

ORGAN TRANSPLANTATION AND ANATOMICAL GIFTS

MAJ John J Fluck¹

1. Introduction.

a. Organ and tissue transplantation has become an everyday miracle of American life, affecting the lives of our sports heroes and our closest colleagues.² As early as the 1940s, medical breakthroughs were already challenging the law's ability to find precedent for the unprecedented.³ Dramatic medical advances in the 1960s drove legislative activity⁴ at both the state⁵ and federal⁶ levels. This timely and comprehensive legislative effort has made this a relatively quiet corner of medicolegal jurisprudence, at least for those who scrupulously follow the rules. Fortunately for military practitioners, those rules are largely encapsulated in the current DoD and Army regulations discussed in detail below.

¹Instructor, U.S. Army Military Police School.

²By 1995, about 110,000 patients had received an organ in the past 9 years. 41,000 patients were awaiting a transplant. Statement of Dr. Ciro Sumayo, Administrator, Health Resources and Services Administration, U.S. Public Health Service at Hearings before the Committee on Labor and Human Resources, U.S. Senate (July 20 1995), concerning reauthorization of the *National Organ Transplant Act*, page 13. Currently, more than 65,000 people await transplant. G. Bruce Weir, "How Do We Decide Who Gets Another Chance at Life," *USA Today*, February 24, 1999, at 13A.

³See, e.g., *Bonner v. Moran*, 126 F. 2d 121 (App. D.C. 1941), requiring the court to resolve whether a cause of action arose when a surgeon removed skin from a consenting 15-year-old for transplantation to a severely burned cousin without the consent of the 15-year-old's parents. Held, the consent of a parent is necessary for a surgical operation on a child. Medical breakthroughs continue to challenge legal scholars and stretch the law's ability to evolve. See, e.g., Jodi K. Fredrickson, "He's All Heart... and a Little Pig, Too: A Look at the FDA Xenotransplant Guidelines," 52 *Food and Drug Law Journal* 429 (1997).

⁴One pair of commentators notes that the four years which elapsed between drafting the Uniform Anatomical Gift Act (1968) and its enactment by all 50 states and the District of Columbia amounts to the "swiftest nationwide adoption of a uniform act in the history of the National Conference of Commissioners on Uniform State Laws." Cotton and Sandler, *The Regulation of Organ Procurement and Transplantation in the United States*, 7 J. Legal Med., 55, note 1, at 60, cited in Jardine, infra, note 6, at 1656.

⁵E.g., state versions of the Uniform Anatomical Gift Act (1968) [hereinafter UAGA(1968)] and the Uniform Anatomical Gift Act (1987) [hereinafter UAGA(1987)]. 22 states have adopted UAGA(1987). The remaining states, except South Dakota [which is considering adoption of UAGA(1987)], follow UAGA(1968), personal conversation with John McCabe, Staff Attorney, National Conference of Commissioners on Uniform State Laws, 25 March 1999.

⁶E.g., Public Law 98-507, *National Organ Transplant Act* (19 October 1984).

b. Despite rapid advances in transplant technique, thousands of lives are lost every year because of a shortage of donated organs. Estimates vary, but an official at the United Network for Organ Sharing contacted in 1990 estimated that 25-30% of the patients needing transplants of organs other than kidneys die before a suitable organ can be found.⁷ Waiting times for organs vary widely. A government official reported in 1995 that median waiting times during the period 1991-1993 varied nationwide from 58 to 768 days for those needing heart transplants and from 23 to 368 days for those needing liver transplants.⁸ Scores die every week because a suitable organ was not found.⁹ The human tragedy manifest in these grim numbers drives policymakers to find new ways to increase the supply of transplantable organs. This trend is readily traced in successive versions of the Uniform Anatomical Gifts Act and successive revisions of the applicable DoD Directive.¹⁰ As a result, it has become easier for an individual to document his intent to make an anatomical gift, and institutional responsibilities to facilitate such donations by either the patient or his next of kin have steadily increased. Institutions benefit greatly, however, from another aspect of this drive to increase the supply of transplantable organs: To encourage harvesting and transplanting anatomical gifts, legislatures and courts have been very reluctant to allow liability in cases where mistakes may have been made by transplant practitioners proceeding in good faith.

c. Table of contents. The second section of this article sketches the organizational structure that manages organ transplantation. The third section outlines the law concerning determination of death as it affects the organ transplant process. The fourth section examines DoD policy. The fifth section discusses anatomical gifts. The sixth section provides an overview of litigation and hospital defenses. The last section recaps references.

⁷Daniel G. Jardine, "Liability Issues Arising out of Hospitals' and Organ Procurement Organizations' Rejection of Valid Anatomical Gifts: Truth and Consequences," *Wisconsin Law Review*, Volume 1990, Number 6, page 1655, note at 1656.

⁸Statement of Dr. Sumayo, *supra*, page 58.

⁹ More than 90 people are added daily to waiting lists. "Every day, 10 people on the list die because their organs did not come in time." G. Bruce Weir, "How Do We Decide Who Gets Another Chance at Life," *USA Today*, February 24, 1999, at 13A.

¹⁰DoD Directive 6465.3, "Organ and Tissue Donation," 16 March 1995.

