Comments

CALIFORNIA'S RESPONSE TO THE PROBLEMS OF PROCURING HUMAN REMAINS FOR TRANSPLANTATION

The drama of removing part of a dead human body and implanting it in a dying body in order to prolong human life has been brought to public attention by the recent heart transplant operations. Although this single type of transplant operation has been the most publicized, transplantable tissue runs the gamut from the corneas, skin, cartilage, tendon, nerve, artery, and bone to the pancreas, kidney, thymus, liver, lung, and heart. This list is by no means exhaustive, and as medical science progresses in the area of foreign tissue rejection, the use of human remains for transplantation can be expected to increase. It is therefore appropriate for each state to examine carefully the legal problems involved in tissue transplantation.

The primary legal problem has been obtaining valid authorization for removal of the needed organs. Common law principles regarding testamentary disposition of a decedent's body developed in the context of burial disputes, at a time when considerations of prolonging human life were not relevant. English law courts accepted the concept developed in ecclesiastical courts that there are no "property rights" in a dead body. According to the leading case of Williams v. Williams, it follows that "it is impossible that by will or any other instrument the body can be disposed of." The Williams case is illustrative of the type of factual situation presented to the common law courts. The testator had directed that his remains be delivered to a lady "friend" to be dealt with as indicated in a private letter. Contrary to the testator's instructions in the letter that the body be cremated, the deceased was buried at his widow's direction. The friend fraudulently obtained permission to disinter and cremate the body, and then sued to recover her expenses. The court held that the

3. Vestal, Taber & Shoemaker, Medico-Legal Aspects of Tissue Homotransplantation, 18 U. Det. L.J. 271, 273-74 (1955). Other writers discussing organ transplantation have relied extensively upon this article as providing a well-documented study of the common law background on rights in a dead human body.
4. 20 Ch. D. 659 (1882).
5. Id. at 665.

671
testator did not have property rights in his dead body sufficient to hold his executors liable for the expenses incurred. Such decisions should not be controlling in situations in which potentially life-saving organs are donated for medical purposes.

Early American courts reiterated the common law formula that since there are no property rights in a corpse, a man cannot by will dispose of his dead body. The courts have acknowledged, however, that for purposes of burial the surviving relatives have the right to receive the body in the same condition as when death occurred, and damages can be recovered from anyone who mutilates or takes any part of the body without the survivor's consent. Thus, the common law has hardly provided a satisfactory legal environment for organ transplants. As stated by the Supreme Court of New Hampshire in 1964, "in the light of current medical advances . . . the need for appropriate statutory provision to implement the desires of the dying to aid the living is increasingly urgent."

This Comment will analyze the extent and effectiveness of California's response to the need for corrective legislation. Part I will focus on the specific rights and duties created by the recently enacted statutory provisions. Part II will explore some of the more profound ethical and philosophical problems involved in human organ transplantation.

I

CALIFORNIA'S RESPONSE

The new Anatomical Gift Act in California authorizes gifts of all or any part of the body for transplantation and other specified purposes. California's implicit legislative intent probably agrees with

6. See, e.g., Enos v. Snyder, 131 Cal. 68, 63 P. 170 (1900). In granting the surviving wife's demand for possession of the remains, the court refused to give effect to a provision in the testator's will that the time, manner, and place of his burial should be "according to the wishes and directions" of the woman with whom he had lived the last several years before his death. The court relied upon the "general English and American authorities" establishing that "in the absence of statutory provisions, there is no property in a dead body, that it is not part of the estate of the deceased person, and that a man cannot by will dispose of that which after his death will be his corpse." Id. at 69, 63 P. at 171.

7. Larson v. Chase, 47 Minn. 307, 50 N.W. 238 (1891). See also Enos v. Snyder, 131 Cal. 68, 70, 63 P. 170, 171 (1900).


10. CAL. HEALTH & SAFETY CODE §§ 7150-58 (West Supp. 1968). California has had a provision authorizing testamentary disposition of the body for many years, and it has been
that which the Congress articulated when it enacted comparable legislation for the District of Columbia:

Because of the rapid medical progress in the field of tissue preservation, tissue transplantation, and tissue culture, and because it is in the public interest to aid the development of this field of medicine, it is the policy and purpose of Congress in enacting this chapter . . . to encourage and aid the development of reconstructive medicine and surgery and the development of medico-surgical research . . . by facilitating antemortem and postmortem authorizations for donations of tissue.\textsuperscript{11}

To accomplish this purpose, legislation must provide a donor with a convenient and effective means of expressing his donative intent, and the donee-physician with clear information as to the rights and duties which the gift creates.

\textit{A. The Donor's Rights}

Under the new Act, anyone competent to execute a will may make an anatomical gift.\textsuperscript{12} Thus, in California, every person over the age of 18 years and of sound mind\textsuperscript{13} possesses legal capacity to authorize removal of his organs after death. The gift may be made by will and "shall become effective immediately upon the death of the testator regardless of the validity of the will in other respects or of the fact that the will may not be offered for or admitted to probate."\textsuperscript{14} Since the statute also provides for gifts made by documents less complicated than a will, the provision authorizing gifts by will facilitates the making of anatomical gifts only if the prospective
cited by many authors as a progressive statute. \textit{Cal. Prob. Code} § 20 (West Supp. 1968). However, the new Act is patterned almost completely after tentative drafts of the Uniform Anatomical Gift Act of which a major impetus was the common law rule in many states. Therefore, a direct contrast to the underlying common law problem was felt to be more helpful than a comparison to the previous California statute. The National Conference of Commissioners on Uniform State Laws gave final approval to the final draft of the Uniform Act on July 30, 1968, less than two weeks before the governor signed the California Act into law. The final draft will be frequently referred to for comparative purposes as well as the second tentative draft where California has departed from the Uniform Act model.


