

“A GEM OF A BOOK.” —Donald Berwick, MD

G R O W F I N D H E L P L E A D

P A R T N E R S E E K C H A N G E

T R U S T B U I L D A C T



(P)LUCK

Lessons We Learned for Improving
Healthcare and the World

Alfred Sadler and Blair Sadler

Advance Praise for *(P)LUCK*

“The behind-the-scenes story of how twin brothers—doctor and lawyer—collaborated with scores of unsung heroes to modernize emergency medical services, help create the physician assistant profession, help write the model law for organ donation and develop other programs that save thousands of lives a year. *(P)LUCK* is an inspiring model for how to lead major change—a great read, couldn’t put it down.”

—James A Guest
Past President and CEO of Consumer Reports

“An inspirational story of meaningful work devoted to public service, health, and wellbeing. Blair, a lawyer, and Fred, a physician, make the decision to work as a medical-legal team, even before they are quite sure where their talents can be most useful. They end up playing a significant role in establishing the national approach to organ donation, addressing critical shortages in the U.S healthcare workforce, establishing the new profession of physician assistants, contributing to the young field of bioethics, and building the nation’s emergency medical response capability.”

—Mildred Solomon, EdD
President, The Hastings Center

“They reverse engineer their effectiveness . . . in a series of lessons learned offering guidance for the leadership of change, always emphasizing initiative, optimism, resilience, and above all, cooperation. . . . No matter which of their several quests they describe, Blair and Fred also reveal a level of agility and creativity that marks the best leaders. They always seem to find a pathway out of paralysis and conflict into shared possibility.”

—From the Foreword by Donald M. Berwick, MD
President Emeritus and Senior Fellow
Institute for Healthcare Improvement

“A jewel of a book full of keen insight about humane purpose, perseverance, and the power of TWO in making a lasting difference in service to others.”

—Leonard L. Berry
University Distinguished Professor of Marketing
Texas A&M University

“I love this book and it should be required reading for all, including students. The fifteen ideas for catalyzing change can bring out the best in all of us. Read it today and plan for your future!”

—Maureen Bisognano
President Emerita and Senior Fellow
Institute for Healthcare Improvement

“A great story, very readable and well written, with lessons for us all.”

—Lord Nigel Crisp
Chief Executive, National Health Service, England 2000–2006

“This book is full of gems on how to scale a brilliant idea into widespread adoption. The Sadler brothers have had a major impact on the health sector over the past fifty years. This is their story.”

—Gary Cohen,
Cofounder and President, Health Care without Harm

“The authors meticulously and smoothly trace the development of one of the Uniform Law Commission’s most important contributions to our country. The reader cannot escape the conclusion that we Uniform law Commissioners know well: our work cannot achieve optimum impact without the thoughtful input from experts, practitioners, and relevant interest groups who will be affected by our model laws.”

—Howard J. Swibel
Past President, Uniform Law Commission
Chair, Uniform Law Foundation

“The Sadler brothers were there at the beginning, shaping the early days of bioethics and drafting seminal legislation governing organ transplantation. In this charming account, they demonstrate how individuals can make a difference, offering a wise prescription for a new generation of leadership.”

—Joseph J. Fins, MD
Professor of Medical Ethics and Professor of Medicine
Weill Cornell Medical College

“The authors demonstrate how the repeated sharing of ideas in a transparent manner can increase the investment of others in the need for change and affect the lives of many Americans.”

—Carl Fasser
Past President, Physician Assistant Education Association
Professor and Program Director, PA Program Baylor College of Medicine

“The authors provide a first-hand account of the early days of the Robert Wood Johnson Foundation as a national philanthropy. They also describe the design, launch, and evaluation of the Foundation’s very first national program focused on regional emergency medical communications systems, which served as a prototype for much of the Foundation’s grantmaking for many years.”

—Calvin Bland
Former Chief of Staff and Special Advisor
The Robert Wood Johnson Foundation

“In this comprehensive report of their journey to enhance health care for the public good, the Sadlers have captured the worth and value of teamwork. The lessons learned are shared for all of us who aspire to improve relationships in our work.”

—Loretta C. Ford, PNP, EdD,
Cofounder of the first Nurse Practitioner Program in 1965
University of Colorado

“The authors’ stories challenge and empower us to identify comparable decisions and opportunities in our own lives. This book inspires and equips.”

—Megan Mayer - author, retired lawyer, Chair, Network for Impact

“This book is a testament to *(P)luck*—risk taking, teamwork, persistence, creativity, and luck. Their lessons learned provide very valuable wisdom gained from decades of life in the trenches, with skin in the game.”

—Donald Pedersen PhD, PA
Past President of the Physician Assistant Education Association and
Past Director of the University of Utah Medex PA Program.

“Over the course of five decades, Fred and Blair Sadler have virtually defined synergism in their pursuit of worthwhile goals. From early on in their careers, they parlayed serendipitous encounters and bold actions that took them into numerous important “rooms where it happened”—resulting in laws, movements, and novel career pathways that changed America’s healthcare system for the better.”

—Laurence H. Beck, MD, Adjunct Professor of Medicine; University of
Pennsylvania Perelman School of Medicine

(P)LUCK

Other books by the authors:

Alfred M. Sadler, Jr., Blair L. Sadler, and Ann A. Bliss, *The Physician's Assistant—Today and Tomorrow* (New Haven: Yale University Press, 1972).

Alfred M. Sadler, Jr., Blair L. Sadler, and Ann A. Bliss, *The Physician's Assistant—Today and Tomorrow: Issues Confronting New Health Practitioners, 2nd edition*. (Pensacola, FL: Ballinger, 1975). https://pahx.org/wp-content/uploads/2016/11/Sadler_Sadler_Bliss_2nd_Edition.pdf

Alfred M. Sadler, Jr., Blair L. Sadler, and Samuel B. Webb, Jr, *Emergency Medical Care: The Neglected Public Service*. (Cambridge, MA: Ballinger Publishing Co., 1977).

Thomas E. Piemme, Alfred M. Sadler, Jr., Reginald D. Carter, and Ruth Ballweg, *The Physician Assistant: An Illustrated History* (Gilbert, AZ: Acacia Publishing, 2013). pahx.org/pa-history-book/

(P)LUCK

**Lessons We Learned for
Improving Healthcare
and the World**

Alfred Sadler & Blair Sadler



**SILICON
VALLEY
P R E S S**

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ISBNs: 9781735873176 (hc); 9798985842807 (pbk); 9781735873183 (ebook)
Library of Congress Number: 2022903822

Cover design by Jonathan Bush
Book design by Mayfly Design



It is not the critic who counts; not the man who points out how the strong man stumbles, or where the doer of deeds could have done them better.

