ASPECTS OF PRIVATE AND PUBLIC LAW REGARDING THE HUMAN BODY FROM THE MEDICO-LEGAL STANDPOINT.

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# TABLE OF CONTENTS

## PREFACE

<table>
<thead>
<tr>
<th>Chapter</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>1</td>
</tr>
</tbody>
</table>

## CHAPTER I: VOLUNTARY STERILISATION

<table>
<thead>
<tr>
<th>Sect.</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Introduction</td>
<td>5</td>
</tr>
<tr>
<td>B.</td>
<td>Some Theological Views</td>
<td>10</td>
</tr>
<tr>
<td>C.</td>
<td>The American Position</td>
<td>12</td>
</tr>
<tr>
<td>D.</td>
<td>The British Position</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>1. Bravery v. Bravery and the</td>
<td>24</td>
</tr>
<tr>
<td></td>
<td>issue of criminal assault</td>
<td></td>
</tr>
<tr>
<td></td>
<td>2. The issue of civil liability</td>
<td>38</td>
</tr>
<tr>
<td>E.</td>
<td>The Comparative Position</td>
<td>41</td>
</tr>
<tr>
<td></td>
<td>1. Canada</td>
<td>41</td>
</tr>
<tr>
<td></td>
<td>2. Germany</td>
<td>42</td>
</tr>
<tr>
<td></td>
<td>3. France</td>
<td>45</td>
</tr>
<tr>
<td></td>
<td>4. Scandanavia</td>
<td>46</td>
</tr>
<tr>
<td></td>
<td>5. Japan</td>
<td>47</td>
</tr>
<tr>
<td></td>
<td>6. India</td>
<td>47</td>
</tr>
<tr>
<td></td>
<td>7. South Africa</td>
<td>48</td>
</tr>
<tr>
<td>F.</td>
<td>Conclusion</td>
<td>49</td>
</tr>
</tbody>
</table>

## CHAPTER II: COMPULSORY STERILISATION AND CASTRATION

<table>
<thead>
<tr>
<th>Sect.</th>
<th>Title</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>A.</td>
<td>Introduction</td>
<td>56</td>
</tr>
<tr>
<td>B.</td>
<td>Some Theological Views</td>
<td>58</td>
</tr>
<tr>
<td>C.</td>
<td>The American Position</td>
<td>61</td>
</tr>
<tr>
<td>D.</td>
<td>The Comparative Position</td>
<td>79</td>
</tr>
<tr>
<td></td>
<td>1. Britain</td>
<td>79</td>
</tr>
<tr>
<td></td>
<td>2. Denmark</td>
<td>82</td>
</tr>
<tr>
<td></td>
<td>3. Holland</td>
<td>82</td>
</tr>
<tr>
<td></td>
<td>4. Germany</td>
<td>83</td>
</tr>
<tr>
<td></td>
<td>5. France</td>
<td>84</td>
</tr>
<tr>
<td></td>
<td>6. Belgium</td>
<td>84</td>
</tr>
<tr>
<td></td>
<td>7. India</td>
<td>85</td>
</tr>
<tr>
<td></td>
<td>8. Italy</td>
<td>86</td>
</tr>
<tr>
<td></td>
<td>9. South Africa</td>
<td>87</td>
</tr>
<tr>
<td>E.</td>
<td>The Propriety and Morality of</td>
<td>87</td>
</tr>
<tr>
<td></td>
<td>Compulsory Sterilisation and Castration</td>
<td></td>
</tr>
<tr>
<td></td>
<td>1. Eugenic</td>
<td>87</td>
</tr>
<tr>
<td></td>
<td>2. Punitive</td>
<td>87</td>
</tr>
<tr>
<td>F.</td>
<td>Conclusion</td>
<td>97</td>
</tr>
</tbody>
</table>
# CHAPTER III: TRANSSEXUALISM: PROBLEMS OF SEX DETERMINATION AND ALTERATION

<table>
<thead>
<tr>
<th>Section</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Introductory Medical Aspects</td>
<td>100</td>
</tr>
<tr>
<td>B. Legal Aspects</td>
<td>112</td>
</tr>
<tr>
<td>1. Britain</td>
<td>112</td>
</tr>
<tr>
<td>a. England</td>
<td>113</td>
</tr>
<tr>
<td>b. Scotland</td>
<td>116</td>
</tr>
<tr>
<td>2. Denmark and Sweden</td>
<td>122</td>
</tr>
<tr>
<td>3. Germany</td>
<td>124</td>
</tr>
<tr>
<td>4. Switzerland</td>
<td>126</td>
</tr>
<tr>
<td>5. Canada</td>
<td>128</td>
</tr>
<tr>
<td>6. United States</td>
<td>130</td>
</tr>
<tr>
<td>7. Argentina</td>
<td>136</td>
</tr>
<tr>
<td>C. Conclusions</td>
<td>138</td>
</tr>
</tbody>
</table>

# CHAPTER IV: MEDICAL EXPERIMENTATION

<table>
<thead>
<tr>
<th>Section</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Introduction and Background</td>
<td>148</td>
</tr>
<tr>
<td>B. The Law: Unsettled and Unsatisfactory</td>
<td>154</td>
</tr>
<tr>
<td>1. The American cases</td>
<td>158</td>
</tr>
<tr>
<td>2. The British cases</td>
<td>166</td>
</tr>
<tr>
<td>3. Summation</td>
<td>172</td>
</tr>
<tr>
<td>C. Codes and Ethics</td>
<td>173</td>
</tr>
<tr>
<td>D. Conclusions</td>
<td>182</td>
</tr>
</tbody>
</table>

# CHAPTER V: HUMAN TRANSPLANTATION OF ORGANS

<table>
<thead>
<tr>
<th>Section</th>
<th>Pages</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. Introductory Medical Aspects</td>
<td>190</td>
</tr>
<tr>
<td>B. The Common Law and the Use of Treatment of Dead Bodies</td>
<td>198</td>
</tr>
<tr>
<td>C. Legislation Dealing with Use of the Body and Its Various Parts for Medical or Scientific Purposes</td>
<td>212</td>
</tr>
<tr>
<td>1. Britain</td>
<td>212</td>
</tr>
<tr>
<td>2. France</td>
<td>218</td>
</tr>
<tr>
<td>3. United States</td>
<td>219</td>
</tr>
<tr>
<td>D. The Definition of Death</td>
<td>226</td>
</tr>
<tr>
<td>E. The Problem of the &quot;Consenting&quot; Living Donor</td>
<td>241</td>
</tr>
<tr>
<td>F. Some Moral and Ethical Aspects of Organ Transplantation</td>
<td>251</td>
</tr>
<tr>
<td>G. Conclusions and Recommendations</td>
<td>261</td>
</tr>
</tbody>
</table>
CHAPTER VI: EUTANASIA

A. Some Introductory and Theological Observations 275
B. The Legal Position
   1. Scotland 287
   2. England 292
   3. United States 301
   4. Germany 305
   5. Norway and Sweden 307
   6. Switzerland 308
   7. Other Countries 310
C. Concluding Remarks 312

APPENDICES 322
How inviolate is the human body? With the rapid, manifold advances in medical science has come a concomitant host of problems - legal, ethical, theological - as to what bodily intrusions\(^\text{x}\) of a medical nature are to be accepted. This thesis is an attempt to look at these problems from two basic perspectives. First, from the perspective of the individual in society, how far he alone may determine the extent of physical intrusion to be accomplished upon his body by medical means? Secondly, from the perspective of the state or of society, how far it may regulate, limit or impose medical intrusion upon the human body?

It was felt that the answers to these two fundamental questions could best be illustrated by investigating their application in selected areas of currently controversial surgical procedures. As a result, the practices of sterilisation /

\text{x} "intrusion" here is not meant to imply lack of consent \textit{per se}, but only physical encroachment, with or without consent.
sterilisation, sex-alteration, experimentation, transplantation, and euthanasia were selected for study. All are controversial, not merely from the medical point of view, but also from the legal and moral points of view. Few, if any, enjoy a settled or even very clear place in the eyes of the law.

In such circumstances and with the human and material resources available at Edinburgh University, a comparative legal approach to these subjects was indicated. The English speaking legal systems, for obvious reasons of linguistics and materials availability, and more particularly those systems nearest at hand and best known to the author - Scotland, the United States and England - comprise the bulk of the comparison. Where possible, relevant case and comment from continental jurisdictions, from South Africa's Roman-Dutch system, and occasionally from other countries have been drawn upon for aid. These comparisons /
comparisons, though limited, will hopefully prove elucidatory.

This paper, being a medico-legal analysis, is composed predominantly of information drawn from these two disciplines. The medical comments are meant to be solely introductory and their superficiality will be only too clear evidence of the author's limited training in and knowledge of the field. Clarity and readability are the keynotes here and if some depth has been sacrificed to achieve them, then perhaps it has not been done all in vain.

Religious beliefs and feelings have been prominent in the development - or conspicuous lack thereof - of legal rules governing these controversial medical practices and must be given some degree of prominence in this paper if any realistic understanding of current legal attitudes is to be gleaned.

Finally, the author has felt free to state his own views and conclusions throughout this paper, but has attempted to limit them - at least in more blatant form - to the designated concluding remarks in each of the chapters.

Because /
Because of the limited case and statute law relevant to the subjects of this paper, and because of its topical nature, heavy reliance has been placed on periodicals - both medical and legal - and on various public lectures and discussions, not to forget the responsible press.

It is hoped that this paper will go some distance toward accomplishing three related purposes: that of stating the general, existing legal position in the areas discussed, that of raising at least the legal issues that remain to be resolved in these areas and that of suggesting general or specific means to reform and appropriate legal treatment insofar as those topics discussed are concerned.
VOLUNTARY STERILISATION

A. INTRODUCTION

Sterilisation is a medical operation, performable on either male or female, whereby the ability to procreate is eliminated. It in no way precludes further sexual intercourse from a physiological standpoint and does not, as is sometimes erroneously thought, desex the individual. The sex drive, potency and capacity for orgasm remain, and are reported sometimes to increase as a result.¹

In the man, the most common surgical method of sterilisation is called vasectomy, accomplished by cutting and tying the vas deferens above the testis. This operation takes only about five minutes, may be performed in a doctor's office under local anaesthesia, requires no abdominal incision and results in cutting off the seminal flow to the penis.

In the woman, the operation, as might be expected, is somewhat more complex. Similar in risk and severity to an appendectomy, it is performed normally by cutting and tying the Fallopian tubes between the ovaries and the womb. The procedure is called salpingectomy or tubal ligation and requires opening the abdomen.

There /

There is some controversy as to the reversibility of sterilisation operations, it generally being considered likely only in the male. Even so, the male reversal rate has been estimated at only thirty-five to forty per cent., although more recent estimates based on understandably limited data place the rate above fifty per cent.  

Castration is to be distinguished from sterilisation. It involves complete removal of the primary sex glands, the testes and the ovaries in the male and female respectively. It has often been thought that castration desexes an individual, rendering him impotent as well as sterile, but modern medical opinion does not invariably support this position. Where castration is performed after puberty, desire and ability for sexual intercourse can remain. Castration is, of course, an irreversible surgical procedure, though at least one testicular transplant has been reported.

Sterilization /

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2 Dr. G.M. Phadke of India, reporting to the Proceedings of the 7th Conference of the International Planned Parenthood Federation in Singapore in 1963 gave evidence of successful restoration of fertility capability after vasectomy in 21 of 37 (57%) cases, after up to a 15 year lapse. Blacker & Jackson, "Voluntary Sterilization for Family Welfare", 1966 The Lancet 973; V.J.O'Conner, "Anastomosis of Vas Deferens After Purposeful Division for Sterility", J.A.M.A., 162-163 (1948); a recent remark by a Canadian woman doctor that all males be sterilised at age 16 by vasectomy and undergo reversal surgery at the time of their marriage, aside from any other criticisms that might be made, seems to quite incorrectly assume that reversal of vasectomy is certain. See The Times, April 19, 1968.


4 Ibid.

Sterilization may be performed on a number of indications. The motivation for it may be simply therapeutic or curative. Sterilization may be, and has indeed been, practiced for eugenic reasons in an attempt to improve a particular stock or race on whatever medico-socio-cultural criteria may be determinative. It can and has been practiced for punitive purposes, as a form of punishment or retribution to criminals or other societal deviates.

One might think that at least in its "therapeutic" uses, sterilization would be clearly acceptable as a means of improving or preserving health. However, such is not the case. Sterilisation, along with a small number of other surgical procedures, most of which will be discussed subsequently, is tied up with the deep cultural, moral and religious feelings ordinarily associated with the sanctity of the means given man for the reproduction of life. Plainly and simply, surgical procedures involving the human reproductive organs and their capacity often may run afoul of prevailing moral and religious attitudes, which have an inevitable way of making themselves felt through the given society's legislative acts or judicial machinery. So it would seem with sterilisation. Catholic theology opposes the practice. So does Orthodox Jewish theology. The end result of the operation - sterility without impotence - causes many, whether /
whether rightly or wrongly, to fear licentiousness as its inevitable by-product.

It is probably true that "therapeutic" sterilization is the least-frowned upon, by society and its judges, but just what does "therapeutic" encompass in the eyes of medicine and the law? A reference to a surgical operation beset by similar, if more severe, problems - abortion - might be helpful here. It represents the only operation which in itself has been considered illegal by the common law. Initially, there was no therapeutic exception to the illegality of abortion in England. It took the courage of Dr. Bourne to graft a therapeutic exception onto the law of abortion in England, similar in scope to that contained in the Infant Life Preservation Act of 1929, which allowed for legal termination of pregnancy when necessary to save the life of the mother. The defence in Bourne was that abortion was necessary to avoid the young girl being rendered a "mental wreck". In Scotland, abortion has not been so restricted, thanks to the Crown Office's discretionary powers of prosecution. While Bourne may or may not be the law of Scotland, "therapeutic" abortion has long been synonymous with all such operations /

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7 Offences Against the Person Act, 1861, § 58.
8 Rex v. Bourne (1939) LR 2 KB, 687.
9 See Gordon, op. cit., p. 379.
operations performed in reputable medical fashion - above board, in hospital safety, by registered practitioners. In America, legally accepted "therapeutic" abortion has long been narrowly limited to cases where it was thought necessary "to preserve the life of the mother", but recent legislative reform has widened the definition to include protection of the mental and physical health of the mother and prevention of likely deformed or abnormal births.

Most recently in Britain, the Abortion Act of 1967 has greatly expanded the indications for legal termination of pregnancy, without expressly stating them to all be "therapeutic".

With sterilization, it would seem that unless and until legislative enactment, in prudence a reasonably narrow interpretation must be given "therapeutic" indications for the operation, similar to those granted doctors by the Bourne case, if the surgery is to fall clearly within the common law exemption from liability for assault provided by medical necessity.

Whether, in sterilization and other controversial, morally coloured /

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12 California (1967).
13 Colorado (1967); N.C. Carolina (1967).
14 11 Eliz. 1967, Chap. 87.
15 Expanding on the indications in the above-mentioned American statutes by allowing consideration of the effect of the birth sought to be avoided by abortion on existing children's health in the family, based on actual and reasonably foreseeable environmental considerations.
coloured, operations, "therapeutic" will eventually come to have the broader scope many would assign to health  in its full sense remains to be seen.

whether therapeutic sterilization is or is not any more defensible on moral grounds than other reasons for the operation, it is at least the form of the operation most clearly justified in the eyes of the law. While non-therapeutic voluntary sterilisation is either illegal or open to serious legal doubts in most Western countries, its therapeutic-counterpart appears to be almost everywhere judged or opined legal.

B. SOME THEOLOGICAL VIEWS

Theological thought and observation differs quite widely in the Western World as to whether or not sterilisation is to be invariably condemned and punished. Catholic thought regards sterilisation as a mutilation which deprives the person of a normal vital function of his body and being. It is considered grave and immoral conduct unless carried out in the interests of the health of the whole body.  One of the leading Catholic authorities on medical ethics has stated,

"...a /

16 defined by the W.H.O., as "...a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". L.C. Green, "Sterilisation and the law", 5 Maleva L.R.105(1963).

17 As, further reading will show, appears to be the case at least in America, Canada, England, Scotland, France, Belgium, Denmark, Germany, Scandinavia, Switzerland, Japan, Singapore and India.

...a treatment or mutilation of the reproductive organs which results in sterility is morally justifiable only when these conditions are fulfilled: (1) the purpose of the treatment or operation must not be (directly) contraceptive; (2) the procedure must offer some hope of benefit to a patient who suffers from serious pathology; and (3) a less drastic procedure which offers more or less equal hope of benefit is not reasonably available."

In other words, the sterilisation of an individual may be undertaken only when there exists a present, serious threat to his life or health which cannot be "averted by any other lawful means". Under this Catholic Rule of Double Effect, sterilisation is not regarded as wrong when it is the "unintended" byproduct of an operation performed for another legitimate therapeutic purpose (as to remove an ovarian carcinoma). This Rule is said to be enforced in Catholic Hospitals, even when the surgeon and patient are both non-Catholic.

