

Alberta's New Organ and Tissue Donation Law: The Human Tissue and Organ Donation Act

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In 2006, Alberta passed new legislation concerning donation of human organs and tissues. According to the Government of Alberta, the intent of the legislation is to “broaden the scope of and modernize” Alberta’s 33-year-old legislation, the *Human Tissue Gift Act*.¹ In introducing the Bill to the Alberta Legislature, MLA Dave Rodney outlined a number of modifications that will flow from the new statute. These include the following: changes to definitions within the legislation (aimed at both modernizing the terminology and to reflect some of the other changes to the HTGA); provisions that permit living donation by minors in some circumstances; the creation of independent assessment committees designed to protect the interests of minors who are living donors; changes to consent requirements; provisions directing mandatory consideration for donation; provisions respecting quality assurance mechanisms, including registries of personnel and facilities; specific provisions respecting confidentiality of health information; and changes to fines for contraventions of the *Act*.

The *Human Tissue and Organ Donation Act*² was proclaimed into force on August 1, 2009. While some of the modifications made by the *Act* are quite minor, some have the potential to effect broader change in human organ and tissue donation practice. Will the *Act* achieve its aims? Are we in for significant change on the organ and tissue donation front?

In this brief article, I examine the salient aspects of the *Human Tissue and Organ Donation Act*. First, I discuss the changes that relate to cadaveric donation, including consent and mandatory consideration for donation. Second, I focus on the changes related to living donation, including donation by minors and independent assessment committees. Finally, I consider modifications that are relevant to both cadaveric and living donation: quality assurance / registry, confidentiality, and fines for contravention of the *Act*.

1. Deceased donors

Consent and Organ Supply

A perennial and well-documented problem in organ transplantation is the fact that need for organs far outpaces the supply of organs available for transplantation. In 2008, 4,380 Canadians were awaiting transplants, and 215 died while waiting.³ Although statistics on tissue donation are not kept in a similar manner, recent research suggests a significant (and growing) unmet demand.⁴ Governments seem to continually look for ways to increase the supply of organs, and often zero in on law and practice around consent as a perceived barrier to increased participation in organ donation programs.⁵ Alberta’s new law is no exception in this respect, in that a clearly articulated aim of the government in advancing the new legislation was to “strengthen the donation program” by ensuring that the wishes of a deceased potential donor in favour



of donation will be honored, even where those wishes conflict with the express desires of the next of kin. According to Dave Rodney, the notion that the consent of the potential donor should take precedence over any conflicting wishes of the family “represents a change in current practice. Clinicians generally require consent from next of kin even when the known wishes of the deceased were indicated by a donor card or other document.”

Mr. Rodney is quite correct that current practice does not respect the consent of a deceased potential donor if the next of kin does not also provide consent for organ donation. Most human organ procurement agencies take the view that donor consent, on its own, is not sufficient to permit the removal of organs from a potential donor’s body.⁶ But it is questionable whether a change to the legislation was needed in order to permit agencies (such as HOPE, the Human Organ Procurement Exchange agency in Alberta) to rely on the deceased’s signed donor card.

Section 4 of the HTGA provides:

- 4(1) Any adult person may consent,
- (a) in a writing signed by the person at any time, or
 - (b) orally in the presence of at least 2 witnesses during the person’s last illness, that the person’s body or the part or parts of it specified in the consent be used after the person’s death for therapeutic purposes, medical education or scientific research.

...

(3) On the death of a person who has given a consent under this section, **the consent is binding and is full authority for the use of the body or the removal and use of the specified part or parts for the purpose specified**, except that no person shall act on a consent given under this section if that person has reason to believe that it was subsequently withdrawn. [emphasis added].

The new legislation, section 9 of the HTODA, provides as follows:

- 9(1) A consent required by this Act must be
- (a) in writing,
 - (b) dated, and

- (c) signed
- (i) by the consentor and a witness, or
- (ii) if a consentor cannot sign for any reason, by 2 persons who witnessed the agreement to the donation by the consentor.

...

- (3) A consent on the form provided on a certificate of registration issued under the Health Insurance Premiums Act is valid notwithstanding that it is not dated.

The new legislation obviously provides more explicitly for the validity of a potential donor’s consent where that consent is manifested as a signed organ donor card (the back of the Alberta Health Insurance premiums card). However, section 4 of the old *Act* said much the same thing, albeit in slightly less direct language. Looking at the two sections side-by-side, it is difficult to conclude that the new statutory language will lead to a change in current consent practice.

