SUGGESTED REVISIONS TO CLARIFY THE UNCERTAIN IMPACT OF SECTION 7 OF THE UNIFORM ANATOMICAL GIFT ACT ON DETERMINATIONS OF DEATH

FREDERIC A. LUYTIES

An old problem in a new context has been troubling the medical profession: when is a person dead[1] for purposes of an organ transplant? The problem is not how to insure that a person is dead before dissection, embalming, or burial[2] takes place, but rather how to insure that a person is dead while at the same time preserving his organs for transplantation into another living body.

Preferably, removal of healthy organs from a "dead" donor is undertaken after brain death has occurred but while circulation, respiration, and heartbeat continue to function under artificial stimulation. Defining death in terms of brain function alone is designated as an unconventional definition of death. In contrast to the brain death definition is the traditional medical definition of death: the irreversible cessation of all vital functions, including respiration, circulation, and heartbeat.[3] This definition, which is also the traditional legal definition of death, is designated the conventional definition of death.

Since the conventional definition of death has been the only legally recognized definition to date, the legality of unconventional determinations of death, so called because based on an unconventional definition of death, and also of transplant surgery dependent on these determina-

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[1] That this is not a new problem can be seen by reading a text entitled *The Uncertainty of the Signs of Death*, published in 1746 for one "M. Cooper."

[2] *See* THE UNCERTAINTY OF THE SIGNS OF DEATH (1746). On dissection, the author, tongue in cheek, noted: "Those, indeed, who are dissected, run no Risque of being interr'd alive." *Id.* at 196. Embalming is cautioned against prior to decomposition of the body. *Id.* at 201-02.

On the latter note and in the spirit of the former observation, see J. MITFORD, THE AMERICAN WAY OF DEATH 56-57 (1963). There the author captures the irony of the funeral industry's "solution" to the problem of premature burial by juxtaposing her own comment to a statement found in a textbook on embalming practices as follows:

> 'One of the effects of embalming by chemical injection, however, has been to dispel fears of live burial.' How true; once the blood is removed, chances of live burial are indeed remote.

[3] *E.g.*, Smith v. Smith, 229 Ark. 579, 589, 317 S.W.2d 275, 281 (1958) (judicial notice taken that a person breathing, though unconscious, is not dead); Thomas v. Anderson, 96 Cal. App. 2d 371, 376, 215 P.2d 478, 482 (1950) (death "does not occur until the heart stops beating and respiration ends"); United Trust Co. v. Pyke, 199 Kan. 1, 4, 427 P.2d 67, 71 (1967) (death is the "cessation of all vital functions without possibility of resuscitation"); *cf.* BLACK'S LAW DICTIONARY 488 (4th ed. 1951) (death is the "total stoppage of the circulation of the blood, and a cessation of the animal and vital functions consequent thereon, such as respiration, pulsation, etc.").

tions, is uncertain. However, the Uniform Anatomical Gift Act (UAGA),[4] which has been enacted in 41 states,[5] suggests a partial solution, since it may provide authorization for any determination of death which the medical profession considers acceptable. This comment will explore the legality of unconventional determinations of death in light of the UAGA.

In order to appreciate the impact of the UAGA on the determination of death, the technical aspects of determining death and the approaching medical consensus on a new definition of death will first be presented.

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[4] *See* HANDBOOK OF THE NATIONAL CONFERENCE OF COMMISSIONERS ON UNIFORM STATE LAWS 182-93 (1968). The Uniform Anatomical Gift Act [hereinafter cited as UAGA] was approved July 30, 1968, by the National Conference of Commissioners on Uniform State Laws.

[5] Thirty-eight states have enacted anatomical gift acts patterned after the final draft of the UAGA: Alabama, No. 164, [1969] Ala. Acts; Arkansas, No. 4, [1969] II Ark. Acts; Colorado, ch. 239, [1969] Colo. Laws; Connecticut, Act No. 425 (3 CONN. LEG. SERV. 440-43 (1969)); Florida, ch. 69-88 (2 FLA. SESS. LAW SERV. 209-12 (1969)); Georgia, GA. CODE ANN. §§ 48-401 to -409 (Supp. 1969); Hawaii, No. 81, [1969] Hawaii Laws; IDAHO CODE ANN. §§ 39-3401 to -3411 (Supp. 1969); Illinois, ILL. ANN. STAT. ch. 3, §§ 551-61 (Smith-Hurd Supp. 1970); Indiana, IND. ANN. STAT. §§ 35-4801 to -4809 (Supp. 1969); Iowa, IOWA CODE ANN. §§ 142A.1-.10 (Supp. 1970); Kansas, ch. 301, [1969] Kan. Laws; Maine, ME. REV. STAT. ANN. tit. 22, §§ 2901-09 (Supp. 1970); Michigan, MICH. STAT. ANN. §§ 14.523(51)-(60) (Supp. 1970); Minnesota, MINN. STAT. ANN. §§ 525.921-.93 (Supp. 1970); Missouri, MO. ANN. STAT. §§ 194.210-.290 (Supp. 1969-70); Montana, MONT. REV. CODES ANN. §§ 69-2315 to -2323 (Supp. 1969); Nevada, ch. 119, [1969] Nev. Stats.; New Hampshire, N.H. REV. STAT. ANN. §§ 291-A:1-9 (Supp. 1969); New Jersey, N.J. STAT. ANN. §§ 26:6-57 to -65 (4 N.J. SESS. LAW SERV. 536-39 (1969)); New Mexico, N.M. STAT. ANN. §§ 12-11-6 to -14 (Supp. 1969); North Carolina, N.C. GEN. STAT. §§ 90-220.1-.9 (Supp. 1969); North Dakota, N.D. CENT. CODE §§ 23-06.1-01 to -09 (Supp. 1969); Ohio, OHIO REV. CODE ANN. §§ 2108.01-09 (Page Supp. 1969); Oklahoma, OKLA. STAT. ANN. tit. 63, §§ 2201-09 (Supp. 1969-70); Oregon, ORE. REV. STAT. §§ 97.250-.290 (1969); Pennsylvania, PA. STAT. ANN. tit. 35, §§ 6101-11 (5 PA. LEG. SERV. 363-66 (1969)); Rhode Island, R.I. GEN. LAWS ANN. §§ 23-47-1 to -7 (Supp. 1969); South Carolina, S.C. CODE ANN. §§ 32-711 to -720 (Supp. 1969); South Dakota, S.D. COMPILED LAWS ANN. §§ 34-26-20 to -41 (Supp. 1969); Tennessee, TENN. CODE ANN. §§ 53-4201 to -4209 (Supp. 1969); Texas, TEX. REV. CIV. STAT. ANN. art. 4590-2(1)-(8) (Supp. 1969-70); Utah, UTAH CODE ANN. §§ 26-26-1 to -8 (Supp. 1969); Vermont, No. 53, [1969] Vt. Laws; Washington, WASH. REV. CODE ANN. §§ 68.08 ——— (Supp. 1969); West Virginia, ch. —, [1970] W. Va. Acts; Wisconsin, WIS. STAT. ANN. §§ 155.06(1)-(9) (3 WIS. LEG. SERV. 266-69 (1969)); Wyoming, WYO. STAT. ANN. §§ 35-221.1-.9 (Supp. 1969).

Three states enacted and have retained anatomical gift acts patterned after the second tentative draft of the UAGA: California, CAL. HEALTH & SAFETY CODE §§ 7150-58 (West Supp. 1970); Louisiana, LA. REV. STAT. ANN. §§ 17:2351-59 (Supp. 1970); Maryland, MD. ANN. CODE art. 43, §§ 149-H to -S (Supp. 1969).

As of April 1970, the following jurisdictions, as far as research disclosed, had not enacted anatomical gift acts based on the UAGA: Alaska, Arizona, Delaware, District of Columbia, Kentucky, Massachusetts, Mississippi, Nebraska, New York, and Virginia. As of April 15, 1970, a bill to enact the UAGA in Arizona had passed both houses of the legislature. However, it had been referred to a joint conference committee because the Senate refused to accept a House amendment. Ariz. Legis. Rev., Apr. 15, 1970, at 2.

