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THE LEGAL PROBLEMS OF ORGAN TRANSPLANTATION

EMILE ZOLA BERMAN†

I. INTRODUCTION

THE MEDICAL PROFESSION has for several years been able to remove from the body of a donor and implant into the body of a recipient organs such as the kidney. Recently, medical science has progressed to the point where such transplants involve an organ as vital to human existence as the heart. Transplanting the heart, in addition to raising anew the problems created by organ transplants generally, presents issues of greater scope and dimension for the physician and lawyer. The ensuing discussion will focus on the legal aspects and implications of these transplant operations.

Unlike other organ transplants in which the donor is alive at the time of the operation, in heart transplants the donor must be dead at the time the organ is removed. This fact raises the threshold question of when a donor is legally dead. A definition of death must therefore be formulated in order to guide the doctor who may be subject to criminal sanctions and civil liability if he removes the heart from a donor who is not legally dead. In organ transplants from a deceased donor additional questions arise as to the right of the donor to dispose of his organs upon his death, the procedures to be followed to insure that the donor has agreed to the removal of his organs, and the right of the donor's family to object to the transplant. Moreover, as in all types of surgery, both the donee of a transplant and the living donor must give their "informed voluntary consent" to the operation. The doctor must therefore inform the donee of the risks of the transplant operation and the possible consequences of the receipt of another's organ, and must advise the living donor of the risks involved in the loss of an organ. Finally, there is a legal problem concerning the application of the "rescue doctrine." Under this doctrine one who is injured in an attempt to rescue a person placed in danger by the negligence of another has a right of recovery against the negligent tortfeasor.[1] Where the rescue requires the transplantation of an organ, the question arises whether the organ donor may rely on this doctrine to recover from the negligent tortfeasor for adverse effects resulting from the transplant.

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1. Wagner v. International Ry., 232 N.Y. 176, 133 N.E. 437 (1921).

It is the purpose of this Article to discuss the questions raised and to consider some approaches to solutions.

II. A LEGAL DEFINITION OF DEATH

Traditionally, the standard for determining the time of death has been the cessation of heart beat and respiration. In *Black's Law Dictionary* death is defined as:

> The cessation of life; the ceasing to exist; defined by physicians as a total stoppage of the circulation of the blood, and a cessation of the animal and vital functions consequent thereon, such as respiration, pulsation, etc.[2]

Until recently, the law has accepted this traditional medical definition.

Since the concept of the death is one of finality, the present ability of physicians to revive the heart after it has stopped beating should logically move the point of death to the time when the cessation of the heart beat is irreversible. Marshall Houts, in his authoritative work, *Death,* after reviewing the authorities and keeping in mind the present state of medical knowledge, has offered the following legal definition of death:

> Death is the *final* and *irreversible* cessation of *perceptible* heart beat and respiration. Conversely, as long as any heart beat or respiration can be perceived, whether with or without mechanical or electrical aid, and regardless of how the heart beat and respiration were maintained, death has not occurred.[3]

While this definition of death takes into consideration the recent medical advances of heart resuscitation, the underlying standard of determining death is the same as in the traditional definition, *i.e.,* the cessation of heart beat and respiration.

In light of the present state of medical knowledge, many authorities have questioned whether the present standard for the definition of death is adequate. They contend that the traditional criteria should be replaced, and propose that cessation of brainwave activity is a more reliable index of death.[4] These investigators state that death occurs when electrical brain activity, measurable on an electroencephalograph (EEG), ceases. Even if the cessation of brainwave activity were accepted as a more reliable index of death, the question still remains as to the period for which this cessation must persist before we may

2. BLACK'S LAW DICTIONARY 488 (4th ed. 1951).

3. M. HOUTS, DEATH § 1.03 (4) (1967).

4. *E.g.,* Hamlin, *Life or Death by EEG,* 190 J.A.M.A. 112 (1964).