Given the clear language in the HTGA specifying that a donor’s consent is binding and provides full authority for the removal and use of organs, together with the language of section 4(1), which plainly states that a consent is valid if provided in writing and signed by the deceased person, why are procurement agencies reluctant to rely on donor consent? There are several factors that might contribute to this unwillingness to act on a donor’s wishes in the absence of further consent by the donor’s next of kin – legal uncertainty, concern for the family, and worries about the public perception of organ procurement programs.⁷

Several legal considerations lead to the uncertainty expressed by those involved in organ transplantation programs. First, while it has long been held at common law that there is no property in a dead body,⁸ families (or the executor of the deceased’s estate) have traditionally been understood to have property-like interests in the body of the deceased.⁹ The scope of these rights is limited, but families do have possessory rights of control, as well as duties respecting dead bodies. There are also *Criminal Code* provisions prohibiting interference with and mutilation of dead bodies.¹⁰

These legal mechanisms have never been engaged in the context of organ retrieval for purposes of transplantation, but nevertheless might be viewed



as a potential threat by those involved in transplant programs. The likelihood of any member of a transplant society or organ procurement agency being held liable in a lawsuit brought by the family or next of kin of a deceased donor who has signed an organ donor card is extremely low.¹¹ And the risk of a participant in organ or tissue retrieval being convicted of an offence under s. 182 of the *Criminal Code* is nil. But the very idea of a lawsuit or possible charge might be enough to chill the practice of actually relying on donor consent, instead of seeking consent from the donor's family.

It is important not to lose sight of the influence exerted by factors unrelated to consent law on donation rates. Demographics and mortality rate play an important role in numbers of organs and tissues available for transplantation.

Aside from these general legal considerations, it seems quite clear that at least some organ procurement professionals are uncertain about the law, in light of comments made at two workshops I attended in February and March 2009.¹² I was asked to speak about consent to organ and tissue donation, and I discussed both the old and the new legislation in the course of this presentation. Both workshops included members of HOPE and the Comprehensive Tissue Centre (CTC). And, at both workshops, the same comment was made (each time by a member of HOPE) that it was their understanding that once a potential donor has died, the donor's consent ceases to have any legal effect. The view of the HOPE participants was that they have no legal protection in relying on a consent form signed by a deceased potential donor.

Another workshop participant, a member of the CTC, noted that her understanding of consent policy at the CTC was that, while a potential donor could be approached respecting possible tissue donation after death, and could be informed as to possible uses of tissue, procedures involved in tissue donation and the

like, actual consent must be obtained from the donor's next of kin after the donor's death.

These misapprehensions as to the validity of consent obtained from a donor, prior to the donor's death, are difficult to reconcile with the statutory language and suggest the need for further legal education for the public generally, but also an urgent need for such training for members of organ and tissue procurement agencies in particular.¹³ Indeed, given the apparently well entrenched misunderstanding about the continuing validity of consent, it seems that the government's express aim of clarifying the consent rules respecting organ donation will be frustrated without a robust educational initiative to accompany the new legislation.

Factors other than uncertainty about the law also lead to the practice of obtaining consent from a potential donor's next of kin, even where the donor has provided consent. Organ and tissue procurement agencies are concerned about the feelings of the families of potential donors, and are hesitant to proceed in absence of next-of-kin consent for that reason, even though they recognize that the legislation would permit them to do so.¹⁴ One practical reason for the reluctance to proceed absent next-of-kin consent is the need for the deceased's medical and social history for purposes of determining the safety of transplanting his or her organs or tissues. Without cooperation from the deceased's family, it would be all but impossible to obtain such information in a timely fashion. In addition, the perception that families need not be included in the decision-making process may lead to reluctance to support the work of organ and tissue procurement agencies, and broad public support is essential to the success of transplantation programs.

