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Anatomical Transplants: Legal Developments in Wisconsin

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ANATOMICAL TRANSPLANTS: LEGAL DEVELOPMENTS IN WISCONSIN

Advances in medicine and surgical technology have resulted in procedures permitting physicians to perform, with increasing degrees of success, the transfer of human body tissue from one individual to another.[1] Such transplants involve skin grafts, bones, corneas, livers, blood and arteries.[2] Also, it is no longer an uncommon experience for transplantation of human kidneys from both living and deceased donors. Where a living donor is involved, both the recipient and donor have subsequently lived active and relatively normal lives.

The enthusiasm over these significant medical advances, however, must be tempered by a recognition of the ethical and legal consequences of the transplant situation. The legal response to anatomical transplants is only beginning to surface, therefore the area has not been well defined. Such response must encompass the respective rights and responsibilities of the donor, recipient and physician. Initial consideration of the area must lead to a recognition that legal constraints should not hamper progress in medical research and technology. Of equal necessity is the recognition that the patient, particularly the donor, has a right to know that his life will not be sacrificed in favor of another.

Anatomical transplants can be undertaken with body parts from either a living or deceased donor. Because of the different statues, the legal responses to each situation have evolved separately. Where the transplant involves a deceased donor, the Uniform Anatomical Gift Act[3] governs in most jurisdictions. Where the donor is living, no such statute generally exists and the controlling law has been court made. In an area of the law just beginning to develop, the Wisconsin court has provided early contributions. Two recent Wisconsin Supreme Court cases concern the application of the UAGA and the consensual problem of a living donor who is legally incapable of giving personal consent to a transplant.

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1. R. MORRIS, RESPONSE TO SUBCOMMITTEE, MEDICAL MALPRACTICE: THE PATIENT VERSUS THE PHYSICIAN, SENATE SUBCOMM. ON EXECUTIVE REORGANIZATION, 91st Cong., 1st Sess. 435 (1969).

2. Uniform Anatomical Gift Act (U.L.A.), Commissioner's Prefactory Note, at 16.

3. The Uniform Anatomical Gift Act is referred to in this article as the UAGA.

I. DECEASED DONOR SITUATION

In Wisconsin a transfer of body tissue from a deceased donor is controlled by the Uniform Anatomical Gift Act.[4] The drafters of the UAGA recognized the expanding use of human body tissue in medical research and transplantation and were aware that pre-UAGA laws inadequately dealt with the situation. A uniform approach was needed:

> both the common law and the present statutory picture is one of confusion, diversity and inadequacy. This tends to discourage anatomical gifts and to create difficulties for physicians, especially for transplant surgeons.[5]

A. Historical Development

Under English common law, no property rights existed in a cadaver that would permit a gift of that body or any part thereof. The rights of possession and disposition of the body were solely under ecclesiastic control.[6] The concept that no individual could control a corpse was first embraced by American courts in the nineteenth century. An early Missouri case held that "there is no property right in a corpse, the relations have, in regard to it, only the right of interment, and this right having been once exercised . . . no right to the corpse remains except to protect it from insult."[7]

During the nineteenth century the question of whether any property rights existed in a body was frequently litigated. Such litigation can be traced to several sources including disputes between the decedent's spouse and next-of-kin concerning the control of the body for burial purposes,[8] attempts by relatives to be recompensated by third parties for the alleged mishandling of corpses,[9] and the expanding need for cadavers in medical research and teaching.[10]

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4. WIS. STAT. § 155.06 (1973).

5. UAGA (U.L.A.), Commissioner's Prefatory Note, at 17.

6. P. JACKSON, THE LAW OF CADAVERS 126 (2d ed. 1950) [hereinafter cited as LAW OF CADAVERS].

7. Guthrie v. Weaver, 1 Mo. App. 136, 143 (1876).

8. Pierce v. Proprietors of Swan Point Cemetary, 10 R.I. 227, 14 Am. Rep. 667 (1872).

9. Koerber v. Patek, 123 Wis. 453, 102 N.W. 40 (1905).

10. *In re* Johnson's Estate, 169 Misc. 215, 220, 7 N.Y.S.2d 81, 85 (1938). The court noted that alternatives to the shortage of bodies for medical purposes were unauthorized autopsies and body snatching from graveyards. Even murder was used: "the development of a business in homicide [was] carried on by two enterprising murderers

As a result, the rigid English position was modified to recognize "a qualified property right, one of custody, control and disposition of a res that itself is not material property."[11] This "quasi-property"[12] right was granted to the person responsible for burial, usually the spouse or next-of-kin, and extended to a right of possession for such burial, but did not extend to a property right in the commercial sense.[13] Interference with this right "by mutilation or otherwise disturbing the body"[14] was deemed an actionable wrong compensable by pecuniary damages. Similarly, the improper disinterment of a body became an actionable form of trespass.[15] A demand for an autopsy contracted under an insurance policy was held to be directed to the person properly in control of the deceased's body, and, if the demand was not made within a reasonable time after death, failure by such spouse or next-of-kin to accede to the demand would not defeat the beneficiaries' claim under the policy.[16]

Judicial recognition of a quasi-property right in the spouse or next-of-kin to a decedent's body led to a further question. Whose intention controlled when the decedent's expressed intention on the disposition of his own body conflicted with that of his spouse or next-of-kin? Because no property interest was held to exist in a body, courts often held that the decedent was incapable of controlling the disposition. The California court in *Enos v. Snyder*[17] invalidated an attempted testamentary disposition where the decedent willed his body to his mistress to be disposed of as she wished, without regard to the desires of his wife and child:

> It follows that a man cannot by will dispose of his dead body. If there be no property in a dead body it is impossible that by will or any other instrument that body can be disposed of.[18]

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named Burke and Hare, who obeying the law of supply and demand provided eager doctors with what they greatly needed but could not legally obtain in sufficient quantity."

11. LAW OF CADAVERS, *supra* note 6, at 133-34.

12. Pierce v. Proprietors of Swan Point Cemetary, 10 R.I. 227, 234, 14 Am. Rep. 667, 670 (1872).

13. Larson v. Chase, 47 Minn. 307, 50 N.W. 238 (1891).

14. *Id.* at 310, 50 N.W. at 239.

15. LAW OF CADAVERS, *supra* note 6, at 176.

16. Johnson v. Banker's Mutual Casualty Co., 129 Minn. 18, 151 N.W. 413 (1915).

17. 131 Cal. 68, 63 P. 170 (1900).

18. *Id.*. at 69, 63 P. at 171.