For an analysis of the deviations from the official text of the UAGA in the enacting states, see Sadler, Sadler & Stason, *Transplantation and the Law: Progress Toward Uniformity*, 282 NEW ENG. J. MED. 717, 718-20 (1970). *See also* Louisell, *The Procurement of Organs for Transplantation*, 64 NW. U.L. REV. 607, 626-27 (1969); Richards, *Medical-Legal Problems of Organ Transplantation*, 21 HAST. L.J. 77 (1969).

The applicability of the UAGA to the unconventional determination of death will then be treated. Throughout this discussion, ambiguities apparent in the UAGA will emerge. Amendments will therefore be proposed to clarify the uncertainty and to promote the intended purpose of the legislation.

Finally, it should be noted that determinations of death are circumscribed by various possibilities of civil or criminal liability. Potential legal sanctions thus furnish a very practical reason for a doctor's desire for legal justification when he makes an unconventional determination of death. Reported cases arising out of transplants have not been found, however, and fears of liability are often couched in only the vaguest of terms. Thus, no current vocabulary of claims in this special area appears available. Nevertheless, in terms of traditional claims, the fears seem to concern, on the one hand, suits by survivors of donors for the infliction of mental distress based on the unauthorized mutilation of dead bodies[6] and, on the other, charges of medical wrongdoing, including wrongful death[7] and homicide,[8] for the premature determination of death. The first class of claims has been carefully neutralized by the UAGA. Provided that there is good faith compliance with an anatomical gift and the "mutilation" (the removal of organs and the attendant procedures) therefore authorized by the donor or another, that type of claim appears to be of little significance.[9] The charges and claims to which the Act does not expressly apply, medical malpractice and homicide, accordingly present an uncertain threat to the doctor in his treatment of a donor *qua*

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[6] *See* W. PROSSER, THE LAW OF TORTS 51 & n.13 (3d ed. 1964) [hereinafter cited as W. PROSSER]; *cf.* Eastin v. Ochsner Clinic, 200 So. 2d 371 (La. Ct. App.), *aff'd* 251 La. 34, 202 So. 2d 652 (1967). These claims have traditionally been couched in terms of unauthorized autopsy, *e.g.*, *In re* Estate of Mgurdichian, 30 App. Div. 2d 732, 291 N.Y.S.2d 453 (App. Div. 1968) (recovery limited to survivor with duty of burial); mutilation, *e.g.*, Koerber v. Patek, 123 Wis. 453, 102 N.W. 40 (1905); or mishandling of a dead body, *e.g.*, Torres v. State, 34 Misc. 2d 488, 228 N.Y.S.2d 1005 (Ct. Cl. 1962).

[7] In a claim arising from an unconventional determination of death, the major question would be whether that determination and the resulting withdrawal of supportive therapy and/or removal of organs violated a standard of care owed the patient by the doctor. *See* 3 M. HOUTS & I. HAUT, COURTROOM MEDICINE, DEATH § 1.05, at 1-49 (1969) [hereinafter cited as M. HOUTS & I. HAUT].

[8] Under the traditional legal definition of death—the "cessation of all vital functions without possibility of resuscitation," United Trust Co. v. Pyke, 199 Kan. 1, 4, 427 P.2d 67, 71 (1967), the opinion was that a physician who withdrew the life-supportive systems or who removed a critical organ from a donor before conventional death was reached was committing an act of homicide. Louisell, *Transplantation: Existing Legal Constraints*, in CIBA FOUNDATION SYMPOSIUM, ETHICS IN MEDICAL PROGRESS: WITH SPECIAL REFERENCE TO TRANSPLANTATION 78, 98 (G. Wolstenholme & M. O'Connor eds. 1966). *See* Taylor, *Gift of Life*, 70 J. KAN. MED. SOC. 87 (1969).

One writer has even reached the conclusion that a prosecution for murder for withdrawing life-supportive devices prior to conventional death would be justified because the three requirements for proving murder would be met: malice aforethought (or intent that death should result), an act that resulted in death, and a lack of justification or excuse. Fletcher, *Prolonging Life*, 42 WASH. L. REV. 999, 1000, 1003 n.11, 1007 (1967).

[9] *See* notes 37-38 *infra* and accompanying text.

patient and constitute the major practical consideration in analyzing the effect of an unconventional determination of death.

TECHNICAL CONSIDERATIONS

Since traditionally the failure of heartbeat, circulation, and respiration signalled the fact of death, the negative inference of this definition was that death did not occur *until* these vital functions stopped. Under modern medical standards, however, the persistence of these vital functions does not prove the nonexistence of death just as their absence does not prove death, since they can be restored and artifically sustained. Since the brain cannot be resuscitated or artifically sustained, however, the complete cessation of brain function is a more reliable sign that death of the other organs of the body is imminent and inevitable.

The determination-of-death dilemma can emerge in the transplant setting as follows. A patient with severe head injuries may possess salvageable organs. Unable to survive spontaneously, he may be sustained artificially by devices which normalize or stimulate heartbeat and maintain respiration and circulation.[10] Upon a diagnosis that the patient's brain has been irreversibly damaged and that the patient could never again spontaneously lead even a vegetative existence, the doctors could wait until the life-supportive devices fail, in which case conventional death would occur despite the use of the devices. Transplantation of the critical organs such as the heart, lungs, kidneys, and liver at that point, however, would be out of the question because of extensive damage.

On the other hand, the surgeons can perform transplant after brain death but before the artificial devices are withdrawn while the organs remain oxygenated.[11] Since the presence of oxygen minimizes organ deterioration as a factor threatening the success of the surgery and permits a more methodical transplant, the latter procedure is preferable.[12]

Still, doctors have had to contend with the conventional legal frame-

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[10] *See* UAGA § 7, Comment, ¶ 2. *See generally* Bleasel, Bailey, Gunner & Dwyer, *A Heart Transplantation: 2. The Donor*, 1 MED. J. AUSTL. 665-66 (1969); Fletcher, *supra* note 8, at 999; Sen, *Human Heart Homotransplantation*, 22 AM. J. CARDIOLOGY 826 (1968).

[11] When the circulation of oxygenated blood throughout the body ceases, the bodily organs become irreparably damaged in sequence at approximately the following intervals: the cerebral cortex within five minutes; the midbrain, brain stem, and liver within 15 minutes; the heart within 30 minutes; the kidneys within 45 minutes; the corneas within six hours; and the skin within eight hours. M. HOUTS & I. HAUT, *supra* note 7, § 1.01(3), at 1-10; Couch, Curran & Moore, *The Use of Cadaver Tissues in Transplantation*, 271 NEW ENG. J. MED. 691, 692 (1964); Shumway, Angell & Wuerflein, *The Heart—Progress in Transplantation of the Heart*, 5 TRANSPLANTATION 900, 902 (1967); Editorial, *The Moment of Death*, 14 WORLD MED. J. 133 (1967). See M. HOUTS & I. HAUT, *supra*, § 1.01(3)(d), at 1-10, for a discussion of the three stages of brain death.

[12] *See* Williams, *Transplantation Problems*, 65 NURSING TIMES 849 (1969); Williams, *Transplantation—Other Tissues and Organs*, 65 NURSING TIMES 818-19 (1969) (best way to perform a transplant).

work, which prompted a search for legal justification within that framework.[13] However, the theories developed to justify the unconventional determination of death without redefining death are unsatisfactory,[14] and a new definition of death in light of the realities of modern medicine is emerging.

