In this paper, we assume that organ donation policy in the United States will continue to be based on an opt-in model, requiring express consent to donate, and that families will continue to have the prerogative to make donation decisions whenever the deceased person has not recorded his or her own preferences in advance. The limited question addressed here is what should be done when a potential donor dies unexpectedly, without any recorded expression of his or her wishes at hand, while a family decision is being sought.

We embrace the prevailing view that it is ethically permissible, if not obligatory, to preserve the deceased person's organs for a reasonable time while a responsible family member is being sought. Like the Institute of Medicine Committee on Increasing Rates of Organ Donation, we believe that preserving the family's opportunity to choose donation under these circumstances is ethically preferable to failing to so do. The slim chance that some families, when found, will be offended or distraught by the modest surgical steps taken to preserve medically useful organs is outweighed by the good that is achieved by enhancing opportunity for all families and by saving lives. In light of the strong ethical case for preserving family choice, state statutes governing organ donation and retrieval should specifically authorize organ preservation during the short period when family consent for donation is being sought.

It may come as a surprise to many readers that only a handful of state statutes now explicitly authorize preservation under these circumstances. This is all the more surprising because it is common practice to initiate and continue medical interventions such as

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mechanical ventilation and other preservation procedures after patients have been declared dead according to neurologic criteria while families are notified of the patient's death and are approached about donation. In other words, hospitals and organ procurement organizations (OPOs) apparently assume that they now have the necessary authority to preserve organs after death has been declared according to neurologic criteria because it so clearly serves the dual purposes of modern organ donation statutes — facilitating donation and respecting individual choice.

The lacuna of state organ donation statutes relating to temporary authority to preserve organs has attracted attention in recent years because of the increasing policy interest in facilitating organ donation after sudden cardiac death. In these cases, when the heart has irreversibly ceased to function, some organs can be preserved in a minimally invasive manner by making the necessary small incisions in the body cavity to perfuse them. On its face, preserving the deceased person's organs pending a family decision after "cardiac death" seems legally indistinguishable from the preservation procedures now being followed after so-called "brain death." In both cases, preservation procedures must proceed during the short timeframe when family members are being located or when identified family members are being approached and making decisions about organ donation. If the legal authority to undertake preservation procedures is implicit in the customary context of "brain death," one would reasonably expect it to be available in the context of "cardiac death." However, hospitals have expressed some hesitancy about their legal authority to preserve organs after declaration of "cardiac death" in the absence of explicit statutory authorization, in part based on a fear of litigation by upset family members. This paper aims to dispel that uncertainty.

The easiest way to solve this problem, of course, is for legislatures to amend their organ donation statutes to confer the necessary authority explicitly. The modest aim of this paper, however, is to demonstrate that the authority is already implicit in most, if not all, governing state statutes. Further, hospitals and organ procurement organizations face no significant risk of liability when they take the necessary steps to preserve organs under these circumstances. The argument will proceed as follows: first, we argue that preservation of organs while seeking family consent is implicitly authorized by the Uniform Anatomical Gift Act (UAGA), the model for all state organ donation statutes; second, even if courts were to conclude that these statutes do not confer the necessary authority, preserving organs under these circumstances (i.e., without explicit statutory authority) would not violate the rights of family members and would not pose any meaningful risk of liability.

### Uniform Anatomical Gift Act

First drafted in 1968, the Uniform Anatomical Gift Act has been adopted in some form by every state and is the country's primary source of statutory law on organ donation. The UAGA was drafted to synthesize the nation's laws regarding organ donation and "encourage the making of anatomical gifts." It authorizes individuals over the age of 18 to make gifts of any parts of their bodies, effective upon the death of that individual, and delineates who can make the decision to donate a recently deceased individual's organs if that individual did not express a preference prior to his or her death. In 1987, the UAGA was amended to clarify the Act's original language to emphasize that anatomical gifts can only be revoked by the donor prior to death and to state unequivocally that the purpose of the Act was to encourage organ donation. Although 26 states revised their statutes to incorporate the 1987 language, many failed to do so and significant variations in state statutes have now emerged, leading the National Conference of Commissioners on Uniform State Laws to revise the UAGA once again in 2006, for the purposes of clarifying ambiguities that have arisen during the past 20 years, increasing rates of donation, and promoting uniformity. At least 20 states have already adopted the 2006 Act.

### Organ Preservation When Deceased Has Recorded a Desire to Donate

The 1968 UAGA and all state laws explicitly provide that an individual's statement of intent to donate is legally binding. The 1987 amended version of the UAGA strengthened the legal force of authorization to donate by stating, "An anatomical gift that is not revoked by the donor before death is irrevocable and..."
does not require the consent or concurrence of any person after the donor’s death. This language prevents a family member from contravening the expressed intentions of the deceased regarding organ donation; it also protects medical professionals from liability that might stem from suits by distraught family members who disagree with the wishes of their deceased relative. The 2006 Act further strengthens the principle of donor control by banning persons other than donors “from making, amending or revoking an anatomical gift” by the deceased person.

A legally binding authorization to donate one’s organs also constitutes a legally binding authorization for organ preservation, even if a family member objects or has not been identified. The trickier question, however, is whether organ preservation is authorized by the statute in the absence of a known donor authorization, pending efforts to ascertain the donor status of the deceased or to identify family members and seek their consent.