This view is accepted by the author of a familiar treatise on wills.[19] According to this view, the body is not property which can be disposed of by will, and the spouse or next-of-kin has a superior right to determine the place and method of burial. The minority view, however, seems to embrace the more reasonable idea that the decedent does have sufficient interest to assert the method of disposition. Therefore, the right to possession of a body for preservation and burial would rest with the surviving spouse or next-of-kin only in the absence of any testamentary disposition by the decedent himself.[20] Qualifying this view, the New Hampshire court recently held:

> It has been said that the wishes of a decedent will be carried out so far as possible, but that rights in matters of burial or disinterment are not absolute, and will be governed "by rules of propriety and reasonableness determinable by a court of equity upon due application."[21]

The problem of who possessed the right to control the disposition of a body was not entirely settled. The determination was based on a balance of the conflicting interests. On one hand, there existed the right of the decedent to determine the proper method for disposal of his remains. This right was balanced by the rights of the family, the deceased's spouse or next-of-kin.

With the increasing need for bodies in medical research and transplantation, a third and sometimes conflicting interest arose. This was the interest of society to permit the medical sciences to use cadavers in its effort to prolong life:

> The recent advance of the medical profession in the field of homotransplantation has transposed the question of testamentary disposition from the limited field of family squabbles into that of public concern. The pivotal social issue is no longer the "tender sentiment of the bereaved spouse," but rather the need of society. This shift was precipitated by the realization of the lifesaving potential which this new field of medical craft presents. We have seen more than once that public welfare may call upon our best citizens for their lives; why not for the bodies of those of our citizenry who express a desire that their cadavers be employed for the advance of science.[22]

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19. W. PAGE, WILLS, § 16.19 (Bowe-Parker Rev., 1960).

20. 47 Minn. at 310, 50 N.W. at 239.

21. Holland v. Metalious, 198 A.2d 654, 655 (N.H. 1964).

22. Note, *The Law of Testamentary Disposition — A Legal Barrier to Medical Advances*, 30 TEMP. L.Q. 40, 44 (1956).

The common law provided no assistance for the medical profession in its effort to obtain corpses. Without the deceased's prior express authorization, the spouse's or next-of-kin's desired disposition of the deceased's body was controlling. Despite the deceased's authorization, there was no assurance, in the event of disagreement, whether the spouse or next-of-kin would have the controlling interest in the body's disposition or whether the deceased's own plan would be deemed reasonable. The rules varied from jurisdiction to jurisdiction and even within jurisdictions.[23] Therefore, the best common law solution was to obtain the consent of both the decedent and the relatives. This, however, was often impractical and delay often minimized the usefulness of the cadaver.

Some assistance for the medical profession was provided by the anatomical laws of the nineteenth century.[24] The laws provided for the delivery of bodies of unclaimed indigents and inmates of governmental institutions to hospitals and medical schools. But as the medical use of bodies increased, the needs of related sciences requiring bodies expanded. The development of the homograft (transfer of tissue from one human being to another) procedure has demonstrated that today the number of corpses provided by the anatomical laws is inadequate.

The donation of one's body by will has also proved ineffective as a solution to the limited supply of organs for transplants. A disposition by will must await the probate of the will. The usual delay between the date of death and probate results in the body becoming useless for transplantation purposes:

> The organs such as kidneys and liver must be removed from the cadaver donor as soon after death as possible — not within days or even hours but within minutes. At death the discontinuation of circulation of blood to some organs whose oxygen demands are extremgly high causes irreversible damage.[25]

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23. *Compare* Scott v. Riley, 16 Phila. 106 (Pa. C.P., 1883) which stated that "a person by will can determine absolutely what disposition shall be made of the remains," *with* Pettigrew v. Pettigrew, 207 Pa. 313, 56 A. 878 (1904) where the court said that "the paramount right is in the surviving husband."

24. Holland v. Metalious, 198 A.2d 654, 656 (N.H. 1964). The court stated: "At the same time, the policy of using unclaimed bodies to advance scientific study has been given recognition over a period beginning at least as early as 1869."

25. Wasmuth & Stewart, *Medical and Legal Aspects of Human Organ Transplantation*, 14 CLEV.-MAR. L. REV. 442, 447 (1965).

As a result, the most effective means of disposition of an organ would be by gift executed prior to death pursuant to a statutory authority.

B. *Development of Wisconsin Anatomical Law*

Early in the twentieth century, the Wisconsin Supreme Court embraced the holding of *Larson v. Chase*,[26] a Minnesota Supreme Court decision, thus recognizing a quasi-property interest in cadavers. In subsequent decisions the Wisconsin court underscored the principle that the deceased's next-of-kin had certain rights with respect to the body. In *Koerber v. Patek*,[27] it was held that the complaint of a son who controlled the disposition of his mother's body stated a proper cause of action for actual damages[28] where the stomach of the body was removed without the son's consent. In a later case, *Wilde v. Milwaukee Electric Railway and Light Co.*,[29] a good faith standard was set forth where an action was brought by a father alleging the mishandling of his daughter's corpse following a streetcar accident. A jury in *Wilde* had determined that the defendant had acted in good faith in moving the corpse and the supreme court approved the instructions given to the jury. These cases did not, however, indicate what would happen if the decedent's plan to dispose of his body conflicted with the intentions of his kin. Absent any statutory directive, the case law was inadequate.

Wisconsin's first anatomical law was passed in 1863.[30] It provided that the public officer was in charge of disposing of corpses at public expense. If a body was not claimed for burial within forty-eight hours by a friend or relative, the public officer could deliver the body to a member of a county or state medical society. A recipient-physician was required to use the body "only for the advancement and promotion of anatomical science within this state."[31] The latest version of this statute, section 155.02, provides a more limited source of bodies but

26. 47 Minn. 307, 50 N.W. 238 (1891).

27. Koerber v. Patek, 123 Wis. 453, 102 N.W. 40 (1905).

28. The *Koerber* court concluded that the sense of outrage and mental suffering which directly resulted from the wilful act of the defendant were proper independent elements for the recovery of compensatory damages.

29. 147 Wis. 129, 132 N.W. 885 (1911).

30. Wis. Laws 1868, ch. 53, §§ 1-3.

31. *Id.*

enlarges the class which may request corpses. The corpse must be that of a person who was an inmate of a state, county or municipal institution and was unclaimed by any relative upon proper notice. The possible recipients may be either of the two Wisconsin medical schools or an accredited school of mortuary science.

It is evident that this statute was and is too limited to provide any real assistance in the expanding anatomical transplant area. Therefore, Wisconsin's first anatomical gift act was passed in 1961.[32] The act permitted any adult of sound mind to make a lifetime gift of all or part of his body to a medical school or bank for scientific, medical or educational purposes. The gift was evidenced by a written instrument witnessed by two people and was revocable at anytime during the donor's lifetime. The donee was given a right to accept or reject the gift and the surviving spouse or next-of-kin could provide funeral services before delivery of the corpse to the donee. Liability of any person carrying out invalid written instructions of the donor was limited if the person acted in good faith in following the donor's directives.