The credit belongs to the man who is actually in the arena, whose face is marred by dust and sweat and blood; who strives valiantly; who errs, who comes short again and again, because there is no effort without error and shortcoming; but who does actually strive to do the deeds; who knows great enthusiasms, the great devotions; who spends himself in a worthy cause; who at the best knows in the end the triumph of high achievement, and who at the worst, if he fails, at least fails while daring greatly . . .

President Theodore Roosevelt
at the Sorbonne in Paris, France
April 23, 1910

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Foreword

Donald M. Berwick, MD, MPP

I am a little embarrassed to admit it, but reading this book made me wish I had an identical twin. As Blair and Fred Sadler—who are identical twins—recount their journey together as a dyad of change agents, bound together by upbringing, values, and love, we witness a deep partnership that is sorely lacking in these fractious, isolating, contentious, modern times. This manuscript uses the words *I*, *me*, and *my* approximately 270 times. *We*, *us*, and *our* appear approximately 719 times—more than two-and-a-half times as often. What would the larger world be like with that ratio of commitments?

We need not imagine the answer. These authors don't just preach the embrace of interdependence, they live it. Their account is meticulously generous to others, but Blair and Fred show themselves, over and over, as effective catalysts for structural improvements in healthcare—in organ transplantation policy, in nurturing the identity and roles of advanced practice nurses and physician assistants, in redesigning emergency medical services, and in helping to establish the field of bioethics. They reverse-engineer their effectiveness for the reader in a series of lessons learned,

offering guidance for the leadership of change, always emphasizing initiative, optimism, resilience, and above all, cooperation. They know and they show that, with trust and authenticity, people can achieve together milestones that they never, ever could accomplish alone.

Beyond the written lessons, this book also charmingly evinces a brio that must be a root cause of the authors' enormous achievements. How cannot the reader smile when imagining the scene in which twenty-something Blair spots US Supreme Court Chief Justice Earl Warren at a squash match, introduces himself, and ends up, along with Fred, having more than one lunch in Warren's Supreme Court office, teaching him about organ transplantation policy as well as squash? Or reading Blair's account of the seven-hour siege he waged in the waiting room of an associate director at the National Institutes of Health, in order to convince him—successfully—that the NIH should, in an unprecedented move, hire the pair of twins as a single medical-legal team? (“Sometimes,” they write, “persistence is not an option. It is the only option.”)

Beyond sweetness, there is above all an invaluable example in their unrelenting commitment to help not just others but also each other. At age fourteen, during a fateful tennis match, Blair and Fred made the decision to cooperate rather than compete. They built on that decision year after year after year: in college, in professional training, and in their lifelong shared agendas of progressive public policy. This book leaves no doubt at all that that decision taken in their youth was a keystone to their success throughout their years.

It is no accident that, of all the struggles they have waged together, none seems to grip their imaginations and

passions more tightly than their decades-long efforts to improve the policy and management environment for organ transplantation. Perhaps an ultimate form of cooperation—to give of one’s own body—organ transplantation reveals the most fundamental values and beliefs we hold about our interdependencies and duties to each other. Blair and Fred’s wisdom is evident as they seek the proper balance between absolute volunteerism, which they regard as essential to a proper organ transplantation regime, and a passionate hope to relieve avoidable suffering among the tens of thousands of people awaiting organs.

No matter which of their several quests they describe, Blair and Fred also reveal a level of agility and creativity that marks the best leaders. They always seem to find a pathway out of paralysis and conflict and into shared possibility.

Must one be or have an identical twin to hold and act upon the elements of character that Blair and Fred reveal in this book? These include a commitment to others, total partnership, zest as a team, never accepting *no* as the only answer, never fearing to bring messages to centers of power, and unremitting trust. I hope not. That they share a common genome of course helps these two pioneers team up and render change in the world (and have fun in the process). But in offering us their lessons learned in this gem of a book, they demonstrate that, twins or not, we all have a chance to succeed better together than apart.

I propose that we consider what our world could be like if we all imagined ourselves as twins with each other—if we all imagined that we could feel and act toward each other as Blair and Fred do in this book. How would we then confront a pandemic, roll back climate change, make healthcare a

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human right, or address racism and poverty? Reading this book gives us a glimpse of what would then be possible. And yes, it makes us a bit envious of the privilege of togetherness that Blair and Fred got by their happy accident of birth.

—Donald M. Berwick, MD, MPP,
President Emeritus and Senior Fellow
Institute for Healthcare Improvement
2022

Preface

(P)LUCK

As a doctor and a lawyer, and identical twin brothers with a history of collaborative teamwork, we decided to write *(P)luck* to share some of the most important lessons we learned along the way. Our hope is to inspire and motivate others who want to make positive changes in the world by using a powerful blend of serendipity and the assertive action required to plunge into uncharted waters.

Pluck is a word often used to describe determination, resolve, audacity, even courage (with the word “luck” built in)—a combination we cultivated. We were fortunate to play key roles in the development of the early laws concerning organ donation and transplantation, the emergence of the brand-new physician assistant profession, the birth of bioethics, and the transformation of emergency medical systems from a wasteland to a vital component of health-care. Our journey, which began more than fifty years ago, took us inside rooms where major decisions were made that have had a multigenerational impact on healthcare in the United States.

Over a nine-year period, we served as a medical-legal team at the National Institutes of Health, Yale University

School of Medicine, the Robert Wood Johnson Foundation, and The Hastings Center on Bioethics.

The power of collaboration helped us lead and accelerate the pace and scale of critically needed change. In *(P)luck*, we describe the value of a spirit of persistent risk-taking, including taking roads less traveled while embracing a mind-set focused on possibility. Those interested in or committed to making innovations in healthcare, environmental activism; social, economic, and racial equity; or education, will find that significant transformation is possible by drawing on the principles offered in our fifteen lessons for stimulating change.

We invite you to join us on our lived journey of exploration, collaboration, and action.

Introduction

Our First Green Light

Imagine that . . .

Your father is succumbing to end-stage heart disease, and you have heard that a heart transplant could save his life. But there are no laws enabling organ donation, so you have no choice but to sit by and watch as the man you know and love dissolves into a husk of himself.

A horrifying traffic accident occurs right in front of you. You rush to the battered cars, eager to assist, and see that the drivers have suffered life-threatening injuries. You want to call for help, but 911 does not exist. There are no cellphones. When you finally summon an ambulance, what arrives is a glorified station wagon, with no medical equipment on board.