2. Structure of the national system.

a. National. In 1984, Congress funded the Task Force on Organ Procurement and Transplantation.¹¹ The task force was asked to assess the issues surrounding organ transplantation, design a comprehensive nationwide system consonant with its assessment, and propose implementing regulations to make that system a reality.¹² Congress also funded the National Organ Procurement and Transplantation Network, a nonprofit private organization with the mission of: (1) compiling a national list of those in need of organs; (2) establishing a national system to match available organs and those in need; and (3) developing equitable distribution standards and quality control standards for the acquisition and transportation of donated organs.¹³

b. Regional. The regional tier was also funded through the authorization of grants for Organ Procurement Organizations [hereinafter OPOs]. OPOs are nonprofit organizations with "defined service area[s]... of sufficient size to assure maximum effectiveness in the procurement and equitable distribution of organs."¹⁴ The OPOs' mission was more focussed-- the statute required them to have: [1] "effective agreements to identify potential organ donors with a substantial majority of the hospitals... in [their] service area;" [2] to commence "systematic efforts... to acquire all usable organs from potential donors," and, [3] to handle the logistical details of organ transplantation.¹⁵

c. Local. Finally, to guarantee local hospital participation in the national scheme, hospitals were barred from Medicare and Medicaid reimbursement unless they agreed to: (1) ensure that families of potential organ donors were aware of donation options; (2) promptly identify potential organ donors and notify their regional OPO; and (3) abide by Network standards respecting organ donation.¹⁶

d. Nationwide prioritization of recipients. Harvested organs die quickly. Accordingly, matching organs to recipients ("donees") has always been a race against the clock. Once, this race could only be won at the regional level-- organs harvested in Utah went to Utah donees. Organ harvesting is still managed regionally. But automation advances have made it possible to find

¹¹Note at 633, 42 U.S.C.A. Section 273.

¹²Id. citing Title I of Pub.L. 98-507, Section 101.

¹³42 U.S.C. Section 274(b).

¹⁴42 U.S.C. Sections 273(b)(1)(E) and 274.

¹⁵42 U.S.C. Section 273(b)(3).

¹⁶42 U.S.C. Section 1320b-8(a)(1).

optimal matches of harvested organs to donees almost instantly and on a national scale. New regulations mandate creating a national registry of individuals needing organs and ranking them by degree of need.¹⁷

3. Determination of death.

a. The body's vital organs quickly lose their viability when blood circulation ceases. Some are useless for transplantation only 20 to 30 minutes after blood circulation stops. The heart and liver lose viability even more quickly. Being able to recover these organs from "a brain-dead, heart-beating cadaver" is a priceless, lifesaving opportunity.¹⁸ Accordingly, the timing and standards applied in determining death of a potential donee are crucial aspects of the overall organ donation process. HSC Reg 40-32, para 5(a), provides that a determination of death "must be made in accordance with accepted medical standards [and]... must include one of the following:

(1) Irreversible cessation of circulatory or respiratory functions in an individual.

(2) Irreversible cessation of all functions of the entire brain including the brain stem."

b. This standard echoes the one espoused in the 1980 Uniform Determination of Death Act. The Act has, as of March 1999, been enacted by 41 U.S. jurisdictions with only minor variations.¹⁹ At least two states-- Ohio and West Virginia-- have statutorily extended the Act to provide civil and criminal immunity for

¹⁷42 CFR 121.1 - 121.12, effective 1 October 1998. The regulations envision a strictly needs-based prioritization of potential recipients. See, e.g., 42 CFR 121.4(a)(3)(i), requiring that "patients be listed without regard to ability to pay or source of payment" in order to help meet the policy goal of "reduc[ing] the inequities resulting from socioeconomic status." The impact of these changes on the DoD policy of making organs from DoD donors available first to Military Transplant Centers is uncertain.

¹⁸Chiminello and Attaya, "Organ Transplantation and Anatomical Gifts," JAGC Medicolegal Deskbook (May 1991), page 4.

¹⁹Enacting jurisdictions include Alaska, Arizona, Arkansas, California, Colorado, Connecticut, Delaware, District of Columbia [D.C. Code Section 6-2401, Georgia [O.G.C.A. Section 31-10-16], Idaho, Indiana, Kansas, Maine, Maryland, Michigan, Minnesota, Mississippi, Missouri, Montana, Nebraska, Nevada, New Hampshire, New Mexico, New York [substantially similar], North Dakota, Ohio, Oklahoma, Oregon, Pennsylvania, Puerto Rico, Rhode Island, South Carolina [Code Sections 44-43-450, 44-43-460], South Dakota, Tennessee, Utah, Vermont, Virgin Islands, Washington, West Virginia, Wisconsin, and Wyoming. *U.L.A. Civil Procedure and Remedial Laws*, Volume 12 Supplementary Pamphlet (1995) and personal conversation with John McCabe, Staff Attorney, National Conference of Commissioners on Uniform State Laws, 25 March 1999.

physicians who make death determinations in accordance with the terms of the Act and other parties "who act in good faith in reliance on [such] a determination of death."²⁰ Alabama has modified an earlier uniform act extending its definition of death to include those in which two doctors concur that "respiratory and cardiac function are maintained by artificial means" and who have suffered "a total and irreversible cessation of brain function."²¹

c. Equating brain death with the legal definition of death has been approved by both the American Medical Association and the American Bar Association. However, the determination must be made in accordance with accepted medical standards²² and state law. Careful practitioners will want to ensure that local law agrees with HSC Reg 40-32 and the Uniform Determination of Death Act standard.²³

d. Attorneys in states that have not adopted the uniform act or some other statutory definition of death and whose hospitals must defend against a lawsuit alleging a defective death determination may find help in the Supremacy Clause and NYC Health and Hospital Corporation v. Sulsona.²⁴ The Sulsona court was faced with a hospital's petition for a declaratory judgment to define time of death for a brain-dead potential kidney donor and with no statutory definition of death to follow. The court held that death would be determined in accordance with generally accepted medical standards and consonant with the general legislative intent favoring donation embodied in the state's anatomical gift act statute. Accordingly, the court allowed the donor to be declared dead and the hospital to harvest the donor's kidneys.

