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Giving the Gift of Life: A Survey of Texas Law Facilitating Organ Donation.

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GIVING THE GIFT OF LIFE: A SURVEY OF TEXAS LAW FACILITATING ORGAN DONATION

ERIC C. SUTTON*

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This article is dedicated to the memory of my son, Richard Eric Sutton.

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I. INTRODUCTION

The development of new and improved drug therapies, combined with refinement of surgical techniques has ushered in a new era in medicine wherein the transplantation of human organs and tissues into the bodies of dying or seriously ill patients has become common place.[1] For some individuals, transplantation is the only treatment standing between them and certain death. For others, transplantation offers the only real opportunity to significantly improve the quality of their lives.

As of October 1990, 21,730 persons were on the United Network for Organ Sharing's transplant waiting list for a kidney, heart, heart and lung, liver, lung or pancreas.[2] Despite the need and demand for organs suitable for transplantation, many people die while awaiting transplantation because of an acute shortage in the availability of organs.[3] In order to address the problem of the shortage of donated

1. *See* Starzl, *Transplantation*, 256 J. A.M.A. 2110 (Oct. 17, 1986) (cyclosporine drug created avalanche of cadaveric transplantations).

2. United Network for Organ Sharing, 6 UNOS UPDATE 22 (Special Edition) (Nov. 1990).

3. THE PARTNERSHIP FOR ORGAN DONATION, INC., AND THE ANNENBERG WASHING-

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organs for transplantation, as well as to provide for a rational and equitable system of allocation of donated organs, numerous federal and state laws were developed to facilitate and encourage the donation, retrieval, and use of organs and tissues for transplantation. At the federal level, the United States Congress promulgated legislation leading to the creation of a National Organ Procurement and Transplantation Network to regulate the procurement and distribution of organs for transplantation.[4]

At the state level, numerous laws were enacted to govern donations of organs, determination of a potential donor's death, and the role of hospitals in encouraging and facilitating organ transplantation. The laws governing transplantation are, therefore, a combination of both federal and state enactments which are intertwined and form a vital link in the chain of events and circumstances leading from organ recovery and donation to organ transplantation.

What follows is a summary analysis and critique of those Texas statutes which have been enacted to encourage, facilitate, and regulate the transplantation of cadaveric organs for transplantation.[5] All of these laws are essential components of the system which has evolved to make transplantation a viable treatment that prolongs and improves the quality of peoples' lives.

TON PROGRAM IN COMMUNICATIONS POLICY STUDIES OF NORTHWESTERN UNIVERSITY, SOLVING THE DONOR SHORTAGE BY MEETING FAMILY NEEDS: A COMMUNICATIONS MODEL, Consensus Report 2 (1990); *see also* Mertz, *The Organ Procurement Problem: Many Causes No Easy Solutions*, 254 J. A.M.A. 3285 (Dec. 1985).

4. National Organ Transplant Act, Pub. L. 98-507, title II, § 201, 98 Stat. 2344 (codified at 42 U.S.C. § 274 (Supp. IV 1986)). The National Organ Transplant Act mandated that the United States Secretary of Health and Human Services contract with a private not-for-profit entity to organize and maintain a National Organ Procurement Network on behalf of the federal government. *See id.* The contract for establishment of the network has been awarded to The United Network for Organ Sharing. For an analysis of the responsibility of UNOS in creation of the National Organ Procurement Network, see McDonald, *The National Organ Procurement and Transplantation Network*, 259 J. A.M.A. 725-26 (Feb. 5, 1988) and Prottas, *The Structure and Effectiveness of the U.S. Organ Procurement System*, 22 INQUIRY 365-76 (Winter 1985) (analysis of system for procuring organs prior to establishment of the National Organ Procurement Network).

5. Cadaveric organ transplantation is the retrieval of organs from individuals who have been diagnosed as clinically dead (brain dead), but whose heart functions, respiration and circulation are being maintained by artificial mechanical means. A discussion of the legal issues related to living organ and tissue donation is beyond the scope of this paper.

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II. DETERMINATION OF DEATH

A. *Introduction*

Numerous Texas statutes have been enacted which address the consequences of an individual's death. For example, these laws outline the requirements for: (i) making a testamentary gift of a person's property upon their demise;[6] (ii) designating who is to receive their property when an individual has died intestate;[7] (iii) establishing a method for collecting damages for wrongful death;[8] and (iv) punishing a person who is found criminally culpable for the death of another.[9] However, none of these statutes specifically define how death is determined.

B. *Historical Background*

Traditionally, "the accepted standard for determining death" was couched in terms of "the permanent cessation and absence of respiration and circulation."[10] The invention of respirators and other mechanical devices which could maintain a person's respiration and circulation of blood throughout the body for an indefinite period of time began to raise the question of whether such a traditional definition was still applicable.[11] The development of organ and tissue transplantation as a viable treatment for many diseases and disorders added additional fuel to the debate over whether traditional definitions of death were adequate to deal with these revolutionary advances in medicine.[12]

As a result of this controversy, new medical criteria for defining

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6. TEX. PROB. CODE ANN. § 59 (Vernon 1980).

7. *Id.* § 38.

8. TEX. CIV. PRAC. & REM. CODE ANN. § 71.001 (Vernon 1980).

9. TEX. PENAL CODE ANN. § 19.01 (Vernon 1989).

10. PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL RESEARCH, DEFINING DEATH: MEDICAL, LEGAL, AND ETHICAL ISSUES IN THE DETERMINATION OF DEATH 3 (1981) [hereinafter Report of President]. For quite some time Black's Law Dictionary had been defining death as: "The cessation of life; defined by physicians as the total stoppage of the circulation of the blood, and a cessation of the animal and vital functions consequent thereon, such as respiration, pulsation, etc." BLACK'S LAW DICTIONARY 488 (4th ed. 1968).

11. *See When is a Patient Dead*, 204 J. A.M.A. 1000 (June 10, 1968) (vital signs alone no longer adequate method of determining death).

12. *See* Capron & Kass, *A Statutory Definition of the Standards for Determining Death: An Appraisal and a Proposal*, 121 U. PA. L. REV. 87, 89 (1972) (undermining status of beating heart as most reliable sign that person is alive).

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death which combine the concept of "brain death" with the common law definition of "death" were developed.[13] This criteria establishes the principal that a "brain . . . that no longer functions and has no possibility of functioning again is for all practical purposes dead."[14] This view is of particular significance to the transplant community since the vast majority of solid organs are "harvested" from individuals whose heart beat, blood circulation, and respiration are maintained by artificial means, but whose brain functions have spontaneously and irreversibly ceased.[15] The reason for this is that "once a donor's breathing and heartbeat cease . . . the solid organs are damaged and quickly become nonviable for transplantation."[16]

C. *Emergence Of A Change In Statutory And Case Law*

In the 1970's the development of this new criteria for determining death, founded in part upon analysis of brain function, gradually made its way into legislative debate and courtroom controversies. The state of Kansas adopted the first statutory revision of the common law definition of death by merging language defining death in terms of the "absence of spontaneous respiratory and cardiac function" with alternative wording which viewed death as the "absence of spontaneous brain function."[17]

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13. *See, e.g.*, Report of the Ad Hoc Committee of the Harvard Medical School to Examine the Definition of Brain Death, *A Definition of Irreversible Coma*, 205 J. A.M.A. 85 (Aug. 5, 1968) [hereinafter Ad Hoc Committee] (defines irreversible coma as new criteria for death); Report of the Medical Consultants on the Diagnosis of Death to the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Guidelines for Determination of Death*, 246 J. A.M.A. 2184 (Nov. 13, 1981) [hereinafter Medical Consultants] (proposing adoption of Uniform Determination of Death Act); Ashwal & Schneider, *Brain Death in Children: Part I*, 3 PEDIATRIC NEUROLOGY 5 (January-February 1987) (reviewing historical data and guidelines for determining brain death during childhood).

14. Ad Hoc Committee, *supra* note 13, at 85.

15. A significant number of kidney transplants are performed using a kidney removed from a living related organ donor. Segments of livers are also now being transplanted from living related donors.

16. THE NEW YORK STATE TASK FORCE ON LIFE AND THE LAW, TRANSPLANTATION IN NEW YORK STATE: THE PROCUREMENT AND DISTRIBUTION OF ORGANS AND TISSUES 21 (1988).

17. KAN. STAT. ANN. § 77-202 (Supp. 1980) (repealed by Act of July 1, 1984, ch. 345, § 4); *see also* State v. Schaffer, 624 P.2d 440, 447 (Kan. 1981) (quoting full text of section 77-202). The original definition of death adopted by Kansas was replaced by a new statutory definition under the state's Uniform Determination of Death Act. *See* KAN. STAT. ANN. § 77-205 (1984). The new statute provides that: "[a]n individual who has sustained either (1) irre-

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The question of which criteria to use to determine death also became an issue argued in the courtroom.[18] Interestingly, many of the cases confronting this issue involved criminal prosecutions for first degree murder wherein the defendant argued that brain death criteria were improperly used to establish that the defendant had caused a person's death.[19] Eventually, the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (hereafter referred to as President's Commission) concluded that the traditional definition of death should be restated in a uniform statutory law to be adopted by all states.[20] In adopting this recommendation, the President's Commission joined by the American Medical Association, the American Bar Association and the National Conference of Commissioners On Uniform State Laws endorsed the Uniform Determination of Death Act (hereafter referred to as the UDDA).[21] This model act provides, in part, that: "An individual who has sustained either (1) irreversible cessation of circulatory and respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards."[22]

The vast majority of states and the District of Columbia, following the Uniform Determination of Death Act model or drafting their own

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versible cessation of circulatory and respiratory functions, or (2) ireversible *cessation of all functions of the entire brain, including the brain stem*, is dead. A determination of death must be made in accordance with accepted medical standards." *Id.* (emphasis added).

18. *See* Tucker v. Lower, No. 2831, at 98-100 (Richmond, Va. L. Eq. Ct. May 23, 1972).

19. *See, e.g.*, Commonwealth v. Golston, 366 N.E.2d 744, 748 (Mass. 1977); Arizona v. Fierro, 603 P.2d 74, 76-77 (Ariz. 1979); State v. Watson, 467 A.2d 590, 590-91 (N.J. Super. Ct. App. Div. 1983); Nebraska v. Meints, 322 N.W.2d 809, 812 (Neb. 1982); People v. Eulo, 472 N.E.2d 286, 288-89 (N.Y. 1984).

20. Report of President, *supra* note 10, at 1.

21. *Id.* at 2. The complete text of the Uniform of Determination of Death Act is as follows:

> Section 1. [Determination of Death] An individual who has sustained either (1) irreversible cessation of circulatory or respiratory functions, or (2) irreversible cessation of all functions of the entire brain, including the brain stem, is dead. A determination of death must be made in accordance with accepted medical standards.
>
> Section 2. [Uniformity of Construction and Application] This act shall be applied and construed to effectuate its general purpose to make uniform the law with respect to the subject of this Act among states enacting it.
>
> Section 3. [Short Title.] This Act may be cite as the Uniform Determination of Death Act.

22. *Id.* at 2.

definition, have now enacted statutes establishing brain death as one of the criteria for determining death.[23] The concept of determining death, using both traditional standards and more modern brain death criteria, now appears fully integrated into both standard medical practice and the legal system.[24]

D. *The Texas Statute Defining Death*

In 1979, the Texas legislature adopted a statutory determination of death act and in 1989 codified this legislation in the Texas Health and Safety Code.[25] The act provides as follows:

> § 671.001. Standard Used for Determining Death
> (a) A person is dead when, according to ordinary standards of medical practice, there is irreversible cessation of the person's spontaneous respiratory and circulatory functions.
> (b) If artificial means of support preclude a determination that a person's spontaneous respiratory and circulatory functions have ceased, the person is dead when, in the announced opinion of a physician, according to ordinary standards of medical practice, there is irreversible

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23. ALA. CODE § 22-31-1 (1984); ALASKA STAT. § 09.65.120 (Supp. 1987), ARK. CODE ANN. § 20-17-101 (Supp. 1983); CAL. HEALTH & SAFETY CODE § 7180 (West Supp. 1989); COLO. REV. STAT. § 12-36-136 (1985); CONN. GEN. STAT. ANN. § 19a-504(a) (West 1986); DEL. CODE ANN. tit. 24, § 1760 (1987); D.C. CODE ANN. § 6-2401 (Supp. 1988); FLA. STAT. ANN. § 382.085 (West 1986); GA. CODE ANN. § 31-10-16 (1985); HAW. REV. STAT § 327C-1 (Supp. 1984); IDAHO CODE § 54-1819 (1988); ILL. ANN. STAT. ch. 110 1/2, para. 302(b) (1978); IND. CODE ANN. § 1-1-4-3 (West 1988); IOWA CODE ANN. § 702.8 (West 1979); KAN. STAT. ANN. § 77-202 (1980) (repealed by Act of July 1, 1984, ch. 345, § 4); KY. REV. STAT. ANN. § 446.400 (Michie/Bobbs-Merrill Supp. 1988); LA. REV. STAT. ANN. § 9:111 (West Supp. 1989); ME. REV. STAT. ANN. 22, § 281 (Supp. 1988); MD. HEALTH-GEN. CODE ANN. § 5-202 (Supp. 1982); MICH. COMP LAWS ANN. § 333.1021 (West 1980); MISS. CODE ANN. § 41-36-3 (1981); MO. ANN. STAT. § 194.005 (Vernon 1982); MONT. CODE ANN. § 50-22-101 (1987); NEV. REV. STAT. § 451.007 (Michie 1986); N.H. REV. STAT. ANN. § 141-D:2 (Supp. 1987); N.M. STAT. ANN. § 24-2-5 (1988); N.C. GEN. STAT. § 90-323 (1985); OHIO REV. CODE ANN. § 2108.30 (1987); OKLA. STAT. ANN. tit. 63, § 1-301(g) (West Supp. 1989); OR. REV. STAT. § 432.300 (1987); PA STAT. ANN. tit. 35 § 10203 (Purdon Supp. 1988) R.I. GEN. LAWS § 23-4-16 (1985); S.C. CODE ANN. § 44-43-460 (Law. Co-op. 1985); TENN. CODE ANN. § 68-3-501 (1987); TEX. REV. CIV. STAT. ANN. art. 4447t (Vernon Supp. 1989) (codified at TEX. HEALTH & SAFETY CODE ANN. §§ 671.001 - 671.002 (Vernon 1991)); VT. STAT. ANN. tit. 18, § 5218 (1987); VA. CODE ANN. § 54/1-2972 (1990); W. VA. CODE § 16-19-1 (1991); WIS. STAT. ANN. § 146.71 (1989); WYO. STAT. § 35-19-101 (1988).