As noted above, the need for consent (or the mechanism by which consent is obtained) is often perceived as a barrier to increasing the availability of organs and tissues for transplantation. It is not at all clear, however, that the form of consent system in place in a particular jurisdiction plays a major role in the number of organs and tissues available for transplantation. In part, this may result from the fact that consent practice departs somewhat from the strict legal rules in place.¹⁵ Janssen and Gevers have noted that comparing "presumed consent" and "explicit consent" systems can be misleading if actual consent practice is not accounted for. Their study of 10 European jurisdictions demonstrates that the distinction between these two consent systems is less significant



than might be assumed, because regardless of the law on the books, in practice, relatives of the deceased are almost always consulted before organs are procured.¹⁶

It is also important not to lose sight of the influence exerted by factors unrelated to consent law on donation rates. Demographics and mortality rate play an important role in numbers of organs and tissues available for transplantation.¹⁷ Moreover, statistical comparisons around donation rates are not always useful due to different approaches used in calculating donation rates.¹⁸

Mandatory consideration for donation

Section 7 of the HTODA is a completely new provision that speaks to mandatory consideration for donation. The section requires the medical practitioner who determines that a person has died to “consider and document in the patient record the medical suitability of the deceased person’s tissue or organs for transplantation.”¹⁹ As in the case with the consent provisions in the new legislation, the express purpose of this section of the *Act* is, according to MLA Dave Rodney, “to significantly increase the conversion of potential donors into actual donors.”²⁰

The remainder of section 7 provides that if the medical practitioner determines that the tissue or organs of the deceased may be suitable for donation, he or she must notify a donation agency. In turn, the donation agency must seek consent for donation from the deceased’s next of kin under s.4(2) (and document its efforts to do so), unless it determines that the deceased is a medically unsuitable donor. Section 7(4) states that the donation agency “shall not” seek consent to donation if the medical practitioner has already done so, if the medical practitioner advises that he or she has personal knowledge that the deceased would have refused to consent, or if a consent has already been given.

Discussion with one physician who works in both the emergency and intensive care context suggests that current practice is for physicians to raise the topic of organ donation with the family of a potential donor, and if the family expresses interest in further considering or discussing organ donation, the physician will contact the relevant procurement agency.²¹ Assuming this is typical of physicians who work in the emergency room and the ICU,²² the mandatory referral provision will demand a change in practice. There is no reason why

physicians would not still be able to approach the family and raise the issue of organ and tissue donation, but even if the family is opposed to donation, the physician remains under an obligation to inform HOPE or the CTC if the potential donor is medically suitable. Given the circumstances in which discussions about organ and tissue donation take place, this new reality will require careful navigation and close collaboration between physicians and procurement agencies.

It remains to be seen whether, even if practice does change, there will be a manifest difference in the number of organ and tissue donations as a result. There is little literature on point. This may be a result of the variety of legislative methods employed, or it may simply reflect the multi-factorial nature of decision-making around consent to organ and tissue donation.²³ Different Canadian jurisdictions have used a variety of approaches ultimately aimed at increasing the number of organs and tissues available for donation. Some have adopted a “mandatory reporting” regime, where health care providers or facilities are required to notify a procurement agency that an individual has died (some of these statutes also refer to notification of imminent death).²⁴ Other jurisdictions use a “required request” approach, where health care providers are obliged to raise the issue of organ donation with the deceased’s family;²⁵ some provinces also use these two approaches in combination.²⁶

Ontario’s legislative provisions (referred to by the Trillium Gift of Life Network as “routine notification and request” or RNR) came into force in January 2006. The Network notes on its website that in the first seven months of 2006, when the RNR approach was actively used in the critical care and emergency departments of 13 Ontario hospitals, “[r]eferral calls to TGLN ... increased by 200% (from 1181 to 3552), tissue donors increased by 123% (from 218 to 495), and organ donors ... increased by 5% (from 86-90) compared to the same period [in 2005].”²⁷ It is unclear whether this increase in donation rates has been maintained over the longer-term.

As noted above, there is little published literature as to the long-term effects of this legislative approach.²⁸ Any attempt to predict what effect section 7 of the HTODA might have is made more difficult in view of the fact that Alberta’s legislation varies slightly from that in place in other Canadian jurisdictions. The *Act* does not mandate notification – what it requires is that



the medical practitioner who determines death must *consider* whether the deceased is a medically suitable potential donor. Only if the physician determines that the individual is medically suitable is he/ she required to notify a procurement agency and in that case, the required request provision (s. 7(4)) is engaged. It is not easy to foresee whether, and if so, to what extent, the additional discretion afforded by the HTODA will affect the provision's impact on donation rates.