Protestant opinion does not denounce sterilisation per se. In what is one of the leading of the few Protestant works on medical ethics, voluntary sterilisation is considered to be a proper /

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proper subject for the individual's free exercise of choice and responsibility, functions claimed necessary to any concept of morality. 22

C. THE AMERICAN POSITION

Several American states specifically provide that voluntary sterilisation undertaken for therapeutic reasons is legal. 23 At the same time, the three states with specific statutory prohibitions against voluntary sterilisation in force all make exception for therapeutic sterilisation performed in the face of "medical necessity". 24

Two states have recently passed a comprehensive set of statutes providing for voluntary sterilisation without limitation to therapeutic indication. 25

As for the remaining states - the vast majority - there is no legislation whatsoever concerning the legality of voluntary sterilisation. Some sparse case law exists, but is not dispositive. As a result, the American lawyer to-day can only offer an "informal guess" as to how the courts would treat a criminal assault charge or a civil damage suit brought for the performance of, or submission to, a contraceptive (non-therapeutic) /

22 Fletcher, Morals and Medicine. London: Gollancz, 1955, see especially Chap. 5.
(non-therapeutic) sterilisation.

However, this uncertainty has not seemed to have a very significant deterrent effect on the estimated 100,000 voluntary sterilisations that are sought and obtained every year in the United States, as many as fifty per cent perhaps being for non-therapeutic, solely contraceptive indications. There are no reported figures to challenge or corroborate these estimates. In a questionnaire sent to some 1,000 practitioners of the American Urological Association the following questions were asked and responses elicited: (1) "Do you perform vasectomy for purposes of sterilisation?" - fifty-two per cent, yes, forty-seven per cent, no, one per cent, no answer; (2) "Have you encountered any legal complications incident to this operation?" - Eighty-five per cent, no, ten per cent, yes, five per cent, no answer. Just how widespread the practice really is no one can say with any certainty.

In /

28 Rieser, loc.cit.
29 Dees, in 82 Am. J. of Ob. & Gyn. 572(1961) reports on 670 voluntary sterilisations - mainly therapeutic (including "multiparity") - performed at one hospital alone between 1956 and 1958 and states the operation is "fairly commonplace" in most parts of the United States.
In light of these rather startling estimates, it seems somewhat unusual that only three American cases are to be found in the law reports dealing expressly with the legality of a surgical sterilisation operation.

The cases are, Christensen v. Thornby (Minn.) 255 NW. 620 (1934), Shaheen v. Knight, 11 P. a. D. & C. 2d 41 (C. P. (Lycoming) 1957), and Hall v. Hudge (Wash.) 391 P. 2d 201 (1964). All three civil cases were breach of contract actions brought by husbands who had voluntarily submitted to vasectomy at the hands of their respective physicians and subsequently, to their chagrin, impregnated their wives.

In Christensen plaintiff sought damages against his physician for failure to insure plaintiff's sterility as allegedly promised. No neglect in performance of the vasectomy was alleged, only a deceitful representation of permanent sterility. The sterilisation was performed with the consent of both plaintiff and his wife, in order to avoid dangerous predicted consequences resulting from another pregnancy due to the wife's impaired health. Notwithstanding, a healthy child was born to the couple without complication.

The Minnesota Supreme Court held that under the facts of the case, the voluntary sterilisation was justified on therapeutic grounds due to the wife's poor health. In such circumstances, it /
it held neither the contract nor the operation itself to be against public policy and void or illegal on that basis. The Court, in concluding plaintiff had not stated a cause of action in deceit, did not feel obliged to rule on the propriety or legality of a voluntary sterilisation performed without medical indication.

Christensen was cited with approval in Shaheen v. Knight, supra, which also involved an irate husband suing his physician for failure to permanently sterilise on breach of contract grounds. However, in Shaheen no medical necessity existed for the operation, only plaintiff's desire for permanent sterility to avoid the birth of further children (had four), so that he could, "support his family in comfort and educate it". 30

When faced with the defence that such a contract to perform a purely contraceptive sterilisation was contrary to public policy and therefore unenforceable, the Pennsylvania Court stated, 31

"We are of the opinion that a contract to sterilise a man is not void as against public policy and public morals...It is only when a given policy is so obviously for or against the public health, safety, morals or welfare that there is a virtual unanimity of opinion in regard to it, that a court may constitute itself the voice of the community in declaring such policy void...There is no virtual unanimity of opinion regarding sterilisation."

30 The case is reported in Foote, op.cit. pp.629-630.
31 Ibid.
This Court was relying on the general Pennsylvania rule regarding a court's power to declare a practice as one consistent with or contrary to public policy, as stated in Memlin v. Genoe, 340 Pa. 320, 325, 17 A.2d 407, 409 (1941), in the following, oft-quoted terms,

"The right of a court to declare what is or what is not in accord with public policy does not extend to specific economic or social problems which are controversial in nature and capable of solution only as the result of a study of various factors and conditions. It is only when a given policy is so obviously for or against the public health, safety, morals or welfare that there is a unanimity of opinion in regard to it, that a court may constitute itself the voice of the community in so declaring. There must be a positive, well-defined, universal public sentiment, deeply integrated in the customs and beliefs of the people and in their conviction of what is just and right and in the interests of the public weal."

While holding the contract to sterilise was not void as against public policy, the Court in Shaheen did hold that public policy forbade the recovery of damages for the birth of a healthy child to plaintiff and his wife as a result of the breach of that contract.

The most recent case dealing with voluntary sterilisation in America is Ball v. Mudge, supra. Likewise, breach of a contract to sterilise was alleged, as well as the defendant physician's /

physician's negligence in performance of the vasectomy. Plaintiff sought damages for expenses of delivery and rearing of a healthy-born fourth child. Again, as in the two earlier cases, defendant doctor had judgment in his favour.

While Shaheen was cited, the Court in Ball expressed no opinion on the question of whether a voluntary sterilisation was against public policy. However, as in Christensen, medical indication was present, plaintiff's wife already having delivered the normally suggested maximum of three children by Caesarean section.

These three cases taken together indicate that a contract for voluntary sterilisation on therapeutic grounds (for the wife's health protection) is not against public policy. Only Shaheen reasons similarly where the purpose of the voluntary sterilisation is non-therapeutic. The other two cases are silent.

One appellate court in New York has stated in an opinion upholding a ban on the showing of a film about sterilisation, "The content of the picture is devoted to an illegal procedure". Ford Productions v. Graves 3 N.Y.8.2d 573. It has not apparently been expanded upon or discussed in subsequent opinion.

There /

There appear to be no reported American decisions imposing any clinical liability on a physician for the performance of a sterilisation operation, whether therapeutic in nature or not.

The result is, that absent statute, the legality of non-therapeutic voluntary sterilisation in the majority of the United States is open to some doubt, leaving doctors and lawyers alike to little more than guesswork regarding the criminal liability or civil unenforceability that might result from a contract for the performance of such an operation. In the absence of medical indication, most physicians are advised not to and will not perform such operations. 34

The recent voluntary sterilisation legislation enacted in Virginia and North Carolina expressly negates any civil or criminal liability of physicians for the non-negligent performance of a surgical sterilisation within the procedures set out in

34 Moya Woodside, op.cit., p.155; also sources mentioned at 87, 89 infra. Perhaps because conservatism prompts them to guide their conduct by comments which consider voluntary sterilisation contrary to public policy and consent as no defense. Witness the following,

"...Here we are faced with asocial conduct, not performed to advance any valid primary interest, intentional in character and full of risk of physical injury to the subject, as well as to the public interest in maintenance of the reproductive capacity, and we look in vain for any reason why society should consider consent justification."

in the two similar acts. The legislation contains no restrictions on the purposes for which a voluntary sterilisation may be sought and legally performed. It does, however, require a written request by the patient to the doctor, consent of the spouse, performance in a licensed hospital, only after a full explanation of the operation's consequences to the patient by the physician, concurrence in the decision to sterilise by another practitioner and a thirty day waiting period. Other states may well follow suit.

There has been some criticism of this legislation, such as its lack of provision for psychiatric examination and concurrence in the desirability of voluntary sterilisation where unsatisfactory effects are potential, particularly where the subject is unmarried, young, has few children or has a past history of psychiatric difficulties. The Constitutionality of these two Acts has not been challenged as yet. However, their nullification would seem unlikely when less rigidly safeguarded schemes for compulsory sterilisation have been upheld. *Buck v. Bell*, 274 US 200, 47 S.Ct. 564(1927).

There are a number of possible grounds of civil liability to /

to which the physician might yet be held liable for the performance of a sterilisation. Aside from breach of contract, the subject sterilised might conceivably try to recover damages from the performing physician on any one of the following theories: assault, negligence (malpractice), intentional or negligent infliction of mental suffering and distress, invasion of privacy or interference with the marital relationship. However, in all but the contract cause of action, consent of the suing party is decisive and if voluntary, knowing, without fraud, free from mistake, and accompanied by the necessary capacity, it negates any civil liability for the invasion complained of in American tort law.37

Even if a court held a consent to voluntary sterilisation invalid and void on public policy grounds, so as to characterise the operation a criminal assault, it is unlikely any cause of action for civil assault would lie, as plaintiff would have been equally a guilty wrongdoer by consenting to such an unlawful physical intrusion.

It might be asked if medical malpractice may be found in the absence of negligence, because it is measured against "accepted medical practice" in the community, not simply non-negligent performance /

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performance. If other local physicians do not perform voluntary sterilisation on principle, would this make the offending physician guilty of malpractice, the subject's consent and the absence of fault notwithstanding? The situation is somewhat novel. 38

As to the contractual liability, there seems to be no reason why a physician should not be held liable for reasonable, foreseeable damage resulting to the plaintiff from the doctor's breach of a contract for voluntary sterilisation (Shaheen and Bell, supra). 39 This presumes, of course, the plaintiff can establish a warranty by the physician that the operation would be successful in sterilising him and, more difficult, compensable damages as a result of its breach. 40

If the person sterilised is married and has proceeded without the consent of his spouse, voluntary sterilisation may be grounds for a civil action of some sort by the non-consenting spouse either against the party sterilised or against the performing physician. The nonconsenting spouse may try to sue the doctor for loss of consortium, but will fail if the sterilisation was performed non-negligently and with the subject's consent, as these elements make it nontortious. 41 Anyway, no such relief has been granted previously by the courts due only to /

41 Prosser, Torts (3rd ed. 1964) §119.
to a spouse's sterility rather than his impotence. The irate spouse might also sue the physician for interfering with the marital relationship, but is unlikely to succeed in the absence of showing an attempt to actually undermine affection between the couple. 42

If one spouse conceals a pre-marital sterilisation, it may be grounds for annulment on a fraud theory. 43 In the United States a unilaterally undertaken sterilisation without the consent or knowledge of the other spouse may be grounds for divorce or annulment on the basis that it constitutes "cruelty" to, or "constructive desertion" of, the unknowing spouse. An American Court has held the persistent use of contraceptives by a husband to be grounds for divorce, Kreyling v. Kreyling (N.J. CR.1942), 23 A.2d 803; unilateral submission by a husband to non-therapeutic sterilisation would appear no different.

In practice, there are probably few dangers of civil liability resulting from the performance of, and submission to, a non-therapeutic voluntary sterilisation. This result can be explained and is probably why so few cases are litigated in proportion to the alleged prevalence of the practice. 45 First, few /

42 Ibid, §118.
45 see footnote 27 and accompanying text.
few doctors would perform such a procedure without the written consent of both the patient and his spouse. Second, most men and women would not be likely to want to publicise the voluntarily incurred sterilisation by bringing suit against their doctor or against their spouse on that ground.

The American position remains unclear in the final analysis. The Law Department of the A.M.A. states non-therapeutic voluntary sterilisation is against public policy and therefore that consent to it is likely to be held invalid.46

This conclusion is probably over-conservative,47 but perhaps motivated by the thought, "better safe than sorry". It is, however, not typical of a medical profession generally conservative on questions of legal liability. Witness, for example, one physician's remarks on the doctor's dangerous exposure to civil suit by performance of a voluntary sterilisation,

"The unpredictable time of disappearance of sperm from the semen, the more rare occasion of spontaneous re-anastomosis of the vas deferens (natural reanastomosis of severed tubes resulting in male post-operative fertility once again), imply unplanned pregnancies. The trend for the public to falsely assume that physicians are financially sound, heavily insured and would travel to extremes to avoid publicity, brightens the temptation to institute suit. The physician would be well advised to abandon the procedure entirely except for legally authorized eugenic reasons and specific therapeutic indications."48

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47 Shartel & Plant, loc cit.
48 Rieser, op.cit., p.141.
The situation in America, with several exceptions noted above, waits to be clarified by legislative or judicial action dealing specifically with voluntary, non-therapeutic sterilisation.

D. THE BRITISH POSITION


The American uncertainty on the legality of non-therapeutic voluntary sterilisation is shared by Britain, where a somewhat ominous cloud was cast over the whole issue by the split decision and dissenting dictum by Lord Denning in Bravery v. Bravery (1954) 3 A.S.R. 59, 1 W.L.R. 1169. The mist has yet to be cleared away.

In that case the wife brought a divorce action on grounds of cruelty, alleging her husband had obtained a vasectomy in 1938, after the birth of their first child, without her knowledge or consent, and had thus caused her health to suffer, her maternal instinct to be frustrated and her married life to fall apart.

The sterilised husband in turn alleged as a defence that his wife had consented to the sterilisation operation. The majority members of the court (Sir Raymond Evershed, M.R., and Hodson, L.J.) found the wife to have consented and denied that she had made out a case of cruelty.

Addressing /
Addressing himself in dissent to the sterilisation operation, Lord Justice Denning opened up what is probably the most difficult legal question related to voluntary sterilisation. Namely, is the means and the ends of such an operation sufficiently contrary to public policy and common decency so as to make consent no defence to its criminal characterisation?

To this issue, Denning, L.J., stated at pp.67-8:

"...a sterilisation operation. When it is done with the man's consent for a just cause, it is quite lawful, as, for instance, when it is done to prevent the transmission of an hereditary disease: but when it is done without just cause or excuse, it is unlawful, even though the man consents to it. Take a case where a sterilisation operation is done so as to enable a man to have the pleasure of sexual intercourse without Shouldering the responsibilities attaching to it. The operation then is plainly injurious to his wife and, to any woman whom he may marry, to say nothing of the way it opens to licentiousness; and, unlike contraceptives, it allows no room for a change of mind on either side."

It would be difficult to find support for some of Lord Denning's remarks. Other, clearly legal, methods of contraception could have exactly the same results as those ascribed to sterilisation in particular, aside from its relative irreversibility.

The two majority justices felt obliged to comment on the above:

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49 See Phadke & O'Connor at footnote 2.
50 Hughes, "Two Views on Consent in the Criminal Law", (1963) 26 Mod.L.R. 233,238.
above observation of Lord Denning, by stating at p.63:

"We also feel bound to dissociate ourselves from the more general observations of Denning, L.J. (not in fact necessary to the resolution of the case) ... in which he has expressed his view (as we understand it) that the performance on a man of an operation for sterilisation, in the absence of some "just cause or excuse" is an unlawful assault, an act criminal per se, to which consent provides no answer or defense."

To support his position that the patient's consent did not relieve the sterilisation of its criminal character, Denning, L.J., cited the old English prize-fight case of Regina v. Coney (1882) 8 Q.B.D. 534, in which Swift, J., commented that the spectators to the fight were all guilty of assault as aiders and abettors, the consent of the contestants to the fight notwithstanding. However, the assault, because of its prize-fight nature, was also considered to constitute a breach of the public peace, for in the words of Stephen, J., at p.549, "prize-fights are disorderly exhibitions, mischievous on many grounds."

Lord Evershed, M.R. and Hodson, L.J., again took exception to this analogy drawn by Denning, L.J., in Bravery and stated at p.64:

"In our view, these observations are wholly inapplicable to operations for sterilisation as such, and we are not prepared to hold in the present case that such operations must be regarded as injurious to the public interest."

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51 "assault" will be used throughout as including battery so as to simplify the distinction between Anglo-American and Scottish terminology.
Denning, L.J., went on in *Bravery v. Bravery* to cite the case of *Rex v. Donovan* (1934) 2 K.B. 498, to support his proposition that the voluntary vasectomy performed on Mr. Bravery was a criminal assault which public policy would not allow consent to excuse. In *Donovan* the defendant was charged with caning a seventeen year old girl for his perverted sexual gratification. He pleaded the girl's consent as a defence. On appeal from his conviction for indecent assault, the reviewing court found error in the summing up to the jury made by the court below -- the question for the jury being held to be not one of consent or no consent, but rather whether the blows were likely or intended to do bodily harm (i.e. a hurt inferring with the health or comfort of the victim).

Justice Swift, speaking for the English Court of Criminal Appeal in *Donovan* used the tautologous 52 *mala in se* -- *mala prohibita* distinction to determine the issue of the girl's consent being a defence to the criminal assault charge, stating at p.507 that,

"If an act is unlawful in the sense of being in itself a criminal act, it is plain that it cannot be rendered lawful because the person to whose detriment it is done consents to it."

Swift, J., further commented at p.507 that,

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52 Williams, The Sanctity of Life and the Criminal Law, pp.103-105.
"As a general rule, although it is a rule to which there are well established exceptions, it is an unlawful act to beat another person with such a degree of violence that the infliction of bodily harm is a probable consequence and when such an act is proved, consent is immaterial. (emphasis added)"

Once again, the majority justices in _Bravery v. Bravery_ countered Lord Justice Denning's reference to the above remarks in _Donovan_ by stating they found none of the examples of criminal assault in that case to "bear any close analogy to an operation for sterilisation, which was nowhere mentioned_. _Bravery v. Bravery, supra_, at p.64.

