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Organ Transplantation With an Incompetent Donor: Kentucky Resolves the Dilemma of *Strunk v. Strunk*

By JOE C. SAVAGE*

There is in fact a true law—namely, right reason—which is in accordance with nature, applies to all men, and is unchangeable and eternal.[1]

Time Magazine called it a "Solomonic decision, but not without severe debate."[2] The *London Daily Mirror* reported it as a case where "brotherly love . . . triumphed in a life or death battle with the law."[3] The *Law Week Summary and Analysis of Current Law* emphasized that the case was one containing "the basic question of a court's power to invade the body of one person for the benefit of another."[4] The Louisville *Courier-Journal* stated it was a "carefully limiting decision."[5] Judge Earl T. Osborne, in the majority opinion in the Kentucky Court of Appeals, stated, "We are fully cognizant of the fact that the question before us is unique."[6] Judge Samuel Steinfield, in the dissenting opinion, stated, ". . . I have been more troubled in reaching a decision in this case than in any other."[7] And for this writer,

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1 M. CICERO, DE RE PUBLICA, III, xxii (Sabine & Smith translation).

2 TIME, Nov. 7, 1969, at 54.

3 London Daily Mirror, Nov. 20, 1969, at 3, col. 1.

4 38 U.S.L.W. 1049 (Oct. 7, 1969).

5 The Courier-Journal (Louisville, Kentucky), Sept. 27, 1969, § A, at 1, col. 1.

6 Strunk v. Strunk, 445 S.W.2d 145, 147, (Ky. 1969).

7 *Id.* at 149.

who was the attorney for the family involved, the case was most unique and challenging.

The case was *Strunk v. Strunk*, 445 S.W.2d 145 (Ky. 1969), and the issue presented in the case: Does a court of equity have the power to permit a kidney to be removed from an incompetent ward of the state upon petition of his committee, who is also his mother, for the purpose of being transplanted into the body of his brother, who is dying of a fatal kidney disease? The Court of Appeals, by a four-three decision, held that it did.

Seldom in Kentucky law has a case stirred the passions of legal minds as much as *Strunk*. For those in favor of the transplant, the question was simple. Would the incompetent rather have a brother or a kidney? The relatively inconsequential risk to the incompetent donor compared to the life-saving potential to the recipient makes for an extremely compelling argument.

For those opposed to the transplant, the case conjured up thoughts of experimentation on human subjects incapable of understanding the nature of the proceedings, reminiscent of a society now some twenty-five years removed from the face of this earth wherein such procedures were performed to the shock and dismay of an entire world. The first sentence of the dissenting opinion sums up this reaction.

> Apparently because of my indelible recollection of a government which, to the everlasting shame of its citizens, embarked upon a program of genocide and experimentation with human bodies I have been more troubled in reaching a decision in this case than in any other.[8]

It is the purpose of this article to discuss *Strunk* in detail, reporting the relevant facts of the case and discussing the majority and dissenting opinions of the Court of Appeals. I also hope to make a reasonable appraisal of the legal implications of the case. But first, a brief discussion of the medical and legal background against which this case arose is presented.

CURRENT STATUS OF MEDICINE.

In transplantation, as in most all areas of medicine, progress has been amazing. The impossible of yesterday has become the

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[8] *Id.*

reality of today. Even so, the practice is in its infancy, and the real practical health benefits which transplantation makes possible are as yet not fully realized.[9]

There are four types of transplants:

1. Autografts–The transplanting of tissues within the same person–for example, a skin graft from one area of the body to another. The success rate with such transplants is higher than with any other because there is no rejection of the transplanted tissue.

2. Isografts–The transplanting of tissue between identical twins, *e.g.* a kidney transplant.[10]

3. Homografts–The transplanting of tissues between persons. The more common transplants have involved blood, skin, cornea, cartilage, tendon, bone, and kidney. Although less frequent, there recently have been transplants of the pancreas, thymus, liver, lung, stomach, intestine, duodenum, and more dramatically, the heart.[11] Various degrees of success have been reported. The main medical problem is the natural tendency of the body to reject foreign matter.

4. Heterografts–The transplanting of tissues from an animal to a person. This has the least degree of success at present because this method has the greatest degree of rejection of the transplanted tissue and immunological reaction in the recipient. As research develops, however, this could become the most promising type of transplant because it would remove many legal problems.

Transplantation opens up fantastic medical possibilities for enriching and expanding human life. Like an old and defective automobile that needs new parts, the human body could pick up fresh replacements and go on "running." The life-saving potential is staggering. Approximately 6,000 to 10,000 persons per year, in this country alone, could be saved by a successful kidney transplant.[12] Many thousands more die of coronary artery disease, and could be saved by a successful heart transplant. As medical

[9] For an interesting and informative discussion of this topic, *see* Note, *Law and Life: Organ Transplants,* 20 S. CAR. L. REV. 765 (1968).

[10] The first kidney transplant was performed on identical twins in 1954.

[11] Ford, *Human Organ Transplantation,* 15 CATH. LAW. 136 (1969).

[12] Stason, *The Role of Law in Medical Progress,* 32 LAW & CONTEMP. PROB. 563, 568 (1967).

science progresses and these transplants, particularly the homograft variety, become more successful, the demand for such transplants will mushroom.

The amazing thing to realize is that the difficulty in performing all these transplants will not lie with inadequate supply. Given 50,000 plus highway deaths each year, there should be an abundance of transplantable organs. The problem will lie with the shortage of trained medical personnel and medical facilities, and with outdated and restrictive laws.

CURRENT STATUS OF LAW.

While much has been written in the last few years concerning the need for law to develop in this area, little development has occurred.[13] There is still very little case law and, with the exception of the passage in several states of the Uniform Anatomical Gift Act,[14] which will subsequently be discussed, very little comprehensive statutory law. In effect, then, society is attempting to solve questions of vital importance by reference to statutes and case law never intended to apply.

The legal issues involved are best classified as follows:

1. Legal Implications Concerning the Donor.
   - A. The Live Donor.
     1. The Adult.
     2. The Minor.
     3. The Incompetent.
   - B. The Deceased Donor.
2. Legal Implications Concerning the Recipient.

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[13] Berman, *The Legal Problems of Organ Transplantation*, 13 VILL. L. REV. 751 (1968); Finesilver, *Organ Transplants: A Multi-Discipline Challenge*, 5 TRIAL 40 (1969); Ford, *supra* note 11; Sanders & Dukeminier, *Medical Advance and Legal Lag: Hemodialysis and Kidney Transplantation*, 15 U.C.L.A. L. REV. 357 (1967-68); Stickel, *Organ Transplantation in Medical and Legal Perspectives*, 32 LAW & CONTEMP. PROB. 597 (1967); Note, *Law and Life: Organ Transplants*, 20 S. CAR. L. REV. 765 (1968); Note, *Organ Transplantation and the Donation: A Proposal for Legislation*, 10 WM. & MARY L. REV. 975 (1969).

[14] THE UNIFORM ANATOMICAL GIFT ACT (1968). The Act was approved by the Commissioners on Uniform State Laws on July 25, 1968. HANDBOOK OF THE NATIONAL CONFERENCE OF COMMISSIONERS ON UNIFORM STATES LAWS 95-96 (1968). The full text of the Act is set forth in the Appendix to this article.

