and Daniel Fox of the Center for Assessing Health Services at the State University of New York (SUNY) at Stony Brook began their research on routine inquiry at the request of the New York State Department of Health. They assisted the department in preparing its mandated evaluation of the first year of required request in New York. The two researchers moved on from there, asking, “What are the other states doing?” Andersen, a policy analyst at the center for nearly five years, earned a master of public administration degree from Harvard University’s Kennedy School of Government. Fox, who holds a doctorate in history also from Harvard, is professor of humanities in medicine at SUNY-Stony Brook and director of the Center for Assessing Health Services. His research interests also include comparative health systems, chronic disease, and policies regarding another emotionally charged issue: acquired immunodeficiency syndrome (AIDS).
Since July 1985, forty-four states and the District of Columbia have passed routine inquiry laws to increase the supply of organs and tissues for donation. These laws aim to increase the potential donor pool by requiring hospital personnel to request consent of potential candidates or their families for donation, or at least inform people of the option. How effective these laws have been is unknown, since most of the evidence is anecdotal and contradictory.

Until recently, efforts to increase the supply of organs and tissues for transplantation focused mainly on state legislation and regulation. In 1986, however, acting on a recommendation of the national Task Force on Organ Transplantation, Congress required hospitals to establish written protocols to identify potential organ and tissue donors. This legislation supersedes state law but does not prevent states from establishing more stringent requirements.

This article describes the results of a survey conducted during fall 1987 to find out which states have passed routine inquiry laws, how those laws have been implemented, and what their effects on organ procurement have been. The texts of the laws and proposed legislation provided the data for our analysis, supplemented by information obtained through interviews with legislative analysts and representatives of state health departments. We interviewed persons in the Office of Organ Transplantation and the Health Care Financing Administration (HCFA) for information on current federal activity related to routine inquiry protocols.

Following a summary of the origins of routine inquiry laws, the article describes how the states have enacted and implemented routine inquiry laws; how the Uniform Anatomical Gift Act has been amended to include routine inquiry; what actions the federal government has taken to improve organ procurement; and what the relationship between federal and state regulations is likely to be. We conclude with a description of what is known about the effects of the laws in Oregon, New York, and California—three of the earliest states to enact them.

Origins Of Routine Inquiry

Organ donation in this country relies on the concept of encouraged voluntarism. Either the donor must give consent or surviving persons close to the donor must authorize the donation in the absence of a prior decision; consent is not presumed. It is a system of “opting in” rather than “opting out.”

The legal structure of organ donation is state-based and legislative. It is built on the concept that binding organ donation is a creation of state law regulating the disposition of dead bodies in the interest of public health
and safety. Although there has never been a federal organ donation law that covers all states and territories, the Uniform Anatomical Gift Act, promulgated in 1968, provided a model that was modified by each state. By 1973, the Gift Act was enacted in some form in all fifty states. In general, it authorizes an individual to donate all or any part of his or her body, and it specifies who can give consent to donation in the absence of a prior decision by the decedent. To facilitate implementation of the act, many states have adopted statutes that require drivers’ licenses to serve as donor cards, when signed by the holder. However, in 1986 less than 20 percent of the population in any state carried such cards.

Despite its adoption by all states, the act has not increased donations to the extent envisioned. Jeffrey Prottas reported that no organ procurement agency will remove organs solely on the approval of a signed donor card, although its presence may encourage family members to consent to donation. Paul Lee and Paul Kissner argued that the shortcomings of the Gift Act result from the unwillingness of transplant personnel to exploit its provisions fully because of liability concerns and bad publicity, even though the act has been uniformly upheld under litigation.

In the early 1980s, advances in extrarenal transplantation and the large numbers of patients on transplant waiting lists stimulated a reexamination of organ donation policy. Bioethicist Arthur Caplan described a policy of “required request” that could increase donations simply by not overlooking opportunities for requesting consent. He cited public opinion surveys that found strong public support for organ donation, confirmed by the finding that over 60 percent of families gave consent when they were asked. Thus, he argued, if hospitals were required to give families the option to consent to donation, the supply of organs and tissues likely would increase. Unlike policies of presumed consent or marketing of organs, which present a number of ethical problems, required request would restrict voluntarism only for hospitals and health care providers, not for individual prospective donors and their families.

