

THE BODY AS PROPERTY: ETHICAL ISSUES

by

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I accepted with some trepidation your kind offer to deliver this Paper. After all, it is hardly likely that the Australian Society of Legal Philosophy would be aware that my current concern with bioethical issues and my membership of the Bar and the Law Reform Commission was preceded by some twenty years as a commercial partner in a large firm of solicitors. There is precious little opportunity for the injection of jurisprudential and philosophical principles into the documents needed to obtain stock exchange listing for a public company, or an international agreement for the acquisition of a newspaper, such as *The News of the World*.

My trepidation increased when I looked at your program and saw that Professor Julius Stone was to open the discussion on the first paper. That name induced Pavlovian reflexes and I immediately thought of my student days and of other names such as Kant, Savigny, Mill and Bentham. "Bentham" - my alarm began to subside. Surely, here was a respectable precedent for my own direct down-to-earth approach to law-making, sufficient to allow me to find a proper place in these proceedings of yours. Even better, Bentham's behaviour in relation to his own corpse was such as to warrant a seminar in its own right. Has there ever been an action by a great lawyer and reformer that was more down-to-earth, more physical, and less involved with the world of theory and cerebration than that which the dead Jeremy Bentham imposed by his will on University College, London?

Many of you have, no doubt, visited that institution but I wonder how many were prepared for the sight of Jeremy Bentham's dead

body, reassembled, reconstituted, stuffed, painted, polished, dressed in his own clothes and sitting among his own furniture, cane in hand gazing down the corridor at the generations of students and college members who pass by? And just for company his body is wheeled into the dining hall of the College two or three times a year to accompany the members at certain dinners. I have taken Bentham's body as living proof - perhaps permanent proof is a better expression - of the view that there is no legal duty to bury a dead body. While we are talking of the law's attitude towards the burial of dead bodies and the propriety of behaviour in relation to cadavers may I refer you to a remarkable decision of the Supreme Court of Papua and New Guinea in 1971 where the question was whether there had been a violation of the provision in the criminal code that prohibited improper and indecent interference with a dead human body and provided criminal penalties for persons who neglected to perform "any duty...touching the burial of a human body". The issue was whether these provisions had been transgressed by the defendants who had cooked and eaten the body in question rather than bury it.¹

After that eclectic, if not incoherent, preamble I now propose to try to explain in terms of principle some of the things that I have done in law-making and the preparation of guidelines in recent years.

A Philosophy of Law Reform?

On 5th July last, I attended the first of a series of Workshops on Law Reform organised by the Law Foundation of New South Wales.² The opening discussion concerned the desirability of law reform agencies consciously developing a philosophy of law reform. Professor Alice Tay said that a single philosophy of law reform may not be feasible in a pluralist society such as ours. She suggested that every matter of law reform will involve fundamental values of some kind and that prior recognition of their nature is necessary so that the inevitable conflict of values that will arise may be dealt with.

Mr. Justice Kirby said that he has frequently been confronted with the question, "By what principle or according to what value was a particular decision of the Australian Law Reform Commission made?" He also said that in his experience these questions were nowhere more persistent and, perhaps, more difficult to answer than in the field of bio-ethics, which is the field that I intend to explore today. He said that many commentators start from an absolutist or religious position and reject utterly the idea of pragmatic or practical solutions of the kind that law makers and law reform agencies sometimes offer. The Chief Justice of New South Wales suggested that it may be sufficient for law reform bodies to express their views clearly and to explain the bases upon which those views have been developed. Time may be needed before more fundamental principles could emerge.

My own comment was that two possibilities should be recognised. The first is that a law-making body or a law reform body could develop a broad approach or philosophy to be applied as a general rule. The second is that particular principles may be applied to a discrete project or piece of legislation which may or may not be consistent with the general philosophy but which may be nonetheless coherent and defensible. I have an open mind on the utility of developing a general philosophy of law reform, particularly after witnessing the "considerations" that sometimes impel members of parliament to pass laws or not to pass them.