The Wisconsin anatomical gift act was an attempt to reduce the shortage of needed corpses. It left many questions unanswered, however, and was indicative of the type of statute which created the need for the UAGA. The act did not specifically permit a gift to any particular individual donee. The methods of revocation of the donor's gift were not indicated, nor was legal protection of the physician carrying out the donor's intention covered. A definition of death was not attempted. The act ignored any reference to a conflict of interest when the physician caring for the donor also attended a donee in immediate need of a transplantation. Finally, conflicts of law problems where either the donee or donor resided in different states were not addressed.

The UAGA became effective in Wisconsin on July 2, 1969.[33] The act provides comprehensive coverage for the donation of a body or any part thereof by means of a written instrument. To facilitate the operation of the donative procedure, the gift may be made by document, card or will. A specific donee may or may not be named. Delivery of the document is not necessary

32. Wis. Laws 1961, ch. 395.
33. Wis. Laws 1969, ch. 90.

to validate the gift. The card may be carried on the person of the donor. In Wisconsin, a potential donor may have a decal affixed to his motor vehicle driver's license indicating he carries an authorized UAGA donor card on his person.[34] Where the gift is devised, it becomes effective upon the testator's death without waiting for the probate of the will.

Such donation may be made by an adult of all or part of his body to take effect at death. No indication is given as to what method, if any, may be used by a minor to donate his body. Special provisions in Wisconsin's version of the UAGA (which differ from the parent act) concern the right of revocation of the gift if the donor is a minor and, under special circumstances, if the donor is married.[35] If the donor dies before the age of eighteen and is unmarried, either parent may revoke the gift. If the entire body of the donor is given for purposes of anatomical research, the gift is revoked unless the surviving spouse has consented in writing to the disposition. The act does not specify if such revocation by parent or spouse may be made prior to death.

An innovative feature of the statute establishes a hierarchy of related persons who may donate the decedent's body for anatomical purposes where no contrary intention of the decedent is known nor any opposition to the gift is expressed by any member of the same or prior class of the hierarchy.[36] For example, an adult son or daughter may donate a parent's body provided neither the deceased's spouse nor one of the other children of the deceased express opposition to the plan.

The class of approved donees is greatly expanded over the old anatomical gift act. Among the approved donees are hospitals, physicians or surgeons, accredited medical or dental schools, medical or dental banks or storage facilities, or specified individuals for such individuals' personal transplantation requirements.[37]

The gift may be amended or revoked if the appropriate document is already delivered to the donee by any of the following: (1) a statement signed by the donor and sent to the donee, (2) an oral statement made in the presence of two witnesses and communicated to the donee, (3) a statement made

34. WIS. STAT. § 343.17(3)(a) and (b) (1973).
35. WIS. STAT. § 155.06(2) (1973).
36. WIS. STAT. § 155.06(2)(b) (1973).
37. WIS. STAT. § 155.06(3) (1973).

during terminal illness to the attending physician and communicated to the donee, or (4) a signed document or card found with the deceased's personal effects.[38]

If the document is still in the possession of the donor, it can additionally be revoked by destruction, cancellation or mutilation.[39] Also, the gift may be accepted or rejected by the donee.[40]

Two critical and controversial areas are covered in subsections 7(b) and (c).[41] The first regards death; the act refrains from defining when death occurs. Subsection 7(b) states that the time of death will be determined by the attending physician although such physician may not participate in the removal or transplantation of the body part. The second, subsection 7(c), provides a limitation on civil or criminal liability for any person who acts in good faith in accordance with the UAGA.

C. *Section 7(b)*

The question of time of death is critical to transplantations. The closer to the time of death that a body organ is removed, the greater are the chances that the transplantation will be successful:

> In the area of corneal transplantation, where the rejection reaction is virtually nonexistent, several hours may elapse between death and removal and storage of the eyes. Skin, bones and blood vessels similarly may be used many hours after death. But kidneys deteriorate rapidly and must be obtained from a living donor or soon after cessation of circulation in the donor in order to survive and function. Principles akin to those controlling kidney transplantation apparently apply in the field of heart, lung and liver transplantation which is still in the developmental stage.[42]

On the other hand, the actual point at which life terminates is not clear and is often difficult to determine. A recent incident demonstrates the problem.[43] A hospital patient who had suffered a severe heart attack was declared clinically dead when all brain activity ceased. His heart and breathing were artifi-

38. WIS. STAT. § 155.06(6)(a) (1973).
39. WIS. STAT. § 155.06(6)(b) (1973).
40. WIS. STAT. § 155.06(7)(a) (1973).
41. WIS. STAT. § 155.06(7)(b) and (c) (1973) [hereinafter cited as 7(b) and 7(c)].
42. 2 D. LOUISELL & H. WILLIAMS, MEDICAL MALPRACTICE, ¶ 19.12 (1973).
43. Milwaukee Journal, Feb. 12, 1975, § 1, at 1, col. 2.

cially maintained while preparation began for surgery to remove organs for transplantation. During this preparation, an attending physician noticed that the "deceased" blinked his eyes. The patient was quickly taken to the intensive care unit where his condition stabilized and thereafter improved. By accepted medical standards death had occurred prior to the patient's recovery.

The drafters of the UAGA recognized that the legal conception and articulation of what constitutes death had lagged far behind the standards of the medical profession.[44] For example, a legal dictionary defines death as the "total stoppage of the circulation of the blood and a cessation of the animal and vital functions consequent thereon."[45] But presently it is not uncommon to stimulate the heartbeat by an electric pacemaker or to cause blood circulation by external cardiac massage.[46] Recent medical definitions use stoppage of the brain functions as a more accurate indication of death. The consensus in the medical profession is that death consists of a state where a condition of permanent unconsciousness (irreversible coma) exists and the body functions can no longer continue spontaneously.[47] A prominent group of physicians[48] examined "brain death" and compiled three criteria which make up an "irreversible coma." These were a total unawareness to externally applied stimuli and inner need and complete unresponsiveness, no movements or breathing, and no reflexes. Additionally, this committee considered a flat electroencephalogram[49] to be "of great confirmatory value" in the diagnosis of death.[50]

The UAGA drafters decided not to establish a definition of death. Rather, the act was drafted to permit the attending physician to make a good faith determination of when death occurs. A safeguard against the possibility that the life of the

44. UAGA (U.L.A.) § 7, Commissioner's Note, at 40.

45. BLACK'S LAW DICTIONARY 488 (Rev. 4th ed. 1968).

46. Wasmuth, *Organ Transplantation*, LEGAL MEDICINE ANNUAL 393, 408 (1969).

47. Luyties, *Suggested Revisions to Clarify the Uncertain Impact of Section 7 of the Uniform Anatomical Gift Act on Determination of Death*, 11 ARIZ. L. REV. 749 (1969).