\textsuperscript{13} \textit{Cal. Prob. Code: § 20} (West Supp. 1968). The standard of "competence to execute a will" in the second tentative draft of the Uniform Act was changed in the final draft to "of sound mind and 18 years of age or more." Not only does this modification help to achieve uniform standards throughout the country, but it also eliminates the need to examine two diverse code sections among the laws of a single state when one could easily provide the essential information.

donor is for other reasons already in the process of preparing a will or
codicil; it does not encourage the making of wills for the sole purpose
of donating parts of the body after death.

A document signed by the donor is sufficient to effect a gift. If
the donor is unable to sign the document but understands the nature
and consequences of the gift, the donative instrument may be signed
for him in the presence of two witnesses. It is provided further that
delivery of the document during the lifetime of the donor "is not
necessary to make the gift valid." Apparently, this disclaimer was
intended to foreclose any argument that "transfer" or "constructive
delivery" is required as a condition of validity.

The provisions of the Act allowing donations of parts of the body
by will or other signed document undoubtedly furnish the prospective
donor with a convenient method for expressing his donative intent.
However, they do not assure that the authorization will be effectual.
In fact, the provisions indicating that delivery of the document to the
donee is not required may result in the failure of many intended gifts.
It has been reported, for example, that movie star Tyrone Power
bequeathed his corneas to an eye bank for possible transplantation.
By the time anyone read the will, however, he had already been buried
and the bequest failed. Thus, while it may not be a legal requirement,
delivery of the donative instrument may in fact be a practical
necessity. Even then, whether the gift will be effective is likely to turn
on the chance occurrence of the donor dying in the presence of a
physician or in the hospital to which the document has been delivered.

To provide an effective means of donation, the unique demands
of tissue and organ transplantation must be recognized. The initial
problem is to avoid creating unnecessary formality and rigidity, the
frequent result of viewing the authorization of anatomical gifts as
merely a matter of extending testamentary powers with respect to
disposition of property. If a living recipient is to benefit from the
donation, action must be taken promptly in all cases. Certain
"critical" tissues are suitable for removal only during the brief period

16. Id.
17. Id.
20. Sadler & Sadler, supra note 1, at 18. However, the pendulum should not be allowed to swing so far in the direction of convenience of expression that sufficient guidance is not provided for giving effect to the donative intent.
following death when cellular metabolism continues throughout the body cell mass.\textsuperscript{21} Even a "noncritical" part such as the cornea must be removed within six hours. Thus, there is little time to wait for an undelivered document to be found. If the donative intent is to be capable of fulfillment, there must be legislative awareness and sensitivity to the fact that with a nonliving donor time is of the essence.

In this regard, the truly significant provision of the new Act is found in one short sentence at the end of section 7153(b): "The document may consist of a properly executed card carried on the donor's person or in his immediate effects."\textsuperscript{22} While no particular form is required or even indicated, the following model should satisfy the statute's requirements\textsuperscript{23} as well as the intention of most donors:

\begin{quote}
I, the undersigned, desiring that my body be made available upon my death for medical purposes, and being 18 years or more of age and of sound mind, do hereby donate and give any needed part of my body to any licensed hospital or surgeon available at my death for use in reconstructive surgery.

I do hereby authorize any licensed hospital or surgeon to remove and dismember any part of my body and to take any other action as may be necessary to accomplish said medical purpose.
\end{quote}

(name of donor) (address)

Provision is also made in the new Act for revocation of the gift in case of a donor's "change of heart."\textsuperscript{24} Four ways are set out by which a delivered document may be revoked, with further provisions for cancelling an undelivered document and revoking a will.\textsuperscript{25} The provision recognizing ordinary methods of revoking or amending wills raises a special problem. It is apparently standard practice in drafting a will to insert a provision such as: "I hereby revoke all other and

\begin{itemize}
\item \textsuperscript{21} Stason, \textit{The Role of Law in Medical Progress}, 32 \textit{Law \\& Contemp. Prob.} 563, 568 (1967).
\item \textsuperscript{22} \textit{Cal. Health \\& Safety Code} § 7153(b) (West Supp. 1968).
\item \textsuperscript{23} See \textit{Fla. Stat.} § 736.18(4) (1965); \textit{Md. Ann. Code} art. 43, § 149L(b) (Supp. 1968).
\item \textsuperscript{24} This play on words is intended to illustrate why heart transplants have had such an impact on the general public as well as the medical and legal profession. Not only has the "heart" been referred to in several common figures of speech, there is also the problem of the many emotional, aesthetic and religious ties which make it difficult to suddenly start thinking of the heart as only a "muscular bag". See Sadler \\& Sadler, supra note 1, at 6. See text accompanying notes 75-76 \textit{infra}.
\item \textsuperscript{25} \textit{Cal. Health \\& Safety Code} § 7155 (West Supp. 1968).
\end{itemize}
former wills executed by me." Thus, a later will might easily revoke by omission an earlier authorization for transplantation. A legislative intent to facilitate antemortem donations would be better served by a requirement that anatomical donations must be specifically revoked. All states adopting Anatomical Gift Acts should include such a provision to preclude revocation of the gift by inadvertence in revising a testator’s estate plans.

The California Assembly added a particularly interesting provision after Senate passage of the original bill. Section 7151(b) provides:

Only the decedent shall have the authority to donate his body or any part thereof, if it is made known that the deceased at the time of his death was a member of a religion, church, sect, or denomination which relies solely upon prayer for the healing of disease.