The practical chances of any law reformer or law maker ever being able in our community to apply such a general philosophy systematically and effectively are likely to be low. Yet I suppose that the desirability of having such a general philosophy is undeniable.

For my own part I favour personal autonomy and individual freedom. I readily admit that my decisions on issues in bioethical matters have been pervaded by attitudes - philosophical conclusions if you like - which include a strong belief that society and its laws should promote or at the least try not to reduce personal autonomy

and individual freedom of choice and action. I have based many of my law reform decisions upon the belief that the individual is *not* primarily some kind of social debtor whose obligations to the community outweigh or do no more than balance his rights and privileges.³

Belief in personal autonomy and liberty naturally leads to a belief in the entitlement of persons to become sufficiently informed to be able to give comprehending consents to actions that affect their bodily integrity and well-being. In turn this means that such a consent should be allowed to take effect. Thus, if a person gives an informed or comprehending consent to something that would otherwise constitute a battery or a trespass, in my opinion that consent should, in general, prevail. It follows that I do not hold in much esteem Lord Denning's strictures in *Bravery v. Bravery*.⁴ I believe that judges should be more than ordinarily careful before frustrating the mature decisions of citizens by invoking public policy, ancient common law principles or their own notions of morality. I am here referring to the legal confusions which surround surgery, body contact sports and some forms of sexual behaviour.⁵

However, such are the frailties of law makers that even the strongest advocate of personal autonomy and freedom may be forced by notions of justice and fairness to compromise his principles. Let me give you examples:

(i) I suppose it follows from my emphasis on personal autonomy and from traditional economic attitudes of the West, that trade and commerce in human bodies and body materials is both natural and desirable provided that there is a demand for them. Indeed, a school of thought exists which goes further and argues that we will never have enough human tissues for the succour of the sick and the dying until we permit open markets in those tissues.⁶ My opinion, for better or worse, and that of my colleagues at the Australian Law Reform Commission, was, when we had the opportunity to prepare model laws on the subject, and is, that commerce in human body materials should be prohibited and made an offence. We provided for certain

exceptions. We also allowed the reimbursement of expenses incurred by donors.⁷ I cannot claim that our decision was logical or even plainly right in principle. All I can say is that we believed it to be mostly right on the ground that lawful commerce in human tissues would lead to social evils and to exploitation of the weak. However, I am now learning that strong opinions are held in the medical profession that human artificial insemination programs could be seriously affected if payment of so-called expenses to semen donors was discontinued.⁸ Where does that leave our prohibition?

(ii) A second example: the question arises whether personal autonomy should extend beyond the point of death. There appears to be a widespread social belief that personal autonomy extends beyond death and includes a power on the part of the individual to control what happens to his or her dead body. Yet I can see no good reason why this should be so. I believe that the dead should be treated with decency, and that it is wrong to cause distress to surviving family members by offending sincerely held beliefs. However, it seems to me that we are not dealing here with a question of personal autonomy. We are dealing with deep-rooted attitudes and nothing more, attitudes that are in fact changing.⁹ Despite this view of mine, I agreed with my colleagues at the ALRC that our model law would be consent-based, thus allowing personal autonomy to extend beyond the point of death.¹⁰

Human Tissue Transplants - Law-Making at the Australian Law Reform Commission

The Australian Law Reform Commission (ALRC) received a reference from the Attorney-General in July 1976 to inquire into the need for laws to regulate the removal and use of human organs and tissues for medical therapy, transplantation and research. The ALRC division comprised seven Commissioners, including Sir Zelman Cowen, Sir Gerard Brennan and Mr. Justice Kirby.¹¹ I was Commissioner-in-Charge of the project.