You work two jobs, but you cannot afford basic healthcare. Your child's asthma attacks are increasing in severity and frequency. Finally, a new government program extends health benefits to your family, but the nearest doctor's office is 50 miles away, and you must wait four months for an appointment.

You learn that in 1932, when there were no safe and effective treatments for syphilis, several hundred African-American men were recruited into a study to observe the effects of the disease on them over time. Yet, in the late 1940's, when it was discovered that penicillin could cure syphilis, these men continued to be observed and were never offered the treatment which would have cured them. You realize you live in a country, where that study was supported for decades by the US Public Health Service and the Centers for Disease Control.

Each of these situations sounds like a nightmare. But in 1967, this was healthcare in America. At that time, organ transplantation laws were haphazard and underdeveloped. Medicare and Medicaid had just been enacted to provide health benefits to millions of people, but there were not enough primary care physicians and nurses to serve them. Emergency medical services, where they were available, offered little more than a ride to the nearest hospital. Bioethics—now a staple in medical, law, graduate, and undergraduate schools—did not yet exist as a field of study.

Back then, more than fifty years before starting this book, we worked together as a doctor-lawyer team dedicated to improving healthcare in the United States. During a nine-year period, we learned a great deal about change, and how it can be accelerated to make a difference in peoples' lives.

Our story begins in Philadelphia, where, during our years in medical and law schools, we often considered medical issues through a legal lens, and wondered how an informed perspective on both disciplines could—and perhaps should—impact public policy. We decided to try out some

of our ideas in a setting beyond informal discussion. Our first presentation occurred in an amphitheater at Boston's Massachusetts General Hospital. Blair was a newly minted lawyer, and Fred was a medical student in his senior year. Needing to make a presentation as part of his six-week surgical elective, he asked Paul Russell, the attending surgeon, if he could invite Blair to join him in discussing the Good Samaritan question—namely, should doctors stop to render aid at the scene of an accident and risk being sued if the patient didn't do well? Russell enthusiastically agreed.

Though all fifty states and the District of Columbia have Good Samaritan laws, such a policy was relatively new in the mid-1960s.¹ Many debated what form a Good Samaritan law should take. This seemed like an ideal subject for our presentation. We agreed that a sound Good Samaritan policy could benefit society. Certainly, the principle behind it—that people should love and help one another to the best of their abilities—is a foundational teaching, not just of the Christian Bible from which the Good Samaritan parable is drawn, but of every major religion. This talk was an opportunity for us to begin to discover if, how, or where a medical-legal team could pursue interdisciplinary collaboration.

We began our presentation by describing the underlying ethical and legal issues. What were the objectives of a Good Samaritan policy? If the goal was to encourage health professionals and others to help people during medical emergencies, how, in our litigious society, could a helper be protected against a lawsuit in the case of a bad outcome? Clearly the law played a role in balancing the reasonable interests of the victim, while encouraging people to help one another. How should legal immunity be defined, and should

it apply only to healthcare professionals or to all people who might stop to lend a hand?

Medical-legal issues had not yet become a broad area of study, but the medical students, interns, and doctors attending our talk had entered their profession because they wanted to help people. They certainly were aware that questions concerning legal liability could cast a shadow over their interactions with patients.

As the Q&A period wrapped up and the audience filed out of the room, Russell told us, “This was one of the best presentations we’ve had.” This was the first of four green lights that were essential for us begin our nine-year collaborative adventure.

We came of age during the reckoning of the civil rights movement, and were called by President John F. Kennedy in his inaugural address to “ask not what your country can do for you—ask what you can do for your country.” The late 1960s through the early 1970s were tumultuous years, marked by the Vietnam War and widespread protests, a nationwide coming-to-terms with our country’s racist history and policies, the assassinations of Dr. Martin Luther King, Jr. and Robert F. Kennedy, and the resignation of President Richard Nixon.

Beginning in 1967, at age twenty-six, we joined the United States Public Health Service (USPHS) as a medical-legal team, launching a journey that took us from the National Institutes of Health, to The Hastings Center, Yale University Medical School, and ultimately the Robert Wood Johnson Foundation.

We were rookies in the fields of law and medicine when we began our public policy journey, yet we repeatedly found

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ourselves in the rooms where advances happened; in government agencies, academia, new institutions, and philanthropic foundations.

We witnessed where and how change was accelerated, and we also saw what slowed it. We encountered strategies that opened doors and some that slammed them shut. We met and worked with role models who were effective change agents, and we discovered mentors who selflessly promoted good ideas in the service of common goals. In their inspiring company, we learned to stay open to new opportunities and were impressed by how often doing so seemed to make those opportunities appear.

Our healthcare system and our country will continue to face new challenges, as well as perennial ones. Try to imagine the programs and policies that could be put in place, the resources that could be leveraged, and the personal actions that could be taken—all under the banner of improving health and healthcare *for everyone*. Whether you are volunteering for an hour a week or seeking a direction for your career, if you want to make a positive impact, the possibilities are endless: in healthcare, environmental activism, criminal justice reform, economic inequity, and education reform. Our own experiences described in this book, and the solutions we recommend, demonstrate how transformation is possible, even in a contentious political climate, if we pursue it with courage, creativity, persistence, collaboration wherever possible, and a little bit of pluck.

CHAPTER 1

Taking the Road Less Traveled

*Two roads diverged in a wood, and I—
I took the one less traveled by,
And that has made all the difference.*

—Robert Frost, “The Road Not Taken”

At our home in Allentown, Pennsylvania, our parents created a culture of intellectual curiosity, espoused tolerance for all people regardless of race or beliefs, and promoted service as a way of life. With a PhD in organic chemistry, our father worked in scientific research throughout his career. He also volunteered as a scoutmaster, promoting service to our community and stewardship of nature. Our mother began her career as an English teacher but also taught mathematics to prisoners at the jail on Rikers Island in New York City. Later she earned a master’s degree in psychology and became a counselor.

Our father introduced us to the wonders of nature. Our mother, who sang in choirs and played the piano and organ, immersed us in music and art. They both focused our attention on the world beyond our kitchen table. At a young age, we were reading *The New York Times* on Sundays and having

lively family discussions about national and global affairs. Our parents instilled in us a sense of possibility: the drive not only to understand what is, but also to imagine what could be.

We were educated from kindergarten through high school in public schools. Our graduating class at Allentown High had more than 800 students. The school was best known for its champion football, basketball, and wrestling programs. For our undergraduate studies, we were fortunate to receive scholarships to Amherst College, a leading liberal arts college in Massachusetts, recognized for its rigorous academic program and a social environment that mirrored our family's values.