That Justice Swift's quoted remarks in _Donovan_ were intended to cover to-day's voluntary sterilisation operations seems highly unlikely. His remarks were directed toward "violence" and "beating" and the "infliction" of bodily harm, terms hardly reconcilable with the uncomplicated, hospital-performed, consented to and asked for vasectomy involved in _Bravery v. Bravery_. Furthermore, aside from abortion, the common law has not chosen to treat surgical operations as illegal in and of themselves.

Lord Denning did, however, limit his remarks regarding the consent issue in _Bravery_ to sterilisations not performed for

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"just cause or excuse". He goes on to give one example of such a "just cause" for sterilisation, but leaves us in the dark as to the general area this limitation encompasses.

No less an authority on the criminal law than Dr. Glanville Williams has criticised Rex v. Donovan, finding its reasoning tautologous, too wide, unsupported by prior authority and of doubtful wisdom. Dr. Gordon, in his recent work on Scottish criminal law, sees the case as consistent with his theory that consent is a good defence to assault where it does not involve another crime, provided that a limited degree of injury or harm is caused. He does, however, state that just what that degree of injury is is "undecided and unknown".

Another writer on the subject feels the Donovan test of bodily harm is a reasonable criterion for determining the effectiveness or not of consent as a defence to criminal assault, but feels the test is in need of greater refinement. He refers to a classic law review article by Professor Beale dealing with "Consent in the Criminal Law", wherein support for Dr. Gordon's theory may be found. Beale states,

"In cases of actual personal injury, whether homicide, mayhem or battery, consent of the injured party is no excuse to the wrongdoer if the act consented to tends to a breach of the peace or to severe bodily harm."

(emphasis added)

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54 Braavery v. Bravery, supra, p.67 (eugenic reasons).
55 Ibid.
56 Williams, loc.cit.
57 Gordon, op.cit., p.77r.
59 8 Harv.L.R. 317(1895).
In reality, it is submitted, consent will or will not be accepted as a defence to the characterisation of a surgical intervention - in this instance, sterilisation - as a technical assault based on a broad test of public policy. The degree of the harm or injury involved is not the decisive criterion, but is rather only a major element in determining whether or not the operation is contrary to public policy. Surgical operations, by their very nature and though thought beneficial to the patient, involve injury or physical harm at least in the short run. As a result, the criminality of a surgical procedure should not simply be judged by the degree of injury caused, but rather by its effect on the individual concerned as a responsible member of society and on other members of the public. It is a social policy decision. Consent is a relevant factor in the making of this decision, but the question of necessity - in an immediate medical and a broader social context - is perhaps the consideration that should be determinative.

These considerations, it is suggested, are what Lord Denning was struggling to formulate as a test of consent in Bravery v. Bravery. Broadly stated, the question becomes one of how anti-social /

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60 §226a of the German Criminal Code is instructive, "One who does physical injury to another with the other's consent does not act criminally provided that the act, in spite of such consent, does not offend against (good morals) general morality" See Schöenke - Schröder (13th ed. 1967).

61 Hughes, (1963) 26 loc. cit. 233, 237.
social, distasteful or "indecent" a particular physical invasion must be in order to negative any defence that the victim or patient's consent would normally constitute for the harm or injury involved? The only consent that will serve as an absolute defence to a criminal charge is, of course, the consent of the community or of the state. However, it must be considered to what extent the individual's consent to the otherwise-criminal intrusion deprives it of its disrupting social or public effect. For it is this latter effect that justifies criminal penalty.

It is further submitted that this broad, public policy question can and should not be answered by the courts in any given case, but that the question should be answered by statute. In the meantime, consent should nullify any criminal liability for the performance of a voluntary sterilisation. In the absence of some compelling social justification, as evidenced in a statute on this subject, it is the desirable course to maximize personal freedom.

While the law of England and Scotland regarding voluntary sterilisation remains to be stated authoritatively and Bravery v. Bravery clarified, some fundamental observations can be made with a reasonable degree of certainty. Initially, if a sterilisation /

63 Granville Williams op.cit., p.106.
sterilisation operation were carried out in Britain to-day without consent it would be considered an unlawful mutilation constituting criminal assault. However, in a medical-surgical context, consent and medical necessity ordinarily operate as defences to the initial characterisation of the operation as an assault, presuming the object of, or the motivation for, the sterilisation is "lawful". The difficult issue lies as to the lawfulness of the surgery and the question is open to doubt as we have seen.

What then is a lawful purpose? Aside from the obiter dictum of Mr. Justice (as he then was) Denning in Bravery, supra, the caselaw in England and Scotland is barren of authority. As already stated, the issue of lawful purpose is intimately tied up with that of consent.

In a 1960 report, however, the Med. and Den. Defence Union of Scotland felt confident enough to state,

"...if a sterilisation operation were performed with the full consent of the patient by a responsible surgeon and if the reason for doing it was substantial and not obviously immoral by present-day standards, it is exceedingly improbable that the Court would hold the act to be criminal." 66

In /

In the same Report, the English Medical Defence Union went further and reached a similar opinion regarding non-therapeutic sterilisations. The opinion of junior and senior counsel was that such operations were not within the Offences against the Person Act, 1861, which requires by §18 and §20 that the wounding at issue be "unlawfully and maliciously" caused, but they did recognise that *Rex v. Donovan* cast a shadow of doubt over the issue if the purpose of the sterilisation were held to be "unlawful" or *mala in se*.  

Referring to this 1960 opinion, the Secretary of the English Medical Defence Union has recently stated, rather boldly,

"In view of this opinion we now have no hesitation in advising members of the medical profession in Britain that sterilisation carried out merely on the grounds of personal convenience, in other words as a convenient method of birth control, is a legitimate legal undertaking."

Whether such advice is justified in view of the unsettled present legal climate remains as yet for litigation to prove.

Lord Devlin in a 1960 address to doctors, seems to have accepted the opinion of the English Medical Defence Union that non-therapeutic voluntary sterilisation is lawful if proper consent is.

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68 It is questionable whether *Rex v. Donovan* would constitute assault in Scots law, although it might well have been a crime due to the element of indecency in the case. *Brit. Med.-J.* 1960, 2, 1516.

is given and the operation is performed for a purpose "not otherwise criminal". He also felt that if voluntary sterilisation was to be unlawful, it should be specifically so declared by statute; but that "the law should not try to catch it as a form of assault".

This latter observation by Lord Devlin raised what, in the eyes of many, is a major failing or mis-direction of the criminal law - namely, that it should feel compelled to treat surgical operations as *prima facie* assaults, to be justified only by the saving grace of consent or necessity. Such a viewpoint has been called "insulting, misleading and anachronistic", one fit for a "crude", earlier period of medical history when surgical procedures and precautions were not safe and satisfactory to the extent /

70 P. Devlin, *Samples of Lawmaking*. London: Oxford Univ. Press, 1962 (1960 Lloyd Roberts Lecture to Medical Society of London), p. 94; (the full statement of Sir Patrick, "I would suggest as a broad principle that an assault should not be treated as criminal if it is done: (a) for the purpose of averting danger to life or grave and immediate injury to health; or (b) with the consent of the other party and for a purpose which is not otherwise criminal.

Abortion, for example, is a crime in itself and so consent to it would remain irrelevant; the act would have to be justified under the first head. If it is thought that sterilisation, although done by consent should be prohibited except for grave medical reasons, then it should be made a crime in itself and the law should not try to catch it as a form of assault."

See also, Williams, (1962) *Crim.L.R.*, 154, 158.

71 Ibid.
extent they are to-day. The thrust of the law, it is argued, should consider bona fide medical procedures as desirable from the outset, with only certain deviations or practices being prima facie unlawful.

It is probably correct to say that surgical operations are treated by the criminal law as prima facie assaults in Scotland just as they are in England. However, some legal opinion sees the Scottish position as not being identical to the English. The 1960 Scottish Medical and Dental Defence Union opinion claimed the elements of "evil intent" and "attack" necessary to a criminal assault charge in Scotland are missing in the surgical operation context.

In any event, the generally negative approach to surgical practice by the criminal law has served to impede a clear understanding of the legality of controversial operations like sterilisation. In such a climate the lawyer can often only guess at results, caution, and leave the real risk of performing such operations up to the physicians. Such uncertain circumstances can only prompt the medical profession to avoid these operations.

Aside from problems due to the above approach of the criminal law /

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72 T.B. Smith, "Address", loc.cit.
73 Ibid.
75 1960 Brit.Med.J. 2,1516,1517 (The Opinion refers to Alison's Principles of the Crim.Law of Scotland, V.1, p.175 for support, which does not appear to be there).
76 Shartel & Plant, loc.cit.
law to surgical operations, others are created because of the moral overtones sterilisation has for most of Western society to-day. If, for instance, the practice were considered sufficiently "antisocial" by current standards in Scotland, the Supreme Criminal Court, according to one view, could exercise its declaratory power to characterise the operation as a new crime, the patient's consent notwithstanding. 77 The Scottish Medical and Defence Union suggest this might occur where voluntary sterilisation were performed on a prostitute in order to aid her in the plying of her trade. 78

While no such power exists in England in theory, it might well be cautioned that in practice, at least since 1961, 79 a very similar discretion exists in the House of Lords where the behaviour at issue has strong moral overtones.

Gordon has summed up the Scottish legal position in the following terms:

"Questions have been raised in England as to the legality of operations for sterilisation or castration, but the question has not arisen in Scotland. It is unlikely that the courts would to-day create new crimes of this kind, so that unless and until they are made illegal by statute, operations for sterilisation or castration will be treated in the same way as other surgical operations." 80

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80 Gordon, op. cit., p.775.
As to sterilisation this suggestion appears to be the wisest course. However, it is respectfully submitted that Dr. Gordon perhaps overgeneralizes by speaking of sterilisation and castration in the same terms. Whereas sterilisation has no debilitating physiological or sexual effects, castration has long been used historically to weaken the so-called resolve of enemies to fight (perhaps due to its psychological effect only).

Blackstone considered castration a maim, resulting in deprivation of that physical part which gives a man his courage and resolve to "fight for the king". Sir James Fitzjames Stephen concurs in this opinion in his Commentaries. Several fairly recent American cases have held the loss of even a single testicle to constitute a maim, and to be grounds for the criminal charge of mayhem.

Some authors believe that where castration is performed for a non-medical purpose, even with the consent of the subject it still amounts to mayhem. Under more modern statutes which have extended criminal liability /

81 Nova Woodside, op.cit., p.132-139, reports from sterilisation (eugenic) studies in No.Carolina, no general drop in libido, general health and vigor, or ability for orgasm, as a result of the operation.
83 4 Bl.Com., 205.
84 Stephen, Commentaries, Bk.IV,p.79.
85 Peo. v. Konke 376 Ill.171,33 N.E.2d 216(1941); Peo. v. Taylor 319 Ill.205,149 N.E.767(1925).
86 Miller & Jean loc.cit.
liability for mayhem to include the disabling of any member or organ, it is not unreasonable to even consider sterilisation as mayhem, though most opinion has dismissed this suggestion, the malicious element of the crime being absent.

It would appear then, that while the present-day extent of the crime of mayhem is unclear, it may well continue to apply to castration, but probably not to sterilisation. Consequently, distinction between the two is appropriate in any legal analysis of the consent question, for consent was traditionally not a defence at common law to a charge of mayhem.

2. The issue of civil liability

The potential civil liability involved - both to the physician performing a sterilisation and to the subject spouse submitting - appears likewise to be problematic in Britain, although perhaps to a lesser degree than the question of criminal liability.

As in American Tort Law, consent will negate the imposition of civil liability under English Tort Law or Scots Law of Delict. However /

89 Shartel & Plant, supra, p. 115.
90 See Minty, loc. cit.
91 Witness, Wright's case, Co.Litt 127a, 1 Hawk P.C. 108 (1604), where the accused was held guilty of mayhem for striking off the hand of a "lustie rogue" to enable him to beg more effectively, despite the request of the other; Perkins, Crime Law, Brooklyn: Foundation Press, Inc. 1957, p. 653; Glanville Williams, supra, pp. 102-3.
However, if the physician in Britain operates to sterilise a married person on non-therapeutic ground without the consent of the other spouse he may well lay himself open to a civil action for damages. The 1966 Annual Report of the English Medical Defence Union indicated such a course might constitute loss of consortium to the unconsenting spouse - notwithstanding the lack of authority for finding loss of consortium from an impediment not to intercourse, but merely to conception.\textsuperscript{94} The Report did, however, express the view that a voluntary sterilisation operation, if carried out with the patient's consent, is lawful and the consent valid.

Aside from the loss of consortium action, unilateral submission to sterilisation in Britain probably would afford the unconsenting spouse grounds for divorce by reason of "cruelty" - both in England and in Scotland\textsuperscript{95} - though the wife /

\textsuperscript{94} 1966 \textit{Solicitor's J.} 729.

wife may have a slightly easier time proving her case. It is interesting to note in this regard that the Royal Commission on Divorce Report (1956) thought the fact one party had been sterilised before marriage should not in itself be the basis for a decree of nullity.

96 Compare Fowler v. Fowler (1952) T.L.R. 143, wherein Lord J. Denning stated at pp. 147-148,

"Where one party takes contraceptive measures, or insists on them, against the will of the other, this is not itself cruelty. It only becomes cruelty when there is no reasonable excuse for it, and it is done out of a desire to inflict misery on the other... If a man takes contraceptive measures against the will of his wife... without reasonable excuse for so doing, then it is easy to infer that he does it with intent to inflict misery on her... But when a wife herself takes contraceptive measures, or asks her husband to take them, her conduct can often be attributed to fear of the consequences to herself, without any intention of injuring him. She fears the pains and risks of child-birth. This is very unnatural and unfortunate, but it is not cruelty unless she has also an intention to inflict misery on her husband."

It is interesting to note it was also Lord Denning in Bravery v. Bravery who opined that a husband's submission to sterilisation even with his wife's consent, might subsequently constitute cruelty as to her when she realised the full impact of the consent.

97 Criticised in Binney, op.cit., p.119.
E. THE COMPARATIVE POSITION

1. Canada

In Canada, voluntary sterilisation is allowed by statute in Alberta and British Columbia, but otherwise there is no direct Canadian authority on the legality of the practice. However, in the unreported Ontario Supreme Court case of Chivers & Chivers v. Weaver & McIntyre the question of valid consent was held to be the only issue of relevance in ruling on an assault action brought against several doctors for the performance of a voluntary sterilisation. The implication would seem to be, therefore, that the Court felt the operation itself was not unlawful if a valid consent existed.

Of course, the legality of therapeutic sterilisation is not questioned in Canada, although the operative procedure must be properly authorised beforehand or justified by an emergency condition requiring immediate treatment during other surgery.

A private Parents Information Bureau operates in Canada and arranges for vasectomies with co-operating doctors, apparently on the presumption there are no legal restraints on the practice. 250 men were sterilised under this programme in the first /

99 Ibid.
100 Murray v. McMurchy (1949) 2D.L.R. 442.
first six months of 1962 alone. 101

2. Germany

In Germany to-day there is no legal prohibition which threatens the surgical practice of voluntary sterilisation with criminal penalties. 102 Certain sterilisation laws passed during the Nazi period from 1933-1945 were abolished by the Allies after the War. 103 This post-war abolition repealed §226b of the Criminal Code, which had been used by the Nazis to punish unauthorised sterilisations, but made no mention of §226a, 104 which dealt with crimes against good morals ("Gute Sitten"), but fell into disuse during the Nazi period.

The famous Dr. Dohrn case 105 skirted the issue as to whether or not §226a has application to the practice of voluntary sterilisation. Dr. Akel Dohrn was alleged to have performed some 1,300 sterilisations on consenting women with sizable families in Germany between 1947 and 1961, but the indictment brought against him on grounds of criminal assault (see St.G.B. §224, 225) was limited to 149 cases. The lower court found Dr. Dohrn guilty in forty cases, finding the operations to be criminal assaults against "good morals", even where both husband and wife had freely consented. In the other

102 B.G.R. St. 20, 81; MW 1965, 355.
103 Gesetz II (Kontrollrat, 30/1/46).
104 Quoted in footnote 60, at p.30.
105 Cited, 102. Acknowledgement, E. Schanze of Frankfurt for research and translation assistance.
109 cases, only two of which were justified on strictly medical grounds, he was acquitted.

On appeal to the B.G.H., (Federal High-Court or "Bundesgerichtshof"), the issues were stated by the court to be (1) whether the women had legally consented to the sterilisations (all were sexually experienced, with at least four children), and (2) whether voluntary sterilisation was criminally punishable. In reversing the lower court conviction and acquitting Dr. Dohrn in all cases, the B.G.H., claimed it need not decide whether the "against good morals" test of §226a applied, as §226a had been superseded by §226b as regards sterilisations during the Nazi period and the latter had been abolished by the Allied Kontrollrat in 1946. As a result, the court stated, no criminal law provision in Germany covered voluntary sterilisation and if this gap were to be filled, it was for the legislature to accomplish.

There is feeling that §226a does indeed still apply to voluntary sterilisation, as to other corporal injuries, not having been specifically repealed by either the Nazis or the 1946 Kontrollrat, and that it should be judicially decided if voluntary sterilisation /
sterilisation is, in fact, criminal as an act against good morals. In the application of §226a, the German courts are said to look to the objective qualities of the act performed, not to the motivations of the actors. As a consequence, a morally good reason for consenting will not excuse the act at issue if it is felt, nonetheless, to offend common decency.