A New Medical Definition of Death

The medical profession, prior to the UAGA and continuing after its enactment, has apparently been approaching a consensus on the basic elements of death: a condition of permanent unconsciousness (also called irreversible coma) and a state where the bodily functions can no longer continue spontaneously.[15] For example, the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death has proposed the following criteria to measure the existence of a "permanently nonfunctioning brain":[16]

> 1. *Unreceptivity and Unresponsitivity.*—There is a total unawareness to externally applied stimuli and inner need and complete unresponsiveness . . . . Even the most intensely painful stimuli evoke no vocal or other response . . . .
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> 2. *No Movements or Breathing.*— . . . [N]o spontaneous muscular movements or spontaneous respiration . . . .
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> 3. *No Reflexes.*— . . . The pupil will be fixed and dilated and will not respond to a direct source of bright light. . . .
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> 4. *Flat Electroencephalogram.*—Of great confirmatory value is the flat or isoelectric EEG.[17]

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[13] *See, e.g.*, Fletcher, *supra* note 8, in which the author attempts to justify the discontinuance of life-supportive therapy prior to conventional death on the basis of the classification of discontinuance as an omission outside the realm of the reasonable expectations of a patient. *Cf.* Kutner, *Due Process of Euthanasia: The Living Will, A Proposal*, 44 Ind. L.J. 539 (1969), in which the author suggests that pregiven consent to the discontinuance of artificial devices prior to conventional death would furnish the necessary legal justification.

[14] Both of the theories mentioned in note 13, *supra*, fail because they ultimately depend for their validity on an artificial classification of the discontinuance of supportive therapy as an omission. A fortiori, neither furnishes legal justification for the positive act of removal of organs before conventional death.

[15] *See* Halley & Harvey, *Medical v. Legal Definitions of Death*, 204 J.A.M.A. 423, 425 (1968); *accord*, Voigt, *The Criteria of Death Particularly in Relation to Transplantation Surgery*, 14 World Med. J. 143, 146 (Oct. 1967). *Compare A Definition of Irreversible Coma—Report of the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death*, 205 J.A.M.A. 337, 338 (1968) [hereinafter cited as *Ad Hoc Committee Report*], *with* UAGA § 7, Comment, ¶ 2. The same elements are implicit in other articulations of the time of death. *See, e.g.*, Murray, *Organ Transplantation: The Practical Possibilities*, in Ciba Foundation Symposium—Ethics in Medical Progress: With Special Reference to Transplantation 54, 69 (G. Wolstenholme & M. O'Connor eds. 1966); Biörck, *When Is Death?*, 1968 Wis. L. Rev. 484; Halley & Harvey, *Medical v. Legal Definitions of Death*, 204 J.A.M.A. 423 (1968); Richards, *supra* note 5; Wecht & Aranson, *Medical-Legal Ramifications of Human Tissue Transplantation*, 18 DePaul L. Rev. 488 (1969).

[16] *Ad Hoc Committee Report*, *supra* note 15, at 337 (emphasis omitted).

[17] *Id.* at 337-38. Other medical authorities consider the flat EEG, which demonstrates a lack of brain activity, a requisite to a determination of brain death. *See, e.g.*, Friedlander, *Electroencephalography*, 5 Lawyers Med. J. 151, 178 (1969);

The criteria must be observed 24 hours later and there must be no change.

Oxygenated organs, including a beating heart, can be removed under these criteria, which have been generally well received both in the medical and in the legal profession.[18] However, while students of the problem in both law and medicine seem to have rejected the conventional definition of death, legislators have not codified a new definition and courts have not been presented with the opportunity to solve the problem.

The UAGA, although containing no actual definition, does have an impact on the question of death and thus may provide the vehicle whereby a court can reach the question in the context of organ transplants where reconsideration of the conventional definition is most needed. The nature of that impact can best be considered by examining the principal questions to which this analysis is addressed: First, does the UAGA authorize a doctor to use any medically acceptable—including unconventional—definitions in the determination of death? Second, are doctors now protected from liability for unconventional determinations of death, even if medically unreasonable, if made in good faith? The first question requires consideration of Section 7(b) of the Act. The second question involves

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Hamlin, *Life or Death by EEG*, 190 J.A.M.A. 112 (1964); Williams, *Transplantation —Problems*, 65 NURSING TIMES 849 (1969). *See also* Wecht & Aranson, *Medical-Legal Ramifications of Human Tissue Transplantation*, 18 DEPAUL L. REV. 488, 493-94 (1969) (lengthier list of criteria to determine death suggested by the Ad Hoc Committee on Human Tissue Transplantation of the Duquesne University School of Law).

[18] *See, e.g.*, Corday, *The Patient's Rights Must Always Come First*, in PROCEEDINGS OF THE NATIONAL MEDICOLEGAL SYMPOSIUM 58, 61 (1969); Sadler, Sadler, Stason & Stickel, *Transplantation—A Case for Consent*, 280 NEW ENG. J. MED. 862, 865 (1969). *See also* 5 TRIAL 28 (Dec.-Jan. 1968-69) (the guidelines "continue to be the most generally accepted medical definition of death"); *Hearing on S. 2999 Before the Senate Comm. on the District of Columbia*, 91st Cong., 2d Sess., at 17, 30 (1970) [hereinafter cited as *Hearing on S. 2999*] (Ad Hoc Committee criteria not "absolutely agreed upon" but "moving forward toward unanimity"). *But cf.* Halley & Harvey, *Definitions of Death*, 69 J. KAN. MED. SOC. 280, 281 (1968) ("Standards for the establishment of such brain death have been proposed . . . but are not officially accepted by the medical profession."); 159 HARVARD LAMPOON (1969), at 70 (Special parody issue—TIME), in which what may come to be entitled the "Harvard Ad-Lib Committee's Definition of Irreversible Coma" is advanced:

> Folded hands for at least 20 minutes (ten, if with lily), clearly defined X marks in both eyes, a silly smile, references to the 'pearly gates' or the 'last round-up' and a funny smell in the ward.

For evidence of recognition by the legal profession of the need for a new defintion of death, see M. HOUTS & I. HAUT, *supra* note 7, §§ 1.01-.08, at 1-3 to -73 (which provides a lengthy and current analysis of the legal and medical problems in the determination of death); Sommer, *Additional Thoughts on the Legal Problems of Heart Transplants*, 41 N.Y. ST. B.J. 196 (1969); Comment, *Medico-Legal Problems with the Question of Death*, 5 CAL. W.L. REV. 110 (1968); Comment, *Need for a Redefinition of "Death"*, 45 CHI.-KENT L. REV. 202 (1968-69); Comment, *Liability and the Heart Transplant*, 6 HOUSTON L. REV. 85 (1968). *Contra*, Randall & Randall, *The Developing Field of Human Organ Transplantation*, 5 GONZAGA L. REV. 20, 37-38 (1969); Stickel, *Organ Transplantation in Medical and Legal Perspectives*, 32 LAW & CONTEMP. PROB. 597, 608 (1967); Wheeler, *Anatomical Gifts in Illinois*, 18 DEPAUL L. REV. 471, 484 (1969).

section 7(c).[19]

UAGA AND DETERMINATIONS OF DEATH

The potential justification for the unconventional determination of death under the UAGA rests on Section 7(b) of the Act:

> The time of death shall be determined by a physician who tends the donor at his death, or, if none, the physician who certifies the death. The physician shall not participate in the procedures for removing or transplanting a part.

In the cryptic first sentence, the UAGA may be providing that determinations of death are solely a medical problem to be answered on the basis of medical criteria. On the other hand, courts which have paid lip service in the past to the idea that the time of death is a qestion of medical judgment have apparently meant that only the time at which all vital functions ceased (the traditional legal definition) was a question of fact.[20] That is, the question of the existence of death was resolved within the context of traditional legal criteria, not on the basis of medical criteria elicited from experts. Therefore, in a pre-UAGA claim arising out of a doctor's withdrawal of supportive therapy or a surgeon's removal of an organ before conventional death, a court could have instructed a jury to determine, in terms of the existing definition of death, whether the signs which were observed by the doctor constituted conventional death. The question is then what is the import of the first sentence of section 7(b).