Fred found his medical calling early

When Blair and I were five years old, we both developed severe middle-ear infections. Our mother called our pediatrician, Dr. John Pfromm. Dr. Pfromm appeared in our attic bedroom well past dinnertime on a Friday night, speaking so soothingly that it assuredly was his voice and manner, and not just the tetracycline he gave us, that brought relief.

I wanted to do something that would affect people in the way Dr. Pfromm's visit affected me. During my senior year at Amherst, I accepted a scholarship offer from Hahnemann Medical College (later to become Drexel University College of Medicine) in Philadelphia.

Blair discovered his legal interest in college

My decision to go to law school was conceptual rather than career driven. I didn't necessarily want to be a lawyer, but I saw law school as an opportunity to develop analytical reasoning. Law was great preparation for rigorous thinking and debate. I received a scholarship to attend the University of Pennsylvania Law School.

We graduated from Amherst the year before President John F. Kennedy received an honorary degree from the College and addressed the crowd at the groundbreaking ceremony for the new Robert Frost Library. His speech on October 26, 1963, captured the essence of the school and of that time in our nation:

[W]hat good is a private college or university unless it is serving a great national purpose? The library being constructed today, this college itself—all of this, of course, was not done merely to give this school's graduates an advantage, an economic advantage, in the life struggle. It does do that. But in return for that, in return for the great opportunity which society gives the graduates of this and related schools, it seems to me incumbent upon this and other schools' graduates to recognize their responsibility to the public interest.

Privilege is here, and with privilege goes responsibility. . . There is inherited wealth in this country and also inherited poverty. And unless the graduates

of this college and other colleges like it who are given a running start in life—unless they are willing to put back into our society, those talents, the broad sympathy, the understanding, the compassion—unless they are willing to put those qualities back into the service of the Great Republic, then obviously the presuppositions upon which our democracy are based are bound to be fallible.

President Kennedy's remarks amplified a message we heard as students at Amherst, in lectures and seminars, in our advisors' offices, and in our commencement address. The speech he delivered that October day traveled far beyond the Amherst campus, resonating throughout history, not just because it was one of his finer speeches, but also because it was one of his last. He was assassinated twenty-seven days later.

President Kennedy's call to service, combined with the energy of the civil rights movement in the southern states, influenced many young people in our generation to become agents of change. The appeal Kennedy made in that speech still rings true:

The problems which this country now faces are staggering, both at home and abroad. We need the service, in the great sense, of every educated man or woman, to find ten million jobs in the next two-and-a-half years, to govern our relations . . . with over 100 countries, to govern those relations with success so that the balance of power remains strong on the side of freedom, to make it possible for Americans

of all different races and creeds to live together in harmony, to make it possible for a world to exist in diversity and freedom. All this requires the best of all of us.

Kennedy used Robert Frost's words to beckon the young people of America to take "the road less traveled" in service of the greater good. He understood that taking new paths will often lead to new discoveries, and that our country was in desperate need of them.

What If There Is No Road?

Law school and medical school are known to occupy every waking moment of students' lives, but our busy schedules did not prevent us from getting together. Our schools were just two miles across town. As often as we could, we met up to play tennis or squash or to share a meal with classmates. Just as we had at our childhood kitchen table, or in the dining hall at Amherst, we discussed our latest discoveries, questions, and ideas. With one of us studying medicine and the other law, we found ourselves looking for connections between the two disciplines.

We continued to have these conversations as our graduate and post-graduate education progressed. Blair passed the Pennsylvania bar exam in 1965 and clerked for two appellate judges on the Superior Court of Pennsylvania. He honed his writing skills by drafting judicial opinions and developed a deeper understanding of the judicial system by observing the interactions between the court's seven judges and the lawyers who appeared before them. Fred was

finishing his senior year of medical school and preparing to start a surgical internship at the Hospital of the University of Pennsylvania in July 1966.

When we look back, we shouldn't be surprised that we wanted to work together. We had been by each other's sides in many of our biggest endeavors. Collaboration is a hallmark of many twin relationships. So is competition. We remember the moment when we confronted the choice between the two.

We were fourteen years old, slumped on a bench beside a public tennis court, catching our breath, sweat dripping from our faces, our arms hanging like limp dishrags from our shoulders. We had just exhausted ourselves playing a competitive match neither of us wanted to lose. That was when it occurred to us: *What if, instead of struggling against each other in trying to win, we helped each other become better players?*

We became each other's personal hitting partners and coaches. We spent countless hours helping to improve each other's games, which led us to success on the Allentown High School tennis team. In college, we were introduced to squash, developed our skills, and joined the Amherst College squash team, where the same collaborative strategy helped us bring our team to national recognition, ranked fourth in the country. Collaboration had become a core value to us and a lens through which we looked at the world.

The question remained: What could a medical-legal team do in the world, and where could we do this work? To the best of our knowledge, no medical-legal team had pursued a joint career path. We couldn't find any precedent, not even one "less traveled." If we were going to pursue it, we needed to figure out how.

Creating a New Path

During the summer of 1966, we worked together on a position paper that addressed ethical dilemmas that could arise in response to advances in health sciences. We explored areas such as organ donation and transplantation, the use of human beings in research, the Good Samaritan problem, and the evolving definition of death. Writing this paper ignited our curiosity about these issues and helped open our minds to all sorts of options. If we wanted to work on these issues together, how, and where could we do so?

To help us answer these questions, Blair sought the advice of his law school mentor, Prof. Anthony Amsterdam.

Blair reflects

There were countless stories about Anthony Amsterdam's genius, and he lived up to all of them. When I was a student at Penn, someone posted a travel advertisement for the city of Amsterdam on the professor's office door. The ad copy said, "If Amsterdam doesn't amaze you, nothing will." Highly appropriate.

He had a photographic memory that served him so well that he once argued a case before the US Court of Appeals for the District of Columbia with no notes. When he began quoting a case from memory, one of the justices interrupted him and said, "You said that's on page 228? I can't find it."

Amsterdam responded, "I'm sorry, Your Honor, it is on page 228. Your book must be misbound." Indeed, the book was misbound.

Such stories trailed Anthony Amsterdam like gold dust. He had accomplished so much by the time I met him, and he was only in his early thirties. In addition to his achievements as an advocate and a writer, he was an inspiring professor and a generous mentor. When I called and said, “My brother and I have this position paper we’ve been working on. Would you look at it and tell us what you think?” he didn’t hesitate. “Let’s meet for dinner,” he said.

Fred and I came to the dinner with our paper and two questions. First, did our medical-legal collaboration idea make any sense? Second, could we pursue such a collaboration now, or should we wait until we were further along in our careers?

Amsterdam’s eyes were deep-set and intense, and they looked like they could scorch the paper in his hand. When he looked up, his message was clear: “Yes, this is a great idea.”