Schönke-Schröder, after comment on the Böhrn case, states the present law in Germany including §226a does not prohibit voluntary sterilisation on medical, medico-social or grave eugenic indications, but does condemn voluntary sterilisation for mere social, non-therapeutic reasons.

The Draft Penal Code (1962) seems to make, in more general terms, a broadly therapeutic definition the criterion to avoid criminal liability in all surgical procedures.

In a still more recent comment on voluntary sterilisation, a young German jurist has suggested that only proper consent to the

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108 Ibis.
109 "§161 Med.Treatment. Operations and other treatments which according to medical knowledge and experience and according to the principles of a scrupulous physician are necessary and are performed in order to prevent diagnose, cure or alleviate illness, suffering, body damage, physical complaints and psychic disturbance are not punishable as physical harm."
the operation should be a subject of the law, but that otherwise the state has no right to intrude upon the private freedom and conscience of an individual by attempting to control his decision to, or not to, procreate. 110

Relying largely on Article 6, §1 of the Grund Gesetz, Dr. Wulfhorst sees it as isolating the means of personal, family contraception from the reach of the State and regulation by law. The Sittengesetz requirement of Article 2, §1, G.G., means a practice may be prohibited if widely felt to be offensive to "simple morality", and as such he feels it cannot be used as a basis to prohibit voluntary sterilisation. 111 He concludes that the German Constitution protects voluntary sterilisation from prosecution, 112 it remaining for the courts to agree or disagree.

3. France

In France, the operation for voluntary sterilisation is a criminal offence, unless it can be clearly shown that it was carried out only to preserve the patient's life or health. 113 Otherwise, it is considered a substantial battery, "illicit and incompatible with human dignity", 114 which cannot be excused or justified /

111 Ibid., p.651.
112 Ibid., p.654.
113 G. Hughes, op.cit., p.242.
114 Green, op.cit., quoting from Lloyd, Public Policy, 1953, p.29.
Justified by the consent or request of the subject. Contrary to the Anglo-American common law's characterisation of consent as a defence to otherwise criminal-assaults, the French law considers consent as irrelevant and no excuse to criminal conduct of any kind. The justification for surgical operations must be sought in some legislative pronouncement of public policy.

A 1938 case in the criminal chamber of the Cour de Cassation convicted a physician under Article 309 of the Penal Code (relating generally to offences of battery and wounding) for the performance of a vasectomy.

4. Scandanavia

In Denmark, under a 1935 statute, voluntary sterilisation or compulsory sterilisation may be carried out on certain sexual offenders with an eye toward facilitating their early release, as is also the case in Norway under a 1931 Act.

Some 2,000 people are said to be sterilised a year in Denmark for medical, eugenic and social reasons. In Sweden, much the same situation exists, most permissions for voluntary sterilisation on eugenic, medical or social (i.e., incapable of burdens of additional childbirth and care) grounds being given by /

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115 Hughes, loc. cit.
116 Ibid.
117 See Chapter on Compulsory Sterilisation (McWhinnie).
118 Green, op. cit., p. 106.
by the Board of Health, but some by two concurring private physicians. 120

5. Japan

In Japan, under the Eugenic Protection Law of 1948 some 121
340,000 were sterilised in the first decade of its operation.
Besides medical and eugenic reasons, the Act allows for voluntary sterilisation when the mother's health might suffer adversely from another pregnancy because of poor living conditions or the simple anxiety of having more children. 122

6. India

In India, more than 2.3 million have been voluntarily sterilised since the country's Family Planning Programme began in 1951. 123 Prime Minister Mrs. Indira Gandhi has stated that "Family Planning...is at the base of our whole endeavor of national development" and has endorsed the goal of six million sterilisations by 1970-1971. 124 Sterilisation is largely a local matter of each of the fifteen states and safeguards attendant upon the procedure vary. In Maharashtra, for example, the spouse seeking voluntary sterilisation must have at least three children, one of whom is a male heir and be given time to consider his /

120 Ibid., pp.157-158.
121 Ibid., p.146.
124 Ibid.
his or her decision before it is acted upon. 125

7. South Africa

In South Africa there appears to be no legislation or case reports on the legality of voluntary sterilisation. Gordon, Turner and Price take quite a strong stand on this matter,

"It is often said that to sterilise a patient simply to prevent him or her from having children is, in the absence of definite clinical indication, an illegal act. It must be plainly and categorically stated that there is no modern legal authority for such a statement and it does not seem to be based on any definite rule of Roman-Dutch law." 126

On the basis of this authority it would appear the medical practitioner is left to prevailing professional ethics and his own conscience when performing non-therapeutic sterilisations, as he is in many other jurisdictions.

In its domestic relations aspects, Hahlo has suggested that unilateral submission to sterilisation by one spouse without consent of the other evidences an intent to end the normal marital relationship and as such a basis for divorce on grounds of constructive desertion. 127

A conflict of authority appears to exist between two divisions of the South African Supreme Court on the related point /

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point where sterility of one spouse, known only to him or her, existed before marriage. In *Venter v. Venter* (1949(4) S.A. 123(n), it was held that pre-marital sterility itself provided no ground for setting aside a marriage. In *van Niekerk v. van Niekerk* 1959(4) S.A. 658(G.W.), the court held (per Wessels, at 671),

"in Roman-Dutch law *impotencia procreandi* (whether or not it flowed from *impotentia coeundi*) was a ground for setting aside a marriage, and this is still our law to-day."

The proviso was added, however, (De Vos Hugo, J., at 675-676) that the rule should be confined to cases where the procreation of children is a clear object of the marriage and the woman is of child-bearing age. The cases can be distinguished, however, because *van Niekerk* involved fraud, concealment of sterility by the affected spouse, whereas *Venter* did not. Comment on the cases finds *Venter* to represent the proper Roman-Dutch law on the issue. 128

E. CONCLUSION

Aside from the legal uncertainties surrounding voluntary sterilisation, 129 & 130 there are other criticisms often voiced to /

to its practice. Several thoroughgoing psychiatric studies caution that careful advance consideration and thought is wise before submitting to a voluntary sterilisation, particularly in the case of women, as it is "impossible to prepare any schematic principles as indications for sterilisation" and the result may be undesirable in a substantial minority (c.10%) of cases.\(^{131}\)

Aside from undesirable mental effects on the person sterilised, if married, his or her spouse might be tempted to fear promiscuity due to the operation eliminating any fears of pregnancy. On the other hand, it may be that recent advances in birth control technique have largely negated this argument.

Though literature of the voluntary sterilisation of males is less profuse in the psychiatric area, it also indicates the operation may not always be helpful, or at least not harmless, to health and that in all cases a thorough psychiatric examination of the man and wife should be preliminarily undertaken.\(^{132}\)

Recently /

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Recently, an American doctor wrote that in his experience a voluntary sterilisation,

"...never is requested merely as a contraceptive measure. There are invariably deeper and usually unconscious reasons for the operation. These just as invariably require psychiatric evaluation." 133

This psychiatric opinion obviously represents but a segment of medical opinion. Dr. Blacker in England, long an advocate of voluntary sterilisation, suggests the operation be performed on any mother or father where contraception has proved impracticable or unreliable resulting in the birth of unwanted children, where the physical or mental health is liable to suffer or deteriorate from the birth of future offspring or where the living standards or well-being of existent children would suffer. 134

The traditional Christian view - proscribing all direct sterilisation - can be found in the encyclical of Pope Pius XI on "Christian Marriage": 135

"Christian teaching establishes...that private individuals have no other power over the members of their bodies than that which pertains to their natural ends; and they are not free to destroy or mutilate their members, or in any other way render themselves unfit for their natural functions, except when no other provision can be made for the good of the whole body."

The /

135 Casti Connubii, New York, 1931, p. 33.
The Church of England takes a basically similar stance on the issue.\textsuperscript{136}

From a philosophical-moral point of view, the question becomes under what circumstances the state is justified in circumscribing individual liberty by prohibiting voluntary sterilisation. It is certainly doubtful whether present population growth - in England or elsewhere - could justify the intervention of the criminal law to compel fertility by threat of sanctions on grounds of public policy or social need.\textsuperscript{137} However, if the state has a right or responsibility to maintain a certain standard of common morality through its use of the criminal law, then perhaps it is justified, once it determines voluntary sterilisation to be contrary to, or inconsistent with, the prevailing moral or social consensus, to prohibit its practice.\textsuperscript{138} On the other hand, perhaps the state has no moral right to enforce its conception of morality by the criminal law, absent a showing that the proscribed behaviour has a harmful effect on others in the society.\textsuperscript{139}

If this is the position to be taken, then it must be asked whether the voluntary nature of the sterilisations removes any danger.\textsuperscript{136}


\textsuperscript{137} Hughes, \textit{op. cit.}, p. 239.


\textsuperscript{139} Mill, \textit{On Liberty}. 
danger of the harms against whose occurrence society has an interest in protecting itself.

Considerable speculation has been raised in American circles since the Supreme Court decision in *Griswold v. Connecticut*, 381 U.S. 479, 14 L.ed. 2d 510, 85 S.Ct. 594 (1965). In *Griswold*, the Court struck down a Connecticut statute making it criminal to dispense information and instruction to married persons on contraception to prevent conception. The majority opinion by Mr. Justice Douglas held the petitioner's right of marital privacy to be protected against unwarranted governmental intrusion by a "penumbral" emanation from the basic Bill of Rights guarantees in the Constitution. The case is significant for its wide-ranging dicta, evidenced by Mr. Justice Goldberg's concurring opinion remarks at *Griswold*:

"...the intimacy of husband and wife is necessarily an accepted and essential feature of the institution of marriage, an institution which the state not only must follow, but which always and in every age it has fostered and protected. It is one thing when the State exerts its power either to forbid extra-marital sexuality...or to say who may marry, but it is quite another when, having acknowledged a marriage and the intimacies inherent in it, it undertakes to regulate by means of the criminal law the details of that intimacy."

Whether this decision indicates the Supreme Court may distinguish married from unmarried persons when ruling on birth control /

140 Joined by Chief Justice Warren and Justice Brennan.
control practices (and is not sterilisation one form of contraception?) is not, as yet, clear. It can now at least be argued, however, that sterilisation - being one form of birth control - cannot be prohibited by the state when it is the course decided upon and consented to by a married couple. 141

Perhaps the best conclusion regarding the legality of voluntary sterilisation is provided, strangely enough by an opinion of the Wisconsin Attorney General's Office, now more than thirty years old,

"Even if we assume that the scientific and sociological view should prevail, nevertheless, the law follows science, in some fields by perhaps a generation, for the law can reflect the advances of science only when they have been accepted by the people generally... The consequences to a physician from the performance of an operation of this kind should the courts hold it illegal could be serious. Until the law is settled, it is not prudent for a physician to perform a sterilisation operation, except within the ancient field of surgery, viz., when it is a therapeutic measure." 142

The opinion, undoubtedly thought conservative by many at the time, may have been too optimistic, for after several decades the law still is not settled and the physician is still secure - relatively - only when the sterilisation is performed for recognised "therapeutic" purposes.

In the final analysis, the balance will be struck at varying points /

141 See Footnotes 110-112 re same conclusion reached by the German author in N.J.W. 1967:649.
142 Holman, 156 J.A.M.A. 1310(1954).
points along the continuum from state control to individual freedom, depending on the existent system of religious, cultural and moral values in any given society. In practice, continued improvement in means of mechanical and chemical contraception, it is submitted, will very largely meet the need or desire for voluntary non-therapeutic sterilisation. But, in the limited number of cases where voluntary sterilisation will continue to be desired, a favourable legal climate is predictable in to-day's secular and impersonal world, barring the positive showing of harmful results to others in society as a consequence.
A. INTRODUCTION AND BACKGROUND

Compulsory sterilisation is an involuntary or unconsented to surgical operation in present times, rendering the patient or victim - depending on one's characterisation of the practice - sterile or incapable of procreation, though not incapable of coitus.

Castration, the predecessor of surgical sterilisation, was practiced in Biblical times and before by the Assyrians, Chinese, Hindus, Egyptians, Greeks, Persians and Romans for various reasons of security, punishment and control of captives, criminals or slaves. In Java, the Malay Peninsula, Australasia and the Amerindians, the aborigines have long practices excision of the sex glands for religious purposes.

De-sexing was introduced into England, primarily as a punitive measure for rapists, by the Normans. However, at common law, private acts of de-sexing were considered to constitute /

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1 The nature or quality of consent that is, or should be, necessary to constitute the operation as truly voluntary rather than involuntary in fact and practice is a difficult problem and will be discussed subsequently in this Chapter.
2 See explanation of surgical sterilisation in Chapter on Voluntary Sterilisation, p. 5.
3 Joseph Fletcher, op.cit., pp. 143-144.
4 Ibid.
constitute grave demembration. Seton of Pitmedden, expressing the Scottish position in the late seventeenth century, characterised the law dealing with castration in the following terms:

"Castratis virilium is one of the most atrocious demembrations; and when a man does it to himself, he is ali homicida. And so punishable with death and confiscation of Goods, And it's equivalent if one suffered himself willingly to be castrated by another." 5

Seton understandably does not mention surgical sterilisation, for it did not exist as a medical art in his day and is, in practical terms, a twentieth-century development. 6 Nonetheless, his learned remarks on mutilation seem just as applicable to sterilisation as mutilation in his words was

"Cessation and Privation of the Office, and distinct Operation of a Member, albeit no particle of it to be cut off." 7

Mackenzie felt that mutilation or the disabling of a member of the body was a capital crime, but Erskine takes exception, saying by Statute Rob.II, c.11, mutilation was to be punished by the same form of process to be used against a manslayer, but that the punishment was not to be capital.

In his American work, Professor Perkins supports Mackenzie's view with common law authority, stating that the early /

5 Supplement in Sir George Mackenzie, Laws and Customs of Scotland in Matters Criminal, 1699, p.16.
6 Fletcher, loc.cit.
7 Mackenzie, op.cit., p.6(supp).
8 Erskine's Institutes of the Law of Scotland, Book IV, Title IV, 1828, p.104+4(par.50).
early penalty for mayhem was mutilation, except in the case of castration, where the punishment was death. 9

Hume, in his Commentaries seems to concur with Erskine's discussion of the Statute Robert II. He states the statute had an intended in terrorem effect and that the record in fact showed not a single instance of a capital conviction for the offence of mutilation thereunder. Hume cited "scourging and banishment forth of Scotland" as the usual penalty. 10

There is no modern Scottish discussion of compulsory sterilisation and castration. However, Glaister has stated flatly that the only lawful sterilisation is therapeutic sterilisation, the consent of the patient notwithstanding. 11 Gordon, on the other hand, feels that, barring a statute, both consensual sterilisation and castration would be treated as any other surgical operation: lawful if

"recognized by the profession as appropriate and carried out in accordance with proper professional standards." 12

B. SOME THEOLOGICAL VIEWS

The contemporary German theologian, Haring, does not

merely /

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11 Glaister, loc.cit.
12 Gordon, op.cit., pp.774-75.
merely denounce the practice of compulsory sterilisation itself as wrong, but condemns participation in any such procedures by the judiciary and the medics as sinful. He states,

"More difficult is the case in which the law is not only unjust but actually demands that something sinful in itself be done. We have a sad instance in the laws of those states requiring sterilisation. Even worse would be a law demanding denial of the faith. No judge may co-operate in enforcing or applying these laws - particularly when the law requires the sterilisation of individuals who have never committed the slightest crime, but who are considered "unfit" for marriage or parenthood because of heritage or mental deficiency! What shall we say of the decision of the court which must determine that a certain individual is to be classified as "unfit"? Some writers are inclined to doubt the guilt of a judge who must apply the law by making a decision according to the terms of the law, always provided that he does all in his power to avoid "passing the sentence". However, it seems to me that the official who is primarily responsible for the actual procedure, the physician or other official who makes the "certification" that this innocent individual is fit "only to be a descendant", is guilty of formal co-operation in sin. The law in this instance is no defense, for it requires something unjust, something no one is permitted to do. Obviously, those who actually carry out the law and perform the operation are principals in the crime." 13

(From Chapter: "Sins against Love of Neighbour", subpart d, "Cooperation in Evil by Judges and Attorneys").

Reverend /

Reverend Fletcher pays scant attention to the question of the morality of compulsory sterilisation in his book, *Morals and Medicine.*

Professor Paul Ramsey of Princeton Theological Seminary has expressed the view in his contribution to a recent symposium on "Morals, Medicine and the Law" that, "not everyone simply by being, has the right to propagate". He does, however, temper this remark by questioning whether proper safeguards can be established by the law to insure that this type of philosophy does not become subject to "misuse" by "errant humanity".

Ramsey is apparently fearful that man, given the power by laws to deny certain members of society the right to propagate, is not capable of formulating satisfactory criteria for the exercise of such power; that inevitably, such a law would be incapable of fair, impartial administration.