A resolution of this question must rest upon an analysis of the entire subsection. In this regard, it should be noted that the second sentence attempts to insure objective determinations of death when made in contemplation of a transplant by separating the determiner of death from the transplant. This proscription is intended to avoid a conflict between a doctor's responsibility for a patient-donor and his interest in a patient-donee.[21] Consequently, one practical effect of the

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[19] Sections 7(b) and 7(c) are the focal point of this discussion; analysis of the other provisions of the UAGA will not be undertaken. For section-by-section analyses of the Act, see Sadler & Sadler, *Transplantation and the Law: The Need for Organized Sensitivity*, 57 GEO. L.J. 5 (1968) [hereinafter cited as Sadler & Sadler]; Sadler, Sadler, Stason & Stickel, *Transplantation—A Case for Consent*, 280 NEW ENG. J. MED. 862 (1969); Stason, *The Uniform Anatomical Gift Act*, 23 BUS. LAW. 919 (1968). *See also* Comment, *California's Response to the Problems of Procuring Human Remains for Transplantation*, 57 CALIF. L. REV. 671 (1969) (a section-by-section analysis of the California Anatomical Gift Act); Richards, *supra* note 5 (which updates the appendices to the Sadler & Sadler article containing an analysis of the anatomical gift laws of each state).

[20] *Ad Hoc Committee Report, supra* note 15, at 338-39.

[21] The effectiveness of this provision will depend on interpretation of the term "participate" in relation to the terms "removing" and "transplanting." Participate could encompass everything from physically removing an organ, to performing an autopsy to determine acceptability of the desired organs for transplantation, to transporting a body to a transplant center, to testing the donor for tissue compatibility, to preserving the body's metabolic functions to maintain oxygenation of

section is that transplanters will forestall transplantation until another doctor has determined that death has occurred and therefore insure that the time of death does precede removal surgery. Presumably a transplanter will not "jump the gun"[22] by removing an organ before death is declared by the attending doctor for fear of a doctor determining and certifying that death occurred *after* removal.

Thus, the first sentence of section 7(b), because it identifies the party prohibited from the transplant,[23] might function solely to supplement the one unambiguous purpose of the section: preventing conflicts of interest. However, the Committee of the Whole of the National Conference of Commissioners on Uniform State Laws rejected a proposal which would have limited the scope of the entire subsection to the conflict-of-interests problem. One commissioner introduced the proposal in the course of a brief speech reflecting his narrow concept of the purpose of section 7(b):

> [A state commissioner:] . . . Why don't we delete the first sentence [of section 7(b)]? We don't want the doctor who certifies the death to participate in the procedures for removing the organ, because he might jump the gun. . . . So I would recommend that the second sentence read that *the physician who attends the donor at the time of his death or who certifies to his death shall not participate in the procedures for removing or transplanting a part*, and leave entirely outside this thing the question of when the person dies.[24]

In addition, more expansive interpretations of the section by the drafters of the Act militate against such a narrow construction and show that the section promotes a particular purpose: insuring that determina-

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the organs, to being merely a nonparticipating member of a transplant team. Of these different possibilities only the last one seems certain to fall outside the scope of participation. *See* Transcript of Proceedings in Committee of the Whole of National Conference of Commissioners on Uniform State Laws 101-02 (July 25, 1968) [hereinafter cited as 1968 Proceedings]; Sadler & Sadler, *supra* note 19, at 27.

22 *See* text accompanying note 24 *infra.*

23 Apparently a transplant surgeon could benefit from the protection afforded doctors under the Act as long as he was not the section 7(b) determiner of death, even though he was *an* attending physician and was also consulted in the determination of death. Limiting factors, however, are the good faith requirement and the uncertain breadth of "determine" in the determination of the time of death. It seems, however, that the UAGA's explicit isolation of the determiner of death from the transplant but not a corresponding separation of the transplanter from the determination of death may inadequately prevent all the primary conflicts of interest. Consideration might therefore be given to reformulations of section 7(b) which would bring about a more symmetrical balancing of the competing interests in donor and donee on the part of all doctors involved. For example, to clarify the intention to prevent all conflicts of interests which could possibly be detrimental to a donor, the following formulation of section 7(b) seems suitable (the addition is italicized):

> The physician [who determines death] shall not participate in the procedures for removing or transplanting a part; *and the physicians or surgeons who remove and transplant a part shall not participate in the determination of the time of death.*

24 1968 Proceedings, *supra* note 21, at 103 (emphasis added) (emphasized portion would have constituted the amended section 7(b)).

tions of death are to be made solely on the basis of medical criteria and, therefore, are not to be judged according to past judicial definitions of death.

Framers' Construction of UAGA

This conclusion is confirmed by several sources. First, the comment to Section 7 of the UAGA supports the interpretation that under the Act the question of death is totally a medical question. The pertinent part of the comment reads:

> *Subsection (b) leaves the determination of the time of death to the attending or certifying physician.* No attempt is made to define the uncertain point in time when life terminates. This point is not subject to clear cut definition and medical authorities are currently working toward a consensus on the matter. Modern methods of cardiac pacing, artificial respiration, artificial blood circulation and cardiac stimulation can continue certain bodily systems and metabolism far beyond spontaneous limits. *The real question is when have irreversible changes taken place that preclude return to normal brain activity and self[-]sustaining bodily functions.* No reasonable statutory definition is possible. The answer depends upon many variables, differing from case to case. *Reliance must be placed upon the judgment of the physician in attendance. The Uniform Act so provides.*[25]

The comment apparently answers in the negative the question posed in the Prefatory Note of the UAGA whether "the time of death [should] be defined *by law* in any way."[26] More importantly, by combining an explanation of the "real question" of the time of death, where the drafters show that prior judicial definitions are not relevant to the time-of-death question in the transplant setting, with the direction to leave the determination to doctors and their judgment, the comment is evidence that the Act considers the time of death to be a question of fact to be determined solely on the basis of medical criteria.

Second, the chairman of the Special Committee on the UAGA of the National Conference of Commissioners on Uniform State Laws confirmed that the intention of the drafters was to defer to the medical profession on the question of the definition of death when he stated at a session of the Committee of the Whole that:

> [W]e have considered this matter [the time of death] in the [Special] Committee at great length and reached the conclusion that *it would be most unwise for us in a legal enactment to try to put into words a definition of the time of death.*
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> . . . .
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> . . . [T]he complexity of the criteria has left us with the unanimous conclusion that *we should not try to invade the*

[25] UAGA § 7, Comment, ¶ 2 (emphasis added).
[26] HANDBOOK OF THE NATIONAL CONFERENCE OF COMMISSIONERS ON UNIFORM STATE LAWS 183 (1968) (emphasis added).

area of medical judgment, but instead should leave this problem to the doctors in charge.[27]

Finally, the technical consultants to the Special Committee on the UAGA showed what was intended by the Act in the time-of-death question during an appearance before the Senate Committee on the District of Columbia in its consideration of the UAGA. While they attempted to show primarily why guidelines for determining death should not be included in the Act, they showed indirectly that the UAGA does (or should) allow a death determiner to make unconventional determinations of death and to be judged on the basis of the reasonableness of the medical criteria used—not by the previous legal criteria. The consensus of the drafters was:

> This question of medical proof [of death] is a medical determination of fact—whether the criteria [were] reasonable under the circumstances.
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> . . . .
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> Senator GOODELL. How is the court going to make the judgment or a jury to find what the law is? . . . *Are there any laws on the books that define death?*
>
> Mr. BLAIR SADLER. *No; there are not. The question of death is determined by a court or by a physician based on medical proof as to reasonable criteria* on certain things and certain circumstances.[28]

Despite this assertion, the consultants, as well as the commissioners, may have been mistaken in their assumption that the time of death has in the past been a question of fact determined solely on the basis of medical

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[27] 1968 Proceedings, *supra* note 21, at 101-02 (emphasis added).

