1980

Death: Multiple Definitions or a Single Standard

Susan L. Brennan

Richard Delgado
University of Alabama - School of Law, rdelgado@law.ua.edu

DEATH: MULTIPLE DEFINITIONS OR A SINGLE STANDARD?

SUSAN L. BRENNAN*
RICHARD DELGADO**

Recently developed medical techniques, including hyperalimentation[1] and artificial pulmonary and cardiac support,[2] enable physicians to maintain many patients, who formerly would have suffered rapid death, for extended periods in a comatose, nonsentient condition.[3] These advances have prompted extensive discussion of the medical and legal status of such patients, as well as the implications of the technologies used to sustain them in a twilight condition.[4] Courts and commentators have wrestled with problems such as: (1) recognizing the dying patient's right to terminate life-sustaining treatment;[5] (2) specifying the legal protections to be afforded a dying patient before irrevocable med-

* Attorney-Adviser to Judge Edna G. Parker, United States Tax Court. J.D. 1979, University of Washington.

** Professor of Law, University of California at Los Angeles. J.D. 1974, University of California at Berkeley. The authors gratefully acknowledge the assistance and comments of Jesse Dukeminier, Roger Dworkin, Special Trial Judge Fred S. Gilbert, Jr., Peter McAllen, and Richard Vogt in the preparation of this Article.

1. Hyperalimentation is the introduction of a feeding line into the large neck veins and right heart so that concentrated supplemental dextrose and amino acids may be given to a patient and fluid balance may be maintained. STEDMAN'S MEDICAL DICTIONARY 667 (4th ed. 1976).

2. Some of the artificial cardiac and respiratory systems used with patients who have suffered cerebral death include intra-aortic balloons that inflate and maintain the heart, and ventilating machines with tubes that are inserted into the windpipe. Absent failure of one of the other vital organs of the body, such as the kidneys or liver, nutrition and metabolic output can usually be maintained by such mechanical means. Interview with Clynn R. Ford, M.D., cardiac surgeon affiliated with University of Utah Medical School and Intermountain Medical Clinic in Salt Lake City (July 24, 1978).

3. *E.g.*, R. VEATCH, DEATH, DYING, AND THE BIOLOGICAL REVOLUTION 2 (1976); Beecher, *Ethical Problems Created by the Hopelessly Unconscious Patient,* 278 NEW ENG. J. MED. 1425 (1968); Dukeminier, *Supplying Organs for Transplantation,* 68 MICH. L. REV. 811, 843-45 (1970).

4. *See, e.g., In re* Quinlan, 70 N.J. 10, 355 A.2d 647 (1976), *cert. denied,* 429 U.S. 922 (1976) ("right to die" case); Delgado, *Euthanasia Reconsidered—The Choice of Death as an Aspect of the Right of Privacy,* 17 ARIZ. L. REV. 474 (1975); Kutner, *Due Process of Euthanasia: The Living Will, A Proposal,* 44 IND. L.J. 539 (1969). *See* notes 6-7 *infra*.

5. *See, e.g., In re* Quinlan, 70 N.J. 10, 355 A.2d 647 (1976), *cert. denied,* 429 U.S. 922 (1976); Cantor, *A Patient's Decision to Decline Life-Saving Medical Treatment: Bodily Integrity Versus the Preservation of Life,* 26 RUTGERS L. REV. 228 (1973). Right to die questions (active and passive euthanasia) must be sharply differentiated from the definition of death questions with

ical procedures such as autopsy or removal of organs for transplantation are carried out;[6] (3) clarifying the rights of various parties to participate in the decisions surrounding termination of treatment;[7] and (4) defining the moment of death.[8]

These discussions, even the definitional ones, pose agonizingly difficult issues. Often scientific and normative questions interpenetrate. For example, it is difficult to address the medical/definitional question, "Is this patient dead?" without confronting the moral question, "Should this patient be allowed to die?"[9] Similarly, the normative decision whether to sustain a patient with massive brain injury turns, explicitly or implicitly, on a medical assessment of the patient's chances of regaining sentient life.[10]

The definitional issues are made even more difficult by uncertainty over whether there should be a single standard or multiple standards. The medical community recognizes at least three competing standards, or criteria, by which persons may be regarded as dead.[11] Which should be used? Who should decide which standard should be applied to particular cases?

This Article explores the implications of adopting a contextual, or functional, approach to defining death, in which the question, "Is *X* dead?" is answered differently depending on the purpose for which the question is asked and the consequences that flow from the answer.[12]

---

which this Article is principally concerned. The former ask, *should* this patient be allowed (or forced) to die? The latter ask, *is* the patient in fact dead?

6. *See, e.g.,* New York City Health & Hosp. Corp. v. Sulsona, 81 Misc. 2d 1002, 367 N.Y.S.2d 686 (Sup. Ct. 1975); UNIFORM ANATOMICAL GIFT ACT; Kutner, *supra* note 4. For a discussion of the Uniform Anatomical Gift Act, see notes 119-27 and accompanying text *infra*.

7. *E.g., In re* Quinlan, 70 N.J. 10, 41-42, 355 A.2d 647, 664 (1976), *cert. denied,* 429 U.S. 922 (1976) (right of parent to assert daughter's privacy-based interest in discontinuing life-support treatment); UNIFORM ANATOMICAL GIFT ACT § 7(b) (delegating to physician the decision to declare an individual dead for purposes of removing organs for transplantation).

8. *See* notes 25-27 *infra*.

9. *See* Capron, *Death and the Law: A Decade of Change,* 63 SOUNDINGS 290, 291-92 (1980).

10. *In re* Quinlan, 70 N.J. 10, 54, 355 A.2d 647, 667 (1976), *cert. denied,* 429 U.S. 922 (1976). *See generally* Delgado, *supra* note 4.

11. *See* notes 33-35 and accompanying text *infra*.

12. Although Professor Roger Dworkin proposed a contextual definition of death, he did not carry out an applied analysis. Dworkin, *Death in Context,* 48 IND. L.J. 623, 629-32 (1973). Dworkin was seemingly content to propose the case for such definitions generally, while leaving to future writers the task of proposing definitions to accommodate the interests involved in the various areas in which death entails legal consequences. *See* notes 28-31 and accompanying text *infra*.

The suggestion that death be treated as a series of events, each containing its own legal and

Three illustrative areas are examined; in each, the decision to regard an individual as dead has significant legal and social consequences. The first area is double indemnity life insurance.[13] When an insured's life is artificially prolonged beyond the time limit specified in a policy, his or her survivors may be deprived of benefits. In cases of lingering death, it becomes critical, therefore, to determine whether the insured's death satisfies the terms of the policy. The second area concerns provisions related to the timing and performance of autopsy and burial.[14] The third is organ transplantation, in which a central concern is defining the death of a potential donor early enough for a transplant to be successful.[15]

Analysis indicates that the most satisfactory approach is to formulate a separate physical definition of death for each situation, rather than to attempt to use a single, all-purpose standard. Furthermore, at least two of the three areas can be dealt with more satisfactorily under specific standards tailored for each setting, rather than by setting out alternative criteria and allowing the physician to choose among them.

I. MULTIPLE DEFINITIONS OF DEATH

Traditionally, the law has treated a missing person as dead after an

---

medical sequelae, itself raises a number of questions, most of which can only be touched upon here. Included are questions such as: (1) On what legal or medical bases should such standards be adopted? (2) By whom should such definitions be formulated? and (3) What should be done in cases in which competing standards appear to require inconsistent treatment of particular patients? For example, consider the hypothetical case of a patient who has validly expressed the desire to have his organs made available for transplant, under a statutory scheme that provides for removal of the organs upon brain death. *See* notes 120-39 and accompanying text *infra*. The patient may also be a homicide victim. Additionally, he may have a large family that, due to the sudden and shocking manner of his death, may want to delay funeral services in order to come to terms with its grief. *See* notes 104, 112-13 and accompanying text *infra*. In such an instance, arguments in favor of an early definition of death would conflict with those in favor of a later one. The surgeon will want to begin operating as soon as possible; the homicide detective will want to take the body to the coroner's office and proceed with an autopsy immediately, and the family may want to delay any declaration of death until it has had the time to cope with its grief. Legislatures need to consider the adoption of rules which establish priorities among such conflicting interests. These "conflict of standards" problems are not considered here.

13. *See* notes 38-96 and accompanying text *infra*.

14. *See* notes 97-116 and accompanying text *infra*.

15. *See* notes 117-52 and accompanying text *infra*. Other problems, such as property and wealth transmission, prosecutions for homicide under the "year and a day" rule, termination of life estates, and gifts made in contemplation of death (the "three year rule"), all of which require fixing a moment of death, are not considered. Nor do we discuss the question of when a physician may cause a patient, admittedly alive, to die: *i.e.,* issues of positive and negative euthanasia.

unexplained absence of five to seven years.[16] Similarly, when persons have died in a common disaster, the Uniform Simultaneous Death Act specifies that each decedent shall be considered to have survived the other decedents for the purpose of estate distribution.[17] Provisions of this sort vary from context to context. Thus, the law currently recognizes and uses multiple definitions of death. This type of definition of death, however, is used not to define the biological state of death itself, but rather to present nonphysical presumptions in the form of legal rules that are responsive to various purposes.[18] The rules need not refer to the concept of death at all. For instance, in the first example mentioned above, the rule might read: "Remarriage after a spouse's five-year absence is not bigamy."[19]

A second type of definition is used in areas in which it is necessary to make a physical observation and a decision about the status of a body. Physical definitions of death have been used in two distinct situations. In the first, the decision that a person is physically dead is made without eliminating all chance of the person's revival. For example, an insured who suffers brain death following an accident may be pronounced dead in order to allow recovery of insurance proceeds by the survivors, but the decision does not necessarily end his or her chances for revival.[20] Similarly, the criminal laws of all jurisdictions require a demonstration that the victim is physically dead as a prerequisite to a successful homicide or manslaughter prosecution.[21] Proof that the vic-

16. *See* cases and statutes cited in Dworkin, *supra* uote 12, at 633 nn.75 & 76, 634 nn.77-82, 635 nn.83-96.

17. UNIFORM SIMULTANEOUS DEATH ACT (including Commissioners' Prefatory Note).

18. In this approach, the legal rule permits another persou, such as a spouse, to act *as though* the individual who fulfills the couditions of the presumption were dead for certain purposes, such as remarriage. It would not necessarily mean that he could be treated as dead for other purposes (organ transplants, for example).

19. This form of rule can be contrasted with rules governing autopsy, burial, and organ transplantation. *See* notes 97-152 and accompanying text *infra*. These rules inevitably require a reference to the physical condition of a body. For example, a rule that forbade autopsy until heart-lung death might read as follows: "Autopsy before cessation of cardiovascular function is homicide."

20. In one case, an Israeli boy returned to normal health after being in an "irreversible coma" for two weeks. Pearson, *The Time of Death—A Legal, Ethical and Medical Dilemma,* 18 CATH. LAW. 243, 253-54 (1972).