In the same Symposium, Rabbi Emanuel Rackman indicates Judaism's general prohibition against sterilisation, subject to the requirement of self-preservation. Discussing state-sponsored eugenic sterilisation, he expresses similar doubts to /

to those of Professor Ramsey, saying,

"I dread the extension of the State's police power to include control of the procreative faculties of one person for the benefit of another". 17

C. THE AMERICAN POSITION

While the lawfulness of voluntary, non-therapeutic sterilisation is unclear in the United States in the absence of statute, there are twenty-six states with eugenic sterilisation laws, twenty-three of which are of a compulsory nature. All of the various laws designate feeble-minded or mentally retarded persons as within their ambit, all but two include the mentally ill, some fourteen include epileptics and twelve specifically include criminals - most on eugenic grounds, not on punitive grounds. 19

There are, however, two notable exceptions in the laws of California and Washington. California Penal Code §645 20 provides for sterilisation as a penalty for the crime of carnal abuse of a female under ten years old. Washington has a similar /

18 See Chapter on Voluntary Sterilisation.
20 "Whenever any person shall be adjudged guilty of carnal abuse of a female person under the age of ten years, the court may, in addition to such other punishment or confinement as may be imposed, direct an operation to be performed upon such person, for the prevention of procreation."

Cal.Penal Code §2670 also allows sterilisation of recidivists convicted at least twice of rape, assault with intent to commit rape or seduction, or certain other crimes and who show while inmates they are "moral or sexual degenerate or pervert".
similar statute. 21

Seventeen of the state laws apply only to the institutionalised, nine to both. Most of the twenty-three compulsory sterilisation statutes provide for notice, a hearing and judicial appeal, but six states still do not require a hearing and three make no provision for judicial appeal. 22 California makes provision for a formal hearing only if objection is filed by the patient, but it is the practice of the Department of Mental Health to authorise sterilisations only in cases where the inmate "consents" thereto. 23

A United States Doctor in Pennsylvania claimed to have performed the first sexual sterilisation to prevent procreation in 1889. In Indiana, 600-700 reform school boys were sterilised by Dr. Harry C. Sharp, who devised the vasectomy operation even before passage of the State's sterilisation Act in 1907. 24

In 1897 the first eugenic sterilisation bill was introduced into the Michigan legislature, but defeated. Pennsylvania passed a similar law in 1905, but it was vetoed in a strongly worded message by the governor. 25

In /

23 Calif.Dept. of Men's Health Policy and Operations Manual, §3520.2, "Sterilisation will not be authorised in any case unless the patient consents thereto".
24 Ferster, op.cit., p.592.
25 Ibid., p.593.
In 1907 the first sterilisation law was successfully enacted in Indiana and although subsequently declared unconstitutional, was the basis for other laws which by 1950 had accounted for the sterilisation of over 50,000 persons in America, 20,000 in California alone. By 1964 the cumulative total had reached 63,676. Of these persons, 27,917 were sterilised on grounds of mental illness, 32,374 on grounds of mental deficiency and some 2,387 on other grounds.

Notwithstanding these formidable figures, in recent years the practice of state-inspired sterilisations has come under increasing criticism. In 1963, the figure for California was seventeen sterilisations, Virginia stood second in the nation with thirty-nine, surpassed only by North Carolina with 240 sterilisations performed.

While it is unclear how much of this decrease is a response to outside, public or social pressure and how much is due to a change of belief of those actually administering the eugenic sterilisation laws, several factors may be suggested as accounting for the decrease in yearly sterilisations performed under statutory authority in the United States: a more humanitarian attitude /

26 Williams v. Smith, 190 Ind. 526, 131 N.E.2(1921).
27 Williams, The Sanctity of Life and the Criminal Law, p.84.
28 Verster, op.cit., p.632.
29 Ibid.
30 Ibid., p.633.
attitude toward the treatment of institutionalised patients, an increasing awareness of the limited state of man's understanding of human genetics and hereditary transmission, and partly as a result, an increasingly unclear and questionable legal basis and support, particularly under the American Constitution, for the practice of state compulsory sterilisation.

The legal decisions regarding sterilisation begin in 1912, shortly after enactment of the first United States statute by Indiana in 1907, and are reported as recently as 1966. (As early as 1872, however, the 8th Amendment's "cruel and unusual punishment" clause was held to have been enacted to prohibit, among other practices, castration. It should be noted also that of the twelve states with eugenic sterilisation laws specifically applicable to criminals, none authorises castration.) The early cases decided before 1925 struck down most of the statutes when they were challenged in the courts - not in basic principle, but largely for procedural /

31 quoted footnote 37.
33 15 Syra L.R. 739(1964).
34 State v. Filled 70 Wash. 65,126 Pac.75(1912), appears to be the only case before 1925 upholding a compulsory sterilisation law. Here it was applied to a man convicted of statutory rape and was held not to constitute cruel punishment.
procedural deficiencies which were held to deny "due process of law" to the persons involved.\(^{35}\) One notably different approach, however, which recently has been receiving some attention,\(^{36}\) was used by a lower federal court in *Mickle v. Henrichs*,\(^{37}\) wherein the state of Nevada was restrained from performing a compulsory sterilisation (vasectomy) on a convicted rapist and probable epileptic, the Court holding it to be a mutilation which constituted "cruel or unusual" punishment under the state constitution.\(^{38}\) The Court in *Mickle*\(^ {39}\) stated that,

"Vasectomy in itself is not cruel... but, when resorted to as a punishment, it is ignominious and degrading, and in that sense it is cruel".

Because the relevant state clause was in the disjunctive ("or") rather than in the conjunctive ("and"), as is the federal prohibition, the usual or unusualness of the punishment was not decisive on the result. However, in *Davis v. Berry*\(^ {40}\), the federal conjunctive prohibition was held to be in issue with the /

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\(^{35}\) As required by U.S.Constitution, amendment XIV (and most state constitutions), which asserts that no state can deny a person of "life, liberty, or property, without due process of law". This guarantee is essentially one of procedural fairness in the administration and application of government authority.


\(^{38}\) The state constitutional provision being derived from U.S.Constitution Amend. VIII: "Excessive bail shall not be required, nor excessive fines imposed, nor cruel and unusual punishment inflicted".

\(^{39}\) *Mickle v. Henrichs* at p.690.

\(^{40}\) *Davis v. Berry* 216 Fed.413 (S.D.Iowa 1914).
the state compulsory sterilisation statute which was applied punitively to recidivistic felons. The Court held,

"While it is true that there are differences between the two operations of castration and vasectomy, and while it is true that the effect upon the man would be different in several aspects, yet the fact remains that the purpose and the same shame and humiliation and degradation and mental torture are the same in one case as in the other. And our conclusion is that the infliction of this penalty is in violation of the Constitution, which provides that cruel and unusual punishment shall not be inflicted."

As applied to defectives and the insane for allegedly "eugenic" rather than punitive purposes, the courts have not regarded compulsory sterilisation as a cruel and unusual punishment.

Between 1925 and 1933 a rush of cases involving state sterilisation schemes - both eugenic and punitive in nature - came before the courts and were all upheld against various legal /

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42 Perhaps the use of these terms here should be defined: "eugenic" sterilisation meaning that performed to prevent the likelihood that some mental or physical defect, disorder or abnormality will be passed to future offspring by hereditary transmission or to prevent those already affected with such conditions from undertaking parenthood; "punitive" sterilisation meaning that performed for penal reasons, whatever they may be, as for retribution or punishment, or revenge, or deterrence (another penal purpose - that of reformation or rehabilitation of the offender - would appear to be more eugenic than penal in nature, but these fine distinctions are beyond the scope of this paper.)
legal attacks. Then, in 1933 the trend showed some sign of shifting and most of the decisions found dealing with compulsory sterilisation since that time have invalidated the laws and orders involved, thus casting considerable doubt on the continued legality of compulsory sterilisation in the United States. These cases all merit some discussion.

In 1925, the Michigan Supreme Court upheld the sterilisation of a sixteen year old feeble-minded girl, with the consent of her parents and after notice and a hearing had been provided. The Court reasoned as follows,

"There is no element of punishment involved in the sterilisation of feeble-minded persons. In this respect it is analogous to compulsory vaccination (an analogy to be soon after used by Mr. Chief Justice Holmes in the landmark U.S. Supreme Court case of Buck v. Bell, discussed infra.) Both are nonpunitive. It is therefore plainly apparent that the constitutional (state) inhibition against cruel and unusual punishment has no application to the surgical treatment of feeble-minded persons."

Mr. Justice Wiest filed a vigorous, thoroughgoing dissent in the case, stating bluntly,

"This act violates the Constitution, goes beyond the police power and is void...The bodies of citizens may not, under legislative mandate, be cut into, and the power or procreation destroyed by ligation or mutilation of glands or carving out of organs."

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The Smith case set the stage for the most well-known American case dealing with sterilisation, Buck v. Bell. In Buck, Mr. Chief Justice Holmes upheld a Virginia statute, under which Carrie Buck, an eighteen year old-feeble-minded girl who had shortly before given birth to a feeble-minded child and who herself was the daughter of a feeble-minded mother, was sterilised. The law was challenged on due process grounds, but weathered the attack by providing for notice and a hearing to the subject and by allowing for appeal to the courts. The Virginia statute was more carefully drawn than those earlier state laws which up to Buck v. Bell had been overturned on due process of law grounds.

The opinion in Buck was remarkably short considering its significance. It finished with the following comments,

"We have seen more than once that the public welfare may call upon the best citizens for their lives. It would be strange if it could not call upon those who already sap the strength of the state for these lesser sacrifices, often not felt to be such by those concerned, in order to prevent our being swamped with incompetence. It is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. The principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes. Jacobson v. Massachusetts, 197 U.S. 11, 25 S.Ct. 358. Three generations of imbeciles are enough." 45

Buck /

45 274 U.S. 200, at 207.
Buck has been criticised often, but never overruled. Mr. Chief Justice Holmes' analogy of compulsory sterilisation to military service is faulty, for the latter involves the country calling on its citizens not for their lives, but only to expose them to the risk of loss of life. In Jacobsen the court sustained a $5 fine for petitioner's refusal to accept compulsory vaccination, it did not order submission. Furthermore, vaccination has an uncontestedly beneficial effect on the subject and on the society, without depriving the former of any of his capabilities, contrary to compulsory sterilisation.

A number of state court decisions, following in the wake of Buck v. Bell, upheld various sterilisation (and at least one castration) statutes.

In State v. Schaffer, compulsory sterilisation of certain state institutionalised inmates was upheld against challenge on grounds it violated due process, was an excessive use of state police (legislative) power and was unfairly discriminatory.

In Davis v. Walton, the compulsory asexualisation (castration) of an "habitual sexual criminal" was upheld against charges it was /

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47 See annotation on "Asexualization or Sterilization of Criminals or Defectives" in 87 A.L.R. 242.
49 Davis v. Walton 74 Utah 80, 276 Pae 921(1929).
was cruel and unusual punishment or that it denied the convict "equal protection of the laws".\footnote{U.S. Constitution, amend. XIV, no state can deny any person "equal protection of the laws" (in their enactment, interpretation and enforcement).} \footnote{State v. Troutman, 50 Idaho 673, 299 P.2d 668(1931).} \footnote{State v. Troutman, 50 Idaho 673, 299 P.2d 668(1931).} State v. Troutman, held a compulsory sterilisation statute valid, stating that,

"...if there be any natural right for natively mental defectives to beget children, that right must give way to the police power of the state in protecting the common welfare, so far as it can be protected, against this hereditary type of feeble-mindedness."

The case of \footnote{He Clayton, 120 Neb. 680, 234 N.W. 630(1931).} He Clayton validated a statutory directive providing that certain feeble-minded and insane inmates or habitual criminals could not be discharged or paroled without first submitting to sterilisation.

Two years later, however, in \footnote{Brewer v. Valk, 204 N.C. 186, 167 S.E. 638(1933).} Brewer v. Valk, a statute providing for the sterilisation, at public cost, of any mental defective upon petition of his next of kin or legal guardian to specified state authorities was overturned, the court holding it an unconstitutional violation of due process of law for failing to provide the subject with proper notice and a full hearing in order to insure having his position fully and fairly heard. The decision did not question the legality per se of the state sterilisation of defectives, but rather limited itself to the inadequate /
inadequate procedural safeguards contained in the statute at issue in the case.

The Brewer case did, nevertheless, give ambitious eugenicists in the United States a renewed warning of the scrutiny with which the courts would examine compulsory sterilisation statutes. The year following saw publication of the well-known Brock Committee Report\textsuperscript{54} in England. The Report was critical of the limited American experience with compulsory sterilisation\textsuperscript{55} and in favour of statutory provision for voluntary sterilisation only.\textsuperscript{56} Two years later, a committee of the American Neurological Association, chaired by Dr. Abraham Myerson, came out with a similar recommendation that legislation be limited to voluntary sterilisation: careful application of such laws was suggested in certified cases of hereditary-linked diseases, such as schizophrenia, manic-depressive psychosis, feeble-mindedness and possibly epilepsy.\textsuperscript{57}

Not long after publication and discussion of these reports, the United States Supreme Court handed down its second and most recent opinion dealing with sterilisation. The case, \textit{Skinner v. Oklahoma}\textsuperscript{58}, reflects a considerable change in the

\textsuperscript{54} 1934 Cmd 4485.
\textsuperscript{55} \textit{Ibid.}, p.36.
\textsuperscript{56} \textit{Ibid.}, p.37.
\textsuperscript{57} Abraham Myerson, "Certain Medical and Legal Phases of Eugenic Sterilisation", \textit{52 Yale Law Journal} 618, 628-631(1943).
High Court's attitude from the position it had taken fifteen years earlier in *Buck v. Bell*, *supra*. *Skinner* challenged the Oklahoma law, which provided for compulsory sterilisation of "habitual" criminals, basing his attack on the equal protection of the laws clause of the United States Constitution. The statute at issue defined habitual criminals as those persons convicted two or more times of felonious crimes involving "moral turpitude". It then distinguished between larceny and embezzlement, including only the former in its classification as a crime involving the necessary "moral turpitude", though both crimes were very similar and both punished the same by state law. Mr. Justice Douglas, after opening his majority opinion with the highly appropriate phrase, "This case touches a sensitive and important area of human rights", went on to invalidate the contested Oklahoma law, relying on the Fourteenth Amendment's equal protection clause. He concluded,

"...strict scrutiny of the classification which a state makes in a sterilization law is essential, lest unwittingly or otherwise invidious discriminations are made against groups or types of individuals in violation of the constitutional guaranty of just and equal laws.

when the law lays an unequal hand on those who have committed intrinsically the same quality of offense and sterilizes one and not the other, it has made as invidious a discrimination as if it had selected a particular race or nationality for oppressive treatment." 59

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59 316 U.S. 535, at 541.
Mr. Justice Jackson, in a separate concurring opinion, chose to emphasize what may well have been the real, unstated foundation of the decision, namely that of bodily integrity and the limits of state-sponsored interference, with, or infringement of, that integrity. He stated succinctly,

"There are limits to the extent to which a legislatively represented majority may conduct biological experiments at the expense of the dignity and personality and natural powers of a minority - even those who have been guilty of what the majority define as a crime." 60

Just what effect *Skinner* has had on *Buck v. Bell* is unclear and unstated. No further hints have come from the United States Supreme Court, although state-sponsored sterilisations throughout the country have decreased in the interim. The two cases are not specifically at odds; *Skinner* struck down a compulsory sterilisation statute because it violated the equal protection clause of the Fourteenth Amendment, whereas *Buck* upheld a compulsory sterilisation statute which was contested only on due process grounds under the Fourteenth Amendment. Nonetheless, Mr. Justice Jackson's quoted concurring remarks hint at an alternative ground for invalidating such statutes - that of the cruel and unusual punishment clause. 62

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60 316 U.S. 535, at 546.
62 Quoted at footnote 38.
As noted, prior cases in the lower courts have split on the question, but the Supreme Court has recently shown some signs of giving this long-overlooked clause of the Constitution (eighth Amendment of the "Bill of Rights") new and wider scope.

Recent academic comment has also suggested that sterilisation is one form of punishment - at least in its punitive if not in its eugenic form - that might well soon be held to contravene protections against cruel and unusual punishment, because it may well in some cases at least be so degrading to the subject, "as virtually to deny the defendant's humanity.

Several recent American cases have suggested that a new justification, based on economic considerations, may be sought for:

63 Compare *Mickel v. Henrichs*, *supra*, p.6; with *State v. Bellen*, *supra*, footnote 60.
65 *79 Harvard L.R.* 635, 637 (1966). In *Trop v. Dulles*, 356 U.S. 86 (1958), the USSC indicated that the 8th Amendment required all punishment to be "within the limits of civilized standards", which the Court defined as those "evolving standards of decency that mark the progress of a maturing society". (31 *Albany L.R.* 97, 101 (1967). This definition of the "cruel and unusual punishment" clause is broad enough to cover sterilisations, which, while perhaps cruel, because of their wide-spread practice could not be considered also as unusual within the literal meaning of the 8th Amendment.

The state court in *Cannon v. State* 196 A 2d 399 (Del. 1963) refused to uphold a sentence imposing whipping, relying on the "cruel and unusual punishment" clause, which it stated was to be construed by 20th century concepts of severity of punishment.
for compulsory sterilisation laws in the future.

Two judges presiding over probate courts in Ohio have ordered sterilisations despite the absence of any sterilisation law in the state, expressing judicially that such action was warranted to reduce public welfare costs. Beginning with the most notable of their decisions, In re Simpson, these two judges have ordered the sterilisation of five mentally retarded females. At least one of the judges has indicated an intention to continue on with this practice. In re Simpson involved sterilisation of a young imbecile mother, the judge relying on his discretionary interim power at law and in equity to provide for the welfare of incompetents. The case has been severely criticised as an abuse of judicial discretion, but apparently has not been overruled.

