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DETERMINING DEATH: THE LEGAL AND THEOLOGICAL ASPECTS OF BRAIN- RELATED CRITERIA†

J. STUART SHOWALTER*

I. INTRODUCTION

The perplexing questions surrounding what has come to be rather loosely referred to as the "definition of death" issue have received more comment in medical-legal literature in the past few years than perhaps any other single issue. The subject has been the topic of numerous conferences and countless exchanges among religious leaders, attorneys, medical specialists, hospital personnel, and ordinary laymen. It continues to be a key issue in lawsuits around the nation and has been the subject of intensive consideration by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. Nevertheless, many issues remain unsettled.

The question gains interest because it is so unique to our modern era. From the beginning of history, death was a simple occurrence—one was either dead or alive. Death was simply "[t]he cessation of life; the ceasing to exist"¹ In the past two decades, however, advances in medical technology have made the standard definition of death anachronistic under certain circumstances. Artificial maintenance of respiration and circulation now creates legal difficulties in the areas of homicide, negligence claims, insurance, transplantation of anatomical parts, workers' compensation, probate law, and taxes. Similarly, difficult ethical, moral, and social questions surround the determination of when or whether a

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¹ BLACK'S LAW DICTIONARY 488 (4th ed. 1951).

person is medically and legally dead.

Recognizing the controversy surrounding the so-called "definition of death," and responding to inquiries from a number of Catholic health care facilities, this article discusses the issues from the perspective of Catholic health care.

It is important to recognize at the outset that some writers and commentators improperly classify the issue as one of *defining* death. In reality, however, a definition—the expression of the essential meaning of the word "death"—is not the central issue. What is truly at issue is the recognition of criteria, beyond the traditional absence of cardiorespiratory function, which physicians can use accurately, reliably, and practically to diagnose death. Therefore, this article has studiously avoided using the expression "defining death," preferring instead to refer to brain-related criteria for *determining* death's occurrence as a relatively precise event in one's personal history. The brain is identified as the appropriate organ because it is the integrating, unifying force of the human person.

Research for this study involved a winnowing process that has operated to eliminate many of the topics that, though important, are not directly concerned with the acceptance of death-determinative criteria. Among these are: euthanasia, both active and passive;³ abortion; the so-called right to be well born;⁴ criminal and tort liability of physicians;⁵ the moral implications of extraordinary life support measures;⁶ the validity and advisability of the "living will";⁷ the Uniform Donor Act and transplants of anatomical parts;⁸ and the right to refuse treatment either for oneself or for an incompetent.⁹

The foregoing issues primarily are concerned with answering the question, "Should the patient be allowed to die?" This study, on the other hand, addresses "Is the patient dead?"⁹ Furthermore, the study ex-

³ See, e.g., Fletcher, *Abortion, Euthanasia, and Care of Defective Newborns*, 292 *NEW ENG. J. MED.* 75, 75-77 (1975); Rachels, *Active and Passive Euthanasia*, 292 *NEW ENG. J. MED.* 78, 78-80 (1975); *A Right to Die?*, *NEWSWEEK*, Nov. 3, 1975, at 58, 58-69.

⁴ See, e.g., Fletcher, *supra* note 2, at 76.

⁵ See, e.g., Fletcher, *Prolonging Life*, 42 *WASH. L. REV.* 999, 1000-04 (1967).

⁶ See, e.g., *In re Quinlan*, 70 N.J. 10, 42-51, 355 A.2d 647, 665-69, *cert. denied*, 429 U.S. 922 (1976). The New Jersey Supreme Court, in its historic decision which permitted the removal of life support systems from Karen Quinlan, stated that there is "a real distinction between the self-infliction of deadly harm and a self-determination against artificial life support or radical surgery, for instance, in the face of irreversible, painful and certain imminent death." 70 N.J. at 43, 355 A.2d at 665.

⁷ See, e.g., Kutner, *The Living Will—Coping With the Historical Event of Death*, 27 *BAYLOR L. REV.* 39, 39-52 (1975).

⁸ See, e.g., Berman, *The Legal Problems of Organ Transplantation*, 13 *VILL. L. REV.* 751, 752-54 (1968).

⁹ See, e.g., *Quinlan*, 70 N.J. at 38-41, 355 A.2d at 662-64.

⁹ One must recognize that in answering the question of when death occurs, the concept of

amines whether criteria for answering the questions are necessary and proper subjects of legislative action. Before considering the legal aspects, however, it is important to review the subject from the perspective of the Catholic Church's teaching.

II. THEOLOGICAL CONSIDERATIONS

Quite clearly, the Roman Catholic Church views all life as being sacred from the moment of conception.¹⁰ Pope John Paul II, in the Homily during the Mass he celebrated on the Mall in Washington, D.C. in 1979, reasserted the Church's constant teaching on the sanctity of human life: "I do not hesitate to proclaim before you and before the world that all human life—from the moment of conception and through all subsequent stages—is sacred, because human life is created in the image and likeness of God."¹¹ From this heavy emphasis on the sacredness of life, however, one should not conclude that the Catholic Church teaches that life should be sustained at all costs or that every means of modern technology must always be employed to maintain a dying person.