21. *See, e.g.,* WASH. REV. CODE ANN. § 9A.32.010 (homicide defined as the killing of a human being) § 9A.32.030 (murder in the first degree defined), § 9A.32.050 (second degree murder defined), § 9A.32.060 (manslaughter in the first degree defined), § 9A.32.070 (manslaughter in the second degree defined) (1976). In some jurisdictions, proof of death can be circumstantial. *E.g.,* W. LAFAVE & A. SCOTT, HANDBOOK ON CRIMINAL LAW 16-17 (1972). In these situations, there is no direct observation of a body to determine its physical condition; in this respect, they resemble cases which state nonphysical presumptions of death.

tim is cerebrally dead may be sufficient to permit criminal charges to be brought against the perpetrator,[22] even though it does not necessarily mean that the victim will not recover.[23]

In other situations, however, the physical definition of death leads to a decision to take irreversible action that will end the person's existence. For example, the decision to pronounce an individual dead for the purposes of transplantation of vital organs, autopsy, or cremation bars any chance of subsequent revival.

Nonphysical presumptions of death have long been used for different purposes, and this type of definition of death has not been the subject of significant legal dispute. Physical definitions of death, however, have recently been the subject of heated debate.[24] Three distinct resolutions have been suggested: (1) physicians should be permitted to decide when a person is dead for a specific purpose;[25] (2) a single definition of death should be adopted by statute for all physical contexts;[26] and (3) death should be defined functionally, with the criteria depending upon the context in which the decision is made and the consequences that will flow from it.[27]

Professor Roger Dworkin advocates the latter contextual approach to defining death. In a 1973 article,[28] Dworkin reviewed the various proposals for defining death, and concluded that no single standard is

22. *E.g.*, State v. Fierro, 124 Ariz. 142, 603 P.2d 74 (1979); Commonwealth v. Golston, 373 Mass. 249, 366 N.E.2d 744 (1977). *See* NEWSWEEK, May 20, 1968, at 68; Pearson, *supra* note 20, at 247 (describing case of homicide victim being prepared for removal of heart for transplantation, in which police and medical authorities questioned whether removal of the organ could constitute the cause of death so as to relieve the liability of the perpetrator of the criminal assault).

23. *See* Pearson, *supra* note 20, at 253-54.

24. *See, e.g.*, notes 28-37 and accompanying text *infra*.

25. *E.g.*, UNIFORM ANATOMICAL GIFT ACT § 7(b), *construed in* New York City Health & Hosp. Corp. v. Sulsona, 81 Misc. 2d 1002, 367 N.Y.S.2d 686 (Sup. Ct. 1975); *In re* Bowman, 94 Wash. 2d 407, 412, 617 P.2d 731, 734 (1980) (rejecting the view that the medical profession should determine the definition of death: "The law has independent interests in defining death which may be lost when deference to medicine is complete.").

26. *E.g.*, Capron, *The Purpose of Death: A Reply to Professor Dworkin*, 48 IND. L.J. 640, 643 (1973). *See* Capron & Kass, *A Statutory Definition of the Standards for Determining Human Deaths: An Appraisal and Proposal*, 121 U. PA. L. REV. 87 (1972).

27. *See, e.g.*, Biorck, *When is Death?*, 1968 WIS. L. REV. 484; Corday, *Life-Death in Human Transplantation*, 55 A.B.A.J. 629 (1969); Friloux, *Death, When Does it Occur?*, 27 BAYLOR L. REV. 10 (1975); Leavell, *Legal Problems in Organ Transplants*, 44 MISS. L.J. 865 (1973); Pearson, *supra* note 19, at 242; Wasmuth, *The Coneept of Death*, 30 OHIO ST. L.J. 32 (1969); Comment, *The Criteria for Determining Death in Vital Organ Transplants—A Medico-Legal Dilemma*, 38 MO. L. REV. 220 (1973); Note, *Legislation: The Need for a Current and Effective Statutory Definition of Death*, 27 OKLA. L. REV. 729 (1974); Comment, *Medical and Legal Views of Death: Confrontation and Reconciliation*, 19 ST. LOUIS L.J. 172 (1974).

28. *See* Dworkin, *supra* note 12, at 629-31: "It would be odd indeed if all . . . different

adequate for all physical contexts.[29] He proposed that the law treat death, not as a unitary event susceptible to a single definition, but as a process, sometimes prolonged, in which each stage might be considered to constitute death for particular purposes.[30] Dworkin argued that this approach would best enable the law to accommodate the interests of patients, physicians, survivors, and society.

Critics of Dworkin's proposal argue that multiple definitions of death would introduce confusion and uncertainty into the law, erode trust between patients and doctors, and run contrary to "biological reality."[31] Dworkin's critics, however, are unable to explain why multiple physical definitions of death would generate this parade of horribles, when multiple nonphysical definitions do not. The greater consequences to the individual who is defined as dead in the first type of case might weigh against governing the decision by a "mere" nonphysical presumption.[32] Nevertheless, this does not explain why the *same* physical criteria must be used in each context.

The critics' contentions are particularly inapt, given that the medical and legal communities already recognize at least three different definitions of death, each relying on different physical criteria. The common law "cessation of vital functions" standard prevails in twenty-two American jurisdictions. Under this standard one is dead when the heart and lungs cease to function.[33] Under the "whole-brain" death

---

situations were susceptible to resolution by one definition of death." *Id.* at 631. Dworkin offered examples of areas of the law which already have adopted special definitions of death:

> Numerous property and wealth transmission issues raise death questions: When may an estate be probated? When may property of a testate or intestate decedent be distributed? When does a life estate end? When does property pass to a surviving joint tenant? When do life insurance benefits become payable and health insurance benefits cease to accrue? When may property escheat? When do agents, conservators, attorneys and trustees lose their authority to act, and when do banks become liable for admitting persons to safe deposit boxes and paying money out of accounts? When is an estate tax due? When is a gift within three years of death so that it may be said to be in contemplation of death? . . . [W]ho died first in the event that persons with interests in one another's estates perished in a common disaster?
>
> . . . [W]hether a person who remarries is a bigamist and whether the remarriage is valid . . . . [W]hether one may be a voter or elected to an office . . . . Coroners' obligations and the mandatory contents of death certificates require determinations of the time of death. And occasional unusual statutes make other matters turn on whether and when someone has died.

Id. at 629-30 (footnotes omitted).

29. *Id.* at 629-31.

30. *Id.*

31. Capron, *supra* note 26, at 643; Kennedy, *Special Article: The Kansas Statute on Death—An Appraisal,* 285 NEW ENG. J. MED. 946, 948 (1971).

32. Imagine, for example, a rule that permitted removal of organs for transplantation after a patient's completing a two-year stay in a hospital.

33. Capron, *supra* note 9, at 297.

standard, of which the "Harvard" or "irreversible coma" definition is best known, a person with a permanently nonfunctioning brain is considered dead.[34] The third standard is that of neocortical or "part-brain" death, under which a person who has suffered irreversible loss of sentient capacity is considered dead.[35]

Despite the criticism, Dworkin's views have influenced legislation in a number of states.[36] The debate continues, however. The Presi-

---

34. *See* note 89 *infra*.

35. *See id.*

The sequence of events that takes place in a patient whose brain has been irreparably destroyed is as follows:

> The most frequent causes of brain death are massive head injuries, massive spontaneons brain hemorrhage secondary to complications of hypertension or rupture of a congenital berry aneurysm, and lack of blood pumped into the brain because of cardiac arrest or systemic hypotension. Brain death occurs when the swelling is so severe that the pressure within the cranial cavity exceeds the pressure of blood flowing into the brain and the brain stem, causing cerebral circulation to cease. In this condition, there is no clinical evidence of brain function. Intense stimulation may bring no response or voluntary motor movements, and there are no eye movements at the brain stem level. Spontaneous respiration ceases because the vital respiratory centers of the brain have been destroyed. The patient depends entirely on mechanical support to maintain cardiorespiratory function. Normal cardiac functioning can be achieved, mechanically, even in the presence of total brain destruction, and can continue for as long as an hour after a patient is pronounced dead and the respirator discontinued.
>
> However, mechanical maintenance of heartbeat and circulation can be continued only for a limited period of time when the brain stem has been destroyed. It is this limited survival period that distinguishes between brain death and the persistent vegetative state. In the later state, irreversible damage occurs to the cerebral cortex, but the brain stem continues to function. Considerations involved in dealing with this condition are entirely different from those involved in brain death and require the drawing of a line between severe dysfunction and no function at all. . . .
>
> Determination of whether cessation of brain function has occurred may be made in a matter of minutes. The decision as to whether it is irreversible may require several days. Ingestion of suppressant drugs and low body temperature may cause a reversible loss of brain function, so these possibilities must be screened out before a person is pronounced brain dead.

In re Bowman, 94 Wash. 2d 407, 417-18, 617 P.2d 731, 736-37 (1980).

36. *See* notes 128-37 *infra* (statutes incorporating differential, or alternative, criteria for death). No legislature seems to have fully adopted the Dworkin proposal that there should be as many definitions of death as there are contexts posing separable configurations of interests. A number of states specify multiple criteria of death and provide that when any one of them is satisfied, the individual is dead for all purposes; others provide for multiple criteria, with the physician permitted to select among them according to his or her judgment.

Recent legislative approaches to defining death may be classified as follows:

(1) Statutes based on the "Kansas model." *See* KAN. STAT. ANN. § 77-202 (Supp. 1980). These statutes specify separate, alternative heart and brain standards, without attaching them to particular contexts. They are "to be utilized for all purposes," with the physician presumably "choosing the standard that seems appropriate in given cases." Statutes in this mold include: MD. HEALTH ANN. CODE art. 43, § 54F (1980); N.M. STAT. ANN. § 12-2-4 (Supp. 1979); OKLA. STAT. ANN. tit. 63, § 1-301(g) (Supp. 1980-1981); OR. REV. STAT. § 146.087 (Supp. 1978).

(2) Statutes that make heart-lung death primary, but provide for resort to a brain-based standard when "artificial means of support preclude a determination that [heart-lung] functions have ceased." MICH. COMP. LAWS ANN. § 333.1021 (1980). *See also, e.g.*, ALA. CODE § 22-31-1 to -4

dent's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research recently urged Congress and the states to adopt an "up-to-date" definition of death which would require that both the upper or "higher" brain and the "lower" brain or brain stem be dead.[37] Their study, and resulting recommendation, are virtually certain to reopen the multiple definition controversy. Given this prospect, it is timely to examine the feasibility and desirability of defining death differently in specific contexts.

II. DEFINING DEATH IN THE CONTEXT OF DOUBLE INDEMNITY LIFE INSURANCE

Many life insurance policies provide for increased (usually doubled) benefits if the insured dies of accidental causes. Such indemnity clauses are not intended to provide windfalls to the beneficiaries,[38] but

---

(Supp. 1980); ALASKA STAT. § 9.65.120 (Supp. 1980); HAWAII REV. STAT. § 327C-1 (Supp. 1979); IOWA CODE ANN. § 702.8 (1979); LA. REV. STAT. ANN. § 9:111 (West Supp. 1981); TEX. REV. CIV. STAT. ANN. art. 4447t (Vernon Supp. 1980-1981).

(3) Statutes based on brain death, following a model bill proposed by the American Bar Association in 1975. The ABA bill provides: "For all legal purposes, a human body with irreversible cessation of total brain function . . . shall be considered dead." ABA, SUMMARY OF ACTION OF THE HOUSE OF DELEGATES 19 (1975-78). *See, e.g.*, CAL. HEALTH & SAFETY CODE § 7180 (West Supp. 1981); MONT. REV. CODES ANN. § 50-22-101 (1979); TENN. CODE ANN. § 53-459 (1977); W. VA. CODE § 16-19-1(c) (Supp. 1980). Similarly, the Uniform Brain Death Act provides for determination of death on "irreversible cessation of all functioning of the brain including the brain stem," but approves, in a Comment, nse of traditional cardiopulmonary criteria when artificial life-support systems are not used. UNIFORM BRAIN DEATH ACT § 1.