In all three of the recent California cases there were no statutory provisions applicable or relied upon by the court, but nonetheless submission to sterilisation was ordered by the judge as a condition of probation. In the first case from Los Angeles County, Andrade v. So Pasadena Munic Court, the defendant decided upon probation after submission to sterilisation /

66 In re Simpson, 180 N.E. 2d 206 (Ohio Probate Court 1962).
67 Ferster, op.cit., p.607.
69 Ferster, op.cit., p.609.
sterilisation rather than a jail sentence when he pleaded guilty to a charge of non-support of his children. Subsequently he regretted his choice and began litigating. Andrada asked and was denied habeas corpus by the California Supreme Court. He asked the United States Supreme Court to review the case and decide if

"conditioning probation upon sterilisation constituted cruel and unusual punishment and violated procedural due process", 70

The Supreme Court denied certiorari, In re Andrada. 71 The trial judge involved has also indicated he will continue to favour such a practice in non-support cases. 72

In the next case, People v. Tania, 73 a couple convicted of welfare fraud were involved. They were offered a reduction of sentence contingent upon filing of a stipulation by counsel or a report from the Santa Barbara Co. Hospitals that the defendants had "voluntarily" submitted to the (sterilisation) operations. 74 The matter was not appealed. 75

Most recently, In the Matter of Hernandez, 76 was before the /

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70 Andrada v. So Pasadena Munic Court, 33 U.S.Law Week 327-8 (1965).
72 Feister, p.610.
73 People v. Tania, Record Case No.73313, Santa Barbara Superior Court, July 7, 1965.
74 Probation Order, People v. Tania, supra, August 30, 1965.
75 Feister, loc. cit.
76 In the Matter of Hernandez, No 76757 Santa Barbara Superior Court, June 8, 1966.
the California courts. Here again, a twenty-one year old girl was offered the "choice" between submission to sterilisation and immediate probation and a six months jail term, which was the maximum penalty for her offence of being in a room where narcotics were being unlawfully and knowingly used. The subject had two daughters - one illegitimate - on welfare. It was her first offence and her probation report recommended straight probation. The municipal court judge, however, added on the sterilisation requirement at the probation hearing without apparent reason.

On prompt writ of habeas corpus appeal to the Superior Court, the writ was granted, the sterilisation provision was stricken from the probation order the defendant was released to the custody of her probation officer. The Superior Court held the trial judge had no authority under any state statutes to impose sterilisation as a condition of probation and that in so doing he had abused and exceeded his judicial authority.77&78

In one final case the New York Times recently reported that an unwed mother convicted of incinerating her four day old son agreed to be sterilised on the judge's promise that he would reduce her sentence for murder if she did.79

All /

77 Ferster, Ibid.
78 The Times, June 9, 1966, p.10.
All of these cases indicate that the emphasis in compulsory sterilisation or pseudo-voluntary sterilisation cases may be shifting from a scientific basis grounded on genetics to one grounded simply on social and economic considerations. Iowa's statute is indicative of this trend, providing for sterilisation of any persons within the state who would procreate a child likely to "...become a social menace or (economic) ward of the state".80

It would seem that the statutory approach of Utah in this area is superior. Its recent statute provides for compulsory sterilisation of those "likely" to be incapable of assuming parental responsibilities and only in such cases where the operation would also "benefit" the subject.81 At least this approach, though vague, looks to the individual concerned and his welfare, not just to the potential economic burden the state will be saved by sterilisation of the subject.

Legally speaking, this seems to be the unsettled position that the decreasing practice of compulsory sterilisation finds itself in in the United States to-day. The morality of this situation and the outlook for the future will be discussed after we have had a comparative look at the practice of compulsory /

compulsory sterilisation in other jurisdictions of the world.

D. THE COMPARATIVE POSITION

1. Britain

There is no modern statutory reference in Britain regarding sterilisation - compulsory or voluntary - or its more severe counterpart, castration. The comprehensive Report of the Departmental Committee on Sterilisation is, however, well worth considering, though its recommendations have never been implemented by legislation. The Committee concluded voluntary sterilisation should be permitted by legislative safeguards in medical cases where recognised opinion thought it would advantage defective couples by removing the fear of procreating more of their kind, where it would allow certain institutionalised patients to be released, where it would prevent such hereditary defects as blindness, deaf-mutism, haemophilia and brachydactyly, shown to be transmissible and in other cases where family history gave reasonable ground for believing mental defects and disorders likely to be transmitted.

The Committee felt compulsory sterilisation would be an unwarranted intrusion upon personal integrity in the existing state.

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82 See the "Introduction and Background" text at pp. 56-58.
83 1934 Cmd. 4485.
84 Ibid., p. 30-41.
state of genetic knowledge and that it would tend to associate mental institutions with compulsory sterilisation rather than with humanitarian treatment. 85

Again, as recently as 1966, opinion in Britain has called for laws on the subject of voluntary sterilisation. 86

The Brock Committee Report stressed the importance of clear procedural safeguards if any legislation, even that dealing only with voluntary sterilisation of those in state institutions, was to be enacted. It feared, and rightly so, the unreality or de facto involuntary nature of many "consents" to sterilisation given in circumstances of confinement involving the mentally defective. 87 This is particularly so where reduction in detention period, parole or discharge is to be the result of submission to sterilisation. 88

It has, in fact, been questioned whether in any circumstances an institutionalised patient or prisoner is really capable of giving free, uncoerced consent. 89 It would appear clear that such circumstances, at least when the patient or prisoner is mentally defective or disordered, give rise to the objectionable

85 Ibid.
88 See footnote 78 and accompanying text (p. 77) as a recent example.
89 F.B. Smith, Address, loc. cit.
objectionable inference, in the words of Dr. John Marshall, that,

"one group of individuals is assuming the power to interfere with the bodily integrity of another group who are unable, by reason of their impaired facilities, to meet them on equal terms." 90

Glanville Williams has suggested a situation 91 - castration of a sexual psychopath who pleads for the measure to obtain relief from his uncontrollable abnormality - where he feels the voluntary nature of the procedure is clear. 92 In such circumstances, he is of the opinion that the English judges would not regard such a de-sexing operation as unlawful. He draws attention to the recent case of Cowburn 93 where the postulated circumstances did, in fact, exist. However, the Court of Criminal Appeal refused to give any assurance that such an operation would be lawful; Williams explains this result as forthcoming because the question was not properly in issue before the Court. 94

Such a questionable use of voluntary castration is exactly what the West German Ministry of Justice is hoping to enact in a newly-proposed bill. 95 The castration is to give convicted sex.

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90 Marshall, op. cit., p.73.
92 But as to its effectiveness, see note 145
93 The Times, May 12, 1959; 1959 The Lancet 1090.
sex criminals an alternative to incarceration. Despite Dr. Williams' observations, it is contested that a truly voluntary consent can be given in such a situation. 96

2. Denmark.

Similarly, in Denmark provision is made for voluntary as well as compulsory castration of sexual offenders and psychotics, but again where release is at least in part dependent on submission to such an operation, its true consensual or voluntary character is missing. 97 Under such laws, Denmark castrated some 600 men between 1929 and 1956. 98 The compulsory castration provisions of the 1935 Danish Act have never been used. 99

Even with the so-called voluntary castration of sexual offenders, less than ten cases occur annually at Herstedvester. 100 In early 1967 a bill was introduced into the Danish Parliament with the intent to "amend" the current law relating to compulsory sterilisation and castration by abolishing certain instances of compulsory sterilisation. 101

3. Holland.

There /
There is only one reported account in Dutch case law on compulsory sterilisation. The Rechtbank (court of first instance) at Roemond convicted a man with homosexual inclinations of a sexual crime (unspecified) and ordered him to submit to curative treatment for an indefinite period while retained in custody. The order, however, was made conditional on defendant's refusal to submit himself to castration. The court rejected the argument that such a serious intrusion into human life could only be warranted by express legislative authority, which did not in fact exist. There was no appeal from the case.

Learned comment has strongly criticised the decision, indicating that express statutory authorisation would have been indispensable for such an order; the preparedness of the patient at the time of trial for castration (as opposed to at the time of operation) being irrelevant.

4. Germany

Germany had compulsory sterilisation laws during the Nazi period from 1933 until 1945, but these laws were abolished by /

103 Acknowledgement to Mr. J. M. J. Chorus of Leiden and Edinburgh University.
by the Allies in 1946. It is interesting to note in this regard that the Nuremberg war trials condemned compulsory eugenic as well as punitive sterilizations carried out in Nazi Germany, but in many instances there was no true distinction in practice between the two. As a result of the abolition of these laws and in the absence of new legislation, the general prohibitions of the criminal law against corporal bodily injury and destruction of one's ability to procreate would prohibit compulsory sterilisation in West Germany to-day.

5. France

Carbonnier, discussing the French law of natural persons and the inviolability of their bodies, suggests that the state's interest may, in limited situations, warrant restriction of the exercise of individual free will over control of one's body. He mentions only the narrow examples of compulsory vaccination and arrest, giving no mention to sterilisation. Castration is made a felony by the French Penal Code.

6. Belgium

Under the Belgian law there is authority for the viewpoint.

107 Strafgesetzbuch §224-225.
108 Droit Civil, Vol.1, Title I(1957).
109 French Penal Code (Art.325).
viewpoint that sterilisation is only justified when it is performed for therapeutic purposes, "pour liberer le patient d'une affection physique grave". It would appear, therefore, that no legal provision is made for compulsory sterilisation in either Belgium or France.

7. India.

In India, perhaps the exigencies for compulsory sterilisation are most pressing, due to grinding poverty and a burgeoning population. The country's population now stands at about 500 million and is expected to treble in the next forty-six years (during which same period mainland China's population of 710 millions is expected "only" to double). India has considered compulsory sterilisation of couples with more than three children, but the prospect has now apparently been ruled out because it would violate the "conscience clause" of the Indian Constitution which insures religious freedom. However, voluntary sterilisations are carried out on a wide scale on both males and females, with government incentives ranging from a few rupees to transistor radios.

Again /

112 The Irish Times, Aug. 30, 1967, p.5. Indian Const., Clause 25(1) "subject to public order, morality and health and to the other provisions of this Part, all persons are equally entitled to freedom of conscience and the right freely to profess, practice and propagate religion". Sources conferred with by this writer indicate no basic elements of Hinduism would be violated by the imposition of compulsory sterilisation in India.
Again, under prevailing conditions of severe poverty and lack of education, do not such inducements make the voluntary characterisation of such sterilisations at least questionable? In any event, the decade ending September 1965, saw more than one million Indian citizens sterilised, sixty-eight of them male. 114 In May of 1965 alone, more than 57,000 Indians (eighty percent males) submitted to sterilisation and government ambitions run to much higher figures. 115 Apart from private clinics, there are over 3,000 hospitals and institutions and some 256 "mobile units" equipped for free voluntary sterilisations. By March 1967, at least 2.3 million such operations had been achieved. 116

8. Italy

In Catholic Italy the practice of sterilisation has been punishable as an offence under the Italian Criminal Code. 117 However, in April of this year the Minister of Health recommended abrogation of the offence; whether any positive legislative action has been taken on this proposal is not clear but does not appear to have been. 118

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114 Blacker & Jackson, loc. cit.
115 Ibid.
117 See N.Y. Herald Tribune, April 22-23, 1967, p. 3.

In South Africa there is no provision made for compulsory sterilisation. Recently, a candidate for parliament there advocated the compulsory castration of sexual offenders after their second conviction, but his proposal did not receive sympathetic or favourable press coverage and he was soundly defeated in his election bid partly because of it.

There is, finally, no mention in the Quebec Civil Code of sterilisation and, perhaps indicative of the esteem in which the Louisiana Civil Code holds the subject, it is there discussed only in relation to the castration of bulls.

E. THE PROPRIETY AND MORALITY OF COMPULSORY STERILISATION AND CASTRATION.

1. Eugenic

Sir Francis Galton defined Eugenics:

"...as the study of agencies under social control which impair or improve the racial qualities of future generations." 121

Assuming, for the moment, that man has the right to legislate for the improvement of his race or stock by the use of /


120 Mr. D. Carey Miller. (There is So. African authority to the effect that voluntary sterilisation is not illegal by any definite rule of Roman-Dutch law, Gordon, Turner, and Price, Med. Jurisprudence, p. 68. See Chapter on Voluntary Sterilisation for further discussion and So. African authority on the issue of sterilisation as a ground for marriage dissolution).

121 Albany L.J. 97(1967).
of compulsory sterilisation, genetic science has "advanced" to the stage to-day when it is no longer possible to determine those "manifestly unfit" to procreate because of the assurance they will transmit serious mental, physical or behavioural defect or abnormality. In the words of one physician,

"we have made just enough progress in the field of genetics to realize how little we do know and how vast is the uncharted area". 123

At the same time, it is probably true enough that,

"controversial as may be the extent to which mental defectives and certain categories of psychotics contribute to the annual budget of crime, it is beyond doubt that their contribution and that of their offspring considerably exceed the average rate." 124

Dr. Abraham Myerson, one of the leading authorities in the field, has stated that most so-called subjects for eugenic sterilisation belong rather in the unexplored areas of psychiatric understanding, not at the hands of such an "incipient" science as genetics. 125

Genetically, it has been learned that nearly all serious, common

122 Chief Justice Holmes in 
124 Mannheim, Criminal Justice and Social Reconstruction.
125 Myerson, loc.cit.
common hereditary ills - instantly, feeble-mindedness, blindness and the like - are carried by recessive as well as multiple genes, with the result that the person showing no sign of disease or defect may transmit it and he who himself is affected may produce normal offspring. The end result is, for example, that the majority of feeble-minded children are the product of normal, healthy parentage. 126

Such facts have made it clear that compulsory sterilisation of all sufferers of mental defect or abnormality - regardless of its shown hereditary transmission more often than not - would have only a limited effect on the total incidence of inherited mental defects in the community. 127 Furthermore, estimates indicate that sterilisation of all institutionalised mental patients would only make it possible for the release of between three and five per cent 128 while at the same time hindering the cause for voluntary institutionalisation by making such confinement at times synonymous with compulsory sterilisation. 129

These /

126 Williams, The Sanctity of Life and the Criminal Law, p. 86, (indicating some sources put this estimate as high as 89%).
127 According to Carr-Saunders, a fairly substantial reduction in congenital mental deficiency could be expected "in a century or so" through use of sterilisation; Professor J. B. S. Haldane has said the sterilisation of all mental defectives would only cut down their general incidence by 10% in the next generation and in some categories no noticeable effect could be expected before 30 or more generations. Mannheim, on cit., p. 32.
129 1934 Cad 4485. Not so under such acts as the Mental Health (Scotland) Act 1960.
These considerations notwithstanding, it can still be argued that a "slow rate of progress" is better than none when, for example, mental defectives or haemophiliacs are involved. The issue in these types of cases becomes one of whether a desirable but "slow rate" of progress in eliminating the incidence of these conditions justifies the personal invasion of bodily integrity that unquestionably is also involved?

One eugenic argument for compulsory sterilisation not affected by present lack of genetic understanding is that the feeble-minded are not capable of rearing healthy offspring endowed to them and that society and they themselves would benefit by preventing the bad effects of children being reared in such unhealthy or undesirable environments. Glanville Williams considers this argument alone strong enough to justify eugenic sterilisation, though only in cases which he considers to be voluntary. Taking issue with Professor Williams, another author has cited authority for the proposition that the feeble-minded just as often make good parents as do "normal" parents. Williams does, however, recognise the de facto compulsory /

130 Mannheim, loc. cit.
131 Williams op. cit., pp. 86-89.
compulsory nature of sterilisation when offered the inmate as a condition of release, but nonetheless considers this choice between continued institutionalisation and freedom with loss of the right to procreate as the only realistic alternative available in these circumstances.\textsuperscript{133}

Catholic dogma is in disagreement with this position. It considers confinement and supervision the less drastic and only moral way to deal with the problem of defectives, whether eugenic sterilisation is sought to be carried out only pursuant to the individual by the state.\textsuperscript{134} The right to restrict personal freedom when necessary for protection of the individual concerned or of the state is acknowledged, but it is said not to include interference with the bodily integrity of the subject by mutilation of the physical, God-given ability to procreate.\textsuperscript{135}

The Reverend Joseph Hassett, S.J., raises an interesting point in an article, saying that,

"no person has the moral right to procreate unless he can assume his subsequent obligations with reasonable care." \textsuperscript{136}
Does this mean a defective, copulating by little other than blind urge, is immoral if his undirected physical urges result in the procreation of offspring he cannot care for? Query whether the defective or mentally disordered has the necessary mental capacity to act immorally? Reverend Hassett uses the statement to support his view that the state may properly confine certain defectives, when necessary to protect them or society from harm.

Episcopalian Reverend Joseph Fletcher takes issue with the Catholic distinction between confinement and sterilisation, arguing that both, in fact, involve loss of the individual's right to procreate - the former, often, by less humane means. He states, 137

"The argument that all people regardless of their stature as persons, have a natural-law right to their procreative faculties and that we may not rightfully take them away, is just as fully circumvented by segregation as by sterilisation...There is no difference between compulsory sterilisation and compulsory segregation. The latter quite effectively takes away sexual freedom and destroys procreation."