e. The death determination must be made by the donee's physician and generally one other physician (optimally a neurological or neurosurgical specialist). Transplant team members are disqualified from making this determination. The determination, including the time and date of pronouncement of death, must be written in the donee's chart and progress notes.²⁵ When the local medical examiner has jurisdiction by law or

²⁰Ohio - R.C. Section 2108.30 and West Virginia - Code Section 16-10-3.

²¹Code of Alabama, Section 22-31-1(b).

²²Adoption of these standards by the medical community is virtually assured by the AMA's early action. Some local conferences have expanded the general guidelines with detailed criteria. See, e.g., the cardiopulmonary and neurological guidelines issued by the New York Determination of Death Consensus Conference as "Voluntary Consensus Guidelines for Determination of Death" at [HTTP://wings.buffalo.edu/faculty/research/biotethics/man-bdg.html](http://wings.buffalo.edu/faculty/research/biotethics/man-bdg.html).

²³Chiminello and Attaya, supra, page 4.

²⁴367 NYS 2d 686, 76 ALR 3d 905 (NY Sup 1975). See, esp., the annotation at 76 ALR 3d 913.

²⁵Chiminello and Attaya, supra, page 4.

agreement, authorization must be obtained from that office before the organs are harvested. The donee's medical record should contain documentation of this authorization, including the time, date and name of the authorizing official.²⁶ Finally, the donee's medical record must include the primary surgeon's description of the organs removed as well as any abnormalities noted.²⁷

f. Other conflict-of-interest considerations. Neither the attending physician nor anyone else involved in the "immediate care of the patient" will participate in any procedures connected with removing or transplanting the patient's organs.²⁸

4. DoD policy.

DoD Directive 6465.3 [hereinafter "the Directive"], originally issued on 14 March 1987, was revised and reissued on 16 March 1995. Even though they were promulgated earlier, AR 40-3²⁹ and HSC Reg 40-32³⁰ generally prescribe procedures consistent with the Directive's policies. The Directive's guidance is also consistent with the current- and rather general- requirements established by the Joint Commission on Accreditation of Healthcare Organizations.³¹

a. Encouraging the execution of donor cards. Maximizing the execution of voluntary organ and tissue donor cards while "avoid[ing] coercion" is a primary policy goal of the Directive.³² Thus, ASD(HA) is tasked to "make organ and tissue donor cards³³ available to all DoD beneficiaries,"³⁴ and the Directive's Guidelines specify that "opportunities... to make organ and/or tissue donation pledges should be made available "with arrival at the first duty station, at regular physical examinations during issuance and reissuance of ID cards, in all MTFs, and at military unit meetings."³⁵ MTFs must stock and provide blank donor cards and informational material.³⁶ Finally, to ensure that a patient's

²⁶Chiminello and Attaya, supra, page 5.

²⁷Chiminello and Attaya, supra, page 5.

²⁸HSC Reg. 40-32, infra, para 8(a).

²⁹AR 40-3, Chapter 18, "The Army Organ Transplant Program," 15 February 1985.

³⁰HSC Regulation 40-32, *Organ and Tissue Donation*, 22 October 1992.

³¹See Joint Commission on the Accreditation of Healthcare Organizations (JCAHO) Standard RI 2 (1999). Note, however, that JCAHO standards are revised annually.

³²DoD Directive 6465.3, para D(1).

³³Defined by para C(2) of the Directive as "a legal document signed by an individual, properly witnessed under the rules of informed consent, and indicating a desire to have one or more organs and/or tissues removed at death for donation to another individual." State statutes generally contain local forms adapted from the UAGA.

³⁴DoD Directive 6465.3, para E(1)(a).

³⁵DoD Directive 6465.3, "Guidelines," para 11.

³⁶DoD Directive 6465.3, "Guidelines," para 12.

desire to donate organs or tissues is not overlooked, the Defense Medical Systems Support Center is directed "to enter donor information in the Defense Enrollment Eligibility Reporting System software, the Composite Health Care System software, and the Realtime Automated Personnel Identification System software."³⁷

b. Discussing organ donation with the prospective donee's next of kin.

(1) To ensure that the primary next of kin are properly notified of the death before they are telephoned and asked to donate the decedent's organs, hospitals must first notify the Casualty Area Command whenever the primary next of kin is not already available at the hospital where the patient died.³⁸

(2) "Unless prohibited medically, legally or for religious reasons, organ and tissue donation shall be discussed with the next of kin³⁹ in every death in a military MTF."⁴⁰ This discussion "shall" occur even if the patient previously signed a donor card because organs and tissues will not be harvested "in conflict with the wishes of the next of kin."⁴¹ Incidentally, the converse is also true: Even if the next of kin wants to donate organs or tissues, nothing will be harvested from an adult who earlier "stated either orally or in writing" that he did not wish to donate.⁴²

(3) If the primary next of kin agrees to donate organs or tissues, it may be necessary to prove that authorization later.

³⁷DoD Directive 6465.3, para E(1)(c).