48. The Harvard Medical School Ad Hoc Committee to Examine the Definitions of Brain Death.

49. This is the record of an electroencephalograph, an instrument that records the electrical impulses of the brain and is referred to as an EEG.

50. Capron & Nass, *A Statutory Definition of the Standards for Determining Human Death: An Appraisal and a Proposal*, 121 U. PA. L. REV. 87, 89 (1972).

dying donor will be sacrificed prematurely in favor of the donee was added by the requirement that the time of death should be determined by a physician who is not participating in the removal or transplantation operations.

But problems do exist. Proper donors are difficult to obtain:

> The source of kidneys for cadaver transplantation is usually from a patient in the hospital who dies suddenly from unrelated causes. Sudden severe brain damage, as seen from massive hemorrhage or head injury, or death from complicated heart operations, are the most common situations in which the cadaver donor kidneys can be salvaged. Such patients can usually be supported by cardiac massage and/or artificial respiration until it is obvious the situation is hopeless and death inevitable.[51]

Another problem is that while the physician must make a good faith determination of the time of death, there is no requirement that this decision must be based on a conventional, medically acceptable determination. Two contrasting tests for death demonstrate the significance of the differences between a conservative and an unconventional method:

> 1. The Schwab Test—The procedure used by Dr. Schwab for pronouncing death using the EEG was evolved for determining when a patient whose body processes were being sustained artificially could be pronounced dead. His test includes the absence of spontaneous heartbeat and respiration, and thus it satisfies the most stringent legal criteria. However, the flat EEG recording period of 1 hour may involve substantial risk to the recipient. The longer the surgeon must wait, the more the donor's heart tissue deteriorates, progressively lessening the chances of a successful transplant, and thus increasing the surgeon's liability to the recipient's survivors for proceeding without chance of success. Dr. Schwab's test for death is most beneficial to the donor.
> 2. The Crafoord Test—Although reports of this Swedish doctor's kidney transplants are conflicting, it seems he did use the EEG but proceeded with the kidney transplant before respiration had stopped. The physicians may pronounce "all hope lost" on the basis of either flat EEG or an EEG that was becoming progressively flatter. This procedure withholds all treatment from the donor and thus denies any possibility of a recovery similar to that of Landau. Thus, from the point of

51. Wasmuth, *Organ Transplantation,* LEGAL MEDICINE ANNUAL 393, 492 (1969).

> view of organ deterioration, this method would be most beneficial to the recipient.[52]

The act does not indicate whether a physician using the unconventional Crafoord Test, or even a test considered medically unreasonable, will be excluded from liability provisions.

Some states have drafted statutory definitions of death. The first attempt at a legislative resolution of the problem was made in 1970 by Kansas.[53] The Kansas statute provides alternative definitions of death which are used for all legal purposes in the state. The first method involves the absence of spontaneous respiratory and cardiac function, while the other involves the absence of spontaneous brain function. Either method must be based on ordinary medical standard.

A better solution than augmenting the UAGA by each state's own definition might be provided by the adoption of a uniform legal definition of death. Such definition must necessarily have a medically sound basis with an adequately flexible standard within which innovative transplant work of physicians can be performed. A definition arguably fulfilling these requirements was suggested by the ABA's House of Delegates at the 1975 Chicago convention. The delegates passed a resolution recommending a uniform legal definition of death as a state of "a human body with irreversible, total cessation of brain function."[54]

D. Section 7(c)

The second critical area of the UAGA is section 7(c). This section provides the attending physician with freedom from civil or criminal liability if the physician acts in good faith. Such immunity was deemed necessary by the UAGA drafters so that physicians would not be intimidated when faced with the prospect of performing an innovative and risky transplant operation. The problem with such a standard parallels that of the determination of death. The question is how the law can control a transplant procedure which, while entered into in good faith by the physician, is unconventional by the standards of the rest of the medical profession.

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52. Comment, *Liability and the Heart Transplant*, 6 HOUS. L. REV. 85, 98-99 (1968).

53. KAN. STAT. ANN. § 77-202 (Supp. 1971).

54. Milwaukee Journal, Feb. 25, 1975, § 1, at 5, col. 1.

The UAGA received its first litigational test in Wisconsin in the case of *Williams v. Hofmann*.[55] The central issue concerned the constitutionality of section 7(c) in the Wisconsin version of the UAGA. The case was appealed to the Wisconsin Supreme Court upon the overruling of plaintiff's demurrer to the affirmative defenses interposed by the defendants to the complaint.

The plaintiff's wife had been admitted to Milwaukee County General Hospital and placed under the care of one of the defendants, Dr. James Hofmann. Mrs. Williams was placed on a mechanical respirator after her breathing suddenly stopped. The next morning, a Saturday, Dr. Hofmann told the plaintiff that his wife had died and secured from the plaintiff a written consent for the removal of his wife's kidneys. Plaintiff subsequently learned, while making funeral arrangements, that his wife was not actually pronounced dead until the following Monday morning. Plaintiff alleged in his complaint that his wife was kept alive by means of life supportive devices until 9:00 a.m. on Monday, even though Dr. Hofmann pronounced her dead at 8:20 a.m. and the kidney removal operation began at 8:35 a.m.

Williams sought recovery of damages based on two theories. One was brought in the capacity of special administrator to his wife's estate alleging assault and battery and negligence. The second action was brought in his individual capacity for "intentional mutilation of a corpse, negligent mutilation of a corpse and negligence in communicating an erroneous and premature death message."[56]

The defendants (Dr. Hofmann, Dr. Kauffman — the transplant surgeon, and Milwaukee County) answered, denying most of the complaint's material allegations and asserting three affirmative defenses. Plaintiff demurred to the affirmative defense that the defendants acted in good faith reliance upon the consent signed by plaintiff and were, according to section 155.06(7)(c) of the UAGA, immune from liability.

The court's analysis, beginning with a general discussion of the UAGA, emphasized that the act applied to a transplant operation after the death of the donor.[57] The only time that the

55. 66 Wis. 2d 145, 223 N.W.2d 844 (1974).
56. *Id.* at 149, 223 N.W.2d at 846.
57. *Id.* at 150, 223 N.W.2d at 846.

act applies to living human beings was for the purpose of determining the time of the donor's death. Therefore, the court reasoned that since the act did not apply to treatment of the donor prior to death, nor to treatment of the live donee, the act's liability limitation did not extend to such treatment.