We decided to adopt an inter-disciplinary approach. Nineteen consultants to the Commission were appointed including 15 leading medical practitioners drawn from all States and Territories of Australia, a philosopher, two moral theologians and a scientist. The opinions of these consultants were obtained in personal meetings, group meetings and by written papers. The Commission communicated directly in Australia and overseas with governments, medical associations, churches, community groups, universities, television, radio and the press, as well as with individuals known to have expertise in the subject. The Commission produced working papers which were widely distributed in Australia and overseas, and conducted public hearings in every State and Territory of the Commonwealth, keeping a complete transcript of all information and evidence given by the public. National and State television were used as well as radio and the press, for the public discussion of questions and issues raised by the reference.¹²

A year later we produced a report and a model statute that were tabled in the federal Parliament in September 1977. When our work began, the first thing we learned was that the human body in the short space of thirty years had become an object of great intrinsic value. Throughout history the dead human body had been a worthless thing to be disposed of as rapidly as possible. Suddenly, many of its tissues had acquired the capacity to cure the sick, the defective and the dying. The demand for human body materials was, and is, enormous and unsatisfied the world over.

The issues were unusually difficult. Possibly, the most disturbing was the question whether there should be a statutory recognition of a new concept of death normally called "brain death". It is not really possible to prepare a useful law that will regulate surgical transplantation of human organs without studying, and forming views on, death by reference to cessation of brain function.¹³

Other questions which the Commission had to answer were:

- * Should donation of body parts by living persons be controlled?

- * Should removal of body parts from minors and persons lacking mental capacity be permitted?
- * Who should have the power to remove tissue from dead bodies in the absence of consent or objection by the deceased while alive?
- * Should it be lawful to implant tissue into an unwilling or unconscious recipient?
- * Should it be lawful to make medical use of tissues made available by autopsy?
- * Should privacy of donor and recipient be ensured?

We had satisfied ourselves that the answer to an initial fundamental question was that the use of human tissue for medical therapy is desirable and should be encouraged. We then found that the supply of human tissue in Australia is inadequate. This led us to the two remaining preliminary questions, namely, how to encourage tissue donation and how to increase the supply. We learned that the statutes on this subject already in existence in Australia and throughout the western world all rested upon one basic principle, namely, that human body materials should be obtained only by donor consent, either from the dead person during his or her lifetime or from the next of kin after death. The necessity for obtaining consent from living persons has never been questioned except for one remarkable case in Pennsylvania in 1978.¹⁴

We were then led to a further question. In view of the continuous acute shortage of human organs and tissues for surgical transplant in all parts of the western world should the basis of the laws be questioned? Should human tissue come not from a "giving" source but from a "taking" source?

There is still public debate on two opposing concepts known as "contracting-in" or "opting-in" on the one hand, and "contracting-out" or "opting-out" on the other hand. The systems of acquisition

of body parts in force until that time were systems of "contracting-in", i.e., systems under which the body parts of a person were not available for any purpose of a therapeutic nature unless he or she consented during his or her lifetime.

"Contracting-out" asserts that all body parts of dead persons should be available to the community unless the deceased recorded an objection during his or her lifetime. 1976 saw the appearance of the first "contracting-out" statutes in the western world. The French law received particular attention.¹⁵ These laws were responses to the acute shortages of human tissues in those countries and were introduced as a means of alleviating those shortages. The Council of Europe in 1978 prepared a model code of laws to govern the transplantation of human body materials and recommended to all its member nations (twenty-one in all, stretching from Turkey to Iceland) the adoption of the "contracting-out" principle.¹⁶

After our inquiries and public consultation, we decided that we were not justified in recommending to the Australian community the adoption of "contracting-out". We found a clear divergence of views, many persons taking very positive attitudes. It was plain even then that a strong body of opinion existed in favour of "contracting-out". On the other hand, many people strongly opposed "contracting-out". The idea of the human body being generally available after death as a source of parts for the community appeared not to be acceptable to the majority.

The model law prepared by the Australian Law Reform Commission was constructed on the basis of consensual giving. That was the general principle. There were, however, circumstances in which the Commission recommended some departure from the principle, for example, in relation to certain aspects of autopsy, and in some circumstances, where a dead person exhibited no objection during his or her lifetime and the close relatives after death indicated non-objection.

