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HUMAN ORGAN TRANSPLANTATION: LEGAL ASPECTS

THOMAS J. FORD *

IT IS A COMMONPLACE that ours is an age of complexity. A feature of a complex age is the phasing out of simple solutions precisely because it becomes obvious that the problems of a complex age have no simple solutions. When medical science opens doors revealing new vistas of life to human eyes, we must together deal with balancing the tensions that then arise between science, culture, law and morality. On December 3, 1967 the attention of the world was riveted on South Africa where Dr. Christian Barnard transplanted a human heart to replace the worn-out organ in the body of Lewis Warshansky. Further heart transplants followed rapidly so that today the world has witnessed more than 100 and Dr. Philip Blaiberg has celebrated the first anniversary of his transplant lease-on-life with the heart of a mulatto, Clive Haupt, beating strongly within his breast. But transplants have been with us for more than a generation. Corneas were successfully transplanted in the 1940's. A human kidney was first transplanted in 1954. Many other tissues are now being successfully transplanted, including skin, cartilage, tendon, nerve, artery, heart valve and bone. The pancreas, the thymus, the liver and lung have been transplanted in man. Eye banks, bone banks, artery banks, pituitary banks and blood banks have been established.

Although forty of our states have laws regarding human tissue and organ transplants, the present laws concerning same are a composite of archaic common-law principles, autopsy, unclaimed body and medical examiner's statutes, and patch-work donor legislation. The chart annexed (Appendix A) illustrates the situation in the various states.

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The failure of the law to keep step with medical progress, the severe time demands requiring the speedy removal of tissue and organs, and the need for uniform legislation in this field, has become obvious. Uniformity is needed not only because of the great diversity of statutory provisions on the subject or the lack of any statutory provisions on the subject, but also because of the high mobility of the American population. Although a gift of tissue or organs may be executed in state A, death may occur in state B and the organs given may be needed in state C. Jet travel makes international donation perhaps feasible. There is a further need for uniformity to protect the doctor, donee and others involved against a suit for damages and/or criminal prosecution for an alleged unlawful and unauthorized autopsy, transplant or dissection.

Transplants of human tissues and organs involve the patients, their families and their doctors. They include:

- A. Donation by a person to be effective during his lifetime.
- B. Donation by a person to be effective at his death.
- C. Donation by next-of-kin of a cadaver.
- D. Use by medical examiners, doctors and others of cadaver tissue and organs.

The right of an adult person of sound mind to *voluntarily consent* to a tissue or organ transplant from his body during his lifetime has not been questioned. However, consent must be *informed* as well as *voluntary*.

New York's highest court has imposed a duty on doctors to inform the patient

of the novelty of the operation, the risks involved, the broad details of its execution and the fact that it is a procedure not yet generally accepted by the medical community.¹ The same court held that the hospital is not responsible when the surgeon selected by the patient departs from standard medical procedure.

When a minor donates his tissues or organs the consent of his parent or guardian is necessary.²

A donor of an organ cannot recover against a tortfeasor of the donee under the "Rescue Doctrine".³ This case involved the donation of a kidney by a mother to her son. The son had recovered damages in a cause of action for malpractice against his physicians for the loss of his kidneys. When the mother sued on the grounds that her obligation to donate her kidney also arose from the physician's negligence in the treatment of her son, her claim was denied.

Early common-law decisions in England held there were no property rights in the body of a deceased person. The English Courts further concluded that since a body is not property, it is not a part of the decedent's estate, and thus a person could not direct the disposition of his remains. American courts did not accept this reasoning and, therefore, in American law the theory of a "quasi-property right" evolved giving a decedent

¹ *Fiorentino v. Wenger*, 19 N.Y.2d 407, 227 N.E.2d 296, 280 N.Y.S.2d 373 (1967).

² *Bonner v. Moran*, 126 F.2d 121 (D.C. Cir. 1941) (A skin transplant from a 15 year-old minor to his cousin without either parents' knowledge or consent).

³ *Sirianni v. Anna*, 55 Misc. 2d 553 (Sup. Ct. Erie County 1967).

in his lifetime, or the next-of-kin after his death, authority to direct the post-mortem disposition of the body. It has been stated in New York that the wishes of a decedent with respect to the disposition of his remains are paramount.⁴ There are few cases dealing with donation of human tissue or a human organ by either the decedent or the next-of-kin. The severe time demands requiring the speedy removal of the tissue or organ involved and the reluctance of those concerned to resolve disagreements over donations by litigation explain the almost total lack of case law on this subject.

