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ORGAN TRANSPLANTATION AND THE DONATION: A PROPOSAL FOR LEGISLATION

INTRODUCTION

On December 3, 1967, the first human heart transplant operation was performed in Cape Town, South Africa.[1] Since then, more than one hundred such operations have been attempted in thirty-six medical centers in sixteen countries. Approximately one-half of these recipients are still living.[2] Dr. Theodore Cooper of the National Heart Institute has estimated that in America alone there are annually eighty thousand potential heart recipients by virtue of their otherwise untreatable heart disease.[3] Organ transplantation has recently been the subject of much medical, legal, and ethical speculation, with the result being the production of many articles emphasizing that new legal problems have been created by the medical profession.[4] This discussion will focus on legal questions arising from the donation of human organs with the ultimate goal of creating legislative guidelines. The questions presented can be divided into those involving the donor and those involving the donation. The heart transplant situation has drastically changed the position of the donor because any removal of this organ must occur almost simultaneously with death.[5] So long as there is no clearly defined moment of death, the

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1. N.Y. Times, Dec. 4, 1967, § A, at 1, col. 2.

2. *Time*, Dec. 6, 1968, at 59.

3. Statement by Theodore Cooper, M.D., Ph.D., Director Designate of the National Heart Institute, before the Subcommittee on Government Research, Committee on Government Operations, United States Senate, April 1, 1968.

4. *See generally Reports on S. J. Res. 145 Before the Subcomm. on Government Research*, 90th Cong., 2nd Sess. (1968); 114 CONG. REC. 19 (daily ed. Feb. 8, 1968) (remarks of Senator Mondale); *The Ethics of Transplants*, Nat'l Observer, Jan. 22, 1968, at 22; Warwick, *Organ Transplants: A Modest Proposal*, Wall Street J., June 24, 1968, at 12, col. 3; Castel, *Some Legal Aspects of Human Organ Transplantation in Canada*, 46 CAN. B. REV. 345 (1968); Sanders & Dukeminier, *Medical Advance and the Legal Lag: Hemodialysis and Kidney Transplantation*, 15 U.C.L.A. L. REV. 357, 394 (1968); Stickel, *Organ Transplantation in Medical and Legal Perspective*, 32 LAW & CONTEMP. PROB. 579 (1967); Note, *Heart Transplants: Legal Problems and the Need for New Legislation*, 19 CASE W. RES. L. REV. 1073 (1968); Note, *Legal Problems in Donation of Human Tissues to Medical Science*, 21 VAND. L. REV. 352 (1968).

5. The heart is the first of the several vital organs to be transplanted. Such operations necessarily rely on cadaver donors. Though cadavers have been used as donors in kidney transplantation, they are not preferred. *See* Couch, Curran & Moore, *The Use of Cadaver Tissues in Transplantation*, 271 *New Eng. J. Med.* 691 (1964); Murray, Barnes & Atkinson, *Fifth Report of the Human Kidney Transplant Registry*,

potential donor has cause to worry that he may be jeopardizing his own safety by becoming the subject of an anatomical gift.[6] This problem, while recognized at law, is one more properly resolved by the medical profession and much progress has been made toward an appropriate solution.[7]

A legal discussion must center on possible legislation surrounding the donation of anatomical gifts. Questions immediately arise concerning the procedures of donation, but of greater importance are questions involving the use of organs when the decedent has not made a proper disposition of his body. May a donation be made on his behalf and, if so, under what conditions? With these questions in mind, this discussion will explore legislative programs dealing with cadaver organs in historical perspective and then propose legislative directives that harmonize the conflicting interests involved.

Historical Background

At early common law there were no recognized interests in dead bodies.[8] The body was deemed to come under the ecclesiastical jurisdic-

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5 *Transplantation* 752 (1967). The success rate where cadaver donors were used has been established at thirty to forty percent. *Id.* at 744. With the use of living donors who are parents, brothers, or sisters of the recipient, the success rate is sixty-five to seventy percent. *Id.* at 756. The difference in success between using a living, related donor and using a cadaver, unrelated donor, is due to relationship and not the fact the donor is living in one case and dead in the other. Stickel, *supra* note 4, at 601.