What The States Have Done

The speed with which routine inquiry and required request laws have passed indicates strong state support (Exhibit 1). Exceptions are South Carolina, South Dakota, and Utah, where state legislators considered proposed laws in 1986 and 1987 but failed to pass them. The Vermont legislature considered bills in 1987 and 1988 authorizing hospitals to ask nonemergency patients if they had signed an organ donor card, but the legislation did not pass. Only Idaho and Wyoming have taken no action.

Structure of laws. Although there is agreement about the purpose of
the laws, their structure varies. State laws differ primarily in the degree of hospital monitoring, the extent of health department involvement in implementation via regulations, whether hospitals are required to request donations or only to inform families of the option, and the conditions under which exceptions to the requirement may be made.

Oregon, New York, and California provided models for the states that later passed similar legislation. The laws passed by Oregon and New York are the most alike. Each requires that, in the absence of prior notice of contrary intention, hospital personnel or their designees request consent for anatomical gifts from the families of potential donors. Each request and its outcome must be recorded in the medical record and on the death certificate. New York’s law requires that the hospital also submit a certificate of request with the death certificate. The state health departments are responsible for setting implementation regulations.

In contrast, California’s law requires no involvement by the state health department and specifies no mechanism for recording the out-

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comes of requests for organ and tissue donations. Hospitals are required to inform families of the option to consent to donation, rather than to request consent. The hospital also must notify an organ procurement agency when consent for donation is granted, but it is not required to notify the agency before the family is informed of the option of donation.

The laws passed since 1985 fall into two groups: those that require hospitals to request anatomical gifts (Oregon and New York models); and those that require them to inform families of the option of donation (California model). Twenty-six states and the District of Columbia have required request laws; eighteen others require that hospitals inform families about organ donation. Georgia, Kentucky, and Tennessee do not require hospitals to approach the families. Instead, they are required to notify an organ procurement agency when they identify potential donors.

It is unclear whether the difference between the two types of laws results in distinctly different practice and effects or is merely a difference in language. In some states—Rhode Island, for example—the words “request” and “inform” are both used to describe what the hospitals must do. However, other states may have chosen to require hospitals to “inform” to avoid forcing reluctant hospital employees to ask for organ donations at a time of great emotional stress for the families.

**Health department involvement.** The laws vary in the degree to which they require the involvement of state health departments in implementation and oversight. Like Oregon and New York, sixteen other states require their health departments to establish any rules and regulations necessary to implement the law. Fifteen states require that their health departments establish rules for training hospital employees who are making the requests; ten of these states require that they also establish request procedures. In nine states and the District of Columbia, health departments must establish procedures to facilitate effective coordination among hospitals and procurement agencies.

The regulations that health departments have established usually reflect concerns of hospitals, physicians, and the transplant community. For example, in Illinois, the health department may issue a rule that the need for organs and tissues has been adequately met, and the requirement is suspended. This provision recognizes the hospitals’ concerns that they could be required to request unneeded donations. Pennsylvania’s law allows the health department to make exceptions to the requirement for hospitals that it deems unable to comply. Standards for training the persons who approach the families recognize the importance of careful preparation for handling an often difficult situation. Requirements that health departments help to draw up agreements between hospitals and transplant and organ procurement programs (Louisiana and Ohio, for
example) address coordination problems.

**Record keeping.** Most routine inquiry laws require that hospitals record the outcome of their encounter with the families of potential donors. The record provides both a way to monitor compliance and statistics for possible later evaluation. Twenty states require that the outcome be recorded in the patient’s medical record; six of these require additional documentation on death certificates or certificates of request. New York and Delaware require all three forms of reporting. Michigan requires that hospitals keep a log of requests and submit a report to the health department annually. Sixteen states do not specify record keeping.

Legislation requiring health departments to compile statistical reports or to evaluate the effectiveness of routine inquiry protocols is less common. New York and Nebraska require an initial report on implementation. Michigan, Massachusetts, Tennessee, and New Mexico require annual reports on the number of requests made and organs donated.