That one is not obliged to use every possible means of keeping a person alive, has roots which go back at least to St. Thomas Aquinas and Francisco de Vitoria in the 13th and 15th centuries, respectively.¹² Aquinas recognized that the obligation to preserve life is tempered by considerations relating to the proper pursuit of one's final end, the "happiness of eternal life with God."¹³ De Vitoria expanded on Aquinas and raised a number of points worth highlighting here:

- (1) A sick person is required to take food *if* there exists some hope of life.

"death" that is applied will depend on the observer's biases and preconceived notions of the desired result. Furthermore, the context in which the question is raised may determine the outcome. As Justice Oliver Wendell Holmes once wrote, "[a] word is not a crystal, transparent and unchanged, it is the skin of a living thought and may vary greatly in color and content according to the circumstances and the time in which it is used." *Towne v. Eisner*, 245 U.S. 418, 425 (1918) (citation omitted). Thus, what is death for purposes of estate taxes may not be death for purposes of determining criminal liability for homicide, and neither may be the proper definition of death for determining when a vital organ may be removed from a body for purposes of transplantation. In short, scholars and legislators recognize the need for a workable measure of when someone stops living because serious legal, ethical, and medical implications hang in the balance.

¹⁰ See generally *MORAL RESPONSIBILITY IN PROLONGING LIFE DECISIONS* 1-2 (D. McCarthy & A. Moraczewski eds. 1981) [hereinafter cited as *PROLONGING LIFE DECISIONS*]; POPE JOHN XXIII *MEDICAL-MORAL RESEARCH AND EDUCATION CENTER, THE NEW TECHNOLOGIES OF BIRTH AND DEATH* 34 (1980) [hereinafter cited as *NEW TECHNOLOGIES*]; VATICAN CONGREGATION FOR THE DOCTRINE OF THE FAITH, *DECLARATION ON EUTHANASIA* 1-5 (1980).

¹¹ *NEW TECHNOLOGIES*, *supra* note 10, at 19.

¹² Atkinson, *Theological History of Catholic Teaching on Prolonging Life*, in *PROLONGING LIFE DECISIONS*, *supra* note 10, at 95-100.

¹³ *Id.* at 97.

(2) But, if the patient is so depressed or has lost his appetite so that it is only with the greatest effort that he can eat food, this . . . creates a kind of impossibility and the patient is excused at least from mortal sin, especially if there is little or no hope of life.

(3) Furthermore, the obligation to take drugs is even less serious. This is because food is "*per se* a means ordered to the life of the animal" and is natural, whereas drugs are not. A person is not obliged to employ every possible means of preserving his life, but only those that are *per se* intended for that purpose.

(4) Nevertheless, if one had a moral certitude that the use of a drug would return him to health, and that he would die otherwise, then the use of the drug would be obligatory. If he did not give the drug to a sick neighbor, he would sin mortally, so it seems he would have the same responsibility to save his life. Medicine is also *per se* intended by nature for health.

(5) On the other hand, it is rarely certain that drugs will have this effect [of preserving life], so it is not mortally sinful to declare abstinence from all drugs, though this is not a praiseworthy attitude to take since God has created medicine because of its usefulness.

(6) It is one thing not to protect or prolong life; it is quite another thing to destroy it. A person is not always held to the first.

(7) To fulfill the obligation to protect life, it is sufficient that a person perform "that by which regularly a man can live." Again, if a person "uses foods which men commonly use and in the quantity which customarily suffices for the conservation of strength," then the person does not sin even if his life is notably shortened thereby, and this is recognized.

(8) Thus, a sick person would not be required to use a drug he could not obtain except by giving over his whole means of subsistence. Nor would an individual be required to use the best, most delicate, most expensive foods, even though they be the most healthful. . . .¹⁴

These principles, which changed only slightly through the centuries, were enunciated in 1957 by Pope Pius XII during an address to an international meeting of anesthesiologists:

[N]ormally one is held to use only ordinary means—according to circumstances of persons, places, times, and culture—that is to say, means that do not involve any grave burden for oneself or another. A more strict obligation would be too burdensome for most men and would render the attainment of the higher, more important good too difficult. Life, health, all temporal activities are in fact subordinated to spiritual ends. On the other hand, one is not forbidden to take more than the strictly necessary steps to preserve life and health, as long as he does not fail in some more serious duty.¹⁵

In the same address, Pope Pius XII turned to the question of who should

¹⁴ *Id.* at 98-99 (footnotes and parentheticals omitted).

¹⁵ Address by Pope Pius XII, *The Prolongation of Life* (Nov. 24, 1957), reprinted in 4 *THE POPE SPEAKS* 393, 395-96 (1957).

make the determination of death: "It remains for the doctor . . . to give a clear and precise definition of 'death' and the 'moment of death' of a patient who passes away in a state of unconsciousness."¹⁶

For Christians, death is not seen as the destruction or annihilation of the person. Although dissolution of the spirit-body bond that exists during our life on earth is painful, death, viewed as transformation of the person to a new state of existence, is not. Furthermore, the Christian believes that he will be resurrected: that the body in some way will share in the new life promised by Jesus Christ. Thus, the Christian is able to view the determination of death from a wider perspective than the purely medical. This understanding provides the proper perspective for approaching the legal aspects of the determination of death.