37. *See* Cohn, *A Matter of Life and Death: Standard Definition Sought: Congress and States Urged to Define Death Standard*, Wash. Post, July 10, 1981, § A, at 1, col. 2. After working with the Commission, the American Bar Association, the American Medical Association, and the National Conference of Commissions on Uniform State Laws have all approved the recommendations. *Id.* For further discussion and testimony about the definition-of-death problem, see Minutes, President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (May 17, 1980) at 5; *Id.* (July 11-12, 1980) at 1-8. *See* R. Hilts, *Revised Definition of Death Suggested*, Wash. Post, Sept. 17, 1980, § A, at 8, col. 3 (describing President's Commission discussion of draft proposal that would provide for alternative heart-brain criteria for death).

38. The purpose of insurance is to transfer losses from the insured to the insurer. Consequently, the benefits conferred should do no more than reunburse the insured for losses suffered. This rule, known as the "principle of indemnity," is intended to keep insurance policies from turning into a form of wagering contract by which the insured "wins" if the loss occurs. In addition, insurance proceeds which exceed the loss suffered create inducements to allow the loss or even intentionally to cause it. R. KEETON, BASIC TEXT ON INSURANCE LAW § 3.1(a)-(b) (1971).

Although these concerns are most relevant where the loss insured against involves property damage, they apply to life insurance as well. For example, the insured's family might be persuaded not to prolong the life of a dying patient by use of a respirator, especially if the high costs of continued medical care would be eliminated by the termination of treatment. Of course, this incentive is lessened by the natural affection that most family members would feel for the dying patient.

rather are meant to compensate for the increased psychological and physical trauma caused by accidental death. Typically, the insurer attempts to limit its liability by providing that the added benefits are payable only if death occurs within a specified time after the accident.[39] Limiting the period in which the insured may "linger" helps assure that the accident, rather than some intervening event, was in fact the cause of death.[40] Time limitations, however, also create a disincentive to maintain the life of the accident victim and have therefore been the subject of considerable controversy.

A. Analytical Approaches to Time Limit Clauses

Courts have split over whether to enforce double indemnity time limits in cases of lingering death, and legislatures have done little to reduce the confusion. Only Pennsylvania has clearly resolved the issue by enacting regulations that flatly forbid the use of time limits.[41] Courts in

39. The timing element distinguishes double indemnity provisions from other life insurance and raises important questions about the definition of death.

40. *See* Burne v. Franklin Life Ins. Co., 451 Pa. 218, 301 A.2d 799 (1974). In *Burne,* the court held a time limit void as against public policy when death was clearly caused by the accident. The court distinguished a previous case, Sidebotham v. Metropolitan Life Ins. Co., 339 Pa. 124, 14 A.2d 131 (1940), in which the insured was denied benefits under a 90-day clause, recognizing that such provisions should be upheld when genuine questions of causation do exist. The insured in *Sidebotham* suffered three different injuries: two exposures to carbon monoxide and one fall from a hospital bed. Death occurred within 90 days of the last accident, but that accident could not be said with certainty to have been the cause of death. In any event, only the first injury would have been covered by the policy, and it also could not be shown with certainty to be the cause of death. *Id.*

But see Karl v. New York Life Ins. Co., 139 N.J. Super. 318, 353 A.2d 564, (Super. Ct. Law Div. 1976), *rev'd in part on other grounds,* 154 N.J. Super. 182, 381 A.2d 62 (Super. Ct. App. Div. 1977) (Where insured's death was clearly caused by the accident, his survivors were entitled to recover, even though insured did not die until eleven months after the accident.).

An analogous use of the passage of time to establish lack of causation is applied in the law of homicide. At common law a person could not be guilty of murder if the victim survived for a year and a day after the blow. Advances in medicine have provided more reliable methods for establishing cause of death, but most states still apply the year-and-a-day rule. W. LaFave & A. Scott, *supra* note 21, at 266-67.

41. 31 Pa. Code §§ 89.43, 89.61(h), 89.80(e), 89.97(d), 133.12 (1981). These amendments to the Pennsylvania Code of Insurance Regulations were first proposed by the State Insurance Commissioner in an official bulletin of the Pennsylvania Insurance Department, 8 Pa. Bull. No. 12, at 797 (1978). In light of the recent court decisions in Pennsylvania, including Burne v. Franklin Life Ins. Co., 451 Pa. 218, 301 A.2d 799 (1974) and I.N.A. Life Ins. Co. v. Commonwealth, 31 Pa. Commw. Ct. 416, 376 A.2d 670 (1977), the Commissioner of Insurance had requested an opinion from the State Attorney General allowing him to announce a policy barring the use of time limits. The Attorney General subsequently issued an opinion stating that the Commissioner had authority to disapprove any policies "which purport to cut off accidental death benefits by any arbitrary time limit." Official Opinion No. 22, Op. Att'y Gen. Pa. 74, 78 (1974). Accordingly, the Commissioner, following the public policy announced in *Burne,* proposed the regulations cited above,

other states continue to uphold them occasionally.[42]

Five analytical approaches to time limits may be extracted from the cases: strict construction; recognition of the expectations of the parties; adhesionary contracts, including assent and public policy; unconscionability; and unjust enrichment. Strict construction of policies containing time limits has led, of course, to denial of benefits to insureds who did not die within the specified period. Courts applying the other analyses have generally reached the opposite conclusion.

1. *Strict Construction*

The weight of authority favors literal enforcement of time limitations incorporated in insurance contracts.[43] Three recent cases are illustrative; each upheld the enforceability of time limits, rejecting arguments that these clauses violated public policy. In *Fontenot v. New York Life Insurance Co.*,[44] the Louisiana Court of Appeals held that a ninety-day time limit was a valid bar to recovery by the insured's survivor when the insured's accidental death occurred thirteen days after the end of the ninety-day period. The court reasoned that the clause was valid because its terms were clear and unambiguous and violated no public policy.[45]

---

which, in substance, bar any requirement in accidental death policies that death must occur within a specific time period.

42. *See, e.g.*, Bentley v. Independent Life & Accident Ins. Co., 47 Ala. App. 15, 249 So. 2d 631 (Civ. App. 1971) (death not within 90 days); Stinchomb v. Mutual Life Ins. Co., 305 So. 2d 84 (Fla. Dist. Ct. App. 1975), *cert. denied*, 318 So. 2d 402 (1975) (amputation of leg not within 90 days); Travelers Ins. Co. v. Pratt, 130 Ga. App. 331, 203 S.E.2d 302 (1973) (amputation of foot not within 90 days); Randall v. State Mut. Ins. Co., 112 Ga. App. 268, 145 S.E.2d 41 (1965) (death not within 90 days); Douglas v. Southwestern Life Ins. Co., 374 S.W.2d 788 (Tex. Civ. App. 1964) (death not within 90 days where life was prolonged by extraordinary medical care); Harlan v. Aetna Life Ins. Co., 6 Wash. App. 837, 496 P.2d 532 (1972) (loss of an eye not within 90 days).

43. The tenacity with which courts adhere to the literal terms of time limits is strikingly illustrated by a 1938 decision in which an insurer denied benefits to the widow of an insured who died a mere five hours after a 30-day time limit expired, after remaining pulseless for the 24-hour period immediately preceding his death. Mullins v. National Cas. Co., 273 Ky. 686, 117 S.W.2d 928 (1938). According to his physician, he would not have survived past the 30-day limit without Herculean medical care. The Kentucky court observed that the condition precedent of liability, death within 30 days of the accident, was clear, and that both parties voluntarily agreed to the time limit, concluding: "The parties to an insurance contract have the right and the power to contract what accidents and risks shall be covered by it and what shall not be, and . . . the courts may not make a new or different contract for the parties at the instance of one of them." *Id.* at 690, 117 S.W.2d at 931. *See generally* Annot., 118 A.L.R. 334 (1939). The medical efforts were undoubtedly more primitive than those now possible with modern techniques such as respirators and hyperalimentation. *See* notes 1-2 and accompanying text *supra*.

44. 357 So. 2d 1185 (La. Ct. App. 1978), *cert. denied*, 359 So. 2d 622 (1978).

45. *Id.* at 1187-88. The opinion does not mention what public policy grounds were argued.

In *Rhoades v. Equitable Life Assurance Society,*[46] the Ohio Supreme Court held a ninety-day time limit valid against the claim of a beneficiary whose insured died 116 days after the accident that caused his death. In a terse opinion, the court refused to "rewrite the contract" for the parties or to interfere with their freedom to bargain. The beneficiary argued that the clause violated public policy, presumably by encouraging premature termination of medical treatment. The court rejected this argument, declaring that such clauses have the valid function of assuring causation of death by accidental means. The court noted, however, that this was not the sole factor affecting its decision, and that time limitation clauses were enforceable according to their terms even when the accident was shown to have caused an insured's death.[47]

A recent Texas appellate decision stressed slightly different considerations. In *Douglas v. Southwestern Life Insurance Co.,*[48] the court denied benefits to a widow under ninety-day clauses in two policies when her husband's death occurred 120 days after a car accident, even though the attending doctor had asserted that the insured would not have survived the ninety-day period absent the "extraordinary medical care" he received.[49] The court held that the clauses did not violate public policy by encouraging the withholding of medical treatment from insureds so that death would occur within the time limit.[50] Without discussing the relative bargaining positions of the parties, the court

46. 54 Ohio St. 2d 45, 374 N.E.2d 643 (1978).

47. *Id.* at 48 n.3, 374 N.E.2d at 645 n.3.

48. 374 S.W.2d 788 (Tex. Civ. App. 1964).

49. The nature of the medical treatment is not mentioned in the opinion. A letter received by the law firm which represented the plaintiff-beneficiary, however, describes the treatment as including several operations on the insured's liver and intravenous feeding of a special diet. Open letter from Dr. Manning B. Shannon (Oct. 4, 1961) (on file with the authors). There was no use of a respirator or mechanical life support. In an affidavit, Dr. Shannon stated that the insured's death was directly caused by the accident in question and that it had been reasonably certain that the insured would die within the time limit. "It was only because of extraordinary medical measures taken . . . that he did live as long as he did"; without them "he would certainly have died" within the time limit. Affidavit of Dr. Manning B. Shannon, in Dallas County, Texas (Sept. 7, 1962) (on file with the authors); Letter from Marvin Wise to Susan L. Brennan (Nov. 1, 1977) (on file with the authors).

50. The court's ruling is not entirely unreasonable, especially since it appears that the patient was conscious and lucid, although very ill, on the 90th day. Given the strong instinct for life, the court may have been correct in concluding that, in situations like this, there is little incentive to discontinue medical treatment merely to ensure that the policy proceeds are payable. The widow had argued that the clause should be set aside because: (1) it only required proof of loss and not actual loss within 90 days; (2) the clause was unclear as to whether payment of benefits was conditional on proof of loss, actual loss, or visible wounds, and the ambiguity should be resolved against the insurer; and (3) the clause failed to expressly exclude benefits for death occurring more

noted that they could have contracted for a longer limit had they so desired.[51]

Plaintiff also argued that death ought to be defined as commencement of the "act of dying within 90 days"[52] and that this took place at the time of the accident.[53] According to this view, the fatal injuries signaled the beginning of the act of dying, an act that was not complete until 120 days after the accident. The court peremptorily rejected this argument, stating, "Death is not an ambiguous term, and there is no room for construction. Death has been defined as the termination of life; and as the state or condition of being dead."[54] The plaintiff's argument seems specious, as it does not resolve the question of causation. Many acts, including being born, could be seen as commencement of the "act of dying." Still, the court's rejoinder is less than illuminating. Defining death in terms of being dead, although concise, offers little guidance for doctors, nurses, insurers, coroners, and family members who must take practical action based on an individual's legal status.