Legal Implications Concerning the Donor.

A. The Live Donor.

With the live donor, the main legal problem is consent. It is, of course, axiomatic that any non-emergency medical procedure performed will result in an assault and battery for which the surgeon will be liable unless a voluntary, informed consent is obtained from the patient. Such consent requires the doctor to explain to his patient the procedure to be performed, with its attendant risks, and the patient must actually understand and consent. If he does not understand, or if he is coerced into making the decision, then he has not had the opportunity to make a rational choice of whether to proceed.[15]

1. The Adult.

There has been little or no problem in transplantation with the competent, adult donor. After having the donation and its consequences explained, the adult need only sign the consent form and the surgeons may proceed.

Some writers, however, have questioned whether a person can make a rational decision to donate a part of his body in such an emotionally charged situation. With the life of a family member usually hanging in the balance, it is contended, the donor is too pressured. He must rush to the aide of his stricken loved one, or he must face the scorn of his family and friends.[16]

Frequently, the decision to submit to any medical procedure is made under less than calm or reflective circumstances. Besides, the doctrine of informed consent reflects a fundamental principal in law that the competent adult should have the right to determine what medical procedures will be performed on his person. Such freedom of choice should include the right to decide whether to donate a part of his body as well as the right to decide whether to undergo any other type of procedure.

Where the donor falls short of being a competent adult, the problem of consent is greatly magnified. This would be the case

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[15] The first case on informed consent in Kentucky was *Tabor v. Scobee*, 254 S.W.2d 474 (Ky. 1952). The most recent case is *Haywood v. Allen*, 406 S.W.2d 721 (Ky. 1966).

[16] Sanders & Dukeminier, *supra* note 13, at 389; Stickel, *supra* note 13, at 603.

should a minor, or an incompetent, become a prospective donor.[17] It is interesting to note that prisoner volunteers were used as kidney donors in Denver, but this practice was soon discontinued because of the consent problem despite considerable experience which demonstrated unique medical and scientific advantages in their use. While there was no question that these prisoners were competent adults, it was argued that they were making these donations under the impression, whether real or imagined, that their actions would result in some form of leniency, such as an earlier parole. The reason given for the discontinuance of the practice was that the use of prisoners, however properly handled, was deemed inevitably to lead to abuse if accepted as a reasonable precedent and applied broadly.[18]

2. The Minor.

Case law has generally held that a minor cannot, by himself, give a valid consent, and that the physician who proceeds without obtaining the consent of the minor's parent or guardian is committing assault and battery.[19]

The drafters of the original Restatement of Torts[20] indicated that where a minor is old enough to understand the attendant risk, the physician may proceed without obtaining the consent of the minor's parent or guardian. This proposition, however, did not receive wide support and was dropped by the drafters of the Restatement Second.[21] As a practical matter, what physician is going to proceed with only the minor's consent, trusting that the minor is old enough to understand and that this decision will later be made in a court of law after the physician has been sued?

There are no reported cases on the issue of consent of a minor

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[17] By a competent adult, I mean one who has not been adjudged incompetent in a court of law, and one who has reached the age of majority under the law of the state where he resides. Thus, in Kentucky, one would be a competent adult if he were eighteen or over, and had not been adjudged incompetent pursuant to Kentucky's statute on incompetency, KY. REV. STAT. [hereinafter KRS] § 2.015 (1968); KRS § 203.010 (1962) *et seq.*

[18] Stickel, *supra* note 13, at 603-04.

[19] Bonner v. Moran, 126 F.2d 121 (D.C. Cir. 1941). See Annot., 139 A.L.R. 1370 (1942).

[20] RESTATEMENT OF TORTS § 59, comment *a* (1934).

[21] *See* RESTATEMENT (SECOND) OF TORTS § 59 (1964).

donor in a proposed transplant. There were, however, three unreported declaratory judgment proceedings in the Supreme Court of Massachusetts, all decided in 1957.[22]

In each of these cases, one identical twin was suffering from kidney disease which would prove fatal if a kidney were not transplanted from the healthy identical twin. The Peter Bent Brigham Hospital, Boston, was therefore faced with the very real problem of whether to proceed with such a transplant in view of the fact that the twins were all minors. The physicians obtained the consent of the parents to proceed, but wondered whether such consent was sufficient, and filed declaratory judgment actions in the Supreme Judicial Court.

The first and most important case involved twins who were nineteen years of age. The Court conducted a full hearing on the matter, obtaining testimony not only from the parents, but also from both twins, as well as the medical staff. Attorneys for the parties were present.

The Court was particularly concerned with the question of "benefit" to the healthy donor. Even with parental consent, the Court reasoned, medical procedures should not be performed on a minor unless they are reasonably necessary for his physical or mental health. Concerning this issue, a psychiatrist, who had interviewed both twins, testified that if the operation were not performed, and the sick twin were to die, the healthy twin would suffer a "grave, emotional impact."

The Court held that the surgeons and the hospital could proceed. They found that the operation was necessary in order that the sick twin survive, that the healthy twin had been fully informed and understood the nature of the operation and its consequences and had consented to it, and that there would be a grave emotional impact upon the healthy twin if the surgery were not performed and the sick twin were to die. This evidently was sufficient "benefit" for the donor so that the transplant could be performed.

[22] 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); For further discussion of these cases, see Curran, *A Problem of Consent: Kidney Transplantation in Minors*, 34 N.Y.U. L. REV. 891 (1959).

The other two cases were quite similar. In both there was a hearing, all parties were present and testified, and there was psychiatric testimony concerning the "benefit" to the donor.[23] The twins were younger in these cases, however, being fourteen. The Court was very careful to note that, despite this age of fourteen, the minors did understand the nature of the proceedings and consented.

Thus in all three of these Massachusetts cases, the Court established the following criteria:

1. The parents must consent as in any medical procedure on a minor;

2. The minor donor must understand the consequences of his donation, and give his informed consent, even though technically, by itself, such consent has no legal validity; and,

3. The transplant must benefit the donor.

This "benefit" to the donor was in these three cases, as I assume it must always be, of a psychological nature, that is, the failure to make the donation and the resulting death of the recipient would cause "grave, emotional impact" on the donor.

What would the Massachusetts Court do if the minor donor is younger than fourteen? Should it make any difference that the child is so young that he cannot understand the medical consequences of the transplant? Should the understanding of the minor be an essential element of proof where the Court finds that the transplant would be beneficial to the donor and the parents have consented to the procedure?[24] Evidently the court thought so, but the issue was not squarely presented to them.

I was recently informed of a case in Washington where a county court authorized a skin transplant from a healthy three

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[23] Professor Curran in his article cited in note 22, *supra*, discusses at great length this psychiatric testimony and points out that even though this type of testimony may appear speculative, it has on several occasions been used to support rather monumental decisions. He gives as an example the famous school segregation case, *Brown v. Board of Education*, 347 U.S. 483 (1954).