**Organ Preservation While Ascertaining Donor Status or Seeking Family Consent**

As noted above, in the typical case of organ donation, when death has been declared according to neurological criteria, it is standard procedure for hospitals to maintain organ viability until confirmation of donation status is obtained. Many procedures already underway before the potential donor died, such as mechanical ventilation and use of invasive lines, are continued. In addition, the transplant team typically initiates new procedures, such as the following: collecting blood, urine, and sputum for analysis to determine candidacy for donation; beginning new medications in attempts to maintain the now-dead body’s physiologic “balance”; and, if they are not already in place, inserting invasive lines to measure pressure in heart, lungs, and other cardiopulmonary parameters, and to administer medications and fluids.

Under what statutory authority are these procedures now being conducted? In our opinion, the authority is implicit in the provision of the UAGA (and, we are reasonably confident, of every state statute) that authorizes the OPOs’ medical personnel to make a “reasonable search” for information regarding the donor status of the deceased individual. Similarly, the Act authorizes the OPO to make a “reasonable search” for a family member to approach for donation. Although the “reasonable search” clauses do not authorize organ preservation in so many words, the purpose and language of the Act, viewed in its entirety, indicate that organ preservation efforts are an implicit part of a “reasonable search” for donor status or for next of kin.

Were it read otherwise, the pool of available organs would be drastically reduced, frustrating the stated purpose of the UAGA to increase organ donation. If the pool of potential donors is to include the large number of cases where donation status is unknown at the time death is declared, or where the family is not present when death is declared, as the UAGA drafters so clearly intended, hospitals must engage in preservation efforts while consent is being sought. This argument is reinforced by another provision of the UAGA which authorizes the retrieval of organs upon the consent of the person of last resort under state law (e.g., the coroner) after a “reasonable effort” has been made to “locate and inform [next of kin]” of their prerogative to donate organs. This provision assumes, of course, that organs will have been preserved during the search.

This reading of the “reasonable search” clauses of the Act provides the statutory basis for the common practice of preserving organs in cases involving death declared according to neurological criteria. Assuming that this is a correct reading of the Act in brain death cases, there seems to be no legal reason for reading the Act differently in cases involving cardiac death cases. If there is a difference between the two clinical contexts, it has nothing to do with the existence of statutory authority, which would appear to exist in both situations; it must instead relate to a perceived ethical difference between the preservation methods used in the two contexts. Although our purpose here is to address the perceived legal impediments, we do not see any ethically relevant difference between the methods used to preserve organs in cases of brain death and those used to preserve organs in cases of sudden cardiac death. The intra-arterial and intra-peritoneal cooling methods used in case involving cardiac death seem no more invasive than insertion of an arterial line or central line in the bodies of potential brain-dead donors, and consent for the intrusion should be presumed in both situations or neither of them. We believe that consent should be presumed for a short period of preservation in both situations, as the UAGA permits.

**The Immunity Clause**

The UAGA includes a good-faith immunity clause to protect medical personnel from civil and criminal liability for efforts they make to comply with the Act. Section 18(a) of the 2006 Act provides that “[a] person that acts in accordance with this [statute] or with the applicable anatomical gift law of another state, or attempts in good faith to do so, is not liable for the act in a civil action, criminal prosecution, or administra-
tive proceeding.”30 Although state laws have modified the UAGA language in minor respects, the essence has been preserved in most, if not all, states.31

The good faith immunity clause32 can be read in two ways. A narrow reading would immunize someone from liability only if their conduct is specifically and clearly authorized by the “terms of the Act.” However, such a narrow reading would essentially make the good faith clause superfluous because it would do nothing more than declare that a person who complies with the Act cannot be held liable for violating it. Thus, the only plausible reading of the clause is that it immunizes actions that are taken honestly to serve the goals of the Act, even if the language of the Act is ambiguous or the actor did not knowingly violate it. As the UAGA commentary states, the test is subjective: from the beginning, the drafters’ intention clearly has been to encourage doctors, hospitals, and other actors to read the Act liberally to serve its purpose (to encourage organ donation),33 rather than being deterred from doing so by fear of liability for what might turn out to be an incorrect reading of the language. A person would not be immunized, however, for any actions that are expressly forbidden by the Act (i.e., not “in accord with [its] terms”).34 Courts have often referred to the UAGA’s public policy goals when interpreting the “good faith” immunity clause of the UAGA. For example, in Carey v. New England Organ Bank,35 the Superior Court of Massachusetts observed that “a central purpose to the UAGA is to ‘encourage the making of anatomical gifts’... [i]f the court were to construe narrowly the application of the good faith immunity, that would only inhibit the successful recovery of anatomical gifts.”36

Under a proper reading of the UAGA, organ preservation efforts by medical personnel covered by the UAGA would constitute “good faith attempts to comply” with the Act because, as we argued above, they seem to be implicit in the authority to conduct a “reasonable search” for donor status in order to preserve the possibility of organ donation until family members are consulted, and to do otherwise would frustrate the underlying goal of the Act. This is precisely the kind of problem that led the drafters to include the “good faith” immunity clause in the Act.

