September 2017

People v. Eulo: New York Adopts the Brain Death Standard for Homicide Cases

Follow this and additional works at: http://scholarship.law.stjohns.edu/tcl

Part of the Criminal Law Commons

Recommended Citation

Available at: http://scholarship.law.stjohns.edu/tcl/vol29/iss4/6

This Article is brought to you for free and open access by the Journals at St. John's Law Scholarship Repository. It has been accepted for inclusion in The Catholic Lawyer by an authorized editor of St. John's Law Scholarship Repository. For more information, please contact cerjann@stjohns.edu.
COMMENT

PEOPLE v. EULO: NEW YORK ADOPTS THE BRAIN DEATH STANDARD FOR HOMICIDE CASES

At common law, death was deemed to occur at the moment circulation and respiration ceased. In determining the moment of death, no consideration was given to brain function, because no method existed for

---

1 See BLACK'S LAW DICTIONARY 488 (rev. 4th ed. 1968). Death is defined as:
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.


The focus on circulation and respiration grew out of the ancient notion that the heart was the central organ of the body. 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. 337, 339 (1968) [hereinafter cited as Irreversible Coma]; Hirsh, Brain Death: Medico-Legal Fact, or Fiction?, 3 N. Ky. Sr. L.F. 16, 16 (1975). Prior to the nineteenth century, the tests for determining the permanent cessation of circulation and respiration were considered unreliable. See President’s Comm’n for the Study of Ethical Problems in Medicine and Biomedical Research, Defining Death, U.S. Supt. Docs., No. PR 40.8; ET 3/ D34, 13-14 (1981) [hereinafter cited as President’s Comm’n]. Reports of reviving “corpses” and clawed coffins, as well as medical articles citing putrefaction as the only sure sign of death, undermined public confidence in the medical community. Id. In reaction to this, physicians began striving to perfect their skills, and ultimately developed more accurate instruments, in particular the stethoscope, for diagnosing death. Id. at 14-15. Nevertheless, despite the advances of modern medicine, the “clinical detection of cessation of respiration and heartbeat . . . is [still] subject to human error under adverse circumstances.” 3 M. HOUTS & I. HAUT, COURTROOM MEDICINE § 1B.00, at 1B-4 (1984).
testing brain activity. Today the mechanical respirator has made it possible for physicians to continue a patient's respiration and circulation artificially, even after all brain functions have irreversibly ceased. This advancement has prompted the medical community to reevaluate its traditional position on when the moment of death occurs. It is now

* In re Bowman, 94 Wash. 2d 407, 412, 617 P.2d 731, 734 (1980) (en banc). Although brain activity was not considered, it generally was known that the brain died shortly after the cessation of the other vital functions. 3 M. Houts & I. Haut, supra note 1, § 1B.00, at 1B-3; see Irreversible Coma, supra note 1, at 338. Indeed, the practice of pronouncing death upon the cessation of heartbeat was fairly accurate because the heart, lungs and brain are so interdependent that brain death necessarily occurs within thirty minutes of the cessation of the other vital functions. See Guthrie, Brain Death and Criminal Liability, 15 CRIM. L. BULL. 40, 46 (1979); President's Comm'n, supra note 1, at 16-17.

The first experiments aimed at recording the electrical activity of the human brain were conducted by Dr. Hans Berger, a German psychiatrist, who published the first paper on the human electroencephalogram (EEG) in 1929. C. Binnie, A. Rowan & T. Gutter, A Manual of Electroencephalographic Technology 1 (1982). An electroencephalogram is a recording of the electrical activity of the cerebrum. Id. at 3. The electrical currents associated with the brain cells are conducted through the saline solution that surrounds the brain, see Electroencephalography, A Symposium on its Various Aspects 65 (J. Hill & G. Parr ed. 1963), and are transmitted to a recording device by means of electrodes placed on the scalp, id. at 59. Most normal EEGs show a rhythmic activity, C. Binnie, A. Rowan & T. Gutter, supra, at 20, which changes continually with changes in mental activity, emotional state, drowsiness, or sleep, id. The typical EEG will also change gradually during the lifetime of an individual and will vary among individuals. Id.

3 M. Houts & I. Haut, supra note 1, § 1B.00, at 1B-3. An artificial respirator actually "ventilates" the body by forcing air into the lungs. See President's Comm'n, supra note 1, at 15-16. This activity compensates for the inability of the thoracic muscle to perform this function. See id. If the body is properly ventilated, "respiration" (the interchange of dissolved gases and metabolites across cell membranes) can take place. Byrne, O'Reilly, Quay, & Salsich, Brain-Death—The Patient, The Physician, and Society, 18 Gonz. L. Rev. 429, 453 n.74 (1982-1983). Preservation of the body under such circumstances is limited; while a child may be kept functioning for several weeks, an adult usually cannot be sustained more than two to ten days. See President's Comm'n, supra note 1, at 17. However, because the brain dies in stages and cellular decomposition of the other organs does not begin until all components of the brain are dead, viable organs can be removed from the body at the moment of brain death and transplanted to a needy donor. See Hirsh, supra note 1, at 18.

Unlike a victim of brain death, a patient who is resuscitated at the moment of "clinical death" may fully recover. Id. However, there may have been such a severe injury to the brain that total and irreversible loss of function, or brain death, will result despite resuscitation. See President's Comm'n, supra note 1, at 16. The most frequent causes of total and irreversible loss of brain function are: 1) direct trauma to the head; 2) massive spontaneous hemorrhage into the brain; and 3) anoxic damage (due to absence of oxygen supply) as a result of cardiac or respiratory arrest or severely reduced blood pressure. Id.