One thing is certain, and that is the need for a collaborative approach between health care providers and government, as well as educational initiatives by government to ensure that Alberta physicians and related health care providers are aware of the mandatory consideration provision. At the date of publication, there have been no educational initiatives related to the new legal obligations created by the Act, although work to develop communications for relevant stakeholders and organizations is ongoing.²⁹

2. Living organ donation

The HTGA permits living tissue and organ transplants. The *Act* states that a living transplant may be done only in accordance with the Act, and the sole provision concerning living donation in the legislation discusses consent. Section 3(1) provides that "any adult person who is mentally competent to consent and is able to make a free and informed decision" may provide consent, in writing, for removal of tissue or organ from his or her living body. The *Act* further specifies that an agent named in a personal directive may consent to living organ or tissue donation if the directive gives the agent authority to consent.

The HTODA offers a great deal more detail around living donation. First, the *Act* permits donation of "by-products" (defined as "tissue or an organ that is a waste product of a medical procedure"³⁰), tissues³¹ or organs.³² An adult may donate by-products, tissues or organs, provided that consent is given, or, if the adult lacks capacity, where consent is provided by a duly authorized agent under a personal directive or a court-appointed guardian who has the authority to consent on the basis of the court order appointing him or her.³³

In addition, minors can now donate tissues or organs in some (fairly carefully circumscribed) circumstances. Section 5(2) provides that a minor's tissues or organs can

be donated if the donation is approved by an independent assessment committee and a guardian provides consent to the donation. The role of the independent assessment committee is to ensure that: the minor (to the extent possible considering his or her age) agrees to the donation without coercion and understands the nature and consequences of the donation; that only regenerative tissues or organs are to be donated if the minor is under sixteen years of age; that the donation process poses a minimal risk to the minor; and that all adult members of the recipient's immediate family have been eliminated as potential donors. A minor aged sixteen or older³⁴ can consent to donation of by-products, and a guardian can consent to the donation of by-products if the minor is younger than sixteen.

Few other Canadian jurisdictions legislatively permit living organ or tissue donation by minors, and there are certainly reasons to be concerned about the practice of living donation by this group.

Few other Canadian jurisdictions legislatively permit living organ or tissue donation by minors,³⁵ and there are certainly reasons to be concerned about the practice of living donation by this group. The provision for independent assessment and the restrictions around age and type of tissues / organs that may be donated reflects a degree of caution. The government appears to be attempting to strike a balance between allowing minors to participate in organ and tissue donation, while at the same time safeguarding the interests of a vulnerable population. It is likely that minors will act as living donors only in exceptional circumstances.³⁶

On the broader question of consent to living organ donation, as Downie, Shea and Rajotte have noted, human tissue and organ donation legislation has in the past required that a living donor be able to provide a "free and informed consent", while all that is required in the case of a deceased donor is that consent has been provided.³⁷ It is interesting to note that in Alberta's new legislation, the language of "free and informed consent" has been removed from the section outlining the rules



around consent in the context of living donation. The *Act* defines “consent”³⁸ as “consent given for a donation that meets the requirements of section 9,” and section 9 contains no reference to the need for voluntary or informed consent. Section 8 of the *Act* notes that “a consent given in accordance with this *Act* is binding” and authorizes examination by a medical practitioner in order to ensure that the donated tissues or organs are medically acceptable for purposes of donation, as well as the removal and use of the specified tissues or organs for the purposes specified. Section 8(3) does state that a person is not to act on a consent if he or she has personal knowledge that the donor objected to the donation,³⁹ but there is no wording anywhere in the *Act* to suggest that consent means “informed consent”. It is unclear whether there is a reason for the removal of the reference to informed or voluntary consent, but it would be very surprising if any court asked to interpret the legislation did not import the notion of free and informed consent when elaborating on the consent requirement.

3. Other changes in the HTODA

Quality Assurance

The HGTA does not contain any provisions respecting quality assurance mechanisms. The HTODA does contain such a provision, which prohibits the performance of transplantation by anyone who is not registered in accordance with the *Act*, and requires that all transplantation procedures take place in a surgical facility that is similarly registered.⁴⁰ This section of the *Act* is not yet in force.⁴¹

Confidentiality

Section 12 of the HTODA provides that information may be collected, used and disclosed for purposes of assessing a potential donor’s suitability, to use or obtain a donation, or to assess medical suitability of a deceased person as a potential donor. Section 12(2) provides that no person shall disclose any information from which the identity of a donor, potential donor or transplant recipient could be identified, and a person who does disclose such information could be subject to a fine of up to \$50,000.⁴² Section 12(3) sets out exceptions to the prohibition on disclosure of identifying information – such information can be disclosed where it is permitted or mandated by a court order or where disclosure has been agreed to in writing.