Indeed, it could be argued that organ preservation pending request from families is not only permitted by the Act, but may actually be required by it. If, as is the goal of the UAGA, organ donation becomes the ordinary expectation of individuals and their families, the real legal risk faced by hospitals may be liability for failing to take steps to preserve the organs, rather than taking such measures without explicit consent.37

The Legal Interests of Families
The previous section of this paper demonstrated that the UAGA provides implicit authorization for organ preservation pending efforts to contact families and to seek their consent to donation. Legally speaking, this authority exists in any case where the deceased person’s wishes are unrecorded and the family has not previously been approached, regardless of whether the deceased has been declared dead according to neurological criteria (involving continued ventilation and often new interventions designed to maintain the body’s physiologic balance) or according to cardiopulmonary criteria (involving the perfusion of the organs and the accompanying incisions). In this portion of the paper, we address the case law pertaining to the

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that the Church (not the heirs of the deceased) held any and all rights to the dead body, and had the duty to assure a proper burial. Early American courts followed suit, holding that no one could have a property right in dead bodies. However, American courts did transfer the duty to bury the dead from the church to the family of the deceased, as a New York appellate court explained in Foley v. Phelps: "the right which inhere in the nearest relative... was a right to the possession of the body for the purpose of burying it; that is to perform a duty which the law required someone to perform." The right to possess the body for burial purposes discussed in the earliest American cases like Foley was not a property right according to any conventional understanding, but was instead a manner of declaring that next-of-kin bore the responsibility for burial and for establishing a legal basis for enforcing that duty.

The principle that the next of kin has a right to possess the body for burial provided the legal foundation for tort actions against persons who interfered with that right or with the family's interest in proper treatment of the body, such as grave robbers who procured the bodies for medical education, and coroners and medical examiners who performed autopsies without proper statutory authorization. As the scientific value of autopsies increased at the end of the 19th century, so too did judicial protection of the next of kin's interests in proper treatment of the deceased's body. Thus, in the 1916 case of Hasselbach v. Mt. Sinai Hospital, an appellate court of New York held that, while there are no property rights in a dead body "in the ordinary commercial sense," the next of kin can recover damages for unauthorized mutilation of the body during autopsy which results in mental suffering, a position that was taken by other state courts as well, and that continues to be the general rule.

It is important to emphasize that these tort actions were generally grounded in the emotional suffering experienced by distressed families as a result of the disturbance, desecration, or mutilation of the body or of the deprivation of an opportunity to bury or otherwise dispose of the body properly in accord with the family's religious beliefs and customs. The family interest being protected by these tort actions has at times been called a quasi-property right and at other times a legitimate claim of entitlement. Regardless of the terminology used, however, the consensus among courts is that the family's interest in the body is not a property right in the traditional sense of the term. Indeed, the very use of the phrase "quasi-property" interest is so incompatible with the historical understanding that Professor Prosser was moved to ridicule it in an oft-quoted passage of his treatise on tort law: A number of decisions have involved the mishandling of dead bodies.... In these cases the courts have talked of a somewhat dubious "property right" to the body, usually in the next of kin, which did not exist while the decedent was living, cannot be conveyed, can be used only for the one purpose of burial, and not only has no pecuniary value but is a source of liability for funeral expenses. It seems reasonably obvious that such "property" is something evolved out of thin air to meet the occasion, and that it is in reality the personal feelings of the survivors which are being protected, under a fiction likely to deceive no one but a lawyer.

The right to recover damages for emotional harm resulting from interference with the family's interest in a proper disposition and preservation of the deceased person's body does not, of course, supersede statutory provisions that authorize autopsies to be performed. Autopsy statutes have long existed in most states, and are typically broadly written, authorizing medical examiners to perform autopsies without family consent whenever they are "in the public interest." The broad language "in the public interest" gives authorities wide latitude in determining when autopsies are necessary. However, in the absence of family consent or explicit statutory authorization, an "autopsy" would clearly amount to "mutilation" under the common-law precedents. Under the legal principles just described, medical examiners and hospitals do not have authority to perform autopsies at will; they must trace their action to a statute in order to avoid liability.

It is clear enough that the customary organ preservation efforts being addressed in this paper do not in any way interfere with the family's right (and duty) to take possession of the body for burial or other disposition. The key question under the precedents summarized above is whether these preservation practices could nonetheless lead to liability for infliction of emotional distress because they amount to "mutilation." In our opinion, the type of intervention undertaken to preserve the deceased person's organs would not provide a plausible basis for liability under these precedents. While autopsies require extensive cutting and examination, organ preservation efforts constitute only slight interferences with a corpse, and are generally limited to the insertion of cooling solution into the body's veins and arteries through a femoral tube, and the accompanying incision. Thus, organ preservation does not constitute the kind of actionable conduct that prevents the possession of the body for burial or grossly alters the state of the corpse. Organ preservation does not delay or prevent the family's ability to
possess the body for burial purposes, and does not signifi-
cantly alter the physical condition of the deceased
individual. Moreover, to the extent that the cause of
action requires a finding of objectively outrageous
conduct or subjectively severe distress, it is highly
unlikely that a trial court would even allow such a case
to get to a jury as long as the hospital and the physi-
cians adhered to the standard of post-mortem care.