In New York the applicable statutory authority lies in Section 4201 of the Public Health Law which had its origins in the Penal Law and by a series of amendments, since 1960, has reached its present status. It is entitled "Cadavers—prearranged disposition" and now provides in substance that:

1. A person 18 years of age or over has the right to direct the manner in which his body may be disposed of after his death and also the right to dispose of any part of his body which becomes separated therefrom during his lifetime. Although the statute sets the age at 18 years, it would be wise to obtain the consent of at least one of the parents of a minor donor.

2. Such person shall receive no remuneration or other thing of value.

3. Any donation shall be by written authorization of the deceased made during his lifetime and signed before at least

two witnesses who also must be 18 years of age or over and who also must sign. The donee need not be named.

4. The hospital or doctor who removes the organ, may not charge the estate of the donor for services rendered.

5. The hospital, the donee, the doctor and nurse are protected against civil or criminal liability provided the donor has executed a valid, written consent.

6. The authorization may be revoked by the donor by a similarly executed written instrument.

7. The body as defined in the statute refers to the human body or any part of it including the blood.

Absent the written authorization of the decedent, a lawful cadaver transplant may be made under Section 4210 of the Public Health Law with the written consent of the surviving spouse or next-of-kin. However, next-of-kin are not defined in the Statute and this omission proves troublesome. Further the consent must specify the purpose and extent of the dissection authorized. A consent to an autopsy does not include permission to remove organs unless specifically granted. Section 4210a makes an unauthorized dissection a misdemeanor.

Section 4211 of the Public Health Law permits the delivery of an unclaimed body to a medical college, school or university for the purposes of medical, anatomical and surgical science and study. However, there is a waiting period of 24 to 48 hours before this may be done.

In line with recent developments, the New York State Legislature has created a Temporary State Committee on Vital Organ Transplants under the Chairmanship of Supreme Court Justice J. Irwin

⁴ See *In re Herskovits*, 183 Misc. 411 (Sup. Ct. Queens County 1944).

Shapiro. Hearings commenced in New York on December 12, 1968, and a final report was due the Legislature, February 15, 1969. However, Judge Shapiro has requested an extension of the deadline because of the vast amount of information to be collated.

The Division of Medical Sciences of the National Research Council which is supported by the Surgeon-Generals of the Army and Navy and the National Institute of Health of the Public Health Service have instituted studies with respect to human tissue and organ transplantation. As a result of these studies and the work of the National Conference of Commissioners on Uniform State Laws, a final draft of a Uniform Anatomical Gift Act was proposed on July 30, 1968. It received the approval of the American Bar Association on August 7, 1968. A copy of the Act is annexed (Appendix B). This law has since been passed by the legislatures of Maryland, Kansas, Louisiana and California and gives every indication of general public support. It is presently under study by the Legislatures of Pennsylvania, New Jersey and New York, among others. Hawaii and Virginia have sought to deal with the problem by authorizing the coroner or medical examiner of any county to retain tissues at the time of autopsy to be used for necessary or advisable scientific investigation including research, teaching *and therapeutic purposes*. The Virginia statute authorizes the medical examiner to authorize a transplant of the organ of the decedent under his jurisdiction when there is *insufficient time to contact the*

next-of-kin of the decedent. This "fait accompli" approach has been urged by a doctor and lawyer team—Dukeminier and Sanders, in an article entitled "Organ Transplantation: A Proposal for Routine Salvaging of Cadaver Organs".⁵ Instead of Donation Legislation they propose a system in which the attending physician would be allowed to remove cadaver organs "routinely" unless objections were entered before such removal. The burden would shift to the person who did not want the organ removed and he would be required to make known his objections immediately. I believe that this method, which ignores the sentiments and rights of the next-of-kin, could arouse such hostility and resentment to organ transplantation as to set its cause back 20 years. Legislation such as the Uniform Anatomical Gift Act allows for the advances of medical science yet respects the interests and rights of doctors, patients and next-of-kin.

The Uniform Act provides:

1. Any person, 18 years of age or more, and of sound mind may donate all or any part of his body.
2. It defines the next-of-kin and allows the individuals specified to make the gift *immediately before death* as well as *after death*.
3. It allows the donee to refuse the gift and specifies who may become donees.
4. It simplifies the making of the gift and renders a donative statement in a Will sufficient without the necessity of Probate.