---

than 90 days after the accident, creating an ambiguity which should be construed against the insurer. 374 S.W.2d at 790-93.

51. *Id.* at 793-94. *See also* notes 58-72 and accompanying text *infra* (time limit clauses as contracts of adhesion).

52. 374 S.W.2d at 793.

53. *Id. See* Letter from Marvin Wise to Susan L. Brennan, stating that counsel argued that death occurred at the time of the accident (Nov. 1, 1977) (on file with the authors).

54. 374 S.W.2d at 793. A California appellate court accepted reasoning similar to that of the plaintiff in *Douglas* in upholding the claim of an insured who died more than two years after a motor vehicle accident. The court found that the insured's injuries had set in motion a "process of nature" that had inexorably led to his later death. In such cases, therefore, the time of death "relates back" to the date of the accident so as to permit recovery under double indemnity clauses. National Life & Accident Ins. Co. v. Edwards, 119 Cal. App.3d 326, 332.

In the main case cited by *Douglas* for the proposition that death is simple and unambiguous, the medical definition of death was not in issue; the issue was whether children placed in a home by a widow were entitled to compensation under a workman's compensation statute. Compensation would be due only if the widow had died "with children under the age of sixteen." The argument was that abandonment should be considered the equivaleut of death; the widow had not died in any physical sense at all. The sharp difference between severing a maternal relationship to one's children and physically dying gave the court little trouble in holding that the word "die" had a definite, unambiguous meaning. Stead v. Department of Labor & Indus., 188 Wash. 171, 61 P.2d 1307 (1936).

In the other case relied on in *Douglas,* a Texas court construed a clause in a will providing that the testator's property should pass to his children if he and his wife should die "at the same time." The court held that the testator intended the word "death" to mean that both parents were in the "state of being dead" at the same time, rather than in the "act of dying" simultaneously. Sanger v. Butler, 45 Tex. Civ. App. 527, 101 S.W. 459, (1907). Unlike *Burne,* neither of these two cases posed the competing heart-brain death standards question. *See* note 40 *supra.*

2. *Recognition of the Expectations of the Parties*

Other courts have based the decision of whether to enforce time limits in insurance contracts upon the reasonable expectations of the parties at the time the contract was made. In *Interstate Life & Accident Co. v. Waters,*[55] the Mississippi Supreme Court allowed benefits to an insured amputee, although actual severance of his leg occurred after the expiration of the policy's thirty-day limit. The court reasoned that the parties could have foreseen that recovery would be allowed, even though the amputation took place after the thirty-day limit.[56] Because the delay was essential to preserve the insured's life, and a rule denying recovery might encourage medical risk taking, the court ignored the time limit, citing the rule that, "A contract of insurance should be given a fair and reasonable construction . . . consonant with the apparent object and plain intention of the parties."[57]

Despite the holding in *Waters,* however, it is unlikely that parties would be able to foresee benefits being allowed if an insured's life were artificially prolonged beyond an insurance policy's time limit. Furthermore, even if the parties considered this problem when they contracted, it is not clear that only one result would be foreseen.

The insurance companies in these cases could argue that the parties, if they had thought about it at all, would have foreseen that the time limit clause would bar recovery. The insureds, on the other hand, could argue that the insurance company, if it had thought carefully about it, would have foreseen that the clause would be disregarded so as not to pressure doctors and patients to make unwise medical decisions. Both views are plausible. Hence, the expectations of the parties are an uncertain base on which to sustain or void time limits in cases of artificial prolongation of life.

3. *Adhesion Contracts*

A dissenting opinion in *Fontenot v. New York Life Insurance Co.* suggests that time limits ought to be voided due to their adhesionary nature.[58] An adhesion contract is a "standardized agreement dictated by the predominant party to cover transactions with many people rather

55. 213 Miss. 265, 56 So. 2d 493 (1952). The court held that, although actual amputation of the leg occurred after the time limit, the loss covered by the policy occurred within the period once the doctor found that, to prevent killing the insured, the amputation would have to be delayed. *Id.* at 272-73, 56 So. 2d at 495-96.

56. *Id.*

57. *Id.* at 272, 56 So. 2d at 495, (quoting 44 C.J.S., *Insurance* § 296, at 1163-64 (1945)).

58. 357 So. 2d at 1189 (Watson, J., dissenting).

than one person, and . . . resembl[ing] an ultimatum . . . rather than a mutually negotiated contract."[59] Contracts may be voided for adhesion where a court finds that (1) there is no true assent to a specific term; or (2) although there is such assent, the term violates public policy.[60] The *Fontenot* dissent purported to find both grounds applicable.

a. *Assent*: Objection to enforcement of a time limit clause on the first ground—lack of assent—seems, in general, less promising than a public policy objection. Since insureds usually pay only a relatively small premium to gain double protection, courts may well find that insureds would have agreed to the time limitation even if they had known that it might be applied against them in the event of lingering death.[61]

b. *Public Policy*: Some courts have voided double indemnity time limits on public policy grounds, either under an unconscionability/adhesion test, or independently.[62] In *Burne v. Franklin Life Insurance Co.*,[63] the Pennsylvania Supreme Court refused on public policy grounds to enforce a ninety-day clause even though the insured did not die until four and one-half years after the car accident which caused his death. The court found that without the extraordinary medical care he received, the insured, whose brain was severely damaged, would have died within the ninety-day limit.[64] The court reasoned that since the

59. J. CALAMARI & J. PERILLO, THE LAW OF CONTRACTS § 9-44, at 341 n.39 (2d ed. 1977). *See also* Siegelman v. Cunard White Star Ltd., 221 F.2d 189 (2d Cir. 1955) (upholding a shipping company's reliance on a limitation period in a contract of carriage in a suit by the husband for injuries suffered by his wife while a passenger on the ship). The dissent stated that the contract of carriage was an adhesion contract, in which the "dominant party 'legislates' for both" and "in which one predominant unilateral will dictates its law to an undetermined multiple rather than to an individual . . . , as in all contracts which, as the Romans said, resemble a law more than a meeting of the minds." *Id.* at 206 (Frank, J., dissenting).

60. *See* J. CALAMARI & J. PERILLO, *supra* note 59, § 9-44, at 343 (noting that these two reasons for voiding adhesionary contracts conflict with insurers' argument that the insured has a duty to read and is hence bound by the terms of a policy he or she signs).

61. *See id.*, at 498-501. The authors state that rather than pure foreseeability, the proper test for applying the rule of changed circumstances ought to be whether the risk was assigned to either party, *i.e.*, whether the parties expressly provided who would bear the risk, or whether they failed to consider what would happen if an event occurred which changed the circumstances of the contract.

62. For a discussion of the majority approach to double indemnity time limits, see notes 43-54 and accompanying text *supra*. Courts that adhere to the majority rule enforce such clauses according to their terms so long as they are clear and unambiguous, rejecting public policy arguments that they be declared void.

63. 451 Pa. 218, 301 A.2d 799 (1973).

64. *Id.* The insured, who had been struck by a car, remained in a "vegetative" state for the

function of these limits is to assure that death is caused by accidental means, the clause should not be applied where causation is established.[65]

An equally important basis for the decision in *Burne* was the court's belief that decisions to curtail medical treatment should not be influenced by the threat of loss of insurance benefits if care prolongs an insured's life beyond the time limit.[66] The court stated that enforcing the clause, which originated in medicine's early days, would pose a "gruesome paradox": although proceeds would be paid if an insured died within the time limit, benefits would be denied if an insured's death were protracted, requiring his or her family to bear the expense of additional medical care.[67]

---

entire four-and-one-half years that he continued to live. In the words of the court, "Mr. Burne's existence was that of a complete and hopeless invalid, unable to speak, subject to seizures and requiring constant nursing and medical care." *Id.* at 221, 301 A.2d at 801.

When the Supreme Court of Pennsylvania first considered *Burne,* the justices decided in favor of the insurance company. The Chief Justice, however, had not participated in the decision, and within two weeks of the decision, two new justices were appointed to the court, one replacing the Chief Justice and one replacing a participating judge. Plaintiff's counsel petitioned for reargument and won the case by a 5-2 decision. Thus, the precedential value of this decision must be weighed in light of the changing composition of the Pennsylvania court. Telephone Interview with Joseph E. Gallagher (attorney for plaintiff), Gallagher, O'Malley, Morgan, & Bour, in Scranton, Pennsylvania (July 19, 1978).

The extraordinary medical treatment employed for the insured consisted of extensive brain surgery. Immediately after the injury, he underwent bilateral brain surgery, and twelve days afterward, part of the temporal lobe of his brain was removed. Without these extraordinary procedures, performed at a total cost of $15,000, the insured would have died soon after the accident. No respirators or artificial means of support were used to prolong his life. *Id.*

65. 451 Pa. at 225, 301 A.2d at 803. *But see* Harlan v. Aetna Life Ins. Co., 6 Wash. App. 837, 496 P.2d 532 (1972) (rejecting the public policy argument for voiding double indemnity clauses as applied to loss of an eye after the 90-day period).

Whether insurance companies will follow *Burne* and agree to waive time limits when causation of death by accident is proved remains unclear. One writer, by interviewing several insurance companies, discovered that many insurers had an in-house policy of waiving time limits where the insured's death was caused by the accident. Note, *Death Be Not Proud—The Demise of Double Indemnity Time Limitations,* 23 DEPAUL L. REV. 854, 863 (1974).

In one metropolitan area, responses to the authors' inquiries were largely negative, with most major companies stating that they would not normally waive a time limit. Responses from insurers in another area, however, elicited some doubt about denying benefits under time limits due to the *Burne* line of cases and due to proposed regulations which would bar any use of time limitations in Pennsylvania.

66. 451 Pa. at 221-23, 301 A.2d at 801-02. The court, in noting that medical progress has enabled death to be delayed almost indefinitely, refused to clarify the application of time limits in insurance policies to the euthanasia context when it stated that "The purpose of this opinion is not to introduce [the euthanasia] controversy into the area of life insurance policies but to *forestall it*." *Id.* at 222 n.3, 301 A.2d at 801 n.3 (emphasis added).

67. *Id.* at 222, 301 A.2d at 802.

Similarly, in *Karl v. New York Life Insurance Co.*,[68] a New Jersey trial court permitted a beneficiary to recover double indemnity proceeds in two policies, even though the insured died eleven months after the criminal assault which caused his death. The court found that the insured's death was caused by accidental means, and that upholding the time limit would be contrary to public policy, in providing an incentive to discontinue medical care.[69] Rejecting the insurer's argument that the limitation should be enforced due to its clear language and the low cost of accidental death coverage, the court observed that the low cost exists in part because of the small proportion of deaths caused by accident, so that when causation is clear, the timing of the death is relatively unimportant.[70]

Appellate courts in other states have struck down limitations on time of death contained in particular policies, some on public policy grounds, and others for a combination of reasons.[71] A blanket rule against time limits, however, relieves only part of the dilemma in cases of artificially prolonged life. Like unconscionability, a blanket rule against time limits would ensure that payment will not be denied merely because an accident victim whose brain has been destroyed lives too long. Such a blanket rule, however, requires case-by-case application and does not answer the question of when proceeds are paya-

68. 139 N.J. Super. 318, 353 A.2d 564 (Super. Ct. Law Div. 1976) *rev'd in part on other grounds,* 154 N.J. Super. 182, 381 A.2d 62 (Super. Ct. App. Div. 1977). An additional multiple causation problem was present in that during the eleven months between the accident and his demise, the insured suffered from a lung infection which the insurer claimed could have caused his death. *Id.* at 324, 353 A.2d at 565.