6. *In Re Potter*, an unreported English case in 2 British Med. J. 394 (1963) and The Times (London), July 26, 1963, at 9, col. 4, brought the question of time of death before the court. Potter, suffering from a skull fracture, had been kept "alive" for twenty-four hours after there was deemed to be irreversable brain damage, while physicians awaited consent for donation of his kidney. When consent was given, the respirator was turned off and Potter stopped breathing. An inquest was held to determine when death had occurred and, whether the physicians were guilty of anything by turning off the respirator. Though no action was taken, there was criticism of the taking of the organ prior to a positive pronouncement of death.

A similar case arose recently in Sweden where a kidney was taken from an unconscious woman suffering from a brain tumor and believed beyond therapy. Reported in Biorok, *On the Definitions of Death,* World Med. J. 137, 138 (1967). The donor was maintained on a respirator for thirty-six hours after the operation. Again, when the machine was turned off there was no spontaneous breathing. The Royal Board of Medicine said that the physician should be responsible for determining the time of death. *See* Sanders and Dukeminier, *supra* note 4, at 408.

7. On Dec. 4, 1968, the American Medical Association set guidelines for heart transplant cases, stipulating that two doctors (not of the transplant team) should confirm the death of the donor. "The fact of death must be demonstrated by adequate, current and acceptable scientific evidence in the opinion of the physicians making the determination." Richmond Times Dispatch, Dec. 5, 1968, at 1, col. 7.

8. For an in depth review of the historical development of the law of dead bodies,

tion which saw to its burial. Only an "emotional" interest was vested in the family. Blackstone explained the legal significance of a corpse in the following manner:

> A shroud . . . is the property of those, whoever they were, that buried the decedent; but stealing the corpse itself, which has no owner (though a matter of great indecency) is no felony unless some of the graveclothes be stolen with it.[9]

The law could not comprehend a property interest which was incapable of being owned, and as there was no willingness to determine ownership in dead bodies, they were held to have "no property." This doctrine was not tested at that time because the corpse was of no commercial value. This was soon to change.

The early development of the science of anatomy left medical centers in great need of cadavers and, as the law had made no provision for their acquisition by science, a void was created and quickly filled by grave robbers. Without contradicting Blackstone, body stealing was soon held to be a misdemeanor.[10]

In reaction to the medical needs of the period, anatomy acts were passed[11] allowing all unclaimed bodies previously buried at public expense to be donated to science. These acts did not completely fill the demand and body stealing continued. Finally, in *Williams v. Williams*,[12] an interest in someone other than the public was recognized. The court, while rejecting the concept of testamentary disposition of one's own body, did recognize a right to custody and possession in the executor. He was the logical one to exert the right as he had the duty to bury.

There was no litigation in this area during the first several decades of American case law. In 1872 however, a quasi-property concept was

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see Comment, *Property in Corpses*, 5 ST. LOUIS L. J. 380 (1958); Comment, *The Law of Dead Bodies: Impeding Medical Problems*, 19 OHIO ST. L.J. 455 (1958).

9. 4 W. BLACKSTONE, COMMENTARIES *236; *see* State v. Doepke, 68 Mo. 208 (1878). Grave robber took coffin and contents; held, larceny as to coffin only.

10. Rex v. Lynn, 100 Eng. Rep. 394 (K.B. 1788). In calling body stealing a misdemeanor, the court distinguished BLACKSTONE, *supra* note 9, which stated only that the theft of a body was not a felony.

11. For a survey of American anatomy legislation, *see Law of Dead Bodies, supra* note 8, at 475 (Appendix 1).

12. 20 Ch. D. 659 (1882). The court stated that:

> The law in this country is clear, that after the death of a man, his executors have a right to the custody and possession of his body (although they have no property in it) until it is properly buried. It follows that a man cannot by will dispose of his dead body. *Id.* at 665.

advanced by the Rhode Island court.[13] This property interest, though amounting to essentially the English custody and possession,[14] was an attempt to guarantee the right to burial without allowing the broad incidents of ownership associated with property. Thus, there developed in both systems an interest upon which a third person could maintain an action for interference with the remains.[15]

The common law thus developed both a public interest, which expanded with scientific advancement, and a vested interest in a third person, either executor or next-of-kin. Nowhere however, was the right to dispose of one's own remains established. It was even suggested that, in the absence of statute, testamentary disposition was not permitted.[16] English courts consistently refused to enforce testamentary bequests although American courts later divided on the issue.