[24] Based primarily on the three unreported Massachusetts cases, Professor William J .Curran and Dr. Henry K. Beecher, in a recent article published in the *Journal of the American Medical Association*, state that a minor donor in a transplant situation should be at least fourteen years of age, with sufficient intelligence and maturity to understand the procedure. In cases involving donation of an organ to a member of the immediate family, the authors suggest that the arbitrary age level of fourteen be more flexible and that the age of seven would not be too young "if they were found clearly to understand the nature of the procedures and the loss and risks to themselves involved." Curran & Beecher, *Experimentation in Children*, 10 J.A.M.A. 77, 83 (1969).

year old twin to his badly burned brother.[25] This is the only case of which I am aware in which the donor was obviously too young to meet the second criterion established by the Massachusetts Court.

3. *The Incompetent.*

Prior to *Strunk*, there was no reported case in the United States concerning whether an incompetent could donate part of his body. *Strunk* was thus a case of first impression.[26]

With regard to medical treatment in general, the same basic considerations applicable to minors have been held to apply to incompetents. Thus, an incompetent cannot validly consent to a medical procedure, but consent must come from the committee or the person having the care, custody or control. The procedure must also be of some benefit to the incompetent.[27]

With regard to transplants, the incompetent donor could be compared to the minor donor, but there is one major difference. It is quite possible to have a minor donor of sufficient intelligence to understand the consequences of the proposed donation. Such understanding, of course, would be impossible with the incompetent.

B. The Deceased Donor.

The common law was never concerned with transplants of organs from a cadaver and consequently is most unsuitable to

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[25] McMahon v. McMahon, Civ. No. 607074 (King County, Wash., August 20, 1963). The burned boy was brought to the Children's Orthopedic Hospital and Medical Center in Seattle with burns over forty per cent of his body. Following the court's authorization to proceed, a successful transplant was performed. The burned boy recovered and the donor twin has suffered a minimum of disfiguration. The case was not reported. Letter from Hon. Lucien F. Marion, partner in the firm of Perkins, Coil, Stone, Olsen & Williams, Attorneys at Law, Seattle, Washington, Nov. 27, 1969. The case is discussed at length in Herron & Marion, *Homografting in the Treatment of Severe Burns, Using an Identical Twin as a Skin Donor: Medical and Legal Aspects,* 75 PAC. MED. & SURGERY 4 (Jan.-Feb., 1967).

[26] In the case of *In re Edwin Troweridge Dickinson,* in the probate court for the District of Darien, Connecticut, that court, on November 4, 1960, authorized a kidney transplant from an incompetent to his sister. The court, after a full hearing, found that the proposed donation would be for the psychological benefit of the incompetent. This case was brought to my attention by Hon. Bruce Lankford, attorney for the University of Kentucky, who was informed of its existence by letter from Hon. Marvin L. Gruss, partner in the firm of Hawthorne, Ackerly and Dorrance, Attorneys at Law, New Canaan, Connecticut.

[27] Williams v. First Nat'l Bank & Trust Co., 328 S.W.2d 152 (Ky. 1959).

present medical need. In particular, two common law doctrines restrict use of organs from cadavers. They are:

(1) The deceased cannot bequeath his body for medical purposes; and

(2) The next of kin has control over the body and therefore must consent to the removal of any organs.[28]

These two common law doctrines result in a ridiculous anomaly. A person, while alive, may donate a part of his body for transplantation, but he has no legal way to effectuate the same gift after his demise. Any donation after death can be made only by the next of kin. To require the consent of the next of kin severely limits the opportunity to obtain a needed organ. The next of kin are usually the most bereaved and are easily offended by such a request. The decision often must be made quickly from the medical standpoint, yet the next of kin are seldom prepared to make a quick decision. They may have religious objections to a dismembering of the body, objections which may or may not have been shared by the deceased prior to his death.[29]

Beyond the issue of consent, however, lies the far more critical issue in transplanting vital organs from a cadaver, namely the exact time of death. Much has been written on this question, medically and legally.[30]

The problem, of course, is that if one is to donate an organ necessary for his own life, he must be dead in order to do so. There is therefore an inherent medical conflict in transplanting from a cadaver. On the one hand, there is pressure from society to extend for as long as possible the "life" of a person about to die. On the other hand, it is essential for a successful transplant to remove the organ from the body as soon as possible after death has been pronounced. For example, it has been stated that kidneys ought to be transplanted no later than thirty

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[28] Sanders & Dukeminier, *supra* note 13, at 395; 10 WM. & MARY L. REV., *supra* note 13, at 977-78.

[29] Finesilver, *supra* note 13, at 40. In this article, the writer speaks in terms of the three religious doctrines of reincarnation, resurrection and resuscitation, and points out that there probably would be little difficulty with next of kin who follow the first two doctrines, but that those persons believing in resuscitation are of the opinion that human bodies will be restored at some future time. This would be incompatible with the donation of human organs.

[30] *See, e.g.*, Berman, *supra* note 13, at 752; Sanders & Dukeminier, *supra* note 13, at 407; Stickel, *supra* note 13, at 606; 20 S. CAR. L. REV., *supra* note 13, at 772.

minutes after "death." If not, post-mortem deterioration is excessive and they cannot be used.[31]

The problem is that death, biologically speaking, does not occur at any one sudden moment. It is therefore extremely difficult to establish a criteria for fixing the time of death. Some parts of the body may remain alive long after others have ceased to function.

Most physicians have traditionally fixed death at the time when the heart stops beating and circulation ceases.[32] Other medical personnel are beginning to argue that the time should not be fixed at the time of cessation of heart beat, but at the time of cessation of brain function, as indicated by the absence of waves on an electroencephalogram.[33] Of course, this does not offer an easy solution because physicians have debated how long the EEG brain wave should remain "flat" before death should be pronounced. Some feel this time could be as short as three or four hours, while others feel it should be as long as twenty-four to forty-eight hours.[34]

If doctors cannot agree on the criteria for establishing the time of death, surely attorneys or judges should not be expected to do so. And legislators can only follow medical advice. So in the final analysis, the medical profession will have to establish these criteria.

Legal Implications Concerning the Recipient.

Of course, the recipient must also consent to the transplant. Since he is the principal beneficiary, however, this consent is seldom a problem. Even with a minor or an incompetent, the guardian or parent, or committee or person having custody, should be able to give consent with no necessity of court action.

The difficult legal problems with regard to the recipient arise because of the scarcity of available organs for transplantation. In this context, there are two sources available, the live donor and the cadaver.

Concerning the live donor, the recipient has the burden of finding a person who will be willing to give a part of his body.

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[31] Stickel, *supra* note 13, at 601.
[32] Sanders & Dukeminier, *supra* note 13, at 407.
[33] *Id.* at 409.
[34] *Id.* at 409-10.

Of course, if the organ to be transplanted is necessary to sustain the life of the donor, such as the heart, it would be illegal to proceed with the transplant even with the donor's consent. To do so would be homicide. Short of homicide, however, there does not appear to be any reason why a donor could not give a part of his body, even though it might have a substantial adverse impact upon him. The real problem is finding a donor. Usually the live donor is a member of the recipient's immediate family. No one else would be motivated to make such a gift. But suppose the donation is not a gift at all, but a proposed sale?[35] Should this be illegal? If not, how should such an exchange be taxed?[36]

A sale of organs might not be as preposterous a proposition as it may first seem if one realizes that blood is often sold today by blood "donors." Given the economics of supply and demand, does it seem unlikely that a person with a fatal kidney disease would want to purchase a kidney, and that a "down and out" donor would want to make such a sale, for say, ten thousand dollars?