24. *See* Kaufman & Lynne, *Brain Death*, 19 NEUROSURGERY 850 (November 1986) (brain death widely recognized by public and law); *see generally* Angstwurm & Einhaupl *Organ Donors and Brain Death Diagnosis: Experiences in the Diagnosis and Documentation of Brain Death*, 26 TRANSPLANT PROCEEDINGS 95-97 (February 1984) (discussing proper diagnosis of brain death).

25. *See* TEX. HEALTH & SAFETY CODE ANN. §§ 671.001 - 671.002 (Vernon 1991).

> cessation of all spontaneous brain function. Death occurs when the relevant functions cease.
> c) Death must be pronounced before artificial means of supporting a person's respiratory and circulatory functions are terminated.
>
> § 671.002 Limitation of Liability
> (a) A physician who determines death in accordance with Section 671.001(b) is not liable for civil damages or subject to criminal prosecution for the physician's actions or the actions of others based on the determination of death.
> (b) A person who acts in good faith in reliance on a physician's determination of death is not liable for civil damages or subject to criminal prosecution for the person's actions.[26]

The Texas legislature has thus preserved the traditional criteria for determining death while at the same time allowing for an alternative method for such a determination when a person's respiration and circulation are maintained by artificial means. The law follows the recommendation of the President's Commission in that it addresses "general physiological standards rather than medical criteria and tests, which will change with advances in biomedical knowledge and refinements in technique."[27]

The Texas statute does not adopt the UDDA model legislation, but instead follows, with some variation, what is known as the Capron-Kass Model Act.[28] The Texas statute, like the Capron-Kass Model Act, does not open itself to the criticism that the determination of someone's death is left to an "arbitrary decision between two apparently equal yet different 'alternative definitions of death' [respiratory and circulation function vs. brain function]."[29] Like the Capron-Kass model, the Texas statute makes brain death criteria operative only when "artificial means of support preclude a determination that a per-

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26. *Id.*

27. Report of President, *supra* note 10, at 1.

28. Capron & Kass, *supra* note 12, at 111. Capron and Kass proposed that death be defined as follows:

> A person will be considered dead if in the announced opinion of a physician, based on ordinary standards of medical practice, he has experienced an irreversible cessation of spontaneous respiratory and circulatory functions. In the event that artificial means of support preclude a determination that these functions have ceased, a person will be considered dead if in the announced opinion of a physician, based on ordinary standards of medical practice, he has experienced an irreversible cessation of spontaneous brain functions. Death will have occurred at the time when the relevant functions ceased.

Id.

29. *Id.* at 112.

son's spontaneous respiratory and circulatory functions have ceased."[30]

Significantly, the Texas statute provides immunity from civil and criminal prosecution for physicians who make a determination of death in accordance with the standard set out in the act relating to cessation of brain functions.[31] In addition, other persons are shielded from civil and criminal actions when relying in good faith on a physician's determination of death.[32] The inclusion of an immunity provision in the Texas statute has an important impact on transplantation in that "physicians and nurses are in a position to facilitate organ donation but too frequently do not."[33] One of the reasons cited for a reluctance on the part of physicians and nurses to support transplantation is the fear of incurring "legal liability as a result of declaration of brain death or participation in the donation process."[34] The Texas statute, with its immunity provision, should lessen a physician's fear of legal liability when relying on the Texas statute to determine death and thereby pave the way to organ donation and transplantation.

To date, only one reported Texas case touched on the Texas Determination of Death Act. In *Nethery v. State*,[35] the appellant was convicted of capital murder and was sentenced to death.[36] The appellant argued, *inter alia*, that his conviction should be reversed because the intervening cause for the decedent's death was a failure of others to follow the requirements of the Texas Determination of Death Statute.[37] Specifically, the appellant claimed that the decedent was improperly removed from life support systems.[38] The Texas Court of Criminal Appeals found this argument without merit because there was no evidence that the victim had ever been connected to life sup-

30. TEX. HEALTH & SAFETY CODE ANN. § 671.001(b) (Vernon 1991); *see also* Capron & Kass *supra* note 12, at 112 (rejects definition of death which includes two alternatives).

31. *See* TEX. HEALTH & SAFETY CODE ANN. § 671.002(a) (Vernon 1991).

32. *Id.* at § 671.002(b).

33. U.S. DEP'T OF HEALTH & HUMAN SERVS., ORGAN TRANSPLANTATION: ISSUES AND RECOMMENDATIONS 43 (1986) [hereinafter cited as Task Force Report].

34. Task Force Report, *supra* note 33, at 44.

35. 692 S.W.2d 686 (Tex. Crim. App. 1985).

36. *Id.* at 691. Stephen Ray Nethery killed a Dallas police officer. *Id.* at 695.

37. *Id.* at 704.

38. *Id.*; *see also* TEX. HEALTH & SAFETY CODE ANN. § 671.001 (Vernon 1991) (current version of Determination of Death Statute). Under the current statute, death must be pronounced before life support can be terminated. *Id.* § 671.001(c).

port equipment.[39]

The Texas Determination of Death Act clearly and concisely provides the foundation upon which physicians can make an unambiguous determination of death based upon ordinary standards of medical practice.[40] The statute addresses the advances made in medical science which make reliance solely on the more traditional definition of death a problematic stumbling block for transplantation of organs and tissues. It forms one of the first links in the intricate chain of events that leads from donation of a decedent's organs to transplantation. The statute also provides immunity from civil and criminal prosecution which should allow physicians and other health care professionals to facilitate the donative process.[41] In the final analysis it brings certainty to the area where certainty is absolutely essential; the dividing line between life and death.

III. TEXAS ANATOMICAL GIFT ACT

A. *Introduction*

The transplantation of organs or tissues into the body of a dying or ailing individual is dependent upon an altruistic act; a willingness to give a part of oneself so that another life may be saved or the quality of their life improved. A proposal for how such an act of giving was to be accomplished within the context of a legal framework was formulated in 1968 by the National Conference of Commissioners on Uniform State Laws (hereafter referred to as Commissioners) with the drafting of the Uniform Anatomical Gift Act (hereafter referred to as the UAGA).[42] The proposed UAGA established the rules governing the donation of bodies or body parts for the purposes of research, education, therapy and transplantation. In recommending that each state adopt the UAGA, the Commissioners asserted that it would "provide a useful legal environment throughout the country for this new frontier of modern medicine."[43] The UAGA gained rapid ac-

39. *Id.*

40. *See supra* note 26 and accompanying text.

41. TEX. HEALTH & SAFETY CODE ANN. § 671.002 (Vernon 1991).

42. UNIF. ANATOMICAL GIFT ACT, 8A U.L.A. 15 (1968) [hereinafter in text UAGA (1968)]. For early analysis of the TAGA see generally, Comment, *"How To Do It" Donation of Bodies or Body Parts Under the Texas Anatomical Gift Act*, 27 BAYLOR L. REV. 141, 141-147 (1975); Comment, *The Texas Anatomical Gift Act*, 7 HOUS. L. REV. 274, 274-286 (1969).

43. UNIF. ANATOMICAL GIFT ACT, *supra* note 42, at Prefatory Note.

ceptance and, with the exception of Connecticut, has been adopted by all states and the District of Columbia.[44]

B. *The Texas Anatomical Gift Act: Analysis*

In 1969 the Texas legislature, following the example of other states, adopted its version of the Uniform Anatomical Gift Act called the Texas Anatomical Gift Act (hereafter referred to as TAGA) and provided the statutory mechanism which authorizes the donation of organs and tissues for transplantation (as well as other recognized purposes).[45] The TAGA substantially retains the original intent of the language contained in the UAGA. What follows is an analysis of the most significant aspects of the TAGA.

C. *TAGA Definitions*

Most notable among the terms defined in the TAGA is the definition of "decedent."[46] This definition does not, nor does any other

44. ALA. CODE §§ 22-19-40 to 22-19-47, 22-19-60 (1975); ALASKA STAT. 13.50.010-13.50.090 (1990); ARIZ. REV. STAT. ANN. §§ 36-841-36-849 (1985 & Supp. 1990); COLO. REV. STAT. §§ 12-34-101-12-34-109 (1985 & Supp. 1991); 16 DEL. CODE ANN. tit. 16) §§ 2710-2719 (Supp. 1990); D.C. CODE ANN. §§ 2-1501-2-1511 (1981); FLA. STAT. ANN. §§ 732.910-732.922 (1986 & Supp. 1990); GA. CODE ANN. §§ 44-5-140-44-5-151 (1985 & Supp. 1990); 10 GUAM CODE ANN. §§ 83101-83109 (1990); ILL. ANN. STAT. ch. 110 1/2, ¶¶ 301 - 311 (Smith-Hurd 1978 & Supp. 1990); IND. CODE ANN. §§ 29-2-1-1-29-2-16-10 (West 1988); IOWA CODE ANN. § 142A.1-142A.10 (West 1989); KAN. STAT. ANN. §§ 65-3209-65-3217 (1985); KY. REV. STAT. ANN. §§ 311.165-311.235 (Baldwin 1972); LA. REV. STAT. ANN. §§ 17:2351- 17:2359 (West 1982); ME. REV. STAT. ANN. tit. 22 , §§ 2901-2910 (1980); MD. EST. & TRUSTS CODE ANN. §§ 4-501-4-512 (1982 & Supp. 1990); MASS. GEN L. CH. 113, §§ 7-14 (1975 & Supp. 1990); MICH. COMP. LAWS §§ 333.10101-333.10109 (1990); MINN. STAT. §§ 525.921-525.94 (Supp. 1991); MISS. CODE ANN. §§ 41-39-11, 41-39-31-41-39-53 (Supp. 1991); MO. REV. STAT. §§ 194.210-194.290 (1983 & Supp. 1991); NEB. REV. STAT. §§ 71-4801-71-4818 (1990); N.H. REV. STAT. ANN. §§ 291-A:1-291-A:9 (1987 & Supp. 1991); N.J. REV. STAT. §§ 26:6-57-26:6-65 (1987 & Supp. 1991); N.M. STAT. ANN. §§ 24-6-1-24-6-11 (1978 & Supp. 1990); N.Y. PUB. HEALTH §§ 4300-4308 (West 1985); N.C. GEN. STAT. §§ 130a-402-130a-412.1 (1990); OHIO REV. CODE ANN. §§ 2108.01-2108.10 (Anderson 1990); OKLA. STAT. tit. 63 §§ 2201-2209 (1984 & Supp. 1990); OR. REV. STAT. 97.250-97.295 (1989); 20 PA. CONS. STAT. §§ 8601-8608 (1975 & Supp. 1990); S.C. CODE ANN. §§ 44-43-310-44-43-400 (Law. Co-op. 1985); S.D. CODIFIED LAWS 34-26-20-34-26-41 (1986); TENN. CODE ANN. §§ 68-30-101-68-30-111 (1987); TEX. HEALTH & SAFETY CODE ANN. §§ 692.001-692.016 (Vernon 1991); VT. STAT. ANN. tit. 18, §§ 5231-5237 (1987); V.I. CODE ANN. tit. 19 §§ 401-409(Supp. 1990); WASH. REV. CODE ANN. §§ 68.50.340-68.50.510 (1985 & Supp. 1990); W. VA. CODE §§ 16-19-1-16-19-9 (1991); WYO. STAT. §§ 35-5-101-35-5-112 (1988).

45. Texas Anatomical Gift Act, TEX. REV. CIV. STAT. ANN. art. 4590-2 (Vernon 1968) (codified at TEX. HEALTH & SAFETY CODE ANN. §§ 692.001-692.016 (Vernon 1991)) [hereinafter in text TAGA].