That institutionalisation constitutes de facto sterilisation for most subjects is probably true. It is not, however, an irreversible situation, as is sterilisation in many instances. Nonetheless, there is something to be said in /

137 Fletcher, op.cit., p.168.
in favour of Reverend Fletcher's viewpoint in that institutional confinement is a gross interference with mental and physical freedom and integrity, while in cases where sterilisation would warrant release only the latter invasion of physical integrity occurs, but only for the benefit of personal freedom from confinement.

Since the field of eugenics is severely limited by man's lack of genetic understanding, it would appear that society can well afford to wait for a time before legislating against what may be its own potential. One only has to look at a previously proposed eugenic sterilisation statute in the United States to confirm that there is at least some truth in this /

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138 One of the most recent developments to come to light in man's slowly progressing fight to understand human genetics and heredity concerns studies carried out by Dr. Patricia Jacobs (1965) and Drs. Price and Whatmore (1967) in Britain and by Dr. Mary Telfer in America (1968) attempting to relate male chromosomal abnormality (xxy or xyy) and predisposition to criminal behaviour. These studies, thus far, "appear to confirm British observations that gross chromosomal errors contribute, in small but consistent numbers, to the pool of anti-social, aggressive males who are mentally ill and who become institutionalized for criminal behaviour." They do not comment on hereditary transmission of such chromosomal abnormalities (see 159 Science 1249 (March 15, 1968), The Times, March 19, 1968 and March 24, 1968 and Price and Whatmore, "Behaviour Disorders and Pattern of Crime amongst xyy males identified at a Maximum Security Hospital", Carstairs, Scotland, a paper, 1967).
The case against sterilisation of the insane then is that there is no urgent social problem that will be solved by it, and at present the scientific basis for it is too much in controversy to warrant acknowledging even here so formidable a power in the state. This is not to say that some day the scientific predictions may not be so high as to outweigh the invasions of /

139 Ferster, op.cit., p.618; quoted from Laughlin, Eugenical Sterilisation in the United States, 446-447(1922).
of personal dignity involved. It is to say that they do not yet. We can afford to wait."

Finally, it is the author's opinion that if Buck v. Bell were to come before the United States Supreme Court tomorrow for decision, it would be overruled, or at least not cited and followed as good authority, by the High Court.

2. Punitive

Compulsory sterilisation and castration continue as punitive measures in some countries though clearly on a very limited or reduced basis. In the United States, more recent statutes providing for compulsory sterilisation have been careful to avoid any reference to the criminality of the subject, due to the Supreme Court's decision in Skinner v. Oklahoma, supra, and because of increasing cognizance of the potential effect of constitutional guarantees - both state and federal - against cruel and unusual punishments. As a result, when compulsion is used it is invariably for avowedly "eugenic" purposes.

Repeated sex offenders are those most commonly proposed as suitable subjects for compulsory sterilisation or castration. And, somewhat surprisingly, the practice has been supported as ethically sound when employed by society to restrain the convicted /

141 McWhinnie, loc.cit.
142 See text at pp.73-74 (footnotes 62-65).
143 Kalven, loc.cit.
convicted rapist from procreating. Contrary to oft-stated opinion, neither sterilisation nor castration insures that the rapist or sexual psychopath will no longer be motivated to commit further sexual offences. Either operation merely removes the sometimes complicating factor of resultant pre-pregnancy in such instances by inducing sterility in the actor, no more. In any event, such operative procedures are attempted physical solutions to a problem basically mental and psychological. The cause of, and answer to, the sexual psychopath's abnormal urges lie in his cranian, not in his scrotum. Castration, like sterilisation, insures neither a reduction in libido nor in sexual act capability. The only certainty of the operation is that its effects are "very variable."

F. /

144 Fletcher, op. cit., pp. 169-171.
145 William F. Ganong, M.D., Med. Physiology. Blackwell Scientific Publications, Oxford & Edinburgh, 1967, pp. 190-191. See also Jamieson and Kay, Surgical Physiology. Edinburgh: E. & S., Livingstone, Ltd., 1965, p. 735, where the authors state that, "Castration after puberty is followed by atrophy of the seminal vesicles and prostate, but not of the penis. The extragenital sex characteristics, having developed at normal puberty, do not regress. Sterility is invariable, but desire may persist. Impotence is therefore not invariable, but is common as a result of the psychological disturbance; it could probably be avoided in most cases by sympathetic discussion before operation."

F. CONCLUSION

Compulsory sterilisation and castration will exist - blatantly and in their cloaked "voluntary" forms - so long as any given society prefers the invasion of bodily integrity and dignity entailed (at least when not undertaken freely) to the added social burden and responsibility of confinement and care of those thought to be "unfit" to procreate. In man's present state of knowledge, it is submitted that such treatment of any individual is only medically and morally justified when carried out pursuant to his free, uncoerced request, once the full implications of the operation have been brought home to him or to those private persons closest to him and responsible for his welfare. As one eminent name in this field has concluded, 147

"There should be no castration; neither of sexual offenders, nor of other categories, neither on a compulsory nor even on a voluntary basis, unless on strictly medical grounds. Moreover, sterilisation should be on a voluntary basis only. It should have no penal character whatsoever; therefore, it should not be applied to lawbreakers as such and should, in particular, not be made a condition of their discharge from a penal institution, great as the temptation may sometimes be to do so."

In the final analysis, the question is one of the degree to which a particular society is willing to go in insuring and respecting /

147 Mannheim, op.cit., p.34.
respecting the human dignity and bodily integrity of a certain, less fortunate minority within its midst. In a free society, the question of who is 'fit' to be a parent should not have to be asked. Emphasis should rather be placed on socialisation, treatment and supervision of individuals who are sexually, mentally or physically defective or disordered, not on sterilisation and castration so as to make it possible to "turn them out" into society again with minimum bother or compassion on the reasoning that they cannot reproduce their kind or that they have been rendered docile and 'harmless' thanks to the scalpel. As several British commentators have recently observed, 148

"The too ready use of castration could hinder the development of other methods, such as hormone treatment, psychotherapy or institutional regimes. In this country research, and not legislation, is needed..."

There surely must come a point, to which medical advances have perhaps already brought us, where society - represented by a legislative majority - no longer has the right to use its knowledge to manipulate and mutilate the bodies of those it feels somehow do not fit the desired social mould.

We know pitifully little about the Mendelian transmission of criminality, mental defectiveness and abnormality and physical /

physical defectiveness. In such circumstances, who is to judge with any certainty those unfit to procreate. What are the criteria? Who can qualify as an expert? Based on such an insecure foundation, can any compulsory sterilisation law insure against arbitrary and abusive interpretation and implementation at the hands of "errant humanity"? This danger is too high a price to pay, for,

"...the time has come to question just how far we can safely go in the process of bending the nature of Man for the sake of social comfort and convenience. We need the natural product - warts and all." 149
TRANSSEXUALISM:

PROBLEMS OF SEX DETERMINATION AND ALTERATION.

A. INTRODUCTORY MEDICAL ASPECTS

Transsexualism,¹ sometimes called eunism, is a little understood term. Medical comment is sparse, and there is little more than an inconclusive smattering of legal comment on transsexualism.

What does this infrequently heard term mean? Transsexualism has been called a "split between the psychological and the morphological sex...";² "a female personality in a male body".³ The individual concerned, in most cases a male,⁴ has an intense, usually obsessive desire for a complete sexual transformation.

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¹ The term seems to have been coined by Dr. Harry Benjamin of the United States. His works on the subject include, "Transsexualism and Transvestism As Psychosomatic and Somato-Psychic Syndromes"; 8 American Journal of Psychotherapy 219(1954), "Clinical Aspects of Transsexualism in the Male and Female", 18 Amer. J. of Psy. 458(1964), and The Transsexual Phenomenon. N.Y.: The Julian Press, Inc., 1966.


⁴ Barr and Hobbs, "Chromosomal Sex in Transvestites", 1954 The Lancet 1109; One commentator indicates the male to female ratio is about 3.7 to 1 (603M to 162F cases). Pauly, "Male Psycho-sexual Inversion: Transsexualism", 13 Arch. Gen. Psychiatry 172,179(1965).
transformation; physically, mentally, legally and socially.\(^5\) Contrary to the transvestite, who merely desires to, and is gratified by, "enacting" the woman's role by dressing himself in women's clothes, the transsexual wants to "be" a woman, to "function" like a woman, and to be "accepted" as one; dressing as one is only one means to this end.\(^6\) Some authorities feel, however, that the urge of the transsexual male to be "all woman" is normally, in fact, the result of a rather shallow and distorted view of what a woman is really like socially, sexually, anatomically and emotionally.\(^7\)

The male transsexual has the feeling of "being in reality a woman",\(^8\) whom nature by some cruel mistake has burdened and embarrassed with male genitalia. As a result, his visible sex organs are objects of disgust and deformity. Consequently, he "only lives for the day when his hated sex organs can be removed".\(^9\) So long as they live with these male organs, transsexuals are miserable, morbidly longing for the "conversion" surgery they think will make them look as they really should.

If /

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6 Benjamin, 8 Amer. J. of Psy. 219,220(1954).
8 Hamburger and Sturup, op.cit., pp.391-392.
9 Benjamin, loc.cit.
If such conversion surgery is not readily available, which is normally the case due to the many legal dangers attendant to the operation(s),\textsuperscript{10} the transsexual may well attempt self-castration, other mutilations and even suicide, or fall into a reactive psychosis.\textsuperscript{11} Such self abuse is apparently not at all rare.\textsuperscript{12}

The so-called "conversion" surgery sought so obsessively by true transsexuals actually consists of several operative procedures. Normally, however, they are advised only after psychiatric and hormonal treatment of the patient has failed.\textsuperscript{13} While the problem is not physiological, but psychological - psychosexual, there appear to be no satisfactory curative methods currently at the disposal of psychiatry; it is felt that the transsexual's "mind cannot be adjusted to (accept) the body".\textsuperscript{14}

If psychiatric and hormonal treatment is ruled out as ineffectual, or prescribed along with surgery, the operation may /

\textsuperscript{10} Of 100 cases reviewed by Pauly, 48 were successful in obtaining some alteration of sexual anatomy; 42 were surgically castrated, 30 obtained penectomy and 20 an artificial vagina. Pauly, op.cit., p.176.

\textsuperscript{11} Bamberger and Sturup, loc.cit.; Benjamin, op.cit.,p.229.

\textsuperscript{12} Ibid.; In discussing a selection of 100 reported cases involving transsexuals, Pauly reports that 6 performed auto-castration, 3 amputated their penises and 9 attempted self-mutilation. Pauly, op.cit., p.176. See, for example, the discussion of a Swiss case in 1963 Excerpta Criminologica 81066, at footnote 67.

\textsuperscript{13} Hamburger and Sturup, loc.cit.

\textsuperscript{14} Ibid.

\textsuperscript{15} Benjamin, 18 Amer. J. of Psy. 458,468(1964).
may—barring legal complications—be carried out. It involves castration, castration, perhaps formation of the scrotum into female, labia-like folds by plastic surgery, and even may include formation of an artificial vagina by inlay grafting.

Once the surgery has been performed it is far from a foregone conclusion that the patient's problems and anxieties will be solved. That "conversion surgery" will bring relief to the patient is true, that it will bring lasting relief is quite another matter. The subject's feminisation cravings may continue and meet tragic frustration in the realisation that he or "she" cannot acquire child-bearing ability, but has accomplished only a change in the secondary sex characteristics. Some patients demand the implantation of ovaries or "uteri, thinking they can thus become capable of pregnancy. "There seems to be an endless pursuit of a goal which is clearly impossible." 18

Even informed enthusiasts of "conversion" surgery concede such.

16 Sometimes, in young transsexuals, the sexual motive for the operation to include creation of a vagina may be quite strong. The transsexual may well be attracted to normal heterosexual men and perhaps even to promiscuity. Benjamin, The Transsexual Phenomenon, pp.113-114.
17 Benjamin, 8 Amer. J. of Psy. 226.
18 Pauly, op. cit., p.178.
such a realisation on the patient's part as the possible "tragedy and the pitfall" of such a gamble. After all, conversion surgery produces only a eunuch, not a woman. It is not a "conversion" of sex, but only an "alteration".

Transsexualism is to be distinguished from another, more mild sexual deviation with which it is sometimes confused: transvestism. The two are not synonymous. Whereas all transsexuals are transvestites, few of the latter are...

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19 Ibid., to the present, no full long range studies have been undertaken to ascertain post-operative patient adjustment. In one sampling of 48 patients who had undergone "conversion" surgery of varying degrees, 20 felt themselves definitely improved, 6 definitely not, 11 were equivocal and there was no follow-up data on the other 11. Pauly, op.cit., p.177; Worden and March, op.cit., p.1298. Pauly refers to cases where resort to prostitution and serious depression have followed "conversion" surgery as indications that claims of "success" for the practice are sometimes over-stated. Ibid., p.178.
are the former. The more mildly disturbed transvestite has no desire for conversion surgery. For him, his sexual organs are a source of satisfaction, not disgust and hatred. He is normally heterosexual, more often than not engages in relatively normal marital sex and seeks his devotional outlet merely by dressing in women's under and/or over garments. His problem is largely one of social and legal understanding, as will be mentioned, not of obsessional urge for full acceptance as a woman. He, contrary to the transsexual recognises himself as a man, or woman, whichever is consistent with his sex organs and secondary sex characteristics.

The transsexual will have homosexual inclinations, but not consider them as such because he feels himself to be "in reality a woman" and consequently such desires, if in fact they exist, will be interpreted as quite natural and consistent with his true sexuality.

The incidence of transsexualism, while difficult to estimate, is clearly very low. Hamburger, et al., have reported knowledge of a mere five actual cases in all of Denmark, five such cases and their treatment are reported from:

21 Hamburger and Sturup, loc.cit.
from Sweden, at least several have been reported in Britain in the past decade or two, and Dr. Benjamin, reporting on forty-four cases of "conversion" surgery, estimates there are no more than several hundred transsexuals in the United States.

The most publicised transsexual case was probably that of Christine Jorgensen, a young man who went to Denmark shortly after 1950 and eventually succeeded in undergoing "conversion" surgery for "change-of-sex". A thorough report of his case has been published by his attending physician, who operated only after insuring freedom from legal liability.

The transsexual may, and in most instances will, differ from the hermaphrodite or intersexual, who is possessed of bisexual organ characteristics. Normally, the transsexual will be of a unitary sexual phenotype and karyotype: few if any male transsexuals have been found to possess a female chromosomal constitution. The hermaphrodite, on the other hand, will always have a contradictory sexual constitution. Klebs first classified hermaphroditism in 1876 into three basic /

22 Benjamin, L8 Amer. J. of Psy. 469.
24 Benjamin, loc.cit. See footnote 12 where Pauly discusses 100 reported cases.
25 Hamburger and Sturup, loc.cit.
26 Hanueii, loc.cit.; Worden and Marsh, loc.cit.; Anonymous v. Weiner, supra.
three basic categories: (1) 'True hermaphroditism', where there are both testicular and ovarian elements in the gonads (one gonad may be a testes, the other an ovary); (2) male pseudohermaphroditism, where there are testes, but an otherwise more or less feminized status; and (3) female pseudohermaphroditism, where there are ovaries, but an otherwise virilized status. Whereas the transsexual may be considered as raising the problem of bringing the individual's mind into harmony with his body, the intersexual or hermaphrodite raises the problem of bringing the individual's body - by surgical alteration - into harmony with his "rightful" sex.

The hermaphrodite may pose severe problems of sexual determination, from a medical - not to mention just yet a legal - point of view. The problem is basically one of determining biologic sex, whereas with the transsexual the influence of psychologic sex on evident biologic sex must be assessed. The problem is alleviated somewhat by general agreement that there exists only two biologic sexes - male and female - and two genders - masculine and feminine.

The

The evidence for biologic (intersexuality) or psychologic (transsexualism) bisexuality is seen not to contradict this basic assumption, but rather only to show that there are within the two sexes many degrees of maleness and femaleness and of masculinity and femininity. 29

Sexual determination is complicated by the existence of no less than eight recognised criteria of sex: chromosomal sex, gonadal sex, sex hormone pattern, internal sex organs, genital sex, *habitus*, assigned sex and sex role. 30 The first two of these criteria are normally thought to be crucial in determining ultimate gender identity. 31

Some acquaintance with these criteria of sex is essential to appreciate the complexities involved in ruling on the "proper" or "rightful" sex of an individual. The *sex chromosome* constitution (karyotype) of a person is detected by use of the sex chromatin test. It is established at conception when the female egg or ovum (*x*) is fertilised by the male sperm (*x* or *y*). The *xx* female chromosome match can be seen as a dark mass in the nuclei of certain body cells, such as the skin or lining of the mouth, whereas the male /

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31 Stoller, *loc.cit.*
male xy cannot. Because of unusual chromosome matches or mosaicism, such as xo, xxy, yxy or even xy/xx/xyy, the sex chromatin test may not be dispositive.

Even if sex chromosome constitution is determined, it must still be decided how decisive this is on the determination of "rightful" sex. The y chromosome is generally considered to exist only in a male, regardless of the number of x chromosomes that may accompany it in the cellular nuclei. As such, the y chromosome is probably the most important sex determinant and is possibly the carrier of strong testes-promoting genes. Notwithstanding this fact, there are reports of male pseudohermaphroditism (bilateral testicularity), yet the presence of a normal female karyotype without the presence of the male y chromosome. And, contrariwise, cases of 'true hermaphroditism' with apparently normal xx (female) chromosome patterns are reported without satisfactory explanation.