69. *Id.* at 325, 353 A.2d at 568.

70. *Id.* at 328, 353 A.2d at 569.

71. *See, e.g.,* Strickland v. Gulf Life Ins. Co., 240 Ga. 723, 242 S.E.2d 148 (1978). The Georgia Supreme Court found that the policy provided coverage if an insured suffered dismemberment of a leg by amputation within 90 days of injury by accident. The court nevertheless refused to enforce the clause against an amputee whose leg was severed 118 days after the accident, since the clause might, under the reasoning of *Burne,* violate public policy. Moreover, performing the amputation within the time limit would have endangered the amputee's life. *Id.* at 726-31, 242 S.E.2d at 150-52. The court also noted that the time limit, because of its adhesionary nature, might be unconscionable based on the circumstances existing when the insured agreed to the policy terms. *Id.* at 725, 242 S.E.2d at 149.

See also National Life & Accident Ins. Co. v. Edwards, 81 L.A.D.J. 1574 (Cal. App., June 1, 1981). The court stated that it did "not find it necessary to hold that such clauses are invalid as a matter of public policy." Nevertheless, the court invalidated the 90-day time limitation at issue as a "reasonable extension of the process of nature rule already the law in California." *Id.* at 1575.

Other courts have approved public policy, including not discouraging medical care, as a ground for invalidating time limits, but have held that ascertainment of public policy is for the legislature or the insurance commissioner. *E.g.,* Kirk v. Financial Sec. Life Ins. Co., 75 Ill. 2d 367, 389 N.E.2d 144 (1978) (upholding double indemnity policy for this reason).

ble. If the victim survives for an extended period with the aid of life-support machinery, the insurance company may be able to avoid payment during that entire time unless the beneficiaries bring suit.[72]

4. *Unconscionability*

Another basis on which courts could void time limits is unconscionability.[73] To satisfy the prevailing test for unconscionability, a court must find one-sided bargaining, oppression, or unfair surprise.[74]

Although courts apparently regard unconscionability as a possible ground for voiding time limits, no court seems to have found a case that presents a suitable factual basis for doing so. In *Mullins v. National Casualty Co.*,[75] for example, the court rejected the beneficiary's argument that a time limit was unconscionable, refusing to use the parties' unequal bargaining positions to upset the contract's allocation of risks.[76] The court presumed the parties knew what risks were covered by the clause when they contracted. It refused to rewrite the contract, concluding that the time limit was reasonable given the low cost of premiums charged for extra protection.[77]

In light of *Mullins* and the bulk of case law upholding insurance time limits, unconscionability appears unlikely to support invalidation of time limits. Even if it were applicable, it would require a case-by-

72. *See* I.N.A. Life Ins. Co. v. Commonwealth, 31 Pa. Commw. Ct. 416, 376 A.2d 670 (1977). Pennsylvania recently enacted regulations aimed at clarifying the application of time limits, but did not consider the case of artificially prolonged life. These rules were quickly followed by an Attorney General's opinion disapproving any policy that attempted to cut off accidental death benefits by means of a time limit. *See* note 41 *supra*.

73. Unconscionability is discussed in R. KEETON, *supra* note 38, § 6.2, at 348. Keeton states that "an insurer will not be permitted an unconscionable advantage in an insurance transaction even though the policyholder or other person whose interests are affected has manifested fully informed consent." *Id.*

To support insureds' nse of this principle against insurers, courts could employ U.C.C. § 2-302(1) to void time limitations:

> If the court as a matter of law finds the contract or any clanse of the contract to have been unconscionable at the time it was made the court may refuse to enforce the contract, or enforce the remainder of the contract without the unconscionable clause, or it may so limit the application of any unconscionable clause as to avoid any unconscionable result.

U.C.C. § 2-302(1).

74. U.C.C. § 2-302(1) (Official Comment). *Cf.* Campbell Soup Co. v. Wentz, 172 F.2d 80 (3d Cir. 1948) (in which the court refused to grant specific performance of an unfair adhesiouary coutract, but indicated it would rule differently in an action at law); R. KEETON, *supra* note 38, § 6.2, at 348 (1971) (discussing disparity in bargaining positions between insurer and insured, which presents an opportunity for the insurer to overreach in drawing the insurance contract).

75. 273 Ky. 686, 117 S.W.2d 928 (Ct. App. 1938).

76. *Id.* at 688-90, 117 S.W.2d at 930-31.

77. *Id.* at 690, 117 S.W.2d at 931.

case approach, which would create uncertainty regarding whether benefits are payable in particular cases.

5. *Unjust Enrichment—Restitution*

In order to secure double indemnity coverage, the insured pays a premium consisting of the dollar amount of the double indemnity benefit multiplied by the probability of the occurrence of a catastrophic accident which will result in death within the contractually specified period.[78] For example, suppose an insured wants $100 worth of double indemnity coverage during the term of the policy. Assume further that the probability of an accident which would be followed by death within the contractually specified number of days is one percent during the term of the policy. Therefore, the base premium would be one percent multiplied by $100, or one dollar. In this manner, for every 100 insureds, paying a total of $100 in premiums, there would be an average of one double indemnity payout of $100.[79]

Those insureds who entered into double indemnity coverage agreements prior to the common use of life-support machinery paid premiums based on the statistical probability that they would be victims of catastrophic accidents which would result in death within the contractually specified number of days. Subsequently, although the frequency of disastrous accidents may have remained unchanged, the use of life-support machinery has reduced the probability of death within the contractually specified number of days. If the insurer is allowed to escape payment of the double indemnity benefit to the insured's beneficiaries, while still charging a premium price based on time limits that do not take use of life-support machinery into account, an injustice will result. The insured has paid a much higher premium than is required for the risk being borne by the insurer, and the insurer is awarded a windfall at the expense of the insured, based on the inflated premiums which it collected for a now-decreased risk.

A basic principle underlying unjust enrichment actions, and at the very core of the law of restitution, is that "one person is accountable to another on the ground that he would unjustly benefit or the other would unjustly suffer loss. . . . A person who has been unjustly enriched at the expense of another is required to make restitution to the

78. *See generally* E. VAUGHN & C. ELLIOTT, FUNDAMENTALS OF RISK AND INSURANCE 17-18 (2d ed. 1978).

79. This simplified calculation does not account for different risks among different insureds, or for the insurer's overhead costs and profits.

other . . . ."[80] It is clear that, in the aggregate, insurance companies which charged high premiums for a now-decreased risk will be awarded an unearned benefit, and the pool of insured persons will suffer an unjust loss from payment of the inflated premium. In order to prevent this injustice, the insurer should pay double indemnity benefits for accidents which would have resulted in death during the contractually specified period but for the use of life-support machinery.

Difficulty in the application of the law of restitution to this situation may result from the rule that restitution may not be awarded to a plaintiff who has completed performance.[81] Literal application of this rule[82] would result in the anomaly of the beneficiaries being able to sue in restitution for double indemnity benefits only if the insured has failed to make all premium payments prior to death. Fortunately, the courts have often mitigated the harshness of this doctrine by taking liberties in analyzing the facts before them to obtain a just outcome.[83] Furthermore, the strong public policy prohibiting insurance companies from charging excessive rates[84] would favor application of the doctrine of restitution to this situation, so that insureds would receive benefits commensurate with the premiums paid.

Nevertheless, unjust enrichment offers a weak basis for voiding time limit clauses in cases of lingering death. Advances in life-support machinery have been well reported and publicized in the media.[85] Insurers can argue that insureds, in most cases, took these altered facts into account at the time of purchase, and hence no injustice results from enforcing time restrictions.

B. Accommodating The Interests

The case law dealing with double indemnity accident victims whose

80. Restatement of Restitution § 1 (1937).

81. *See generally* Comment, *Restitution—Availability as an Alternative Remedy Where Plaintiff Has Fully Performed a Contract to Provide Goods or Services,* 57 Mich. L. Rev. 268 (1958).

82. No justification for this rule appears to exist other than that such a result was established early in the history of the writ of indebitatus assumpsit. J. Calamari & J. Perillo, *supra* note 59, § 15-6, at 577.

83. *See, e.g.,* Oliver v. Campbell, 43 Cal. 2d 298, 273 P.2d 15 (1954).

84. All states provide for regulation of insurance rates, in part to prevent excessive rates. E. Vaughn & C. Elliot, *supra* note 78, at 138. Although life insurance rates have generally not been regulated, there is a trend which recognizes that regulation against excessive premiums is necessary in this area as well. *See generally* J. Belth, The Retail Price Structure in American Life Insurance (1966).

85. The *Quinlan* case, for example, received nationwide publicity. *See, e.g.,* N.Y. Times, Nov. 11, 1975, § A, at 1, col. 3. *See also Murder Charges Dropped for a Nurse in Maryland,* N.Y. Times, Mar. 30, 1979, § A, at 16, col. 6; sources cited in note 148 *infra*.

lives are artificially prolonged is inconsistent and essentially result-oriented.[86] In some respects, this is not surprising. Time limitations, originally designed to insure proof of causation, have been rendered less useful by medical advances that permit doctors to control the timing of a person's death.[87] Thus, one approach to the problem of time limit clauses would be to say that if the accident causes death, the time limit should be disregarded. A few courts have followed this approach.[88] Other courts have not, perhaps fearing that such action would create a morass of new causation issues or would amount to rewriting the contract for the parties.

A better solution would be to define death more specifically in the context of accident insurance. One of the varieties of brain death[89] appears to be the most logical standard. Thus, when an insured has suffered irreversible cerebral death as a result of an accident and has no chance of revival, death should be held to have occurred for double indemnity insurance purposes.[90]

Physicians should welcome this standard, as it would relieve them of possible pressures to discontinue life support in order to protect insurance benefits for the survivors. It enables insurance companies to set premiums with respect to a determinable standard, rather than the present case-by-case approach. It minimizes the costs of litigation.

---

86. *See* notes 43-85 and accompanying text *supra*.

87. *See* notes 1-2 and accompanying text *supra* (hyperalimentation and cardiac support machinery).

88. *See, e.g.,* notes 63, 68, 71 *supra*.

89. *See* 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 (1968). Under this "irreversible coma" or "Harvard" test, a permanently nonfunctioning brain is evidenced by: (1) unreceptivity and unresponsiveness; (2) lack of spontaneous movements and breathing for one hour; (3) lack of elicitable reflexes; and (4) a flat EEG. The criteria provide that the test should not be used in cases of hypothermia or where ingestion of central nervous system depressants like barbiturates is suspected. This is the most commonly accepted test.

See also text accompanying note 35 *supra* (part-brain neocortical death). Part-brain definitions provide that the patient be declared dead when higher lobe (thinking, feeling) activity permanently ceases.