[28] *Hearing on S. 2999, supra* note 18, at 43 (emphasis added). The following testimony preceded the drafters' views expressed in the text:

> Dr. ALFRED SADLER. These [brain dead persons] are people that have suffered irreversible brain damage, are comatose, . . . have no reaction to any stimulation, [and] cannot breathe on their own[,] and this is demonstrated to be irreversible[,] and [they] are then declared dead.
>
> Senator GOODELL. We don't provide that [the brain dead person is dead] as a matter of law by your recommendations . . . where you have asked us to leave out the definition of death completely. The basis was that there is nothing in the law that requires us to do so.
>
> Dr. ALFRED SADLER. Right. . . .
>
> . . . .
>
> Mr. BLAIR SADLER. . . . The point is that you make a determination of death on whatever criteria you are going to use for other situations, as well as in the transplant setting. . . .
>
> I think that if there is a question raised, it is a question of medical proof, like anything else. If anyone wants to allege that adequate criteria will not be used or other criteria will not be used, they can always have their redress in court. *Id.* at 42-43.

See also Sadler, Sadler & Stason, *The Uniform Anatomical Gift Act—A Model for Reform*, 206 J.A.M.A. 2501, 2504 (1968), where the two consultants and the chairman of the Special Committee again used the past lip service treatment of the time of death in the courts to bolster their contention that the time of death should not be defined in law. By referring to the choice of the commissioners to "maintain this policy," however, they suggest somewhat more positively that the Act authorizes all medically acceptable determinations of death, although the past "policy" may have been one to define death in conventional terms.

criteria. Pointed out earlier was the observation that the courts have actually considered the time of death in terms of legal criteria, considering only compliance with the criteria to be a question of fact.[29] One of the members of the committee, moreover, interprets the Act merely to perpetuate this principle. Reasoning that while the UAGA purports to leave the determination of death to medical judgment, he concludes that

> it seems clear that this judgment must be made on the basis of the cessation of all vital signs. The [UAGA] *provides no legal justification* for turning off a respirator on a hopelessly unconscious patient with irreversible, widespread brain damage.[30]

Another writer contends that a definition of death must be legislated in order to avoid the dictum in a recent court decision in his state that the time of death occurs when all vital functions have irreversibly ceased to function.[31]

Thus, despite a relatively clear indication of the intention of the framers, it must be concluded that the Act does not command a court to construe section 7(b) to allow not only the doctor to employ modern standards in determining death but also the jury to judge the doctor's determination by those same standards. On the other hand, as long as there is no conflict of interests, a court will probably follow the preferred construction because it is more attuned to the medical realities as well as to the purpose of the UAGA to allow the medical profession to use any reasonable criteria in determining death.

State Construction of UAGA

The states which have enacted the UAGA have shed little light on the problem by their interpretation of the time-of-death provision. Those which have amended section 7(b) have not changed the first sentence to insure that it sanctions reasonable medical definitions of death regardless of the definitions contained in previous case law. Indeed, in five out

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[29] *See* text accompanying note 20 *supra.*

[30] Curran, *The Legal Meaning of Death*, 58 AM. J. PUB. HEALTH 1965, 1966 (1968). The writer's interpretation is based in part on what he perceives as the public's fear of transplant surgeons determining the death of donors prior to transplant surgery. *Id.* However, since section 7(b) also attempts to avoid the situation where the overeager surgeon could ignore a donor's chances of survival in order to insure the success of a transplant, the doctor's gauging of public opinion as a reason for the lack of legal justification is unpersuasive. His reading of the time-of-death clause, by being founded upon a questionable premise, is therefore susceptible to attack.

See also Hamner, *Legal Death—Can It Be Defined?*, 38 J. MED. ASS'N ALA. 610, 613 (1969), in which the writer assumes that section 7(b) gives the doctor facing the question of death "the right to use his own method of determination," thus implying that not only the criteria but also the application of the criteria to measure the fact of death are matters of fact for the doctor to determine.

[31] Taylor, *supra* note 8, at 87 (commenting on United Trust Co. v. Pyke, 199 Kan. 1, 4, 427 P.2d 67, 71 (1967)). The writer takes this stand in spite of the fact that the enactment of the UAGA followed the case in question, since he believes the Act does not apply to the definition of death.

of seven cases where the states have amended the section, they altered only the conflicts provision.[32] And of the two states which did change the time-of-death provision, only Connecticut helped clarify the perceived intent of the drafters to have the determination of death made solely on the basis of medical criteria.[33] While the Connecticut version does not make absolutely clear that only medical criteria will be considered in judging determinations of death and consequently does not overrule prior judicial definitions of death, it seems to improve the chances of the time-of-death clause being interpreted in that manner.

> The time of death shall be determined by two physicians who attend the donor at his death, or if none, two physicians who certify death, *who shall use generally recognized and accepted scientific and clinical means to determine such time of death.*[34]

One shortcoming of the Connecticut version is that it uses "means," not "criteria." Thus, it could still be interpreted as follows: In determining the time at which all vital functions have irreversibly ceased (conventional definition of death), a doctor shall use recognized medical means. In other words, the Connecticut amendment might simply be restating a principle of negligence—that actions of doctors are tested under the standard of what is acceptable in the medical profession. If interpreted in this manner it would add nothing to the present clause.

Thus, in order to effectuate the intent of the drafters by insuring that only medical criteria will be considered and that contrary judicial definitions will be inapplicable, section 7(b) should be amended more fully than done in Connecticut. To accomplish these purposes, section 7(b) should be amended to read:

> The time of death shall be determined by a physician who tends the donor at his death, or, if none, the physician who certifies the death. *The time of death shall be considered in law to be solely a medical question which shall be determined on the basis of generally recognized and accepted scientific and clinical criteria, notwithstanding any legal definition of death to the contrary.*[35]

Returning to the first question posed, it can be said that the present

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[32] The changes in Colorado, Missouri, and Pennsylvania reflected an apparent concern that the second sentence's proscription of participation by death-determining physicians in transplant operations was incomplete. *See* ch. 239, § 7(2), [1969] Colo. Laws 841-42; MO. ANN. STAT. § 194.270(2) (Supp. 1969-70); PA. STAT. ANN. tit. 35, § 6107(b) (5 PA. LEG. SERV. 366 (1969)). Apparently for the same reason, Ohio amended the time-of-death clause—the first sentence of section 7(b). OHIO REV. CODE ANN. § 2108.07(B) (Page Supp. 1969). On the other hand, Iowa and South Carolina have limited the scope of the conflict-of-interests clause for one noncritical type of transplant—the enucleation of eyes. IOWA CODE ANN. § 142A.7(2) (Supp. 1970); S.C. CODE ANN. § 32-718 (Supp. 1969).

[33] Colorado changed the time-of-death provision to provide that the time and cause of death have to be formally certified before transplant surgery can begin. Ch. 239, § 7(2), [1969] Colo. Laws 841-42.

[34] Act No. 425, § 7(b) (3 CONN. LEG. SERV. 442 (1969)) (amendment italicized).

[35] UAGA § 7(b) (the proposed amendment is italicized).

section 7(b) was intended to authorize all medically acceptable determinations of death. However, certain obstacles impede interpretation of the section in this manner. First, it is phrased in such a way that it does not literally provide authorization, but instead it *assumes* authorization. Second, while a major purpose of the framers in drafting the time-of-death clause seems to have been to avoid defining death, in avoiding that position, they appear to have overcompensated by failing to articulate their corresponding intention to make the entire question of the time of death one of fact. When this failure is combined with the problem that past judicial consideration of the time of death has resulted in a legal definition of death, contra to the framers' assumption, the need for revision becomes compelling. Finally, if more reason for revision be needed it is this: Not all courts can necessarily be expected to conclude that doctors are authorized to make unconventional determinations of death in conjunction with UAGA-authorized body gifts even if confronted with the intention of the drafters to negative the older, anachronistic definitions of death and to leave the definition of death to the medical profession.

In the event that section 7(b) is not amended or, at any rate, that a court finds no authorization under the section as it presently reads, a doctor could assert a good faith determination of death in an attempt to qualify for the protection from liability afforded by the disclaimer in section 7(c).