MODERN LEGISLATIVE DEVELOPMENT

As evidenced by the early anatomy acts,[17] legislative development has been responsive to medical innovation. First, the early sophistication in anatomy study resulted in an onslaught of autopsy laws.[18] These were justified as being in the public interest because they allowed autopsy only to determine the cause of death when it was surrounded by suspicious circumstances. Also, the interruption with the normal disposition of the body was only temporary.

Next, following several successes with skin grafts and corneal transplantation,[19] ten states adopted legislation allowing voluntary testamen-

13. Pierce v. Proprietors of Swan Point Cemeteries, 10 R.I. 227 (1872). This concept of quasi-property was explained as follows:

> There is a duty imposed by the universal feelings of mankind, to be discharged by someone towards the dead, a duty, and we may also say a right to be protected from violation; and it may therefor be considered as a sort of quasi-property, and it would be discreditable to any system of law not to provide a remedy in such a case. *Id.* at 238.

14. Williams v. Williams, 20 Ch. D. 659, 665 (1882).

15. In England it was clear that such a right vested in the executor, but in America the executor was not named until the reading of the will which often was after the funeral. The case of Pettigrew v. Pettigrew, 207 Pa. 313, 56 A. 878 (1905), settled the question in America as the court developed the next-of-kin chain to determine in whom the right vested.

16. 20 VA. L. REV. 478 (1934).

17. Annot., 48 A.L.R. 1209 (1927).

18. *See Law of Dead Bodies, supra* note 8, at 475 (app. 1).

19. Corneal transplantation was the logical pioneer in this field because the rejection potential was virtually non-existant. *See* Paton, *Corneal Transplantation: A Historic Review*, 33 AM. J. OPHTHAL. 1, 3-5 (1950).

tary donation of one's body for certain scientific endeavors.[20] For the first time, the law recognized a legally vested interest in the decedent to dispose of his remains.

During the 1950's and early 1960's, the number of states having donation statutes rose sharply from ten to forty-two.[21] This increase was primarily a reaction to the first kidney transplant in 1954[22] and the many subsequent successes.[23] As the living were generally used as donors,[24] new legal questions emerged involving informed consent, donor insurance rates, and workman's compensation rights. Although these problems suggested legislation directed toward the living, kidney transplantation, by awakening the public to the potential of such a medical technique, created an awareness of the need for donation statutes. The statutes which were passed were much like the initial ten and, while broadening the legislative base, added little in originality.

20. ALA. CODE tit. 22, § 184(1) (1958) (adopted 1947); CAL. HEALTH & SAFETY CODE § 7100 (West 1955) (adopted 1947); LA. REV. STAT. ANN. § 17:2351 (1963) (adopted 1950); ME. REV. STAT. ANN. tit. 22, § 2881 *et seq.* (1964) (adopted 1951); MONT. REV. CODES ANN. § 69.2311 *et seq.* (1967) (adopted 1943); NEV. REV. STAT. § 451.440 *et seq.* (1963) (adopted 1911); N.Y. PUB. HEALTH LAW § 4201 (McKinney 1964) (adopted 1881); N.C. GEN. STAT. § 90.216.1 *et seq.* (1965) (adopted 1951); ORE. REV. STAT. § 97.132 *et seq.* (1961) (adopted 1947); WASH. REV. CODE ANN. § 68.08.250 *et seq.* (1962) (adopted 1909).