III. LEGAL ASPECTS

A. Background

A major focus of cases and law review articles on this subject is the definition of "death" found in the 1951 edition of *Black's Law Dictionary*: "The cessation of life; the ceasing to exist; defined by physicians as a total stoppage of the circulation of the blood, and a cessation of the animal and vital functions consequent thereon, such as respiration, pulsation, etc."¹⁷ To this, the case law has added: "[D]eath occurs precisely when life ceases and does not occur until the heart stops beating and respiration ends. Death is not a continuing event and is an event that takes place at a precise time."¹⁸

For many years this venerable language was sufficient in all respects, and it remains so today in most instances. But the advent of artificial life support systems has raised serious questions about the traditional legal concept of death. Thus, *Black's* definition received much criticism,¹⁹ resulting in an expanded new definition in the fifth edition of the

¹⁶ *Id.* at 396.

¹⁷ BLACK'S LAW DICTIONARY 488 (4th ed. 1951).

¹⁸ *Thomas v. Anderson*, 96 Cal. App. 2d 371, 375, 215 P.2d 478, 482 (Ct. App. 1950).

¹⁹ See, e.g., Halley & Harvey, *Medical vs. Legal Definitions of Death*, 204 J. A.M.A. 103, 104 (1968); Horan, *Determination of Death*, in PROLONGING LIFE DECISIONS, *supra* note 10, at 58; Ufford, *Brain Death/Termination of Heroic Efforts to Save Life—Who Decides?*, 19 WASHBURN L.J. 225, 227 (1980); Comment, *Lovato v. District Court: The Dilemma of Defining Death*, 58 DEN. L.J. 627, 627 (1981). Even prior to the advances in medicine which occasioned the current definition of death, see BLACK'S LAW DICTIONARY 360 (rev. 5th ed. 1979), the definition embodied in the fourth edition of *Black's* was sometimes the cause of judicial absurdity. For example, in *Gray v. Sawyer*, 247 S.W.2d 496 (Ky. Ct. App. 1952), the Kentucky Court of Appeals, in resolving a question of survivorship, noted that this definition of death theoretically required a finding that an accident victim was still alive even though she had been decapitated, because blood was spurting from her body thus indicating continuance of pulsation. *Id.* at 497.

dictionary.²⁰

It is important to recognize one aspect of *Black's* original definition: it refers the reader to medical standards for its substance, and modern medicine does not agree that death means only the cessation of pulse and respiration or that it is an instantaneous process. In one sense, from the moment of birth, one's life is a slow process of dying. Indeed, medicine can document various levels of death within human experience: heart death, death of various levels of the brain, and cellular death.²¹

Thus, the longstanding legal definition, based upon circulation and respiration, was sufficient for a time when all that was required to pronounce a patient dead was a mirror and a stethoscope. The precise moment of death was seldom necessary to determine, because if one stopped breathing and his heart did not beat, he was dead; there was no reason to be more precise than the *day* of death. Recent events, however, have graphically shown the importance in modern society of being able to use other criteria for determining death and for determining precisely when death occurs.

Nothing brought these considerations more clearly into focus than the advent of cardiac transplantation surgery. Indeed, while a heart that has not been beating for some time is worthless to its recipient, a heart still beating is indispensable to its owner (at least by the old definition). The 1972 case of *Tucker v. Lower*²² illustrates the point.

In 1968, the decedent, Bruce Tucker, sustained serious head injuries as a result of a fall. Though heroic measures were attempted, he was unable to breathe without the assistance of a respirator. Approximately 24 hours after the accident an electroencephalogram (EEG) showed no cerebral activity. Tucker was removed from the respirator, and following a period of 5 minutes, during which he exhibited no spontaneous respirations, he was pronounced dead. Authorization had been obtained to transplant his heart into the chest of a patient who was suffering cardiac failure. (The authorization was obtained from the local medical examiner since no relative of Tucker could be located. The diligence of the medical personnel's search was an issue in the trial that followed.) The transplant was accomplished, but the heart recipient died about a week later.

When Tucker's family was finally located, his brother filed a wrong-

²⁰ BLACK'S LAW DICTIONARY 360 (rev. 5th ed. 1979).

²¹ See W. SPITZ & R. FISHER, *MEDICOLEGAL INVESTIGATION OF DEATH* 12-13 (2d ed. 1980); Beecher, *Ethical Problems Created by the Hopelessly Unconscious Patient*, 278 *NEW ENG. J. MED.* 1425, 1426-28 (1968); Article, *The Time of Death—A Legal, Ethical and Medical Dilemma*, 18 *CATH. LAW.* 243, 246 (1972).

²² No. 72-2831 (Va. Ct. Law & Eq., May 25, 1972). This important case has received some attention in the literature. See Fletcher, *New Definitions of Death*, 2 *PRISM* 13 (1974); Comment, *But When Did He Die?: Tucker v. Lower and the Brain-Death Concept*, 12 *SAN DIEGO L. REV.* 424, 424-30 (1975).

ful death claim for \$1 million. At the close of the evidence the judge instructed the jury:

[Y]ou shall determine the time of death in this case by using the following definition of the nature of death. Death is a cessation of life. It is the ceasing to exist. Under the law, death is not continuing but occurs at a precise time. . . . In determining [it] you may consider the following elements . . . [among them] the time of complete and irreversible loss of all function of the brain.²³

The jury took approximately 1 hour to return a verdict for the physicians absolving them of the death of Tucker.