The problem of determining the precise moment of death took on added significance as human organ transplants became more common. See Showalter, Determining Death: The Legal & Theological Aspects of Brain-Related Criteria, 27 CATH. LAW. 112, 117 (1982). When a potential heart donor has been clinically dead for more than a few minutes, a pro-
widely accepted among physicians that a patient who has suffered a total and irreversible cessation of brain function is dead, despite the fact that breathing and heartbeat are maintained by a respirator. The states in-

spective recipient's chances for survival with the new heart are slim. The Dying Patient 108 (O. Brim, H. Freeman, S. Levine, & N. Scotch eds. 1970). Similarly, kidneys from such donors have an 88% incidence of post-operative renal failure, while those received from brain dead donors who are maintained on artificial respirators fail only between 10% and 20% of the time. See New York City Health & Hosps. Corp. v. Sulsona, 81 Misc. 2d 1002, 1005-06, 367 N.Y.S.2d 686, 689-90 (Sup. Ct. Bronx County 1975). Because the success of the transplant depends upon whether or not the donated organ is "living," see 3 M. Houts & I. Haut, supra note 1, § 1B.00, at 1B-4, it is crucial to determine whether or not the donor is in fact dead; the removal of a vital organ from a live patient will be fatal and may expose the physician to civil or criminal liability, see Sulsona, 81 Misc. 2d at 1006, 367 N.Y.S.2d at 690. See generally S. Wilcox & M. Sutton, Understanding Death and Dying—An Interdisciplinary Approach 54 (1977) (early transplants prompted concern for protecting physicians against malpractice and homicide charges; Guthrie, supra note 2, at 60 (transplant surgeons face possibility of criminal liability if brain death not legally accepted).

In response to the need for certainty in determining whether or not an artificially maintained prospective donor is indeed dead, an ad hoc committee of the Harvard Medical School undertook an in-depth study of the characteristics of the brain dead patient. See Irreversible Coma, supra note 1; see also infra note 5. Its report established the following criteria as indicative of brain death: 1) unreceptivity and unresponsivity to even the most painful stimuli; 2) an absence of spontaneous muscular movements or spontaneous respiration over a period of at least one hour; 3) an absence of elicitable reflexes; and 4) a flat electroencephalogram (valued as corroborative, but not dispositive). See Irreversible Coma, supra note 1, at 337-38. The test must be repeated 24 hours later with no change, and the physician must eliminate hypothermia and central nervous system depressants as causative factors. See id. at 338. Subsequent studies have attempted to augment this list by suggesting that the absence of cerebral blood flow is also evidence of brain death. See A Collaborative Study, An Appraisal of the Criteria of Cerebral Death—A Summary Statement, 237 J. A.M.A. 982, 982 (1977) [hereinafter cited as Appraisal Summary]; Hirsh, supra note 1, at 25 & n.36. Nevertheless, the Harvard criteria generally have been considered quite reliable, President's Comm'n, supra note 1, at 25, and have been cited most frequently in the courts in brain death cases, see, e.g., Lovato v. District Court, 349, 354 n.9, 450 N.E.2d 940, 945 n.9 (1983); State v. Meints, 212 Neb. 410, 420, 322 N.W.2d 809, 815 (1982); In re Bowman, 97 Wash. 2d 407, 418, 617 P.2d 731, 737 (1980) (en banc). * In re Haymer, 115 Ill. App. 3d at 353-54 & n.8, 450 N.E.2d at 944 & n.8; Swafford v. State, 421 N.E.2d 596, 598 (Ind. 1981); Abram, The Need for Uniform Law on the Determination of Death, 27 N.Y.L. Sch. L Rev. 1187, 1189 (1982); Leng, Death and the Criminal Law, 45 Mon. L. Rev. 206, 210 (1982).

Total brain death is distinguishable from the state of coma, referred to as a "chronic vegetative state," see 3 M. Houts & I. Haut, supra note 1, § 1B.00, at 1B-5, or "cerebral death," see Guthrie, supra note 2, at 48. A certain amount of confusion has arisen over the use of these terms, because some authors use them interchangeably. See, e.g., 3 M. Houts & I. Haut, supra note 1, § 1B.00, at 1B-80; Irreversible Coma, supra note 1, at 337. See generally President's Comm'n, supra note 1, at 87 (irreversible coma "is used as an umbrella term for a variety of comatose states"). "Brain death," however, actually refers to the total and irreversible loss of all brain functions, and includes both cerebral death (evidenced by loss of consciousness and personality manifestations) and brain stem death (evidenced by
loss of the autonomic nervous functions). Leng, supra, at 206 n.3 (citing 2 *The Lancet* 1311 (1979)). Patients in a chronic vegetative state, on the other hand, suffer irreversible brain damage, but retain the ability to perform such vital functions as respiration, cardiac contractions, regulation of blood pressure, and temperature control. See Veith, Fein, Tendler, Veatch, Kleiman & Kalkines, *Brain Death: An Emerging Consensus*, 238 *J. A.M.A.* 1651, 1652 (1977). There are no recorded incidents of brain dead patients regaining any functions when the Harvard criteria have been fulfilled. See *In re Haymer*, 115 Ill. App. 3d 349, 356, 450 N.E.2d 940, 946 (testimony of physician); see also Veith, Fein, Tendler, Veatch, Kleiman & Kalkines, supra, at 1652 (no incidence of recovery in 2,642 case studies when Harvard criteria met).

A group of staunch critics has asserted that a determination of death should be based upon the total anatomic destruction of the heart and lungs, and not upon the cessation of their function. See Byrne, O'Reilly, Quay & Salsich, supra note 3, at 494; Byrne, O'Reilly & Quay, *Brain Death: An Opposing Viewpoint*, 242 *J. A.M.A.* 1985, 1985-86 (1979). Some consider this view to be unsound and note that anatomic destruction can be established only by pronouncing the patient dead and removing the organs for examination. See Veith & Tendler, *In Response to an Opposing Viewpoint on Brain Death*, 243 *J. A.M.A.* 1808, 1808 (1980); see also Horan, *Definition of Death: An Emerging Consensus*, 16 *Trial* 22, 26 (Dec. 1980) (one does not ordinarily wait for anatomic destruction of tissue before pronouncing death).