This provision is apparently unique among the existing statutes of the various states as well as the tentative and final drafts of the Uniform Act. Subject to the prohibition of section 7151(b), the donative authority provided by the new Act also vests in certain enumerated surviving relatives, who may give all or part of the decedent’s body unless the deceased person had given contrary instructions. Although the donor’s control over the disposition of his body is absolute if expressed, it is likely that such expressions will be infrequent in the near future. Thus, the powers vested in survivors are of critical importance.

The statute establishes the donative power and priority among survivors. However, the Assembly added a significant amendment which provides that any adult person in the next degree of kindred may make the gift if a person at a closer degree “is not immediately

27. The physician is provided with a general good faith protection. See text accompanying note 64 infra. Also relevant is the provision indicating that a gift by will becomes effective immediately upon the donor’s death regardless of the validity of the will in other respects. See text accompanying note 14 supra. However, no one wishes to have his good faith tested by a jury, and the second provision implies that the will must be valid in some respects, which may not be the case when the prior will is revoked. A provision requiring that anatomical gifts must be specifically revoked minimizes the uncertainty confronting doctors and surviving relatives.
29. CAL. HEALTH & SAFETY CODE § 7151(c) (West Supp. 1968).
30. The Florida statute has a unique provision to encourage the distribution of donation cards. FLA. STAT. § 736.18(6) (1965) provides: “All hospitals, doctors, surgeons, civic clubs, welfare organizations and the state board of health are hereby authorized to prepare and make available for free use and distribution copies of such written instrument and copies of this act.”
This is an excellent addition to the new Act and illustrates the type of legislative sensitivity which is required if an enabling act of this nature is to be effective. The statute also provides that surviving relatives have the authority to donate the deceased body of a minor or a stillborn infant. Such a provision is especially desirable in view of the fact that persons under 18 years of age are statutorily precluded from executing such gifts themselves.

Surviving persons authorized to make the gift may do so by a signed document executed "either after death or before death during a terminal injury or illness if the person whose body or any part thereof is to be given is precluded by his injury or illness from executing the document of gift." The Maryland statute includes a provision authorizing such a gift to be made by telegraphic consent, and the final draft of the Uniform Act allows gifts by "telegraphic, recorded telephonic, or other recorded message." The utility of such provisions is obvious, and a similar authorization should be quickly incorporated into the new California Act.

B. Rights and Duties of the Donee-Physician

The donee-physician also has an interest in the donor having the right to and means of giving parts of his body for medical purposes. In addition, the statute's clear indication of donative priority among surviving relatives provides the physician with the essential information regarding valid authorization for the gift. Especially significant to the physician is the provision allowing proper consent to be obtained from virtually any kindred if he is the only one "immediately available" at the time and place of death. Similarly, the effectiveness of the donor's gift is dependent upon a willing and able physician fulfilling the terms of the bequest.

Several permissible donees are enumerated in the new California Act as being eligible to receive anatomical gifts for certain specified purposes. The list includes licensed hospitals, physicians, and surgeons.

32. CAL. HEALTH & SAFETY CODE § 7151(c) (West Supp. 1968).
33. Id.
35. UNIFORM ANATOMICAL GIFT ACT § 4(e).
36. The rights and duties of the donee and physician are treated in this paper as though involving the same person. However, this is not always the case as licensed hospitals, approved body parts banks, and specific individuals as well as physicians and surgeons are eligible to receive anatomical gifts. See note 38 infra and accompanying text. The fact that the donee and physician may be different persons is not of analytical importance to the issues discussed.
37. See text accompanying note 31 supra.
for use in transplantation to individuals, as well as any specific potential recipient of a transplant operation.\textsuperscript{33} In order to “encourage and aid the development of reconstructive medicine and surgery,”\textsuperscript{34} the rights and duties of the donee-physician must be clearly specified to eliminate any possible uncertainty as to the proper removal procedure.

One provision in the new Act requiring immediate attention relates to the specification of a donee:

The gift may be made to a named donee or without the naming of a donee. If the gift is made without the naming of a donee, it may be accepted by and utilized under the direction of the attending physician at or following death.\textsuperscript{40} Noticeably absent is any provision to cover the not unlikely situation where a donee is named in the donative instrument but is not reasonably available to accept and utilize the gift at the time and place of death. If the named donee is not available to utilize the gift, the statutes of Florida,\textsuperscript{41} Kansas,\textsuperscript{42} Maryland,\textsuperscript{43} and the Uniform Anatomical Gift Act\textsuperscript{44} allow the attending physician to accept the gift as an alternative donee, in the absence of an express indication that the donor desired otherwise. These provisions permit full utilization of intended gifts and are presumably in accord with the probable intention of most donors. The omission of a similar provision in California appears to have been purely inadvertent and should be quickly remedied by appropriate legislative action.