In some autopsy cases, courts have expanded upon
their discussion of the family's rights and have made it
clear that families are not entitled to receive the body
exactly as it was when the person died. In fact, quite
the reverse is true: hospitals have an ethical duty —
and perhaps a legal duty, as well — to prevent the
avoidable family distress that can be associated with
seeing the body after it has been put through the inva-
sive and disfiguring procedures often associated with
efforts to save the person's life, especially with resusci-
tative protocols. Not surprisingly, families themselves
have sometimes filed suit when a hospital failed to take
the usual precautions and negligently allowed them to
observe the body in its exact state at death.

Families expect to see their deceased relatives not
as they are at the moment of death in the emergency
room, with tubes still inserted and evidence of the
resuscitative efforts all around, but rather as they
remembered them before the medical crisis arose. In
order to prepare the body for family viewing, hospi-
tals must physically clean the body, remove tape and,
unless an autopsy will be performed, remove all tubes.
The family explicitly authorizes none of these acts,
which are taken out of respect for the dignity of the
deceased and the feelings of the family members. In
short, the steps that are often needed to avoid fam-
ily distress after death of a loved one are much more
invasive and body-altering than the minor incisions
and insertion of tubes needed for organ preservation
in cases of uncontrolled cardiac death.

We are not suggesting that altering the body to pre-
serve organs is the same as cleaning and preparing
the body for family viewing. The latter ameliorates
the effects of necessary life-saving efforts, while the
former effectuates a new intrusion. Rather, our point is
that the legal obligations arising in post-mortem care
are not grounded in any prohibition against "altering
the body." Instead, the gravamen of any legal obliga-
tion lies in unjustifiably causing distress to the family.
Viewed from this perspective, the practice of perfusing
the deceased person's organs for the purpose of pro-
tecting the family's opportunity to donate them should
be seen not as an unwarranted alteration of the body
or an interference with the family's rights, but rather
as an expression of respect for the family's ultimate
prerogative to allow the deceased person to become an
organ donor. We do not mean to suggest that hospitals
would be liable for failing to preserve the organs, but
it should be abundantly clear that there is no plausible
basis for holding them liable for doing so.

In sum, organ preservation in cases of uncontrolled
cardiac death violates no legally protected interest of
the family members. It does not constitute "mutilation
of the body" and falls comfortably within the general
principle that hospitals have no duty to deliver corpses
to families in their exact condition at death. Alteration
of the body for the purpose of perfusing organs, if car-
ried out in accord with the standard of post-mortem
care, would not provide an objective basis for a find-
ing of severe emotional distress, and would be more
likely regarded, ex ante, as an expression of respect for
families and as a proper measure for preserving the
opportunity to bestow the gift of life on someone else.
We feel quite confident in concluding that the com-
mon-law precedents provide little basis for a cause of
action by the family of a deceased person for preserv-
ing organs while seeking their consent for donation.
The risk of liability is de minimis.

Recent Constitutional Litigation
Recent constitutional litigation relating to post-mor-
tem recovery of body parts has introduced a new wrin-
gle into the legal conversation by connecting the tra-
ditional common-law principles just described with
modern case law under the due process clause. The
recent litigation relating to this problem has arisen
in challenges to state statutes authorizing retrieval of
corneas during autopsies without the advance con-
sent of families. The families' main claim is that these
statutes deprive them of their "property" without due
process of law. Courts have been divided on these
claims, which we will discuss below. It is important to
make a pivotal point at the outset: even if the families
are said to have a "property" interest in the deceased
person's body under state law, and even if the retrieval
of body parts without consent of the next of kin would
be constitutionally suspect, the perfusion of the organs
while seeking family consent does not deprive them of
that interest and is entirely consistent with the charac-
terization of the family's interest as a "property" inter-
est for constitutional purposes. From this standpoint,
everything that follows is a digression. However, we
undertake the digression because these cases are too
easily misunderstood as harbingers of a fundamental
transformation of the law governing organ removal.

Although state legislatures and courts have recog-
nized and protected family interests in possessing the
body, making burial decisions and, more recently, in
making decisions about donation of body parts, these
interests do not amount to property interests. More-
over, these interests are derived entirely from state law and have no independent constitutional protection. The thin nature of these family interests under state law is amply illustrated by the fact that they are superseded in every state by legally authorized autopsies, and — even more tellingly — by the fact that a state could constitutionally adopt a presumed consent (opt-out) model displacing the family’s decision-making role altogether. Finally, even though states have chosen to adopt an opt-in model and to confer on families the prerogative to decide whether to donate body parts in the absence of a decision by the deceased person, it does not follow that the state must treat all body parts the same. In effect, corneal retrieval statutes make an exception to the opt-in model for this particular body part.