21. ALAS. STAT. § 13.05.035 (1962); ARIZ. REV. STAT. ANN. § 36-841 *et seq.* (1956); ARK. STAT. ANN. § 82-406 *et seq.* (1960); COLO. REV. STAT. ANN. § 91-3-5 *et seq.* (1963); CONN. GEN. STAT. REV. § 19-139 (Supp. 1965); FLA. STAT. ANN. § 736-08 *et seq.* (1963); GA. CODE ANN. § 88.2001 *et seq.* (Supp. 1967); HAWAII REV. LAWS § 64-14 (Supp. 1965); ILL. ANN. STAT. ch. 3, § 42(a) (Smith-Hurd 1961); IND. ANN. STAT. § 6-510 *et seq.* (1967); IOWA CODE ANN. § 142.12 (Supp. 1966); KY. REV. STAT. ANN. § 311.352-56 (1963); MD. ANN. CODE art. 43, § 149 (1965); MASS. GEN. LAWS ch. 113, § 7-10 (Acts 1967); MICH. STAT. ANN. § 14.523 (Supp. 1968); MINN. STAT. ANN. § 525.18 (Supp. 1967); MISS. ACTS H.B. No. 1070 (1966); MO. ANN. STAT. §§ 474.310, 194.190 (Supp. 1967); NEB. REV. STAT. § 71-1339 *et seq.* (Supp. 1965); N.J. REV. STAT. § 26:6-51 (1964); N.M. STAT. ANN. § 12-11-1 *et seq.* (Supp. 1967); N.D. CENT. CODE § 23-06-01 (Supp. 1967); OKLA. STAT. tit. 63, § 105 *et seq.* (1964); PA. STAT. tit. 35, § 5001 (1964); R.I. GEN. LAWS ANN. § 23-42-1 (Supp. 1966); S.C. CODE ANN. § 32-701 (1962); S.D. CODE § 27.1302 (1939); TENN. CODE ANN. 32-601 *et seq.* (Supp. 1967); TEX. REV. CIV. STAT. ANN. art. 4590-1 (1960); VA. CODE ANN. § 32-364.1 (Supp. 1966); W. VA. CODE ANN. § 16-19-1 (Supp. 1967); WIS. STAT. ANN. § 155-06 (Supp. 1967). *See also,* D.C. CODE ANN. 2-251 *et seq.* (Supp. 1966).

22. At Peter Bent Brigham Hospital in Boston, a healthy kidney from one twin was successfully transplanted into the other who was dying of kidney failure. Merrill, Murray, Harrison & Guild, *Successful Homotransplantation of the Human Kidney Between Idential Twins,* 160 J.A.M.A. 277 (1956).

23. Well over a thousand kidney transplants have been performed on patients throughout the world during the past fifteen years, with the majority occurring during the past five years. *See* Murray, Barnes & Atkinson, *supra* note 5, at 752.

24. *See generally supra* note 5.

At this time, the National Conference of Commissioners on Uniform State Laws began drafting the Uniform Anatomical Gift Act which will shortly be presented to the states for approval.[25] Generally, it takes the best and often the majority view of the forty-two existing statutes and draws them together in one concise document. Although its approval coincides with the recent transplant operations, the act relies heavily on the status of the law prior to heart transplantation and cannot fairly be called heart transplant legislation.

The only legislative developments to occur since the heart transplants are two state statutes[26] which adopt the Uniform Anatomical Gift Act in its present tentative form[27] and a Virginia statute[28] giving limited donative authority to the State's chief medical examiner in cases where the decedent comes under his jurisdiction.

PRESENT STATUS OF DONATION LEGISLATION

A review of the donation law in general, with specific emphasis upon the "transplant states," [29] and the treatment under the Uniform Anatomical Gift Act[30] is necessary at this point.

Who may execute a gift?

The UAGA adopts the majority view stating that anyone ". . . of sound mind and 18 years of age or more may give all or any part of his body." [31] Fourteen states increase the age to twenty-one while five states

25. The Uniform Anatomical Gift Act [hereinafter cited as U.A.G.A.] was drafted by the National Conference of Commissioners on Uniform State Laws and by it approved and recommended for enactment at its Annual Conference meeting in Philadelphia, Pennsylvania, July 22-31, 1968. The Act, including prefatory note and comments, was approved by the American Bar Association at its meeting in Philadelphia, August 7, 1968. A similar act has been proposed in Canada. *See* Castel, *supra* note 4.

26. KAN. STAT. ANN. art. 32, 65-3201 *et seq.* (Supp. 1968); MD. ANN. CODE art. 43, 149 (h-s) (Supp. 1968).

27. Statson, *The Uniform Anatomical Gift Act*, 23 BUS. LAWYER 919, 920 (1968).

28. VA. CODE ANN. § 19.1-46.1 (Supp. 1968).

29. The states of Virginia, Texas, California, New York, Massachusetts, and Minnesota either have performed or are equipped to perform transplants in their medical centers.

30. For a detailed discussion of the U.A.G.A., *see* U.A.G.A. with prefatory note and comment; Stason, *supra* note 27 at 919 *et seq.;* Stickel, *supra* note 4, at 606; 21 VAND. L. REV., *supra* note 4, at 364-66.