That gave me the courage to ask, “Is it completely absurd to attempt this now?”

“Absolutely not,” he answered. “This idea is too good. You should go for it.” Then he added, “I have some ideas for your paper,” and we proceeded to take meticulous notes.

Had Anthony Amsterdam said he was unsure about our idea; we might have halted. Had he said, “Fred, finish your surgical training first,” or “Blair, practice law for a few years,” we would likely have switched directions. Instead, his reaction switched on a second green light for us. Prof. Amsterdam took us seriously, and that helped us take

ourselves seriously. We had a paper to revise and more exploring to do.

In the following weeks, we met after work hours in one of the few air-conditioned rooms we could find: the judge's chambers in City Hall, where the Superior Court of Pennsylvania was housed and where Blair worked.

Fred reflects

Exhausted from grueling shifts at the hospital, I stretched out on the floor of Blair's judge's air-conditioned conference room while Blair clacked away on the typewriter. Temporarily sheltered from Philadelphia's sweltering heat, we worked into the night, honing our position paper.

At the same time, I was getting serious about looking for career opportunities. Although I liked surgery, I was excited by my part in preparing for our Good Samaritan presentation as well as the other times we explored medical-legal issues.

Several of my physician friends were entering the US Public Health Service (USPHS), and I began to inquire about those options. At the National Institutes of Health (NIH), talented young physicians worked in research labs, like those of future Presidential Medal of Freedom winner, Anthony Fauci. Alternatively, doctors could serve at the Centers for Disease Control (CDC) or join the Indian Health Service (IHS), both of which were part of the USPHS. Any of those were viable options, but how could a medical-legal team serve? There was no mechanism

for us to apply together. These two-year appointments were designed for individual MDs and PhDs in the medical sciences. They probably wouldn't know what to do with a JD. If we applied to the NIH cold, our applications would likely be ignored. We had to demonstrate the value of a medical-legal collaboration before submitting an application. Who was the right person to read our paper?

Another surgical intern, David Rilling, told me that Luther Terry, who had served as the US surgeon general from 1961 to 1965, had recently become the vice president of health affairs at the University of Pennsylvania's Medical Center. He would know where a medical-legal team could best serve our country. Possibility rang a bell, and it was up to us to respond.

Luther Terry was as known for his bravery as Anthony Amsterdam was for his genius. During his tenure as surgeon general, he took on the tobacco industry, stating boldly and unequivocally in 1964 that smoking was hazardous to your health.² He is the reason we have a SURGEON GENERAL WARNING on cigarette packs. Just a year out of his appointment, Terry was now running a major university medical center. He could easily have ignored a request from an intern and a young lawyer to read their fifteen-page paper. He not only read our paper, but he then welcomed us into his office for a discussion.

We didn't need to convince Terry of the relevance of the work we hoped to do. He already knew it was relevant. After having led the nation on health policy issues, he understood the intersection of medicine and law, and he was

well-versed in the operations of various health agencies in Washington. He told us, “We’ve never had a lawyer in the Public Health Service. We should have done this years ago.”

Terry still knew many people working at the NIH, and he invited us to use his name and call his successor as surgeon general, William Stewart, as well as James Shannon, the director of the NIH, among others. He also suggested revisions to our paper to help us convince these government leaders that the NIH would benefit from a medical-legal team that would analyze the legal implications of projects they funded, as well as ethical issues they would need to address.

Terry was a true mentor because of his generosity of time, advice, and encouragement. Had fate not placed him at the University of Pennsylvania Medical School, and had he not graciously received two young strangers and their big idea, our path might have ended there. Instead, he flashed our third green light. Encouraged by the reception we received, we applied right away to the USPHS. We drove to Bethesda, where we had numerous interviews in the fall of 1966.

Blair reflects

We received acknowledgments of our applications. Then five months passed with no response. With my judicial clerkship soon ending, I needed to know the direction we were going next. I wasn’t sure who to contact at NIH, but I kept remembering how receptive, kind, and caring the associate director, John Sherman, had been during our visit. Maybe he could check on our applications. In February, I drove down to Bethesda, went to NIH, and asked to see him.

Sherman's secretary told me that he had meetings booked all day, but I could wait in the outer office. He might have a few minutes free at the end of the day. I don't think she expected me to do that, but I did. Persistence wasn't an option; it was the only option. I wasn't about to give up now.

When the secretary finally waved me inside, I handed Sherman our paper and reminded him of our visit months earlier. "I remember your visit well," he said. "You have a great idea here, but you haven't heard back from us?" He picked up the phone, and in less than half an hour, our prospects were looking up. He promised to follow up soon. Our fourth green light had turned on. As I drove home that night, possibility shimmered on the horizon once again.

On March 28, 1967, our 26th birthdays, we received Western Union telegrams inviting us to serve in the US Public Health Service, at the rank of senior assistant surgeon, stationed in the NIH director's Office of Program Planning, in Bethesda, Maryland. Through a combination of thorough research, clear writing, collaboration, persistence, serenity, and generous mentorship, four essential green lights had turned on. We were ready to begin our travels on a new road.

CHAPTER 2

The NIH and Organ Transplantation

Teachers open the door, but you must enter by yourself.

—Chinese Proverb

We met Joseph S. Murtaugh, our new chief at the National Institutes of Health, for the first time on July 3, 1967. He sat behind his desk, looking every bit like Hollywood’s image of a 1960’s civil servant: white button-down shirt, narrow tie, black-rimmed glasses, and short-cropped hair accented with silver at the temples.

We came to know Murtaugh’s brilliance, humility, and unwavering dedication to the American healthcare enterprise. He jokingly called himself one of “the great unwashed” because, unlike his colleagues with an MD or PhD after their names, he did not hold an advanced degree. Still, his genius was no secret. Murtaugh was easily one of the NIH’s best writers, and he drafted NIH director James Shannon’s annual presentation to Congress, which regularly awarded the NIH more funding than it requested. Whenever the NIH had a public policy or strategic program issue, it usually fell on Murtaugh’s desk, as director of the Office of Program Planning.

On day one, we arrived in his office as he was grappling with such an issue, and he wanted to talk to us about it. Stacks of papers were piled everywhere. The phones rang constantly. Murtaugh pushed two newspaper clippings toward us. The headlines were “Bare Human Gland Sale” and “Coroner’s Aide Robs Corpses.”

“Gentlemen,” he said, “we have a problem.”

The Pituitary Challenge

Medical advances can often stir up ethical issues, which ripple into two courts: the court of law and the court of public opinion. These news articles described a public relations nightmare brewing at the National Pituitary Agency (NPA), which operated with NIH funding. Founded in 1963, the NPA had been collecting 72,000 cadaver pituitary glands annually for research purposes. The intent was noble.