90. We might, of course, refer to the patient's condition by a different name, such as "in a condition of disbursibility." Alternatively, we could reserve the question of whether the patient is alive or dead, but decide that when he or she reaches a particular state of irreversible decline, we will call the insurance contract by a different name, such as "payable." It would be clear in each case, however, that we are really referring to a state of bodily deterioration on which legal consequences turn. It would seem most natural, as well as in keeping with current language, to call this, simply, "death" (or, perhaps, "insurance death"). A patient in this condition will be considered dead for insurance purposes only, of course. Removal of organs, autopsy, and other steps require their own definition, and may occur at different times.

At the same time, few if any societal interests are endangered. Defining an individual as dead for insurance purposes at time *A* rather than time *B* scarcely conveys an attitude of disrespect for human life.[91] Rule[92] and act utilitarian[93] considerations also support adoption of an early standard, as there is a net gain to those most immediately affected, as well as to society generally. The proposed rule is also consistent with principles of justice,[94] since nothing (no organ, for example) is taken from the insured, nor is he foreclosed from an option (such as continued life) for the benefit of another.

Freedom of contract considerations are not implicated. Insurance companies and purchasers of accident insurance will be able to buy and sell insurance contracts incorporating brain death as easily as under any other standard, and with more certainty than is presently available. The only change will be in the cost of premiums for policies of varying lengths. A ninety-day policy under the cardiovascular standard may turn out to be the actuarial (and cost) equivalent of a seventy-five-day policy under a brain death standard.

Arguably, some survivors will suffer psychological stress as a result of having a loved one declared insurance-dead while the victim still lies breathing in a nearby hospital. If payment of insurance proceeds takes place before the funeral and burial, this may aggravate feelings of guilt common when a loved one dies. Additionally, the insurance-dead person may have an interest in not having his or her insurance benefits

91. The decision to distribute the proceeds of the insurance policy does nothing to injure the declining individual in a bodily sense, nor does it signify a hasty rush to "be done with" him. *See* notes 139-49 and accompanying text *infra* (policy considerations affecting definition of death for organ transplant purposes).

92. Utilitarianism is the predominant ethical approach among contemporary normative philosophers. *See generally* H. SIDGEWICK, METHODS OF ETHICS (7th ed. 1907); Smart, *Utilitarianism,* in 8 ENCYCLOPEDIA OF PHILOSOPHY 208 (P. Edwards ed. 1967). Rule utilitarianism holds that conduct is justified to the extent that general adherence to the rule or principle it exemplifies tends to produce a balance of beneficial over harmful effects. *See id.* at 208. To cite a common example, rule utilitarians believe that we should keep promises, even though an occasional departure from this rule might promote utility in a particular case. Society-wide adherence to the rule of promise-keeping has such great benefits that it ought to be enshrined as a general rule.

93. Act utilitarianism holds that conduct is justified insofar as particular acts produce a preponderance of beneficial over harmful consequences for the largest number of people. *E.g.,* J.S. MILL, UTILITARIANISM (1957); Smart, *supra* note 9, at 206-12.

94. Justice claims are those emphasized by a leading school of moral philosophy. "Deontologists," as they are called, believe that conduct is justified insofar as it adheres to moral rules of right conduct and justice. In this view, depriving *A* of a valued possession, which he or she rightfully owns, for the benefit of *B,* would not be right even if it resulted in more benefit to *B* than harm to *A*. *See generally* I. KANT, FUNDAMENTAL PRINCIPLES OF THE METAPHYSIC OF MORALS 37-47 (T. Abbott trans. 1949); Olson, *Deontological Ethics,* in 2 ENCYCLOPEDIA OF PHILOSOPHY 343 (P. Edwards ed. 1967).

distributed. Our legal system presumes that dead persons have an interest in the manner in which their property is distributed,[95] and typically the insurance-dead person will want the beneficiaries to receive the maximum benefit out of the policy, including receiving the proceeds at the earliest possible moment. This need not always be so, however. Some insureds might oppose distribution of the benefits when there is still an opportunity for the beneficiaries to expend all of the benefits on hopeless medical efforts to revive them.

On balance, however, the case for early disbursement seems compelling. If an occasional survivor would suffer stress from early receipt of the double indemnity proceeds, he or she is free to negotiate with the insurance company to receive the proceeds later; most companies will be happy to oblige. The interest of the victim in not having his or her family suffer financial devastation as a result of heroic medical efforts when recovery is extremely unlikely can be best accommodated by a natural death statute that authorizes cessation of medical efforts on brain death. To prevent unjust enrichment of the beneficiaries in the unlikely event that the determination of brain death proves to have been erroneous and the patient revives,[96] the survivors can be required to post bond.

III. DEFINITIONS OF DEATH FOR PURPOSES OF AUTOPSY AND BURIAL

When the moribund individual is not a proposed organ donor and double indemnity considerations are not at issue, the sole question with respect to the timing of death may be when burial and autopsy may be performed. Although there is no universal rule concerning whether these functions may be carried out when the person has suffered brain

95. For example, we respect wills.

96. The case of the Israeli boy who returned to normal health after being in an "irreversible" coma for two weeks shows that revival, although unlikely, is not impossible. *See* note 20 *supra*. Because time limiting clauses were originally drafted with an eye to causation, *see* notes 87-88 and accompanying text *supra*, it is worth noting that a hybrid alternative solution is possible. Under this approach, double indemnity benefits would be payable in every case in which it could be demonstrated that death was the result of accident, but payment would only be made upon brain death of the insured. Thus, a person who is moribund but not brain dead at 90 days would be entitled to have the proceeds of the policy distributed when he dies (becomes brain-dead). In the approach described in the text, such a person would not be entitled to payment, because his death occurred after the contractual time limit. The alternative approach would require that a court or legislature be prepared to discard early death as a guarantee of causation, which few courts and legislatures seem prepared to do at this time.

death, or only when all vital functions have ceased,[97] the most common practice seems to favor the latter standard.[98]

A. Purposes of Autopsy and Burial

The main legal purpose of an autopsy is to determine the precise cause of death when there is evidence that death has resulted from violent, unlawful, or unknown causes.[99] The circumstances which must be met before an autopsy is required are prescribed by statute in most states; and, except where a law provides otherwise, autopsies may be conducted only after a legal inquest has been held.[100]

The functions of burial are more diverse. The earliest purpose of burial was religious, evidenced by the continuing belief that every person is entitled to a decent burial, and by the circumstance that most funerals assume a religious setting.[101] According to early religious thought, burial provided a resting place for a dead body without which the departed soul would not find peace. A person had the right to proper disposition of his or her remains so that the soul would find rest after the earthly struggle for existence. Therefore, proper disposal of the corpse was considered a prerequisite to resurrection of the soul.[102]

Nonreligious reasons for burying corpses historically included public health and sanitation concerns.[103] While modern society perceives little threat of contracting disease from cemeteries, early religious groups believed that the body continued to carry the cause of death and that contact with a corpse was therefore dangerous even if

97. *See* text accompanying notes 33-35 *supra,* describing competing physical standards for determining death (heart-lung, whole-brain, and part-brain standards).

98. *See* note 34 and text accompanying notes 33-35 *supra*.

99. *See generally* 18 Am. Jur. 2d *Coroners or Medical Examiners* § 14 (Supp. 1978). Typical conditions which merit an autopsy include: sudden death as a result of an unknown cause; death within one year following an accident; and death by unlawful or unnatural means, violence, abortion, suicide, drowning, hanging, burning, electrocution, shooting, stabbing, lightning, starvation, radiation, exposure, alcoholism, narcotics, tetanus, strangling, suffocation, smothering, contagious disease, or rape. *See, e.g.,* Wash. Rev. Code § 68.08.010 (1979).

100. There have been occasional reports, however, of police authorities who have pressed for an earlier autopsy under a statute permitting an individual to be declared dead on brain death. Newsweek, *supra* note 22, at 68; Pearsou, *supra* note 20, at 247 (describing medical examiner who warned doctor of possible prosecution for interfering with an autopsy if the doctor removed heart of donor who was a homicide victim, under a statute that mandated autopsies in homicide cases).

101. *See generally* P. Jackson, The Law of Cadavers and of Burial and Burial Places 31-32 (2d ed. 1950); Alexander, *"The Rigid Embrace of the Narrow House": Premature Burial and the Signs of Death,* 10 Hastings Center Rep. 25 (1980).

102. P. Jackson, *supra* note 101, at 31-32. Following this reasoning, early Christians considered cremation a form of punishment, since destruction of the corpse barred resurrection. *Id.* at 8.

103. *Id.* at 14; Alexander, *supra* note 101, at 28.

death had not been caused by a disease.[104]

A third function of burial, both historic and contemporary, lies in the therapeutic value of group association at the funeral. According to this view, once death changes the interaction of family members, the survivors' need for stability is met by uniting with friends and relatives at the funeral. This rite sustains the bereaved persons by providing a social outlet for expressing grief, offering the sympathy of fellow mourners, and formally signaling the end of their relationship with the deceased.[105]

B. Accommodating The Interests

The finality and irreversibility of autopsy and burial weigh in favor of a later definition of death for these purposes than is indicated for double indemnity insurance contracts.[106] From a medical standpoint, the chance of error resulting from adoption of an early, brain-based standard is slight; other considerations, however, call for a later standard. Some physicians might object to early termination of life support systems as morally inconsistent with their professional duty to do everything possible to sustain life.[107] Others may fear that termination of support systems will lead to tort or criminal sanctions,[108] or cloud causation in an action for wrongful death brought by the survivors against the person responsible for the victim's condition.[109]

---

104. *See* P. Jackson, *supra* note 101, at 10. One plausible explanation for the divergence of viewpoints as to the purpose of burial is that modern cemeteries are constructed far away from residential areas, but older graveyards were built closer to villages and cities, threatening contamination of drinking water and diseases. *Id.* at 10-14.

105. L. Bowman, The American Funeral: A Study in Guilt, Extravagance, and Sublimity 126-28 (1959).

106. *See* notes 38-96 and accompanying text *supra*.

107. Testimony of Frank Veith, M.D., in Minutes, President's Commission for the Study of Ethical Problems in Medicine, and Biomedical and Behavioral Research (July 11-12, 1980) at 1 (on file with the authors); *see* M. Shapiro & R. Spece, Cases, Materials and Problems on Bioethics and Law (1981); Cantor, *A Patient's Decision to Decline Lifesaving Medical Treatment: Bodily Integrity Versus the Preservation of Life,* in Biomedical Ethics 339 (T. Mappes & J. Zembaty eds. 1981).

108. Adoption of an early standard would be meaningless unless it absolved the physician or coroner of liability for wrongful death in carrying out an autopsy on an individual defined as dead.