* See, e.g., State v. Fiero, 124 Ariz. 182, 185-86, 603 P.2d 74, 77-78 (1979); *In re Haymer*, 115 Ill. App. 3d at 354, 450 N.E.2d at 943; Swafford v. State, 421 N.E.2d 596, 602 (Ind. 1981); Commonwealth v. Golston, 373 Mass. 249, 250-51, 366 N.E.2d 744, 747 (1977), cert. denied, 434 U.S. 1039 (1978). Traditionally, the common law relied on the expertise of the medical profession in formulating its definition of death. See *In re Bowman*, 94 Wash. 2d at 412, 617 P.2d at 734; Abram, supra note 5, at 1192. However, the legal community was reluctant to update its long-standing position of death as medical science became more sophisticated and incomprehensible to the layman. Abram, supra note 5, at 1193-94; see also *In re Estate of Schmidt*, 261 Cal. App. 2d 262, 273, 67 Cal. Rptr. 847, 854 (1968) (cessation of circulation and respiration proper definition of death despite medical developments using irreversible coma to mark point of death). Fear of civil and criminal liability, however, prompted physicians to exert pressure on the legal profession for adoption of the brain death standard. See Showalter, supra note 4, at 126-27.

To date, at least thirty-four states have enacted brain-death statutes and nine have incorporated the standard by judicial fiat. See *People v. Eulo*, 63 N.Y.2d 341, 353 n.22, 472 N.E.2d 286, 293 n.22, 482 N.Y.S.2d 436, 443 n.22 (1984). There is an absence of uniformity...
recently, in *People v. Eulo*, the New York Court of Appeals held that defendants who cause the total brain death of their victims can be convicted of manslaughter, even though the victims' circulation and respiration are being artificially maintained.

*Eulo* involved two separate homicide convictions that were consolidated on appeal. In both cases, the defendants had shot their victims in the head, rendering them incapable of breathing without the aid of respirators. Various tests, repeated over the course of several days, indicated that each victim had suffered a total and irreversible cessation of

among the statutes, which fall into four broad categories: (1) statutes providing for alternative determinations of death, based on either brain death or cardiac functions, see, e.g., KAN. STAT. ANN. § 77-205 (1984); (2) statutes providing for a determination of death based on an absence of brain function, only when there is also an irreversible cessation of spontaneous respiratory and circulatory functions, see, e.g., MICH. STAT. ANN. § 14.15 (1021) (Callaghan Supp. 1985); (3) statutes providing for a determination of death based solely on cessation of brain function, see, e.g., ILL. ANN. STAT. ch. 110 ½ § 302 (b) (Smith-Hurd 1978); and (4) statutes providing that a person may be pronounced dead if he or she has suffered an irreversible cessation of spontaneous brain function, see, e.g., OR. REV. STAT. § 146.001 (1983); see Horan, supra note 5, at 23-24.

In an attempt to promote national uniformity, the National Conference of Commissioners on Uniform State Laws has proposed a model statute, the Uniform Brain Death Act, which formed the basis for the current Uniform Determination of Death Act. *President’s Comm'n, supra* note 1, at 119. The act provides 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.

*Id.* The American Bar Association, the American Medical Association and the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research support adoption of this definition. See *Eulo*, 63 N.Y.2d at 353-54, 472 N.E.2d at 233-94, 482 N.Y.S.2d at 443-44. Several states have changed their statutes to reflect the Uniform Determination of Death Act. See, e.g., CAL. HEALTH & SAFETY CODE § 7180 (West Supp. 1985); GA. CODE ANN. § 88-1716 (Supp. 1984); IDAHO CODE § 54-1819 (Supp. 1985).

Recognizing the growing legal acceptance of the brain death concept, Black’s Law Dictionary revised its definition of death in the fifth edition:

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

BLACK’S LAW DICTIONARY 360 (5th ed. 1979).


8 See id. at 346, 472 N.E.2d at 288-89, 482 N.Y.S.2d at 438-39.

9 See id. at 345, 472 N.E.2d at 288, 482 N.Y.S.2d at 438.


11 See 63 N.Y.2d at 346-47, 472 N.E.2d at 289, 482 N.Y.S.2d at 439.
brain function, despite medication and artificial respiration. Fearing an imminent cessation of breathing and circulation despite artificial maintenance, the attending physicians obtained consent from the victims' parents for the use of certain organs for transplantation. The victims were pronounced dead and the donated organs were removed. Upon disconnection of the respirators, the victims' breathing and heartbeats immediately ceased.

The defendants were found guilty of manslaughter and both convictions were affirmed by the Appellate Division. On appeal, both defendants maintained that their conduct did not cause death because "death" traditionally had been defined in New York as an irreversible cessation of breathing and heartbeat, and the victims were still breathing when the transplants were performed. The Court of Appeals, however, affirmed the two convictions, noting that a judicial recognition of brain-based criteria actually would not conflict with prior judicial and statutory definitions of death.

Chief Judge Cooke, writing for a unanimous court, reviewed the evolution of the total brain death standard and noted its increasing ac-

---

18 See id. at 346-48, 472 N.E.2d at 289, 482 N.Y.S.2d at 439-40. In *Eulo* the victim showed no reaction to painful stimuli. *Id.* at 346, 472 N.E.2d at 289, 482 N.Y.S.2d at 439. An electroencephalogram (EEG) produced flat readings, indicating that there was no activity in the part of the brain tested. *Id.* Three days later these tests were repeated with the same results. See id. at 347, 472 N.E.2d at 289, 482 N.Y.S.2d at 439. The neurosurgeon's diagnosis of brain death was reviewed and confirmed by the Deputy Medical Examiner for Suffolk County and another physician. See id.