From this reasoning the court concluded that since the plaintiff's first action brought as special administrator arose from treatment while his wife was still alive, plaintiff's demurrer to the affirmative defense should have been sustained by the trial court.

Plaintiff's second action was brought to recover damages for injuries which defendants allegedly caused to the body after Mrs. Williams had been pronounced dead. The UAGA does apply to this action, and the court dealt with the constitutionality of section 155.06(7)(c) of the UAGA. This was the first time this issue had been appealed to a state supreme court in any jurisdiction which had passed the UAGA.

The court analyzed four separate constitutional questions in reaching its decision that section 155.06(7)(c) was constitutional, and may provide a defense for the defendants if they could demonstrate at the trial court level that they acted in good faith. Plaintiff's first contention was that Article I, section 9 of the Wisconsin Constitution[58] was violated by section 155.06(7)(c) in that the statute abrogated the rights of injured persons by replacing the present negligence standard of care in medical malpractice actions with a lesser standard of good faith.[59] The court summarily dismissed this argument by reminding the plaintiff that section 155.06(7)(c) did not apply to actions brought concerning the medical treatment of the donor prior to death. Plaintiff's right to sue for malpractice or assault and battery were not affected by section 155.06(7)(c).

Plaintiff's second contention was that the term "good faith" was unconstitutionally vague as used in section 155.06(7)(c).[60] In dismissing this argument the court looked at the criteria set

58. WIS. CONST. art. I, § 9:
Every person is entitled to a certain remedy in the laws for all injuries, or wrongs which he may receive in his person, property, or character; he ought to obtain justice freely, and without being obliged to purchase it, completely and without denial, promptly and without delay, comformably to the laws.
59. 66 Wis. 2d at 151, 223 N.W.2d at 847.
60. *Id.* at 152, 223 N.W.2d at 847.

forth in earlier Wisconsin cases that were used to determine if a civil statute was void for vagueness:

> A statute is not necessarily void merely because it . . . prescribes a general course of conduct . . . and questions may arise as to its applicability, and opinions may differ in respect of what falls within its terms . . . .
> Unless a statute is so vague and uncertain that it is impossible to execute it or to ascertain the legislative intent with reasonable certainty, it is valid.[61]

The term "good faith" prescribes a general course of conduct which can be construed only by a careful analysis of the facts. By such analysis, the good faith standard can be applied so that the statute may be executed. The court buttressed its reasoning by citing the *Wilde* case[62] where a good faith standard was approved for jury instructions in a case involving the alleged mishandling of a corpse.

Plaintiff's third argument was that section 155.06(7)(c) denied him equal protection of the law by bestowing a special immunity on transplant surgeons.[63] He argued that there was no rational justification in granting the immunity in transplant operations and not in ordinary medical malpractice situations. The court reasserted that the surgeon was not immunized during the entire transplant operation, but only after the donor died. The rational justification for the immunity was the public purpose of encouraging the removal of anatomical parts for transplant and research.

Plaintiff's final argument was whether section 155.06(7)(c) extended the limitation of liability to persons in other states acting in good faith in accord with the terms of "the anatomical gift laws of another state."[64] This issue was not raised at the trial level, therefore no standing existed with which to raise the issue before the supreme court. The court dismissed this argument by stating "that section 155.06(7)(c) does not empower foreign jurisdictions to make Wisconsin laws" but "only recognizes the lawfulness" of similar actions taken in other jurisdictions in accordance with such jurisdictions' laws.[65]

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61. *Id.* at 152-53, 223 N.W.2d at 847-48.

62. Wilde v. Milwaukee Electric Railway and Light Co., 147 Wis. 129, 132 N.W. 885 (1911).

63. 66 Wis. 2d at 154, 223 N.W. at 848.

64. *Id.* at 155, 223 N.W. at 849.

65. *Id.* at 156, 223 N.W. at 849.

The *Hofmann* decision recognized the constitutionality of the good faith immunity granted to physicians removing anatomical parts pursuant to the UAGA. The court also recognized that good faith must be determined by analyzing the facts of the particular case. What factors are involved in determining if the conduct was in good faith? A commentator gives some guidance:

> The first step in deciding whether such a physician is somehow protected by the UAGA's disclaimer is to determine whether he acts in accordance with section 7(b) (directing that "the time of death shall be determined by a physician who tends the donor . . ."), when he makes any determination of death. The second step is to determine whether a negligent act can be committed in good faith. If both questions can be answered affirmatively, the determiner of death should be immune from liability, provided, of course, that the determination is alleged to be only negligent — not intentionally wrongful.[66]

The key question is whether a negligent act can be committed in good faith. The Wisconsin court did not directly answer this question in *Hofmann*. Rather, it pointed out that "while negligence is not per se bad faith conduct, the extent of and character of the negligence" were factors to be utilized in weighing bad faith.[67] By indirection, the decision implies that a negligent act may, in fact, be committed in good faith. It is the scope and character of the negligence which will determine when good faith no longer exists. Such a standard does offer the physician some protection. A single act of negligence does not seem to destroy the physician's immunity while removing anatomical parts from a body. Where more than one act of negligence occurs, the solution is unclear and the answer is left for future judicial interpretation.

While the good faith immunity offers protection to physicians, the extent of this immunity was limited by the *Hofmann* decision. The court construed the UAGA narrowly and held that the immunity of section 155.06(7)(c) should only extend to the determination of death and the actual removal of the

66. Luyties, *Suggested Revisions to Clarify the Uncertain Impact of Section 7 of the Uniform Anatomical Gift Act on Determination of Death*, 11 ARIZ. L. REV. 749, 761-62 (1969).

67. 66 Wis. 2d at 153, 223 N.W.2d at 848.

body part from the deceased. The court decided not to extend the act's applicability to the entire transplant operation and, by doing so, restricted the scope of its protection. The limitation is consistent with the UAGA as it relates to anatomical law.

II. Living Donor Situations

The scope and nature of the legal problems involved when a living person donates a body part differ from those that exist where the donor is deceased. First, the possibilities for donation are limited by the ability of the donor to function without the organ. The most apparent situation is that of the kidney transplant operation because the kidney is the only vital organ which can be removed from a healthy living donor without jeopardizing the donor's life.[68] Secondly, there does not exist the statutory control comparable to that of the UAGA. Any liability on the part of the surgeon performing the operation will be subject to medical malpractice guidelines. Such liability will not be discussed in this article. Rather, the peculiar problems in the kidney transplantation area which have arisen when obtaining the requisite consent for the transplantation from the donor will be discussed.