The California Act restricts the role of the physician who determines the donor’s death:

The time of death shall be determined by the physician in attendance upon the donor’s terminal injury or illness or certifying his death, and he shall not be a member of the team of surgeons which transplants the part to another individual.\textsuperscript{45} Because time is of the essence in the removal of “critical” parts, the transplant team naturally wants to remove the needed organ at the earliest possible moment\textsuperscript{46}—a motive potentially in conflict with the

\textsuperscript{33} CAL. HEALTH & SAFETY CODE § 7152 (West Supp. 1968).
\textsuperscript{34} See text accompanying note 11 supra.
\textsuperscript{35} CAL. HEALTH & SAFETY CODE § 7153(c) (West Supp. 1968).
\textsuperscript{36} FLA. STAT. § 736.18(8) (1965).
\textsuperscript{37} KAN. GEN. STAT. ANN. § 65-3204(c) (Supp. 1968).
\textsuperscript{38} Md. ANN. CODE art. 43, § 149L(c) (Supp. 1968).
\textsuperscript{39} UNIFORM ANATOMICAL GIFT ACT § 4(c).
\textsuperscript{40} CAL. HEALTH & SAFETY CODE § 7156(a) (West Supp. 1968).
\textsuperscript{41} Louisell, supra note 2.
obligation to sustain the life of the prospective donor. Requiring that the two functions of determining the extinction of life and removing donated parts be performed by separate individuals minimizes this possible conflict of interest.

On the other hand, it is essential that adequate channels of communication remain open between physicians administering to the donor and those representing the recipient. Effective communication facilitates successful transplantation and permits transfer of important knowledge concerning the nature of the disease affecting the donor and relevant immunological data. Therefore, the Commissioners on Uniform State Laws apparently concluded that using language which prohibited the attending physician from being a member of the transplant “team” was potentially too restrictive and narrowed this prohibition to read: “The physician shall not participate in the procedures for removing or transplanting a part.” Just changing the language, however, avoids the real issue. The problem is to guarantee that at least one doctor present is directly responsible only to the prospective donor, while assuring the physician that it is not a violation of his duty of undivided loyalty to the donor to communicate important knowledge to those removing the donated part. A provision directly stating this objective would be more appropriate.

The new Act specifies that the donee has the discretion to either accept or reject the gift. Arguably, this right allows the donee-physician to perform “any examination necessary to assure medical acceptability of the gift for the purposes intended.” This latter provision was added to the final draft of the Uniform Act to allow a proper evaluation of the donor’s condition and prevent the transmission of any disease that might cause injury to the transplant recipient. It has been reported, for example, that four early recipients of kidney transplants developed terminal cancer from organs taken from donors affected with the disease. It is not surprising, therefore, that members of the medical profession regard a post mortem examination of the donor as essential. While the right to examine for

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47. Sadler & Sadler, supra note 1, at 26-27.
48. **Uniform Anatomical Gift Act** § 7(b), Comment.
49. **Uniform Anatomical Gift Act** § 7(b). See Sadler & Sadler, supra note 1, at 26-27.
51. **Uniform Anatomical Gift Act** § 2(d).
52. Sadler & Sadler, supra note 1, at 28.
54. **Uniform Anatomical Gift Act** § 2(d), Comment.
acceptability may reasonably be implied from the right to accept or reject the gift, it is suggested that the Act be amended to specifically permit the necessary pre-transplant examination.

If the donee accepts, any part included in the gift may be removed from the body immediately after death and prior to embalming, with only the usual requirement that no undue mutilation be caused. Presumably, any part of the body not donated must then be surrendered to the surviving relatives for burial. If the gift is of the entire body, the donee may authorize embalming and funeral services. What is not clear is the effect on the rights of the donee and surviving relatives if the gift is of the entire body, but the donee is able to or elects to accept only a part. As to the burial arrangements in such a case, it would seem preferable that surviving relatives have the initial option to arrange the funeral services and that the donee should have secondary responsibility for assuring a proper burial if surviving relatives are unable or unwilling to do so. Recognizing the interests of survivors in having the decedent “laid to rest” is not necessarily inconsistent with aiding therapeutic surgery and carrying out the primary intention of the decedent.

A more serious problem arises with respect to the possible conflict between the medical need for transplantable tissue and society’s interest in having the cause of death determined when death occurred in suspicious circumstances. Public health problems as well as the discovery of crime may, on occasion, supersede private interests in transplantation. Thus, a provision in the original bill was amended to make anatomical donations “subject to and inferior to the laws of this state prescribing the powers and duties of the coroner.” Informal arrangements between transplant surgeons and coroners are

56. See, e.g., N.J. REV. STAT. § 26:6-55 (Supp. 1968); OHIO REV. CODE ANN. § 2108.01 (1968); TENN. CODE ANN. § 32-605 (Supp. 1968); UNIFORM ANATOMICAL GIFT ACT § 7(a).
57. CAL. HEALTH & SAFETY CODE § 7156(a) (West Supp. 1968).
58. Louisell, supra note 2.
59. S.B. 290, § 7158, Cal. 1968 Sess. California Legislature. The significance of the italicized phrase added to this section by the Assembly is augmented by the fact that specifically deleted from the original bill was a proviso that the coroner shall allow the donee to take donated parts where not reasonably necessary for performance of the coroner’s duties. While the deletion of such a provision qualified by the standard of reasonableness is difficult to justify, the answer may lie in a suggestion by commentators to the Uniform Act that the statutes regulating the coroner’s duties be themselves reexamined and amended to direct the coroner to expedite autopsy procedures where potentially transplantable parts are involved. See UNIFORM ANATOMICAL GIFT ACT § 7(d), Comment. Informal arrangements between transplant surgeons and coroners represent an unstable compromise at best.
currently in effect in some localities to permit prompt removal of organs in legitimate situations. Under current legal standards, the physician is best advised to obtain a clearance from the coroner’s office, as standard practice, before removing any donated part in cases where the coroner has potential jurisdiction.