Scientists at Johns Hopkins University and other academic institutions extracted human growth hormone (HGH) from the pituitary glands, which were used for NIH-funded clinical trials at various centers around the country. Pediatricians and endocrinologists were studying HGH deficiency in children, which affects one out of every 3,800 newborns and causes hypopituitary dwarfism.*

Problems arose in Los Angeles and Minneapolis when some of those glands were taken without consent. When pathology assistants in the local coroners’ offices learned that the NPA would pay two dollars (the equivalent of fifteen

* In the 1980s, scientists discovered how to synthesize human growth hormone using recombinant DNA technology. In the 1960s however, researchers and patients who needed HGH obtained it from human cadaver pituitary glands.

dollars in 2022) for pituitary glands, they saw an opportunity to make some extra cash. They started taking cadaver glands without obtaining permission from the next of kin and shipping them to the NPA at Johns Hopkins University.

Imagine the public outcry we would hear if people learned that their tax dollars were being used by state medical examiners' offices to fund research on body parts taken and sold without consent. When this story was exposed in the press in the 1960s, the NPA, along with its funder, the NIH, had to deal with the fallout. Joe Murtaugh told us, "I want you to find out everything you can about the law regarding the use of cadaver material for medical purposes and figure out what we need to do to assure our grantees comply."

This was our first assignment as officers in the USPHS. What began as "solving the pituitary problem" led us from the Georgetown Law Library to the Uniform Law Commission, the American Bar Association, Congress, and eventually on a worldwide exploration.

Connectors, Mavens, and Salespeople

Malcolm Gladwell's 2000 book, *The Tipping Point: How Little Things Can Make a Big Difference*, asks why some ideas, trends, and messages take off while others fall flat. Gladwell proposed that trends catch fire when three kinds of people get involved: *connectors*, *mavens*, and *salespeople*. Connectors, as the name suggests, bring people together, intentionally linking individuals in their broad social spheres, for the benefit of both. Mavens accumulate, understand, and share deep knowledge. Salespeople persuade others, in small and large ways, to get on board with new ideas.

Though Gladwell's book was published thirty-seven years after we embarked on our first assignment at the NIH, looking back, we can see the connectors, mavens, and salespeople, in addition to catalytic public events, that pushed forward organ donation law at unprecedented speed.

Our journey to understand the laws relating to the use of cadavers for medical purposes began at the Georgetown Law Library reading tables, where we spent the summer of 1967 poring over legal volumes. We were becoming, according to Gladwell's terminology, mavens. Back then though, we simply saw ourselves doing what we were trained to do.

Our training in medicine and law taught us that the first step for solving a problem or answering a question was always the same: research. We needed to understand the current body of scientific knowledge and the laws and precedents already in the books.

The state laws regulating the treatment of someone's body after death fell into four categories: autopsy statutes, unclaimed body statutes, medical examiner (or coroner) statutes, and, in some states, organ donation laws. If a death occurred due to homicide or suicide, in an accident, or in a case involving a potential threat to public health, such as an infectious disease or viral pandemic, state laws authorized medical examiners to perform an autopsy to investigate the cause, regardless of the next of kin's wishes. These laws, however, did not provide examiners with the legal authority to take cadaver organs or tissues for any other purpose, not even altruistic ones, without consent.

Many states permitted the next of kin to authorize an autopsy on the deceased, but autopsy statutes were not so broad that they authorized the procurement of organs and

tissue for donation, education, or research. Several states had laws regarding unclaimed bodies, providing that they could be delivered to medical schools and hospitals for educational purposes, but only after a twenty-four-hour waiting period, during which time the hospital was obliged to seek the next of kin.

Many states had recently adopted organ donation laws, but the statutes varied wildly. Forty-one states had statutes that specifically provided authority to individuals to donate all or parts of their body after their death for medical, scientific, or therapeutic purposes. But these statutes ignored the importance of many medical issues, such as the time sensitivity of organ donation for transplants. Too often, the act of donating was treated as an extension of the distribution of property after death, a process that often took days or weeks, by which time organs were no longer useful for transplantation purposes.

We developed a broader understanding of the laws governing the treatment of dead bodies. Our research helped us discover the nation's leading health law scholars, and we began making calls. We visited health law leaders around the country. In Pennsylvania, we saw Cyril Wecht, who was an MD, JD, pathologist, and the medical examiner for the city of Pittsburgh. We had found his 1966 publication, "The Medico-Legal Autopsy Laws of the Fifty States and the District of Columbia" to be invaluable.³

The scope of our research grew beyond the questions, "What are the current laws regarding dead bodies?" and "How do we assure that NIH grantees abide by them?" to "What should organ donation laws be?"

We presented our findings to Murtaugh. The pathology

assistants in California and Minnesota had broken state laws. The NIH needed to take measures to prevent these breaches from occurring again. None of the organ donation statutes in any state provided comprehensive ethical or medically sound guidance for the donation and use of tissue and organs for research or transplantation.

Murtaugh recognized that the NPA's pituitary-gland problems might well apply to any NIH-funded program using cadaver tissue or organs for research. Indeed, several institutes within the NIH were either engaged in or funding research using cadaver tissue or organs. He invited us to present our findings at a weekly meeting, internally referred to as the "College of Cardinals," chaired by NIH director, James Shannon, and attended by the directors of every NIH institute—including the Heart Institute, the Cancer Institute, the Institute of Mental Health, the Institute of Allergy and Infectious Diseases, and the Institute of Arthritis and Metabolic Diseases.

That is how we found ourselves sitting around an enormous mahogany conference table, surrounded by NIH luminaries. We were seventh on the meeting agenda, and when Murtaugh introduced us, he described what had happened with the NPA, what he had asked us to do, and what we had discovered.

"I'm concerned," he told the group. "There could be other places where we are not assuring compliance in programs we fund." He said the institute directors should expect calls from us: "They are going to meet each of you individually. I want you to put them on your calendars, open your doors to them, and show them your lists of grants

involving the use of organs and tissue; so they can review regulations, enforcement, and potential vulnerabilities.”

Everyone in the room understood the gravity of the situation. Our access to every director at the NIH rapidly expanded our understanding of the breadth of projects the agency funded and introduced us to the major players in the areas of organ and tissue transplantation. That information would prove to be invaluable throughout the coming weeks.