If our society is going to permit such sales, will this create one standard of medical care for the rich and one for the poor? But has there not always been better medical care available for those able to pay for it?

If the recipient is unable to find a live donor, he must find a suitable cadaver. At present, the problem of which recipient is to receive a given cadaver organ is determined by logistics and medical criteria. The logistics factors exist because the recipient must receive the organ quickly. Medical criteria exist because the organ must be matched as to both blood type and tissue type.

Should there be medical advance, however, to the extent that a cadaver organ can be transplanted in most any recipient regardless of match, or, regardless of delay, these criteria will

[35] On the sale of organs, see *id.* at 390. The authors cite an article in the *Lexington Herald-Leader*, Jan. 19, 1968, § 1, at 14, col. 3, where a man in Michigan offered to sell his heart for one million dollars. The writers point out that such a removal of the heart would be homicide—but suppose the man had offered to sell his kidney?

[36] On taxation of organs for sale, see Sanders & Dukeminier, *supra* note 13, at 391-93. The authors point out that the tax consequences might include (1) income tax consequences for the donor; (2) gift tax consequences to the donor, if the gift is made to an individual; and (3) estate tax consequences, if the organ is sold by the next of kin from a cadaver.

vanish. They will be replaced, I suppose, only by the laws of supply and demand. Many legal problems will need to be resolved at that point, some of which have already been referred to. Can the next of kin sell the cadaver organ? If so, what are the tax consequences both to the recipient and to the estate of the deceased?

LEGAL REFORM.

Law, as the most conservative of man's institutions, is usually the last to respond to change. As Chief Justice Burger stated a few years ago, "The law always lags behind the most advanced thinking in every area. It must wait till the theologians and the moral leaders and events have created some common ground, and some consensus."[37]

With transplantation being a relatively new medical procedure, the law has not kept pace. There is very little case law in this country. And while it is true that many states have enacted in the last twenty years or so statutes dealing with transplantation in some manner, most of these statutes are wholly inadequate.

Recently however, several states have adopted statutes modeled upon the recently drafted Uniform Anatomical Gift Act.[38] Drafted by the National Conference of Commissioners on Uniform State Laws, and approved by the American Medical Association and the American Bar Association, the Act is now under consideration by many state legislatures.[39] The Act probably will be adopted in nearly all of the states in the near future.

The Act is limited to ante-mortem gifts. It does not cover either inter-vivos gifts or the usual problems related to bodies, such as the authority to perform an autopsy or the leaving of a body to a medical school. Most states already have statutes covering these problems.

The Act establishes who may make a donation, to whom it may be made, and for what purpose. It defines the procedure to be employed and allows revocation of the donation. Finally, the Act provides that the treating physician must determine the

[37] Burger, *The Law and Medical Advances*, 67 ANNALS OF INTERNAL MEDICINE 17 (Supp. 7, Sept. 1967).
[38] See Appendix for full text. *See also* note 14, *supra*.
[39] WM. AND MARY L. REV., *supra* note 13, at 980.

time of death and allows for immunity from civil liability if the surgeon removes the organ while acting in good faith.

While a step in the right direction, the Act fails to provide guidance for some very knotty legal problems, such as, whether an organ may be sold, a definition of the time of death, and the criteria to be used in selecting from several possible recipients the one who will receive the organ.

In addition, the Act retains the basic presumption of the common law that a person's body should not be disturbed without the consent of the next of kin. Many writers are of the opinion that, unless this basic presumption is changed, so that a cadaver's organs may be freely used for transplantation unless there is an objection, there will forever be a shortage of available organs.[40]

At present, then, there is little case law directly applicable to transplants, and very little statutory law. We have a quagmire of common law principals never intended to apply, and many irrelevant statutes chiefly concerned with subjects such as autopsy, unclaimed bodies, donations of bodies to medical schools, and coroner or medical examiner systems. While the Uniform Anatomical Gift Act will go far to remedy this situation, many are of the opinion that the Act does not comprehensively deal with the problems.

STRUNK v. STRUNK: THE FACTS[41]

At the time of the hearing, Arthur L. Strunk was fifty-four years of age and his wife, Ava Strunk, fifty-two. They were (and still are) long-time residents of Kentucky, presently living in Williamstown. Their two living children, Tommy

[40] *Id.* at 984; Sanders & Dukeminier, *supra* note 13, at 410. Doctor Sanders and Professor Dukeminier are of the opinion that the law should be changed from a "*condition precedent of consent* to a *condition subsequent of objection.*" *Id.* at 412.

But see Ford, *supra* note 11, at 139. Mr. Ford is in complete agreement with the presumption of the Uniform Anatomical Gift Act and disagrees with what he calls the "fait accompli" theory proposed by Sanders and Dukeminier. Ford feels this would result in a serious setback for transplantation because it would convey the impression that the medical profession was "grubbing" for organs.

[41] All of the following facts are as reflected in the transcript of testimony taken before Judge Robert Harrod of the Franklin County Court on August 19, 1969, *In the Matter of Jerry Strunk, an Incompetent,* upon petition filed on August 5, 1969, in the Franklin County Court by the petitioner, Ava Strunk. This transcript is part of the record on file with the Franklin Circuit Court, Frankfort, Kentucky.

Strunk and Jerry Strunk, were twenty-eight and twenty-six years of age, respectively. Tommy Strunk had graduated from high school, had attended Eastern Kentucky University for a while, and was enrolled as a part-time student at the University of Cincinnati where he was a dean's list student. He had been married for seven years.

In 1962, Tommy was informed that he had a kidney ailment. His condition slowly deteriorated to such an extent that in 1966 he was advised that his condition was critical and that he had approximately three to five years to live. His condition was diagnosed as glomerulos nephritis, an inflammation of both kidneys resulting in their destruction.

Beginning in 1969, Tommy was accepted as a patient for treatment on the artificial kidney machine at the University of Kentucky Medical Center at Lexington, Kentucky. This procedure is known as hemodialysis.

At the University of Kentucky Medical Center, as in hospitals throughout the United States, there are approximately five times as many persons in need of hemodialysis as receive it. This places upon medical personnel the extremely difficult burden of choosing among persons with fatal kidney disease those who are to survive and those who must be left to die. With several thousands of persons dying in the United States each year of kidney disease who could be supported by hemodialysis, this is a problem of fantastic proportions both medically and legally.[42]

At the time of the hearing on August 5, 1969, Tommy required hemodialysis one day out of every five, at a cost of five hundred dollars per treatment. His kidney function was two to three per cent of normal. Obviously hemodialysis was absolutely necessary to keep Tommy alive.