46. TEX. HEALTH SAFETY CODE ANN. § 692.002(2).

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section of the Act, define how the death of a donor is determined. Therefore, one must also look to the Texas Determination of Death Act[47] for guidance in this regard because the TAGA provides that the gift by a decedent becomes effective only upon their death.[48] The TAGA also describes a decedent as a person, stillborn infant, or fetus. The Act, therefore, also allows for the donation of a fetus. In light of the on-going battle between the pro-choice and pro-life forces on the issue of abortion, this could be a potential source of controversy as new technology brings about additional advances in transplantation.[49]

D. *The Manner of Executing a Gift of One's Own Body*

The TAGA establishes the method by which a person may make a gift of all or part of their own body.[50] This can be accomplished by will or through use of another document for this purpose.[51] If the donor chooses to use a will to effectuate the gift it need not be probated.[52] If the donor chooses to use the alternative document it must be signed by the donor and witnessed by two people.[53] The donor must have testamentary capacity in order to make such gift.[54] The donor, therefore, must: (i) be of at least 18 years of age or have been legally married; or (ii) be a member of the United States armed forces or auxiliary thereof or maritime service at the time the document or will was executed; and (iii) be of sound mind.[55] The execution and witnessing must be done in each party's presence.[56] The TAGA also provides that the alternative document may be in the form of a donor card that the donor carries.[57] The Act makes no specific mention of the use of a driver's license as a donor card other than the general proviso that the donor may use "a document other than a will."

47. TEX. HEALTH & SAFETY CODE ANN. § 671.001-671.012 (Vernon 1991).

48. TEX. HEALTH & SAFETY CODE ANN. § 692.003(c), (d) (Vernon 1991).

49. *See* Bard, Baker, & Siwolop, *Fetal Tissue Transplants: A Technology Raising Hope - And Controversy*, BUS. WK., Dec. 7, 1987, at 116-19 (new technique uses fetal tissue to treat Parkinson's disease); *see also* Mahowald, Silver & Ratcheson, *The Ethical Options in Transplanting Fetal Tissue*, 17 HASTINGS CENTER REP. 9-15 (Feb. 1987).

50. TEX. HEALTH & SAFETY CODE ANN. § 692.003 (Vernon 1991).

51. *Id.* § 692.003(b).

52. *Id.* § 692.003(c).

53. *Id.* § 692.003(d).

54. *Id.* § 692.003(a).

55. TEX. PROB. CODE ANN. § 57 (Vernon 1980).

56. *Id.*

57. *Id.*

However, article 6687b which governs the issuances of drivers licenses in Texas, authorizes the use of the reverse side of the Texas driver's license for that purpose.[58] A statement of gift printed on the license complies with the requirements of the TAGA.[59]

Despite the clear intent and language of the TAGA and UAGA, the execution of donor cards and other documents of gift do not guarantee that the donor's intent to donate will be honored. Although donor cards (and other documents of gift) "are an explicit statement of an individual's wish to be an organ donor . . . physicians are reluctant to retrieve organs on the basis of these cards alone, and almost always require the consent of the next of kin."[60] In light of the reluctance of physicians to retrieve organs by relying exclusively on the authority of the donor document, one suggestion is that upon the execution of a donor document, the donor initiate a "family discussion" wherein the donor makes his wishes known to his next of kin.[61] The family discussion is an important tool in facilitating donation since "the public is generally willing to honor a relative's wish to be a donor and give permission if asked to donate a loved one's organs."[62]

E. *Persons Who May Execute Gift*

As discussed *supra*, physicians are extremely reluctant to participate in the organ donation process where next of kin have not consented to retrieval and donation.[63] Therefore, one of the most important sections of the TAGA deals with obtaining consent from

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58. TEX. REV. CIV. STAT. ANN art. 6687b, § 11B(a) (Vernon Supp. 1991).

59. *Id.* The Texas Anatomical Gift Act referred to in section 11B(a) is now codified at TEX. HEALTH & SAFETY CODE ANN. § 692.001-692.016 (Vernon 1991).

60. Task Force Report, *supra* note 33, at 29.

61. *See* UNITED NETWORK OF ORGAN SHARING, *A Guide for the Donation of Organs and Tissue and Transplantation*, (1990) (special pamphlet); AMERICAN COUNCIL ON TRANSPLANTATION, *Facts About Organ & Tissue Donation* (1987); Johnson, *10,000 Good Reasons to Donate Life*, S. TEX. BAR J. 762 (1987).

62. Task Force Report, *supra* note 33, at 38.

63. Miller, *A Proposed Solution to the Present Organ Donation Crisis Based On a Hard Look At the Past*, 75 CIRCULATION 20, 21 (1987). Miller states that :

> Lack of trust by physicians and hospital administrators in the legal validity and authority of donor documents and fear of lawsuits has been well documented. Unfortunately, it is not uncommon for hospitals and physicians to allow the wishes of the next of kin, if opposed to organ donation, to override those of the decedent despite the UAGA's clear provisions that a relative's veto of an organ donation is a violation of the Act and that a properly executed donor card is deemed to be a binding and legal document.

Id.

the next of kin (and others) for retrieval and donation of a decedent's organs and tissues. TAGA provides a mechanism whereby other persons can donate all or a portion of a decedent's body for transplantation.[64] The persons who may consent to donation of decedent's body are ranked in order of priority as follows:

1. the decedent's spouse;
2. the decedent's adult child;
3. either of the decedent's parents;
4. the decedent's adult brother or sister;
5. the guardian of the person of the decedent at the time of death; or
6. any other person authorized or under an obligation to dispose of the body.[65]

A person of a lower priority can make a designation of gift only if persons of higher priority are not available at the time of death.[66] The statute prohibits a person from making a gift of the decedent's body or any of the decedent's body parts if there "is actual notice of contrary intentions by the decedent."[67] A person may not make a gift if there is actual notice of opposition to such a gift by someone of the same or higher priority as that of the person desiring or attempting to make a gift.[68] The gift must be made by execution of a document of gift signed by that person.[69] The gift can be executed by a "telegraphic, recorded telephonic or other recorded message."[70]

F. *Amendment or Revocation of Gift*

The TAGA provides methods whereby the gift can be amended or revoked by the donor.[71] The authorized methods of revocation or amendment vary depending on whether the donor has made the donation by will or some other document and whether or not the donor has delivered the will or document of gift to a designated donee.[72]

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64. TEX. HEALTH & SAFETY CODE ANN. § 692.004 (Vernon 1991).
65. *Id.* § 692.004(a).
66. *Id.* § 692.004(b).
67. *Id.* § 692.004(b)(2).
68. *Id.* § 692.004(b)(1).
69. *Id.* § 692.004(c).
70. *Id.*
71. *Id.* § 692.008.
72. *See id.*

G. *Determination of Time of Death*

The physician who certifies death and the time of death is prohibited by the TAGA from participating in either removing or transplanting donated organs or tissues.[73] This is an important feature of the law because it addresses the issue of a possible conflict of interest that may arise if the physician who declares death has a vested interest in transplanting the organs or tissues to his or her patients. A 1985 Gallup Poll evaluated, among numerous other issues, the reasons why persons might be disinclined to donate their organs.[74] Twenty-three percent of those polled indicated that an important reason for not wanting to donate organs was the concern that "they might do something to me before I *am* really dead."[75] Additionally, twenty-one percent of those surveyed stated that another important reason for not donating is the fear that "the doctors might hasten my death if they needed my organs."[76] The prohibition against the physician who certifies death participating in the retrieval or transplantation of donated organs, therefore, can be viewed as crucial to assuaging concerns that organs and tissues may be retrieved prematurely and guarantee that the judgment of those called upon to determine death is not effected by factors which constitute a serious conflict of interest.

H. *Hospital Protocol on Donation*

In 1987 the Texas legislature adopted an important addition to the TAGA requiring hospitals to become more involved in facilitating organ and tissue donation.[77] Texas law now requires that each hospital "develop a protocol for identifying potential organ and tissue donors from among those persons who die in the hospital."[78] In addition, at

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73. *Id.* § 692.009.

74. *See* THE GALLUP ORGANIZATION, INC., A GALLUP SURVEY: THE U.S. PUBLIC'S ATTITUDE TOWARD ORGAN TRANSPLANTSORGAN DONATION, 26 (January 1985) (reasons for refusing to permit organ donation) [hereinafter Gallup Poll].

75. *Id.*

76. *Id.* The other reasons listed by the Gallup Survey were that: (i) people do not like to think about dying; (ii) people do not like the idea of people cutting them up after they die; (iii) the people asked never thought about it; (iv) people want their bodies intact and healthy for the resurrection or after-life; (v) other members of their family would object; (vi) it is against their religion; or (vii) it is complicated to give permission. *Id.*

77. *See* TEX. HEALTH & SAFETY CODE ANN. § 692.013 (Vernon 1991) (protocol for identifying potential donors).

78. *Id.* § 692.013(a).

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or near the time of death the hospital is required to ask an authorized representative of the patient whether the patient is an organ or tissue donor.[79] If the hospital representative is advised that the patient is not a donor, the hospital representative must then advise the patient's representative of the option to donate.[80]

The foregoing amendment of the TAGA gives recognition to and attempts to solve, at least on a state level, a major problem impeding organ donation. Despite the urgent need for donor organs and tissues, less than twenty percent of the people who die under circumstances conducive to organ donation become donors.[81] The reasons posited for the failure of persons or their next of kin to donate a deceased's organs for transplantation are complex, multifaceted and subject to much public debate and study.[82] However, the acute shortage of organs and tissues for transplantation has been exacerbated, in part, because of the failure of health professionals to facilitate transplantation by "identifying potential donors and raising the issue of donation with families."[83] In response to this problem, lawmakers in the 1980's made what they hoped would be a major step toward increasing organ donation. They enacted federal and state laws designed to make hospitals, physicians and health care professionals participate in the organ procurement process by mandating that they help identify potential donors, inquire as to whether a deceased or soon-to-be deceased person has declared his or her desire or intention to be an organ donor, and, in appropriate circumstances, encourage the decedent's relatives to donate the decedent's organs and/or tissues.[84]

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79. *Id.* § 692.014(a); *see also id.* § 692.004 (listing persons authorized to make anatomical gift).

80. *Id.* § 692.014(c). If the representative approves the donation the hospital must notify a qualified organ procurement organization. *Id.*

81. Clark, Robinson & Wickelgren, *Interchangeable Parts*, NEWSWEEK, Sept. 12, 1988, at 61. The problem with organ donation is not the lack of candidates. *Id.* Approximately 25,000 healthy people die unexpectedly each year and could provide healthy organs. However, most of these individuals do not become donors. *Id.*

82. *See* Task Force Report, *supra* note 33, at 34 (not all recommendations made by Task Force received unanimous approval); *see also* Gallup Poll, *supra* note 74, at 26 (nine reasons people refuse to donate organs).

83. Task Force Report, *supra* note 33, at 43.

84. J. SWERDLOW, MATCHING NEEDS, SAVING LIVES: BUILDING A COMPREHENSIVE FOR TRANSPLANTATION AND BIOMEDICAL RESEARCH 16 (1989) (required request laws active in four states and District of Columbia) [hereinafter Swerdlow]. For an early proponent of required request legislation, see generally Caplan, *Ethical and Policy Issues In the Procurement*

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Sutton: Giving the Gift of Life: A Survey of Texas Law Facilitating Organ

These laws are referred to as "required request laws (requesting a donation)" or "routine inquiry laws (offering the option to donate)."[85] These laws contrast with proposed laws which "presume that the deceased had consented to donate his organs for transplantation."[86] Frustration over the organ donor shortage lead to suggestions that "presumption of consent" and other more aggressive methods of organ retrieval are a more appropriate way to address the organ donor shortage.[87] With respect to solid organ removal, the "required request/routine inquiry" legislation must be given the opportunity to "work" before more aggressive methods, which may create a backlash of opinion against transplantation, are implemented.

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of Cadaver Organs for Transplantation, 31 THE NEW ENG. J. OF MED. 981, 981-983 (volunteerism approach to organ donation unsuccessful); Caplan, *Organ Procurement: It's Not In the Cards*, 14 THE HASTINGS CENTER REP. 10 (Oct. 1984) (suggesting mandatory decision to donate as part of application for driver's license, social security card, or tax return); Caplan, *Requests, Gifts, and Obligations: The Ethics of Organ Procurement*, 23 TRANSPLANTATION PROC. 51, 53-54 (June 1986) (advocating new legislation requiring family members to decide whether to donate when death occurs).

85. MAXIMUS, INC., EVALUATION OF METHODS USED BY STATES TO EXPAND THE NUMBER OF ORGAN AND TISSUE DONORS ES-6 (April 1988) (both terms trated as synonomous). The Maximus report was prepared under a contract with the United States Department of Health and Human Services. *Id.* at ES-1. Required Request/Routine Inquiry laws have not been immune to criticism. *See, e.g.*, Martyn, Wright & Clark, *Reconsidering Required Requests*, 18 HASTINGS CENTER REP. 27-34 (Apr. - May 1988) One criticism of "required request" laws is that they create conflicts. *Id.* at 27. For example, "required request" laws create a clinical conflict in that once a person is listed as "brain dead" and becomes a potential donor, the doctor is required to consider organ preservation over brain preservation. Also, a declaration of brain death under such laws creates a psychologicl conflict among the patient's caretakers. *Id.* at 28. Nurses who once cared for the patient with a view towards recovery now view the patient as a quasi-cadaver. *See id.* A social/economic conflict is created by "required request" laws because an organ procurement industry supported by legislation may shift the focus from patient care to economic concerns. *See id.* at 30. *But cf.* Caplan, *Professional Arrogance and Public Misunderstanding*, 18 HASTINGS CENTER REP. 35 (Apr. - May 1988) (although some problems exist with required request laws, there have been positive results).