Following Opportunity

As we continued to ask questions and follow up on opportunities, we deepened our expertise and shifted to another “tipping point” role. We became connectors. A month after our “College of Cardinals” meeting, we found ourselves sitting across from Prof. E. Blythe Stason, the mild-mannered former dean of the University of Michigan Law School, who was serving as a commissioner of the Uniform Law Commission (ULC), known then as the National Conference of Commissioners of Uniform State Laws.

The ULC was made up of law professors, lawyers, and judges from each state, whose function was to help make state laws more uniform and current. Since its founding in 1892, the ULC has identified subjects to investigate, then assigned a small working committee to each, charged with analyzing the issues and, if appropriate, developing and drafting a model law for states to adopt. The committees present the model laws to the ULC membership at their annual conference, and the commissioners return to their home states ready to promote the laws to their legislatures.

They traditionally meet one week before the annual meeting of the American Bar Association where their newly adopted model laws are again presented and widely disseminated.

When we met Stason, he was chairing a ULC committee that had been working for a year on a model law related to organ donation and transplantation. Stason's six-member committee had been analyzing the donation issue and developing the first draft of what had been titled the Uniform Gift of Human Tissues Act. Concurrently, we had been examining the existing donation laws, piecing together a nationwide landscape of related research projects, and analyzing how medical research and therapeutics were impacted by donation laws.

Stason fired off questions, and we responded with information, ideas, and questions of our own. He was a law professor in the forty-fifth year of his distinguished career, and he could have shown up as an expert lecturing to neophytes. Instead, he recognized the research we had done and the understanding we had of the medical, legal, and ethical issues involved. He also saw that our work at the NIH had wired us into the medical and scientific communities. He said, "I want you two to be my official consultants on this law."

During this time, Joseph Murtaugh retired from the NIH to become the first staff director of the newly created Board on Medicine of the National Academy of Sciences (later the National Academy of Medicine). Donald Whedon, director of the National Institute of Arthritis and Metabolic Diseases (NIAMD) agreed to supervise us, and we told him about Prof. Stason's invitation to consult on the model law. Whedon immediately understood the importance to the NIH of

a uniform donation law and wholeheartedly encouraged our collaboration with the ULC.

At Whedon's invitation, we returned to the weekly NIH directors' meeting to present the findings from our meetings with various institute directors. By the end of that meeting, NIH associate director, John Sherman, directed us to broaden our inquiry into all matters relating to organ donation and transplantation.

Within three months, we had gone from investigating a pituitary procurement crisis to reviewing all NIH grants that used cadaver material, to helping draft a model organ donation law for every state. Along the way, we learned how valuable mentors can be. Murtaugh, Stason, and Whedon entrusted us with great responsibility. They did so because they understood we were all working to solve the same problem, and we had shown them we were up to the task.

Christiaan Barnard Changes Everything

Just five months after we arrived at NIH, an historic event in South Africa brought organ transplantation to worldwide attention. On December 3, 1967, Christiaan Barnard performed the first human heart transplant, at the Groote Schuur Hospital in Cape Town.⁴ The procedure sparked a global conversation about transplantation and led *Time* magazine to name Barnard its "Man of the Year."

Transplantation already had a long history, beginning with the first bone graft in 1668, the first skin graft in 1822, the first corneal transplant in 1906, the first cadaveric knee joint transplant in 1908, and the first arterial reconstruction

using vein tissue in 1911.⁵ Barnard's procedure had also been preceded by kidney, liver, and lung transplants, yet none caused the same stir as the first heart transplant.

Barnard's success generated a flurry of activity in the United States among some high-profile, highly competitive cardiothoracic surgeons, including Adrian Kantrowitz of New York, Norman Shumway at Stanford (under whom Barnard had studied), Michael DeBakey and Denton Cooley in Texas, Thomas Starzl in Denver, and David Hume in Richmond. Unfortunately, the dismal patient survival outcomes after their various heart transplant surgeries revealed that the surgical technique of transplantation was far ahead of immunological science: effective anti-rejection drugs had not yet been developed, and these first transplant patients rejected their new hearts within hours or days. Barnard's first transplant patient, who lived for eighteen days, was considered exceptional.

Public response to these operations ranged from "a miracle" and "the answer to heart disease" to "exceedingly premature," "immoral," and even "criminal." These impassioned reactions seemed tied not only to the heart recipients' bleak outcomes but to the very idea of a heart transplant. An anatomy professor might describe a heart as a "muscular bag," but laypeople saw the heart as much more than its physical function. It was imbued with emotional, aesthetic, and religious meaning.

Organ donation law was a niche subject prior to Barnard's heart transplant surgery, discussed among a small group of scholars. Bioethics and medical law were in their nascent stages of development. After the initial heart transplants though, everyone from experts to the lay public

began talking about the subject. Six weeks after the procedure, a Gallup poll proclaimed that seven out of ten people said they would donate their organs to medical science after their death. People also expressed their opinions, critiques, and concerns in newspapers, on television, and on the radio. A cartoon in *The New Yorker* showed a patient in a hospital bed, partially covered by a large sign that said, “Patient asleep—not a heart donor.” A bumper sticker cartoon warned, “Drive carefully! Dr. Barnard may be watching.”

Heart transplantation raised issues of morality, sociology, philosophy, religion, psychology, economics, politics, and ethics. Congress also took notice. Hearings were held on Capitol Hill under the leadership of democratic senators Walter Mondale and Fred Harris. We were about to learn that, when it came to policy and program development, timing is often the essential ingredient to accelerating change. The need for a new donation and transplantation law for the United States was abundantly clear.

The Uniform Anatomical Gift Act

As we continued our work on the model law, we needed a clear picture of the medical issues relevant to transplantation, such as tissue matching, preserving and transporting organs, evolving surgical techniques, and the new concept of “brain death.” We talked with many of the nation’s leading researchers in these areas. We met with leaders of agencies and organizations interested in transplantation: the National Kidney Foundation, the Eye Banks Association of America, the American Heart Association, the American College of Cardiology, the American College of Surgeons,

the Transplantation Society, tissue banks, and funeral directors' associations.

The model law needed to consider the concerns and needs of these groups while striking a socially acceptable balance that facilitated organ donation and procurement without infringing on deeply held values and rights, particularly those of would-be donors and their families. For instance, how would donors and recipients be selected? How would the law address equity and accessibility? How could the law assure donors that their best interests would be served? How could a law avoid conflict with a person's religious beliefs?

Our research and numerous conversations led us to believe that a successful uniform law needed to balance five interests:

1. An individual's wishes concerning the disposition of his or her body after death,
2. The next of kin's traditional right to possess the deceased's body for burial and religious purposes,
3. Society's need for adequate organs for lifesaving therapy,
4. Society's need for adequate organs and tissue for medical education and research, and
5. Society's need to adequately determine and verify the cause of death in certain circumstances.