**Monitoring compliance.** How compliance will be monitored is rarely specified in the laws. Instead, it is usually part of the regulations adopted for implementation, especially where organ donor identification protocols are made a condition of hospital licensure. While New York has developed a detailed surveillance protocol and elaborate reporting system for monitoring compliance, California does not have a separate mechanism, relying instead on the hospital accreditation survey. Respondents from a number of states noted that surveillance is unnecessary because the hospitals support the legislation and will comply voluntarily. Only Kentucky specifies sanctions for failure to comply: hospitals that do not comply must pay a fine of $100–$500.

**Notification procedures.** Twenty-four of the states require hospitals to notify an organ procurement agency of a potential donor. Because workable agreements between procurement agencies and hospitals are crucial to the effectiveness of an organ procurement system, the absence of this requirement in the law may reduce its effectiveness.

Most states have specified exceptions to the requirement that hospitals request consent for donation or inform families of the option. Almost all laws state that hospital representatives are not required to request consent to donation if there is actual notice of the contrary intention of the decedent. Many allow exceptions if organ donation is contrary to the decedent’s religious beliefs, if approaching the family would cause them undue emotional stress, or if the donation would not be medically suitable and therefore not used.

**Donor cards.** Explicit in some laws, and implicit in those that are amendments to the Uniform Anatomical Gift Act, is the hospital’s exemption from the requirement if the potential donor previously signed a
donor card. However, even with a card, hospitals and procurement agencies rarely will proceed with organ procurement without requesting consent from the family. Thus, the effect of this exemption may be limited.

As the Conference of Commissioners on Uniform State Laws notes in its commentary to the act, discovering who has signed an instrument of donation is a logical first step before requesting consent to donation. By asking admitted patients if they have signed a donor card, the hospital obtains a record of consent to donation and has the opportunity to inform patients of the option in a routine manner. Few states have addressed this type of routine inquiry directly. In 1985, New Jersey enacted such a law, then passed a law in 1987 requiring request for donation. A spokesman in the department of health said that he hoped the earlier law would be repealed because he thought it offended patients. Contrary to action taken by other states, the Vermont legislature in 1987 and 1988 considered but did not pass bills that would authorize hospitals to make inquiries of all nonemergency patients. Hawaii’s 1988 revisions to its anatomical gift act include routine inquiry requirements.

The Revised Uniform Anatomical Gift Act

In August 1987, the National Conference of Commissioners on Uniform State Laws (NCCUSL) drafted a revised Uniform Anatomical Gift Act that incorporates new provisions to address some of the shortcomings of voluntary donation. The revised law was drafted after most states had passed routine inquiry laws and thus did not provide the model that the earlier law did. Even laws adopted by Alaska and Virginia in 1988 did not follow the new model act. Only Hawaii has amended its existing law to incorporate provisions of the new model.

In a preface to the revised model law, the NCCUSL cited a 1985 Hastings Center report on organ transplantation, which stated that the public policy instituted by the act “is not producing a sufficient supply of organs to meet the current or projected demand for them.” The report identified nine inadequacies in the system, including the failure of persons to sign written directives for organ donation, the failure to approach family members systematically, and the failure to obtain adequate informed consent from family members.

The 1987 Gift Act includes provisions on routine inquiry and required request. The routine inquiry provision would require hospitals to ask each patient admitted if he or she is an organ donor, to discuss the option to make an anatomical gift, and to record the patient’s decision in the medical record. The required request provision would require hospitals
to discuss with the family of a dying patient the option of donation if there is no indication of the patient’s decision in the medical record and if the patient is a medically suitable candidate. The hospital would record the outcome of the request in the patient’s medical record and notify the recipient, if known, or an appropriate organ procurement organization. The commissioner of health in each state would be responsible for establishing regulations and/or guidelines for implementation.

The new routine inquiry and required request provisions ensure increased opportunities for requesting consent to anatomical gifts. In addition, they also require emergency personnel to search for information indicating that a person who is dead or near death is a donor.