It was realised by the Commission that the recommendation of a

system of "contracting-in" carried with it the risk that the supply of human tissues for therapeutic purposes would not increase and could even diminish. It was, therefore, important that there should be an increase in community education on the use and necessity of human tissue donations. The Report dealt at some length with community programmes and systems whereby all citizens and young persons should be encouraged to give body parts after death for therapeutic purposes. These systems include the use of driving licence stickers, donor cards carried on the person, metal discs, necklets and bracelets which carry information concerning the wishes of the person wearing them, and other systems for making known a desire to donate.¹⁷

"Brain Death"

In two or three decades the perfection of two medical machines, the ventilator and the respirator, and the skill of the transplant surgeon, have forced mankind to change its perception of death and have illuminated our inability to say unequivocally what death is, or, conversely, what life is.¹⁸

A person who has suffered destruction of the brain and is incapable of breathing spontaneously is also incapable of maintaining heartbeat and circulation of the blood. However, if such a person has been connected to a ventilator it is possible for the machine to maintain respiration and blood circulation. It is also possible for these machines to maintain heartbeat and blood circulation in the trunk of a person who has been guillotined, provided the exposed blood vessels are suitably connected. In both cases the person is dead, not alive, although displaying a number of the characteristics of the living.¹⁹

The growing ability of transplant surgeons to use the organs of these patients to save other lives resulted in long and careful study of brain death. As a result there is now general acceptance world-wide that a person whose brain function has irreversibly ceased, is dead.²⁰

If you spend time considering the morality, ethics, or legal regulation of the treatment of patients with no brain function or with diminished brain function, you are likely to find that those who are brain-dead present the least difficulty. The reason is that with brain death there are only two questions, daunting as they are. The questions are:

- * Has death occurred when all function of the brain has totally and irreversibly ceased?
- * Is it possible for an expert to determine with absolute certainty that brain function has totally and irreversibly ceased? In other words, do we have accurate criteria for that determination?

The answer to each question is "Yes", but the search for the answers obsessed us at the ALRC and took more time than the moral and ethical questions. We learned that the treatment given to a human body after death involves relatively little of concern in terms of morality and ethics in comparison with treatment before death. A corpse should be treated with decency and respect as should surviving relatives and others who may wish to mourn or mark the death in a manner acceptable to the community. However, the expression "a human body before death" is another way of describing a living person.

We found that our philosophical and moral advice, and the views of the churches were consistent with these conclusions.²¹

Accordingly, our work on brain death involved painstaking inquiry of scientific and medical experts. I should say that the moral debate, and the shock of the responsibility that we bore, was particularly intense. The burden of authorising a new definition of human death took heavy emotional toll of some of our members.

As I suggested a moment ago, once it is possible to be assured of certainty in medical diagnosis, the moral dilemmas of

brain death cease to be the most taxing in this field. In my view far more intractable problems arise with patients who are in a state of permanent coma, with the helpless aged, and with the hopelessly defective newborn. The best-known case of the first kind is that of Karen Quinlan in the United States. She has suffered destruction of the upper brain (the cortex), but has some residual brain-stem function sufficient to enable her to breathe spontaneously. She can never again have consciousness, thought, memory or any of the physical senses. She is 28 years old, weighs about 4 stone (27 kg) and has lain in this condition for over 7 years, nourished intravenously.²²

Improving medical techniques now enable the dying aged to be kept alive for longer and longer, and enable the survival of defective newborn children who in the past could never have remained alive. One may well ask whether such patients are vulnerable in terms of loss of bodily freedom. They are. The danger for them is not that their bodies will be treated as community property or "bags of parts" to be dismantled after death for therapy of others, but rather the reverse. Under a kind of paternalistic authoritarianism they may be prevented from dying when they ought to die or would wish to die, or should, humanely, be allowed to die.