The HTGA does not have a section dealing specifically with confidentiality of information, and the government’s purpose in including a section on confidentiality in the new legislation is to align the HTODA with provincial privacy legislation.⁴³ Clearly, there is a need for collection, use and disclosure of personal health information in the context of organ and tissue donation, and it is not surprising to see a confidentiality section in such legislation now, when privacy concerns – particularly in relation to the confidentiality of health information – have become so significant to the public.

There is no wording anywhere in the Act to suggest that consent means “informed consent”. It is unclear whether there is a reason for the removal of the reference to informed or voluntary consent.

Offences / fines for non-compliance

In addition to the above-noted fine for a breach of the confidentiality provisions of the HTODA, section 13 sets out the following penalties for contraventions of the *Act*. The default fine for a knowing breach of the *Act* is (at most) \$10,000. There is a far higher fine, as well as the possibility of a term of imprisonment, for a breach of section 3(2) of the *Act* (the section that prohibits the sale of or trade in tissues, organs or bodies. A breach of section 3(2) can potentially lead to a fine of up to \$100,000.00 and / or imprisonment for up to 6 months.

The HGTA provided for a maximum fine of \$1000 and up to 6 months imprisonment for contravening the *Act*. In drafting the HTODA, the government was concerned with putting in place a fine that would serve as a deterrent to breaching the *Act*. In the context of buying and selling organs, tissues or bodies for purposes of transplantation, medical education or scientific research, the government noted that the objective of such activity is financial gain and that a significant fine must be put in place in order to be a real deterrent.

Although the question of the ethics of a commercial market of organs and tissues remains a live one,⁴⁴ it is



not surprising to see the Alberta government stay the course and continue to disapprove of and prohibit the purchase and sale of organs.

Conclusion

The Government of Alberta has undertaken some much needed work on human organ and tissue donation law in the province. It is clear from statements made during legislative debates on the new legislation that some of these changes are aimed at increasing organ and tissue procurement rates. While this is no doubt a worthwhile objective, it is legitimate to question whether the new legislation will lead either to real change in organ and tissue donation practice or to an increase in organs and tissues available for transplantation. The available evidence does not seem to support the Government's claim that mandatory consideration for donation will lead to a marked increase in the rate of conversion from potential to actual donor. And, although current legislation makes it clear that consent provided by a donor prior to death is binding and gives health care teams full authority to remove and use organs or tissues as specified in the consent, procurement practice does not treat such consent as adequate for purposes of organ donation. Arguably, much more needs to change than simply the statutory language before we will see real change in donation rates.

A related question in terms of consent to organ and tissue donation is that of respecting the autonomy of potential donors. A full discussion of autonomy and its importance in health law and bioethics is beyond the scope of this brief article. It nevertheless bears mention here that although organ and tissue donation legislation inclines in favour of donor autonomy, current practice does not reinforce this aim. Further consideration of this disjunction between theory and practice, as it were, is worthwhile and should be a focus of future work.

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Please note: This article has been peer reviewed prior to publication. The *Health Law Review* is not always a peer reviewed publication but considers the peer review process on request or as part of special issues.

Endnotes

- 1 *Human Tissue Gift Act*, R.S.A. 2000, c. H-15 [HTGA].
- 2 *Human Tissue and Organ Donation Act*, S.A. 2006, c.H-14.5 [HTODA].
- 3 Canadian Organ Replacement Register, Canadian Institute for Health Information, e-Statistics Report on Transplant, Waiting List and Donor Statistics, online: Canadian Institute for Health Information <http://www.cihi.ca/cihiweb/dispPage.jsp?cw_page=reports_corrstats2008_e>.
- 4 In a report prepared by the Canadian Institute for Health Information for the Canadian Council for Donation and Transplantation (CCDT) in 2003, the authors projected a predicted annual shortfall of allograft tissue of anywhere from 23,713 – 51,369 tissues, meaning a shortfall of between 69%-83% of total projected demand: Canadian Council for Donation and Transplantation, *Demand for Human Allograft Tissue in Canada: Final Report* (Canadian Institute for Health Information: Ottawa, May 2003) at 3, online: Council Canadian Council for Donation and Transplantation <<http://www.ccdt.ca/english/publications/final-pdfs/Demand-Allograft.pdf>>. See also Jonathan R. T. Lakey, Mohammadreza Mirbolooki, Christina Rogers & Jim Mohr, "Demand for allograft tissue in Canada" (2007) 8 Cell Tissue Banking 31.
- 5 It is questionable, however, to what extent consent law affects donation rates. See Anke Janssen & Sjeef Gevers, "Explicit or Presumed Consent and Organ Donation Post-Mortem: Does it Matter?" (2005) 24 *Medicine and Law* 575.
- 6 Janssen & Gevers, *ibid.*; J. Downie, A. Shea & C. Rajotte, "Family Override of Valid Donor Consent to Postmortem Donation: Issues in Law and Practice" (2008) 40 *Transplantation Proceedings* 1255.
- 7 Downie, Shea & Rajotte, *ibid.*; Janssen & Gevers, *supra* note 5.