Jerry Strunk, in 1953, was declared by the Harlan County Court to be incompetent and was committed to the Kentucky Training Home (now known at the Frankfort State Hospital and School), Frankfort, Kentucky, an institution for the

[42] *See generally,* Sanders & Dukeminier, *supra* note 13. This is an extremely comprehensive and well written article on this problem of selection of patients for hemodialysis. The authors criticize the selection processes of some medical centers in choosing which persons are to receive hemodialysis where selection is made upon an evaluation of social worth. The authors are particularly concerned with those medical centers who make the selection by a secret or anonymous committee, and wonder what has happened to due process of law.

mentally retarded. Jerry has an IQ of approximately 35, which corresponds with the mental age of approximately six years. He is further handicapped by a speech defect, which makes it difficult for him to communicate with persons who are not well acquainted with him. Although considered a ward of the state, and under the state's custody and control, Jerry frequently is allowed to go on extended vacations during the summer and over Christmas holidays to his home in Williamstown.

Jerry is fully capable of dressing and feeding himself and takes part in many of the activities offered at the Frankfort State Hospital and School. Jerry's prognosis for recovery is, of course, nil. He is mentally retarded and always will be, and presumably will remain in the institution for the rest of his life. He is, however, undergoing a rehabilitation and training program there, and shows some progress.

The relationship between the two brothers over the years has been extremely close. The testimony of Mrs. Strunk perhaps best explains this relationship.

> In the past years Tommy was the one that Jerry looked to. I haven't [gone] to the school and picked up Jerry or took him back for years, due to the fact that he insisted on Tommy coming . . . and taking him back. . . . Tommy has been the one that has given Jerry any kind of normal life that Jerry would hope to have had. He took him to drive-ins, showed him how to ride horses, fish, and do all the things that a normal boy could do. . . . You have to be there in the home to have known of the devotion between these two boys and the love that Tommy has for Jerry and Jerry has for Tommy. Jerry looks up to Tommy; Tommy has been so good to him. Jerry needs Tommy. He needs him in future years because his father and I both have lived two-thirds of our life out; my health is not real good. After we are gone, the only living person who will be there will be Tommy to go to the school and see about Jerry and take him out and let him live a half-normal life and let him know what it is outside of cold institution walls.[43]

Because of the enormous demand of patients for hemodialysis, and because therapy on hemodialysis for an extended period of

[43] Transcript, *supra* note 41, at 13-14.

time was not indicated, the University of Kentucky Medical Center advised Tommy that it was necessary for him to have a kidney transplant. Tommy had the choice of using a kidney from a cadaver, if and when one became available, or one from a live donor if this was possible.

Concerning these two alternatives, the Director of the Renal Division, University of Kentucky Medical Center, testified that a live donor transplant in a suitably matched pair carries a much better statistical outlook for both health and survival than a cadaver transplant. With a well matched live donor, he testified, there was a ninety per cent chance that the kidney graft would survive at the end of a two year period, as compared to a forty per cent survival rate in a cadaver transplant. At the end of this two year period, should there be a failure of the grafted kidney, the patient could die, depending upon the various complications which might arise, or it might be possible to graft another kidney. In that event, the chances of success for the graft and for the patient would be extremely poor.

Tommy's chances for a successful transplant were therefore substantially increased if he could find a live donor. All members of the Strunk family as well as distant relatives were tested and found to be completely unsuitable for the transplant, with the exception of Jerry. The medical testimony on this point was quite clear. "If we do not use Jerry, there will be no other live donor."[44]

Concerning the match from Jerry to Tommy, the testimony was that this was an "A" match. There are four grades of matching, from "A" to "D," "A" being the best possible match. The kidneys are matched both as to blood types and tissue type, the better the match the less the tendency of rejection of the transplanted kidney.

Concerning the risk to Jerry of donating a kidney, the doctor explained that first there was the risk of an operation and general anesthetic, which was "inevitable but very small," and secondly, there was the risk to any patient who must live with one kidney for the rest of his life.[45] The testimony was that one healthy kidney was more than enough to sustain a person through

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[44] *Id.* at 44.
[45] *Id.* at 45.

a normal life span, and that risk of damage or disease to the remaining kidney is extremely small. Based upon the some 2,500 kidney transplants performed to date, there have been no reported fatalities in donors either during surgery or thereafter. Further testimony revealed that insurance companies will accept these people with one kidney at the same premium, so statistically the risk of death is very small. "There are many people born with only one kidney who live a very normal life and never know anything about it."[46]

Concerning the procedure of the surgery, the testimony was that Jerry would be hospitalized for about seven to ten days during surgery and that thereafter he would be ambulatory for approximately four to six weeks.

A real bomb was dropped in cross examination by the guardian *ad litem,* who elicited testimony to the effect that should something later happen to Jerry's remaining kidney, he probably would not be able to undergo hemodialysis or be a candidate for a transplant. Based upon the selection criteria of the University of Kentucky Medical Center, it was the judgment of the witness that the transplant committee would not accept Jerry for hemodialysis or transplant.[47]

While attempting to gather knowledge concerning Jerry's ability to understand the proposed transplant, the University of Kentucky Medical Center had Jerry examined by a psychiatrist, who subsequently testified at the hearing. In view of the very critical question of whether this transplant would be beneficial to Jerry, this psychiatric testimony was of the utmost importance and is quoted at length.

The doctor's diagnosis of Jerry was "mental retardation, moderate to severe." The following is part of his testimony concerning his examination.

> Jerry was quiet and composed. There was no visible evidence of anxiety, depression, elation, or hostility. Likewise I was not able to elicit any evidence of delusions, hallucinations, or bizarre thought content. He did not speak at all spontane-

[46] *Id.*
[47] *Id.* at 70. See Sanders & Dukeminier, *supra,* note 13, at 371, *et seq.* for a discussion of "social worth evaluation."

> ously but gave a quick, staccato like response to all questions. His verbal responses were characterized by monotone with a nasal quality. There was some difficulty understanding some of the responses.
>
> Jerry gave his age as 14. With some prompting from his mother he was able to say that he was now in Lexington. He was not able to name the month or the year but correctly selected July when given a choice of June, July or August. He stated that two plus two equals three and three plus three equals four. He was able to correctly name a penny, nickle, and dime. He said that it took three nickles to make a dime. He stated that these objects were used to buy cigarettes. He identified his favorite cigarette as being 'just like daddy's.' He was not able to name the President of the United States, but was able to identify the late President Kennedy as someone who was 'killed in the heart.'
>
> Jerry give his brother Tommy's age as 55 (correct 28) and states that he likes his brother. He says that he knows his brother is sick and identifies the sickness as 'kidney.' He understands that an issue at hand is to 'give kidney' to help Tommy. He says that Tommy's kidney would be put in the garbage can. He says the operation would hurt and that he might have to be in the hospital two weeks.[48]

The psychiatrist further testified:

> I think he understands about as much as I was able to describe in the paragraph above. I believe he does understand that the giving of a kidney is a helpful or is intended to be a helpful act because of his brother's ill health.[49]

The psychiatrist did not believe that Jerry had sufficient understanding to give an informed consent such as an average person would give. He did feel, however, that Jerry understood some of the procedure. While the given IQ for Jerry at the hospital was 30, the doctor testified that in his opinion the estimate was a bit low and that his IQ could be as high as 50.