There is no shortage of reports of the old or defective being maintained by means of suction devices, tubes, catheters and other apparatuses stuck into every body orifice, when there is no chance of recovery to any normal or acceptable way of living. It is for this reason that "natural death" laws have appeared in the United States and other parts of the West, and groups such as the Society for the Right to Die have been formed. These laws are aimed at preventing the direct exercise of dominion over a helpless body in a way that many see as inhuman and degrading.²³

I will conclude my reference to brain death by suggesting that the related moral, ethical and legal problems have only just begun. I believe that the law should directly recognise the concept of

brain death. Queensland, the Australian Capital Territory and the Northern Territory have already done as recommended by the ALRC model code.²⁴ Victoria has such a bill before its Parliament at this moment,²⁵ and South Australia and Western Australia have indicated their intention to do so. New South Wales and Tasmania have so far stood back. A statutory provision of this kind will, without ambiguity, allow doctors to withdraw the complex and expensive resources of intensive care wards from the 24 hour-a-day care of a corpse. It will also bring an end to the offensive possibility of intensive care specialists being accused of homicide or murder as has happened twice in England in the past two years.²⁶

Brain death as a concept must be allowed to develop in the sight of the community because of the plight of coma victims who are not brain dead and of other helpless old and young patients whose bodies can function only with artificial support.

Removal of Body Parts from Minors

Brain death was arguably the most important subject dealt with by the Commission, but the greatest disagreement was caused by the question of the removal of human body parts from living minors. On this subject there was a division of opinion, the majority expressing the view that there could be circumstances in which human body materials of a non-regenerative kind, e.g., kidneys, may be properly and lawfully removed from minors. The majority concluded that tissue removal from minors should, as a general rule, not be permitted, but that in certain circumstances involving life-and-death within a family, the presence of independent advice from a variety of persons, and the donor having the capacity to understand what is at stake, such a donation could be made. Those members of the Commission who dissented took the view that under no circumstances should any minor ever be permitted to give non-regenerative tissue to any person.²⁷ The dissenting view appears to have prevailed in most of the jurisdictions in which this law has been enacted in Australia to date.²⁸ The result is that in

Queensland, the Northern Territory and (soon) in Victoria,²⁹ a 17 year old person who wishes to give a kidney to a dying sibling will commit a criminal offence if he or she does so.

The Council of Europe in its 1978 Model Code took the same view as the majority of the Australian Commission and decided that there are circumstances in which such a donation is permissible.³⁰

Other Issues

The Commission took the view that under no circumstances should the law permit the use of force, compulsion or peremptory procedures to obtain body tissues from the living, no matter how worthy the purpose. The Commission did not pursue the possible application of the "rescue principle" which has been developed in European law and has surfaced in the United States.³¹ Our conclusion was that the notion of compulsory removal of body tissues from a living person in order to save the life of another poses moral questions for which legal answers are not appropriate. Society should attempt to solve the problems by means other than legislation.

Yet medical and scientific advances are such that we should envisage increasing attempts of a peculiarly physical kind to interfere with bodily integrity. New medical techniques reach out for physical dominion over the human body in new ways. We have already glanced at medicine's ability to keep alive human beings who in the past could never have survived. In relation to new-born children the past few months have seen the rise of litigation which relates to these very matters - the appearance of claims for "wrongful life" in the United Kingdom, and claims for damages for pre-birth medical treatment in Australia.³²

If the body is considered as an object in which rights may be claimed by others, links can be discerned between events which otherwise have no apparent connection. The vulnerability of the body to treatment as property can readily be seen by using this classification

and temporarily ignoring non-corporeal attributes such as spirit, soul and personality. It enables an observer to recognise the chasm between the motivation of a slave owner and the motivation of a transplant surgeon eager to secure supplies of body parts and yet to acknowledge a relationship between them based on the legal treatment of slaves as chattels and the potential legal recognition of claims by the sick to the contents of healthy human bodies. The possibility of threats to the integrity of the human body and to individual liberty can be illustrated by the treatment of the body as a kind of property with the support of the legal system as happened with chattel slavery.³³

Human Reproduction

Contemplation of the human body in terms of property can also be useful when considering the remarkable progress made in recent years in human reproduction with the aid of scientific techniques. Both the ovary and the testicle have been transplanted, and in the opinion of some these tissues have characteristics that call for special ethical and moral study.³⁴ Today, however, I am more concerned with semen and ova, not so much because of the manner of removal as the uses to which they are put in human artificial insemination (AI) and *in vitro* fertilization (IVF) and embryo transplant (or transfer) (ET).