31. U.A.G.A. § 2(a).

do not limit the donor at all.[32] Seven other states use competency to write a will as a standard. Virginia and Massachusetts follow the twenty-one and of sound mind school with Massachusetts adding the further restriction, ". . . and not under the influence of narcotic drugs." [33] The New York statute is in accord with the UAGA, while the Minnesota[34] and Texas[35] statutes vary slightly.

Though not included in the provisions of most states, the view that "the person having the right to a body for burial may likewise consent to such use of the body or any part thereof," [36] has been adopted and expanded by the UAGA.[37]

To whom may a gift be made?

Though six states place no limit on the possible recipients, most statutes explicitly state either to whom or for what purpose donation may be made. Virginia and Minnesota list the possible donees while the statutes of New York, Massachusetts, and California are purpose directed. New York and Massachusetts further state that any such donations must be made without compensation.[38] The UAGA attempts "to achieve a maximum of clarity and precision while assuring flexibility," [39] by listing both possible donees and general purposes.

Manner of execution

The UAGA and the states generally allow such donation to be part of the will of a decedent, effective immediately without awaiting probate. Otherwise, properly attested documents, deeds, or oral declarations can be used to effectuate the gift.[40]

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32. These jurisdictions are Arizona, Illinois, Indiana, Nebraska, North Carolina, Oregon, and the District of Columbia.

33. MASS. GEN. LAWS ch. 113, § 7 (Supp. 1968)

34. MINN. STAT. ANN. § 525.18(2) (Supp. 1967) (anyone not a minor).

35. TEX. REV. CIV. STAT. art. 4590.1 (1960) (anyone of legal age).

36. VA. CODE ANN. § 32-364.1 (Supp. 1968).

37. U.A.G.A. § 2(b).

38. "No donee shall pay or promise to pay any compensation to any person for such gift." MASS. GEN. LAWS ch. 113, § 7 (Supp. 1968). "A person who directs the manner in which his body shall be disposed of after his death . . . shall receive no remuneration or other things of value. . . ." N.Y. PUB. HEALTH LAW § 4201(1) (*McKinney* Supp. 1968-69).

39. U.A.G.A. § 3, Comment.

40. *Id.* § 4.

Amendment or revocation of the gift

Only about one-half of the states having donation statutes make any provision for the subsequent revocation or amendment of the gift. Where such provision is included, the statute takes one of three forms: (1) It states that the law of wills applies—*Minnesota;* (2) It states that the manner of revocation is identical to the manner of execution—*Virginia and New York;* or (3) It specifically duplicates the provisions of one of the above—*California and Texas.* The UAGA combines these approaches in an effort to make revocation easier. The rationale is that one will be more likely to make the gift in the first place if he can easily revoke it.[41]

Although the above classification is not all-inclusive, each legislative act deals with these general questions. Nowhere however, except in Virginia transplant act of 1968, has an attempt been made to effectuate the donation of organs in reaction to the recent advances in organ transplantation.

The Virginia statute

The 1968 session of the Virginia General Assembly passed an act entitled, "Authority of Chief Medical Examiner or deputies to provide organs for transplant." [42] The act gives the State Medical Examiner or his deputies the right to provide organs from a dead body for transplantation in a case where the body is under their jurisdiction and there is insufficient time to contact the next-of-kin of the decedent and still maintain the viability of the organ to be transplanted and no known objection is forseen.

The obvious difference in this and the donation statutes or the UAGA is that it deals specifically with cases where there is no consent given by the decedent or next-of-kin. Its application is restricted to cases

41. *Id.* § 6, Comment.

42. VA. CODE ANN. § 19.1-46.1 (Supp. 1968) states:

> In any case where a patient is in immediate need for an internal organ as a transplant, the Chief Medical Examiner or his deputies where a decedent comes under their jurisdiction; who may provide a suitable organ for transplant and there is insufficient time to contact the next of kin of the decedent in order to maintain the viability of the organ to be transplanted, and no known objection by the next of kin is forseen by the Chief Medical Examiner or his deputies; the Chief Medical Examiner or his deputies may in their discretion where providing the organ for transplant will not interfere with subsequent course of investigation or autopsy provide such organ on the request of the transplanting surgeon.

where the decedent comes under the jurisdiction of the Medical Examiner which is defined in Virginia as, ". . . any case of sudden, violent or suspicious death." [43]

The fact that the act is so restricted, and is further refined to cover only cases where an emergency recipient is available, justifies its being called the first heart transplant statute in the United States.[44] Though it touches only a small amount of potential cadavers, it reaches the largest and most advantageous group from a transplant standpoint because of the two limitations on the source of cadaver organs. First, many fatal diseases are systematic and damage much more than one organ. Moreover, persons dying of old age may have normal but aged organs that, while capable of functioning, would soon wear out if transplanted into a younger person. Thus, automobile accident and homicide victims provide the best source of cadaver donors. Without this act, organs cannot be taken from bodies without the specific permission of the next-of-kin which greatly reduces the availability of cadaver donors.