Autopsies to determine the cause of death could afford a valuable source of organs for transplantation. Statutes in all states authorize the medical examiner or coroner to perform post mortem examinations where he has reasonable cause to believe that death occurred due to violence or in other suspicious circumstances. The medical examiner, therefore, would appear to be the ideal person to sanction the removal of transplantable parts from victims of fatal accidents or other cases within his jurisdiction. While there is apparently some receptivity to the idea of enlarging the medical examiner’s authority, his general statutory power is limited to determining the cause of death, and removal of organs has been allowed only to the extent necessary to complete the autopsy. If permission to perform an autopsy is sought from surviving relatives, a provision could be included in the consent form allowing permanent removal of parts. But if the consent given is limited, the autopsy must be conducted within the terms of the granted authority.

The donee-physician is specifically protected from civil liability in California if he acts “in good faith, in reliance upon, and in accord with, the terms of a gift under this chapter . . . .” The final draft of the Uniform Act extends this protection to a person who acts in accord with the anatomical gift laws of another state or foreign country. A broad protection provision is essential in view of the inevitable conflict between diverse donation statutes when a donor dies in one state after executing an anatomical gift in another.

Ideally, a gift properly executed in one state should be effective in any other state in which the donor dies. Unfortunately, there is no guarantee that the conflict of laws problem will be resolved in favor of recognizing an anatomical gift in a state having either different execution requirements or the common law rules. Moreover, the pressures of time inherently involved in transplant procedures preclude

60. Louisell, supra note 2.
61. Sadler & Sadler, supra note 1, at 15.
62. Id. at 13-17.
63. Louisell, supra note 2.
64. CAL. HEALTH & SAFETY CODE § 7156(b) (West Supp. 1968).
65. UNIFORM ANATOMICAL GIFT ACT § 7(c).
effective judicial resolution of this problem. While a single state such as California cannot guarantee that a gift executed within the state will be valid in any other state in which the donor dies, a comprehensive state statute should make provision for all prospective donors who die within the state. Maryland's Anatomical Gift Act represents one method by which such gifts could be recognized:

A document of gift executed in another state and in accord with the laws of that state thereunto pertaining . . . shall be deemed valid as a document of gift within the State of Maryland, notwithstanding that the said document does not substantially conform to the requirements of [this Act].

Another problem requiring statutory resolution is the possibility of conflicting gifts. Generally, the gift executed on the latest date should take precedence over an earlier document donating the identical part. But it is hardly self-evident that time alone should control when, for example, a gift of specific organs is made to one donee and the whole body is donated to another. As donation cards become widely distributed and volunteers for specific tissue banks increase, overlapping gifts may become a problem of serious dimensions. It has been reported, for instance, that Dr. Christiaan Barnard bequeathed his eyes at the request of a young girl volunteer worker for a Brazilian eye bank. In view of his opinion that "it is immoral to bury a heart if it can still be used," other anatomical donations from Dr. Barnard can be expected. A gift of "my body" following a disposition of specific parts such as the eyes raises different problems than those presented by two gifts of the same part.

Only the statutes of Connecticut and Massachusetts provide for resolution of the problem of conflicting gifts. Apparently based on the theory that the greater benefit will derive therefrom, the Connecticut statute provides that a gift of the whole body shall prevail over a gift of any portion. In contrast, a gift of specific tissue or organs takes precedence in Massachusetts unless the donor has manifested a

67. Since the statutes of most states require the signatures of two witnesses to make a valid anatomical gift, prospective donors in California should have their gifts attested by two witnesses to increase substantially the chances that the gift will be effective if the donor dies outside the state. See generally E. Scolés & E. Halbach, Problems and Materials on Decedents' Estates and Trusts 110-11 (1965).
70. S.F. Examiner, Jan. 23, 1969, at 6, col. 2.
71. Conn. Gen. Stat. Ann. § 19-139b (Supp. 1969). However, there is a possibility that if the gift of a specific part is executed after the gift of the whole body, it will take precedence under this section's general preference for the gift executed on the latest date.
contrary intent.\textsuperscript{72} The Massachusetts resolution seems preferable because the donor's specific bequest in such a case is probably not really inconsistent with the basic intent of the general bequest of the body. The remainder of the body can always be given to the general donee, and thus both the specific bequest and the probable basic intention can be satisfied. As a practical matter, however, until better methods are devised for prolonging the viability of donated organs from cadavers, whichever donee is in the best position to accept and utilize the gift should be preferred. Open-ended donations represent the best method of assuring that the gift will be effectual.

The new California Act also contains a unique requirement that the use of human tissue donated for transplantation "shall be construed, for all purposes whatsoever, as a rendition of a service by each and every person participating therein, and not be construed as a sale of such tissue for any purposes or purposes whatsoever."\textsuperscript{73} Apparently, this provision was designed to alleviate any problems of "implied warranty" in supplying or using human organs for transplantation. Unfortunately, the approach taken confuses protecting the participants from unreasonable risk with the problem of whether to allow payment for anatomical gifts. The latter is a substantial ethical problem in itself and of such a nature that precise legislative formulation is of the greatest importance to assure acceptable results.\textsuperscript{74} If the legislative intent was only to preclude suits based on a theory of implied warranty, the Virginia Code provides a more acceptable solution:

No action for implied warranty shall lie for the procurement, processing, distribution or use of whole blood, plasma, blood products, blood derivatives and other human tissue such as corneas, bones, or organs for the purpose of injecting, transfusing or transplanting any of them into the human body except where any defects or impurities . . . are detectable by the use of established medical and technological procedures employed pursuant to the standards of local medical practice.\textsuperscript{75}