Problems are raised by these procedures that have to do with dominion over the body and with possession and identity of human beings and the materials from which they are made. There are, of course, many other problems, but they are not for present discussion.

I am a member of a Working Party of the National Health and Medical Research Council (NH & MRC) which in the past few weeks has produced Australian National Ethical Guidelines on Medical Research and Experimentation, with special reference to IVF and ET. The Working Party's Report and Guidelines were "strongly endorsed" by the Executive of the Council on 24th August 1982 and were published yesterday.³⁵

In our work on the ethics of IVF we considered a number of fundamental questions. The first was whether the technique is ethically acceptable at all. At this initial stage we decided that we must be able to answer the kind of question which I quoted earlier as giving concern to Mr. Justice Kirby.

Some people approach bioethical activities in terms of absolute moral values. We called this the deontological approach. Others are more prepared to make value judgments and to have regard to the purposes or ends of the procedure. We called this the teleological approach.

Our first decision was that IVF can be justifiable medical practice. It has developed in Australia as a means of alleviating infertility in marriage. We accepted that infertility can be a serious, even tragic, problem for many couples and that its treatment is a proper subject of medical practice. We were aware that some people, using a deontological approach, strongly oppose IVF. However, we took account of the fact that such an approach has also been brought to other practices that are clearly acceptable to our society, for example, contraception which is widely practised.

Although we accepted that IVF may ethically be performed, we expressed the view that it is not yet a fully-established therapeutic procedure and must still be seen as experimental.

Having made this initial decision, a number of other questions which I do not propose to describe here were not difficult to answer. In addition, the present confinement of the practice of IVF to couples in stable domestic relationships tends to reduce the significance of some future disturbing possibilities.

Even so, we were left with a number of novel issues of major importance. These were the ethics of long-term storage of semen, ova and fertilized ova; the ethics of the donation of an ovum by another woman to the couple receiving treatment; and the ethics of

surrogate motherhood. There is also the question of the cloning of human beings.

The first, in my opinion, raises the important question of ownership or dominion over the stored material. We now appear to possess the technology for long-term, perhaps indefinite, storage of IVF embryos, as well as the separate reproductive tissues. Who should own them? Who would own a resulting child? Should the State be allowed to assert ownership or control over these potential citizens?

Subject to the safeguards which are set out below we saw no ethical objection to the preservation and storage of these tissues in recognised institutions such as public hospitals. In view of the incoherence of the law on proprietary rights in human tissues, we decided that indefinite storage is not acceptable and that time limits should be set. The time limits for storage of ova and fertilized ova should be the normal period of reproductive competence of the woman whose ovum is stored, or ten years, whichever is the shorter.

We decided that stored semen and ova should be regarded as belonging to the donor and in the case of an embryo as belonging to the two persons concerned or the survivor. In the absence of unanimity on their part the institution should have the right to make decisions. The institution should also have an overriding power to discontinue or close its storage facility and dispose of the stored tissues. We saw all these matters as requiring careful documentation until specific legal rules are created.

Ovum donation gave us some apprehension at first sight but we found ourselves able to accept this possibility by analogy with AI. Donation of an egg to an infertile couple whose infertility is due to the wife's inability to produce eggs is in our assessment not essentially different from the donation of sperm to an infertile couple for the purpose of artificially inseminating the wife where the husband is infertile.

On the other hand, we concluded that the question of surrogate motherhood is not yet capable of ethical resolution. Surrogate motherhood means that a woman will bear a child for another woman or couple and hand the child over after birth. The transaction may or may not be a commercial one. With IVF there is an unresolved question of profound significance, namely "who is the mother?". This question requires both a social answer and a legal answer. It is to be borne in mind that with IVF a surrogate mother will bear a child to whom she has no genetic relationship under an arrangement with a woman to whom the child *will* have a genetic relationship. Assuming for the moment that the woman who bears the child is the mother, or is *a* mother, does it mean that the woman whose egg was used is *not* the mother or is not *a* mother? Should such a child have two mothers?