The traditional understanding is summarized by the Florida Supreme Court in State v. Powell (1986), which upheld a cornea removal statute over claims that it violated the family members’ right to possess the corpse of their relative.60 The court concluded that the family’s right to possession of a corpse is limited to the right to possession for burial, and does not amount to a right to possess the body exactly as it was at the moment of death.61 Because cornea removal only slightly alters the corpse and does not interfere with the family’s right to possession for burial, the court found that the cornea statutes did not interfere with the traditionally recognized rights of the family. In upholding the statute, the court noted that cornea procurement constitutes a much smaller invasion of the body than does an autopsy (which is allowed without family consent under Florida law as well as the laws of every other state), and that the statute was enacted to advance an important public goal (decreasing the number of blind people in the state by making cornea transplants available to more people).62

Unfortunately, two federal circuit courts have departed from this traditional analysis in two corneal recovery cases. They have concluded that, by recognizing families’ rights to possess the body for burial and to make donation decisions under the UAGA, the state has created what amounts to a “property” interest in the bodies of deceased kin for purposes of the due process clause of the Fourteenth Amendment. As a result, removal of corneas under some circumstances can amount to a deprivation of property without due process of law. In Brotherton v. Cleveland (6th Cir. 1991),63 the Sixth Circuit Court of Appeals held that a county coroner’s practice of removing corneas during autopsies without reading the medical records denied due process to families who had specifically declined to give their consent to organ donation. If the coroner had known about the family’s refusal, the corneal removal statute would have prohibited removal of the corneas. Based on these facts, one can easily understand why the family was moved to sue the coroner and why the federal court was moved to invalidate the coroner’s practice. However, the court could not have reached the result it wanted without establishing the necessary premise — i.e., that the family interests protected under Ohio law amounted to a “property” interest for constitutional purposes.64 Unfortunately, the court used unnecessarily broad language in support of this conclusion. A careful reading of this case would limit it to its unusual facts.

In Newman v. Sathyavagiswaran (9th Cir. 2002),65 the Ninth Circuit Court of Appeals reviewed family objections to corneal removal under a California statute similar to the Ohio statute (authorizing the retrieval of corneas during autopsies as long as the coroner had no knowledge that a family had objection to removal). The problem revealed in this case is that no one made any effort to find out whether families had any objection. As noted above, the California Assembly could have simply directed routine removal of the corneal tissue, making corneal tissue an exception from the general explicit consent (opt-in) rule under UAGA. But it chose instead to create an opt-out model, without establishing any procedures for giving families notice of their right to opt-out. Again, one can understand why the federal court found California’s approach troubling from a due process standpoint. However, in order to reach the conclusion that this odd approach amounted to a constitutional violation, Ninth Circuit had to embrace the premise that the California statutes had created a “property” interest for purposes of the due process clause. As the court explained:

When the coroner removed the corneas from the bodies of the parents’ deceased children and transferred them to others, the parents could no longer possess, control, dispose or prevent the violation of those parts of their children’s bodies. To borrow a metaphor used when the government physically occupies property, the coroner did not merely “take a single ‘strand’ from the ‘bundle’ of property rights; it chop[ped] through the bundle, taking a slice of every strand.”66

In effect, the court said, because the state had decided to accord families the prerogative to decide whether or not to donate body parts, and had not altogether erased that prerogative for corneal tissue, it had recognized a “property” interest in the organs for con-
stitutional purposes (whatever it is called under state law). \(^67\)

It should be apparent that *Brotherton* and *Newman* reflect understandable responses by two federal courts to awkwardly written and poorly conceptualized corneal removal statutes. Notwithstanding the courts' sweeping language, however, it would be a mistake to view these cases as establishing that families have "property" rights in dead bodies. To do so would reverse the settled understanding that the families' interests, all of which are contingent on state law, are limited to possessing the body for burial and making decisions about organ donation when the deceased person has failed to make one.

The corneal removal litigation has involved the application of federal civil rights statutes to alleged infringements of state-created "property" rights. But, families can also characterize their due process claims in terms of infringements of their liberty interests in making decisions about the disposition of the body. Accordingly, let us suppose that courts were also to conclude that the opt-in, explicit consent model established by the UAGA has created a constitution-absence of a donor decision) whether the deceased person's organs should be retrieved for transplantation is not based on and does not entail the much broader principle that families own the deceased person's body or that they have the same "right to decide what shall be done with the body" that a live person has. Instead, the families' decisional prerogative is derived entirely from the authority conferred upon them by state statutes enacted in the wake of the UAGA to make decisions regarding the donation of body tissues and organs. In the absence of such statutory authority, they would have no constitutionally protectable interests of their own. \(^69\)

In sum, the aberrant decisions in *Newman* and *Brotherton*, if properly understood, are not likely to shape the future development of state organ donation laws. Although their reasoning deviates from longstanding authority regarding the limited nature of families' interests in the bodies of their kin, these cases should be read in the peculiar context of poorly conceived state corneal retrieval statutes. In any case, they should have no impact on any future litigation regarding unauthorized organ preservation. Cornea removal

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The gap between the number of organs available for transplant and the number of individuals who need transplanted organs continues to increase. At the same time, thousands of transplantable organs are needlessly overlooked every year for the single reason that they come from individuals who were declared dead according to cardiopulmonary criteria.

...
lessly overlooked every year for the single reason that they come from individuals who were declared dead according to cardiopulmonary criteria. Expanding the donor population to individuals who die uncontrolled cardiac deaths will reduce this disparity, but only if organ preservation efforts are utilized. Concern about potential legal liability for temporary preservation of organs pending a search for family members appears to be one of the impediments to wider use of donation in cases of uncontrolled cardiac death in states without statutes explicitly authorizing such action. However, we think that the risk of liability for organ preservation under these circumstances is de minimis, and that concerns about legal impediments to preservation should yield to the ethical imperative of undertaking it.