In *Bonilla*, the attending physician tested for reflex reactions, reactions to painful stimuli, and spontaneous breathing. See id., 472 N.E.2d at 289-90, 482 N.Y.S.2d at 439-40. An EEG produced flat readings. See id. at 348, 472 N.E.2d at 290, 482 N.Y.S.2d at 440.

19 See id. at 347-48, 472 N.E.2d at 289-90, 482 N.Y.S.2d at 439-40.

37 Id. at 345, 472 N.E.2d at 288, 482 N.Y.S.2d at 438.

18 See id. at 348, 472 N.E.2d at 290, 482 N.Y.S.2d at 440.

19 See id. at 360, 472 N.E.2d at 298, 482 N.Y.S.2d at 448.

20 See id. at 355, 472 N.E.2d at 294, 482 N.Y.S.2d at 444; see also Commonwealth v. Goston, 373 Mass. 249, 253-54, 366 N.E.2d 744, 748 (1977), cert. denied, 434 U.S. 1039 (1978). In discussing the traditional definition of death, the *Goston* court stated that "references to respiration and pulsation must be taken to refer to spontaneous rather than artificially supported functions." 373 Mass. at 254, 366 N.E.2d at 748. The court also noted that the expansive interpretation of the traditional definition represented an "evolutionary restatement" of the common law, and not a different rule. Id., 366 N.E.2d at 749 (quoting Commonwealth v. McHoul, 352 Mass. 544, 547, 226 N.E.2d 556, 558 (1967)). Medical science now recognizes that cessation of respiration and circulation alone are not determinative of death; rather, they are "indicative of death only when they persist long enough for the brain to die." *In re Haymer*, 115 Ill. App. 3d 349, 351, 450 N.E.2d 940, 942 (1983) (quoting Sweet, *Brain Death*, 299 New Eng. J. Med. 410, 410 (1978)).
ceptance among the states. The court saw no impediment to judicial recognition of the concept, despite the failure of the New York Legislature either to approve a brain death standard, or to provide an express definition of the term “death.” The court noted that, while the phenomenon of death never changes, the criteria for determining it have changed to account for the fact that today “a dead body may be attached to a machine so as to exhibit demonstrably false indicia of life.” The court asserted that judicial recognition of such “changed conditions” is supported by the declaration of the Legislature that the “Penal Law should be construed ‘according to the fair import of [its] terms to promote justice and effect the objects of the law.’” Synthesizing the common law approach to the determination of death with the present day medical position, the court fashioned a broad rule of law:

[ordinarily, death will be determined according to the traditional criteria of irreversible cardio-respiratory repose. . . . When, however, the respiratory and circulatory functions are maintained by mechanical means, . . . death may nevertheless be deemed to occur when, according to accepted medical practice, it is determined that the entire brain’s function has irreversibly ceased.]

The court confined its holding to cases involving only total loss of brain function, distinguishing cases in which some brain functions still persist. Chief Judge Cooke applied this rule to the issue of whether the defendants caused the deaths of their victims. The court noted that, despite the trial courts’ failure to instruct the juries on the definition of death, the juries were properly charged that the surgical procedures could

---

81 See 63 N.Y.2d at 349-54, 472 N.E.2d at 290-94, 482 N.Y.S.2d at 440-44.
82 See id. at 355, 472 N.E.2d at 294, 482 N.Y.S.2d at 444; infra note 52.
83 See 63 N.Y.2d at 354, 472 N.E.2d at 294, 482 N.Y.S.2d at 444. Since medical science has made the transplantation of organs possible, the issue of criminal responsibility has received renewed attention. See id. at 355, 472 N.E.2d at 294, 482 N.Y.S.2d at 444. In Eulo, Chief Judge Cooke asserted that these developments make it necessary for the court to “instill certainty and uniformity in these important areas.” Id.
84 Id. at 356, 472 N.E.2d at 295, 482 N.Y.S.2d at 445.
85 Id. at 356-57, 472 N.E.2d at 295, 482 N.Y.S.2d at 445 (quoting N.Y. Penal Law § 5.00 (McKinney 1977)).
86 Id. at 355-56, 472 N.E.2d at 295, 482 N.Y.S.2d at 445.
87 See id. at 358 n.30, 472 N.E.2d at 296 n.30, 482 N.Y.S.2d at 446 n.30. The Eulo court declared that its decision had no bearing on the issue of whether third parties can decide to allow terminally ill patients to die. Id. at 357, 472 N.E.2d at 296-96, 482 N.Y.S.2d at 445-46. The “right to die,” for example, is frequently raised when a patient has previously indicated that he would not wish to be kept alive by a respirator or other extraordinary means. See, e.g., JFK Memorial Hosp. v. Bludworth, 452 So. 2d 921, 922 (Fla. 1984) (terminally ill patient had executed a “living” or “mercy” will).
88 See 63 N.Y.2d at 358-60, 472 N.E.2d at 296-97, 482 N.Y.S.2d at 446-47.
be considered superseding causes of death. However, the court asserted that the transplants would have been superseding causes only if the pronouncements of death were premature and had resulted from the "gross negligence or the intentional wrongdoing" of the doctors "as determined by a grave deviation from accepted medical practices or disregard for legally cognizable criteria for determining death." The court found that there was substantial expert testimony indicating that the tests were in accordance with accepted medical practice. In addition, the court noted that the doctors had some legal authority for using brain death criteria, since a lower court decision had previously accepted the total brain death standard. The court held, therefore, that the juries properly found that the transplants did not break the chain of causation linking the defendants with their victims' deaths and it affirmed both convictions.