86. Miller, *supra* note 63, at 24.

87. *See* Matas, *A Proposal for Cadaver Organ Procurement: Routine Removal With Right of Informed Refusal*, 10 J. OF HEALTH, POL., POL'Y & L. 231, 237-38 (1985) (methods for more active organ retrieval); *see also* Silver, *The Case for A Post-Mortem Organ Draft and a Proposed Model Organ Draft Act*, 68 B.U.L. REV. 681, 694-95 (1988) (Model Organ Draft Act would authorize organ removal without consent); Comment, *Refining the Law of Organ Donation: Lessons from the French Law of Presumed Consent*, 19 INT'L L. & POL. 1013, 1029-32 (1987) (routine request and routine removal laws are superior approaches to organ donation problem); Cantaluppi, Scalamonga & Ponteicelli, *Legal Aspects of Organ Procurement in Different Countries*, 23 TRANSPLANT PROC. 102, 104 (1984) (recognizing presumed consent laws as way to ensure better supply of organs).

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The Texas legislature, in adopting the hospital protocol section of the TAGA, has apparently joined with those other "public policy makers" who believe that enactment of a Texas "routine inquiry/required request" law would help facilitate donation by making hospitals, physicians and other health care professionals participate in the donation process. However, the ability of state agencies to enforce these laws is questionable.[88]

The Texas hospital protocol "required request" amendment of the TAGA is not immune from such criticism. The TAGA does not provide a penalty for failure to comply with the requirement of establishing a hospital protocol or for failure to make an routine inquiry or required request concerning donation. This is in marked contrast to the federal "required request/routine inquiry" law which places a hospital's Medicare and Medicaid funding at risk for failure to comply with the federally mandated hospital protocol and "routine inquiry/required request" law.[89]

The law does require, however, that the hospital "make its protocol available to the public during the hospital's normal business hours."[90] Transplant advocates could, therefore, examine hospitals' protocols, determine which were in compliance with the law, and publicize any non-compliance.

IV. Limitation of Liability under TAGA

A significant feature of the TAGA is its section on immunity from civil damages or criminal prosecution.[91] Specifically, the TAGA states that "a person who acts in good faith in accordance with this chapter is not liable for civil damages or subject to criminal prosecution for the person's action if the perquisites for an anatomical gift are met under the laws applicable at the time and place the gift is made."[92] With respect to the hospital protocol section of the TAGA (§ 692.013 and § 692.014) "a person who acts in good faith" with regard to these sections "is not liable as a result of the action except in the case of the person's own negligence."[93] The term "good faith" is

88. SWERDLOW, *supra* note 84, at 16.

89. Omnibus Budget Reconciliation Act of 1986, Pub. L. 99-509, title IX, § 9318(a), 100 Stat. 2009 (codified at 42 U.S.C. § 1320b-8 (1988)).

90. TEX. HEALTH & SAFETY CODE ANN. § 692.013(a) (Vernon 1991).

91. *Id.* § 692.016.

92. *Id.* § 692.016(a).

93. *Id.* § 692.016(b).

not defined generally in the statute. With respect to the hospital protocol section of the Act, however, the term "good faith" means "making a reasonable effort to locate and contact the member or members of the highest priority class who are available at or near the time of death."[94]

The immunity provision of the TAGA is an essential part of the Act because fear of liability is one of the reasons why physicians and other health care professionals refuse to participate in the organ donation process.[95] The TAGA, like the UAGA upon which the TAGA is substantially modeled, most probably does not "immunize medical conduct prior to removal of organs from the donor."[96] No Texas court has been called upon define the scope of the protection provide by the TAGA's immunity provision. One may logically assume, however, that if such a court challenge were presented that the court would find that the protection afforded by the Act "is limited to immunity for acts relating directly to organ removal and these acts must still conform to ordinary standards of medical care."[97]

V. THE REVISED UNIFORM ANATOMICAL GIFT ACT

The promulgation of the UAGA, upon which the TAGA is modeled, represents a milestone in the drafting and subsequent partial or total enactment by all states and the District of Columbia of uniform state legislation. These laws also represent a bold attempt to legally address the organ donor shortage and the significant legal problems posed by emerging medical and scientific technology. Hopefully, by "clarifying and outlining the procedures and rights of those involved in organ procurement and donation" an increase in the donor supply will result.[98] Unfortunately, the UAGA has not "succeeded in motivating the public to take sufficient action to ensure that an expressed desire to become an organ donor will be honored and implemented at death" nor has the medical community "followed or

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94. *Id.*

95. Task Force Report, *supra* note 33, at 44.

96. Lee, *The Organ Supply Dilemma: Acute Responses to a Chronic Shortage*, 20 COLUM. J. L. & SOC. PROBS. 363, 379 (1986); *see also* Williams v. Hoffman, 223 N.W.2d 844, 847 (Wis. 1974) ("Uniform Anatomical Gift Act does not pertain to the course of treatment received by the donor prior to death").

97. Lee, *The Organ Supply Dilemma: Acute Responses to a Chronic Shortage*, 20 COLUM. J.L. & SOC. PROBS. 363, 379 (1986).

98. Miller, *supra* note 63, at 22.

enforced the UAGA."[99] In 1984, the National Conference of Commissioners on Uniform State Laws (NCCUSL) reviewed the inadequacies in the UAGA with an eye towards amending the model act.[100] Eventually, the NCCUSL endorsed and recommended for state-by-state legislative approval the Uniform Anatomical Gift Act of 1987.[101] The UAGA (1987) represents an attempt to overcome the perceived shortcomings of the its model predecessor. What follows is a brief analysis of the major provisions of the UAGA (1987) and comparison of the same to the TAGA.[102]

A. *Authority of Donor Documents*

As discussed *supra*, one of the major problems contributing to the failure to recover organs from potential donors is the refusal of medical personnel to comply with the provisions of the UAGA (1968) (i.e. to treat donor documents executed by the deceased in accordance with the UAGA (1968) as giving them sufficient authority to retrieve organs for transplantation without the need for consultation and consent of next of kin). One commentator has suggested that this attitude is the result of "a defensive mentality pervasive in modern medicine," a belief "among many doctors that even if an action seems right, it should not be taken without absolute certainty that it will have no legal ramifications or until the doctor has investigated all possible medical and legal ramifications."[103]

The TAGA substantially follows the language and intent of the UAGA (1968) and does not contain any proviso requiring next-of-kin approval to make the gift of one's body parts valid. The TAGA clearly provides that "[a] gift made by will is effective on the death of the testator without the necessity of probate."[104] If the gift is made by proper execution of some other donor document such as a donor card the gift will be "effective on death of the donor."[105] In neither case,

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99. *Id.*

100. UNIF. ANATOMICAL GIFT ACT 8A U.L.A. 3 (Supp. 1991) (Prefatory note).

101. *See id* at 2 (historical note).

102. For a discussion comparing the Uniform Anatomical Gift Act of 1968 with the Uniform Anatomical Gift Act of 1987 see generally Sutton, *The Revised Uniform Anatomical Gift Act: An Analysis*, 4 THE MEDICAL STAFF COUNSELOR 37, 37-41 (Winter 1990).

103. Lee, *The Organ Supply Dilemma: Acute Responses to a Chronic Shortage*, 19 COLUM. J. L. & SOC. SCIENCES 379-380 (1986).

104. TEX. HEALTH & SAFETY CODE ANN. § 692.003(c) (Vernon 1991).

105. *Id.* § 692.003(d).

therefore, must next-of-kin consent be given for organ retrieval after death of the declared donor.

One of the most significant revisions of the UAGA (1968) is found in the section of the UAGA (1987) which specifies how an anatomical gift is made, amended, revoked or how a refusal to donate is declared.[106] After delineating how the gift is made, the UAGA (1987) unequivocally states that "[a]n 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."[107] This revision of the original UAGA (1968) makes it clear that the intentions of the donor prevail over any objection by next of kin.

The methods for revocation or amendment of the gift remain substantially the same in the UAGA (1987) as it is in the TAGA.[108] The UAGA (1987) adds a new provision dealing with the right of an individual to express his refusal to donate which is not found in the TAGA.[109] The UAGA (1987) allows an individual to declare his refusal to donate through execution of a writing in the same manner as required when making a gift, by affixing a statement of refusal to one's drivers license, or by using some other writing to declare the refusal.[110] During a terminal illness or injury, the declaration of refusal may be made orally or by using any other means of communication.[111]

B. *Elimination of Witness Requirement*

The TAGA establishes the method for executing a gift of one's own body by will or by a document other than a will.[112] If another donor document is used "it must be signed by the donor in the presence of two witnesses" and the witnesses "must sign the document in the presence of the donor."[113] There is no requirement that the signatures of the donor or witnesses be acknowledged. The UAGA (1987)

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106. UNIF. ANATOMICAL GIFT ACT OF 1987 § 2, 8A U.L.A. 10-11 (Supp. 1991).

107. *Id.* § 2(h) (emphasis added).

108. *Compare id.* § 2(f) *with* TEXAS HEALTH & SAFETY CODE ANN. § 692.008 (Vernon 1991).

109. UNIF. ANATOMICAL GIFT ACT OF 1987 § 2(i), 8A U.L.A. 11 (Supp. 1991).

110. *Id.*

111. *Id.*

112. TEX. HEALTH & SAFETY CODE ANN. § 692.003(b) (Vernon 1991).

113. *Id.* § 692.003(d).

would eliminate entirely the requirement that the donor document (other than a will) be signed by witnesses.

C. *Affirmative Search for Donor Documents*

The UAGA (1987) requires that under certain circumstances a reasonable attempt be made to locate documents or other evidence that would indicate or declare that the individual is an anatomical donor or that the individual refuses to be a donor.[114] The search must be made by law enforcement officers, firefighters, paramedics, or other emergency rescuers when these individuals find a person they believe to be dead or near the point of death.[115] If documentation is found which indicates that the individual is or is not a donor, the revised UAGA (1987) requires that if the person is taken to a hospital the hospital must be informed of the contents of and provided with the documents.[116]

A hospital also has an obligation to conduct such a search upon admission of a person at or near death provided the information cannot be obtained from other sources.[117] This proposed revision is a logical extension of the NCCUSL's intentions to strengthen the UAGA's original intent that donor documents be treated more seriously by the medical community than they have in the past. However, if this section is to have any appreciable effect on increasing the number of donors from the pool of potential donors, public practice relating to these documents must change in addition to practices of the medical community since "only a relatively small percentage of the general public carry" donor documentation.[118]

D. *Hospital Admission Inquiry*

A somewhat more interesting and controversial change in the proposed UAGA(1987) not presently found in the TAGA provides that upon admission to a hospital each patient who is eighteen or older must be asked by a designated agent of the hospital whether the patient is an organ or tissue donor.[119] If the patient answers negatively

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114. UNIF. ANATOMICAL GIFT ACT OF 1987 § 5(c), 8A U.L.A. 19 (Supp. 1991).
115. *Id.* § 5(c)(1).
116. *Id.* § 5(d).
117. *Id.* § 5(c)(2).
118. Task Force Report, *supra* note 33, at 29.
119. UNIF. ANATOMICAL GIFT ACT OF 1987 § 5(a), 8A U.L.A. 19 (Supp. 1991).

and the patient's physician consents, the hospital representative must discuss the option to donate or refuse to donate with the patient.[120] Copies of documents evidencing an intention to donate or a refusal to donate must then be placed in the patient's medical records.[121]

This provision, which has been propsed as a revision of the TAGA, would govern any admission to a hospital regardless of the circumstances leading to admission. Not surprisingly, this revision has not been free of criticism. In 1988 the American Council on Transplantation stated its fear that such an inquiry "might be counterproductive and could be worrisome to incoming patients."[122] This criticism reflects a concern that patients might be unduly alarmed by such a request in light of the fact that a significant percentage of the general public's concern that identification as an organ donor might lead to premature steps toward organ recovery.[123] On the other hand, one of the ultimate goals of those supporting transplantation is to increase the public's awareness of the acute need for organs for transplantation so that questions concerning a person's decision to be an organ donor would be as routine and non-threatening as any other series of questions that a person might be asked when seeking medical treatment.[124] To reach that point of consciousness, the public must be educated and it is logical for hospitals to play an important role in that process.

E. *Routine Inquiry/Required Request*

Section 5(b) of the UAGA(1987) contains language mandating hospital administrators, or their representatives, to make a routine inquiry of family members of any hospital patient who is at or near death as to whether the patient is an organ donor.[125] If the answer to that question is "No," then the administrator or his appointee must discuss with the patient's family the option to donate and then make a request to donate.[126] No inquiry or request need be made if the gift

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120. *Id.*

121. *Id.*

122. American Council on Transplantation, Press Release (May 23, 1988).

123. *See* Gallup Poll, *supra* note 74, at 20.