A similar case in California decided the same type of issue in a criminal courtroom. The court held that the defendant, who had shot the victim, was the party responsible for the victim's death rather than the physicians who performed the heart transplant, as the defendant had argued.²⁴ Significantly, the judge decided *as a matter of law* that based upon the concept of brain death the victim had died before the physicians removed his heart. Thus he instructed the jury, "since the deceased . . . was dead, before the removal of his heart, there was no issue of fact as to the cause of death."²⁵

In both of these cases the courts recognized the nearly unanimous medical consensus that when the whole brain, including the brain stem, no longer functions, the person is dead. Furthermore, the cases reinforce the opinion that determining when death occurs is a clinical medical judgment, not a legal one.²⁶

Unfortunately, general recognition of this position has evolved slowly enough such that many states have adopted the brain death concept legislatively. These laws, which have met various degrees of criticism from both legal and medical circles, are discussed in the next section.

²³ Comment, *supra* note 22, at 424.

²⁴ *People v. Lyons*, 15 Crim. L. Rep. (BNA) 2240 (Cal. Super. Ct. 1974). For a discussion of the *Lyons* decision, see Friloux, *Death, When Does it Occur?*, 27 BAYLOR L. REV. 10, 14-15 (1975).

²⁵ Friloux, *supra* note 24, at 15 (quoting *People v. Lyons*, 15 Crim. L. Rep. (BNA) 2240 (Cal. Super. Ct. 1974)).

²⁶ See *Bacchiochi v. Johnson Memorial Hosp.*, No. 81-256126 (Conn. Super. Ct., Mar. 17, 1981). The *Bacchiochi* court stated that such decisions, as disconnecting a respirator in a brain-dead person, "are best determined by the family, by the attending physicians and by the hospitals involved, and . . . judicial intervention should be required only where it is necessary to protect those persons who are acting in their professional capacity from possible criminal or civil liability." *Id.*; see *Lovato v. District Court*, 198 Colo. 419, 432, 601 P.2d 1072, 1081 (1979); *Swafford v. Indiana*, 421 N.E.2d 596, 601 (Ind. 1981); *In re Bowman*, 94 Wash. 2d 407, 410, 617 P.2d 731, 732 (1980). The *Bowman* court stated that "the law has adopted standards of death but has turned to physicians for the criteria by which a particular standard is met." 94 Wash. at 412, 617 P.2d at 734; see *Schneck, Brain Death and Prolonged States of Impaired Responsiveness*, 58 DEN. L.J. 609, 621 (1981).

B. Legislation

In all, twenty-nine states had enacted some form of determination-of-death statutes as of early 1982. The various laws fall into three categories: (1) those with *alternative* definitions; (2) those that consider brain function *only* if artificial means of support prevent determination of death by the traditional means; and (3) those that ignore the traditional standards and refer to brain function only.

The first type of statute was adopted in 1970, when Kansas became the first state to pass a brain death statute of any kind. The Kansas statute states:

A person will be considered medically and legally dead if, in the opinion of a physician, based on ordinary standards of medical practice, there is the absence of spontaneous respiratory and cardiac function and, because of the disease or condition which caused, directly or indirectly, these functions to cease, or because of the passage of time since these functions ceased, attempts at resuscitation are considered hopeless; and, in this event, death will have occurred at the time these functions ceased; or

A person will be considered medically and legally dead if, in the opinion of a physician, based on ordinary standards of medical practice, there is the absence of spontaneous brain function; and if based on ordinary standards of medical practice, during reasonable attempts to either maintain or restore spontaneous circulatory or respiratory function in the absence of aforesaid brain function, it appears that further attempts at resuscitation or supportive maintenance will not succeed, death will have occurred at the time when these conditions first coincide. Death is to be pronounced before any vital organ is removed for purposes of transplantation.

These alternative definitions of death are to be utilized for all purposes in this state, including the trials of civil and criminal cases, any laws to the contrary notwithstanding.²⁷

This law has been criticized primarily for having retained, as alternatives, the criteria of both a nonfunctioning brain and cardiorespiratory failure. According to its detractors, the Kansas law

appears to be based on, or at least gives voice to, the misconception that there are two separate phenomena of death. This dichotomy is particularly unfortunate because it seems to have been inspired by a desire to establish a special definition for organ transplantation, a definition which physicians would not, however, have to apply, in the draftsman's words, "to prove the irrelevant deaths of most persons." . . . One hopes that the form the statute takes does not reflect a conclusion on the part of the Kansas legislature that death occurs at two distinct points during the process of dying. Yet this inference can be derived from the Act, leaving open the prospect "that X at

²⁷ KAN. STAT. ANN. § 77-202 (Supp. 1981). Maryland quickly enacted a nearly identical statute. See MD. ANN. CODE art. 43, § 54F (1980).

a certain stage in the process of dying can be pronounced dead, whereas Y, having arrived at the same point, is not said to be dead."²⁸

The second category is represented by Michigan's statute:

A person will be considered dead if in the announced opinion of a physician, based on ordinary standards of medical practice in the community, there is the irreversible cessation of spontaneous respiratory and circulatory functions. *If* 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 in the community, there is the irreversible cessation of spontaneous brain function. Death will have occurred at the time when the relevant functions ceased.²⁹

One version of the last category is found in Georgia: "A person *may* be pronounced dead if it is determined that the person has suffered an irreversible cessation of brain function. There shall be independent confirmation of the death by another physician."³⁰ Another form is seen in a now-supplanted American Bar Association model statute: "For all legal purposes, a human body with irreversible cessation of total brain function, according to usual and customary standards of medical practice, *shall* be considered dead."³¹ As of February, 1982, however, twenty-one states and the District of Columbia had not yet adopted a statutory definition of death.

While certain drafting variations account for the three classifications of the statutes, one salient feature is common to them all: they either explicitly or implicitly refer to the standards of medical practice for the determination of when death occurs. This reemphasizes the fact that, as stated earlier, death is a clinical diagnosis, not a legal decision. As one commentator has observed:

What these statutes . . . are simply saying is that when [the] brain has irreversibly ceased all of its functions [the person is] dead. . . . We should not confuse that acceptable medical fact with the also acceptable medical fact that, in any given case, it may be difficult to prove that the brain has irre-

²⁸ Capron & Kass, *A Statutory Definition of the Standards for Determining Human Death: An Appraisal and a Proposal*, 121 U. PA. L. REV. 87, 109-10 (1972). Other authorities expressed this criticism of the statute:

Lawyers, for their part, have made their common mistake of assuming that because a problem or confusion exists the answer is to pass a new statute. What they fail to appreciate is that medicine is an evolving science and that what constitutes a definition of death by today's standards may be inappropriate tomorrow.

MacDonald & Meyer, *Medicolegal Notes—Defining Death*, 43 MT. SINAI J. MED. 300 (1976).

²⁹ MICH. STAT. ANN. § 14.15 (1021) (Supp. 1981-1982) (emphasis added).

³⁰ GA. CODE ANN. § 88-1715.1(a) (1979) (emphasis added).

³¹ 100 A.B.A. ANN. REP. 231-32 (1975) (emphasis added).

versibly ceased all of its functions.³³

Few cases have interpreted the brain death statutes. In one such case, cf] *State v. Shaffer*,³³ the defendant argued that the statute was unconstitutionally vague because it (1) set forth both the brain-death and the traditional death standards and (2) based the determination on "ordinary standards of medical practice."³⁴ The Supreme Court of Kansas found both arguments without merit, summarily dismissing the first,³⁵ and stating as to the second:

There is disagreement within the medical profession as to exactly what tests should be employed to determine death. This, of course, is not unusual within that profession. . . .

"Ordinary standards of medical practice" change as medical knowledge and technology improve. Under the instructions given in this case, it was for the jury to determine whether the medical standards . . . had been met. Much of the testimony presented at trial went to this very point. The attack on the statute for failure to specifically enumerate criteria is held to be without merit.³⁶

C. States Without Legislation

In a growing number of states the brain-related criteria for diagnosing death have been adopted even in the absence of legislation. For example, in *State v. Fierro*,³⁷ the Supreme Court of Arizona adopted brain-related criteria in a homicide case. The defendant had argued that the termination of life support systems by medical personnel was the cause of the decedent's death and that, therefore, there was insufficient evidence to convict him of murder.³⁸ The court did not agree and stated:

The removal of the life support systems was not the proximate cause of death, the gunshot wounds were, and it was not error to find that the defendant was the cause of the victim's death. . . .

We also believe that the defendant was legally dead before the life support systems were withdrawn. . . . [O]ur legislature . . . has not adopted a definition of death. A statutory definition is not necessary, however.³⁹

³³ Horan, *supra* note 19, at 66.

³⁴ 223 Kan. 244, 574 P.2d 205 (1977).

³⁵ *Id.* at 249, 574 P.2d at 207.

³⁶ *Id.* at 249-50, 574 P.2d at 208-09.

³⁷ *Id.*, 574 P.2d at 209-10. See also *People v. Lyons*, 15 Crim. L. Rep. (BNA) 2240, 2240-41 (Cal. Super. Ct. 1974); *People v. Vanderford*, 77 Mich. App. 370, 372, 258 N.W.2d 502, 503-04 (Ct. App. 1977); *State v. Brown*, 8 Or. App. 72, 75, 491 P.2d 1193, 1194-95 (Ct. App. 1971).

³⁸ 124 Ariz. 182, 603 P.2d 74 (1979).

³⁹ *Id.* at 184, 603 P.2d at 76.

³⁹ *Id.* at 185, 603 P.2d at 77.

After discussing the traditional *Black's Law Dictionary* definition, the court made reference to a "Uniform Brain Death Act" proposed by the National Conference of Commissioners on Uniform State Laws. At that time, the draft of that proposed statute read: "For legal and medical purposes, an individual who has sustained irreversible cessation of all functioning of the brain, including the brain stem, is dead."⁴⁰ The Act also required the determination to be made in accordance with reasonable medical standards.