A Proposal

Through the development of legislation, case law, and public sentiment, three distinct interests in the dead body have emerged; that of the decedent, his next-of-kin, and the public. Over the years, each has enjoyed varying degrees of prominence with the interest of the decedent and the public recently eroding the duty-orientated interest of the survivors. In fashioning legislation, it is necessary to consider the relative importance of each of these interests.

Legislation and the decedent

Although there is little case law, the law and the public have always been sympathetic toward the decedent where he requested a particular treatment of his remains. The court stated in *Pettigrew* v. *Pettigrew*, "The wishes of the testator are always given respectful attention." [45] It is not surprising then, that legislation almost universally gives him such a right. Any proposal must advance the support of the testator's own intentions for to do otherwise would be contra to the public conscience.

There still exists a problem where the decedent dies without evidencing any intention concerning organ donation. There has never been

43. *Id.* § 19.1-43 (1950).
44. Richmond Times Dispatch, Aug. 4, 1968, § B, at 1, col. 6.
45. 207 Pa. 213, 56 A. 878, 879 (1904).

stated a clear legal presumption that failure to make contrary declaration indicated a preference to be buried but such a presumption apparently exists. The concept of burial is closely related to Christian teaching and has, at times, been insisted upon. The traditional view of judgment day bringing forth a re-union of the body and soul gave credence to the concept that the body should be committed intact.[46] The medical profession initially did not exert much pressure on the church as the need of science for cadavers, over and above the unclaimed dead, was rather slight. Today, reformed religious thinking has repudiated any theological concepts which formerly invalidated donation.[47] Moreover, there is a greater need for donations than has ever existed before. Any social stigma associated with anatomical donation has been removed as is evidenced by a recent Gallup Poll report indicating that seven persons out of every ten would make an anatomical gift.[48] Today, there is room for a different presumption.

Accordingly, legislation must give the decedent autonomous control over the disposition of his remains, but where he fails to exercise his vested right the presumption should be changed to favor donation or, at very least, there should be no presumption at all.

Legislation and the next-of-kin

The rights and interests of the next-of-kin in the remains of the decedent are the historic result of a pre-existing duty to bury. These have become entrenched however in legal thought and cannot be removed. Presently, there is an affirmative duty on the medical staff to seek out the next-of-kin and secure consent before proceeding with the organ removal. This is consistent with the presumptions of burial where decedent died without evidencing intent. Logically, if the presumption of burial is changed as proposed, the affirmative duty should shift from the medical staff to the next-of-kin. That is, the surgeons can proceed

46. For a summary of the religious development in this area, *see* Sanders & Dukeminier, *supra* note 4, at 404.

47. In 1956, Pope Pius XII, in an address to The International Meeting of Optholmologists, declared that there was no moral or religious objection to the post-mortem removal of the cornea for grafting purposes. Implicit therein is approval of post-mortem removal of other organs for transplantation. *See* Reich, *Medico-Moral Problems and the Principle of Totality: A Catholic Viewpoint,* MEDICO-MORAL ETHICS FOR A HOSPITAL MINISTRY, VA CHAPLAIN WORKSHOPS, 29, 32 (1967). *See also* Dolgin, *Medico-Moral Problems: A Jewish Viewpoint,* MEDICO-MORAL ETHICS FOR A HOSPITAL MINISTRY, VA CHAPLAIN WORKSHOPS, 23, 27 (1967).