References
1. See, generally, J. F. Childress and C. T. Liverman, eds., Organ Donation: Opportunities for Action (Washington, D.C.: National Academies Press, 2006): at 205-228. Some have argued that a person’s consent for organ donation should be presumed in the absence of evidence of a decision to withhold donation. Under such a legal regime, the family’s traditional prerogative to make the decision regarding organ donation would be displaced by a more limited role of showing that the deceased person, while living, expressed a desire to decline donation, thereby rebutting the presumption of consent. For discussion of presumed consent, see G. Siegal and R. J. Bonnie, “Closing the Organ Donation Gap: A Reciprocity-Based Social Contract Approach,” Journal of Law, Medicine & Ethics 34, no. 2 (2006): 415-423.
2. See Childress and Liverman, supra note 1, at 153-154.
3. Id.
4. Three jurisdictions have statutory law authorizing organ preservation while family members are being contacted: Washington, D.C., Virginia, and Florida; see Childress and Liverman, supra note 1, at 154. These statutes appear to have been adopted specifically to authorize preservation in cases involving cardiac death.
5. It would be impractical and unethical to press families to decide on the spot about organ donation (which would be required if preservation procedures were impermissible). It would also be unethical to approach families about donation before the declaration of death. Therefore, even for the most decisive families, some time after death is declared will be needed to inform them of death, approach them about donation, and allow them to decide. Even for families already at the hospital who know that death is imminent and who already have decided to consent to donation, 30-60 minutes are needed before consent can be finalized.
6. See, e.g., C. J. Doig and G. Rocker, “Retrieving Organs from Non-Heart-Beating Organ Donors: A Review of Medical and Ethical Issues,” Canadian Journal of Anesthesia 50, no. 10 (2003): 1069-1076, at 1069. As a result, “Of the more than 2 million deaths that occur each year in the United States, it is estimated that there are only 10,500 to 16,500 eligible donors for whom death is determined by neurological criteria.” See Childress and Liverman, supra note 1, at 151.
8. As far as we know, the permissibility of organ preservation in uncontrolled cardiac death has never been litigated in the United States.
10. U.S. Department of Health and Human Services Advisory Committee on Organ Transplantation Recommendations, available at <http://www.organdonor.gov/research/acot.htm> (last visited October 2, 2008). The UAGA has undergone several revisions, resulting in new versions in 1987 and 2006. While all states have adopted some form of the UAGA, many have made slight modifications to the text of the Uniform Act, resulting in a regrettable decline of uniformity. Nonetheless, the provisions on which we rely in this article appear to have been adopted intact in most states; accordingly we will ordinarily refer to the language of the Uniform Act itself, rather than to the text of specific state statutes.
12. Uniform Anatomical Gift Act §2 (1968); id.
13. Uniform Anatomical Gift Act §2(b) (1987): An anatomical gift that is not revoked by the donor before death is irrevocable and does not require the consent or concurrence of any person after the donor’s death; id.
19. The 2006 revision of the UAGA aims to remove one source of confusion that has arisen in cases in which people who have executed organ donation documents have also executed advance health care directives directing the withholding or withdrawing of life-sustaining treatment under specified circumstances or directing or authorizing health care agents to withhold or withdraw such treatment. Which document controls these circumstances? In § 21(b), the Act directs that the organs be preserved while the conflict is being resolved: “Before resolution of the conflict, measures necessary to ensure medical suitability of the [organs] may not be withheld or withdrawn” unless doing so is contraindicated by appropriate end-of-life care.
21. After persons have been declared dead according to neurological criteria, their bodies often have wide physiologic fluctuations due in part to the loss of hormone production and regulation in the brain. Interventions undertaken to preserve organs commonly include administration of IV drugs to help control blood pressure and level of smooth muscle contraction in the vessels to maintain organ perfusion without fluid overload; administration of IV drugs to regulate fluid regulation (pressure/death of hypothalamus/pituitary-anti-diuretic hormone control); and continued use and adjustment of IV fluids to maintain fluid balance.
22. These invasive lines include arterial lines (tubes in artery to measure heart contractions, and workload on heart and lungs).
23. See Uniform Anatomical Gift Act (2006), §14(a) ("When a hospital refers an individual at or near death to a procurement organization, the organization shall make a reasonable search of relevant records to ascertain whether the individual has made an anatomical gift.")

24. See Uniform Anatomical Gift Act (2006) §14(g) ("Upon referral by a hospital, a procurement organization shall make a reasonable search for [the pertinent family member or other person authorized] to make an anatomical gift on behalf of a prospective donor.") The drafters of the UAGA added a new provision in 2006 requiring organ preservation for the period needed to conduct an examination to determine the medical suitability of the potential donor's organs unless the deceased person is known to have expressed a contrary intent. See §14(c) of the UAGA (2006). As we read the Act, then, organ preservation is mandatory for the examination period and permitted thereafter for a reasonable period while the family members are being sought and consulted.