Filling the Gaps of Sulsona and Bonilla

It is submitted that the Court of Appeals' adoption of a total brain death standard for homicide cases has filled a critical void in New York law. The only prior recognition of the brain death criteria in New York was at the supreme court level. In New York City Health & Hospitals Corp. v. Sulsona, the supreme court, Bronx County, held that the word

---

29 Catholic Lawyer, Autumn 1985

---

29 See id. at 358-59, 472 N.E.2d at 296-97, 482 N.Y.S.2d at 446-47.
30 Id. at 359, 472 N.E.2d at 297, 482 N.Y.S.2d at 447. If patients are properly diagnosed as dead prior to the transplant, no subsequent surgery can be deemed the cause of death. Id. If the pronouncement of death is premature because of the doctors' negligence, the subsequent surgery can be considered a cause of death, but not a superseding cause. Id.
31 See id. at 360, 472 N.E.2d at 297, 482 N.Y.S.2d at 447. Chief Judge Cooke explained that it would be inappropriate for the court to set forth particular medical tests to be used in diagnosing total brain death, because this would inhibit the development of more sophisticated medical techniques. Id. at 357 n.29, 472 N.E.2d at 296 n.29, 482 N.Y.S.2d at 446 n.29. The court's role was limited to the determination of whether the physicians' procedures conformed to the accepted medical practice. Id.
32 See id. at 360, 472 N.E.2d at 297, 482 N.Y.S.2d at 447 (citing In re New York City Health & Hosps. Corp. v. Sulsona, 81 Misc. 2d 1002, 367 N.Y.S.2d 686 (Sup. Ct. Bronx County 1975)); see also infra notes 35-40 and accompanying text. The court noted that the holding in Sulsona had not been overturned by the Legislature nor any appellate court. See 63 N.Y.2d at 360, 472 N.E.2d at 297, 482 N.Y.S.2d at 447.
33 See 63 N.Y.2d at 360, 472 N.E.2d at 297, 482 N.Y.S.2d at 447.
34 See id., 472 N.E.2d at 298, 482 N.Y.S.2d at 448.
36 81 Misc. 2d 1002, 367 N.Y.S.2d 686 (Sup. Ct. Bronx County 1975). In Sulsona, the New York City Health & Hosps. Corp. brought an action seeking a legal definition of the word "death" as used in §§ 4301 and 4306 of the Public Health Law. Id. at 1003, 367 N.Y.S.2d at 687; see N.Y. PUB. HEALTH LAW §§ 4300-4307 (McKinney 1977). The controversy arose when doctors declined to remove organs from a brain dead patient, thus depriving two potential
“death,” as used in the Uniform Anatomical Gifts Act, was intended to be defined in accordance with the generally accepted practice of the medical community involved in effectuating the purposes of the Act. Brain death was the generally accepted standard in non-homicide cases.

Five years after Sulsona, the supreme court again stated that brain death, as medically defined, was legally sufficient for determining death. These cases represented a step toward acceptance of the brain death standard in New York; nevertheless, they simultaneously created a logical inconsistency in the law: a homicide victim who suffered brain death while in one county could be pronounced dead, while a homicide victim in the same condition in another county was still legally alive.

The resulting confusion is dramatically illustrated in People v. Bonilla, in which the Appellate Division declined to define death on the ground that such a definition would constitute an unnecessary and improper usurpation of “the legislative function.” Choosing, instead, to
donees of needed transplants. 81 Misc. 2d at 1004, 367 N.Y.S.2d at 688. The refusal was based on two grounds: (1) the hospital was doubtful that neurological (brain) death would be recognized legally and feared liability; and (2) the Chief Medical Examiner prohibited the removal of organs from any homicide victims, whether brain dead or clinically dead. Id. The hospital, prompted by these events, commenced the action so that the doctors could legally remove the kidneys of Daniel Sulsona, a gunshot victim who was neurologically dead. Id. at 1004-05, 367 N.Y.S.2d at 688-89. After hearing testimony from five medical experts, the court concluded that there is a uniformly accepted medical standard of death, which includes, inter alia, the brain death criteria. See id. at 1005-06, 367 N.Y.S.2d at 689-90. The court also recognized that there was a “clear legislative understanding” that the Public Health Law “would be affectuated by duly licensed medical doctors acting in accordance with generally accepted medical standards.” Id. at 1007, 367 N.Y.S.2d at 691.

N.Y. PUB. HEALTH LAW §§ 4300-4307 (McKinney 1977) (adopting Uniform Anatomical Gifts Act). The Uniform Anatomical Gifts Act has been adopted by all 50 states and the District of Columbia. See id. Art. 43 (McKinney Supp. 1984-1985). The law provides that any anatomical gift, made by will or other document, becomes effective “upon the death of the donor,” but the word “death” is not defined. See id. § 4303(2).

In re Jones, 107 Misc. 2d at 292, 433 N.Y.S.2d at 986. Cf. Bacchiochi v. Johnson Memorial Hosp., No. 256126 (Conn. Super. Ct. Hartford/New Britain, Mar. 13, 1981) (Connecticut brain death standard applied only to transplant cases); Fabro, Bacchiochi v. Johnson Memorial Hosp., 45 CONN. MED. 267 (1981) (“[i]t is ironic that if the patient had been a donor, she could have been pronounced dead . . . and the respirator could have been withdrawn. Dead for transplantation, but not dead otherwise!”), cited in Abram, supra note 5, at 1201 n.38.