124. *See* UNIF. ANATOMICAL GIFT ACT OF 1987 § 5 comment, 8A U.L.A. 19 (Supp. 1991). Each individual upon admission to a hospital is asked a series of routine questions, such as: "Do you have insurance?" and "Are you allergic to any drugs?" *Id.*

125. *Id.* § 5(b).

126. *Id.*

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would not be medically suitable.[127] This section of the UAGA (1987) substantially follows the intent of the TAGA. The UAGA (1987) does, however, charge the Commissioner of Health (or his state equivalent) with the responsibility to "[establish guidelines] or [adopt regulations] to implement this subsection."[128] The TAGA as presently written does not vest any regulatory power in any state agency in regard to the TAGA's "routine inquiry/required request" provision.

F. *Sanctions for Non-Compliance*

The existing TAGA relies on voluntary compliance by hospitals with regard to the Act's provisions requiring routine inquiry and required requests. The UAGA (1987) states that, while "a person who fails to discharge the duties imposed . . . is not subject to criminal or civil liability "they are subject to appropriate administrative actions."[129] The drafters of the UAGA (1987), in adopting this section, sought to "encourage hospital accrediting agencies, law enforcement [agencies], and other state agencies that have existing disciplinary procedures to impose sanctions for failure to discharge the duties imposed."[130] Thus, if Texas were to adopt the UAGA (1987) it would allow for the imposition of administrative sanctions by hospital accrediting agencies, law enforcement agencies or other state agencies for failure to comply with the procedures imposed in this section of the proposed law.

VI. AUTHORITY OF CORONER OR MEDICAL EXAMINER OR LOCAL PUBLIC HEALTH OFFICIAL TO MAKE DONATIONS

The UAGA (1987) contains a completely new provision which grants to coroners, medical examiners or other similar public officials the authority to "release and permit the removal of a part from a body within that official's custody, for transplantation or therapy."[131] Certain requisites must be met in order to allow for such a release and removal including "a request for the part from a hospital, physician,

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127. *Id.*
128. *Id.*
129. *Id.* § 5(f).
130. *Id.* § 5(f) comment.
131. *Id.* § 4.

surgeon or a procurement organization."[132] In addition, the official must make a "reasonable effort to locate and examine the decedent's medical records and inform" next of kin of the "option to make, or object to making an anatomical gift."[133] The release and removal are also predicated on the "official not knowing of a refusal or contrary indication by the decedent or objection" by next of kin in the priority as set out in this revision.[134] The removal must not interfere with any autopsies or investigations and must be made in accordance with accepted medical standards and cosmetic restoration must be done if appropriate.[135] The revised UAGA (1987) would also allow the appropriate medical official (coroner, medical examiner, or local public health officer) to make such a release and removal if the body is not within the official's custody provided that the requirements pertaining to bodies within the official's custody are also met.[136]

This proposed revision of the Uniform Anatomical Gift Act constitutes a revision of the current TAGA and conflicts with other Texas laws governing the power of medical examiners to dispose of body parts, body tissue and corneal tissue for transplantation and therapy. The medical examiner's authority in this regard is found in the Texas Health and Safety Code and the Texas Code of Criminal Procedure.[137] The Texas Health and Safety Code grants to medical examiners the authority to "permit the removal of eyes, heart, skin, bone, liver, kidney, or pancreas and other tissues proven to be clinically usable for transplants or other therapy."[138] Certain prerequisites must be met in order to trigger the medical examiner's authority in this area. The medical examiner is granted this authority if: (i) circumstances dictate that an inquest be made by the medical examiner; (ii) certain consents are given or if no known objection is made by certain individuals known to the medical examiner; and (iii) the removal will not interfere with an investigation or autopsy.[139]

The Texas Health and Safety Code requires that the medical exam-

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132. *Id.* § 4(a)(1).
133. *Id.* § 4(a)(2).
134. *Id.* § 4(a)(3).
135. *Id.* § 4(a), (5), (6), (7).
136. *Id.* § 4(b).
137. TEX. HEALTH & SAFETY CODE ANN. §§ 693.001 - 693.024 (Vernon 1991); *see also* TEX. CRIM. PROC. CODE ANN. art. 49.25(a) (Vernon 1979 & Supp. 1991).
138. TEX. HEALTH & SAFETY CODE ANN. § 693.002 (Vernon 1991).
139. *Id.*

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iner obtain consent from the next of kin under certain circumstances before the removal of the body part or tissue is permitted. With regard to the consent requisite, the Code makes a distinction between the removal of: (i) visceral organs, (ii) non-visceral organs and tissues, and/or (iii) corneal tissue. The term visceral organs is defined as "the heart, kidney, liver, or other organ or tissue that requires a patient support system to maintain the viability of the organ or tissue."[140] In dealing with visceral organs, the medical examiner must seek the consent of next of kin before the examiner is authorized to permit the removal of a visceral organ for transplantation or therapy.[141]

The term non-visceral organ or tissue is not defined by the code but presumably would include bone, skin, and facial ligaments.[142] The medical examiner must obtain the consent of next of kin if those next of kin are known and available within the first four hours after death is pronounced before the examiner is authorized to permit the removal of a non-visceral organ for transplanation or therapy.[143] If the next of kin cannot be identified and "contacted within four hours after death is pronounced and the medical examiner determines that no reasonable likelihood exists that next of kin can be identified and contacted during the four hour period, the medical examiner may permit the removal of a non-visceral organ or tissue."[144]

With regard to the removal of corneal tissue the consent requirements imposed on the medical examiner are less stringent. In this case, the law provides that a justice of the peace or a medical examiner may permit the removal of corneal tissue from those decedents who die under circumstances dictating an inquest as long as no objection from next of kin is known by the medical examiner or justice of the peace.[145] The consent of the next of kin for removal of the corneal tissue is not a prerequisite to removal of the corneal tissue as long as there is no known objection of such a person. Therefore, this section of the Health and Safety Code in effect presumes that consent is given

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140. *Id.* § 693.001.

141. *Id.* § 693.003(a).

142. Telephone interview with Jim Hayes, Executive Director, South Texas Organ Bank (Jan. 8, 1991).

143. Tex. Health & Safety Code § 693.003(b).

144. *Id.* § 693.003(c).

145. *Id.* § 693.012.

for removal of the tissue.[146]

The Texas Code of Criminal Procedure also contains statutory language pertaining to organ donation. The Code of Criminal Procedure requires that when a person has been designated as a potential organ donor by a licensed physician under circumstances requiring an inquest, the medical examiner must be notified.[147] An inquest must then be conducted on the prospective donor.[148] If an autopsy is performed the examiner must examine the organ to be transplanted "in its whole state."[149] The Code provides that after such examination "the organ to be transplanted will then be released to the transplant team for removal and transplantation."[150]

This provision of the Code of Criminal Procedure contains no provision relating to search for or notification of next of kin. This legislation was enacted prior to enactment of the Health and Safety Code's provisions regarding the authority of the medical examiner to permit removal of organs and tissues discussed above. There is an apparent conflict in these statutes with regard to obtaining consent. To date there are no reported cases that have addressed this conflict.

If Texas were to adopt the UAGA (1987) it would necessitate the repeal of Chapter 693 of the Health and Safety Code dealing with the removal of body parts, body tissue and other corneal tissue. The most significant change in this regard would be the affect of such a procedure on the removal of corneal tissue. The UAGA (1987) requires that the official, in this case the medical examiner or justice of the peace, make a "reasonable effort" to inform next of kin of their option to "make or object to making an anatomical gift."[151]

With respect to corneal tissue, no such effort to inform next of kin is required under the applicable Health and Safety Code statute deal-

146. The constitutionality of presumed consent statutes relating to corneal tissue has been challenged and upheld. *See, e.g.*, Florida v. Powell, 497 So. 2d 1188, 1193-94 (Fla. 1986), *cert. denied*, 481 U.S. 1059 (1987) (statute authorizing removal of corneal tissue during autopsy constitutional because it rationally promotes restoration of sight to blind), Georgia Lions Eye Bank, Inc. v. Lavant, 335 S.E.2d. 127, 128-29 (Ga. 1985), *cert. denied*, 475 U.S. 1084 (1986) (statute authorizing removal of corneal tisue upheld because it promotes interest in public health and welfare). *See generally* Annotation, *Statutes Authorizing Removal of Body Parts for Transplant: Validity and Construction*, 54 A.L.R. 4TH 1215-16 (1987).

147. TEX. CRIM. PROC. ANN. art. 49.25, § 6a(a) (Vernon 1979).

148. *Id.* at art. 49.25, § 6a(b).

149. *Id.* at art. 49.25, § 6a(c).

150. *Id.* at art. 49.25, § 6a (d).

151. UNIF. ANATOMICAL GIFT ACT OF 1987 § 4(2), 8A U.L.A. 15 (Supp. 1991).

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ing with this subject. Because of concern in some states over the impact of such proposed legislation on corneal removal, the Eye Bank Association of America issued a statement supporting "the medical examiners section of the revised Uniform Anatomical Gift Act . . . contingent upon retention of current medical examiner laws as they now exist in any given state."[152]

VII. SALE OF ORGANS AND TISSUES

Federal law makes the sale or purchase of organs a federal crime.[153] The punishment for violation of this law is a fine of "not more than $50,000 or [imprisonment for] not more than five years, or both."[154] The UAGA (1987) also makes the sale of organs a crime.[155] The current TAGA contains no language making sale or purchase of organs a crime. The Task Force on Organ Transplantation recommends that state laws be adopted to prohibit the sale or purchase of organs basing such a position on a rejection of commercialization of organ transplantation.[156]

VIII. DONOR'S LIABILITY

The UAGA (1987) adds a significant addition to the UAGA regarding a donor's liability for making an anatomical gift. The revision provides that an individual and her estate is not "liable for any injury or damage that may result from the making or the use of the anatomical gift."[157] In Texas, section 77.003 of the Civil Practices and Remedies Code extends protection to the donor.[158]

IX. CONCLUSION

It is apparent from review and analysis of the foregoing laws that

152. Report from Eye Bank Association of America, The Uniform Anatomical Gift Act 1 (June 1988) (copy on file at St. Mary's Law Journal).

153. 42 U.S.C. § 274e (1988).

154. *Id.* § 274e(b)

155. UNIF. ANATOMICAL GIFT ACT OF 1987 § 10, 8A U.L.A. 26 (Supp. 1991).

156. Task Force Report, *supra* note 33, at 10; *see also* Murray, *Gifts of the Body and the Need of Strangers*, 17 HASTINGS CENTER REP. 30-38, (Apr. 1987). *But see* Brams, *Transplantable Human Organs: Should Their Sale Be Authorized By Sate Statutes?*, 3 AM. J. OF L. & MED. 183-195; Schwindt & Vining, *Proposal for A Future Delivery Market for Transplant Organs*, 11 J. OF HEALTH POL. POL'Y & L., 483, 483-500 (Fall 1986).

157. UNIF. ANATOMICAL GIFT ACT OF 1987 § 11(d), 8A U.L.A. 27 (Supp. 1991).

158. TEX. CIV. PRAC. & REM. CODE ANN. § 77.003 (Vernon Supp. 1991).

the Texas legislature has attempted to keep abreast with the revolution in medical care brought about by the transplantation of human organs into sick or dying individuals. Texas has enacted a series of comprehensive laws which facilitate the identification of donors and provide a legal blueprint for how the donation of organs for transplantation is to be accomplished in a lawful manner. Significant civil and criminal immunity protection has been afforded to those who rely on these laws.

Despite these efforts to insure that Texas law provides a solid foundation upon which organ donation is built, acute shortages in the availability of organs for transplantation persist. Some experts have suggested, for example, that a revision of the UAGA could lead to an increase in the supply of organs for transplantation.

When it was first promulgated, the UAGA(1968) represented an imaginative approach to addressing, from a legal perspective, the problems confronting a new technology which left its experimental roots, and blossomed into an accepted therapy offering new hope to many sick and dying people. The UAGA(1968) represented the collective wisdom of the time as to how to best meet the challenges posed by transplantation. However, the hope that the UAGA would dramatically increase organ donation and recovery has not been fully realized.

It is unclear whether a revision of the TAGA along the lines as suggested in the UAGA(1987) will lead to an overall increase in organ and tissue donation in Texas. Fundamental changes in attitude on the part of the public and medical community must occur if any such revision is to avoid the same fate as its predecessor statute.