27. This common-sense reading is confirmed by a federal court's construction of California's version of the UAGA in Jacobsen v. Marin General Hospital, 963 F. Supp. 866 (N.D. Cal. 1997), aff'd 192 F.3d 881 (9th Cir. 1999). Jacobsen had been brought to the hospital after he was found unconscious on the side of the highway, having suffered from head trauma of unspecified cause. A search for the next of kin began within hours and continued after he was declared dead according to neurological criteria. His organs were preserved while the search continued for another day. Eventually, when the search did not lead to identification of next of kin, the coroner consented to recovery of the organs. A year later, in a federal diversity action, Jacobsen's parents sued the coroner, the hospital and the OPO for various torts arising out of the recovery of the organs. Among other rulings, the federal district court ruled as a matter of law that the search—which had actually been conducted by the coroner, the Sheriff, and the FBI—had been "reasonable" under the California Anatomical Gift Act. In the course of its ruling, the court assumed that preservation of the organs during the search was authorized by the Act.


29. Unfortunately, it appears the American Medical Association (AMA) does not acknowledge the inconsistency between its support for organ preservation without explicit consent in the context of brain death and its insistence on explicit consent in the context of cardiac death. See AMA, Code of Ethics, Organ Procurement Following Cardiac Death, Section E-2.157, available at <http://www.ama-assn.org/ama/pub/category/8447.html> (last visited October 2, 2008). However, this guidance is consistent with the AMA's 2001 policy on procedures for the newly dead for instructional purposes, such as medical students practicing intubation on recently deceased patients. See AMA, Code of Ethics, Performing Procedures on the Newly Deceased for Training Purposes, Section 8.181, available at <http://www.ama-assn.org/apps/pf_new/pf_online?n=browse&doc=policies&HnE=E-8.181.HTM&SRS_0=t&SC_0=p&SN=1&prev_poi=policies&HnE=E-7.05.HTM&nat_poi=policies&HnE=E-8.01.HTM&> (last visited October 2, 2008).


31. Virginia's illustrative version of the good-faith immunity clause mirrors the original UAGA, stating that "A person who acts in good faith in accord with the terms of this article, or under the anatomical gift laws of another state or a foreign country is not liable for damages in any civil action or subject to prosecution in any criminal proceeding for his act." Virginia Code. Ann., §32.1-295 (2006).

32. Several cases have analyzed the good-faith immunity clause's relationship with the rest of the UAGA, although none has raised any issue regarding organ preservation efforts or whether a "reasonable search" includes organ preservation where the search is conducted. See Nicoletta v. Rochester Eye and Human Parts Bank, 519 N.Y.S.2d 926 (N.Y. 1987); Perry v. Saint Francis Hospital and Medical Center, 886 F. Supp. 1551 (D. Kan. 1995); Seaman's v. Harris County Hospital, 934 S.W.2d 393 (Tex. App. 1996); Carey v. New England Organ Bank, 17 Mass. L. Rptr. 582 (Mass. Sup. Ct. 2004); Colacito v. New York Organ Donor Network, 355 F. Supp. 2d 237 (E.D.N.Y. 2005).


34. In Nicoletta v. Rochester Eye and Human Parts Bank, 519 N.Y.S. 2d 926 (1987), a New York appellate court defined the term "good faith" to mean "an honest belief, the absence of malice and the absence of design to defraud or seek an unconscionable advantage." In Perry v. Saint Francis Hospital and Medical Center, 886 F. 1551 (D. Kan. 1995), the United States District Court for the District of Kansas adopted and expanded on the Nicoletta definition of good faith and observed that the immunity clause "extends protection to doctors and hospitals in all instances but where the challenged actions violate or exceed the terms of UAGA and are taken without a good faith effort to comply with UAGA." See Carey, supra note 32, at 17 Mass. L. Rptr. 582 (2004).

35. Id., at 582. See also Seamans v. Harris County Hospital District, 934 S.W. 2d 393 (Tex. App. 1996).

36. Two recent cases interpret the UAGA and the good-faith immunity clause in situations in which families desired organ donation, rather than opposed it. Carey v. New England Organ Bank, 17 Mass. L. Rptr. 582 (Mass. Sup. Ct. 2004), involved parents who sued the hospital where their son died and its affiliated organ procurement center when their expressed wish that his tissue be donated was unfulfilled. Colacito v. New York Organ Donor Network, 355 F. Supp. 2d 237 (E.D.N.Y. 2005), centered on a wife who sued the organ donation network that failed successfully to donate both of her husband's kidneys, as she had desired. Neither claim was successful because the defendants were found to be immune from liability under the good-faith immunity clause of the UAGA. These plaintiffs counter the commonly held view that families who sue in organ donation cases are families who oppose interference with their deceased relative's remains. Clark, supra note 6, at 937.

37. Neuman v. Sathyavagiswaran, 287 F.3d 786, 790 (9th Cir. 2002).

38. Id., citing Bessemer Land & Improvement Co. v. Jenkins, 111 Ala. 135, 18 So. 565, 567.


40. See Newman, supra note 38, at 287 F.3d, at 791. ("As cases involving unauthorized mutilation and disposition of bodies increased toward the end of the 19th century, paralleling the rise in demand for human cadavers in medical science and use of cremation as an alternative to burial... courts began to recognize an exclusive right of the next of kin to possess and control the disposition of the bodies of their dead relatives, the violation of which was actionable at law.")