THE "GOOD FAITH" DEFENSE AS PROTECTION UNDER THE UAGA FOR UNCONVENTIONAL DETERMINATIONS OF DEATH

Section 7(c) reads:

> A person who acts in good faith in accord with the terms of this Act or with the anatomical gift laws of another state [or a foreign country] is not liable for damages in any civil action or subject to prosecution in any criminal proceeding for his act.

In considering the disclaimer clause, the central question raised is whether the attending physician who makes a determination of death, neither authorized nor forbidden by the UAGA, can be protected from criminal and civil liability if he acts in good faith.

The first step in deciding whether such a physician is somehow protected by the UAGA's disclaimer is to determine whether he acts "in accord with" section 7(b) (directing that "[t]he time of death shall be determined by a physician who tends the donor . . . ."), when he makes any determination of death. The second step is to determine whether a negligent act can be committed in good faith.[36] If both questions can be answered affirmatively, the determiner of death should be immune from

[36] *See* Warfield Natural Gas Co. v. Allen, 248 Ky. 646, 655, 59 S.W.2d 534, 538 (1933) (dictum) (bad faith is "stronger than the idea of negligence"). *But cf.* Whitney v. Huntington, 37 Minn. 197, 201, 33 N.W. 561, 563 (1887) (good faith is "without culpable negligence, or a wilful disregard of the rights of others"). Further analysis of good faith will not be pursued here.

liability, provided, of course, that the determination is alleged to be only negligent—not intentionally wrongful.

To the extent that the attending physician determines death for the purpose of designating when organ removal from a corpse can commence, the physician is acting in accord with the Act.[37] In this post-death setting, he is fulfilling one role in the transplant drama. Consequently, assuming good faith compliance with the terms of an anatomical gift, the doctor should be protected from any claims of mental distress caused by the mishandling of the dead body.[38] However, the doctor in the transplant setting not only determines death of a donor *qua* corpse; he also determines the death of the donor *qua* patient, by which he designates the termination of the doctor-patient relationship because of death. Thus, if a question arises whether a donor was dead at the point of withdrawal of supportive therapy or organ removal, the fact that an attending doctor made the determination that death had occurred before that point would not necessarily justify application of the disclaimer to immunize the doctor from liability for a negligent determination made when the donor was still alive. The disclaimer may only apply to the acts of the attending doctor in his relationship to the donor *qua* corpse with the result that, for example, a malpractice claim based on use of improper criteria to determine death or misapplication of proper criteria may still be heard.

Indeed, the dislcaimer probably does not apply to the acts of the attending doctor with regard to the donor *qua* patient, but the meaning of the disclaimer is difficult to extract from the terms of the UAGA. In addition, it is not discussed in the comment to section 7 and has not been judicially interpreted to date in the states which have enacted the UAGA. Furthermore, the disclaimer has not been interpreted as it was used in the older donation statutes.[39] Although it was explained in the comment to section 7 in an earlier draft of the UAGA, it was merely characterized as "just and necessary" and in line with similar exculpatory clauses in a number of states' donation statutes.[40]

Some idea of the meaning of the disclaimer may be gleaned from the discussion of the UAGA in the Committee of the Whole of the National Conference of Commissioners on Uniform State Laws in August 1967 and July 1968, where the disclaimer was analyzed as it applied to three

[37] *See* Sadler & Sadler, *supra* note 19, at 25; letter from Alfred M. Sadler, Jr., and Blair L. Sadler to the author, Nov. 20, 1969, on file in the University of Arizona Law Library ("Since section 7(b) specifically refers to the donor's attending physician, the protection provision of Section 7(c) would apply to him.").

[38] *See* text accompanying note 6 *supra.*

[39] *See* Sadler & Sadler, *supra* note 19, at 37-54. Appendix C contains a summary of all the older state donation statutes. As far as research disclosed, none of the liability disclaimers in these statutes had been judicially interpreted as of Oct. 1, 1969.

[40] UAGA § 7, Comment (Rev. Tent. Draft No. 2, May 22, 1968).

situations. From those discussions the following conclusions can be drawn. First, good faith was intended to protect the "donee or any doctor" who accepted and used an anatomical gift, ostensibly made in accord with the UAGA, without actual notice of a latent procedural defect in the gift document.[41] Second, protection is also to be afforded the donee who accepts an anatomical gift from a survivor of the decedent without knowledge that the survivor knows of objections to the gift by other survivors or by the decedent.[42] Third, if a gift is accepted after it has been revoked but before actual notice of the revocation is received, the recipient and others acting on the gift are immune from liability.[43] Thus, the drafters of the UAGA manifestly intended that the disclaimer protect the donee and others utilizing an anatomical gift who lack actual knowledge of a flaw in the preparation or communication of the gift.

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[41] *See* 1968 Proceedings, *supra* note 21, at 60-61 (emphasis added):

> MR. RUUD: Suppose that a gift is made under [4](b), but in fact the two witnesses do not sign in the presence of the donor. The donee acts on the good-faith assumption that the document was executed in compliance, as it apparently was, with 2 [sic] (b). Would the donee or any doctor acting in good faith, believing that the gift was made in accordance with the terms of the statute when in fact it wasn't, be safe?
>
> Now, I read 7(c), but 7(c) seems to me to limit the case to a case in which the gift was made in accordance with the statute, and the fact situation that I put is one in which the gift is noncomplying.
>
> MR. STASON: The term used in 7(c) is a little broader than the Commissioner from Texas referred to. Section 7(c) [UAGA, Rev. Tent. Draft No. 2, May 22, 1968] reads:
>
> > A persons who acts in good faith in accord with the terms of this act and a gift made thereunder—
>
> He acts in good faith. If he does not know of the violation of the provisions of the statute, he can still be in good faith, and protected.
>
> . . . .
>
> MR. STASON: It was our conclusion that this language would warrant the physician or the surgeon, in acting pursuant to the document of gift that comes into his possession—*and if there are facts underlying that document of gift which, if known, would indicate that the gift had not been executed in accordance with the specifics of the statute, this is something that he could not be expected to take into account in the short time available, so we say if he acts in good faith, he is protected.*

[42] *Cf.* Transcript of Proceedings in Committee of the Whole of National Conference of Commissioners on Uniform State Laws 26-27 (Aug. 5, 1967); UAGA § 2(c) (by implication).

[43] *Compare* 1968 Proceedings, *supra* note 21, at 89-90, *with* UAGA § 7(c) (Rev. Tent. Draft No. 2, May 22, 1968), which read in part:

> The donee . . . is not liable for damages in any civil action or subject to prosecution in any criminal proceeding for his act if he acts in good faith and without actual knowledge of revocation of the gift and in accord with the terms of a gift . . . .

From this comparison the following seems deducible: First, revocation of a gift could only affect the physician's liability to the survivors in an action based on the mutilation of a dead body; it could have no bearing on a physician's treatment of the donor prior to death; therefore, good faith compliance with the Act without notice of revocation suggests that the good faith disclaimer is not concerned with medical treatment given the donor but only the treatment of the donor as a corpse.

Three states retain variations of the earlier "without actual notice of a revocation" wording in their versions of the UAGA. CAL. HEALTH & SAFETY CODE § 7156(b) (West Supp. 1970); LA. REV. STAT. ANN. § 17:2357(C) (Supp. 1970); MD. ANN. CODE art. 43, § 149-O(b) (Supp. 1969).

Moreover, the committee proceedings contain no hint that the disclaimer should apply to a doctor's treatment of a donor as a patient.