II

PROBLEMS COVERED, UNCOVERED, AND NOT COVERED BY THE CALIFORNIA ACT

The new California Anatomical Gift Act makes it clear that a

\textsuperscript{74} See notes 112-17 infra and accompanying text.
decedent and his surviving relatives have the right to donate his body for medical purposes, contrary to the common law rule that "a man cannot by will dispose of his dead body." It should be just as clear that the new Act is not and was not intended to be a panacea solving all the problems surrounding the transplantation of human remains. In fact, the "unprecedented" speed with which the Uniform Act has been accepted can be attributed in large part to the decision of the Commissioners that the many controversial moral and ethical problems regarding transplantation were not proper subjects for present legislative consideration.77

State Senator Anthony Beilenson, in a press release, expressed the hope that the introduction of his bill, based on the Uniform Act, would stimulate discussion of the many legal, moral, and religious questions raised by the use of human remains for medical and scientific purposes.78 Shortly after passage of the new Act, the Assembly passed a resolution indicating that many questions of public policy remain unsolved and requesting that a study of the general subject of organ transplantation be made.79 The resolution cites the inadequacy of present standards with respect to such questions as who is eligible for vital organ transplant operations, when and under what conditions should these operations be performed and who should have the responsibility for making these decisions. To these profound questions can be added the problems of whether payment for anatomical gifts should be prohibited, and what criteria should be applied in establishing the donor’s death. It is the purpose of Part II of this Comment to explore briefly these problem areas and to indicate some of the important policy considerations relevant to such a discussion.

A. Propriety of Transplantation

The passage of an Act facilitating the donation of organs for medical purposes focuses up the entire question of the propriety of transplantation as a desirable medical procedure in the human situation. It has been questioned whether there is a true social consensus in favor of comprehensively using dead bodies to prolong life on a massive scale.80 Perhaps the issue is brought into its clearest

76. See text accompanying notes 2-6 supra.
77. See Auerbach, Doctors Seek New Laws on Ownership of Bodies, L.A. Times, Nov. 8, 1968, § 1-A, at 1, col. 3.
80. Louisell, supra note 2. Directly relevant to an analysis of the problem posed by
perspective by the future possibility of transplanting the human brain. This would of course raise the question of whether an organ is being transplanted to a body or a body is being transplanted to an organ; in other words, which individual would survive? Even if the issue is confined to currently transplantable parts, it is at least questionable whether the public generally is willing to relinquish the many aesthetic, emotional, and religious ties with such a significant organ as the heart in favor of regarding the human body as a "mere" machine with interchangeable parts. One report, for example, quotes the mother of a recent heart donor as saying she was "proud for my son to go on living in another person." Policymakers should at least consider whether it is desirable for close relatives to regard a decedent as "living" in another person, as well as problems raised, for example, if a large estate is left to the recipient patient on the basis of such a belief. There are of course no easy answers to such questions, but they must be considered.

Accepting transplantation as a potentially valuable technique does not end the inquiry; there remains the question of whether a transplant is appropriate in a given case. While the fact of transplantation does not essentially change the judicial approach to such problems as "informed consent" to medical treatment, the relative novelty of the transplant procedure may evoke a sharper inquiry into whether the operation was warranted as a matter of accepted medical practice. There is of course no litmus paper test; whether a procedure is to be labeled "experimental" rather than "therapeutic" depends on a number of factors including the availability of alternative treatment and the maturity of the surgical

Professor Louisell is a report by a Stanford psychiatrist, Dr. Donald Lunde, that psychiatric complications often result from a combination of the trauma of major surgery and the effects of anti-rejection drugs. Dr. Lunde said that most complications have been only temporary, but three heart transplant patients at Stanford have developed serious mental problems after the operation. He recommends psychiatric screening for prospective transplant patients. S.F. Chronicle, May 8, 1969, at 31, cols. 1-2.

81. Consider also the possibility of ovarian transplants. Doctors are now developing surgical and immunological techniques which they feel will permit them to transplant fertile ovarian tissue into a barren woman. S.F. Chronicle, April 25, 1969, at 28, cols. 4-8. Such a transplant would raise the problem of whose baby it would be: the woman who carried it for nine months or the donor?

82. S.F. Chronicle, Aug. 27, 1968, at 3, col. 3. Compare the statement of Dr. Lunde, psychiatric consultant to Dr. Norman Shumway's heart transplant team at the Stanford Medical Center. "Some of the patients have also felt that by receiving the heart of another person they might take on some of the personality characteristics of the donor." S.F. Chronicle, May 8, 1969, at 31, col. 2.

83. Louisell, supra note 2.
The problem for the law is one of guarding patients from dangerous methods not yet generally accepted while at the same time not unduly inhibiting the development of a valuable new medical technique.

While many types of transplants have attained the status of established medical treatment, others are still in the process of evolving from the purely experimental stage. Not surprisingly, the current debate centers around the propriety of transplant operations involving the human heart. An editorial in the Journal of the American Medical Association stresses the danger of a “rush to reckless adventures in heart transplant efforts by incomplete teams where ambition exceeds multidisciplinary balance.” A Noble prize-winning surgeon has been quoted as saying, “I consider it a crime to perform an operation in a field where fundamental research is not yet finished.” The British Medical Association has called for a slowdown in heart transplants until more can be learned about such operations. Dr. Christiaan Barnard acknowledges that he has been criticized by everyone on his heart transplants, but retorts, “Everyone, that is, except my patients.”

There can be little doubt that the issue of the propriety of transplantation is cluttered by concern over the extent to which the number of such operations has been influenced by the prospect of fame and recognition for the doctors involved. “The sooner national and professional prestige is removed from the field of transplant the better shall we be able to assess what priority it should have over other desirable medical advances . . . .”