95 App. Div. 2d 396, 467 N.Y.S.2d 599 (2d Dep't 1983).
grapple with the troublesome issue of causation,\textsuperscript{44} the majority held that the defendant's actions constituted such a substantial and direct factor in the chain of events leading to the victims' death that the imposition of liability for homicide was warranted.\textsuperscript{45} Justice Titone, concurring in part and dissenting in part, maintained that the transplant surgery could have been a superseding cause, and argued for a modification of the conviction to assault in the second degree because the prosecution had failed to sustain its burden of proof.\textsuperscript{46}

It is submitted that, because the 	extit{Bonilla} decision is only persuasive authority in the other Appellate Departments, another court could adopt Justice Titone's position and expose surgeons to both criminal and civil liability.\textsuperscript{47} While it appears that no United States court has yet imposed

\textsuperscript{44} See id. at 409-12, 467 N.Y.S.2d at 607-10; id. at 413-22, 467 N.Y.S.2d at 610-15 (Niehoff, J., concurring); id. at 432-33, 467 N.Y.S.2d at 621-22 (Titone, J., concurring in part and dissenting in part).

\textsuperscript{45} Id. at 409, 467 N.Y.S.2d at 608. According to the majority, "[t]he bullet wound to the brain was the proximate cause of death and the homicide was properly attributed to the defendant." Id. The court noted that "[i]ntervention of a secondary agency constitutes a defense only if the death is solely attributable to it." Id. The organ removal, therefore, was not deemed a superseding cause.

\textsuperscript{46} Id. at 432, 436-38, 467 N.Y.S.2d at 621, 623-24 (Titone, J., concurring in part and dissenting in part). Justice Titone used the following illustration to emphasize the possibility that transplant surgery could have been a superseding cause:

[I]f the defendant has inflicted a wound which would prove fatal and a third party comes along while the victim has but hours to live and kills him instantly, the third-party's act substantially hastening death constitutes the cause of death and the defendant cannot be convicted of homicide.

\textit{Id.} at 432, 467 N.Y.S.2d at 621 (Titone, J., concurring in part and dissenting in part.) Justice Titone also argued that the acts of the doctors were neither foreseeable nor in the ordinary course of treatment. \textit{Id.} at 434, 467 N.Y.S.2d at 622 (Titone, J., concurring in part and dissenting in part).

A similar position was adopted by a California court in People v. Flores, No. 20190 (Sonoma County Mun. Ct. Cal. Dec. 19, 1973), No. N746-C (Sonoma County Super. Ct. Cal. July 23, 1974). In that case, the defendant, driving on the wrong side of the road, hit an oncoming car. \textit{Id.} One of the passengers suffered brain death, and her heart was removed for transplantation. \textit{Id.} In his defense to a charge of manslaughter, the defendant argued that the acts of the physicians constituted an intervening cause of the victim's death. See \textit{id}. The municipal judge agreed, and defendant was held liable for drunken driving only. \textit{Id.} On appeal to the Superior Court, Flores was convicted of manslaughter, but received a sentence of less than five months. See Veith, Fein, Tendler, Veatch, Kleiman & Kalkines, \textit{Brain Death: II. A Status Report of Legal Considerations}, 238 J. A.M.A. 1744, 1746 (1977). California subsequently adopted the brain death standard by statute. See \textit{CAL. HEALTH & SAFETY CODE §§ 7180-7183} (Deering Supp. 1985).

\textsuperscript{47} In at least one jurisdiction, physicians transplanting organs from brain dead donors were exposed to the risk of liability for wrongful death. See Tucker v. Lower, No. 2831 (Ct. Law & Eq. Richmond, Va., May 25, 1972) (an unreported case appearing in \textit{The National Observer}, June 3, 1972, at 1, col. 1); see also Comment, \textit{But When Did He Die?}: Tucker v. Lower and the \textit{Brain-Death Concept}, 12 \textit{SAN DIEGO L. REV.} 424 (1975) (calling for legisla-
liability for homicide on physicians, the imposition of such liability is theoretically possible. Not surprisingly, the awareness of this fact has had a chilling effect on members of transplant teams. The Bonilla decision, it is submitted, did little to rectify this situation.

The unsettled case law and the legislative impasse on the issue suggest that the Court of Appeals acted properly in announcing a definitive statement regarding a defendant's criminal responsibility for causing brain death. While legislative action is perhaps more desirable, judicial action should not necessarily be precluded. In New York, the Legis-

tative determination of when death occurs based on neurological criteria). Tucker involved a brain dead patient who was attached to a respirator. See Comment, supra, at 425-26. When repeated attempts to contact the next of kin failed, Tucker's heart was removed and transplanted into a waiting recipient. Id. Thereafter, the administrator of Tucker's estate brought a wrongful death action against the surgeons. Id. at 427-28. The crucial issue that the court determined was when the death occurred. Id. at 428. During the trial, the judge ruled that he would reject the defendant's attempt to establish brain death as a rule of law. Id. at 428-29. When charging the jury, however, he gave the following instruction:

[You 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 . . . [You may consider the following elements . . . [including] the time of complete and irreversible loss of all function of the brain.

Id. at 424. The jury returned a verdict for the surgeons. Id. at 429. One juror later stated one of the important factors in arriving at his decision: "It was clearly proved in the trial a man . . . cannot live without a functioning brain." Id.


*8 See Paris & Cranford, Definition of Brain Death, 40 Theology Today 5, 6 (1983). Dr. Arthur Rose, a neurologist at University Hospital in Stony Brook, commented that doctors "will not pull the plug without a court order. The potential liability is just too great." Id. Indeed, the first assistant district attorney of Rensselaer County, Robert Adams, stated that there are a number of district attorneys in New York "anxious to pursue such charges [of homicide]." Id.


Legislative reform is considered more favorable than judicial revision of the common law because judicial revision is contingent upon litigation. Id. at 48. Litigation addresses the conflicting views of the parties involved in a dispute and all the viewpoints relating to the broader issues surrounding the determination of death may not be considered. Id. Since the
ture's failure to act was due in large part to pressure from pro-life groups that feared that the adoption of brain death criteria would lead to the acceptance of euthanasia. The issues surrounding the "mercy killing" of a terminally ill patient, however, are not identical to the issue of brain death because a patient who suffers from the total and irreversible cessa-
courts generally cannot conduct independent investigations, their decisions may not be as well-grounded as a legislative determination based upon extensive research. See id. Furthermore, by interpreting the holding to be confined to the facts of that case, a lower court may disregard a broad rule of law laid down by a higher court. See id. at 49. However, several "pro-legislative reform" commentators do acknowledge that when a legislature fails to act, judicial revision should not be precluded. See Capron & Kass, supra, at 100 n.55.