Apart from the motherhood dilemma, the legal problems and the statutory laws of adoption which normally make unlawful money payments for handing over children, we also bore in mind the fact that the world has yet to see its first surrogate mother from the IVF process. We decided that it is premature to attempt to resolve the ethics of this matter, despite the wide media attention given to it recently.

At this point I will do little more than mention the fact that I am Chairman of the Advisory Committee on Human Artificial Insemination. AI and human artificial insemination by donor (AID) are now widespread and growing practices. That Committee has been set up by the New South Wales Government with terms of reference prepared by the Minister for Youth and Community Services. We are directed to have regard to a wide range of issues raised both by AID and IVF.

The Committee's work will cover matters of immediate concern such as the status of the AID child, fatherhood, the obligation to support and maintain, rights of custody and access, and inheritance of property. We have also identified other significant questions and issues; for example:

- * The right of an AID child to have information about the biological father.
- * What should be placed on the birth certificate of an AID child?
- * In relation to semen donors:
 - should there be absolute privacy of records?
 - what screening and health testing should occur?
 - should they have any right to learn the use to which their semen is put?
 - how many times should the semen of one donor be used so as to reduce the chance of "accidental incest"?
- * Should the practice of AI be confined to the medical profession?
- * Should there be any restriction on a woman's entitlement to receive AI?

We do not expect to report for some months yet. I therefore propose not to take more of your time today. However, should any one of you wish to send us a submission or a comment, we will be more than happy to receive and consider it.

Conclusion

I would like to conclude by repeating a suggestion that I have made on other occasions in recent months in relation to the preservation of the public interest in this age of the New Biology. I agree with a recent letter to *The Times* of London from Dr. Ian Kennedy of Kings College, the 1980 BBC Reith Lecturer. He saw in IVF "another example of the growing number of ethical and legal issues surrounding medical scientific developments". One after another deeply disturbing issues are paraded before the public, for example, brain death, the tragedy of Karen Quinlan, the plight of the defective new born, genetic manipulation and the selection of

candidates for organ transplantation. In his words, "...after the debate what then? There is a danger of leaving behind a trail of muddle as we dash on to the next issue more as voyeurs than social analysts".

The problems cannot be solved nor can the public be reassured by any one professional group whether lawyers, medical men or politicians. Interdisciplinary measures are essential. Nor is there long-term benefit in the creation of ad hoc inquiries with limited terms of reference.

Kennedy suggests that we can do better than we have done and I agree. "What I would hope to see created is a standing advisory committee charged with responding to the whole range of problems we are encountering. Its brief would be to offer ethical guidelines in the form of codes of practice and where appropriate suggest changes in the law."³⁶

Such a body could take its membership from all appropriate constituencies. In Australia it could represent the national interest, and inhibit the fragmentation of effort into diverse, distant groups, which has already begun.

Because of this country's prominence in the development of *in vitro* fertilization and embryo transfer we have an outstanding opportunity to show leadership. A body of the kind suggested would serve as a demonstration to the public of government concern. Practices and developments could be monitored. We might be able to avoid the sterile entrenched attitudes that seem to characterise the abortion debate.

I am sure that nobody expects solutions to appear easily. However, the moral, ethical and social problems precipitated by modern medical advances of the kind I have discussed in this paper will not go away. They will multiply. Somehow, we must achieve a balance between the impulse to ignore them on the one hand and on the other the desirability of extracting the benefits for society which they offer.