Even transplant surgeons apparently do not contend that heart transplants have reached the stage where they offer real hope on any massive scale for heart disease victims. The survival of Dr. Philip Blaiberg for more than a year with a transplanted heart certainly indicates potential value, but the average survival time of the more than 100 heart transplant patients would still appear to be only a few

84. Sadler & Sadler, supra note 1, at 7 n.10.
85. Havighurst, Foreword to 32 LAW & CONTEMP. PROB. at 561 (1967).
87. TRIAL, Feb.-Mar. 1968, at 51.
89. S.F. Examiner, Jan. 23, 1969, at 6, cols. 2-3.
91. Perlman, Stanford Tells Gains in Year of Heart Transplants, S.F. Chronicle, Jan. 30, 1969, at 5, col. 4. The primary complication involved in organ transplantation is the body’s rejection mechanism. Powerful suppressive drugs must be used to protect the transplanted part from damage, but this reduces the body’s tendency to resist infection. The dilemma for the physician is one of “walking a tightrope” between too much drug treatment lowering the body’s
days. This fact poses the problem of when a transplant is within acceptable medical procedures. Dr. Denton Cooley of Houston, apparently the world's most productive heart transplant surgeon, considers a heart transplant successful if the patient survives for three months. Thus, a minimum requirement would seem to be that the patient must have a terminal heart condition which cannot be mended by normal cardiac surgery, and that no other alternative treatment is available which might provide more than three months of life. To this can be added the guidelines which the American Medical Association has established providing that such operations be performed only in institutions having an adequate background in animal research, adequate sources of drugs and satisfactory techniques to prevent rejection, as well as adequate follow-up facilities to evaluate the patient's progress. Obviously, the chances for a successful operation diminish as a patient's condition worsens. However, heart transplants have not yet attained the status which would justify applying the technique in any but the most severe cases of terminal heart disease.

Perhaps much of the doubt about the ultimate wisdom of transplantation is rooted in the fear that using parts of one human being to save another can be subject to great abuse. Recently in South Africa, the heart of an African woman was transplanted without the normal procedure of obtaining the relatives' consent. The doctors...
claimed that the woman was unidentified, but the effort made to ascertain her identity might not have been as extensive as would have been the case with a white patient. Also significant, in the midst of South Africa’s apartheid, is the fact that the world’s most successful heart transplant recipient is a white man who received the heart of a “colored” donor. Especially in view of Dr. Barnard’s quite legitimate observation that Negro Africans are the best donors because they are the least susceptible to coronary disease, safeguards must be devised to prevent racism from affecting choices of survival.

B. Determination of Death

Possible premature pronouncements of death would appear to constitute the most feared abuse in the transplant field. Historically, the definition of death has been left to the medical profession rather than to legislatures. This is understandable in view of the fact that medical criteria may be subject to change which could not be anticipated in any reasonably definite statutory standard. The difficulty arises, however, when the doctors do not agree. The classic definition of death as being manifested by the absence of heartbeat and respiration is under considerable attack from surgeons who claim that such requirements unnecessarily and undesirably inhibit full use of transplantable tissue. These surgeons press for a redefinition of death based on neurological criteria. While it is difficult for the non-medical observer to analyze the technical concepts in any definition of death, the policy considerations upon which the proper criteria should be based can be enunciated.

The first observation which should be made is that the desire to preserve viable organs for transplantation is not a sufficient reason in itself to redefine the moment of death. Any new definition of death must be one that is acceptable in all situations and based on considerations other than that the dying person’s organs are to be used for transplantation. The donor in a transplant situation is the only participant who has nothing to gain. He is literally giving something for nothing, and all conceivable doubt must be resolved in his favor. If there has been too much extension of meaningless vegetable life, let us change the criteria for all patients, not just for those who make anatomical donations.

Much of the confusion as to the proper criteria for determining

98. Id.
death is attributable to a failure to distinguish between artificial and natural maintenance of life. Many critics of the traditional determinants of life argue that the ability to maintain circulatory and respiratory functions should not be the relevant criteria because these functions are capable of being performed artificially. Doctors can keep a patient's heart beating long after his brain has sustained irreversible damage by the use of respirators, new drugs, and shock techniques. Certainly, when all personality has irrevocably ceased to exist, there should be no obligation to sustain the semblance of life artificially. But heartbeat and respiration which is continuing naturally cannot be ignored simply because these systems could be maintained artificially. It is not relevant to determining the moment of death that medical science can duplicate certain bodily functions unless in fact these systems are being supported by artificial means. It must be considered whether natural heartbeat and respiration evidence an inviolable spontaneity of life which cannot yet be fairly characterized as a mere reflex. Heartbeat is irrelevant for purposes of determining the donor's death only if it has been necessary in the particular case to employ artificial means to maintain the system's functioning.

Even if there is a consensus that a potential donor, despite the continuation of natural respiration, is "dead" because he will never return to consciousness, there remains the problem of how much certainty to require from doctors who engage in such predictions. One recent newspaper story told of a woman who was officially pronounced dead only to be found breathing normally an hour later. Apparently, the normal procedures following death were altered in preparation for an organ transplant. She was given a stimulant to extend her metabolism process, but it was discovered that her respiration and heartbeat continued to function without sustained stimulation. She "died" three weeks later. The hospital's chief administrator admitted that this "exceedingly unfortunate" sort of thing does happen rarely but stressed that for all practical purposes the original pronouncement that she was dead was correct. The point is not that this sort of problem occurs more than rarely but that the unselfishness of either the donor's bequest or the survivor's consent requires the greatest deference in determining death in the

100. E.g., Sadler & Sadler, supra note 1, at 27.
101. Rapoport, supra note 95, at 11, col. 3.
104. Id.
transplant situation. The surgeon does not have the right to terminate life because of the high probability of impending death. Certainty is required, and this has apparently not yet been achieved.