³⁸DoD Directive 6465.3, "Guidelines," para 9.

³⁹Defined as follows by para C(3) of the Directive: "The available interested party highest in the following order of priority shall be designated the primary next of kin: the spouse of the donor; an adult son or daughter of the donor; either parent of the donor; an adult brother or sister of the donor; a grandparent of the donor; a guardian of the donor at the time of death. The designated next of kin may waive all referenced rights in favor of the next interested party in the priority list from reference (b) [UAGA (1987)]." Fortunately, the priority list found in Section 3 of UAGA (1987) is identical.

Unfortunately, HSC Reg 40-32's definition of next of kin is not identical-- its attempt to resolve conflicts between family members by favoring senior members of a given class should not be followed. Instead, follow the rules for resolving conflicts provided in local statute. Section 3(b) of UAGA(1987), for example, clarifies Sections 2(b) and 4(e) of UAGA(1968) and provides that a gift cannot be made by someone of a given class who knows of an objection to it by a member of the same or a prior class.

⁴⁰DoD Directive 6465.3, "Guidelines," para 1.

⁴¹DoD Directive 6465.3, "Guidelines," para 5.

⁴²DoD Directive 6465.3, "Guidelines," para 4. Almost all states also have provisions-- often less liberal than this guideline-- facilitating revocation of donor cards and other "documents of gift" modelled on UAGA(1987).

Accordingly, the Directive requires that the authorization be a signed document, a telegram, a recorded telephone conversation or "other recorded message."⁴³

c. Coordinating donations with the OPO.

(1) "All inpatient MTFs shall establish MOUs, MOAs, or contracts among themselves, one of the MTCs [Military Transplant Centers], and the local OPO for organ recovery services." These MOUs must:

(a) Prohibit selling for profit any organs or tissues from a DoD beneficiary;⁴⁴

(b) "Grant DoD recipients, including National Guard and Reserve personnel, access to organs and tissues donated by DoD donors;"⁴⁵

(c) Require the OPO to keep a list of patients dying in the MTF and "record the results of action taken to secure the donation of organs or tissues from each patient who dies;"⁴⁶ and

(d) Be reviewed annually;⁴⁷

(2) These MOUs should:

(a) "Require equitable sharing of organs and tissues to maximize their use at the MTCs;"⁴⁸

(b) Require OPOs to immediately notify the MTF when a civilian facility hospitalizes someone who is a potential donor and an active service DoD beneficiary (this includes USCG and USPHS members);⁴⁹

(c) Require either the OPO or the civilian transplanting institution to pay DoD's retrieval costs when harvested organs or tissues are accepted for transplantation to non-DoD beneficiaries;⁵⁰

⁴³DoD Directive 6465.3, "Guidelines," para 9.

⁴⁴DoD Directive 6465.3, "Guidelines," para 10. See, also, Section 4(b) below.

⁴⁵DoD Directive 6465.3, para D(4). This provision is less innocuous than it seems. It will prevent a regional OPO, trying to favor in-region recipients by excluding an out-of-region DoD recipient from consideration. This is consistent with the new federal regulations mandating nationwide prioritization [see section 2(d) above].

⁴⁶DoD Directive 6465.3, "Guidelines," para 3.

⁴⁷DoD Directive 6465.3, para E(2)(a).

⁴⁸DoD Directive 6465.3, "Guidelines," para 6.

⁴⁹DoD Directive 6465.3, "Guidelines," para 10.

⁵⁰DoD Directive 6465.3, "Guidelines," para 8.

and

(d) Be reviewed by an Army attorney.⁵¹

(3) The Directive also requires MTFs to have and follow written procedures to expeditiously notify OPOs of the potential availability of an organ or tissue donor.⁵²

d. Maximizing use of donated organs by DoD beneficiaries. The 1987 version of the Directive required that DoD beneficiaries receive priority in distributing organs from DoD beneficiaries.⁵³ The current Directive is more ambiguous, stating that the DoD goal is to "maximize the use of donated organs and tissues at both MTCs and civilian transplant centers."⁵⁴ But to ensure that the MTCs win the race as often as possible, the Directive requires MTFs to notify their servicing MTC immediately after it notifies the OPO and underscores this point with the following Guidelines: "Organs and tissues should be made available first to the MTCs and then to the civilian OPOs specified in the MoU..."⁵⁵ and "MoUs... with OPOs should require equitable sharing of organs and tissues to maximize their use at the MTCs."⁵⁶

5. Anatomical Gifts.

a. State law governs. State law governs gifts of organs or tissues by both active-duty⁵⁷ and non-active-duty DoD beneficiaries⁵⁸, so familiarity with the local version of the UAGA is important. UAGA has shared the fate of most uniform acts however, and uniformity among the jurisdictions was lost a while ago. 30 of the United States' 53 jurisdictions still follow versions of UAGA(1968),⁵⁹ and the 23 other jurisdictions have enacted versions of UAGA(1987).⁶⁰ Uniformity has also been undercut

⁵¹DoD Directive 6465.3, para D(5).

⁵²DoD Directive 6465.3, para E(2)(b).

⁵³DoD Directive 6465.3, dated 14 August 1987, paras D(1) and (2). HSC Reg 40-2, dated 22 October 1992, para 6(d), are consistent with this earlier policy requiring that DoD beneficiaries "normally be granted priority access... if such access does not contradict donor intent or existing state or federal laws."

⁵⁴DoD Directive 6465.3, para E(2)(b).

⁵⁵DoD Directive 6465.3, "Guidelines," para 7.