⁵ 279 NEW ENG. J. OF MEDICINE 413 (1968).

5. It provides for card-carrying donors and allows for next-of-kin consent by telegraph, recorded telephonic or other recorded message.

6. It provides for amendment or revocation of the gift by the donor at any time and by any means.

7. It provides that the time of death shall be determined by the physician who attends the donor at his death and that this physician shall not participate in the procedures for removing or transplanting a part.

8. It protects a person who acts in good faith under the authority of the act against damages in a civil action or prosecution in a criminal proceeding.

In short, it is a creditable attempt to constructively and timely deal with the scientific and medical advances of our age. It illustrates the usefulness of medical-legal liaison in this area and the timeliness of this Symposium which is co-sponsored by the Catholic Physicians' Guild and the Catholic Lawyers' Guild, but it is only a beginning and it raises many serious questions which have not yet been resolved.

Foremost is the question of the time of death.

The necessity of a rapid transplant and the certainty that the donor's death will be caused by such transplant makes an early and certain determination of death crucial. Further, the donee's chances of survival are lessened considerably by any delay occasioned by the inability to make a prompt and accurate determination of the moment of death. What doth it profit a donee to receive a "half dead" organ?

At present there is no legal definition of the time of death based on 20th century facts. The National Conference of Commissioners on Uniform State Laws did not feel at the time of their study this past summer that a proper medical consensus existed to enable a formulation of a legal definition of the time of death. Medical science is presently making a valiant attempt to resolve this problem.

Until now the cessation of heartbeat and respiration has been the accepted medical and legal criteria for the determination of death. It is now known that different organs and tissues die at different rates and that a functioning cerebrum is essential to the life of the human being as a person. Consciousness disappears within ten seconds of cessation of circulation and complete and permanent loss of brain function within 15 minutes thereof. The cerebral cortical cells begin to die within 5 minutes. The time of death formerly depended mainly on factors *within* the patient. It may now depend increasingly on factors *outside* the patient: The availability of facilities, the decision to resuscitate, the choice of alternative death concepts ("brain damage," "heart death") and the decision to discontinue emergency survival treatment. The availability of machinery to support cardiac and respiratory function and the conflicting responsibilities of surgeons, coroners and medical examiners require a new definition of death. The following criteria have been suggested:

1. No reflexes, no spontaneous breathing, no muscle activity.
2. A flat EEG.

3. The same results when tested 24 or 28 hours later.

These factors of no reflexes, no spontaneous respiration or muscular activity and a slack EEG repeated after 24 hours appear to be gaining support as the basis for a definition of the time of death.

Until we have agreement on this fundamental fact we shall continue to have situations such as occurred in Houston recently. There the heart of the victim of an assault who had suffered irreversible brain damage, was kept beating by artificial means until a transplant could be performed. The coroner chose to certify the death on the basis of the cessation of heart function. The District Attorney was faced with the problem of whether a defendant can be tried for homicide when under present medical standards the victim actually died under the transplant surgeon's knife.

The times and the needs and the urgencies continue to raise similar problems. The advances in medical science that now give a doctor the power to modify the time of death for his patient also mandate that he act. When he acts in the true and conscientious pursuit of his science and his field, he should be protected by the law.

There are other problems:

Will transplant life saving procedures be available only to the wealthy?

The New York Act provides no remuneration for a tissue or organ gift. The Uniform Act makes no provision in this respect.

Will there be an organ black market if we legislate against remuneration?

How far can a doctor go when the outcome of a transplant operation is problematical?

If the situation is one of desperation. If the patient will die if nothing is done. Then even though the procedure attempted is a departure from past medical practice, if there is a chance of success there will appear to be some support for the attempt.

What criteria shall be used to determine who shall live and who shall die?

In England a notice posted in a hospital directed which patients in the case of cardiac respiratory arrest should be resuscitated and which should not. Those over 65 with certain diseases fell under the interdict. It raised a storm of protests.

And who shall be who when heads are finally capable of transplantings?

The advances in genetics are raising further awesome problems.

National interest in these fundamental questions is reflected in Senate Joint Resolution 145 introduced by Senator Walter F. Mondale. This Resolution calls for the establishment of a 15 member Presidential Commission on Health, Science and Society. The Commission shall undertake a comprehensive investigation and study of the legal, social and ethical implications of medical research and report its findings to the President and the Congress within one year after its first meeting. The President shall appoint Commission members from among representatives of medicine, law, science, theology, philosophy, ethics, health administration and government.