109. *E.g.,* R. Veatch, *supra* note 3, at 6 (discussing example in which defense attorney for assailant charged victim's physician, who had removed heart for transplantation, with being proximate cause of death). Doctors may fear that an action for wrongful death could be brought against them personally. Moreover, if they perform an autopsy or consign the body to an undertaker, they may fear an action for emotional distress. *See* Blanchard v. Brawley, 75 So. 2d 891, 894 (La. Ct. App. 1954) (applying the rule that "the right to dispose of a corpse by decent sepulture includes the right to the possession of the body in the same condition in which death leaves

The cessation of vital functions standard thus seems preferable from a physician's standpoint. This is also the preferred standard for survivors because it eliminates the chances of their loved one's being declared dead prematurely. Certainly the survivors would wish to avoid any possibility of subjecting a person to early burial, cremation, or autopsy.[110] On the other hand, when irreversible coma places a relative into a nonsentient, nonresponsive state, some families want to discontinue treatment and end the ordeal. This may be especially true where great expense is required to maintain life artificially for an indefinite period of time with no prospect of revival.[111]

As for the family's interest in an adequate period in which to grieve, neither an early nor a late standard seems better calculated to promote this result. Under either standard, the time between pronouncement of death and commitment to the ground—usually three to seven days—is an inadequate period for the bereaved to cope with grief over the loss of a loved one.[112] Psychological studies of bereavement indicate that this process requires months or years to complete.[113] Friends or family members may assert a justice-based claim, however, to prevent a burial or autopsy before they are psychologically ready for it.[114] Given the strength of the need to confront impending separation

---

it," and holding that deceased's survivors were entitled to damages for mental anguish by burning of deceased's body); Parker v. Quinn-McGowen Co., 262 N.C. 560, 562, 138 S.E.2d 214, 216 (1964) (denying recovery to deceased's relatives for emotional distress due to unauthorized embalming, since it was a "routine incident in the preparation of a body for burial," unlike unauthorized autopsies); RESTATEMENT (SECOND) OF TORTS § 868 (1979) ("One who intentionally, recklessly or negligently removes, withholds, mutilates or operates upon the body of a dead person or prevents its proper interment or cremation is subject to liability to a member of the family of the deceased who is entitled to the disposition of the body."); W. PROSSER, THE LAW OF TORTS § 12, at 58, § 54, at 329 (4th ed. 1971). *See also* State v. Bradbury, 136 Me. 347, 9 A.2d 657 (Sup. Jud. Ct. 1939) (affirming defendant's conviction for "unlawfully and indecently burning a human body" by incinerating his sister's body in furnace).

The importance of the right to a decent burial was recently reaffirmed in New Jersey, where the State Board of Mortuary Science filed a complaint charging one of its funeral directors with the indecent burial of 1531 stillborn infants of poor people in mass graves containing as many as 40 bodies in one coffin. According to the complaint, such burial practices occurred in a "manner unbefitting the dignity of the deceased and with unethical, unprofessional, fraudulent, and deceitful conduct." N.Y. Times, Dec. 7, 1977, § A, at 25, col. 1.

110. *See* Alexander, *supra* note 101, at 25-29 (such fear has at times assumed phobic proportions).

111. Testimony of Frank Veith, M.D., in Minutes, President's Commission for the Study of Ethical Problems in Medicine, and Biomedical and Behavioral Research (July 11-12, 1980), at 1. *Cf. In re* Quinlan, 70 N.J. 10, 355 A.2d 647 (1976), *cert. denied,* 429 U.S. 922 (1976) (expense was not at issue in this case).

112. *E.g.,* L. BOWMAN, *supra* note 105, at 10-12.

113. *Id.* at 11.

114. Judicial acceptance of tort actions, usually under intentional or negligent infliction of

and sorrow, this interest should not be lightly subordinated for reasons of convenience or cost.

Societal interests, to the extent they bear on the definition of death, coincide with those of physicians and family members. The interest in immediate burial and autopsy is comparatively slight. Unlike transplant operations, autopsies and burials ordinarily need not be performed within narrow time limits.[115] Even if there were some gain in expediting these procedures, it seems to be outweighed by the rule utilitarian consideration that hasty disposition may implicate disrespect for human values.[116] Of course, society has a strong interest in avoiding the burdens of intensive medical care once it is clear that the victim cannot regain sentient life. Nevertheless, society has not enacted legislation requiring that physicians discontinue medical treatment once all hope is lost; it merely permits them to do so when the victim and his or her survivors so request. Therefore, the interests affected by autopsy and burial suggest that the cessation of vital functions standard should govern.

IV. ORGAN TRANSPLANTATION AND THE DEFINITION OF DEATH

To be successfully transplanted, an organ such as a heart or kidney must be removed from the donor at the earliest possible moment.[117] If heart activity is prolonged mechanically for long periods of time in a brain-damaged donor who has no chance of revival, organs may deteriorate and life may be denied to a potential donee. In a recent kidney transplant case, expert medical testimony established that kidney transplants effected after cardiac failure of the donor had an eighty-eight percent incidence of postoperative renal failure; whereas transplants effected promptly after whole-brain death had a mere ten percent chance

---

emotional distress theories, indicates the strength of this interest. *See, e.g.,* sources cited in note 110 *supra*. The interest of the family in not having the body "tampered" with is compelling here. It would not necessarily prove compelling however, when balanced against other interests, such as the interests of those seeking organs for transplantation. *See, e.g.,* Dukeminier, *supra* note 3, at 832.

115. The exceptions are: (1) autopsies necessary to determine whether the deceased suffered from contagious disease that might have been passed on to others; and (2) autopsies necessary to begin immediate criminal investigations. These two categories could be accommodated by a narrowly drawn rule.

116. *See* notes 91-94 and accompanying text *supra* (distributing insurance proceeds under an early standard connotes no disrespect for life). *See also* category (1) of statutory classification, note 36 *supra* (statutes based on Kansas model).

117. *E.g.,* Capron, *supra* note 9, at 293; Comment, *The Criteria for Determining Death in Vital Organ Transplants—A Medico-Legal Dilemma,* 38 MO. L. REV. 220, 224 (1973).

of failure.[118] Without an early definition of death, doctors confront a dilemma: whether to disconnect a donor's respirator in order to save a donee's life by immediate transplant, and thus run the risk of liability for homicide or wrongful death; or whether to prolong the donor's life by artificial means until he (and perhaps the donee as well) dies in all senses of the word.

A. Present State Of The Law

The Commission on Uniform State Laws declined to define death in the Uniform Anatomical Gift Act (U.A.G.A.). Instead, it allowed doctors to decide individually when death has occurred for transplant purposes.[119] The drafters were unable to agree on a statutory definition because of the public controversy regarding the definition of the moment of death and because there is no consensus among the medical profession.[120]

The Act's delegation to doctors of the duty to define death has caused some confusion, which is exemplified in a recent New York case.[121] Two suits were consolidated to determine the time of death under New York's Anatomical Gift Act. In the first action, a hospital sued for a declaratory judgment to define the time of death of a man who had been shot in the brain and suffered cerebral death. The chief medical examiner's policy prohibited homicide victims from becoming donors, so no organs were transplanted.[122] In the second suit, the hospital sought an order to show cause why it should not declare dead a boy who had suffered cerebral failure. The attending doctors, at the risk of civil and criminal liability, removed the boy's kidneys and successfully transplanted them.[123]

In each case, the court had to determine what the legislature intended by the use of the word "death" in the New York Anatomical

118. New York City Health & Hosp. Corp. v. Sulsona, 81 Misc. 2d 1002, 1005-06, 367 N.Y.S.2d 686, 689-90 (1975). *Cf.* Hart v. Brown, 29 Conn. Supp. 368, 289 A.2d 386 (Super. Ct. 1972); Strunk v. Strunk, 445 S.W.2d 145 (Ky. 1969) (courts in both cases authorized parents of child donors and donees to proceed with kidney transplants necessary to save donees' lives, in part because of the high ratio of success of such operations with relatives, when donors who have not suffered cardiorespiratory failure are used). *See also* Beecher, *supra* note 3.

119. Uniform Anatomical Gift Act § 7(b) ("The time of death shall be determined by a physician who tends the donor at his death, or, if none, the physician who certifies the death.").

120. *Id.* § 7 (Commissioner's Note).

121. New York City Health & Hosp. Corp. v. Sulsona, 81 Misc. 2d 1002, 367 N.Y.S.2d 686 (Sup. Ct. 1975).

122. *Id.* at 1004, 367 N.Y.S.2d at 688.

123. *Id.* at 1005, 367 N.Y.S.2d at 689.

Gift Act. According to expert testimony, the legislative failure to provide a clear definition of death discouraged transplants because the resulting uncertainty caused emotional distress to donors' families, fear of liability among doctors, and difficulty for hospitals in establishing proper procedures.[124] The court stated that the legislative failure to define death implied a statutory definitioin consistent with generally accepted medical practices.[125] The court took note of the higher success ratios in kidney transplants after brain death than after cardiorespiratory death,[126] and this recognition may imply that the court preferred the earlier standard. Nevertheless, the court left to the legislature the task of providing the needed clarification or modification of the standard.[127]

The confusion spawned by the failure of the U.A.G.A. to define death has been partly dispelled by the adoption of statutory definitions of death in transplant situations by states such as Alaska,[128] California,[129] Illinois,[130] Kansas,[131] Louisiana,[132] Maryland,[133] Michigan,[134]

---

124. *Id.* at 1006, 367 N.Y.S.2d at 690.

125. *Id.* at 1007, 367 N.Y.S.2d at 691.

126. *Id.* at 1005-06, 367 N.Y.S.2d at 689-90.

127. *Id.* at 1007, 367 N.Y.S.2d at 691.

128. A person is considered medically and legally dead if, in the opinion of a medical doctor licensed or exempt from licensing under AS 08.64, based on ordinary standards of medical practice, there is no spontaneous respiratory or cardiac function and there is no expectation of recovery of spontaneous respiratory or cardiac function or, in the case when respiratory and cardiac functions are maintained by artificial means, a person is considered medically and legally dead, if, in the opinion of a medical doctor licensed or exempt from licensing under AS 08.64, based on ordinary standards of medical practice, there is no spontaneous brain function. Death may be pronounced in this circumstance before artificial means of maintaining respiratory and cardiac function are terminated.

ALASKA STAT. § 09.65.120 (Supp. 1980).

129. 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. Nothing in this chapter shall prohibit a physician from using other usual and customary procedures for determining death as the exclusive basis for pronouncing a person dead.

CAL. HEALTH & SAFETY CODE § 7180 (West Supp. 1981).

130. " 'Death' means . . . the irreversible cessation of total brain function, according to usual and customary standards of medical practice." ILL. ANN. STAT. ch. 110½, § 302(b) (Smith-Hurd 1978).

131. A person will be considered medically and legally dead if . . . there is the absence of spontaneous respiratory and cardiac function . . . or [a] person will be considered medically and legally dead if . . . there is the absence of spontaneous brain function . . . .

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.

KAN. STAT. ANN. § 77-202 (Supp. 1980).

132. A person will be considered dead if . . . the person has experienced an irreversible cessation of spontaneous respiratory and circulatory functions. In the event that artificial means of support preclude a determination that these functions have ceased, a person

New Mexico,[135] Oregon,[136] and Virginia.[137] Generally, these statutes define death as the cessation of vital functions, or, if these functions are maintained by artificial means, as an irreversible cessation of spontaneous brain functions.[138]

B. ACCOMMODATING THE INTERESTS

The principal purpose of the U.A.G.A. and similar state statutory schemes is to facilitate and encourage anatomical gifts.[139] Since organs

---

will be considered dead if . . . the person has experienced an irreversible total cessation of brain function.

LA. REV. STAT. ANN. § 9:111 (West Supp. 1981).

133. (a) A person will be considered medically and legally dead if, based on ordinary standards of medical practice, there is the absence of spontaneous respiratory and cardiac function . . . ; or

(b) 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 . . . .

(c) 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.

MD. ANN. CODE art. 43, § 54F (1980).

134. (1) A person will be considered dead if . . . 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 . . . there is the irreversible cessation of spontaneous brain functions. Death will have occurred at the time when the relevant functions ceased.