The court then concluded that even though the state legislature had not acted, adoption of the criterion of brain death was warranted. "We believe that while the common law definition of death is still sufficient to establish death, [brain death], if properly supported by expert medical testimony, is also a valid test for death in Arizona."⁴¹

In *Lovato v. District Court*,⁴² the issue involved the death of a victim of child abuse whose parents petitioned to prevent the physicians from removing life support systems.⁴³ In response to the arguments that a lower court exceeded its authority in ordering discontinuance of the respirator, the Supreme Court of Colorado stated:

We do not share that opinion. We are of the opinion, as were the medical experts and the respondent court, that sometime prior to [the disconnection of the life support systems] the child had joined that innumerable caravan and moved to his chamber in the silent halls of death.

The prime issue before us is the proper definition of death

. . . .

. . . With advances, including resuscitative technology and organ transplants, the medical community has developed a more complete definition of death. There is a wealth of material describing these advances during the past 10 years. The all but unanimous view endorses the concept of brain death.

. . . .

We recognize the authority of, and indeed encourage, the General Assembly to pronounce statutorily the standards by which death is to be determined in Colorado. We do not, however, believe that in the absence of legislative action we are precluded from facing and resolving the legal issue of whether irretrievable loss of brain function can be used as a means of detecting the condition of death. Under the circumstances of this case we are not only entitled to resolve the question, but have a duty to do so. To act otherwise would be to close our eyes to the scientific and medical ad-

⁴⁰ UNIF. BRAIN DEATH ACT § 1, 12 U.L.A. 16 (West Supp. 1982) (superseded in 1980 by the UNIF. DETERMINATION OF DEATH ACT § 1, 12 U.L.A. 209 (West Supp. 1982)).

⁴¹ 124 Ariz. at 185-86, 603 P.2d at 77-78.

⁴² 198 Colo. 419, 601 P.2d 1072 (1979).

⁴³ *Id.* at 421, 601 P.2d at 1073.

vances made worldwide in the past two or three decades.⁴⁴

Needless to say, the court adopted the brain death standard. Similar cases have also arisen in Wisconsin,⁴⁵ Massachusetts,⁴⁶ New York,⁴⁷ Washington,⁴⁸ Minnesota⁴⁹ and Indiana.⁵⁰

No state has been found in which the concept of brain death has been rejected.⁵¹ *Bacchiochi v. Johnson Memorial Hospital*,⁵² however, is sometimes advanced as such a case. In *Bacchiochi*, a physician who had diagnosed irreversible cessation of all brain function nevertheless refused to disconnect the life support system unless given immunity from prosecution. When the state's attorney would not grant immunity, the patient's family sued to have her removed from the respirator. There ensued 4 days of wasteful and inane legal hearings, "attended by attorneys representing at least eight different parties,"⁵³ following which the judge declined to invoke Connecticut's organ-transplant-related brain death law. The court, however, reinforced the belief that judicial intervention was unnecessary and that the medical diagnosis was determinative. After the state's attorney indicated that he had no intention of prosecuting, the case was resolved without the procurement of a formal order.⁵⁴

Apprehension on the part of physicians, such as that which led to

⁴⁴ *Id.* at 424, 425-26, 601 P.2d at 1075, 1076. This case contains an excellent review of the medical-legal literature on this subject as it existed in 1979. *Id.* at 425-31, 601 P.2d at 1076-80. Colorado has since adopted the brain death concept legislatively. COLO. REV. STAT. § 12-36-136 (Supp. 1981).

⁴⁵ *Cranmore v. State*, 85 Wis. 2d 722, 771-75, 271 N.W.2d 402, 427-28 (1978) (court upheld a conviction for murder under circumstances similar to *Shaffer* without specifically defining death).

⁴⁶ *Commonwealth v. Golston*, 373 Mass. 249, 251-55, 366 N.E.2d 744, 748-49 (1977), *cert. denied*, 434 U.S. 1039 (1978).

⁴⁷ *New York City Health & Hosps. Corp. v. Sulsona*, 81 Misc. 2d 1002, 1006-07, 367 N.Y.S.2d 686, 690-91 (Sup. Ct. Bronx County 1975).

⁴⁸ *In re Bowman*, 94 Wash. 2d 407, 421, 617 P.2d 731, 738 (1980).

⁴⁹ *In re Children's Hosp.*, No. 49143 (Minn. Sup. Ct. July 11, 1978).

⁵⁰ *Swafford v. Indiana*, 421 N.E.2d 596, 602 (Ind. 1981).

⁵¹ In *Douglas v. Southwestern Life Ins. Co.*, 374 S.W.2d 788 (Tex. Civ. App. 1964), a beneficiary under a life insurance policy sued to recover accidental death benefits (ADB). *Id.* at 790. The policy limited ADB to deaths occurring within 90 days of the accident. *Id.* Although the decedent did not die until 120 days after the accident, his beneficiary argued that "[i]t was only because of the extraordinary medical measures taken by the medical staff" that he lived beyond the 90-day period. *Id.* The opinion does not further describe the "extraordinary medical measures," and in fact the court specifically held that "death did not actually occur until approximately 120 days after the accident." *Id.* at 791. This being so, the case is not seen as a rejection of the brain death criteria.