⁵⁶DoD Directive 6465.3, "Guidelines," para 6. Maintaining this DoD preference is inconsistent with new federal regulation mandating national prioritization be based solely on degree of need [see section 2(d) above].

⁵⁷HSC Reg 40-32, para 8(a).

⁵⁸Chiminello and Attaya, page 3, and HSC Reg 40-32, para 8(a).

⁵⁹*Uniform Anatomical Gift Act*, 8A U.L.A. 9 (1968) and personal conversation with John McCabe, Staff Attorney, National Conference of Commissioners on Uniform State Laws, 25 March 1999.

⁶⁰*Uniform Anatomical Gift Act*, 8A U.L.A. (96 Supp.) 2 (1987) and personal

by the legislative compulsion to modify language. The compiled annotations consist largely of variations from the official text, and they currently fill more than 110 pages in the main volume and more than 18 pages in the 1996 Supplement. Nevertheless, a few general observations may prove helpful.

b. Sale of body parts prohibited. UAGA(1987), Section 10(a), like the Directive, prohibits the purchase or sale of body parts. Like the Directive, UAGA(1987), Section 10(b) also notes that this prohibition does not include recovering "reasonable payment for the removal, processing, disposal, preservation, quality control, storage, transportation or implantation of a part." UAGA(1987), Section 10(c), criminalizes violations of the prohibition.

c. Donees and their estates immunized. Section 11(d) of UAGA(1987) shields organ donees and their estates from liability "for any injury or damage they may result from the making or use of the anatomical gift."

d. Hospitals and physicians immunized. Both versions of UAGA⁶¹ extend civil and criminal immunity to physicians and others "who act in accordance with this [Act] or with the anatomical gift law of another state [or a foreign country]."⁶² One potentially critical difference between the two versions of UAGA is the later version's extension of immunity to those who merely "attempt to act in good faith." The 1987 version also expressly extends liability to hospitals to ensure that institutions as well as natural persons enjoy immunity from civil and criminal liability.

e. Special considerations for DoD beneficiaries.

(1) Non-active-duty beneficiaries. Para 18-3(a) of AR 40 -3 announces that the Army assumes no liability if a non-active-duty donor dies as a result of organ donation except to the extent that a valid FTCA claim arises.

(2) Active-duty beneficiaries. Para 18-4 of AR 40-3 establishes special procedures for active-duty members who want to donate a kidney. Among other requirements: (1) The prospective donee must be counseled by a medical officer to ensure that he understands the impact of the donation on his retainability; and (2) if the transplant will be performed outside a MTC, prior approval must be obtained from TSG.

conversation with John McCabe, Staff Attorney, National Conference of Commissioners on Uniform State Laws, 25 March 1999.

⁶¹UAGA(1987), Section 11(c), and UAGA (1968), Section 7.

⁶²UAGA(1987), Section 11(c); substantially identical language at UAGA(1968), Section 7(c).

6. Litigation Overview.

a. As noted earlier, there has not been a deluge of litigation spawned by organ transplantation, at least relative to more active areas of the medical malpractice field. This relative calm does not mean that litigators and academicians have been silent, however. Suits brought by organ recipients and their survivors do not differ from traditional malpractice claims, so there is no reason to discuss them here. Suits brought by the survivors of donors generally have been unable to overcome the good-faith immunity conferred by state versions of the UAGA. But, as subsection (c) notes below, hospitals have found themselves in the courts litigating a wide variety of lawsuits, and some novel theories of liability have been proposed in the literature.

b. Donor suits and the UAGA affirmative defense of good-faith immunity.

(1) (a) Williams v. Hofmann⁶³ stands alone in drawing a bright line between claims accruing before the donor's death and those arising afterward. Plaintiff alleged the following: On a Friday evening, plaintiff's wife was admitted to the hospital after suffering a cerebral hemorrhage. She was placed on a respirator late that night, and early Saturday morning, one of the defendant doctors told plaintiff that his wife was dead. The distraught husband signed a document authorizing the donation of his wife's kidneys. On Sunday, plaintiff had his wife's death announced in church. On Monday, he hired a funeral director, but, when the funeral director told the plaintiff that he could not find the body at the morgue, plaintiff rushed to the hospital where he learned that his wife had been sustained on a respirator until just before he reached the hospital that morning, having been pronounced dead at 8:20 a.m. by one of the defendant doctors and having her kidneys excised by another at 8:35 a.m.⁶⁴

(b) Plaintiff asserted three causes of action. One alleged assault and battery and negligent treatment of his wife while she lived. The second alleged mutilation of her corpse. The third alleged "negligence in communicating an erroneous and premature death message."⁶⁵ Defendants contested the facts, of course, but also asserted their UAGA qualified immunity as an affirmative defense to both complaints. The trial court dismissed all complaints on that ground.

⁶³66 Wis 2d 145, 223 N.W.2d 844, 76 ALR 3d 880 (Wis 1974).

⁶⁴223 N.W.2d at 845.

⁶⁵223 N.W.2d at 846-847.

(c) The appellate court, however, drew a clear distinction between the complaints, holding that UAGA's good-faith immunity extended only to those acts of alleged wrongdoing occurring after death had occurred.⁶⁶ The court refused to extend immunity to the defendants' alleged negligence and misconduct in treating the decedent before she died.⁶⁷ Nor would the court permit immunity to extend to defendants' communicating an "erroneous and premature death message."⁶⁸ The key to avoiding liability in such situations is not difficult to discern. If the hospital had bothered to provide a complete and accurate account of the donor's condition and sought genuine informed consent from the next of kin, this lawsuit could have been utterly avoided.