In response to the critical question of what would be the effect

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[48] Transcript, *supra* note 41, at 74-75.
[49] *Id.* at 76.

on Jerry if the proposed transplant were not approved and Tommy subsequently died, the psychiatrist stated, "I believe he would be saddened by this more or less in the same manner as someone who had normal mentality."[50] He further testified that in his opinion Jerry

> . . . has sufficient understanding of his brother's illness and how he, Jerry, might help his brother, and that he has sufficient emotional capacity to be saddened by the death of his brother and the degree of intellectual function to establish some connection. . . . I do not believe that he could understand it in quite the degree that we could, but he would have some understanding.[51]

Upon cross examination, in response to the question of whether Tommy's death, in the absence of a transplant from Jerry, would have a long-range effect upon Jerry, the doctor replied:

> I don't think I could in all honesty make a long-range prediction. I think he has a normal positive feeling toward his brother. How much and how long he would carry with him a reaction to his brother's death is difficult to assess without Jerry being able to communicate better. . . .
>
> I believe that he would have some guilt feelings in this. As to how long they would last or how long they would be carried in his mind over a period of years, I could not say.[52]

The Commonwealth of Kentucky, Department of Mental Health, as custodian for Jerry, was extremely interested in the case, and a representative of the Department testified at the hearing. This testimony was that the Department is charged with the responsibility for Jerry's welfare, that it considered Jerry's family ties a vital part of his treatment and rehabilitation, and that, therefore, it would be important that the close relationship existing between the two brothers be continued. Thus, the Department argued that the proposed transplant would di-

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[50] *Id.* at 77.
[51] *Id.* at 78.
[52] *Id.* at 81.

rectly benefit Jerry because it offered the best opportunity for Tommy's survival.[53]

STRUNK v. STRUNK: THE PROCEDURE

Upon the advice of their legal counsel, the University of Kentucky Medical Center refused to proceed with the transplant on the ground that Jerry was not capable of giving an informed, voluntary consent. Although informed that his parents were prepared to give such consent, the Medical Center still refused to proceed for the reason that Jerry was not a minor and parental consent was therefore meaningless.

My initial solution for the dilemma which faced the Strunk family was to have Mrs. Strunk appointed committee for her incompetent son, Jerry, and then have Mrs. Strunk, as committee, sign the consent form on his behalf. The Medical Center, however, again upon advice of counsel, took the position that a transplant involving an incompetent donor went far beyond the usual procedures for incompetents, and therefore, even with the consent of the committee, they requested that the committee obtain some type of court order authorizing the transplant.

It thus became necessary to file suit. But who would sue whom and in what court? There were no reported cases in Kentucky, or for that matter in the United States, upon which to rely as precedent. Finally, the conclusion was reached that the mother, who was now committee for Jerry, would file a petition in the county court of Franklin County, which was Jerry's residence since he was institutionalized there. This petition would ask the court to authorize the committee to consent to the transplant.

Filed on August 5, 1969, the petition requested the appointment of a guardian *ad litem* to protect the interests of the incompetent, and an order

> . . . authorizing and empowering the petitioner, as committee for the said incompetent, to consent to the donation of a kidney by the said incompetent, Jerry Strunk, to his brother, Tommy Strunk, and to consent on behalf of the said incom-

[53] *Id.* at 113.

> petent, Jerry Strunk, to all medical and surgical actions and procedures which may be required in the performance of the kidney transplant operation.[54]

The guardian *ad litem* filed an answer alleging that such a procedure would not be in the best interests of the incompetent, but would be detrimental to his health and well being, that it would violate the rights guaranteed the incompetent under the Constitution of the United States and the Bill of Rights of the Constitution of Kentucky, and that the court was without power to force an incompetent to undergo compulsory medical treatment, when such treatment was not necessary for the preservation of the incompetent's life or his continued health and well being.

The case was heard before Judge Robert Harrod of the Franklin County Court, on August 19, 1969. At that time the testimony previously mentioned was introduced. At the conclusion of the hearing the court asked for briefs by all parties concerned: the attorney for the petitioner, the guardian *ad litem,* and the attorney for the Department of Mental Health, as *amicus curiae.*

The basic questions and the arguments presented in the briefs were:

1. Whether the county court or a circuit court had jurisdiction.

Kentucky law requires the committee of an incompetent to be appointed in the county court of the residence of the incompetent, and further provides that the county court shall have "the exclusive jurisdiction of the appointment and *accounting* of committees." (Emphasis added.)[55]

There was no case law establishing jurisdiction in the county court on a case such as this, but neither was there any law prohibiting it. My contention was that "accounting" should be given broad construction, so that the term would include not just actuarial reporting but a general responsibility of the committee to report to and be governed by the county court.

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[54] Copies of the petition are on file in Franklin Circuit Court, Frankfort, Kentucky.

[55] KRS § 387.210(1) (1942).

2. Whether the county court, given jurisdiction, had authority to order the relief sought.

The committee argued that the court did have such authority for two reasons. The first was based on Kentucky statutes and the second on common law.

Kentucky statutes provide that the committee shall be responsible for the "necessary and proper maintenance" of the incompetent.[56] Case law interpreting these statutes was scarce and confusing. In *Williams v. First National Bank and Trust Company of Lexington*,[57] the Court of Appeals held that the committee, as opposed to the incompetent's spouse had the legal right to choose the physician to care for the incompetent's medical needs. And in *Makenson v. Commonwealth*,[58] the Court held that the committee had the responsibility of caring for the "person" as well as the property of the incompetent.

However, in *Baker v. Thomas*,[59] the Court had previously stated that the Kentucky statute "does not contemplate that the committee . . . may exercise any other power than to have the possession, care, and management of the . . . incompetent's estate."[60] Actually, in *Baker* the committee was attempting to adopt children for the incompetent and the case did not involve medical treatment for the incompetent. Nevertheless, the language is there.

The committee's position, then, was based upon *Williams* and *Makenson*, that the committee had authority to consent to the transplant as part of the committee's responsibility to care for the person of the incompetent. This put squarely into issue the question of whether the transplant would really benefit the incompetent. *Baker*, I was prepared to argue if cited, was not in point on its facts and would become ridiculous if applied to a medical procedure. If *Baker* were the law, a committee couldn't even authorize the giving of an aspirin.

Secondly, the committee argued that the court had inherent power, even absent any statutory authority, to authorize this transplant on the ground that the court stood in the position of

[56] KRS § 387.230(1) (1942); KRS § 387.060 (1942).
[57] 328 S.W.2d 152 (Ky. 1959).
[58] 292 Ky. 634, 167 S.W.2d 313 (1942).
[59] 272 Ky. 605, 114 S.W.2d 1113 (1938).
[60] *Id.*

parens patriae and should have authority to order any medical procedure which would be beneficial to the incompetent. Authorities cited for this proposition were the Jehovah's Witnesses cases such as *State v. Perricone*,[61] where the court exercised its power in the interests of the health of a minor and ordered a blood transfusion against the wishes of the parents.