⁵² No. 81-256126 (Conn. Super. Ct. Mar. 13, 1981).

⁵³ See PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, *DEFINING DEATH* 146 (1981).

⁵⁴ *Id.*

Bacchiochi and the hysteria that resulted from the case, has prompted several commentators to renew the call for statutory treatment of the issues.⁵⁶ This Article, however, advances a different solution to the problem, as will be seen below in the conclusion.

D. *The Uniform Determination of Death Act*

Special mention needs to be made of the "Uniform Determination of Death Act" (UDDA). This model statute was proposed by the National Conference of Commissioners on Uniform State Laws and has been endorsed by the American Bar Association, the American Medical Association, the American Academy of Neurology, the American Electroencephalographic Society, and the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. The full text of the proposal reads as follows:

§ 1. [Determination of Death]

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.

§ 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.⁵⁶

This model law is a thoughtful, appropriate, and realistic approach to adopting brain-related criteria to diagnose death, and by requiring cessation of all brain functions, it provides a proper bulwark against euthanasia.⁵⁷ For reasons explained more fully below, the article does not encourage efforts to enact a brain death statute; nevertheless, the UDDA is seen as the best of the various legislative proposals.

⁵⁶ See, e.g., Horan, *supra* note 19, at 58-70; Paris & McCormick, *Living-Will Legislation Reconsidered*, 145 AMERICA 86, 86-89 (1981).

⁵⁶ UNIF. DETERMINATION OF DEATH ACT §§ 1-2, 12 U.L.A. 209 (West Supp. 1982). The UDDA supersedes the Uniform Brain Death Act which had been approved in 1978. The Commissioners, in attempting to explain the need for the UDDA, stated that "[t]he proliferation of model acts and uniform acts, while indicating a legislative need, also may be confusing. All existing acts have the same principal goal—extension of the common law to include the new techniques for determination of death." The UDDA was drafted to clarify the legislative intent and to facilitate the attainment of this goal. UNIF. DETERMINATION OF DEATH ACT, 12 U.L.A. 209, commissioners' prefatory note, at 208 (West Supp. 1982).

⁵⁷ The threat of euthanasia has been cited by some as a reason to oppose brain death statutes. See, e.g., Horan, *supra* note 19, at 68.

IV. SUMMARY

This review of the theological and legal aspects of the brain death controversy shows that there is no moral or ethical objection to relying on irreversible cessation of all functions of the entire brain, including the brain stem, to diagnose death, and at least thirty-five jurisdictions have now adopted this standard. Recognizing this consensus, the fifth edition of *Black's Law Dictionary* changed the definition on which much of the recent controversy centered by adding a separate definition for brain death while revising the definition of death. The new definition reads:

Brain death. Numerous states have enacted statutory definitions of death which include brain-related criteria. "A person shall be pronounced dead if it is determined by a physician that the person has suffered a total and irreversible cessation of brain function. There shall be independent confirmation of the death by another physician."

Characteristics of brain death consist of: (1) unresponsiveness to externally applied stimuli and internal needs; (2) no spontaneous movements or breathing; (3) no reflex activity; and (4) a flat electroencephalograph reading after 24 hour period of observation. An increasing number of states have adopted this so-called "Harvard" definition of brain death, either by statute or court decision.⁵⁸

The revised definition of death reads:

Death. The cessation of life; permanent cessations of all vital functions and signs. Numerous states have enacted statutory definitions of death which include brain-related criteria.⁵⁹

There is therefore a serious question whether additional legislation is necessary or would be superfluous in light of the consensus medical and legal view.

Various reasons have been posited by a presidential commission and others to justify determination-of-death legislation: (1) to eliminate the possibility that courts might not accept the brain death criteria;⁶⁰ (2) to operate as "public acceptance of the brain death concept";⁶¹ (3) to avoid delays in diagnosing death and thus to facilitate organ transplantation;⁶² and (4) to ease the fears of medical practitioners about litigation.⁶³

⁵⁸ BLACK'S LAW DICTIONARY 170 (rev. 5th ed. 1979) (quoting CAL. HEALTH & SAFETY CODE § 7180 (1976) (citation omitted)).

⁵⁹ *Id.* at 360.

⁶⁰ Ufford, *supra* note 19, at 234.

⁶¹ *Id.*

⁶² Horan, *supra* note 19, at 60.

⁶³ Ufford, *supra* note 19, at 234-35. These arguments were recently voiced in testimony before the presidential commission inquiring into the need for termination-of-death legislation. The witness argued that a uniform act was necessary in order to set a single standard for death pronouncements for all purposes; to "avoid maintaining dead bodies on artificial

Upon close scrutiny, however, none of these justifications for additional legislation has logical merit. Their major fault is the hypothetical nature of their premises. That the courts might not accept brain death is, of course, theoretically possible. But the fact is that no court has ever rejected it and, given its overwhelming acceptance, none is likely to do so. Similarly, it has not been demonstrated by any reliable data or other evidence beyond mere testimonial speculation that the public has failed to recognize brain death or that many organ transplants have been frustrated by delays in making the diagnosis.