For every surgical intrusion into the body, consent is a critical legal consideration. A surgeon's liability for a non-emergency procedure is, however, precluded by the patient's voluntary, informed consent. The underlying spirit of this legal axiom was articulated by Justice Cardozo in 1914; "Every human being of adult years and sound mind has a right to determine what shall be done with his own body."[69] Legally sufficient consent, however, requires more than mere affirmance of the treatment. The medical procedure and its attendant risks must be explained to the patient.[70] The amount of

68. Hamburger & Crosnier, *Moral and Ethical Problems in Transplantation*, in Human Transplantation 37, 38 (F. Rapaport & J. Dausset ed. 1968).

69. Schloendorff v. New York Hospital, 211 N.Y. 125, 129, 105 N.E. 92, 93 (1914).

70. *See* Serianni v. Anna, 55 Misc. 2d 553, 285 N.Y.S.2d 709 (Sup. Ct. 1967). A mother donated one of her kidneys to her son whose kidneys had both been removed. The transplant was successful. The plaintiff mother, however, initiated an action alleging that her health was impaired by the loss of one of her kidneys. The court held that notwithstanding the doctor's malpractice which precipitated the need for the transplant, a donor does not have a cause of action against the doctor if the donation was made voluntarily. This case raises the question as to how much information the

disclosure required to discharge the doctor's duty varies not only with the treatment, but with the individual patient's ability to appreciate the significance of that information.[71]

Significant legal questions have arisen in transplantation cases, and have resulted in conflicting decisions where the donor has lacked the requisite capacity to consent to the operation because of minority of age or mental incapacity, and a court has been petitioned to permit the transplant. The problem is both a legal and emotional one. The donee is critically ill and in need of a transplanted kidney. Often the donee has had both of his natural kidneys removed and must use a dialysis machine. The only possible compatible donee is an individual who lacks the ability according to the law to consent to the operation. Is it possible for a minor or legally incompetent donor to agree to the operation despite the legal insufficiency of his consent if the court finds he is able to understand the significance of the treatment? Is a parent's or guardian's consent sufficient to authorize the operation? Though there is no physical benefit to the donor, is a psychological benefit sufficient to permit guardian authorization? These are a few of the questions which the courts have raised in deciding the issue.

The question of consent by a legally incapable individual was first litigated in Massachusetts in 1957. The cases involved identical teenage twins.[72] All three cases held that the hospital and surgeon could proceed with the operation on consent of the parents and of both twins without incurring civil liability. In the *Masden* decision, the court determined that sufficient benefit would flow to the donor twin so as to provide adequate basis for the operation:

> I am satisfied from the testimony of the psychiatrist that grave emotional impact may be visited upon Leonard if the defendants refuse to perform the operation and Leon should

doctor must disclose to discharge his duty so that a patient may knowingly and voluntarily consent to a transplantation.

71. *See* 2 D. LOUISELL AND H. WILLIAMS, MEDICAL MALPRACTICE ¶ 19.12 (1973) as to the special care that must be taken by the physician to insure that the consent of a prisoner-patient is truly voluntary.

72. Masden v. Harrison, No. 68651, Eq. Mass. Sup. Jud. Ct. (June 12, 1957); Hushey v. Harrison, No. 68666, Eq. Mass. Sup. Jud. Ct. (Aug. 30, 1957); Foster v. Harrison, No. 68674, Eq. Mass. Sup. Jud. Ct. (Nov. 20, 1957) *discussed in* Curran, *A Problem of Consent: Kidney Transplantation in Minors*, 34 N.Y.U. L. REV. 891 (1959).

> die, as apparently he will . . . . Such emotional disturbance could well affect the health and physical well-being of Leonard for the remainder of his life. I therefore find that the operation is necessary for the continued good health and well-being of Leonard and that in performing the operation the defendants are conferring a benefit upon Leonard as well as upon Leon.[73]

The courts' analyses were based generally on the effect which the operation would have on the donor twins and specifically on the benefit conferred upon such donors. But equally significant in the courts' analyses was the fact that the donors were capable of an informed and voluntary consent. The *Foster* court stated:

> Carl [the healthy twin] testified before me. He is a boy of fourteen with good understanding and intelligence. He has been fully informed of, and understands the nature of the operation and its possible risks and consequences. He has talked with a donor of a kidney in a similar operation. The mother of the boys consents to the operation. Carl and his mother desire that the operation take place and Carl's consent to it is the result of his own decision, free from pressure or coercion, made with admirable courage, generosity, and appreciation of the factors involved.[74]

Significant legal questions have arisen in transplantation cases where the patient-donor has been a minor or incompetent. As a general rule both minors and mental incompetents are incapable of satisfying the requirements of informed consent. A court is petitioned to determine whether to allow a transplant because of the legal difference between a therapeutic operation on a minor or incompetent, and a non-therapeutic operation. Parental consent is sufficient to permit therapeutic treatment of minors and incompetents. This is because the treatment is for the benefit of the child. In non-therapeutic operations, such as transplants, there is no physical benefit to the donor. The problem is definitely legal as well as emotional.

There is authority, however, for the proposition that parental permission is sufficient to authorize a non-therapeutic operation after an independent and objective investigation.[75]

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73. No. 68651, Eq. Mass. Sup. Jud. Ct. at 4.
74. No. 68674, Eq. Mass. Sup. Jud. Ct. at 2-3.
75. Hart v. Brown, 29 Conn. Supp. 368, 289 A.2d 386 (1972).

A. The Court's Authority

In *Strunk v. Strunk*,[76] the Kentucky Court of Appeals permitted the transplant of a kidney from a 27 year old incompetent ward of the state to his 28 year old married brother. The Superior Court of Connecticut decided similarly in *Hart v. Brown*,[77] where the donor and donee were identical twins, aged seven years. In neither case did the donor have the understanding and intelligence to make an independent decision concerning the operation. The courts invoked the equitable doctrine of "substituted judgment" to judicially authorize the transplants.

The *Strunk* case examined statutory restrictions on a guardian's authority to act for an incompetent and recognized that the guardian had no power to consent to a transplant unless the life of the ward was in jeopardy.

Substituted judgment was first recognized in this country by the court of equity in the nineteenth century to permit a chancellor to deal with the estate of an incompetent.[78] The courts in *Hart* and *Strunk* decided that the doctrine could apply to the personal affairs of the incompetent and therefore would apply to the transplant situation. Substituted judgment, however, has traditionally been utilized only with regard to the ward's proprietary interest.[79] The doctrine is generally thought to have first originated in England in the case of *Ex parte Whitbread*,[80] where the court authorized payments out of an incompetent's estate to be applied to his needy brothers and sisters. Courts which have permitted relief through use of the doctrine have done so where the estate of the ward has been much larger than the ward requires[81] and conduct prior to the ward's incompetency indicated that the ward would act in such a manner, had he the use of his faculties, in order to assist a needy relative[82] or for purposes of avoiding unnecessary estate

76. 445 S.W.2d 145 (Ky., 1969).