MICH. STAT. ANN. § 333.1021 (1980).

135. A. For all medical, legal and statutory purposes, death of a human being occurs when . . . (1) . . . there is the absence of spontaneous respiratory and cardiac function . . . or (2) . . . (a) because of a known disease or condition there is the absence of spontaneous brain function; and (b) after reasonable attempts to either maintain or restore spontaneous circulatory or respiratory functions in the absence of spontaneous brain function, it appears that further attempts at resuscitation and supportive maintenance have no reasonable possibility of restoring spontaneous brain function; in this event death will have occurred at the time when the absence of spontaneous brain function first occurred. . . . The alternative definitions of death . . . of this section are to be utilized for all purposes in this state . . . .

N.M. STAT. ANN. 12-2-4 (Supp. 1979).

136. In addition to criteria customarily used by a person to determine death, when a physician licensed to practice medicine under ORS chapter 677 acts to determine that a person is dead, he may make such a determination if irreversible cessation of spontaneous respiration and circulatory function or irreversible cessation of spontaneous brain function exists.

OR. REV. STAT. § 146.001 (1979).

137. A person shall be medically and legally dead if, (a) in the opinion of a physician . . . , based on the ordinary standards of medical practice, there is the absence of spontaneous respiratory and spontaneous cardiac functions . . . ; or in the opinion of a consulting . . . specialist in the field of neurology, neurosurgery, or electroencephalography, when based on ordinary standards of medical practice, there is the absence of spontaneous brain functions and spontaneous respiratory functions . . . .

. . . Either of these alternative definitions of death may be utilized for all purposes in the Commonwealth . . . .

VA. CODE § 54-325.7 (Supp. 1980).

138. *See generally* note 36 *supra*.

139. *See* Richards, *Medical-Legal Problems of Organ Transplantation,* 21 HASTINGS L.J. 77,

begin to deteriorate immediately upon the donor's death, the statutory purpose can best be served by permitting the removal of organs at the earliest possible moment. Unlike the two contexts just considered, however, the organ transplant situation presents strong countervailing interests and values that must be accommodated.

1. *Donors*

The most compelling interests in transplant situations are those of the potential donors. A donor may oppose an early standard, such as part-brain (neocortical) death,[140] because he may fear that a physician will pronounce him dead when, in fact, his cardiopulmonary functions could have been revived.[141] Brain death is inevitable, however, and a donor may prefer an earlier standard because the probability of success for a transplant to save another's life may thereby be increased.[142]

2. *Donees*

Donees as a class would oppose a late standard because their lives depend upon successful transplants. They would point out that only a very small fraction of brain-dead persons will revive.[143] A legislatively mandated delay in the pronouncement of death reduces the number of viable organs, thereby trading the lives of a small number of donors for those of a much larger number of beneficiaries.[144]

---

95 (1969); New York City Health & Hosp. Corp. v. Sulsona, 81 Misc. 2d 1002, 1007, 367 N.Y.S.2d 686, 691 (Sup. Ct. 1975) (The purpose of New York's Anatomical Gift Act is to encourage the donation of body parts and organs.); Dukeminier, *supra* note 3, at 817. *But see id.* at 818-19 (The drafters of the U.A.G.A. responded as well to other priorities, such as need for autopsies and the need to respect the wishes of donors and kin.).

140. *See* text accompanying notes 34-35 *supra*.

141. *See* Capron & Kass, *supra* note 26, at 108; Kennedy, *supra* note 31, at 946 (Deviation from the single-definition approach could discourage transplantation by destroying public confidence in the myth that death occurs at a single identifiable instant in time and by decreasing public respect for the medical profession.). These fears could be minimized by living will provisions, in which the donor of organs specifies when he or she wishes to be declared dead. Thus, the potential donor could indicate that he or she authorizes the removal of organs on brain death, part-brain death, cardiovascular death, or some other medically and legislatively approved standard.

For a discussion of the thoughts of the dying patient, see E. KUBLER-ROSS, ON DEATH AND DYING 160-217 (1969) (Dying patients are more preoccupied with their own mortality and leaving friends and family, than with technical questions of when a doctor will pronounce them dead.).

142. *See generally* Hart v. Brown, 29 Conn. Supp. 368, 289 A.2d 386 (Super. Ct. 1972) (approving "moral" quality of the choice to donate organs).

143. *See* Comment, *supra* note 27, at 180-81 (patients who have suffered brain death do not recover).

144. *See* Dukeminier, *supra* note 3, at 823 (huge economic losses result when potential donees are unable to obtain needed organs); Leavell, *supra* note 27, at 883 (transplant surgeons use drastic methods to save life of donee, but not life of donor); Note, *Legislation: The Need for a Current and*

3. *Public Policy*

In act utilitarian terms,[145] the argument for an early standard is compelling. Many more lives are saved by use of the early standard than are sacrificed.

Justice claims,[146] however, present formidable obstacles to an early standard. Our society would not countenance removal of vital organs from a live donor for the benefit of another—even if it did so by redefining the donor as dead. If there is even the slightest chance that a donor will recover, justice considerations and respect for bodily integrity militate against the removal of organs.

Rule utilitarian considerations[147] support this conclusion. A rule allowing early removal of organs would have an adverse impact on society's general trust in physicians. Societal respect for individual autonomy also prohibits such a rule.

4. *Physicians*

Some physicians also oppose an early standard because they believe their first obligation is to the dying patient.[148] Donees may also be ter-

---

Effective Statutory Definition of Death, 27 OKLA. L. REV. 729 (1974) (U.A.G.A. does not protect potential donors by its failure to define death.). *Cf.* UNIFORM ANATOMICAL GIFT ACT (Commissioner's Prefatory Note) (U.A.G.A. drafted principally to increase supply of organs for donation.).

145. *See* note 93 *supra* (defining act utilitarianism as ethical principle that actions should be judged by their promotion of good consequences).

146. *See* note 94 *supra* (defining justice claims as duties arising from nonconsequential considerations such as fairness and respect for persons).

147. *See* note 92 *supra* (defining rule utilitarianism as ethical principle that conduct should be judged according to whether the rule or principle it exemplifies would, if generally followed, have good consequences).

148. A number of suits have been filed against physicians arising from termination of care decisions, some apparently influenced by transplant considerations. Tucker's Adm'r v. Lower, No. 2831 (L. & Eq. Ct., Richmond, Va., May 25, 1972) (discussed in Note, *The Citadel for the Human Cadaver: The Harvard Brain Death Criteria Exhumed,* 32 U. FLA. L. REV. 275, 296 (1980)); *Murder Charges Dropped for a Nurse in Maryland,* N.Y. Times, Mar. 30, 1979, § A, at 1b, col. 6.

See also Seattle Post-Intelligencer, June 29, 1978, § A, at 7, col. 1, which describes an Oregon case in which use of a respirator created confusion as to the time when the victim should be declared dead. Life support equipment had been recommended by a physician to maintain cardiac and respiratory functions in a two-month old infant who had "no brain activity" as a result of being beaten by her father. Oregon had adopted a cerebral death statute. OR. REV. STAT. § 146.001 (1979). Nevertheless, the Oregon County Circuit Judge upheld a restraining order barring the doctors from disconnecting the respirator. The Oregon prosecutor maintained that the infant was dead when brain functious ceased in accordance with the statutory standard.

In Massachusetts, a twelve-year-old boy was being kept on a respirator after suffering "irreversible brain damage" caused by a gunshot wound in the heart. Several doctors involved believed the boy was clinically dead, but a chief of neurosurgery believed the boy's brain was merely irreversibly damaged, not dead. The parents brought suit to determine whether he should be

minal patients, but some physicians regard organ transplants as heroic measures that they have no moral or professional obligation to perform.[149]

5. *Resolution of the Competing Interests*

One approach to the resolution of these competing interests is to adopt a single, early, whole- or part-brain standard[150] and observe the results. If the expected increase in the number of organ donations and transplants does not materialize under this standard, the standard could be changed. Alternatively, a statute could provide for multiple definitions of death for transplant purposes and allow the donor or his next of kin to choose the standard he or she wishes to have applied.[151] Finally, the legislature could provide for several different criteria and allow the donor's physician to choose the standard that seems most appropriate.[152] Any of these approaches would provide a larger supply of organs than is available under a cardiovascular standard. At the same time, these standards all minimize conflict with justice-based claims by allowing the donor or someone closely associated with him or her to make the decision to donate.

CONCLUSION

Multiple definitions of death, by specifying different standards for different purposes, permit the legal system to weigh and accommodate a much larger range of interests than is possible under a single standard. In nonphysical contexts, the multiple definition approach has been beneficially employed for some time. Similar advantages are possible in legal contexts, such as distribution of double indemnity life insurance proceeds, as well as in the physical contexts of autopsy, burial, and organ transplants.

---

removed from the respirator. The court ruled that all of the criteria for brain death had not been met. Wash. Star., Aug. 17, 1978, § C, at 8, col. 2.

In Denver, Colorado, a two-year-old girl was maintained by a respirator after a severe beating. The court-appointed attorney asked that the respirator be shut off. *Id.*

In Des Moines, Iowa, a two-year-old boy was being maintained by a respirator. His mother asked that the respirator be removed, but the paternal grandparents requested that life support be prolonged. Doctors have testified that the boy's brain is dead. *Id.*

149. *See* Veatch, *supra* note 3, at 2.

150. *See* text accompanying notes 34-35 *supra*.

151. *See* note 141 *supra*.

152. *See, e.g.*, notes 128-37 *supra*. *But see* text accompanying notes 122-25 *supra* (Failure to specify statutory definition of death can lead to confusion on the part of physicians, medical conservatism resulting in refusal to remove organs when it would otherwise be appropriate to do so, and emotional distress in donors' families.).

The principal argument against multiple standards is that they would induce uncertainty and lack of confidence on the part of the public.[153] This claim is speculative and empirically unproven.[154] Even if it is correct, the interest in certainty should be balanced against the substantial gains to insureds, donors, donees, and survivors that are possible under a functional approach.

A review of three contexts in which the time of death has significant legal and social consequences shows that the arguments for a multiple approach are strong. Therefore, the multiple approach should receive the thoughtful attention of courts, legislatures, and policy-setting bodies charged with defining death and regulating its many consequences.

Perhaps the myth of a single moment of death is worth preserving; perhaps it is not. Society should be selective about which myths are perpetuated, especially when the myths are given the force of law.

153. *See* note 31 and accompanying text *supra*.

154. These arguments have also been implicitly rejected in connection with fetuses, which are viewed as legally protectible, and hence alive, for different purposes at different times. Roe v. Wade, 410 U.S. 113, 163-64 (1973). The decision in *Roe v. Wade* has drawn much criticism. *See, e.g.*, Ely, *The Wages of Crying Wolf: A Comment on* Roe v. Wade, 82 YALE L.J. 920 (1973). However, the opinion has not been criticized for inducing uncertainty or confusion on the part of the public.

SOUTHERN CALIFORNIA LAW REVIEW

VOLUME 54 | SEPTEMBER 1981 | NUMBER 6

Published Six Times Annually by the Students of the Gould School of Law
Law Center
University of Southern California
University Park
Los Angeles, California 90007

Announcing
SOUTHERN CALIFORNIA LAW REVIEW

1981 VOLUME 55 1982

Published Six Times Annually by the Students of the Gould School of Law
Law Center
University of Southern California
University Park
Los Angeles, California 90007