3. Whether the transplant would be beneficial to Jerry.

The real issue, then, after jurisdiction and authority to act, was the one of benefit. We frankly conceded that the court should not grant the relief sought unless the transplant would be beneficial to Jerry. As the main evidence on this issue, the psychiatric testimony was crucial. We argued that this testimony proved the benefit.

4. Whether the transplant would violate any constitutional rights.

The guardian *ad litem* argued that the removal of Jerry's kidney without his understanding or consent would violate his right to be secure in his person, his right to due process, and his right to equal protection under the law.

We argued that his right to due process and equal protection were protected by a full hearing, with representation of a guardian *ad litem*, upon adequate notice, and that, in any event, if his rights were to be violated at all, it would not be by his giving of the kidney, but by the court's refusal to allow him to give it, based upon the testimony that his donation would be beneficial to him.

On September 9, 1969, the Franklin County Court issued an order finding that "it would be psychologically beneficial and in the best interest of the incompetent" to donate the kidney, and the committee was authorized to consent. The guardian *ad litem* appealed *de novo* to the Franklin Circuit Court, and the case was advanced on the docket.

On September 12, 1969, the Franklin Circuit Court affirmed and adopted the findings of fact of the county court. The guardian *ad litem* appealed to the Kentucky Court of Appeals, and the case was advanced on the docket and heard in oral argument before the entire Court.

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[61] 37 N.J. 463, 181 A.2d 751 (1960).

On September 26, 1969, the Court of Appeals, by a four to three vote, affirmed. Both a majority and dissenting opinion were published.[62]

STRUNK v. STRUNK: THE HOLDING

The majority opinion, after a recitation of the pertinent facts, rejected our first contention that the committee had authority to consent based upon statutes.

> Review of our case law leads us to believe that the power given to a committee under KRS 387.230 would not extend so far as to allow a committee to subject his ward to the serious surgical techniques there under consideration unless the life of his ward be in jeopardy.[63]

But the Court then accepted our second contention by stating that a chancery court, absent any statutory authority, does have sufficient power, under the doctrine of "substituted judgment" to authorize the transplant. The Court pointed out that this doctrine of substituted judgment is based upon the English common law concept that the Crown delegated to the chancery courts the right as *parens patriae* to interfere in particular cases for the benefit of such persons as are incapable of protecting themselves. The Court, under the doctrine, may substitute its judgment for the person who is incapable of making a judgment for himself.[64] The court cited an old English case[65] as authority for this doctrine in English law, and a New York case[66] as authority for the doctrine in this country.[67]

Because the Franklin Circuit Court, a chancery court, had found that the operative procedures were in the best interests of Jerry Strunk, the Court, after reviewing all the facts, and particularly the psychiatric testimony and the position of the Department of Mental Health, found that this finding was based upon substantial evidence, and therefore affirmed.

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[62] Strunk v. Strunk, 445 S.W.2d 145 (1969).
[63] *Id.* at 149.
[64] 27 AM. JUR. 2D *Equity* § 69 (1966) was cited by the Court as authority for this proposition.
[65] *Ex parte* Whitebread, 35 Eng. Rep. 878 (Ch. 1816).
[66] *In the Matter of Willoughby, a Lunatic*, 11 Paige 257 (N.Y. 1844).
[67] See Annot., 24 A.L.R. 3d 863 (1969), for a discussion of this doctrine.

The dissenting opinion,[68] citing *Baker v. Thomas,*[69] first stated that Kentucky statutes regarding the power of a committee "do nothing more than give the committee the power to take custody of the incompetent and the possession, care, and management of his property." It did not mention *Williams*[70] or *Makenson,*[71] the later cases interpreting these statutes as giving the committee power to make medical decisions concerning the "person" of the incompetent. But this is not the real crux of the dissent in any event, because the majority also felt that these statutes did apply in this case.

Without mentioning by name the doctrine of substituted judgment upon which the decision of the majority rested, the dissent seemed to reject the doctrine by asserting, "The ability to fully understand and consent is a prerequisite to the donation of a part of the human body."[72]

The dissent then apparently shifted its position, stating that the evidence in this case was insufficient to "conslusively demonstrate" a "significant benefit" to the incompetent, but that if the evidence ever did rise to that "pinnacle," the transplant should be allowed. Concerning the evidence, the dissenters were bothered by the psychiatric testimony, which was "most nebulous," and by the testimony that a cadaver kidney could be used.

The Court apparently was unconcerned by the constitutional questions raised by the guardian *ad litem.* Nowhere were these issues discussed in either the majority or dissenting opinions. In short, then, the decision was based entirely on Kentucky's common law doctrine of substituted judgment.

STRUNK v. STRUNK: THE FUTURE

On October 14, 1969 surgeons at the University of Kentucky Medical Center removed a kidney from Jerry Strunk and placed it in his brother Tommy. The transplant was a complete success. Jerry made a quick recovery and was soon released from the hospital. He has now returned to his previous level of activities and is, at the time of the writing of this article, en-

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[68] 445 S.W.2d at 149.
[69] 272 Ky. 605, 114 S.W.2d 1113 (1938).
[70] Williams v. First Nat'l Bank & Trust Co., 328 S.W.2d 152 (Ky. 1959).
[71] Makenson v. Commonwealth, 292 Ky. 634, 167 S.W.2d 313 (1942).
[72] 445 S.W.2d at 150.

joying the Christmas holidays in the home of his parents. Tommy has also done remarkably well. He was released about four weeks after surgery, with an excellent prognosis. He and his wife are also spending Christmas in the Strunk home.

For this family, *Strunk v. Strunk* was much more than a seven page decision in the South Western Reporter. For Tommy, it meant a vastly improved chance for life. For Arthur and Ava Strunk, it was the happy and satisfying end to a long and sometimes bitter struggle to aid one stricken son and at the same time make life more meaningful for a second. For Jerry, it was the one opportunity in a life of dependence to be of real service to a person he loved. And, what is of perhaps the greatest significance of all, the case is now a matter of history and this family can once again return to the wonderful business of living.

But for those of us in the legal profession charged with the awesome responsibility of leading a society constantly searching for justice, *Strunk v. Strunk* is not merely history. It is the beginning.

In its narrowest construction, *Strunk* holds that a person incapable of understanding the procedures may donate a part of his body for transplantation. This is the first reported case so holding in the United States. The decision will obviously have an impact on future cases involving transplants from incompetents or minors too young to understand or consent.

In its broadest construction, *Strunk* holds that a court of equity has the enormous power to make whatever orders it may deem necessary for the benefit of those not capable of looking after themselves. The case is the most recent and probably the most dramatic example of the doctrine of substituted judgment in this country. I think it is this latter construction that frightened the dissenting judges. It is this kind of power, which, if unchecked, could indeed lead to abuse of individual liberty. "The liberty of a man's person is more precious to him than all the rest that follow."[73]

The possible ramifications of *Strunk* are endless. It is interesting to ponder in what context *Strunk* may next be applied. Perhaps, as in the Washington county court case, a child of tender years will be a prospective skin donor to a burned brother

[73] E. COKE, SECOND INSTITUTE 46.

or sister. Perhaps an incompetent like Jerry Strunk will be a prospective donor for a family member who, instead of caring for the incompetent, neglected him. Perhaps a committee will request that its incompetent be sterilized because she is incapable of caring for children, or because it is likely her children will also be retarded. The Kentucky Court of Appeals has already discussed this possibility without deciding the question.[74]

But however *Strunk* may be applied, and no matter what results may be reached in the future, I am convinced that justice was done in this case. And that, after all, is what it's all about.