- 8 Bernard M. Dickens, "Who Legally Owns and Controls Human Organs After Procurement?" in Walter Land & John B. Dossetor, eds., *Organ Replacement Therapy: Ethics, Justice Commerce* (Berlin: Springer-Verlag, 1991) 385; Daniel Sperling, *Posthumous Interests: Legal and Ethical Perspectives* (Cambridge: Cambridge University Press, 2008).
- 9 *Ibid.*
- 10 Section 182(b) of the *Criminal Code*, R.S.C. 1985, c. C-46 provides that:
Every one who ...
(b) improperly or indecently interferes with or offers any indignity to a dead human body or human remains, whether buried or not, is guilty of an indictable offence and liable to imprisonment for a term not exceeding five years.
- 11 Both the *Human Tissue Gift Act* and the *Human Tissue and Organ Donation Act* exclude civil liability for actions taken in good faith pursuant to the legislation (s. 9, HTGA and s. 11, HTODA).
- 12 The workshops were organized by the Quality Assurance, Information Services and Education division of the Transplant Services Department of the Capital Health Region (now subsumed within Alberta Health Services).
- 13 There is other evidence that the legal validity of consent to organ donation is not well understood either by the general public or by health care providers. See Canadian Council for Donation and Transplantation, "Health Professional Awareness and Attitudes on Organ and Tissue Donation and Transplantation Including Donation after Cardiocirculatory Death" (August 2006), online: Canadian Council for Donation and Transplantation <<http://www.ccdt.ca/english/publications/surveys-pdfs/Survey-Health-Prof.pdf>>. The results of this survey reveal that 69% of health professionals surveyed believed that the wishes of the family would take precedence over the wishes of the deceased potential donor, where a conflict arises. When asked what *should* happen in the event of such a conflict, 80% believed that the wishes of the potential donor should be respected even where the family does not agree. In a similar survey of the public, 64% of those surveyed indicated that they believe that, in practice, the wishes of the deceased individual would be followed where a donor card is signed but the donor's family does not wish donation to go ahead, while 29% believed that the family's views would determine whether or not donation takes place. When asked what should happen in such circumstances, 89% believed that the deceased's wishes should be respected over those of the family: Canadian Council for Donation and Transplantation, "Public Awareness and Attitudes on Organ and Tissue Donation and Transplantation Including Donation After Cardiac Death: Final Report" (December 2005), online: Canadian Council for Donation and Transplantation <http://www.ccdt.ca/english/publications/surveys-pdfs/Public_Survey_Final_Report.pdf>.
- 14 Personal communication, Mike Bentley, Supervisor, Comprehensive Tissue Centre and Islet Lab, Transplant Services, Alberta Health Services.
- 15 See Sjef Gevers, Anke Janssen & Roland Friele, "Consent Systems for Post-Mortem Organ Donation in Europe" (2004) 11 *European Journal of Health Law* 175, where the authors note families often play a different role in practice than that envisaged in legislation.
- 16 Janssen & Gevers, *supra* note 5 at 580-82.
- 17 For example, Canadians die in road accidents far less frequently than do Spanish or American residents. See, e.g., Sonya Norris, *Organ Donation and Transplantation in Canada*, Revised 25 June 2009, online: Library of Parliament <<http://www.parl.gc.ca/information/library/PRBpubs/prb0824-e.pdf>>.
- 18 *Ibid.* Norris also notes that different countries define "donor" differently, with some including those who would be characterized as a "potential donor" (rather than an "actual donor") in Canada. Only actual donors are included in calculations of "donor rate" in Canada.
- 19 Section 7(1).
- 20 Alberta, Legislative Assembly, *Hansard*, (25 April 2006) at p. 1050.
- 21 This also seems to be the position of the Canadian Critical Care Society. See Canadian Critical Care Society, *CCCS Position Paper on Organ and Tissue Donation*, Executive Summary (2001) at 7, available online: <<http://www.canadiancriticalcare.org>>; Graeme M. Rocker and The Canadian Critical Care Society Working Group on Organ and Tissue Donation, "Organ and tissue donation in the intensive care unit" (2002) 167 *CMAJ* 1248.
- 22 And this assumption may well be inaccurate. I have not seen any data reflecting typical practice of physicians in respect to organ and tissue donation; it is unlikely that this is tracked or that