(2) Perry v. Saint Francis Hospital and Medical Center, Inc.⁶⁹ teaches the same lesson. Section 8(a) of UAGA(1987) requires that the donated organs and tissues "be removed without unnecessary mutilation." Plaintiffs alleged that duty was breached in their decedent's "donation" of corneal tissue and bone marrow. In dealing with the family's initial refusal to consent to harvesting, one of the hospital's nurses assured the family that these tissues could be obtained without removing the decedent's eyes or long bones. The widow and children first learned that this was not the case "when the funeral home told them [it] needed heavy clothing to hide the missing bones." Perry at 725. The plaintiffs' case for intentional infliction of emotional distress survived the hospital's motion for summary judgment⁷⁰ in a holding in which the court explicitly rejected the hospital's claim for summary judgment based on the good faith immunity afforded by the Kansas version of the UAGA. Not surprisingly, as in Hofmann, material misrepresentations were found inconsistent with good faith.

(3) (a) Brown v. Delaware Valley Transplant Program⁷¹ and the cases which follow illustrate the length to which other courts have been willing to extend UAGA's good-faith immunity. An unidentified victim was brought to the emergency room after he had been shot in the head. Within an hour, a neurosurgeon determined that the head wound was terminal, notified the local OPO, and placed the victim on life support. Cerebral death was documented 5 hours after the victim had arrived at the emergency room. The state police were unable to conclusively identify the victim or

⁶⁶223 N.W.2d at 847.

⁶⁷223 N.W.2d at 847.

⁶⁸223 N.W.2d at 846-847.

⁶⁹865 F. Supp. 724 (D. Kan. 1994). 886 F. Supp. 1551 (D. Kan. 1995).

⁷⁰Perry, 886 F. Supp. 1551,1565.

⁷¹420 Pa. Super. 84, 615 A.2d 1379, (Pa. Super. 1992), appeal denied 535 Pa. 662, 634 A.2d 216 (Pa. 1993).

locate his next-of-kin after 36 hours of investigative effort.

(b) Relying on Pennsylvania's version of UAGA(1968), which authorized "any other person authorized or under obligation to dispose of the body," the hospital determined that they were that person and signed a donor authorization. The victim's heart and kidneys were removed several hours later.⁷² The state police found the victim's sister about ten hours later, and she and the rest of the family later brought suit for mutilation, intentional infliction of emotional distress, civil conspiracy, and assault and battery.⁷³

(c) The appellate court sustained the trial court's summary dismissal of the complaint, holding that: (1) The state's version of UAGA(1968) "did not require any particular type of search for members of higher classes to establish the unavailability of members of that class;"⁷⁴ and (2) the hospital acted in good faith and was immune from suit.⁷⁵

(4) Kelly-Nevils v. Detroit Receiving Hospital⁷⁶ upheld a trial court's summary dismissal of a suit seeking damages based on the following allegations. An unidentified victim was admitted to the hospital after being shot in the head. He was diagnosed as brain dead and placed on life support. Early the next morning, a young man came to the hospital, identified the victim, and said he was the victim's brother and only living relative. The hospital asked him to authorize donation of the victim's organs and tissues. The brother agreed and "remained at [the victim's] bedside, crying and grieving" until death was formally pronounced. The hospital then harvested the victim's organs and tissues. It turned out that the victim had no brother. Police located his mother four days later and informed her of her son's death. The mother later filed suit, alleging negligence in harvesting the organs without valid consent and mutilation of the victim's body.⁷⁷ The hospital answered that it had acted in good-faith reliance on the "brother's" valid consent, and the court sustained this affirmative defense to all counts notwithstanding the hospital's failure to properly plead the defense.⁷⁸

⁷²615 A.2d at 1380, 1383.

⁷³615 A.2d at 1380-1381.

⁷⁴615 A.2d at 1382 [emphasis in the original].

⁷⁵615 A.2d at 1383.

⁷⁶525 N.W.2d 15 (Mich. App. 1994).

⁷⁷525 N.W.2d at 17.

⁷⁸525 N.W.2d at 20. The court also cited a very similar case, Nicoletta v. Rochester Eye and Human Parts Bank, 136 Misc.2d 1065, 519 NYS 928 (N.Y. 1987), which reached the same result arising from a donor authorization signed by a purported wife.

(5) (a) The court's statement of the facts in Lyon v. U.S. Veterans Administration Medical Center and Minnesota Lions Eye Bank⁷⁹ can hardly be improved: "Shortly after Jack Lyon's death, Dr. Thomas Meyer, a new resident at the VA, met with Hanna Lyon and Sue Lyon. During this meeting Dr. Meyer asked them to sign several forms to authorize an autopsy which they had requested. One of those forms signed had stamped on it "eye donor." The form was identical in all other respects to another autopsy authorization form signed by plaintiffs at the meeting. It is undisputed that the plaintiffs refused to consent to the donation of Jack Lyon's internal organs or tissues. It is also undisputed that at the time they signed the authorization for the autopsy they did not wish to donate his eyes.... Dick Schmidt, an Eye Bank Eucleator, went to the VA to remove Jack Lyon's eyes. He was shown the authorization form signed by Hanna and Susan Lyon. After the eyes were removed Schmidt was informed that the family did not consent to the eye donation. He was instructed by the Eye Bank to transport the eyes to the Eye Bank for proper storage until the matter could be resolved...[Thereafter,] what was said by whom and when it was said is disputed. Eventually, Jack Lyon's eyes were brought to the mortuary where they were reset prior to his burial."⁸⁰ Plaintiffs sued. Defendants filed a motion for summary judgment alleging the hospital and eyebank, having acted in good faith, were immunized by the Minnesota version of UAGA(1987).⁸¹