The legislature should convene a special commission to conduct a comprehensive review of the TAGA as well as other state laws to assess whether revision of these laws is advisable. The commission should also examine what other legislation should be implemented to increase the public's awareness of the needs and benefits associated with making a donation of organs for transplantation or other scientific and therapeutic purposes. Along these lines this review should, among other topics, address the question of whether and how the Texas education system should and could be used to facilitate instruction and discussion of the importance of organ donation and the laws which govern this activity. The commission should study whether the current Texas law requiring that hospitals identify potential donors and inquire of next of kin the desires of both donor and next of kin

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regarding donation is actually producing an increase in the number of donors. The study should review what disincentives exist that work against donation, and inquire as to whether current law is drafted to minimize those disincentives or whether new legislation must be enacted to decrease these negative factors. In the final analysis, laws are reflective of a society's attitudes towards the myriad of problems that its members face. Thus far, Texas has demonstrated its support for organ donation by enacting laws to facilitate that process. It is apparent, however, that these laws need to be reevaluated to assess whether organ donation would benefit by their revision. Such a study may well reveal that what is needed is not substantially new legislation, but a renewed commitment to insuring that the citizens of Texas are made more fully aware of how organ donation can be accomplished under the existing legal framework.

The price for failing to reevaluate our laws and our attitudes towards those laws in this arena may be the needless continued suffering and death of those who might otherwise benefit from "the gift of life." Given the technology available, such a price is totally unacceptable.

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APPENDIX A
TEXAS ANATOMICAL GIFT ACT
TEX. HEALTH & SAFETY CODE ANN.
§§ 692.001 - 692.016 (VERNON 1991)

§ 692.001. Short Title

This chapter may be cited as the Texas Anatomical Gift Act.

§ 692.002. Definitions

In this chapter:

(1) "Bank or storage facility" means facility licensed, accredited, or approved under the laws of any state to store human bodies or body parts.

(2) "Decedent" means a deceased person and includes a stillborn infant or fetus.

(3) "Donor" means a person who makes a gift of all or part of the person's body.

(4) "Eye bank" means a nonprofit corporation chartered under the laws of this state to obtain, store, and distribute donor eyes to be used by ophthalmologists for corneal transplants, research, or other medical purposes.

(5) "Hospital" means a hospital:

(A) licensed, accredited, or approved under the laws of any state; or

(B) operated by the federal government, a state government, or a political subdivision of a state government.

(6) "Part" includes an organ, tissue, eye, bone, artery, blood, other fluid, and other parts of a human body.

(7) "Physician" means a physician licensed or authorized to practice under the laws of any state.

(8) "Qualified organ or tissue procurement organization" means an organization that procures and distributes organs or tissues for transplantation, research, or other medical purposes and is:

(A) affiliated with a university or hospital; or

(B) registered to operated as a nonprofit organization in this state for the primary purpose of organ or tissue procurement.

§ 692.003. Manner of Executing Gift of Own Body

(a) A person who has testamentary capacity under the Texas Probate Code may give all or part of the person's body for a purpose specified by Section 692.005.

(b) A person may make a gift under this section by will or by use of a document other than a will.

(c) A gift made by will is effective on the death of the testator without the necessity of probate. If the will is not probated or if the will is declared invalid for testamentary purposes, the gift is valid to the extent to which it has been acted on in good faith.

(d) A gift made by a document other than a will is effective on the death of the donor. The document may be a card designed to be carried by the donor. To be effective, the document must be signed by the donor in the presence of two witnesses. If the donor cannot sign the document, a person may sign the document for the donor at the donor's direction and in the presence of the donor and two witnesses. The witnesses to the signing of a document under this subsection must sign the document in the presence of the donor. Delivery of the document during the donor's lifetime is not necessary to make the gift valid.

§ 692.004. Persons Who May Execute Gift

(a) The following persons, in the following priority, may give all or any part of a decedent's body for a purpose specified by Section 692.005:

(1) the decedent's spouse;

(2) the decedent's adult child;

(3) either of the decedent's parents;

(4) the decedent's adult brother or sister;

(5) the guardian of the person of the decedent at the time of death; or

(6) any other person authorized or under an obligation to dispose of the body.

(b) A person listed in Subsection (a) may make the gift only if:

(1) a person in a higher priority class is not available at the time of death;

(2) there is no actual notice of contrary indications by the decedent; and

(3) there is no actual notice of opposition by a member of the same or a high priority class.

(c) A person listed in Subsection (a) may make the gift after death or immediately before death. The person must make the gift by a document signed by the person or by a telegraphic, recorded telephonic, or other recorded message.

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§ 692.005. Persons Who May Become Donees

The following persons may be donees of gifts of bodies or parts:

(1) a hospital or physician, to be used only for medical or dental education, research, therapy, transplantation, or the advancement of medical or dental science;

(2) an accredited medical, chiropractic, or dental school, college, or university, to be used only for education, research, therapy, or the advancement of medical or dental science;

(3) a bank or storage facility, to be used only for medical or dental education, research, therapy, transplantation, or the advancement of medical or dental science;

(4) a person specified by a physician, to be used only for therapy or transplantation needed by the person;

(5) an eye bank the medical activities of which are directed by a physician; or

(6) the Anatomical Board of the State of Texas.

§ 692.006. Designation of Donee or Physician

(a) A person may make a gift to a specified donee. If the gift is not made to a specified donee, the attending physician may accept the gift as donee at the time of death or after death.

(b) If the gift is made to a specified donee who is not available at the time and place of death, the attending physician may accept the gift as donee at the time of death or after death unless the donor expressed an indication that the donor desired a different procedure.

(c) A physician who becomes a donee under Subsection (a) or (b) may not participate in the procedures for removing or transplanting a part.

(d) Notwithstanding Section 692.009, a donor may designate in the donor's will or document of gift the physician to perform the appropriate procedures. If the donor does not designate the physician, or if the physician is not available, the donee or other person authorized to accept the gift may employ or authorize any physician to perform the appropriate procedures.

§ 692.007. Delivery of Document

(a) If a donor makes a gift to a specified donee, the donor may deliver the will or document, or an executed copy, to the donee to expedite the appropriate procedures immediately after death. Delivery is not necessary to make the gift valid.

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(b) The donor may deposit the will or other document, or an executed copy, in a hospital, registry office, or bank or storage facility that accepts the document for safekeeping or to facilitate the procedures after death.

(c) On or after the donor's death and on the request of an interested party, the person in possession of the document shall produce the document for examination.

§ 692.008. Amendment or Revocation of Gift

(a) If the donor has delivered the will or other document, or executed copy, to a specified donee, the donor may amend or revoke the gift by:

(1) executing and delivering to the donee a signed statement;

(2) making an oral statement in the presence of two persons that is communicated to the donee;

(3) making a statement to an attending physician that is communicated to the donee; or

(4) executing a signed document that is found on the donor or found in the donor's effect.

(b) If the donor has not delivered the document of gift to the donee, the donor may revoke the gift in a manner prescribed by Subsection (a) or by destroying, canceling, or mutilating the document and each executed copy of the document.

(c) If the donor made the gift by will, the donor may revoke or amend the gift in a manner prescribed by Subsection (a) or in a manner prescribed for the amendment or revocation of a will.

§ 692.009. Determination of Time of Death

The attending physician or, if none, the physician who certifies the death shall determine the time of death. That physician may not participate in the procedures for removing or transplanting a part.

§ 692.010. Acceptance or Rejection of Gift

(a) A donee may accept or reject a gift

(b) If the donee or the donee's physician has actual notice of contrary indications by the decedent or has actual notice that a gift made under Section 692.004 is opposed by a member of the same or a higher priority class, the donee may not accept the gift.

(c) If a donee accepts a gift of an entire body, the decedent's surviving spouse or any other person authorized to give all or part of the

body may authorize the body's embalming and have the use of the body for funeral services, subject to the terms of the gift.

(d) If a donee accepts a gift of a part, the donee shall cause the part to be removed from the body without unnecessary mutilation after death occurs and before the body is embalmed. After the part is removed, the surviving spouse, next of kin, or other person under obligation to dispose of the body has custody of the body.

§ 692.011. Examination for Medical Acceptability Authorized

A gift of all or part of a body authorizes any examination necessary to assure medical acceptability of the gift for the intended purposes.

§ 692.012. Donee's Rights Superior

Except as prescribed by Section 692.015(a), a donee's rights that are created by a gift are superior to the rights of other persons.

§ 692.013. Hospital Protocol

(a) Each hospital shall develop a protocol for identifying potential organ and tissue donors from among those persons who die in the hospital. The hospital shall make its protocol available to the public during the hospital's normal business hours.

(b) The protocol must:

(1) provide that the hospital use appropriately trained persons to make inquiries relating to donations;

(2) encourage sensitivity to families' beliefs and circumstances in all discussions relating to the donations;

(3) establish guidelines based on accepted medical standards for determining if a person is medically suitable to donate organs or tissues; and

(4) provide for documentation of the inquiry and of its disposition in the decedent's medical records.

(c) The protocol must provide that a hospital is not required to make an inquiry under Section 692.014 if:

(1) the decedent is not medically suitable for donation based on the suitability guidelines established by the protocol;

(2) the hospital has actual notice of an objection to the donation made by:

(A) the decedent;

(B) the person authorized to make the donation under Section 692.004, according to the priority established by that section; or

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(C) an unavailable member of a higher priority class; or

(3) the hospital administrator has not been notified by a qualified organ or tissue procurement organization that:

(A) there is a current medical need for organs or tissues; and

(B) the organization is available to retrieve the organs or tissues in a manner consistent with accepted medical standards.

§ 692.014. Hospital Procedures

(a) In accordance with the protocol established under Section 692.013, at or near the time of notification of death, the hospital shall ask the person authorized to make an anatomical gift on behalf of the decedent under Section 692.004, according to the priority established by that section, if the decedent is a donor.

(b) If there are two or more persons in the same priority class authorized to make a gift under Section 692.004, the hospital shall ask those class members reasonably available at or near the time of notification of death.

(c) If the decedent is not a donor, the hospital shall inform the person of the option to donate the decedent's organs and tissues. If the person approves the donation, the hospital shall notify a qualified organ or tissue procurement organization of the potential donation.

§ 692.015. Effect of Other Laws

(a) This chapter is subject to the laws of this state prescribing the powers and duties relating to autopsies.

(b) Sections 692.013 and 692.014 do not affect the laws relating to notification of the medical examiner or justice of the peace of each case of reportable death.

§ 692.016. Limitation of Liability

(a) A person who acts in good faith in accordance with this chapter is not liable for civil damages or subject to criminal prosecution for the person's action if the prerequisites for an anatomical gift are met under the laws applicable at the time and place the gift is made.

(b) A person who acts in good faith in accordance with Sections 692.013 and 692.014 is not liable as a result of the action except in the case of the person's own negligence. For purposes of this subsection, "good faith" in determining the appropriate person authorized to make a donation under Section 692.004 means making a reasonable

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effort to locate and contact the member or members of the highest priority class who are available at or near the time of death.

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APPENDIX B
UNIFORM ANATOMICAL GIFT ACT (1987)
8A U.L.A. 1-27 (SUPP.1991)

§ 1. DEFINITIONS

As used in this [Act]:

(1) "Anatomical gift" means a donation of all or part of a human body to take effect upon or after death.

(2) "Decedent" means a deceased individual and includes a stillborn infant or fetus.

(3) "Document of gift" means a card, a statement attached to or imprinted on a motor vehicle operator's or chauffeur's license, a will, or other writing used to make an anatomical gift.

(4) "Donor" means an individual who makes an anatomical gift of all or part of the individual's body.

(5) "Enucleator" means an individual who is [licensed] [certified] by the [State Board of Medical Examiners] to remove or process eyes or parts of eyes.

(6) "Hospital" means a facility licensed, accredited, or approved as a hospital under the law of any state or a facility operated as a hospital by the United States government, a state, or a subdivision of a state.

(7) "Part" means an organ, tissue, eye, bone, artery, blood, fluid, or other portion of a human body.

(8) "Person" means an individual, corporation, business trust, estate, trust, partnership, joint venture, association, government, governmental subdivision or agency, or any other legal or commercial entity.

(9) "Physician" or "surgeon" means an individual licensed or otherwise authorized to practice medicine and surgery or osteopathy and surgery under the laws of any state.

(10) "Procurement organization" means a person licensed, accredited, or approved under the laws of any state for procurement, distribution, or storage of human bodies or parts.

(11) "State" means a state, territory, or possession of the United States, the District of Columbia, or the Commonwealth of Puerto Rico.

(12) "Technician" means an individual who is [licensed] [certified] by the [State Board of Medical Examiners] to remove or process a part.

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§ 2. MAKING, AMENDING, REVOKING, AND REFUSING TO MAKE ANATOMICAL GIFTS BY INDIVIDUAL

(a) An individual who is at least [18] years of age may (i) make an anatomical gift for any of the purposes stated in Section 6(a), (ii) limit an anatomical gift to one or more of those purposes, or (iii) refuse to make an anatomical gift.

(b) An anatomical gift may be made only by a document of gift signed by the donor. If the donor cannot sign, the document of gift must be signed by another individual and by two witnesses, all of whom have signed at the direction and in the presence of the donor and of each other, and state that it has been so signed.

(c) If a document of gift is attached to or imprinted on a donor's motor vehicle operator's or chauffeur's license, the document of gift must comply with subsection (b). Revocation, suspension, expiration, or cancellation of the license does not invalidate the anatomical gift.

(d) A document of gift may designate a particular physician or surgeon to carry out the appropriate procedures. In the absence of a designation or if the designee is not available, the donee or other person authorized to accept the anatomical gift may employ or authorize any physician, surgeon, technician, or enucleator to carry out the appropriate procedures.