42. See Alderman v. Ford, 72 F.2d 981 (Kan. 1937); Woods v. Graham, 167 N.W. 113 (Minn. 1918); Lashbrook v. Barnes, 437 S.W. 2d 502 (Ky. 1969); Arnaud and Tolliver v. Odom, 870 F.2d 304 (5th Cir. 1989); Crocker v. Pleasant, 778 So.2d 978 (Fla. 2001).

43. Fuller v. Marx, 724 F.2d 717 (8th Cir. 1984).

44. Brathtown v. Cleveland, 923 F.2d 477 (6th Cir. 1991).

45. See Hasselbach, supra note 42, at 159 N.Y.S., at 378.


49. Harris-Cunningham v. Medical Examiner of New York County, 261 A.D. 2d 285, 285 (N.Y. 1999) (explaining that "We reject petitioner's argument that under [the] Public Health Law, the Medical Examiner was under an affirmative duty to seek the consent of a surviving family member or friend, and that absent such consent, or 'compelling public necessity,' could not perform the autopsy.")

50. The Virginia statute on autopsies states, "If in the opinion of the medical examiner investigating the death or of the Chief Medical Examiner, it is advisable and in the public interest that an autopsy be made... an autopsy shall be performed." Virginia Code Ann. §32.1-285; The Virginia statute on dead bodies for scientific study states, "Any person having charge or control of any dead human body which is unclaimed for disposition, which is required to be buried at the public expense, or which has been lawfully donated for scientific study shall notify the Commissioner whenever and as soon as such body comes to his possession, charge, or control and shall, without fee or reward, permit the Commissioner or his agents to remove such body, to be used for the advancement of health science." Virginia Code Ann. §32.1-298.


52. See Darcy v. The Presbyterian Hospital in the City of New York, 202 N.Y. 259, 265 (N.Y. 1911) (Explaining that an autopsy not authorized by state statute was a misdemeanor).

53. See Foley, supra note 40, at 1 A.D. 551.

54. For a recent case emphasizing the conventional view that a "common law cause of action for intentional mutilation of a corpse is essentially a cause of action for intentional infliction of emotional distress" requiring proof of "extreme and outrageous conduct that was intended to cause, or recklessly disregarded the probability of causing, emotional distress," see Jacobsen v. Marin General Hospital, 192 F.3d 881, 887 (9th Cir. 1999). In Jacobsen, the Ninth Circuit held that such a cause of action would not lie against a hospital and OPO that recovered organs from a deceased person after an unsuccessful effort to identify the next of kin because their conduct could not have been intended to cause emotional distress in such a case.

55. See Hasselbach, supra note 42, at 159 N.Y., at 378.

56. Wages et al., 235 Ga. App., at 156 (The family of a deceased woman sued for negligent mishandling of a body killed in a car accident when they entered the emergency room after her death and discovered the body in the state it was in at the time death was declared. As the court explained, "[a]n intubation device protruded from her mouth, which was pooled with saliva and blood. Various tubes and IV devices were connected to her body. Her hair was matted with blood and vomit, and her face and body were caked with blood, broken glass, dirt, gravel, and grass.")

57. See Hasselbach, supra note 42, at 159 N.Y., at 378.

58. We did not say that the risk of liability is zero; that would be foolhardy. For example, a misguided court might conclude that a family deeply offended by a hospital effort to preserve organs might recover for their distress on the theory that even a minor non-restorative alteration of the body after death without family consent is tortious. See the analysis of this theoretical possibility in Clark at 943, referring to the possibility of a broad reading of the phrase "operates upon the body of a dead person" in the Restatement (Second) of Torts, § 868 (1977).

59. See Childress and Liverman, supra note 1, at 240. These states include Florida, Georgia, Ohio, and California.

60. See Powell, supra note 47, 497 So.2d., at 1192.

61. Id., ("Rights in a dead body exist ordinarily only for purposes of burial and, except with statutory authorization, for no other purpose.")

62. Id., at 1191.


64. Brotherton, 923 F.2d., at 482. ("Although extremely regulated in sum, these rights form a substantial interest in the dead body, regardless of Ohio's classification of that interest. We hold the aggregate of rights granted by the state of Ohio to Deborah Brotherton rises to the level of a 'legitimate claim of entitlement' in Steven Brotherton's body, including his corneas, protected by the due process clause of the fourteenth amendment.")

65. Brotherton, 923 F.2d. 477; Newman 497 So.2d 1188.


67. That is not the end of the constitutional analysis. The state may deprive the family of its property interest as long as it affords them due process of law. For present purposes, this means that the state has to justify drawing a distinction between corneal tissue and other body parts. This can easily be done. However our concern in this paper is the misguided premise that the family has a property interest.


69. As with the property analysis, it is possible that the family decisional prerogative recognized by state statutes such as the UAGA has created a liberty interest for purposes of the due process clause such that the state is barred from allowing recovery of corneal tissue without advance family consent. Proponents of this position must also confront the same conceptual hurdle: The families' decisional prerogative in organ donation is a creature of state law. Having recognized family prerogatives for most body parts, why is the state precluded from making an exception for corneal tissue?