Footnotes

1. *Regina v. Noboi-Bosai & ors.* (1971-72) P. & N.G.L.R. 271.
2. Law Foundation Workshops on Law Reform, Winter-Spring 1982.
3. Russell Scott, *The Body as Property*, (Allen Lane, 1981), p.255.
4. *Bravery v. Bravery* (1954) 1 W.L.R. 1169.
5. *R. v. Donovan* (1934) 2 K.B. 498; generally see "Medical Procedures and the Crime of Battery" by P.D.G. Skegg (1974) Crim.L.R. and cases there cited.
6. See, e.g., "The Sale of Human Body Parts", (1974) 72 Michigan L.R. 1182.
7. Australian Law Reform Commission Report No. 7 "Human Tissue Transplants" (A.L.R.C. 7), Ch. 15.
8. *The Week-end Australian*, (Magazine), 24-25 July 1982, p. 2.
9. *The Body as Property*, f.n.3 above, pp. 227, 259.
10. A.L.R.C. 7, Ch. 2.
11. *Ibid.*, introductory page "Participants".
12. *Ibid.*, Ch. 8.
13. *Ibid.*, Ch. 10.
14. *McFall v. Shimp*, Court of Common Pleas of Allegheny County, Pennsylvania Civil Division, 26 July 1978, No. 78-17711.
15. Loi No. 76-1181 du 22 decembre 1976.
16. Resolution (78) 29 adopted by the Committee of Ministers of the Council of Europe, 11 May 1978, Article 10.
17. A.L.R.C. 7, Ch. 16.

18. See A.L.R.C. 7, Ch. 10; *The Body as Property*, (f.n.3 above), Ch. 6; Mushin, Rendell-Baker, Thompson and Mapleson, *Automatic Ventilation of the Lungs*, (Blackwell - 1969).
19. *Ethics in Medical Progress: with special reference to transplantation*, ed. by G.E.W. Wolstenholme and M. O'Connor, published by J. & H. Churchill Ltd., London (1966) - (Record of a CIBA Foundation Symposium); see also A.L.R.C. 7, para. 117.
20. See, for example, unanimous statements of the British Royal Colleges of Medicine of October 1976 (*British Medical Journal*, 1976, 2, 1187) and January 1979, (*The Lancet*, 3 February 1979, p. 261); Uniform Brain Death Act, 1978 (U.S.); Report of the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research of 1981 (U.S.); Resolution of the Council of Europe of 11 May 1978 (f.n.16 above); Law Reform Commission of Canada, Report 15, *Criteria for the Determination of Death*, 1979, 25. The British criteria of 1976 and 1979 have been accepted by the Con-joint Conference of Royal Clinical Colleges in Australia.
21. See, for example, "The Prolongation of Life", an Address of Pope Pius XII to the National Congress of Anesthesiologists, 24 November 1957: (1958) 4 *Pope Speaks: Church Documents Quarterly* 393.
22. *The Body as Property*, (f.n.3 above), 171 et seq.
23. *Ibid.*, p. 176 et seq.
24. Transplantation and Anatomy Ordinance 1978 (A.C.T.); Transplan-tation and Anatomy Act 1979 (Qld.); Human Tissue and Transplant Act 1979 (N.T.).
25. Transplantation and Human Tissue Bill, 1982.
26. *R. v. Steel: R. v. Malcherek* (1981) 2 All E.R. 422.
27. A.L.R.C. 7, para. 112.
28. Qld. and N.T. (see f.n.24 above).
29. See f.n.25 above.
30. f.n.16 above, Article 6, para. 2.

31. See, e.g., "Duty of Wrongdoer to Victim's Rescuer?", *A B.A. Journal* April 1982, p.498; "Kidney Donation from Minors and Incompetents", R. Stetter (1975) 35 *Louisiana L.R.* p 551, at p. 558, and f.n.38; Prosser's *Law of Torts*.
32. *McKay v. Essex Area Health Authority*, The Times L.R., *The Times* of London, 20 February 1982, p. 21 (also p. 1); *Kosky v. St. Vincents Hospital*, *The Age* (Melbourne), 20 August 1981, p. 3.
33. *The Body as Property*, (f.n.3 above), pp. 27-28.
34. *Ibid.*, pp. 222-224.
35. First Report by NH & MRC Working Party on Ethics in Medical Research - Research on Humans - August 1982.
36. *The Times* of London, 11 February 1982.