conclude that death has occurred, since brainwave activity can resume after some period of time.[5]

In heart transplants this problem of definition can be crucial since the removal of the heart precludes any revival of the donor's life, and, thus, the doctor runs the risk of civil liability and criminal sanctions if it should be found that a patient were not legally dead at the time the organ was removed. The problem of determining when a physician can legally remove the heart is further complicated by the fact that successful transplantation depends on removal of the organ as soon as possible after death. As Dr. Elkinton pointed out in his presentation, the longer the doctor delays removal of the heart, the greater the risk that it will be so damaged as to render it unusable for the transplant.[6]

Dr. Schwab, Director of the Massachusetts General Hospital Brain Wave Laboratory, in collaboration with Sidney Rosoff, a New York attorney, has worked out a set of guidelines for a determination of death in transplantations.

> In essence they consist of a triad — three standards — and are based on the patient being unanesthetized, undrugged and at room temperature.
>
> [1] The first is that there must be no reflexes and the pupils must be dilated and fixed.
>
> [2] The second is that there must be no breathing and no spontaneous spasms or muscle movement.
>
> [3] The third is that there be no active brain wave.
>
> [4] Finally, these conditions must prevail for at least 24 hours "because there are cases where there is a flat brain wave which suddenly comes back."[7]

While a person meeting these standards would be irrefutably dead, the requirement that these conditions prevail for at least 24 hours may render that person's organs unusable for purposes of transplantation.

Since the physician who performs an organ transplant may be exposed to criminal sanctions or civil liability, and since in most instances imposition of sanctions or liability will hinge upon the legal determination of the time of the donor's death, it is imperative that a definitive and workable standard for determining the time of

5. The French National Academy of Medicine proposed 2 years ago that a person be considered dead when his EEG has reflected no brain activity for 48 hours. NEW REPUBLIC, Mar. 16, 1968, at 7.

6. Elkinton, *The Dying Patient, the Doctor, and the Law,* 13 VILL. L. REV. 740, 746 (1968).

7. Boston Herald Traveler, Mar. 3, 1968, § 3, at 12, col. 5.

death be established. It is not for the legal profession, however, which lacks the requisite medical expertise, to establish this standard. Only the medical profession can resolve the issue.

III. GIFT OF DECEASED'S TISSUE

Those transplants which involve removal of parts of the body after the death of the donor raise questions concerning the right of a person to donate his organs, the right of survivors to object to their removal when there is such a donation, and the right of survivors, absent a prior donation, to grant permission for the removal of parts of the deceased's body after his death. American courts have recognized limited property rights in dead bodies primarily for the purposes of preservation and burial.[8] In recognizing the existence of these limited property rights, the courts have held that the decedent has the right to direct the manner and place of burial.[9] However, the courts also recognize a right existing in the next of kin for the purpose of preservation and burial.[10] Where conflicts between the wishes expressed by the deceased and those of the surviving next of kin arise, the courts have weighed the relative interests of the parties, giving preference to the desires of the deceased.[11]

To date there have been no cases extending an absolute right to dispose of all or parts of the body to either the deceased or his survivors. In these situations, the courts, in attempting to balance the wishes of the deceased against the desires of his next of kin concerning removal of portions of the body, should give weight to the effect of such removals on the feelings of the surviving next of kin. Thus, where a surviving spouse or next of kin objects to the disposition of the deceased's organs after death, a court should consider the objections, even though the decedent would appear to have the paramount right to determine what disposition may be made of his body.

Most of the states have attempted to resolve some of the problems concerning the disposition of a dead body under common law by enacting statutes permitting a person to donate all or parts of his body to science upon his death. The New York statute on pre-arranged disposition of cadavers is typical of such laws. It provides:

> 1. A person who is eighteen years of age or older has the right to direct the manner in which his body shall be disposed of after his death, and also to direct the manner in which any part

8. Pettigrew v. Pettigrew, 207 Pa. 313, 56 A. 878 (1904).
9. *In re* Schenck's Estate, 172 Misc. 236, 14 N.Y.S.2d 946 (Sur. Ct. 1939).
10. Darcy v. Presbyterian Hosp., 202 N.Y. 259, 95 N.E. 695 (1911).
11. Yome v. Gorman, 242 N.Y. 395, 152 N.E. 126 (1926).