(b) The district court granted summary judgment, notwithstanding plaintiff's claims that decedent had often and routinely informed hospital personnel that he did not want to donate organs, that the stamp "eye donor" had been added to the autopsy form after they signed it, that they had been "badgered" by a VA doctor to ratify the donation later, and that their refusal was grounded in strongly-held religious convictions.⁸²

(6) Georgia had extended its version of the UAGA to permit removal of corneas during autopsy "if no objection is made by the decedent in his life or by his next-of-kin after death."⁸³ Relying on this statute, defendants in Georgia Lions Eye Bank v. Lavant removed the eyes of a baby who had died suddenly. The parents did not object because they received no notice of the removal. When the mother later learned that defendants had removed her dead baby's eyes, she sued, and the trial court found that the Georgia

⁷⁹843 F. Supp. 531 (D. Minn. 1994).

⁸⁰843 F. Supp. at 532.

⁸¹843 F. Supp. at 536.

⁸²843 F. Supp. at 534-535.

⁸³Georgia Lions Eye Bank v. Lavant, 255 Ga. 60, 335 S.E.2d 127, 128 (Ga. 1985), cert. denied, 475 U.S. 1084 (1986).

statute unconstitutionally failed to provide notice and an opportunity to comment.⁸⁴ The appellate court reversed, granting defendants' motion for summary dismissal: "Certainly the General Assembly had it within its power, in the interest of the public welfare, to authorize this procedure, which yearly benefits hundreds of Georgians."⁸⁵

c. Other litigation and theories of liability.

(1) Broward General Medical Center found itself in court, along with the Florida Attorney General, a guardian ad litem, the ACLU, and five other amici curiae, in an action brought by the parents of an ancephalic newborn seeking a judicial determination that the infant be declared dead for purposes of organ donation.⁸⁶

(2) Jacobsen v. Marin General Hospital, California Transplant Donor Network, Inc. and Marin County Coroner's Office⁸⁷ considers the viability of a cause of action predicated on negligent failure to search for next of kin among other allegations. The diversity-jurisdiction suit was brought by the parents of a Danish citizen found unconscious with severe head trauma early on 4 October 1995 in Sausalito, California. Although the FBI was able to identify the man as Martin Jacobsen of New York City, efforts to further identify him or find next of kin were fruitless, and his organs were harvested some 70 hours later. Plaintiffs alleged that the man's evident tourist status along with a Danish inscription on a ring and a Danish poem in his pocket should have led the defendants to ask the Immigration and Naturalization Service about his identity and next of kin. In dismissing all claims at summary judgment, the court relied on the

defendants' search exceeding both the breadth⁸⁸ and the 12-hour

⁸⁴335 S.E.2d at 128.

⁸⁵335 S.E.2d at 129.

⁸⁶In re T.A.C.P., 17 FLW S 691, 609 So. 2d 588 (Fla. 1992). Anencephaly is "the most common severe birth defect of the central nervous system seen in the United States" and is "a congenital absence of major portions of the brain, skull, and scalp, with its genesis in the first month of gestation." T.A.C.P. at 590. The newborn in this case possessed a functioning, but exposed, brain stem which maintained cardiopulmonary functioning without assistance. Florida had not adopted the Uniform Declaration of Death Act, apparently preferring, in the court's words, "to strike out on its own." T.A.C.P. at 592. With only a poorly-drafted statute that did not apply to the facts, the court was forced to fall back on common law and hold that the newborn was not considered dead. T.A.C.P. at 595.

⁸⁷ 963 F. Supp. 866 (N.D.Ca. 1997), affirmed in unpublished opinion by the Ninth Circuit on 3 February 1999 at 1999 U.S. App. LEXIS 1595.

⁸⁸A search "shall include a check of local police missing persons records, examination of personal effects, and the questioning of any persons visiting

floor⁸⁹ on UAGA(1987)'s definition of a reasonable search.

(3) Moore v. Regents of the University of California⁹⁰ illustrates that the activities of avaricious clinical investigators can lead to lawsuits when investigators fail to disclose the commercial value of donated tissue. The plaintiff sought three billion dollars in damages after he learned that his removed spleen, together with almost seven years of regular blood, skin, bone marrow and sperm donations had permitted defendants' researchers to develop a patent for a cell line that defendants' investigators later sold for at least \$330,000 and 75,000 shares in a biotechnology firm.⁹¹ The court held that plaintiff had stated a cause of action for breach of fiduciary duty and a lack of informed consent. One commentator has suggested that the cause of action could be asserted in all organ donation cases.⁹²

(4) Transplanting fetal tissue raises a host of issues subject to the shifting tides of federal policymaking and beyond the scope of this article. Practitioners can find guidance in Arthur R. Bauer, Legal and Ethical Aspects of Fetal Tissue Transplantation, (R.G. Landes Company - Austin, Texas) (1994).