The overriding impetus behind the movement to enact brain death laws has been "hysteria in the medical profession."⁶⁴ There is a "perva-

support systems"; to save the patient's family's emotional and financial resources; and to "serve as a protection against ill-advised pronouncements of death." PRESIDENT'S COMMISSION FOR THE STUDY OF ETHICAL PROBLEMS IN MEDICINE AND BIOMEDICAL AND BEHAVIORAL RESEARCH, meeting III, minutes, July 11-12, 1980, at 1 (Statement of Frank Veith).

The problem was also summarized in 1976 in a report of a Missouri Senate select committee:

B. PROBLEMS RESULTING FROM AN INACCURATE DEFINITION:

1. UNCERTAINTY WITH REGARD TO FUTURE COURT ACTION

Under the common law definition a number of things *could* occur should a Missouri court be called upon to legally define death in the absence of a statute.

a) A court faced with the decision of choosing between the common law definition and the "brain death" definition *could* very well reject the latter.

b) The "brain death" definition *could* be accepted and rejected on a case-by-case basis resulting in legal unpredictability.

c) A court *could* reject both the common law definition and the "brain death" definition and substitute in its place a new definition of death based on a philosophy which does not protect the sanctity of life to the highest degree.

d) Even if the Missouri courts reject the Black's Law Dictionary definition of death and attempt to formulate a standard in line with present medical procedures, the courts *most probably* would not have the benefit of extensive non-partisan medical and legal testimony which the legislature possesses. If the courts were allowed to define death, a party to litigation *might* be able to introduce a great deal more expert testimony in support of its definition than its opponent for reasons such as financial condition, preparation, etc. Therefore, considering the complexity of the issue, to allow the definition of death to be decided judicially does not necessarily insure as thorough an analysis as a legislative determination.

2. PROTECTION OF PHYSICIANS FROM LAWSUITS AND LIABILITY

Because the common law definition is medically inaccurate, a resulting problem is that there exists a *possibility* that a doctor who simply unhooks a respiratory or ventilating machine following a determination of total brain death, could be found guilty of homicide or wrongful death. *Although there are no instances* of physicians being held criminally or civilly liable under these circumstances, the mere *potential* for litigation is a valid concern.

REPORT OF THE MISSOURI SENATE SELECT COMMITTEE ON DEFINITION OF DEATH 3-4 (1976) (Sen. John D. Schneider, Chairman) (emphasis added) (footnotes omitted).

⁶⁴ Paris & McCormick, *supra* note 55, at 88 (quoting Robert A. Burt, professor of medical law at Yale University).

sive fear of liability in the medical world,"⁶⁵ and some physicians have been clamoring for these laws in order to insulate themselves from liability. The fact is that a brain death statute cannot prevent lawsuits. There will still be challenges to the validity of the statute itself,⁶⁶ and physicians will continue to be sued regarding their application of the diagnostic criteria.

Thus, while there is no legal, medical, or moral objection to the Uniform Determination of Death Act or the other brain death statutes, it is submitted that no statute will lift the "medical-legal fog"⁶⁷ that exists in some minds. For example, the mere presence of statutory law may not influence the spouse of the brain-dead patient who perceives a conflict between religion and the termination of life support equipment. Similarly, the mere presence of statutory law may not prevent a physician who fears liability from petitioning a court for permission to disconnect such equipment. Moreover, such a law may not discourage a criminal defendant, intent upon acquittal, from accusing medical personnel of having actually caused the decedent's death. Finally, the mere enactment of a law may not prevent the next of kin, by reason of greed or vindictiveness, from suing the doctor for malpractice and wrongful death.

For these reasons, the UDDA and the other brain death statutes are not a cure-all. They are not the end of the issue. In fact, they represent only the beginning of the educational process needed to avoid the scenarios mentioned above. Therein lies an objection to brain death statutes: that in all the uproar surrounding their adoption there is a real danger of forgetting that serious educational efforts must follow. Physicians must be taught (or retaught) to rely on their medical judgments without fretting over legal liability. Lawyers must be counseled in the propriety of the accepted medical standards. The public must become aware that these criteria represent the highest state of the medical and legal arts.

In at least thirty-five states the brain-related criteria for diagnosing death have been legally recognized. The medical, legal, and religious literature reflect a consensus with respect to the propriety of the criteria. The commotion surrounding legislation is unnecessary and delays the educational process, which offers the only real hope for solving the problems in this field. Therefore, what is needed is a major educational effort:

- (1) to educate lawyers to the fact that the medical standard equates irreversible cessation of the total functions of the brain, including the brain stem, with death; and
- (2) to educate physicians to the fact that the law will recognize this accepted medical standard; and

⁶⁵ Paris & McCormick, *supra* note 55, at 88.

⁶⁶ See, e.g., *State v. Shaffer*, 223 Kan. 244, 246, 574 P.2d 205, 209 (1977).

⁶⁷ Paris & McCormick, *supra* note 55, at 88.

(3) to educate families and patients' counselors to their moral obligations and responsibilities in regard to death.

As one writer put it, "a little commonsense reflection (when advanced life-support systems were beginning to create these difficulties) would have solved the problem and headed off much of the unnecessary great debate which followed"** Although that should have occurred perhaps 20 years ago, it is never too late to hope that this unnecessary tempest can be finally calmed.

** Horan, *supra* note 19, at 59.