(e) An anatomical gift by will takes effect upon death of the testator, whether or not the will is probated. If, after death, the will is declared invalid for testamentary purposes, the validity of the anatomical gift is unaffected.

(f) A donor may amend or revoke an anatomical gift, not made by will, only by:

(1) a signed statement;

(2) an oral statement made in the presence of two individuals;

(3) any form of communication during a terminal illness or injury addressed to a physician or surgeon; or

(4) the delivery of a signed statement to a specified donee to whom a document of gift had been delivered.

(g) The donor of an anatomical gift made by will may amend or revoke the gift in the manner provided for amendment or revocation of wills, or as provided in subsection (f).

(h) 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.

(i) An individual may refuse to make an anatomical gift of the individual's body or part by (i) a writing signed in the same manner as a document of gift, (ii) a statement attached to or imprinted on a donor's motor vehicle operator's or chauffeur's license, or (iii) any other writing used to identify the individual as refusing to make an anatomical gift. During a terminal illness or injury, the refusal may be an oral statement or other form of communication.

(j) In the absence of contrary indications by the donor, an anatomical gift of a part is neither a refusal to give other parts nor a limitation on an anatomical gift under Section 3 or on a removal or release of other parts under Section 4.

(k) In the absence of contrary indications by the donor, a revocation or amendment of an anatomical gift is not a refusal to make another anatomical gift. If the donor intends a revocation to be a refusal to make an anatomical gift, the donor shall make the refusal pursuant to subsection (i).

§ 3. MAKING, REVOKING, AND OBJECTING TO ANATOMICAL GIFTS, BY OTHERS

(a) Any member of the following classes of persons, in the order of priority listed, may make an anatomical gift of all or a part of the decedent's body for an authorized purpose, unless the decedent, at the time of death, has made an unrevoked refusal to make that anatomical gift:

(1) the spouse of the decedent;
(2) an adult son or daughter of the decedent;
(3) either parent of the decedent;
(4) an adult brother or sister of the decedent;
(5) a grandparent of the decedent; and
(6) a guardian of the person of the decedent at the time of death.

(b) An anatomical gift may not be made by a person listed in subsection (a) if:

(1) a person in a prior class is available at the time of death to make an anatomical gift;

(2) the person proposing to make an anatomical gift knows of a refusal or contrary indications by the decedent; or

(3) the person proposing to make an anatomical gift knows

of an objection to making an anatomical gift by a member of the person's class or a prior class.

(c) An anatomical gift by a person authorized under subsection (a) must be made by (i) a document of gift signed by the person or (ii) the person's telegraphic, recorded telephonic, or other recorded message, or other form of communication from the person that is contemporaneously reduced to writing and signed by the recipient.

(d) An anatomical gift by a person authorized under subsection (a) may be revoked by any member of the same or a prior class if, before procedures have begun for the removal of a part from the body of the decedent, the physician, surgeon, technician, or enucleator removing the part knows of the revocation.

(e) A failure to make an anatomical gift under subsection (a) is not an objection to the making of an anatomical gift.

§ 4. AUTHORIZATION BY [CORONER] [MEDICAL EXAMINER] OR [LOCAL PUBLIC HEALTH OFFICIAL]

(a) The [coroner][medical examiner] may release and permit the removal of a part from a body within that official's custody, for transplantation or therapy, if:

(1) the official has received a request for the part from a hospital, physician, surgeon, or procurement organization;

(2) the official has made a reasonable effort, taking into account the useful life of the part, to locate and examine the decedent's medical records and inform persons listed in Section 3(a) of their option to make, or object to making, an anatomical gift;

(3) the official does not know of a refusal or contrary indication by the decedent or objection by a person having priority to act as listed in Section 3(a);

(4) the removal will be by a physician, surgeon, or technician; but in the case of eyes, by one of them or by an enucleator;

(5) the removal will not interfere with any autopsy or investigation;

(6) the removal will be in accordance with accepted medical standards; and

(7) cosmetic restoration will be done, if appropriate.

(b) If the body is not within the custody of the [coroner] [medical examiner], the [local public health officer] may release and permit the removal of any part from a body in the [local public health officer's]

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custody for transplantation or therapy if the requirements of subsection (a) are met.

(c) An official releasing and permitting the removal of a part shall maintain a permanent record of the name of the decedent, the person making the request, the date and purpose of the request, the part requested, and the person to whom it was released.

§ 5. ROUTINE INQUIRY AND REQUIRED REQUEST; SEARCH AND NOTIFICATION

(a) On or before admission to a hospital, or as soon as possible thereafter, a person designated by the hospital shall ask each patient who is at least [18] years of age: "Are you an organ or tissue donor?" If the answer is affirmative the person shall request a copy of the document of gift. If the answer is negative or there is no answer and the attending physician consents, the person designated shall discuss with the patient the option to make or refuse to make an anatomical gift. The answer to the question, an available copy of any document of gift or refusal to make an anatomical gift, and any other relevant information, must be placed in the patient's medical record.

(b) If, at or near the time of death of a patient, there is no medical record that the patient has made or refused to make an anatomical gift, the hospital [administrator] or a representative designated by the [administrator] shall discuss the option to make or refuse to make an anatomical gift and request the making of an anatomical gift pursuant to Section 3(a). The request must be made with reasonable discretion and sensitivity to the circumstances of the family. A request is not required if the gift is not suitable, based upon accepted medical standards, for a purpose specified in Section 6. An entry must be made in the medical record of the patient, stating the name and affiliation of the individual making the request, and of the name, response, and relationship to the patient of the person to whom the request was made. The [Commissioner of Health] shall [establish guidelines] [adopt regulations] to implement this subsection.

(c) The following persons shall make a reasonable search for a document of gift or other information identifying the bearer as a donor or as an individual who has refused to make an anatomical gift:

(1) a law enforcement officer, fireman, paramedic, or other emergency rescuer finding an individual who the searcher believes is dead or near death; and

(2) a hospital, upon the admission of an individual at or near

the time of death, if there is not immediately available any other source of that information.

(d) If a document of gift or evidence of refusal to make an anatomical gift is located by the search required by subsection (c)(1), and the individual or body to whom it relates is taken to a hospital, the hospital must be notified of the contents and the document or other evidence must be sent to the hospital.

(e) If, at or near the time of death of a patient, a hospital knows that an anatomical gift has been made pursuant to Section 3(a) or a release and removal of a part has been permitted pursuant to Section 4, or that a patient or an individual identified as in transit to the hospital is a donor, the hospital shall notify the donee if one is named and known to the hospital; if not, it shall notify an appropriate procurement organization. The hospital shall cooperate in the implementation of the anatomical gift or release and removal of a part.

(f) A person who fails to discharge the duties imposed by this section is not subject to criminal or civil liability but is subject to appropriate administrative sanctions.

§ 6. PERSONS WHO MAY BECOME DONEES; PURPOSES FOR WHICH ANATOMICAL GIFTS MAY BE MADE

(a) The following persons may become donees of anatomical gifts for the purposes stated:

(1) a hospital, physician, surgeon, or procurement organization, for transplantation, therapy, medical or dental education, research, or advancement of medical or dental science;

(2) an accredited medical or dental school, college, or university for education, research, advancement of medical or dental science; or

(3) a designated individual for transplantation or therapy needed by that individual.

(b) An anatomical gift may be made to a designated donee or without designating a donee. If a donee is not designated or if the donee is not available or rejects the anatomical gift, the anatomical gift may be accepted by any hospital.

(c) If the donee knows of the decedent's refusal or contrary indications to make an anatomical gift or that an anatomical gift by a member of a class having priority to act is opposed by a member of the same class or a prior class under Section 3(a), the donee may not accept the anatomical gift.

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§ 7. DELIVERY OF DOCUMENT OF GIFT

(a) Delivery of a document of gift during the donor's lifetime is not required for the validity of an anatomical gift.

(b) If an anatomical gift is made to a designated donee, the document of gift, or a copy, may be delivered to the donee to expedite the appropriate procedures after death. The document of gift, or a copy, may be deposited in any hospital, procurement organization, or registry office that accepts it for safekeeping or for facilitation of procedures after death. On request of an interested person, upon or after the donor's death, the person in possession shall allow the interested person to examine or copy the document of gift.

§ 8. RIGHTS AND DUTIES AT DEATH

(a) Rights of a donee created by an anatomical gift are superior to rights of others except with respect to autopsies under Section 11(b). A donee may accept or reject an anatomical gift. If a donee accepts an anatomical gift of an entire body, the donee, subject to the terms of the gift, may allow embalming and use of the body in funeral services. If the gift is of a part of a body, the donee, upon the death of the donor and before embalming, shall cause the part to be removed without unnecessary mutilation. After removal of the part, custody of the remainder of the body vests in the person under obligation to dispose of the body.

(b) The time of death must be determined by a physician or surgeon who attends the donor at death or, if none, the physician or surgeon who certifies the death. Neither the physician or surgeon who attends the donor at death nor the physician or surgeon who determines the time of death may participate in the procedures for removing or transplanting a part unless the document of gift designates a particular physician or surgeon pursuant to Section 2(d).

(c) If there has been an anatomical gift, a technician may remove any donated parts and an enucleator may remove any donated eyes or parts of eyes, after determination of death by a physician or surgeon.

§ 9. COORDINATION OF PROCUREMENT AND USE

Each hospital in this State, after consultation with other hospitals and procurement organizations, shall establish agreements or affiliations for coordination of procurement and use of human bodies and parts.

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§ 10. SALE OR PURCHASE OF PARTS PROHIBITED

(a) A person may not knowingly, for valuable consideration, purchase or sell a part for transplantation or therapy, if removal of the part is intended to occur after the death of the decedent.

(b) Valuable consideration does not include reasonable payment for the removal, processing, disposal, preservation, quality control, storage, transportation, or implantation of a part.

(c) A person who violates this section is guilty of a [felony] and upon conviction is subject to a fine not exceeding [$50,000] or imprisonment not exceeding [five] years, or both.

§ 11. EXAMINATION, AUTOPSY, LIABILITY

(a) An anatomical gift authorizes any reasonable examination necessary to assure medical acceptability of the gift for the purposes intended.

(b) The provisions of this [Act] are subject to the laws of this State governing autopsies.

(c) A hospital, physician, surgeon, [coroner], [medical examiner], [local public health officer], enucleator, technician, or other person, who acts in accordance with this [Act] or with the applicable anatomical gift law of another state [or a foreign country] or attempts in good faith to do so is not liable for that act in a civil action or criminal proceeding.

(d) An individual who makes an anatomical gift pursuant to Section 2 or 3 and the individual's estate are not liable for any injury or damage that may result from the making or the use of the anatomical gift.

§ 12. TRANSITIONAL PROVISIONS

This [Act] applies to a document of gift, revocation, or refusal to make an anatomical gift signed by the donor or a person authorized to make or object to making an anatomical gift before, on, or after the effective date of this [Act].

§ 13. UNIFORMITY OF APPLICATION AND CONSTRUCTION

This [Act] shall be applied and construed to effectuate its general purpose to make uniform the law with respect to the subject of this [Act] among states enacting it.

§ 14. SEVERABILITY

If any provision of this [Act] or its application thereof to any per-

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son or circumstance is held invalid, the invalidity does not affect other provisions or applications of this [Act] which can be given effect without the invalid provision or application, and to this end the provisions of this [Act] are severable.

§ 15. SHORT TITLE

This [Act] may be cited as the "Uniform Anatomical Gift Act (1987)."

§ 16. REPEALS

The following acts and parts of acts are repealed:

(1) ______________________________

(2) ______________________________

(3) ______________________________

§ 17. EFFECTIVE DATE

This [Act] takes effect ______________________.

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APPENDIX C
Removal Of Body Parts, Body Tissue, And Corneal Tissue

Tex. Health & Safety Code Ann. §§ 693.001 - 693.024 (Vernon 1991)

SUBCHAPTER A. REMOVAL OF BODY PARTS OR TISSUE

693.001. Definition

In this subchapter, "visceral organ" means the heart, kidney, liver, or other organ or tissue that requires a patient support system to maintain the viability of the organ or tissue.

§ 693.002. Removal of Body Part or Tissue Permitted Under Certain Circumstances

On a request from a Texas nonprofit medical facility that performs organ transplants or a nonprofit organization or corporation that procures organs or tissues for transplantation, the medical examiner may permit the removal of eyes, heart, skin, bone, liver, kidney, or pancreas and other tissue proven to be clinically usable for transplants or other therapy or treatment if:

(1) the decedent from whom the body part or tissue is to be removed died under circumstances requiring an inquest by the medical examiner;

(2) consent is given as required by Section 693.003 or, if consent is not required by that section, no objection by a person listed in Section 693.004 is known by the medical examiner; and

(3) the removal of the body part or tissue will not interfere with the subsequent course of an investigation or autopsy.

§ 693.003. Consent Required in Certain Circumstances

(a) A medical examiner or a person acting on the authority of a medical examiner may not remove a visceral organ unless the medical examiner or person obtains the consent of a person listed in Section 693.004.