Pope Pius XII has told us that we are obliged to use ordinary but not extraordinary means to prolong life. That rather simple sentence covers extraordinarily complex situations. In a real sense, we are obliged to "play God" and take a role in the determination of the time of an individual death. It is obvious that these are questions to be decided not by the doctor alone but by the doctor and the next-of-kin and society. Now, there is no escaping the responsibility and the moral choices. It is perhaps the highest function of law to help resolve our doubts and stabilize choice by prescribing a public policy reflecting a consensus of values which pays heed not alone to the scientist but to the theologian, to the sociologist, and to the man in the street. Pure science is separate and distinct from the moral order. A synthesis between its imperatives and moral values must be resolved. I do not believe that this choice can be left to the self-discipline of the scientists alone. Regulation is necessary to prescribe the conditions of human experimentation which will advance the science and yet protect the dignity and health of the individual human being.

As recently as 1963, we had an example of the extremes to which the interests of science will lead responsible men. At that time it was scientifically known that a healthy patient would reject a transplant of foreign cancer cells promptly but that a cancer patient had a delayed and weakened rejection of foreign cancer cells. It became a matter of extreme scientific interest to determine whether weak patients, ill from diseases other than cancer, would reject foreign cancer cells

quickly or slowly. The U.S. Public Health Service and the American Cancer Society financed an experiment for the solution of the problem under the supervision of two doctors from the Sloan Kettering Institute. These doctors, with the permission of a Director of Medicine of the hospital, injected ill and weakened elderly patients with foreign cancer cells and observed them over several weeks. They did not inform them that foreign cancer cells were being placed in their system. Although oral consent was claimed, the doctors did not obtain written consent nor that of the next-of-kin of the patients. The experiment determined that weak, elderly patients have the same rejection power of foreign cancer cells as well patients—but at what cost in human values? ⁶

Dean Harold F. McNiece of St. John's Law School has aptly phrased our problem in a letter to Senator Mondale—the sponsor of Senate Resolution 145.

I believe the situation in the health sciences is analogous to that of the development of atomic energy. The availability of atomic energy has created a technological capacity for great world benefit or cataclysmic disaster and the world has yet to agree to ethical guidelines to insure the former and foreclose the latter. We are on the verge of a similar situation in the health sciences.

It seems to me, therefore, that the most critical area of exploration is the development of ways and means of keeping the social and ethical sciences

(Continued on page 168)

⁶ *Hyman v. Jewish Chronic Disease Hosp.*, 15 N.Y.2d 317, 206 N.E.2d 338, 258 N.Y.S.2d 397 (1965).

“use your freedom as an opportunity for the flesh” (Gal. 5:13). One might call it the “mortifying” act of Christian freedom; the word may not be popular today, but the notion is still Pauline (cf. Rom. 8:13). In any event, it is the act whereby Christian freedom stands forth in all its evangelical newness, unique among all the modalities of freedom that men have claimed or hoped for or dreamed of. “It was that we might be free” in this new way, says St. Paul, “that Christ has freed us” (Gal. 5:1).

Conclusion

The aim of this brief essay has been simply to suggest how the rather fleshless skeleton of the classical conception of the ecclesial relation may be clothed with flesh and animated with blood. The skeleton remains the classical conception of the vertical relationship of authority

and freedom. But it needs to assume a more Christian and therefore more human form by standing forth in the living flesh and blood that is the Christian community. More abstractly, the vertical relationship of command-obedience needs to be completed by the horizontal relationship of dialogue between authority and the free Christian community. The two relationships do not cancel but reciprocally support each other.

This more adequate understanding of the ecclesial relationship does not indeed dissolve the inevitable tension between freedom and authority. But by situating this perennial polarity within the living context of community, it can serve to make the tension healthy and creative, releasing the energies radiant from both poles for their one common task, which is to build the beloved community.



TRANSPLANTS

(Continued)

abreast, as it were, of the biological and chemical sciences. I imagine this will involve a reallocation of research funds and personnel and, more importantly, a reorientation of thinking on the part of legislative bodies, government agencies, foundations and others concerned with the appropriation and expenditure of

such funds. In brief, we must become more concerned with the why of scientific advance and less, relatively speaking, with the how.

Or as Senator Mondale says “Are we wise enough to be so smart?”

We must heed St. Paul’s warning to the Corinthians, “And if I have all knowledge but not have love, I am nothing.”