Berman: The Legal Problems of Organ Transplantation

of his body, which becomes separated therefrom during his lifetime, shall be disposed of.

2. A person who directs the manner in which his body shall be disposed of after his death, pursuant to the provisions of this section, shall receive no remuneration or other thing of value for such disposition and such disposition shall be solely for the purpose of advancing medical science or for the replacement or rehabilitation of diseased, worn-out or injured parts of the bodies of living human beings.

3. Any such donation, authorization or consent made pursuant to the provisions of this section shall be by written authorization of the deceased made during his lifetime and signed by him in the presence of at least two witnesses, aged 18 or over, whose signature shall be affixed thereto. Each instrument may designate the donee, but such designation shall not be necessary to its validity. A donee may be an individual, or a licensed hospital, institution or agency engaged in the advancement of medical science or the restoration of diseased, worn-out or injured parts of living human beings, or a bank maintained for the storage, preservation, and use of the parts of the body. . . . Any such disposition of his own body or parts thereof may be revoked by the donor any time prior to his death by a written instrument executed in the same manner as herein provided for authorizations.

4. "Body," as used in this section, refers to the human body or any part of it, including the blood.[12]

Other states further provide that donations of all or part of the body may be made by the next of kin of the deceased.[13] This power in the next of kin, however, would exist only in cases where the deceased has not expressed his own desires concerning the disposition of his body after death.[14]

Because of the differences in the statutes of the various states a conflict of laws problem can arise when, for example, a donor dies in a state where he is not domiciled. In an effort to provide a solution, the Conference of Commissioners on Uniform State Laws is currently considering a Uniform Anatomical Gift Act.

IV. INFORMED VOLUNTARY CONSENT

In organ transplants, just as in all other operations, the patient must give his "informed voluntary consent" to the operation, and a physician who fails to secure this consent may be subject to civil lia-

12. N.Y. PUBLIC HEALTH LAW § 4201 (McKinney Supp. 1967).
13. *E.g.*, WASH. REV. CODE ANN. § 68:08.260 (1962).
14. *E.g.*, *id.*

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bility. It is the physician's duty to supply the patient with sufficient information concerning the risks involved in the treatment and the results that may reasonably be expected, in order to enable the patient to make a knowledgeable choice whether to proceed with the operation.

Although all jurisdictions agree that the physician has this duty of disclosure, they are in conflict as to the amount of information which must be disclosed. New York appears to hold that the duty to disclose is absolute — the physician must inform the patient not only of the nature of the operation, but also of the dangers and hazards to be anticipated therein. In *Fiorentino v. Wenger*,[15] the surgeon performed an uncommon, drastic spinal tract operation on a 14-year-old patient who died as a result of the operation. The New York Court of Appeals held that, on the evidence, the jury was entitled to find that the surgeon had never explained sufficiently to the parents of the infant the hazards of the operation, the available alternatives, or the fact that the procedure was not employed by anyone else in the country. Accordingly, in New York, a surgeon may be held liable for injuries to a patient where he has withheld facts necessary to the patient's formulation of an intelligent consent, or where he has unduly minimized the dangers of the surgical procedures.