(b) If a person listed in Section 693.004 is known and available within four hours after death is pronounced, a medical examiner or a person acting on the authority of a medical examiner may not remove a non-visceral organ or tissue unless the medical examiner or person obtains that person's consent.

(c) If a person listed in Section 693.004 cannot be identified and contacted within four hours after death is pronounced and the medi-

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cal examiner determines that no reasonable likelihood exists that a person can be identified and contacted during the four-hour period, the medical examiner may permit the removal of a nonvisceral organ or tissue.

§ 693.004. Persons Who May Consent or Object to Removal

The following persons may consent or object to the removal of tissue or a body part:

(1) the decedent's spouse;

(2) the decedent's adult children, if there is no spouse;

(3) the decedent's parents, if there is no spouse or adult child; or

(4) the decedent's brothers or sisters, if there is no spouse, adult child, or parent.

§ 693.005. Immunity from Damages in Civil Action

In a civil action brought by a person listed in Section 693.004 who did not object before the removal of tissue or a body part specified by Section 693.002, a medical examiner, medical facility, physician acting on permission of a medical examiner, or person assisting a physician is not liable for damages on a theory of civil recovery based on a contention that the plaintiff's consent was required before the body part or tissue could be removed.

SUBCHAPTER B. REMOVAL OF CORNEAL TISSUE

§ 693.011. Definition

In this subchapter, "eye bank" means a nonprofit corporation chartered under the laws of this state to obtain, store, and distribute donor eyes to be used by persons licensed to practice medicine for corneal transplants, research, or other medical purposes and the medical activities of which are directed by a person licensed to practice medicine in this state.

§ 693.012, Removal of Corneal Tissue Permitted Under Certain Circumstances

On a request from an authorized official of an eye bank for corneal tissue, a justice of the peace or medical examiner may permit the removal of corneal tissue if:

(1) the decedent from whom the tissue is to be removed died under circumstances requiring an inquest by the justice of the peace or medical examiner;

(2) no objection by a person listed in Section 693.013 is known by the justice of the peace or medical examiner; and

(3) the removal of the corneal tissue will not interfere with the subsequent course of an investigation or autopsy or alter the decedent's postmortem facial appearance.

§ 693.013. Persons Who May Object to Removal

The following persons may object to the removal of corneal tissue:

(1) the decedent's spouse;
(2) the decedent's adult children, if there is no spouse;
(3) the decedent's parents, if there is no spouse or adult child; or
(4) the decedent's brothers or sisters, if there is no spouse, adult child, or parent.

§ 693.014. Immunity From Damages in Civil Action

(a) In a civil action brought by a person listed in Section 693.013 who did not object before the removal of corneal tissue, a medical examiner, justice of the peace, or eye bank official is not liable for damages on a theory of civil recovery based on a contention that the person's consent was required before the corneal tissue could be removed.

(b) Chapter 104, Civil Practice and Remedies Code, applies to a justice of the peace, medical examiner, and their personnel who remove, permit removal, or deny removal of corneal tissue under this subchapter as if the justice of the peace, medical examiner, and their personnel were state officers or employees.

§ 693.021. Definition

In this chapter, "ophthalmologist" means a person licensed to practice medicine who specializes in treating eye diseases.

§ 693.022. Persons Who May Enucleate Eye as Anatomical Gift

Only the following persons may enucleate an eye that is an anatomical gift:

(1) a licensed physician;
(2) a licensed doctor of dental surgery or medical dentistry;
(3) a licensed embalmer; or
(4) a technician supervised by a physician.

§ 693.023. Eye Enucleation Course

Each person, other than a licensed physician, who performs an eye enucleation must complete a course in eye enucleation taught by an

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ophthalmologist and must possess a certificate showing that the course has been completed.

§ 693.024. Requisites of Eye Enucleation Course

The course in eye enucleation prescribed by Section 693.023 must include instruction in:

(1) the anatomy and physiology of the eye;

(2) maintaining a sterile field during the procedure;

(3) use of the appropriate instruments; and

(4) procedures for the sterile removal of the corneal button and the preservation of it in a preservative fluid.

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APPENDIX D
MEDICAL EXAMINER PROCEDURES

TEX. CODE OF CRIM. PROC. ANN. art. 49.25 (Vernon 1979 & Supp. 1991)

Medical Examiners
Organ Transplant Donors; Notice; Inquests

Sec. 6a.(a) When death occurs to an individual designated a prospective organ donor for transplantation by a licensed physician under circumstances requiring the medical examiner of the county in which death occurred, or the medical examiner's authorized deputy, to hold an inquest, the medical examiner, or a member of his staff will be so notified by the administrative head of the facility in which the transplantation is to be performed.

(b) When notified pursuant to Subsection (a) of this Section, the medical examiner or the medical examiner's deputy shall perform an inquest on the deceased prospective organ donor.

(c) If an autopsy is required, the medical examiner or his duly authorized deputy will examine the organ to be transplanted in its whole state and will examine any other clinical evidence on the condition of the organ.

(d) The organ to be transplanted will then be released to the transplant team for removal and transplantation.

(e) Thereafter, the remainder of the body will be removed to some convenient and suitable area designated by the administrative head of the transplant facility for completion of the autopsy.

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APPENDIX E
TRANSPLANTS AND TRANSFUSIONS

TEX. CIV. PRAC. & REM. CODE ANN. § 77.003 (VERNON SUPP. 1991)

§ 77.003. Limitation of Liability

(a) A person who donates, obtains, prepares, transplants, injects, transfuses, or transfers a human body part from a living or dead human to another human or a person who assists or participates in that activity is not liable as a result of that activity except for negligence, gross negligence, or an intentional tort.

(b) The Deceptive Trade Practices-Consumer Protection Act (Subchapter E, Chapter 17, Business & Commerce Code) does not apply with respect to claims for damages for personal injury or death resulting or alleged to have resulted from negligence on the part of the person described in Subsection (a) of this section in connection with an activity designated in said subsection.

(c) The implied warranties of merchantability and fitness do not apply to the furnishing of human body parts by blood banks, tissue banks, or other similar organizations. For purposes of this chapter, those human body parts are not considered commodities subject to sale or barter.

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APPENDIX F
DRIVER'S LICENSE

TEX. REV. CIV. STAT. ANN. art. 6687b § 11b (Vernon Supp. 1991)

ANATOMICAL GIFTS

Sec. 11B. (a) A person who wishes to be an eye, tissue, or organ donor may execute a statement of gift printed on the reverse side of the donor's driver's license. A statement of gift executed on the reverse side of a driver's license complies with the requirements of the Texas Anatomical Gift Act (Article 4590-2, Vernon's Texas Civil Statutes).

(b) A statement of gift must be executed each time a driver's license is renewed, reinstated, or replaced.

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APPENDIX G
SAMPLE BRAIN DEATH-PREREQUISITE FOR ORGAN DONATION DISCUSSION ORGAN DONOR MANUAL

Brain death is the irreversible cessation of all functions of the brain and brain stem. Brain death is the first and foremost criteria for a potential organ donor. The patient who may be a suitable cadaveric organ donor:

*Is Brain Dead

*Is being maintained on a respirator

*Has good renal function

*Has no malignancy outside the cranial cavity.

*Has no signs of systemic infections

DETERMINATION OF BRAIN DEATH

The following guidelines are presented to assist the physician in determining Brain Death.

In accordance with the current state of knowledge, the patient who remains apneic and unresponsive while circulation is maintained, can be declared brain dead if the following conditions are fulfilled:

*There must be absence of:

Drug intoxication, paralyzing agents and muscular relaxants
Cardiovascular shock
Metabolic Disorders
Hypothermia
Remedial Lesions
Cerebral Unresponsiveness

The patient is comatose with absolutely no withdrawal or posturing movement to any painful or external stimuli.

*Brainstem Unresponsiveness - There must be absence of:

Respiratory reflex - The patient must be apneic and must not have any spontaneous respiratory function after being removed from the ventilator and Pa CO-2 is allowed to rise greater than 60mm HG. (Arterial blood gases drawn approximately 5 minutes after cessation of mechanical ventilation is usually sufficient time to document this level of hypercarbia).

Pupillary light reflex,
Corneal reflex,
Oculocephalic reflex, (Doll's Eyes)
Oculovestibular reflex, (Calorics)

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Oropharyngeal reflex, (cough and gag reflex)
*Occurrence of Spinal Reflexes
The characteristics of spinal reflexes have little relevance to the state of the brain.
Preservation of spinal reflexes including mass responses is not inconsistent with complete destruction of the brain.
*Absense of Brain Activity
Electrocerebralsilence (ECS). The EEG has been defined as a valuable adjunct but not essential in diagnosing Brain Death. A flat EEG has been encountered in drug or hypothermic coma with ultimate complete recovery of the patient. Many brain dead patients will retain EEG activity to the time of asystole. Thus the EEG may be helpful, but not essential.
*An Etiology must be established
Drug coma or hypothermic coma may require longer periods of observation than head trauma or stroke.

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APPENDIX H
SAMPLE ORGAN DONOR HOSPITAL PROTOCOL

SOUTHWEST TEXAS METHODIST HOSPITAL
STANDARD POLICY AND/OR PROCEDURE

TITLE: Donation of All or Part of a Body
PREPARED BY:
APPROVED BY:
EFFECTIVE DATE:
STATEMENT OF PURPOSE:
To outline the steps necessary to assist a patient or next of kin to donate all or part of the body.
To adhere to Federal Social Security Act, Section 1138, which requires that hospitals meeting the requirements of title XVIII OR XIX may participate in the program only if the hospital establishes written protocols for the identification of potential organ donors; that families of potential donors are made aware of the option of organ or tissue donation; that protocols encourage discretion and sensitivity to such families and that an organ procurement agency be notified of potential donors.

TEXT:

Identification of Potential Donors

Inquiries to patients and families shall be made only if the potential donor meets the criteria for organ donation. There are two categories of patients that may be considered.
1. The VITAL ORGAN DONOR - (Heart, Liver, Kidney, Pancreas, Lung)
Is brain dead
Is being maintained on a respirator
Has no malignancy outside the cranial cavity
Has no signs of systemic infections
These patients are normally victims of:
Head trauma
Self-inflicted gunshot
Cerebral vascular accident

Range in age from approximately two months to 55 years old. Primary Responsibility: Nursing Service Distribution: Routine Coordinating Responsibility:Laboratory Service

Procedures

1. Physician recognizes patient as an organ donor candidate, and discusses "Brain-Death" and organ donation with next of kin. (Refer to Nursing Policy and Procedure for definitive information.)
2. After family verbal consent is received, physician contacts South Texas Organ Bank (512-732-9612) to verify patient as acceptable donor. Additional lab work will be requested for this verification.
3. Nursing Staff notifies Nursing Supervisors and/or Administration. Contract between Hospital and South Texas Organ Bank on file grants temporary privileges for Organ Bank team to function at Southwest Texas Methodist Hospital.
4. Physician verifies and pronounces "Brain Death," and documents time and conversation with NOK in the progress notes. Time of Brain Death pronouncement is also recorded as time of death in nurses notes and record of death.
5. Have consent form (attached) signed by nearest next of kin. Specify on the consent those organs for which permission has been granted (kidneys, eyes, liver, lungs, heart). Original consent form remains with chart. Make a copy to give to the Organ Bank team.
6. All charges incurred for organ procurement and those after Brain Death procurement will be sent to the Organ Bank.
7. Notify on-call OR staff of the surgery and provide estimated time of arrival of Organ Bank team.
8. Notify funeral home (as designated by family of patient) that we will call them on completion of procedure.
9. Coroner's cases follow established procedures.

Note: Please refer to the South Texas Organ Bank Manual for more definitive information on specific donated body parts. The manual may be found in OR, SICU, Nursing Office, and Administration. The Nursing Policy and Procedure, approved by the Intensive Care Committee, has more detailed instructions, physician orders and procedures for organ donation.

(NOTE: This SPP supersedes SPP 25-9 dated April 2, 1979, which will be removed from the files and destroyed.

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APPROVED: APPROVED:

______________________ ______________________

Director of Education Administrator

Attachment (A403)

SOUTHWEST TEXAS METHODIST HOSPITAL

San Antonio, Texas

DONATION OF BODY OR PARTS THEREOF

Upon my death, I hereby will, give, bequeath, and donate my

(Specify body or parts of body)

to ____

(Individual, hospital, institution, storage bank or can be left blank).

for the purpose of advancing medical science, or for the replacement or rehabilitation of diseased or worn-out organs, members, or parts of living persons.

____

(signature)

____

(witness)

____

DATE

____

(witness)

****

I, __________, being the next of kin of __________, deceased, do hereby consent to the removal of :______________________ (specify body or part of body) for purposes of advancing medical science, or for the replacement or rehabilitation of diseased or worn-out organs, members, or parts of living persons.

____

(Signature of next of kin)

____

(Relationship)

____

(witness)

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____
Date

____
(witness)

INSTRUCTIONS:

1. Four copies are required (Do not use carbon) COPIES MUST BE LEGIBLE
2. Copies of the consent are to be distributed as follows:
   A. Original to Donee, by donor or next of kin.
   B. Copy on the chart
   C. Copy to the donor for his personal file.
   D. Copy for the donor to give the mortician if desired.

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