Federal Government Action

Federal action began with the passage of the National Organ Transplant Act in 1984. This act established a national Task Force on Organ Transplantation to examine “barriers to the improved identification of organ donors and their families and organ recipients.” The task force report of April 1986 recommended that the states that had not already done so adopt routine inquiry laws. It further recommended that the Joint Committee on Accreditation of Healthcare Organizations (JCAHO) require that hospitals have organ procurement protocols as part of their accreditation requirements, that the NCCUSL develop model routine inquiry legislation, and that HCFA require hospitals to have routine inquiry protocols as a condition of participation in Medicare and Medicaid. Although the JCAHO has not adopted the recommendation, the NCCUSL did adopt model legislation in 1987.

Congress, in the Omnibus Budget Reconciliation Act (OBRA) of 1986, amended the conditions of participation to require that hospitals develop routine inquiry protocols. The requirements that hospitals must meet are identical to those of California’s routine inquiry law, which the task force had recommended as a model because it allows the option to grant or deny consent and gives hospital employees the option not to request donations if they are uncomfortable with that action. Hospital employees are required to identify potential donors, provide next-of-kin with opportunities for donation, and refer potential donors to organ procurement agencies.

Medicare/Medicaid participation. On July 31, 1987, HCFA issued proposed rules for the new conditions of participation, with the final rules scheduled to go into effect October 1, 1987. However, implementation was postponed several times. According to a HCFA spokesperson, the delay was caused by requirements of the Gramm-Rudman budget
reduction legislation and by difficulties in completing the regulations to designate organ procurement agencies eligible for Medicare reimbursement. The final rule became effective March 31, 1988 and does not differ from the proposed rule, which states that a hospital may continue to participate in Medicare and Medicaid only if it establishes written protocols to identify potential organ donors that: (1) assure that families of potential donors are made aware that they have an option to donate organs or tissue and an option to decline to donate; (2) encourage discretion and sensitivity with respect to the circumstances, views, and beliefs of the families of potential donors; and (3) require that an organ procurement agency designated by the secretary of health and human services, under 1138(b)(1)(F), be notified of potential donors.\textsuperscript{13}

Compliance with the regulations will be monitored by the state survey agency for Medicare, in most cases the group that reviews the hospital for its JCAHO accreditation. A HCFA spokesperson said that the Medicare reviewers will honor the state’s licensure requirements as long as the hospital meets Medicare’s minimum standards.

While the proposed rules focused on both organ and tissue donors, the final rule states that “except for the requirement that families be aware of their option to donate tissue, the requirements of our regulations do not apply to donated tissues but only to vascular organs.”\textsuperscript{14} This restriction was adopted to avoid imposing a heavy burden on procurement agencies to serve as the contact point for all organ and tissue donations. The organ donor protocols are intended to aid the networks of organ procurement agencies authorized by the 1986 legislation. Hospitals must identify potential donors and then notify the regional organ procurement agencies eligible for Medicare reimbursement. Since tissue banks are not part of the network, tissue donations are not a focus of the federal requirements.

Many of the state laws require hospitals to request consent for donation from all potential donors, tissue as well as solid organ. Some states have more stringent requirements in such provisions as the training of requesters and standards for compliance. According to Linda Sheaffer, director of the Office of Organ Transplantation, the new federal requirements supersede the states’ routine inquiry laws; states, however, may establish more stringent requirements.

States’ responses. Most of the state routine inquiry laws will meet HCFA’s rules. Anticipating the new rules, eight states enacted laws that are identical or very similar to them. Each state would meet the initial requirement—a written protocol. Similarly, they all would meet the requirement that families be informed of the option to donate or to decline donation. How well the state laws would meet the requirement
that hospitals encourage sensitivity in dealing with families depends on the performance criteria HCFA chooses to measure compliance. It is likely, however, that at least the twenty-three laws that require special training for hospital employees who discuss donation with the families would meet the requirement, as would the thirty that allow exceptions to the requirement when there is known opposition by the decedent or family. Notifying an organ procurement agency of a potential donor is a requirement of twenty-three states.

The HCFA regulations would seem to make further action redundant for states without routine inquiry legislation. An attorney with the NCCUSL told us that required request and routine inquiry are now dead issues, both because most states have already passed laws and because HCFA’s regulations will supersede laws with fewer requirements. The model Gift Act legislation the NCCUSL adopted in August 1987, however, incorporated the HCFA requirements and could be used by states wishing to adopt more comprehensive organ donation laws.