(5) One commentator has highlighted the issues arising from the failure to ensure the compatibility of transplanted tissue, pointing out that such a failure raises issues for both the donor and the recipient of transplanted tissue.⁹³

the decedent before his or her death in the hospital, accompanying the decedent's body, or reporting the death, in order to obtain information [leading to the next of kin." California Health and Safety Code, Section 7151.5(b). The court noted that tourists come to San Francisco from throughout the United States as well as from overseas. Regarding the Danish language poem, the court found it "absurd" that this should have led the searchers to the INS. After all, the court reasoned, "a person may enjoy reading French poems so much that she keeps a copy in her wallet." In commendable conformity with precepts of judicial dignity, both trial and appeal courts refrained from observing that decedent left his heart- as well as his kidneys, liver and pancreas- in San Francisco.

⁸⁹California Health and Safety Code, Section 7151.5(b).

⁹⁰793 P.2d 479 (Cal. 1990), cert. denied, 111 S. Ct. 1388.

⁹¹793 P.2d at 482.

⁹²Bernard M. Dickens, "Living Tissue and Organ Donors and Property Law: More on Moore," *The Journal of Contemporary Health Law and Policy*, Volume 8 (Spring 1992), page 73.

⁹³David W. Meyers, *Medico-Legal Implications of Death and Dying*, Section 17:16 "Liability for transplanted tissue," page 502, 1992 Cumulative Supplement (Clark, Boardman and Callahan - New York) (1992). Mr. Meyers notes the utility of *St. Luke's Hospital v. Schmaltz*, 188 Colo. 353, 534 P. 2d 781 (Colo. 1975), in defending such claims. The Schmaltz court strained to characterize a transfusion of AIDS-infected blood as a service rather than a sale of goods, thereby justifying its dismissal of claims based on strict liability and breach of warranty theories of recovery.

(6) Another commentator⁹⁴ sees class-action possibilities benefiting all potential donees who fail to receive an anatomical gift when: (1) the decedent has signed a valid anatomic gift instrument, but (2) hospitals or OPOs, although authorized by UAGA (1987) to harvest the organ, refuse to do so because the next-of-kin refuse to consent. I am not aware of any cases based on this novel theory of liability, but military practitioners should note that our own Guidelines state that "Permission of the next of kin shall be sought even when a valid donation document exists. When a conflict exists between the positive wishes of the donor to provide organs and the wishes of the next of kin, the wishes of the next of kin shall be honored."⁹⁵

⁹⁴Daniel G. Jardine, "Liability Issues Arising out of Hospitals' and Organ Procurement Organizations' Rejection of Valid Anatomical Gifts: Truth and Consequences," *Wisconsin Law Review*, Volume 1990, Number 6, page 1655.

⁹⁵DoD Directive 6465.3, "Guidelines," para 5.

REFERENCES:

1. Federal Statutes/Laws:

National Organ Transplant Act, Public Law 98-507, October 19, 1984, 42 U.S.C. Sections 273 et seq.

2. DoD Regulations/Directives/etc.:

DoD Directive 6465.3 "Organ and Tissue Donation," dated 16 March 1995 (copy attached, pp. 19-23).

3. Army Regulations/Circulars/Letters/Pamphlets:

a. AR 40-3, "Medical Dental and Veterinary Care," Chapter 18, "The Army Organ Transplant Program" (1985).

b. MEDCOM Regulation 40-32, "Organ and Tissue Donation" (1998).

4. Books, Annotations, Medicolegal Literature:

a. 76 ALR 3d 890, "Tort Liability of Physician or Hospital in connection with Organ or Tissue Transplant Procedures," Thomas R. Trenkner (1977).

b. 76 ALR 3d 913, "Tests of Death for Organ Transplant Purposes," Thomas R. Trenkner (1977).

c. 54 ALR 4th 1214, "Statutes Authorizing Removal of Body Parts for Transplant: Validity and Construction," Norayn O. Harlow (1987).

d. 4 ALR 5th 1000, "Propriety of Surgically Invading Incompetent or Minor for Benefit of Third Party," Lisa K. Gregory (1992).

e. Michael Shapiro and Roy Spece, Jr., Bioethics and Law, Part V "Organ Transplantation, pages 740-876 (West Publishing Co. 1981).

f. Cowan, Kantorowitz, Moskowitz and Reinstattein (Editors), Human Organ Transplantation," (Health Administration Press 1987).

g. 61 AmJur 2d, Physicians and Surgeons, Section 179 - " Consent for minors to surgical procedures for the benefit of another; organ transplants;" Section 277 - " Organ Transplants."

h. 22 AmJur 2d, Dead Bodies, Sections 119-133 - "Donation of Body or Body Parts; Uniform Anatomical Gift Act."

5. Law Review Articles:

a. James F. Childress, "Some Moral Connections between Organ Procurement and Organ Distribution," Journal of Contemporary Health Law and Policy, Vol 3:85 (Spring 1987).

b. Daniel G. Jardine, "Liability Issues Arising out of Hospitals' and Organ Procurement Organizations' Rejection of Valid Anatomical Gifts: Truth and Consequences," Wisconsin Law Review, Volume 1990, Number 6, page 1655.

6. Uniform Acts:

a. Uniform Determination of Death Act (1980), 12 U.L.A.

b. Uniform Anatomical Gift Act (1968), 8A U.L.A.

c. Uniform Anatomical Gift Act (1987), 8A U.L.A.

7. State Statutes: (For local completion)

a. State anatomical gift act: (Georgia - O.G.C.A. Sections 44-5-140 et seq.)

b. State law concerning determination of death: (Georgia - O.G.C.A. Sections 31-16-10 et seq.)