48. N.Y. Times, Jan. 17, 1968, § A., at 18, col. 3.

under the assumption that the donation is consented to with the affirmative duty on the next-of-kin to deny such consent. Before making this assumption, the surgeon would (1) be aware of no known objection to the donation and (2) be required to know that the next-of-kin had actual knowledge of the death. In cases where the next-of-kin did not have actual knowledge, the surgeon would be required to take reasonable means, tempered by the situation, to effect notification. If reasonable means failed, then a presumption favoring donation would control. Thus, in summary, the next-of-kin, by coming foward and exercising it, would have a vested interest in the remains of the decedent; otherwise, the interest would be presumed waived. Further, if the next-of-kin could not be notified by a reasonable attempt, the presumption in favor of donation would apply.

Legislation and the public interest

The public interest in cadaver donation is the result of the vast expansion of medical science. Although the scientific use of cadavers is in part responsible for this expansion, it is unfortunate that when science has used cadavers to benefit *science* it has not been in the public interest. Only where the public benefits directly can such medical activity be said to be in the public interest and thus subject to legislation.[49] Criminal autopsy has been determined to be of such vital public interest as to be superior to any other claim to the remains. Logically, if there is no objection to autopsy, why should there be an objection to organ removal? Transplantation is also vital to the public interest and, where that power vested in the decedent or his next-of-kin is not exercised, the public interest should control. This is the thrust of the Virginia transplant act.

Thus, effective legislation should uphold as paramount the interest of the decedent and give him simple, mechanical means to exercise his interest. Where there is no exercise however, legislation should shift the presumption to favor donation. Secondary to the decedent's interest

49. Etheredge v. Norfolk, 148 Va. 795, 139 S.E. 508 (1927) the court, quoting from *In re Jacobs*, stated:

> When a health law is challenged in the courts as unconstitutional on the ground that it arbitrarily interferes with personal liberty and private property without due process of law, the courts must be able to see that it has at least in fact some relation to the public health, that the public health is the end actually aimed at, and it is appropriate and adapted to that end. In re Jacobs, 98 N.Y. 98, 50 Am. Rep. 636. *Id.* at 799, 139 S.E. at 512.

should be the interest of the next-of-kin, but there should be an affirmative duty to exercise it. Finally, the public interest should be correspondingly greater in cases of transplant.

Many questions can effectively be answered by the adoption of the UAGA. In the areas of the right of the decedent to make a gift during life and, the right of the next-of-kin to do so on decedent's behalf, the statute combines the best of all progressive legislation.

Threatened litigation in Richmond, Virginia and Houston, Texas however shows that the UAGA does not complete the job. In Richmond, a transplant operation was attacked by the brother of the donor who denied that the body was unclaimed and stated that no consent was given.[50] In the Houston situation, the heart of a homicide victim was removed for transplanting before an autopsy was performed.[51] Neither of these problems could be disposed of under the UAGA. There is general concensus that younger donors afford the recipient a greater chance for survival. The majority of these donors become available due to some accidental death. Usually there is not time to contact the next-of-kin and in most cases, the decedent will not have made a previous anatomical disposition. It is in this area that the shifting presumptions and duties must be given effect. To this end, the Virginia transplant act complements the UAGA.

Conclusion

Legislation should be uniformly adopted which (1) grants an expeditious manner for one to make disposition of his remains, (2) resolves all conflict in favor of decedent where any such disposition has been made, and, (3) does not presume any intention to be buried where none is given. Further, in such cases where the decedent has not spoken, the right should vest in the next-of-kin who would have an affirmative

50. At the Medical College of Virginia, the heart of Bruce O. Tucker was used in a transplant operation May 25, 1968, after a reasonable search failed to uncover his next of kin. Later a brother denied that the body was unclaimed and stated that no consent was given for the transplant. No litigation has followed to date. Richmond Times Dispatch, May 27, 1968, at 1, col. 1.

51. The question in Houston involved a homicide victim donor. The heart of Clarence Nicks, the donor, was kept going for three hours after the county medical examiner ruled that he was dead. The heart was then removed prior to an autopsy being performed. The questions raised were: 1) Could an autopsy be considered complete with the heart missing? 2) If not, could it affect the prosecution and defense in a murder trial? and, 3) Could the heart transplant team be prosecuted for interfering with a planned autopsy by removing a homicide victim's heart? Washington Post, May 13, 1968, § A, at 6, col. 1.

duty to exercise the right in order to preserve it. Otherwise, a presumption in favor of donation would control. This can best be implemented by the adoption of the UAGA, as proposed, amended only to include a provision similar to the Virginia transplant statute.

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