What mechanism for organ donation would achieve this balance? Should a model law be based on voluntary consent (sometimes referred to as an "opt-in" principle) by which individuals could choose to become donors? Or should the

law include an “opt-out” presumed-consent model, permitting the “routine taking” of organs and tissues unless an individual explicitly objected before death, or unless next of kin objected afterward? Or should the law authorize the compulsory removal of cadaver organs as needed for medical purposes?

Intuitively we stood firmly for voluntary consent as the best option for preserving people’s individual rights. Our work on the pituitary problem had shown us the potential damage that “taking of organs or tissue” could do in the court of public opinion. We could imagine the pushback if news broke about a law that allowed the bodies of loved ones to be operated on and organs given away without permission. Not only would this undermine the likelihood of the law being passed, it could undermine the public’s attitudes toward organ donation, transplantation, and research.

Prof. Stason agreed. Working closely with him, we developed a completely new draft of what was renamed the Uniform Anatomical Gift Act (UAGA). We avoided unpalatable language, such as references to “harvesting” or “salvaging” organs. As a gift statute, the UAGA was based on consent and would encourage volunteerism. The law’s three foundational principles were also cherished American values:

Altruism: The UAGA enabled people to make a gift of life to another human being.

Autonomy: The law preserved an individual’s right to decide what happens to his or her body after death.

Trust: The law inspired a patient to trust the medical profession, and the healthcare system, to be fair and to do no harm.

Full Speed Ahead

Blythe Stason and his committee had already been working on a uniform organ-donation law for a full year when we became involved. We were kids compared to everyone else on his team, but we brought many assets they needed: time, access, medical knowledge, and a depth of understanding of the issues. In just six months, we worked together to transform a rough draft into a polished and thoroughly reviewed model law that was approved by the full committee.

Stason could have taken what we offered, integrated it into the law, and sent us home while he carried the completed draft to the ULC's annual meeting. Instead, with the blessing of its executive director, Allison Dunham, he had us present the Uniform Anatomical Gift Act to the more than 100 commissioners—esteemed lawyers, scholars, and judges—from all fifty states. Stason not only opened another door for us, he taught us a fundamental goal of mentorship: create opportunities for the next generation to emerge into leadership roles.

On July 30, 1968, we took our places on the dais in a Philadelphia hotel ballroom in front the commissioners and their staff members. The commissioners seated in the audience were arranged by the state they represented, each showing their state flag. Looking out across the room, it was clear that our model law was facing the scrutiny of leading lawyers from across the nation.

Stason introduced the purpose and principles of the UAGA, then handed the presentation over to us. We described the issues and answered questions. The UAGA was approved by the full body of the conference, without dissent.⁶ A model law is just that: a model, until it is introduced into each state legislature. After the meeting, the commissioners had the mandate of returning to their home states to promote the UAGA to legislators who would hopefully vote to adopt it as a state law.

A week later, the ULC took their newly approved model law to the annual meeting of the American Bar Association, also in Philadelphia, where we presented to a much larger audience. It received a strong endorsement. The campaign to promote the UAGA had begun. It now had a tipping point's third necessary ingredient: a team of salespeople, of which we were a part.

Soon we received a flurry of invitations from around the country, asking us to speak about the law. Over the next months, we addressed several state legislatures and testified before the District of Columbia committees of both Houses of Congress. Each of the congressional presentations was memorable, as we spoke in hearing rooms we had seen only on television, answering questions about organ donation and transplantation. Much of our testimony was captured in the Congressional Record.

In addition, our detailed analysis of the thirteen most-important provisions of the UAGA was published in *The Georgetown Law Journal* in October 1968.⁷ Our article with Prof. Stason, describing the UAGA, was published in the *Journal of the American Medical Association* in December 1968.⁸

The UAGA had everything necessary to propel it forward: an established apparatus that supported the development of uniform laws; a nationwide network of well-respected commissioners, with Rolodexes full of legislators, to act as its salespeople; a team of mavens available to represent and discuss the law; and a catalytic event that sparked extraordinary national interest and could push legislators to act.

The committee had designed the law to reduce potential opposition and proceed smoothly to adoption. We considered all stakeholders and addressed their needs and concerns. We exercised restraint, recognizing that some organ-donation issues should be addressed by the provinces of medicine, ethics, and other disciplines, while others were better dealt with by the individual states. By design, the UAGA did not legislate issues outside its purview, such as the evolving definition of death. Earlier in 1968, *JAMA* had published a Harvard Medical School committee report describing suggested criteria for brain death.⁹

Confronting a Potential Speed Bump

On August 22, 1968, barely three weeks after the commissioners approved the UAGA, the *New England Journal of Medicine* published “Organ Transplantation: A Proposal for Routine Salvaging of Cadaver Organs,”¹⁰ by UCLA law professor Jesse Dukeminier and physician David Sanders, who promoted a different approach to procuring cadaver organs and tissue. They advocated for “taking” rather than “giving,” suggesting that more cadaver material would become available if organs and tissues were routinely “harvested,”

unless the next of kin explicitly objected. The pair felt there would not be enough voluntary donors to meet the demand.

We saw serious defects in the Dukeminier-Sanders argument. Given that the deceased's family would still need to be asked if they objected to the taking of organs, we believed this approach would not produce more organs for transplantation. We worried about the adverse impact such a thesis, proposed in a highly respected journal, could have, and we needed to refute its views quickly. Fortunately, Sherman and Whedon agreed to write a letter, which the *NEJM* published, calling attention to “numerous errors and omissions” in the Dukeminier-Sanders article and informing the editors that “a detailed response is being prepared which we hope you . . . will consider publishing.”

Sometimes a problem is actually an opportunity. Rather than slowing the adoption of the UAGA, the Dukeminier-Sanders article likely helped. It inspired us to write an article with Stason, and Delford Stickel, a Duke University surgeon and colleague who specialized in transplantation, synthesizing our months of conversations with legal scholars, scientists, and medical practitioners. Writing and publishing the article gave us an opportunity to share the finer points of the uniform law with a broad audience.

“Transplantation—a Case for Consent” appeared in the *NEJM* on April 17, 1969.¹¹ Though the “giving versus taking” debate continued to turn up now and then, nothing slowed the progress of the model law.

With public interest in transplantation soaring, and with solid institutional support in place, the UAGA took off with lightning speed. Of the forty-four state legislatures that met

in 1969, forty-one adopted the law as written, including all of its thirteen provisions. By 1971, the model law was adopted in all fifty states and the District of Columbia with no major modifications. In the 128-year history of the ULC, no model law has been adopted as quickly.

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