77. 29 Conn. Supp. 368, 289 A.2d 386 (1972).

78. *In re* Willoughby, 11 Paige 257, 4 Ch. S. 59 (N.Y. Ch. 1844).

79. Note, *Equity — Transplants — Power of Court to Authorize Removal of Kidney from Mental Incompetent for Transplantation into Brother*, 16 WAYNE ST. L. REV. 1460, 1474 (1970).

80. 2 Meriv. 99, 35 Eng. Rep. 878 (Ch., 1816).

81. In *In re* Flagler, 248 N.Y. 415, 162 N.E. 471 (1928), the incompetent received annual income of $50,000. The court was cognizant of this fact when it applied the doctrine of substituted judgment.

82. *In re* Tash, 126 Misc. 764, 214 N.Y.S. 631 (1926).

or inheritance taxes.[83]

Several courts, however, have expressly refused to apply the doctrine absent any statutory authority.[84] It is the viewpoint of these courts that statutory authority exists in lieu of the common law and all authority of guardians must come from the statutes:

> The enactment of Section 398 of the Probate Code would not have been necessary if the Probate Court could have exercised the power granted therein without such enactment. Moreover, such section sets out in detail the conditions under which the charitable gift may be made, and would seem to negative the doctrine of substituted judgment. It is our view that this section of the Probate Code strongly indicates the legislative intent to confer upon the court a power and authority, which it was believed the court did not have prior to such enactment, namely, to make gifts out of the income from the ward's estate.[85]

There are reasons for skepticism on the use of the doctrine of substituted judgment absent statutory authority. First, the cases show that it is an extremely relative and subjective process to convince the court that the ward would have so acted had he the capability. Secondly, the doctrine offers possibilities of being extended beyond its original limitations: "It is a dangerous doctrine for a court to so substitute its judgment. The doctrine too far advanced might lead to gross abuse."[86]

It is the application of the doctrine to the transplant situation in *Hart* and *Strunk* which, argumentively, leads to "gross abuse." For a court to be convinced that an incompetent would be willing to share part of his excessive proprietary estate with a distant relative may legitimately be inferred from previous conduct indicating a concern for the individual. On the other hand, to infer from friendship or affection a willingness to donate a part of one's body to another person absent an unequivocal statement to that effect while competent, is an entirely different situation. It is even more abusive to infer such gener-

83. *In re* Myles' Estate, 57 Misc. 2d 101, 291 N.Y.S.2d 71 (1968).

84. *In re* Beilstein, 145 Ohio St. 397, 62 N.E.2d 205 (1945); *In re* Guardianship of Estate of Neal, 406 S.W.2d 496 (Tex. Civ. App. 1966).

85. *In re* Guardianship of Estate of Neal, 406 S.W.2d 496, 502 (Tex. Civ. App. 1966).

86. *In re* Beilstein, 145 Ohio St. 397, 402, 62 N.E.2d 205, 207 (1945).

osity to a person who never had the ability to understand what was being asked of him.

B. *Benefit Conferred*

Once the doctrine of substituted judgment was found applicable to transplant situations, the courts in *Hart* and *Strunk* analyzed the issue of whether sufficient benefit would accrue to the donor. Neither court could find any actual physical benefit to the donor resulting from the operation, but each discussed the supposed minimal risks involved. In the *Strunk* case, it was noted that "[t]he risks incurred by the donor are therefore very limited, but they are a reality, even if, until now, there have been no reports of complications endangering the life of a donor anywhere in the world."[87]

The benefits which these courts recognized involved the positive psychological effect that would accrue to the donor. In *Hart*, the court noted that a psychiatric examination of the seven year old identical twin showed that: "[T]he donor would be better off in a family that was happy than in a family that was distressed and . . . it would be a very great loss to the donor if the donee were to die from her illness."[88] In addition, it was noted that the donor was informed of the operation and was, to the extent of her capacity, willing to donate her kidney.[89] The Kentucky court in *Strunk* decided that the operation would be beneficial to the incompetent because his well being would be jeopardized more severely by the loss of his brother than by the removal of a kidney.[90]

Are these "benefits" mere fictions which the courts indulge in to authorize a transplant operation? It is questionable that a person of that mental age is capable of developing such bonds with a relative so that the loss of the relative would necessarily cause permanent psychological scars. The long term physical effects to a donor of a kidney transplant are yet unknown:

> [I]n the case of the living donor, certain serious situations arise which must be weighed very carefully. As with any surgical procedure, removal of a kidney for transplantation into

87. Strunk v. Strunk, 445 S.W.2d 145, 149 (Ky., 1969).
88. 29 Conn. Supp. 368, 388, 289 A.2d 386, 390 (1972).
89. *Id.*
90. Strunk v. Strunk, 445 S.W.2d 145, 146 (Ky., 1969).

> another person carries an inherent risk to the donor. Perhaps more significant is the possible long-term effect upon the donor. Presumably a healthy person, he might in the future develop serious renal disease and be himself in the same position as the person to whom he has donated his other kidney.[91]

Subsequent to *Strunk*, the Louisiana intermediate appellate court in *In re Richardson*[92] refused to find a benefit to the donor even though the court assumed it had the power to permit the operation. The facts in *Richardson* involved a potential donor who was a seventeen year old mental retardate and his 32 year old sister. The court noted that the brother was the most acceptable donor in that the present possibility of rejection was approximately four percent over a period of about four years. The court also noted, however, that Louisiana law affords considerable protection to the property rights of minors.[93] It would therefore be inconceivable to afford less protection to the minor where the loss of an organ is involved "unless such loss be in the best interest of the minor."[94] The court found no such benefit from the occurrence of the operation:

> Counsel for plaintiff argues the transplant could be in Roy's best interest because, if it is successful, Beverly could take care of Roy after the deaths of both Mr. and Mrs. Richardson. Such an event is not only highly speculative but, in view of all of the facts highly unlikely. We find that the surgical intrusion and loss of a kidney clearly would be against Roy's best interest.[95]

C. *The Wisconsin Court*

The Wisconsin Supreme Court was faced with the living donor transplant situation for the first time in the case of *In re Guardianship* of *Pescinski*.[96] The Wisconsin response arose from an appeal of a Washington County probate court's denial