The disclaimer was also explained at the hearing on the UAGA for the District of Columbia, at which one of the consultants to the Special Committee on the UAGA testified to the effect that it would not apply to malpractice or homicide charges where a surgeon removed an organ from a live donor.[44]

The informal interpretations of three major drafters of the UAGA substantiate the proposition that the disclaimer does not apply to a doctor's determination of the donor's death where that application would have the effect of exculpating a doctor's negligence in determining death. The chairman of the Special Committee of the National Conference of Commissioners on Uniform State Laws on the UAGA, Dean E. Blythe Stason, believes that a person acting negligently in determining death is not acting in accord with the terms of the UAGA.[45] The two technical consultants to the Special Committee, Dr. Alfred M. Sadler, Jr., and Blair L. Sadler, both of the National Institutes of Health, agree with Dean Stason. They further stated in a letter to the author that the disclaimer "in no way affects the existing body of laws concerning medical negligence and medical malpractice."[46] Apparently they believe that the

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[44] *See Hearing on S. 2999, supra* note 18, at 33-34 (emphasis added):

> Mr. BLAIR SADLER. . . . The normal remedies that have been open to an individual, either criminal or civil are still open to them under the Uniform Act. . . . [I]f, for example, there [were] some criminal aspects or some negligence by the physician or someone else concerned—*the donor's family* or recipient family or whoever is concerned—would have the legal mechanisms and legal remedies that they already have.
>
> . . . .
>
> Mr. BLAIR SADLER. . . . *[If] the person was not dead when the transplant occurred . . . therefore, the fact is that the physician contributed to the death of the person. The law related to homicide would definitely apply.*

While the thoughts come across poorly the idea is apparent that the removal of an organ prior to the point at which death occurred would render liable the responsible doctors involved.

[45] Letter from E. Blythe Stason to the author, Nov. 20, 1969, on file in the University of Arizona Law Library. Dean Stason phrased it as follows:

> Section 7C [of the UAGA] reads 'A person who *acts* in good faith *in accord with the terms of this act* . . . . is not liable *for his act.*' This could not reasonably be interpreted to exculpate negligence. There are at least two lines of reasoning that lead to this conclusion. First a court is not likely to hold that a negligent physician acts 'in good faith.' Second, the exculpation extends only to acts of a physician in accordance with 'this act,' i.e., the Uniform Anatomical Gift Act. The Act does not deal in any way with negligence, or malpractice or definitions thereof.

[46] Letter from Alfred M. Sadler, Jr., and Blair L. Sadler to the author, Nov. 20, 1969, on file in the University of Arizona Law Library. The full context of the Sadlers' remarks on the good faith clause follows.

> The phrase 'good faith' was not intended to sanction or approve negligent conduct. Please note the language in Section 7(c) which states: 'a person who acts in good faith *in accord with the terms of this Act* . . . .' This only means that a person who follows the procedures outlined in the Uniform Act should not be subject to civil liability or criminal prosecution. It in no way affects the existing body of laws concerning medical negligence and medical malpractice. Thus, if a physician

exculpatory clause affords no protection to the negligent *determiner of death*, since their remarks were made in response to a question of the possible immunity of the negligent determiner of death under the disclaimer.[47]

Another consideration which militates against construing the disclaimer to immunize the negligent determiner of death from liability is that the disclaimer, were it to be interpreted in this manner, might be held unconstitutional. Since many states have constitutional provisions which prohibit the abrogation or limitation of actions for damages for injuries,[48] if the UAGA's disclaimer were to be read to limit the common law right to sue for injuries caused by malpractice,[49] it would be presumptively unconstitutional.[50] Indeed, the same objection has been made to Good Samaritan Acts which typically immunize from liability a doctor who, acting in good faith, negligently renders medical treatment in an emergency situation.[51] Unfortunately, the objection has only been presented,[52] and not answered.[53]

Bolstering the arguments against an extension of the disclaimer to the medical aspects of transplantation is a commonsense consideration.

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acts negligently in the transplant setting, he is subject to the legal remedies which would ordinarily be available to any individual who is alleging harm from medical negligence.

[47] Letter from the author to Alfred M. Sadler, Jr., and Blair L. Sadler, Nov. 7, 1969.

[48] *E.g.*, ARIZ. CONST. art. 18, § 6: "The right of action to recover damages for injuries shall never be abrogated, and the amount recovered shall not be subject to any statutory limitation."; ARIZ. CONST. art. 2, § 31: "No law shall be enacted in this State limiting the amount of damages to be recovered for causing the death or injury of any person."

[49] *See* McCoid, *The Care Required of Medical Practitioners*, 12 VAND. L. REV. 549, 550 (1959). There the author notes that malpractice suits were recognized in England as early as the 14th century, Y.B. Hill, 48 Edw. 3, f. 6, pl. 11 (1374), and have been known in America since 1794, Cross v. Guthery, 2 Root 90 (Conn. 1794).

[50] *See, e.g.*, Moseley v. Lily Ice Cream Co., 38 Ariz. 417, 420, 300 P. 958, 959 (1931):

> It is urged that this provision [ARIZ. CONST. art. 18, § 6] makes the former common-law action for negligence a constitutional one, and that it cannot be abrogated by the legislature. We think there is no question that this proposition, stated in the abstract, is correct.

What the court meant by "stated in the abstract" was that the common law action for negligence could not be abrogated without a meaningful alternative like a workmen's compensation statute.

[51] *See, e.g.*, ARIZ. REV. STAT. ANN. § 32-1471 (Supp. 1969-70) (emphasis added):

> A physician or surgeon . . . or any other person who renders emergency care at a public gathering or at the scene of an emergency occurrence gratuitously and *in good faith* shall not be liable for any civil or other damages as the result of any act or omission . . . unless such person . . . is guilty of gross negligence.

Cf. W. PROSSER, *supra* note 6, at 340 n.75.

[52] 2 D. LOUISELL & H. WILLIAMS, MEDICAL MALPRACTICE ¶ 21.36, at 594.27-.29 (1969), in which the authors elaborated as follows:

> Thus a court . . . might well conclude that it [a Good Samaritan Act] is unconstitutional, especially in a state with a 'right to a remedy' constitutional guarantee, and particularly so in the absence of a clear showing of genuine social necessity for the abolition. *Id.* at 594.28.

[53] *Id.* ¶ 21.01, at 594.3.

Since an attending physician who determines death and withdraws supportive devices in the nontransplant setting would not be protected from charges of negligence by the UAGA disclaimer, the same physician performing the same tasks as a prelude to a transplant similarly should not be protected from liability for negligence.

Despite the above arguments, however, some construe the disclaimer in broader terms. Six state legislatures, by amending or eliminating the disclaimer, have impliedly shown that they have interpreted the clause to exculpate the negligence of physicians, including determiners of death. Montana, for one, eliminated the disclaimer entirely,[54] because objections were voiced that its reach was too broad.[55] North Carolina replaced good faith with "due care."[56] Two other states, Florida and Missouri, added "without negligence" to the good faith portion of the disclaimer,[57] and Oregon's UAGA contains "with probable cause" in place of in good faith.[58] According to one Oregon legislator, the change was necessary because

> [i]f the doctor was anxious to get a transplant out of the donor and was negligent in determining whether the donor was actually dead . . . 'probable cause' would give the donor more protection than the phrase 'in good faith.'[59]

What the legislator apparently meant was that a probable cause standard would give the overly anxious transplanter more reason to consider carefully the diagnosis of death. More importantly, the above statement is proof that at least some believe that the good faith disclaimer exculpates the negligent determiner of death.[60]

Recognizing not only the deficiency in an overly vague disclaimer but also the danger of an unduly narrow one is the South Carolina version:

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[54] *See* MONT. REV. CODES ANN. § 69-2321 (Supp. 1969).

[55] *See* Letter from William F. Cashmore, M.D., Executive Secretary, Montana Board of Medical Examiners, to the author, Oct. 20, 1969, on file in the University of Arizona Law Library:

> [W]hen the Bill [the UAGA] reached the debate stage in the House of Representatives, two attorneys, both members of the Committee on Judiciary, opposed the Bill because of the disclaimer provision particularly. It was their contention that such a clause would protect almost everyone who claimed good intention from civil liability. They felt that it would be very difficult to prove bad faith. . . . Several meetings were held between the opponents and me and the clause was amended out. . . . Only in this way could the opposition be removed.

[56] N.C. GEN. STAT. § 90-220.7(C) (Supp. 1969).

[57] Ch. 69-88, § 9 (2 FLA. SESS. LAW SERV. 212 (1969)); MO. ANN. STAT. § 194.270(3) (Supp. 1969-70).