It has been argued that the public and its representatives can be involved in the formulation and adoption of a standard for determining death. President's Comm'n, supra note 1, at 95. For example, public discussion by such organizations as the press and civic groups could be encouraged. Id. An ad hoc committee "to evaluate public attitudes toward the changes wrought by biomedical advances" could be established. Id. The encouragement of public involvement is desirable because the determination of death concerns "pervasive policy decisions." Charron, Death: A Philosophical Perspective on the Legal Definitions, 1975 Wash. U.L.Q. 979, 985. It is arguable that in a democratic and pluralistic society, such basic questions should not be determined by only one segment of the population. Id. at 986.

See Paris & Cranford, supra note 50, at 6, 9. "Euthanasia" is a derivative of two Greek words meaning "good death" or "happy death." B. Ashley & K. O'Rourke, Health Care Ethics—A Theological Analysis 375 (1982). Generally the medical profession has rejected euthanasia through the Hippocratic Oath and other more recent codes of medical ethics. Id. at 380. Today euthanasia is generally considered to be of two types: active and passive. Id. Active euthanasia is considered the ordinary act of killing for "merciful" reasons, while passive euthanasia is the withholding of treatment, or letting the patient die. Id.

The New York Legislature has rejected a determination of death statute five times. See Paris & Cranford, supra note 50, at 6. Numerous religious and pro-life groups have lobbied against this statute on the ground that it is, inter alia, a "stepping stone to euthanasia." Id. at 9. This position has influenced the political statements of many Catholic bishops, who in turn influence the Legislature. Id. at 10. Senator Bertonazzi of Massachusetts attributes this power over legislators to the bishops' "well-known ability to punish or reward legislators." Id. at 10-11.

A determination of death statute incorporating brain related criteria would probably, however, weaken the arguments supporting the legalization of euthanasia, since it might "eliminate some false classifications of dead individuals [as being] among the living." President's Comm'n, supra note 1, at 11 n.6 (quoting noted Christian ethicist Germain Grisez). By clearly delineating between total brain death and other brain-damaged states, a well-composed determination of death law will in effect prohibit euthanasia by allowing only those who are truly dead to be pronounced dead. Horan, supra note 5, at 26. Furthermore, rather than considering brain death anti-life or immoral, official Roman Catholic dogma supports the adoption of the concept, as long as the declaration of death is medically certain and the brain death is total. See B. Ashley & K. O'Rourke, supra, at 364-68. The rationale for the position of the Church is that when the brain is dead the soul can no longer inform the body. Id. Pope Pius XII stated that verification of the fact of death "cannot be deduced from any religious and moral principle[s] . . . and does not fall within the competence of the Church." Pope Pius XII, The Prolongation of Life (an address to an international congress of anesthesiologists) reprinted in 4 The Pope Speaks 393, 398 (1957).
tion of brain function is already dead. The guidelines annunciated by the *Eulo* court not only preclude any possibility of euthanasia, but also eliminate a number of problems created by the alternative versions of determination of death statutes adopted in other states.

Pro-life groups should direct their lobbying efforts against acceptance of a cerebral death standard. See D. Walton, *Brain Death: Ethical Considerations* 20, 21 (1980). Although often confused with brain death, the term cerebral death actually refers to the irreversible destruction of both cerebral hemispheres, exclusive of the brain stem and the cerebellum. *Id.* A patient suffering cerebral death, therefore, is still capable of spontaneous respiration and circulation. See Law Reform Comm'n of Canada, supra note 51, at 16. This condition is interchangeably called apallic syndrome, neocortical death, persistent vegetative state, or coma. D. Walton, *supra,* at 21. The medical and legal communities overwhelmingly reject the concept of cerebral death as the proper neurological basis for determining death. See President's Comm'n, supra note 1, at 18. Acceptance of a cerebral death standard would presume a determination that the cerebrum, rather than the entire brain, is the vital organ of life. See Guthrie, *supra* note 2, at 48. It has not yet been established, however, that this part of the brain alone is responsible for intelligence and free will. See A. Moraczewski & J. Showalter, *Determination of Death* 18 (1982). Until the center of "humaness" can be conclusively established, a total brain death standard is required. *Id.*

In addition, pro-life groups should advocate improved training and supervision of those who are responsible for interpreting the medical criteria. See B. Ashley & K. O'Rourke, *supra* note 52, at 367. Ethical concern over the accuracy of the criteria and the certainty of the diagnosis is not unique to the brain death controversy. See President's Comm'n, *supra* note 1, at 82. Pronouncements of death based upon heart-lung criteria are also subject to mistake. See *id.*

Archbishop John Roach of Pennsylvania has argued that the role of the Church in the political arena should be based on reasoned argumentation. Paris & Cranford, *supra* note 50, at 14. Following his lead, the Pennsylvania bishops subjected the traditional charges against the determination of death legislation to a critical analysis, and produced a point by point refutation. *Id.* It is submitted that other religious and pro-life groups that have adopted an anti-brain death stance should reevaluate their position in light of the Archbishop's statement.

Statutes that allow physicians to pronounce death based upon either heart-lung or brain-related criteria have been criticized for implying that two different moments of death exist—one for donors and a later one for nondonors. Capron & Kass, *supra* note 51, at 109-10; see, *e.g.*, Md. Health Code Ann. § 5-202 (1983); Tenn. Code Ann. § 68-3-501 (1983). Arguably, such statutes present a confusing picture to the lay public because they do not clearly establish when or why brain-based criteria are to be used. Cf. Charron, *supra* note 51, at 989 (determination of death law must avoid "indeterminacy of application" when all pertinent facts of case known).