- it could be tracked in a meaningful way. Dr. Jim Kutsogiannis, Physician Coordinator for HOPE in Northern Alberta, is currently reviewing charts with a view to ascertaining how often families are asked about tissue donation when a loved one dies. To date, he has reviewed approximately 80 charts in the Edmonton area, and has found that such an approach to family has been documented in only two or three of the charts he has reviewed.
- 23 M. Sque, T. Long & S. Payne, "Organ Donation: Key Factors Influencing Families' Decision-Making" (2005) 37 *Transplantation Proceedings* 543. See also: Carmen Radecki Breikopf, "Attitudes, beliefs and behaviors surrounding organ donation among Hispanic women" (2009) 14 *Current Opinion in Organ Transplantation* 191; Richard S. Kurz *et al.*, "Factors Influencing Organ Donation Decisions by African Americans: A Review of the Literature" (2007) 64 *Medical Care Research and Review* 475; and James R. Rodrigue, Danielle L. Cornell & Richard J. Howard, "Pediatric Organ Donation: What Factors Most Influence Parents' Donation Decisions?" (2008) 9 *Pediatric Critical Care Medicine* 180.
 - 24 British Columbia: *Human Tissue Gift Act*, R.S.B.C. 1996, c. 211, s. 15, Consent to Donation Regulation, B.C. Reg 65/99, s. 3; Manitoba: *The Human Tissue Gift Act*, C.C.S.M. c. H180, ss. 4 - 4.2; Ontario: *Trillium Gift of Life Network Act*, R.S.O. 1990, c. H.20, ss. 8.1 - 8.6.
 - 25 Manitoba: *The Human Tissue Gift Act*, *ibid.*, Ontario: *Trillium Gift of Life Network Act*, *ibid.* (although the language of the Ontario legislation is slightly different than that in these other jurisdictions, the *Act* speaks of "routine notification and request" as part of the legislation); New Brunswick: *Human Tissue Gift Act*, S.N.B. 2004, c. H-12.5, s. 8(1)-(4); Nova Scotia: *Human Tissue Gift Act*, R.S.N.S. 1989, c. 215, s. 6A.
 - 26 See Manitoba and Ontario legislation, *ibid.*
 - 27 Trillium Gift of Life Network, "Routine Notification and Request", online: Trillium Gift of Life Network <<http://www.giftoflife.on.ca/page.cfm?id=F9C07679-A5FE-4970-8C95-0F94FA20523B>>.
 - 28 Siminoff *et al.* noted that required request laws did not have as great an impact as expected on organ and tissue donation rates. The authors noted that "although there was a small immediate increase in procurement after the passage of Required Request laws, these increases were modest and leveled off after the first 2 years." Laura A. Siminoff *et al.*, "Public Policy Governing Organ and Tissue Procurement in the United States: Results from the National Organ and Tissue Procurement Study" (1995) 123 *Annals of Internal Medicine* 10 at 11. See also Richard R. Riker & Bruce W. White, "The Effect of Physician Education on the Rates of Donation Request and Tissue Donation" (1995) 59 *Transplantation* 880 at 880, noting that the effectiveness of such legislation has been questioned.
 - 29 Personal Communication, Bryan Sandilands, Alberta Health and Wellness.
 - 30 Section 1(b).
 - 31 Section 1(m): human tissue excluding organs. Blood, blood constituents, zygotes, oocytes, embryos, sperm, semen and ova are excluded from the scope of the *Act*.
 - 32 Section 1(l): human organ whether whole or in sections, lobes or parts.
 - 33 Section 5(1).
 - 34 Or living independently of a guardian.
 - 35 Those that permit tissue (and in some cases organ) donation by minors are: Manitoba (*The Human Tissue Gift Act*, *supra* note 24), Ontario (*Trillium Gift of Life Network Act*, *supra* note 24), and Prince Edward Island (*Human Tissue Donation Act*, R.S.P.E.I. 1988, c. H-12.1).
 - 36 A full discussion of the ethical concerns involved when minors act as living donors is beyond the scope of this paper. The American Academy of Pediatrics recently published a clinical report on this topic, concluding that "minors can morally serve as living organ donors but only in exceptional circumstances when specific criteria are fulfilled" (Lainie Friedman Ross, J. Richard Thistlethwaite, Jr & the Committee on Bioethics, "Minors as Living Solid-Organ Donors" (2008) 122 *Pediatrics* 454 at 454).
 - 37 Downie, Shea & Rajotte, *supra* note 6 at 1256.
 - 38 Section 1(c).
 - 39 Or, in a case where consent is obtained from the next of kin, "that a person in the same class or a higher priority class as the consentor objected to the donation proceeding."
 - 40 Section 3(6). Section 14(c) permits the Minister to make regulations respecting such registration. According to Bryan Sandilands of Alberta Health and Wellness, section 3(6) of the *Act* will not come into force on August 1, 2009, but will be delayed