[58] ORE. REV. STAT. § 97.290(3) (1969) (emphasis added):

> A person who acts *with probable cause* in accord with the terms of sections 1 to 9 of this Act . . . is not liable for damages in any civil action or subject to prosecution in any criminal proceeding for his act.

[59] Minutes, Ore. Senate Comm. on Judiciary, Apr. 14, 1969, *quoted in* letter from Robert W. Lundy, Legislative Counsel, Ore. Joint Comm. on Rules & Resolutions, to the author, Nov. 19, 1969, on file in the University of Arizona Law Library.

[60] The legislator's motion to substitute "with probable cause" for "in good faith"—after his short explanation—carried. *Id.*

> A person who acts in good faith . . . is not liable . . . for his act. *Provided, however,* that such immunity from civil liability shall not extend to cases of provable malpractice on the part of any physician, surgeon or other medical attendant.[61]

This amendment insures, first, that the good faith disclaimer will not be applied to the acts of medical personnel in treating patients. At the same time, it also insures that doctors and others will be judged by the good faith standard in utilizing parts of dead bodies. Thus, solid protection against mutilation suits will be retained, while medical treatment of patients as it relates to malpractice claims will continue to be judged by the standards observed by the medical profession.

The Sadlers and Dean Stason recently commented on these modifications of the disclaimer as follows:

> The concern has been expressed that this provision [section 7(c)] gives legal protection to negligent conduct or malpractice as long as the individual could argue that his actions were in 'good faith.' . . . These amendments are not harmful but they are unnecessary. In conferring immunity upon individuals who act 'in good faith *in accord with the terms of this Act or under the anatomical gift laws of another state,*' the Commissioners did not modify the law regarding malpractice. The above language so indicates.[62]

The authors appear to beg the question by simply reiterating section 7(c) as an answer to fears of the exculpation of malpractice. The question as suggested above is, what does acting in accord with the Act entail? Thus, they do not satisfactorily explain why the amendments are "unnecessary."

Despite the assurances of the drafters, there remains the danger that the disclaimer could be extended to immunize *all* death determiners from liability as long as they acted in subjective good faith.[63] This outcome

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[61] S.C. CODE ANN. § 32-717(c) (Supp. 1969).

[62] Sadler, Sadler & Stason, *Transplantation and the Law: Progress Toward Uniformity*, 282 NEW ENG. J. MED. 717, 718-19 (1970).

[63] Writers have suggested rather elliptically that the disclaimer protects the unconventional determiner of death who acts in good faith. *See* Corday, *The Patient's Rights Must Always Come First*, in PROCEEDINGS OF THE NATIONAL MEDICOLEGAL SYMPOSIUM 58, 61 (1969), where the author, a heart specialist, states:

> If a surgeon who removes a heart for transplant should be charged with homicide, a jury will have to decide . . . whether the donor was alive when the heart was removed. If the criteria relied upon by the medical witness do not appear reasonable, the jury may not accept his medical opinion. *Fortunately passage of the [Uniform] Anatomical Gift Act will protect the surgeon from such possible criminal or civil prosecution.* (emphasis added).

R. PORZIO, THE TRANSPLANT AGE 67 (1969); Randall & Randall, *The Developing Field of Human Organ Transplantation*, 5 GONZAGA L. REV. 20, 37 (1969), where the authors state:

> The possible criminal or civil responsibility of the physician who makes the determination to discontinue medical treatment in maintaining circulation is apparently governed by the [Uniform] Anatomical [Gift] Act. A person acting in good faith in accordance with the terms of the Act is

of course would be in marked contrast to the purpose of the UAGA to protect the determiner of death from unwarranted liability on the basis of outmoded legal definitions of death only if he would be judged nonnegligent by the members of his profession.

In order to prevent the disclaimer from being interpreted to exculpate negligent diagnoses of death, therefore, those states yet to enact the UAGA[64] should revise section 7(c). To follow the lead of some states, however, would seem to ignore the distinction between medical and nonmedical aspects of a doctor's acts under the UAGA. Indeed, the states which added an unqualified "without negligence"[65] or with "due care"[66] to the good faith requirement may have caused the doctors to become susceptible to claims of negligent mutilation of dead bodies, the prevention of which, however, is surely a basic goal of the disclaimer. Thus, a revision is offered here with a twofold purpose in mind: to avoid the exculpation of doctors negligent in their treatment of patients and to retain the intended immunization of doctors and others from civil and criminal mutilation charges. The following reformulation of section 7(c), based in part on the South Carolina amendment, is therefore proposed:

> A person who acts in good faith in accord with the terms of this Act or with the anatomical gift laws of another state or a foreign country is not liable for damages in any civil action or subject to prosecution in any criminal proceeding for his act; *provided that nothing contained in this or any other clause of this Act shall be construed to exculpate the negligence of any physician, surgeon, or other medical attendant in rendering or discontinuing medical treatment to a patient.*[67]

CONCLUSION

Analysis of the impact of Section 7 of the UAGA on the determination of death in conjunction with anatomical gifts has shown that subsection (b) was intended to authorize determinations of death considered medically proper, irrespective of prior judicial definitions of death. Thus, the question whether a doctor was negligent by withdrawing supportive therapy or the surgeon negligent by removing an organ at a point before the oc-

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not liable for damages for criminal prosecution.
The observation, however, begs the question presented earlier, *viz.* whether the doctor is acting in accord with the Act when he makes a determination of death and a decision to withdraw supportive therapy.

See also letter from R.E. Stevenson to Senator Charles E. Goodell, Washington, D.C., *reprinted in Hearing on S. 2999*, *supra* note 18, at 90: The UAGA will "make it practically possible to exchange tissues across state lines without fear of legal entanglements *or malpractice suits.*" (emphasis added).

[64] Alaska, Arizona, Delaware, Kentucky, Massachusetts, Mississippi, Nebraska, New York, and Virginia. The District of Columbia should also consider the revision.

[65] Statutes cited note 57 *supra.*

[66] Statute cited note 56 *supra.*

[67] UAGA § 7(c) (the proposed amendment is italicized).

currence of conventional death would depend solely on the medical acceptability of the criteria used by the doctor in his unconventional determination of death.[68] The Act therefore assumes a larger role in the scheme of transplantation. Not only are doctors authorized to autopsy and extract organs from—mutilate if you will—dead bodies without fear of liability; they are also authorized to use their best medical judgment in determining the point at which transplantation can be commenced without judicial second-guessing unless their judgment does not accord with acceptable medical practice.

However, the drafters of the UAGA may have misread the previous legal environment on the question of the time of death. Although the courts classified the occurrence of death as a question of fact, it appears that legal criteria constituting the definition of death limited the doctors' options in setting a time of death. In other words, while the previous judicial statements that the time of death is a question of fact in effect bolster the drafters' and the medical profession's argument that death should not now be defined statutorily, the UAGA might inadvertently carry over what the courts actually meant by categorizing the question as one of fact—that, *based on legal criteria,* doctors could determine when death occurred. Since death according to legal criteria was defined in conventional terms, unconventional determinations of death could, therefore, still be considered unacceptable if doctors were prevented from utilizing and being measured according to medical criteria.

On the other hand, courts could go to the other extreme and interpret the disclaimer to immunize doctors from liability for determinations of death regardless of the acceptability in the medical profession of the definition used. The application of the disclaimer to all doctors acting in good faith would be accompanied by an undesirable concomitant—protection for the negligent doctor from liability.

Consequently, to insure the attainment of the goals that the determination of death in the transplant setting is only to be considered a question of fact and that the disclaimer is inapplicable for judging the medical aspects of a doctor's actions in conjunction with transplantation, the amendments to subsections (b) and (c) of section 7 should be incorporated into the UAGA.

[68] *See* M. HOUTS & I. HAUT, *supra* note 7, § 1.05, at 1-49; Stickel, *Organ Transplantation in Medical and Legal Perspectives,* 32 LAW & CONTEMP. PROB. 597, 612 (1967).