When a statute provides for the determination of death based upon the cessation of brain function only, hospitals would ostensibly be precluded from employing the traditional criteria, thereby preventing physicians from pronouncing death unless sophisticated machinery for measuring brain activity was available. Comment, *supra* note 5, at 634; see, *e.g.*, Ill. Ann. Stat. ch 110 1/2 § 302 (Smith-Hurd 1978).
It is suggested that the judicial determination of death rule in New York sets forth a straightforward standard for the medical and legal communities that is also understandable to the lay public. While ordinarily death will be determined by the heart-lung criteria, brain death criteria will be considered only when respiration and circulation are maintained by mechanical means. Furthermore, the cessation of brain function must be total, thereby precluding a diagnosis of death based on a state of coma. Thus, the life of the victim is safeguarded while the physician’s responsibility for a correct diagnosis of death is made contingent solely upon a correct interpretation of the medical data, rather than upon any legal idiosyncrasy.

THE MORAL RAMIFICATIONS OF Eulo

In the broader scheme, People v. Eulo is more than merely a solution to the legal problem of causation—it is an acknowledgement of the essential integrity of human life, and a recognition that, without the unity provided by a functioning brain, the body is merely a group of organs without purpose. By not postponing the legal recognition of the medical fact of death, the individual may properly be accorded the dignity and respect owed to the dead.

Finally, statutes that provide that the physician may pronounce death based on irreversible cessation of brain function are arguably vague because they also offer no guidance as to when the brain-related criteria are to be employed. See, e.g., Ga. Code Ann. § 88-1715.1 (1978). The Georgia statute was subsequently revised to provide that a person may be pronounced dead if he has suffered either irreversible cessation of circulation and respiration or irreversible cessation of all brain functions. See id. § 88-1716 (1985). Cf. Charron, supra note 51, at 989 (law must avoid indeterminacy of application).

People v. Eulo, 63 N.Y.2d at 355, 472 N.E.2d at 295, 482 N.Y.S.2d at 445.
See id. at 355-56, 472 N.E.2d at 295, 482 N.Y.S.2d at 445.
See id. at 356, 472 N.E.2d at 295, 482 N.Y.S.2d at 445.
See id. at 358 n.30, 472 N.E.2d at 296 n.30, 482 N.Y.S.2d at 446 n.30.
See B. Ashley & K. O'Rourke, supra note 52, at 365-66. In determining death, the physician is not called upon to decide whether any life is present (as in the sense of a residual life comparable to that of plants and animals) but must determine whether “human life in the most radical sense of a unified human person is still present.” Id. at 366.
See President's Comm'n, supra note 1, at 35-36 & n.4 (in case of absence of all brain functions, what remains is merely group of artificially maintained subsystems). There are two complementary “whole brain” theories, that the Commission supports. Id. at 32-36. The first theory considers that the major organs of the body work in an integrated manner, while acknowledging that the brain plays an important role. Id. The second theory considers the brain primary, as organizer and regulator of bodily functions. Id. at 34-36. Furthermore, while many of an individual’s vital organs can be either replaced or artificially supported, this is not true of the brain. See Note, The Time of Death—A Legal, Ethical, and Medical Dilemma, 18 Cath. Law. 243, 244-45 (1972).
See R. Veatch, Death, Dying and the Biological Revolution 34, 36 (1976) (“affront to the dignity of individual persons to treat them as alive if they are dead”). When an individ-
Recognition of brain death also puts the responsibility for the prolongation of life into its proper ethical perspective. Those who reasonably have a chance of survival through transplantation surgery are now able to receive the best tissue available. Furthermore, maintenance of life support systems in cases of brain death places a burden on society because valuable medical and economic resources are wasted. Utilization of the brain death standard allows the efforts of the medical profession to be focused on the living rather than the dead. Finally, this approach will spare the patient's family some of the emotional and economic burdens imposed by the needless prolongation of a hopeless situation.

CONCLUSION

In People v. Eulo the New York Court of Appeals was faced with the question of whether or not to recognize brain-related criteria for determining death in homicide cases. Despite repeated rejections of determination of death statutes by the Legislature, the court took the bold step of adopting the brain death standard. In doing so, it handed down a rule that synthesized the common law with the state of modern medicine. As a result, defendants are no longer able to escape liability for their actions through a loophole created by an outmoded legal principle. Justice is served while the dignity of the victim is protected.

Linda Plona Poppe

ual is pronounced dead, the living go into mourning, prepare a funeral, etc. Id. at 26. This reverence is appropriate because a sacred human life once informed the remaining cadaver. B. ASHLEY & K. O'ROURKE, supra note 52, at 372. The practice of transplantation is not inconsistent with the respect normally accorded to the bodies of deceased persons. Id. at 373-74. The Christian view is that this practice is to be encouraged if a true need exists. Id. (citing statement of Pope Pius XII (1956)).


*3 See id.

*4 See Paris & Cranford, supra note 50, at 13; Veith, Fein, Tendler, Veatch, Kleiman & Kalkines, supra note 5, at 1653. On average there are 204 cases of artificial maintenance per month in the major medical centers. Paris & Cranford, supra note 50, at 13.

*5 See Moore, supra note 62, at 384.

*6 See Hirsh, supra note 1, at 37. Medical costs of prolonged maintenance typically are extremely high and could bankrupt the individual responsible for the patient's care. Id. Furthermore, postponement of the declaration of death prevents the family from facing the inevitable reality of the situation and denies them the opportunity to deal with death with dignity. Cf. Veith, Fein, Tendler, Veatch, Kleiman & Kalkines, supra note 46, at 1745.