That HCFA regulations were forthcoming did not deter some states from introducing routine inquiry legislation. Alaska passed a law in 1988 that requires hospitals to request consent for anatomical gifts, and to coordinate recoveries with tissue banks, eye banks, and procurement agencies. A legislative analyst there reported strong support for the bill, even though the closest organ transplant program is in Seattle. He was unaware of the proposed Medicare requirements.

Virginia also adopted legislation in spite of the Medicare regulations. In 1985, as part of its authorization act for hospital licensure regulations, Virginia required hospitals to establish protocols for organ procurement. In 1987, according to a representative of the department of health, a legislative study group recommended that Virginia enact a more stringent routine inquiry law. Our respondent said that the 1985 regulation was intended to warn hospitals and physicians of interest in establishing routine inquiry protocols. However, it has not succeeded in increasing donations. When asked why Virginia would introduce routine inquiry legislation once the Medicare regulations are implemented, he responded that a strong state law is needed to ensure compliance by physicians, many of whom have opposed routine inquiry. The legislature passed a stronger routine inquiry amendment in March 1988. In keeping with recommendations of the Virginia Transplant Council and hospital association, the law requires hospitals to establish protocols for offering families of potential organ and tissue donors the opportunity for donation.

Hawaii adopted an expanded anatomical gift act in 1988 that incorporated the changes recommended by the NCCUSL. The rationale given in the conference committee report for the amendment is that the
changes would improve existing law and aid the state’s effort to increase the supply of organ and tissue donations. No mention is made of the HCFA regulations.

The federal organ procurement protocol regulations have met with little opposition, mainly because they duplicate action already taken by the states. In only a few states will hospitals have to adopt written protocols solely as a result of the HCFA regulations. The regulations are less comprehensive than many states’ laws, especially concerning identification of tissue donors. While the federal regulations establish a minimum routine inquiry requirement in all states, the largest effects on organ procurement may come from the tougher state laws.

**Initial Effects Of Routine Inquiry Laws**

Data about the effects of the routine inquiry laws are difficult to obtain because of the short time the laws have been in place and the limitations of the states’ reporting systems. To assess the initial effects of routine inquiry, we looked at what has happened in New York, Oregon, and California, the states that first implemented the laws.

New York has the most information available because its law required the state health department to report to the legislature on the effects of the required request law by July 1987. In 1986, heart donations increased by 94 percent, livers by 96 percent, and kidneys by 23 percent. There was a 58 percent increase in eye donors.¹⁵

The Oregon Organ Donor Program, a consortium of the procurement agencies, reported that following implementation of the law on February 1, 1986, the number of eyes donated doubled “almost overnight,” and that rate continued into 1987. There was also a 20–25 percent increase in donations of bone and skin. Donations of kidneys, however, decreased in 1986, increasing during the first three quarters of 1986 but then declining during the last quarter because of an unexplained drop in mortality. During 1987, kidney donations went up 12 percent. Although there was some increase in donations of extrarenal organs, the consortium’s spokesperson said that it is difficult to attribute the increase to the routine inquiry law alone, because the addition of new extrarenal transplant programs in the region may have been a factor. The Oregon Organ Donor Program began a pilot study in August 1987 to obtain better information about the effects of the law.

Organ procurement agencies in Los Angeles and San Francisco reported findings similar to Oregon’s. The director of the Regional Organ Procurement Agency in Los Angeles stated that during the first year of routine inquiry the number of referrals increased, but the number of
donors stayed about the same. In 1987, local referral calls dropped by over 500. He cited a decline in the number of trauma deaths as a possible explanation. However, he also thought that the procurement agency may be losing referrals because hospital representatives are not approaching the families at the right time or in a manner likely to result in consent for donation. He encourages the hospitals affiliated with his procurement agency to call for assistance rather than approach the families themselves. Finally, he suggested that public education may have a greater effect in increasing donations than the routine inquiry requirement.

The procurement agency at the University of California-San Francisco Medical Center also has not seen large increases in donations. As in Oregon, some of the increases may be due to other factors, such as better donor management and the opening of more transplant centers in the area. The staff member interviewed cited problems with data accuracy and the lack of a formal study as reasons for the difficulty in evaluating routine inquiry. The lack of a mechanism for monitoring compliance is also a problem, but one that may be partially alleviated when the Medicare regulations go into effect. She also stressed the need for better training of hospital representatives and increased education of the public.