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91. Wasmuth, *Organ Transplantation*, LEGAL MEDICINE ANNUAL 393, 404 (1969).
92. 284 So. 2d 185 (La. App. 1973), *appeal denied*, 284 So. 2d 338 (1973).
93. *Id.* at 187:
Under LSA-C.C. Arts, 1476 and 1477, an unmarried minor is prohibited from making any inter vivos donations of his property. LSA-C.C.P. Art. 4275 unequivocally prohibits the donation of a minor's property by his tutor and, when as in this case both parents are alive and not divorced or judicially separated, LSA-C.C.P. Art. 4501 gives to the father of a minor only those powers enjoyed by a tutor of a minor.
94. *Id.*
95. *Id.*
96. 67 Wis. 2d 4, 226 N.W.2d 180 (1975).

of a petition from the general guardian of Richard Pescinski to permit the incompetent to donate a kidney to his sister, Elaine, aged thirty-eight and mother of six, who had both kidneys removed four years prior to the petition due to severe kidney failure. Though previously sustained by dialysis treatments two or three times per week, the progressive deterioration of her condition made a transplant critical. There was no prospect of a kidney transplant from a deceased donor and all family members, other than her brother, were rejected as unsuitable donors. The potential donor was thirty-nine, mentally incompetent, and a ward of a state institution. As a result of court approved medical tests, it was established that the incompetent was in excellent health, and would be exposed to almost no medical risks as a donor. Court permission was sought to proceed with the operation. The trial court refused such permission, holding that there was no statutory authority for such an order and rejected any inherent equitable power of either the probate court or personal guardian to consent to the operation without a showing of benefit to the ward. The supreme court affirmed.

The court cited, but refused to follow the Kentucky court's adoption of the doctrine of substituted judgment as a sufficient basis for judicial authorization of transplant operations. The doctrine, the majority held, was to be limited to its historical role, any further extension would be unwarranted:

> Historically, the substituted judgment doctrine was used to allow gifts of the property of an incompetent. If applied literally, it would allow a trial court, or this court, to change the designation on a life insurance policy or make an election for an incompetent widow, without the requirement of a statute authorizing these acts and contrary to prior decisions of this court.[97]

While the Wisconsin court declined to permit a kidney transplant from an incompetent donor, it did hint that under proper circumstances it might decide differently. It is significant that the facts in *Pescinski* did not provide an advantageous setting for a precedental decision. In the first place, the age of the potential donor heightened the attendant risks of the transplant operation. Secondly, there was little indication of any close emotional relationship between the brother and sister

97. *Id.* at 8, 226 N.W.2d at 182.

from which the court could have inferred a psychological benefit to the brother. However, it seems that the most crucial fact in *Pescinski* is the absence of any manifestation of consent on the part of the potential donor: "No evidence in the record indicates that Richard consented to the transplant. Absent that consent, there is no question that the trial court's conclusion that it had no power to approve the operation must be sustained."[98] Therefore, while the Wisconsin court refused to recognize the substituted judgment doctrine, it seemed to imply that in a proper situation it might permit the operation. Such decision would depend upon the relation of the parties to each other and any actual manifestations of consent from the potential donor.

By failing to distinguish "real consent" from "legal consent," the court left unanswered a serious question. The lack of consent was a reason for not allowing a transplant; however, the incompetent could not have consented. The reasoning process utilized by the court fails to resolve the issue of whether an incompetent may ever consent.

Justice Day disagreed with the majority. Citing with approval the substantive conclusion of *Strunk*, Justice Day believed that the Wisconsin court possessed adequate equitable authority to permit a kidney transplant from an incompetent.[99] However, certain definite standards were suggested by the Justice which he believed could and should be met in each case before the court utilized its authority. The facts of *Pescinski*, it was asserted, met the proposed guidelines:

> [1] a strong showing . . . that without the kidney transplant the proposed donee or recipient stands to suffer death;
>
> . . .
>
> [2] that reasonable steps have been taken to try and acquire a kidney from other sources;
>
> . . .
>
> [3] that the incompetent proposed-donor, is closely related by blood to the proposed donee, such as a brother or sister;
>
> . . .
>
> [4] showing should be made that the donor, if competent would most probably consent because of normal ties of family;
>
> . . .

98. *Id.* at 7, 226 N.W.2d at 181.
99. *Id.* at 11, 226 N.W.2d at 182.

> [5] that the proposed incompetent donor is in good health;
>
> . . .
>
> [6] that the operation is one of minimal risk to the donor and that the donor could function normally on one kidney following such operation.[100]

With such guidelines established and met in *Pescinski*, Justice Day held that the guardian ad litem's concern that mental institutions would deteriorate to mere storehouses for spare human parts was unnecessary.[101]

Another approach to resolving the problem would be the passage of a relevant statute. The state of Michigan does have statutes based largely upon the 1959 Massachusetts cases which are worthy of note. In Michigan, an adult who is under guardianship as a mental incompetent may give one of his kidneys to a member of his immediate family upon order of the probate court, provided the court determines the prospective donor is sufficiently competent to understand the probable consequences.[102] Another statute provides similarly for a minor aged fourteen years or more, as long as the probate court has appointed a guardian to protect the minor's interests.[103]

III. CONCLUSION

The area of anatomical transplantation will require a unified strategy that encompasses both the living and deceased donor as the need for transplant organs continues to increase. Presently the law utilizes paradoxical approaches. On one hand, there exists the necessity to face the increasing shortage of suitable organs for transplantation. The Uniform Anatomical Gift Act is an innovation and has done much to clarify the law in the deceased donor area. To alleviate the problem of an inadequate supply of replacement organs, at least one radical solution has been suggested:

> We propose herein perhaps for the first time that the laws be broadened to authorize the several states to dispose of all or part of the remains of selected individuals after death, so as to make available a continuing supply of kidneys, hearts,

100. *Id.* at 10-11, 226 N.W.2d at 183.
101. *Id.* at 11, 226 N.W.2d at 183.
102. COMP. LAW ANNOT. MICH. § 701.19a.
103. COMP. LAW ANNOT. MICH. § 701.10b.

> other organs and tissues, even of cadavers to supply all the needs . . . .[104]

This proposal would require a re-thinking of the traditional law regarding cadavers.

Living donor transplants have and will continue to provide another avenue whereby lives are saved through organ transplants, but here lies the necessity for courts and legislatures to act with prudence. While a competent adult has the right to donate his body as he may please, the courts must not on their initiative permit such a donation from an individual, legally incompetent to consent, without a close scrutiny of all the circumstances. It is the court's foremost duty to protect the interest of its ward. Where a court's "sympathies and emotions are torn between a compassion to aid an ailing young man and a duty to fully protect unfortunate members of society,"[105] the decision must be made in favor of such unfortunate individuals.

DAVID J. MATYAS

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104. Gelfand, *Modern Concepts of Property in a Dead Body*, LEGAL MEDICINE ANNUAL 229, 242-43 (1971).

105. Strunk v. Strunk, 445 S.W.2d 145, 149 (Ky., 1969) (Steinfeld, J., dissenting).