Apparently, where a minor is involved, even where the minor is mature enough to understand the nature of his act, the consent of both the minor and the guardian is necessary. In *Bonner v. Moran*,[16] a 15-year-old boy consented to a skin grafting operation for the benefit of his cousin. Recovery was permitted against the doctor for assault and battery since the consent of the parents, in addition to the consent of the child, was held to be necessary for a surgical operation on a minor. The Supreme Judicial Court of Massachusetts, however, seems to require more than the consent of the minor and the guardian. In 1957 it rendered three advisory opinions in declaratory judgment proceedings allowing transplants between minor twins.[17] The court found that each of the donors had consented, that each was mature enough to understand the consequences of his act, and that their guardians had also consented. Nevertheless, in approving the transplants the court felt constrained to find some sort of benefit to the donors and relied on the testimony of a psychiatrist that each donor would suffer "grave emotional impact" if he were not allowed to donate a kidney in an effort to save his brother's life. The court evidently found no authority on point and gave no reason why benefit should be

15. 19 N.Y.2d 407, 227 N.E.2d 282, 280 N.Y.S.2d 373 (1967).
16. 126 F.2d 121 (D.C. Cir. 1941).
17. Foster v. Harrison, No. 68674 (Eq., Mass. Sup. Jud. Ct., Nov. 20, 1957); Huskey v. Harrison, No. 68666 (Eq., Mass. Sup. Jud. Ct., Aug. 30, 1957); Masden v. Harrison, No. 68651 (Eq., Mass. Sup. Jud. Ct., June 12, 1957).

necessary when both the minor and his parents give their informed consent.[18] The better rule would be that the guardian's approval is sufficient, if the subject also consents.

V. THE RESCUE DOCTRINE

Under the rescue doctrine, a negligent tortfeasor is liable to one who is injured while attempting to rescue a party placed in danger by the tortfeasor's negligence.[19] In organ transplants the question is whether an organ donor who makes the donation in order to save the life of a donee who is put in the position of needing a transplanted organ due to the negligence of another can recover against the tortfeasor for illness suffered as a result of the loss of the organ.

In *Serianni v. Anna,*[20] a New York court held that the rescue doctrine gave the donor no such rights. In that case a mother donated one of her kidneys to her son who, after the removal of his kidneys, was kept alive by a mechanical device. The transplant was successful, and the donee was still living 4 years later. The plaintiff mother instituted an action alleging that her health was impaired by the loss of one of her kidneys. The court held that a donor who gives up an organ with full knowledge of the consequences does not have a cause of action against the doctor whose malpractice made the transplant a necessity and granted the defendant's motion to dismiss. The court further noted that no "such theory of suit as alleged in plaintiff's complaint has ever before, it seems, been put forward in any court anywhere."[21] It seemed to the court "that it [was] called upon by this complaint to invent a 'brand new cause of action' presently outside our legal concepts of suable tortious conduct."[22] The court concluded that the premeditated, knowledgeable, and purposeful act of the plaintiff in donating one of her kidneys to preserve the life of her son did not extend or reactivate the consummated negligence of the tortfeasor. The conduct of the plaintiff was a clearly defined, independent, intervening act done with full knowledge of the consequences. The court examined landmark cases which applied the rescue doctrine but found in each that the rescuer acted without knowing his fate. Consequently, the court held that these rescue cases were not applicable since the donor's act had been willful, intentional, voluntary, free from accident, and with full knowledge of its consequence.

18. *See* Curran, *The Problem of Consent, Kidney Transplantation in Minors,* 34 N.Y.U.L. REV. 891 (1959).
19. Wagner v. International Ry., 232 N.Y. 176, 133 N.E. 437 (1921).
20. 55 Misc. 2d 553, 285 N.Y.S.2d 709 (Sup. Ct. 1967).
21. *Id.* at 555, 285 N.Y.S.2d at 711.
22. *Id.* at 555, 285 N.Y.S.2d at 712.

VI. CONCLUSION

Since the recent medical advances in organ transplants raise questions of serious import, it is essential that these questions be resolved in order to protect the rights and interests of donors, donees, and physicians. For some of these answers the law must necessarily look to the medical profession, while for others the present law must be reevaluated in order to balance the need for continuing progress in medical research and the relevant rights of donors and donees.