C. Who is to Receive the Donated Part?

Any potentially life-saving technique involving limited resources, such as the available number of donated parts, inevitably raises the question of which dying patient is to be treated. The problem of deciding who shall be helped to live also involves deciding who should be left to die. Prolonged life should be both meaningful and useful to be worthwhile, but the critical problem is twofold: What are the standards for making this assessment, and who is to make the final decision? It is understandable that specific suggestions for rules of guidance in deciding who is to receive a limited but life-saving treatment are infrequent. “When spelled out they tend to emit a cold totalitarian aura instead of the humane one that comes from an individual doctor’s lonely struggle to chart his conscience amid the reefs of the patient’s reality.”

The troublesome role which social factors can play in selection procedures has been vividly portrayed in a study of several artificial kidney centers. It appears that several such centers base the decision of who is to receive the established but inadequately available hemodialysis treatment on an anonymous committee’s evaluation of the “social worth” of a patient. But many undisclosed preferences and prejudices are inherent in the application of such a standard. One report says a record of public service is a help, but “public service” in a pluralistic society is no less nebulous a concept than social worth; neither standard facilitates a choice between a boy scout leader and a participant in a sit-in at a racially segregated restaurant. The practice of the selection committee at the hemodialysis center at the University of Washington illustrates a disturbing pattern of middle class values being reinforced at the expense of the creative nonconformist. The report’s authors concluded, “The Pacific Northwest is no place for a Henry David Thoreau with bad kidneys.”

When life itself is held in the balance, the principle of equality of worth as a human being must be strictly observed. Selection

107. Id. at 377-78.
108. Id. at 378.
procedures which allow an omnipotent secret committee with no articulated standards to evaluate and compare the social value of other human beings in order to decide who is to be saved from among the dying may well not meet the equal protection and due process demands of the Constitution. The principle that man should not play God with human lives does not necessarily preclude basing such decisions upon rational and nondiscriminatory criteria which are announced in advance. But the sanctity of human life should not be violated by reliance upon nebulous concepts such as the "social worth" of one human being in comparison to another.

The problem of selecting those to receive a limited medical treatment may not be as acute in the transplant situation as with the use of artificial parts because of the importance of tissue typing in the preliminary determination of medical acceptability. If the determination cannot be made solely from medical considerations, a procedure must be chosen which does not permit hidden prejudices or preferences to influence the decision, such as random selection or first come, first served. Concededly, it is easier to assail a bad system than to choose a good one.

D. Payment for "Gifts"

A "gift" act carries an implication that a "sale" is not authorized. The California Act includes a provision requiring that the use of human tissue donated for transplantation be construed as the rendition of a service by each participant and not as a sale of such tissue. However, payment for "rendition of a service" is not expressly prohibited. Several state statutes provide that the donee shall not pay compensation to the donor for an anatomical gift. In contrast, the Mississippi statute is based entirely on the premise that donations of human parts are, in the nature of a contract, as illustrated by the provision regulating revocation:

Any person entering into such a contract may, during his or her lifetime, revoke by a written instrument, signed by both parties, said

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111. Sanders & Dukeminier, supra note 106, at 380.
112. UNIFORM ANATOMICAl GIFT ACT, Prefatory Note 14 (2d tent. draft 1968).
113. See text accompanying note 73 supra.
contract in its entirety, provided, however that if any such person has received any monetary consideration for entering into said written contract, he or she upon revoking said contract shall repay such monetary consideration to those from whom he received the consideration, in full, plus six per cent (6%) interest from the date of the signing of the contract.115

The Uniform Anatomical Gift Act makes no provision dealing with the matter of payment for gifts. The problem is discussed in the prefatory note and comments to the second tentative draft, and the conclusion reached is that not every payment is necessarily unethical. The drafting committee recognized the possible abuses which could arise but pointed out that payments have been frequently made for donations to blood banks without any apparent resulting harm. The committee recommended that the matter of payment should be left "to the decency of intelligent human beings," at least until the matter becomes a problem of some dimensions.116

In California, the provision prohibiting the use of donated tissue from being construed as a sale but not expressly proscribing payment for "rendition of a service" leaves uncertain the validity of payment for the use of human tissue. At the one extreme, it seems unreasonable to prevent a grateful recipient from paying the hospital expenses of the deceased donor. At the other, a prospective donor should not be allowed to advertise and sell his organs to the highest possible bidder. When a man desires to give his body for medical purposes, he should be allowed to give his body to any potential recipient. However, if he chooses to demand or accept payment for donating his tissue after death, he makes himself subject to reasonable restriction by the state to prevent abuse. One answer to possible abuses is to put a ceiling on the amount of payments, such as the hospital and burial expenses of the donor. This could be achieved by having the hospital charge the donor’s expenses directly to the recipient patient. Thus, the best practical answer may be to extend hospitalization insurance to include the costs of both the patient and donor in human organ transplants, thereby spreading the cost over a broader base.117

CONCLUSION

California’s Anatomical Gift Act deals with only one aspect of the transplantation process: that of obtaining the donor’s consent.

With minor modifications, the Act could also maximize the chances that his gift will be effective. Thus, California has taken an important step forward in keeping the law abreast of medical and scientific developments. But there are many profound problems of public policy yet to be resolved in the area of human organ transplantation. The law should not be too quick in arriving at conclusions with respect to the more complicated ethical and philosophical problems involved; the discussion of these important questions has just begun.

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