in its implementation until such regulations are developed.

- 41 *Human Tissue and Organ Donation Act*, S.A. 2006, c. H-14.5, (except s. 3(6)), Proclamation, 1 August 2009, O.I.C. 349-2009, A. Gaz. 2009.I.105,13, 15 July 2009.
- 42 Section 13 (2).
- 43 Alberta, Legislative Assembly, *Hansard*, (25 April 2006) at 1050 (Dave Rodney).
- 44 See, e.g., Tarif Bakdash & Nancy Schepher-Hughes, "Is It Ethical for Patients with Renal Disease to Purchase Kidneys from the World's Poor?" (2006) 3:10 PLoS Medicine 001, available online: PLoS

Medicine <[ftp://ftp.apop.allenpress.com/EP-inbox/PLME_PIPS/PLME_10_24/PDFs/PLME0310_art26_debate_300.pdf](http://ftp.apop.allenpress.com/EP-inbox/PLME_PIPS/PLME_10_24/PDFs/PLME0310_art26_debate_300.pdf)>; A.S. Daar, "Money and organ procurement: Narratives from the real World" in T.H. Gutmann *et al.*, eds., *Ethical, legal, and social issues in organ transplantation* (Munich: Pabst Publishers, 2004) 368; E.A. Friedman & A.L. Friedman, "Payment for donor kidneys: Pros and cons" (2006) 69 *Kidney International* 960; Janet Radcliffe-Richards *et al.*, "The case for allowing kidney sales" (1998) 351 *Lancet* 1950; Michael M. Friedlaender, "The right to sell or buy a kidney: are we failing our patients?" (2002) 359 *Lancet* 971.

UPCOMING EVENTS

11th Annual Emerging Issues in Healthcare Law Conference

Pointe Hilton Squaw Peak Resort, Phoenix, Arizona. February 17-19, 2010

For more information visit

http://www.abanet.org/health/02_programs/01_emerging_issues.html

21st Canadian Bioethics Society Annual Conference – Voices of Communities

Kelowna, British Columbia. June 9 – 12, 2010

For more information visit <http://www.bioethics.ca/index-ang.html>

Public Health in Canada: Shaping the Future Together

Toronto, Ontario. June 13-16, 2010

For more information visit

<http://www.cpha.ca/en/conferences/conf2010.aspx>

11th International Congress on Obesity

Stockholm, Sweden. July 11-15, 2010

For more information visit <http://www.ico2010.org/registration.htm>

2010 World Stem Cell Summit

Detroit, Michigan. October 4-6, 2010

For more information visit <http://www.worldstemcellsummit.com/>

Halifax 10: The Canadian Healthcare Safety Symposium

Halifax, Nova Scotia. October 21 to 23, 2010

For more information visit <http://www.buksa.com>

2nd National Obesity Summit

Montreal, Quebec. April 28 – May 1, 2011

For more information visit <http://www.con-obesitysummit.ca/>