Although New York has enjoyed the largest increases in donations, it also has had a number of implementation problems, most notably with cumbersome reporting requirements. The health department concluded that the certificate of request form that hospitals were required to complete and attach to the death certificate whenever a request for donation was made has not worked. Health department staff discovered that the small number of forms returned was due in part to funeral directors who, finding the unfamiliar form attached to the death certificate, simply threw it away. The department recommended that the form be eliminated, since surveillance and documentation could be accomplished through other means. However, at the same time that New York was trying to eliminate the certificate of request, New Jersey was enacting a routine inquiry law that made it a reporting requirement.

Oregon also noted problems with reporting requirements. The disposition of the request is supposed to be recorded on the death certificate, but because the death certificate is completed by funeral directors who do not know what happened, the system does not work. During the 1987 legislative session, a move to change the requirement failed to pass. The proposal was supported not only by the funeral directors but also by the eye banks, which rely heavily on the good will of funeral directors.

Compliance with the laws in the three states is generally reported to be good. In New York, the health department’s hospital surveillance program has monitored implementation of the regulations through hospital
surveys conducted from January to May 1987. The survey of 150 hospitals (about two-thirds of the total) found that all but twenty hospitals had implemented protocols. Oregon reported problems with very small rural hospitals. A staff member in the health department’s bureau of health facilities said that compliance is monitored through what he called a “nonmonitoring” system, adding that in a small state one does not need to coerce people to comply, especially with a requirement that is perceived as good policy. Neither is there a formal monitoring system in place in California. A respondent in the health department’s licensing division said that the only monitoring they would do would be to review a copy of the protocol at the time of the hospital’s accreditation survey. Two years after implementation, no monitoring had begun.

Conclusions

Routine inquiry legislation has had a brief and inconclusive history. Rarely has a policy been embraced so quickly by the states and then been almost immediately federalized. Part of the explanation for the popularity of routine inquiry may have been that it is exhortation rather than regulation; it encourages action that cannot easily be monitored, much less evaluated. Whether routine inquiry remains a symbol of the moral resolve of the states and the nation or is a first step in the direction of a more stringent standard—presumed consent to donation—remains to be seen. For the present, we can only observe that there is a national consensus that the opportunity to donate organs should not be thwarted by presumptions about the feelings of survivors.

By itself, routine inquiry is not likely to affect significantly the supply of organs after early attention by the media. Moreover, we know very little about the results of increased supply. Future research should examine the outcomes of organ transplant policy and the effectiveness of the systems through which it operates. Research to date has focused instead mainly on the adequacy of elements of the process; for example, the effectiveness of hospital-based as opposed to independent organ procurement organizations. Our evaluation of routine inquiry is yet another evaluation of process. We need to know much more about the results of recent changes in policy that are intended to make transplantation more available, efficient, and equitable. Only then will it be possible to debate rationally how much ought to be allocated for these procedures.
NOTES

1. Forty-four states and the District of Columbia had passed these laws as of September 1988. In descriptions of these laws, the terms “routine inquiry” and “required request” are sometimes used interchangeably. Routine inquiry usually refers to laws that require hospitals to ask patients if they have signed a donor card and to record that information in their medical record, and/or to inform the families of deceased patients of their option to consent to donation. Required request is a narrower term, usually referring only to those laws that require hospitals to request consent to donation.

2. We gathered data for New York at the request of the State Health Department for their legislatively mandated study of the law’s implementation.


7. Caplan, “Requests, Gifts, and Obligations.”

8. While we were conducting the research for this article, the Office of Organ Transplantation, Department of Health and Human Services, contracted with Maximus for an “Evaluation of Methods Used by States to Expand the Number of Organ and Tissue Donors” (April 1988). We reviewed the executive summary after this article had been submitted for publication. They reviewed much of the same data we did and had similar findings about the implementation of routine inquiry. There are some minor discrepancies in the numbers in both studies, because of differences in definition and in stages of implementation when the two studies were conducted.


12. Ibid.


16. Ibid.