APPENDIX

UNIFORM ANATOMICAL GIFT ACT

An Act authorizing the gift of all or part of a human body after death for specified purposes.

SECTION 1. [*Definitions.*]

(a) "Bank or storage facility" means a facility licensed, accredited, or approved under the laws of any state for storage of human bodies or parts thereof.

(b) "Decedent" means a deceased individual and includes a stillborn infant or fetus.

(c) "Donor" means an individual who makes a gift of all or part of his body.

(d) "Hospital" means a hospital licensed, accredited, or approved under the laws of any state; includes a hospital operated by the United States government, a state, or a subdivision thereof, although not required to be licensed under state laws.

(e) "Part" means organs, tissues, eyes, bones, arteries, blood, other fluids and any other portions of a human body.

(f) "Person" means an individual, corporation, government or governmental subdivision or agency, business trust, estate, trust, partnership or association, or any other legal entity.

(g) "Physician" or "surgeon" means a physician or surgeon licensed or authorized to practice under the laws of any state.

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[74] Holmes v. Powers, 439 S.W.2d 579, 580 (Ky. 1968).

(h) "State" includes any state, district, commonwealth, territory, insular possession, and any other area subject to the legislative authority of the United States of America.

SECTION 2. [*Persons Who May Execute an Anatomical Gift.*]

(a) Any individual of sound mind and 18 years of age or more may give all or any part of his body for any purpose specified in Section 3, the gift to take effect upon death.

(b) Any of the following persons, in order of priority stated, when persons in prior classes are not available at the time of death, and in the absence of actual notice of contrary indications by the decedent or actual notice of opposition by a member of the same or a prior class, may give all or any part of the decedent's body for any purpose specified in Section 3:

(1) the spouse,
(2) an adult son or daughter,
(3) either parent,
(4) an adult brother or sister,
(5) a guardian of the person of the decedent at the time of his death,
(6) any other person authorized or under obligation to dispose of the body.

(c) If the donee has actual notice of contrary indications by the decedent or that a gift by a member of a class is opposed by a member of the same or a prior class, the donee shall not accept the gift. The person authorized by subsection (b) may make the gift after or immediately before death.

(d) A gift of all or part of a body authorizes any examination necessary to assume medical acceptability of the gift for the purposes intended.

(e) The rights of the donee created by the gift are paramount to the rights of others except as provided by Section 7(d).

SECTION 3. [*Persons Who May Become Donees; Purposes for Which Anatomical Gifts May be Made.*] The following persons may become donees of gifts of bodies or parts thereof for the purposes stated:

(1) any hospital, surgeon, or physician, for medical or

dental education, research, advancement of medical or dental science, therapy, or transplantation; or

(2) any accredited medical or dental school, college or university for education, research, advancement of medical or dental science, or therapy; or

(3) any bank or storage facility, for medical or dental education, research, advancement of medical or dental science, therapy or transplantation; or

(4) any specified individual for therapy or transplantation needed by him.

SECTION 4. [*Manner of Executing Anatomical Gifts.*]

(a) A gift of all or part of the body under Section 2 (a) may be made by will. The gift becomes effective upon the death of the testator without waiting for probate. If the will is not probated, or if it is declared invalid for testamentary purposes, the gift to the extent that it has been acted upon in good faith, is nevertheless valid and effective.

(b) A gift of all or part of the body under Section 2 (a) may also be made by document other than a will. The gift becomes effective upon the death of the donor. The document, which may be a card designed to be carried on the person, must be signed by the donor in the presence of 2 witnesses who must sign the document in his presence. If the donor cannot sign, the document may be signed for him at his direction and in his presence in the presence of 2 witnesses who must sign the document in his presence. Delivery of the document of gift during the donor's lifetime is not necessary to make the gift valid.

(c) The gift may be made to a specified donee or without specifying a donee. If the latter, the gift may be accepted by the attending physician as donee upon or following death. If the gift is made to a specified donee who is not available at the time and place of death, the attending physician upon or following death, in the absence of any expressed indication that the donor desired otherwise, may accept the gift as donee. The physician who becomes a donee under this subsection shall not participate in the procedures for removing or transplanting a part.

(d) Notwithstanding Section 7 (b), the donor may designate in his will, card, or other document of gift the surgeon or physician to carry out the appropriate procedures. In the absence of a designation or if the designee is not available, the donee or other person authorized to accept the gift may employ or authorize any surgeon or physician for the purpose.

(e) Any gift by a person designated in Section 2 (b) shall be made by a document signed by him or made by his telegraphic, recorded telephonic, or other recorded message.

SECTION 5. [*Delivery of Document of Gift.*] If the gift is made by the donor to a specified donee, the will, card, or other document, or an executed copy thereof, may be delivered to the donee to expedite the appropriate procedures immediately after death. Delivery is not necessary to the validity of the gift. The will, card, or other document, or an executed copy thereof, may be deposited in any hospital, bank or storage facility or registry office that accepts it for safekeeping or for facilitation of procedures after death. On request of any interested party upon or after the donor's death, the person in possession shall produce the document for examination.

SECTION 6. [*Amendment or Revocation of the Gift.*]

(a) If the will, card, or other document or executed copy thereof, has been delivered to a specified donee, the donor may amend or revoke the gift by:

(1) the execution and delivery to the donee of a signed statement, or

(2) an oral statement made in the presence of 2 persons and communicated to the donee, or

(3) a statement during a terminal illness or injury addressed to an attending physician and communicated to the donee, or

(4) a signed card or document found on his person or in his effects.

(b) Any document of gift which has not been delivered to the donee may be revoked by the donor in the manner set out in subsection (a), or by destruction, cancellation, or mutilation of the document and all executed copies thereof.

(c) Any gift made by a will may also be amended or revoked in the manner provided for amendment or revocation of wills, or as provided in subsection (a).

SECTION 7. [*Rights and Duties at Death.*]

(a) The donee may accept or reject the gift. If the donee accepts a gift of the entire body, he may, subject to the terms of the gift, authorize embalming and the use of the body in funeral services. If the gift is of a part of the body, the donee, upon the death of the donor and prior to embalming, shall cause the part to be removed without unnecessary mutilation. After removal of the part, custody of the remainder of the body vests in the surviving spouse, next of kin, or other persons under obligation to dispose of the body.

(b) 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.

(c) 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.

(d) The provisions of this Act are subject to the laws of this state prescribing powers and duties with respect to autopsies.

SECTION 8. [*Uniformity of Interpretation.*] This Act shall be so construed as to effectuate its general purpose to make uniform the laws of those states which enact it.

SECTION 9. [*Short Title.*] This Act may be cited the as the Uniform Anatomical Gift Act.

SECTION 10. [*Repeal.*] The following acts and parts of acts are repealed:

SECTION 11. [*Time of Taking Effect.*] This Act shall take effect. . . .