In /

32 Moore, Sex Determination, Sexual Differentiation and Intersex Development, 97 Canad. Med. Ass. J. 292 (1967);
33 Moore, op. cit., p. 294.
34 Moore, op. cit., p. 293.
35 Cleveland & Chang, Male Pseudohermaphroditism with Female Chromosomal Constitution, 36 Pediatrics 892, 896 (1965), (male genitalia were constructed and the surgeons stated no assurances about the development of appropriate secondary sex characteristics at puberty).
36 Bishop, op. cit., p. 1262.
In light of this knowledge, it has been suggested that chromosomal sex cannot be considered dispositive and that various intersexual conditions are produced by a number of variable circumstances and mechanisms: chromosomal, genetic, endocrinal, body configurational, psychologic and environmental. The answer remains to be found.

In the normal situation, gonadal sex, which refers to the reproductive sex glands evident, will be consistent with chromosomal sex (i.e. ovaries in xx; testes in xy). In those rare instances where both ovaries and testes develop in the same person, he will be hermaphroditic.

The sex hormone pattern refers to the male hormones produced by the testes which result in masculine gender characteristics and female hormones produced by the ovaries which result in feminine gender characteristics. These hormones can be produced in abnormal amount. The testes can under produce male hormones, resulting in feminisation. In the female, the ovaries or the adrenals may have the opposite effect.

The

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38 Moore, *op.cit.*, p. 294; Worden and Marsh, *loc.cit.*, make the following remarks in regard to transsexualism in particular, "These psychological findings make it difficult to conceive of this condition as the result of any single causative factor, be it psychological, physiological, endocrinal or chromosomal. Further research is necessary to determine the relative significance of these possible contributing factors."


40 See footnote 27 at page 107 and accompanying text.

The female pseudohermaphrodite is the result of androgen influence on the foetus, whereas the male pseudohermaphrodite is due to resistance of the tissue to normally circulating androgens.

The internal sex organs other than the gonads may prove to be inconsistent with other criteria of sex, again posing difficulties in correct sex determination. The male and female internal organs are sexless or "undeclared" for the first three months of in utero existence. If, thereafter, development of the foetus is abnormal, either or both kinds of internal sex organs may develop in an otherwise sexually destined individual. A male pseudohermaphrodite, for example, may have female breasts, external genitalia and a blunt-end or pouchet vagina, yet at the same time possess no more than rudimentary internal female organs such as the uterus, fallopian tubes or ovaries. He will, however, have a male karyotype and testes.

Genital sex is the character of the external sex organs or genitalia. It is not invariably reliable as a determinant of /

42 Bishop, loc. cit.
43 Moore, op. cit.; pp.107-108.
of proper sex. It may agree, or disagree, with most other criteria of sex.

The **habit**us or secondary sex characteristics of the individual comprise his bodily form and appearance (phenotype). The individual's **habit**us will normally agree with assigned sex or sex of rearing, for the latter is almost inevitably assigned at birth based on the appearance of the external genitalia.

**Sex role**, the final of the eight recognised criteria of sex, is always inconsistent with genetic sex and normally inconsistent with chromosomal sex in the case of the transsexual. The intangible, psychological factors of habit, like and dislike and the psychosexual makeup of the person constitute sex role. It is this criterion that is probably predominant in causing the conflict of the transsexual. How medical science comes to judge this criterion will perhaps in large measure determine the attitude which the law will take towards the transsexual and his surgeon.

B. LEGAL ASPECTS

1. Britain

In Britain to-day - both in Scotland and England - one can /

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can find case and comment alike dealing with transsexualism in some of its various ramifications. There is, however, no legislative or judicial authority respecting the legality of the operative procedures involved themselves, nor of the legal liability to which a physician performing such operations might expose himself.

Hamburger and Sturup report that two of their British transvestite - transsexual patients have informed them of "understanding" treatment at the hands of the British authorities in question, to the extent of having "legally registered" the patients as women despite the presence of normal male genitals.

a) England

In England, "conversion" surgery is reported to have been performed on one Robert/Roberta Cowell in 1953 without legal incident. The reporter concluded that the procedure would be considered legitimate there "in some exceptional cases". This guarded conclusion may be true, but still there is no dispositive authority. It is respectfully submitted that Dr. G. Williams is skating on very thin ice when he states simply /

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46 Lukianowicz, loc.cit.
simply,

"Even the so-called change-of-sex operation has not been thought of as raising legal problems, although it involves surgical interference with the genital organs." 48

It would seem that one need only look at the treatment accorded surgical operations by the Common Law as prima facie criminal assaults to doubt Dr. Williams' rather bold statement. 49 The law on voluntary sterilisation is far from clear in Britain, so one hesitates to accept his conclusion as to the much more drastic demembration involved in the change-of-sex operation.

Two reported English cases deal with problems closely allied to transsexualism, but neither appears directly in point. In B v. B, 50 the husband for a number of years was granted annulment from his wife, with whom he was unable to accomplish consummation by normal penetration. His wife, apparently an hermaphrodite, had undergone surgery for creation of an artificial vagina to facilitate consummation, but it still proved impossible. The legality of the surgery was not discussed.

In a more recent case, T v. T, the husband was granted a divorce /

49 See relevant discussion in Chapter on Voluntary Sterilisation.
divorce in an undefended action. He alleged his wife refused normal sexual relations and dressed and acted as a man, all to the known detriment of her husband's health and the viability of the marriage. The husband was granted a divorce on grounds of cruelty, it appearing the wife was a transvestite (not a more severe, usually male, transsexual). The settlement of the legality of the "conversion" operation in England must wait for the appropriate test case. It is unlikely that a problem of such infrequent incidence and dealing with sexual matters, which legislatures are notorious for circumventing rather than meeting head on, will be clarified or solved by statute. It is at least arguable, that if the patient truly consents to the surgery and it is considered sound, professional, therapeutic treatment by practicing physicians in the community, that the prima facie assault characterisation of the operation(s) will be overcome by consent and good motive, necessity or some other legal defence acceptable to the court. The concurrence of medical opinion on this matter may attribute a greater faith among practicing physicians and surgeons towards psychiatric opinion than in fact exists. But without it, the "therapeutic" justification for /

for such a controversial, distasteful to many, operation would undoubtedly fail and criminal (and perhaps civil) liability would follow as the performing surgeon's fate.

Finally, it is well to remember, that barring the showing of a recognised therapeutic indication for the "conversion" surgery, the consent of the patient would almost surely be held invalid, the operation being a severe and "unlawful" physical invasion and deemed harmful to the ill-fated transsexual.

b) Scotland

In Scotland, as in England, there is little relevant material. Stair mentions hermaphroditism only incidentally while discussing the validity of marriage, characterising it as a condition, "where the one sex doth not eminently predominate". The only early commentator on Scots Law who mentions the problem of sex classification is Forbes, who in his 'little known and not very authoritative' text states,

"The Sex is Male, or Female, or an Hermaphrodite, i.e. both Male and Female, which is esteemed to be of that Sex, which is most Prevailing in the Person." 55

As mentioned earlier, the hermaphrodite is often not

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53 Institutes, I, 4, 6.
a transsexual. Forbes apparently relied on Justiman's Digest for his statement of Scots Law, which ascribed the more beneficial sex of male to those of doubtful sexual identity at birth. The issue of "true hermaphroditism" has been considered in modern times in Scotland. This issue arose in an unreported case decided by a single judge which involved an individual originally (at birth) registered as a female, but whose sexual identity had been subsequently ordered changed to male in "The Register of Corrected Entries". Later it became necessary because of third party interests to seek judicial determination of this individual's sex. The judge was referred to a number of old authorities, none of which were in point on the question of how to determine sex. Sanchez, in De Sancto Matrimonii Sacramentum Disputationum (Disputatio CVI, p.380), had suggested that in cases of "true hermaphroditism", where male and female characteristics were equally existent in the person, 'he' should be able to make a final and irrevocable choice as to preferred sexual status. Rejecting such a suggestion and following civilian thought in this area, the judge concluded that persons born are either male or female, but added, "This /

56 D.l.5.9; T.B.Smith, loc.cit.
57 See Smith, Short Commentary, p.250.
"This is not self evident, since...it might plausibly be argued that a true hermaphrodite was actually of both sexes and therefore legally of neither. Alternatively, the law might theoretically recognise a third category of hermaphrodites - neither male nor female. These solutions law and public policy, must reject in present conditions and allocate all persons to either the male or female sex." 58

The judge called upon medical evidence, which suggested four fundamental criteria of sex: chromosomal, gonadal, apparent or phenotypical and psychological. The individual concerned allegedly possessed the normal female chromosome constitution (46 xx), testicular as well as ovarian tissue, predominantly female appearing (though predominantly male functioning) genitalia and generally male psychosexual attitudes.

After weighing these medical considerations, the judge concluded that though the party involved was a so-called 'true hermaphrodite', male characteristics prevailed and he should thus be allocated to the male sex.

There is one reported Scottish case dealing with an alleged transsexual, X Petitioner59. It involved a petition brought under §63 of the Registration of Births, Deaths and Marriages (Scotland) Act of 1854 requesting alteration of petitioner's name and sex as it appeared on the Register, from male to female. X was the father of two, but was separated from /

58 This conclusion would seem to be in conformity with prevailing medical opinion on this issue; namely, that there are only two sexes (male-female) and only two genders (masculine-feminine), but that there are many degrees of each. See Stoller, loc. cit., at footnote 28, p.107.
59 1957 S.L.T. 61(Sh.Ct.).
from his wife, his feminine characteristics having caused a breakdown of the marriage. While raised as a male, he had long since been a transvestite, had developed feminine breasts and had atrophied male genitalia. At the time the petition was brought he was an Infirmary patient where he was quite happy to act like a woman. The petition was denied, being interpreted to allow only changes of entries originally entered incorrectly, not incorrect because of alleged changes in sex subsequent to registry at birth.

If for no other reason than the infrequency of judicial pronouncement in this area, the Sheriff's words are worth quoting. He concluded,

"The doctors are careful to stress that this is not a case of hermaphrodisim, but is a genuine case of the very rare condition of transsexualism and that the changes which have taken place are quite irreversible. For the present purpose, I, of course, accept that diagnosis. It is, however, stated that skin and blood tests still show X's basic sex to be a male and that the changes have not yet reached the deepest level of sex determination. It seems to be accordingly that while X could be described as an abnormal male, it would not be possible to describe him as a female."

X Petitioner, who had registered a change of name to a female form in the Books of Council of Session, was also permitted by the British Medical Association to appear by this name.

60 at p.62.
name on their register of qualified medical practitioners. Judicial sanction was, however, not needed or sought for this action.

In discussing the case, Professor Smith has expressed the possibility that if medical expert opinion of sufficient repute supported a petitioner's claim that sex really had changed, the Court of Session might by declarator recognise such a change of sexual status. At present, it appears unlikely. Such a change in sex might be supported by expert medical opinion, either because sex had been originally misappraised or because an individual without clear-cut gender identity (hermaphroditic gender identity) had made the relatively easier "shift" from one side of the sexual identity line to the other. None of the eight earlier mentioned criteria of sex are absolutely dispositive of the issue, and due to their predominantly physiological nature, it is difficult to imagine a "change" of sex so convincing as to gain "unquestionable" medical support. However, medical science may yet discover a single criterion, dispositive of "true" sexual identity. (It might also be asked at this point whether or not the law should define a dispositive /

62 See generally, Stoller, op.cit., but especially p.456; also, see the medical sources cited supra dealing with hermaphroditism, which contain case history examples.
dispositive criterion of sex?)

While the Scottish supreme court in civil matters, the Court of Session, might so declare such a change of sexual status, to the satisfaction and relief of a petitioning transsexual, is it not also possible that the Scottish supreme court in criminal matters, the High Court of Justiciary, could use its declaratory power to define new crimes to hold the performance of a "conversion" surgery as a criminal action? The fact that both these courts are composed of the same men lessens the thrust of this query. Still, the arguably indecent or criminal aspects of the severe demembration involved in such desmasculinising surgery could well persuade and prevailing standards of decency, the patient's consent and psychosexual craving for the operation notwithstanding. Professor Smith seems to feel the performance of "conversion" surgery on psychiatric indication alone

"could rarely be justified by our law - if the organs were healthy and their removal would only contribute to psychological adjustment." 63

However, it should be borne in mind that the physician, operating under bona fide standards and credentials in Scotland, is given a very wide discretion by the law, as enforced /

enforced. As Dr. Gordon has put it,

"In practice, however, there is a very wide umbrella which covers all surgical operations performed by recognised doctors in accordance with accepted medical procedures...
The only exception in practice to the protection afforded to surgical operations is where the operation itself is illegal and the only example of such an operation which has so far been considered by the common law is abortion." 64

And so, as in England, the legal position of the transsexual in Scotland vis-à-vis his right to change his sexual status and of the physician vis-à-vis his liability for performance of a "conversion" operation remains clouded and unsettled.

2. Denmark and Sweden

Britain aside, how has the problem of transsexualism been legally treated or received in other countries of Europe? Christine Jorgensen underwent his "conversion" surgery in Denmark. This was perhaps fortunate from a legal point of view, as Denmark, along with Norway and Sweden, allow for voluntary castration of patients whose sexuality makes them a danger to society or when it causes considerable mental disturbance or social deterioration. 65 Holland and certain parts of Switzerland have similar such laws. Normally, in these countries the operation is performed, while above-board, only /

65 Hamburger and Sturup, loc.cit.
only on resident citizens. This is to prevent influx from elsewhere to obtain treatment. 66

Notwithstanding these provisions, application was made to the Danish Ministry of Justice for permission to perform a surgical castration in the case of Mr. Jorgensen. After consideration by the Medico-Legal Council, permission to operate was granted. 67 A year subsequently, upon the continuing obsessive wish of the patient for removal of his male member also, the operation was performed. But this was only

"after it had been established that no legal complications would follow the operation as planned". 68

Some accommodation is also made in Denmark and Sweden for transvestites to dress in public as women without legal harassment, but this is apparently only in "extremely rare cases". 69

In Sweden, "conversion" surgery is apparently carried out in certain cases without legal complication. One doctor in the country reported that in carefully selected cases such surgery was indicated, referring to five such operations recently performed. 70 Similarly in France there are recent reports of two /

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66 Benjamin, *The Transsexual Phenomenon*, p.120.
68 *Ibid.*. This was easier to ascertain in light of the legislation re castration operative in Denmark (i.e. Danish Sterilisation and Castration Act of 1935).
70 Benjamin, 18 *Am. J. Psy.* 469.
two cases of transsexualism involving surgical treatment.\footnote{71}

3. Germany

Germany has had some experience with the transsexual's problems. In 1943 a man of 35 is reported to have undergone "conversion" surgery (castration and peotony) and six months later to have been satisfied with his life as a woman.\footnote{72}

More recently, the Hamburg journal \textit{Polizei} carried an article on the "Rechtsprobleme der Intersexualitat". It discussed the decision of a Berlin court which denied a change of sex status. The court was of the opinion, similar to that expressed by the Sheriff in \textit{X Petitioner}, supra, that the basic legal detriment of sex was the individual's natural, physical condition at the time of his birth, not any subsequent changes that may occur in that condition due to behaviour patterns, medication or operative procedures.\footnote{73}

A Berlin (K.G., Kammergericht) case\footnote{74} and a similar case from the Oberlandesgericht in Frankfurt\footnote{75} form the modern German judicial authority on the legal aspects of sex alteration operations. There are no decisions of the BGH or Constitutional.

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\begin{itemize}
\item \footnote{72} Huelbe, "Ein Tranvestit: Der Fall Heinrich B.", \textit{Kriminalisik} 3: 91(1949), cited in Hamburger and Sturup, \textit{ibid.}, p.395.
\item \footnote{73} 1967 (July-August) \textit{Excerpta Criminologica} (1099).
\item \footnote{74} \textit{Natl.} 1963, 1084.
\item \footnote{75} \textit{Natl.} 1966, 407.
\end{itemize}
Constitutional Court in point. Both of these lower court cases came to the conclusion that alteration of sex by surgical removal of the secondary sexual organs will not be accepted by the court, either as a basis for altering a passport (Berlin) or to avoid possible prosecution for homosexuality (Frankfurt). There is no absolute ruling in the two cases on the legal implications of "conversion" or sex alteration surgery; the courts limited themselves to the facts at issue. In the Frankfurt case, petitioner seeking recognition of his artificial sex operation was a well-known male prostitute who wanted to rid himself of the danger of criminal prosecution by formal recognition of his status as female.

The two cases are criticised in a recent article authored by a lawyer and a physician. The authors come to the conclusion that, (1) transsexualism is very rare, (2) it is not reversible even by modern hormonal and other treatment, (3) transsexuals tend toward self-demonstration and suicide, (4) the medical ("conversion") operation is, in such circumstances, often the only way to help the individual, and (5) this fact should be realised by the law, rather than denying the importance.

Acknowledgement to E. Schanze of Frankfurt for the necessary research and information.

importance of sex change operations in the law of persons, except in cases of hermaphroditism, as these two earlier-noted decisions apparently do.  

In Hamburg, it has been recently noted, the police department issues a special card to local transvestites, based on a physician's certificate. The card does not give them permission to cross-dress as they do, but merely states the bearer is known to the department as a transvestite. This is apparently enough to absolve them from any suspicion of criminal intent due to their "dressing" and, therefore, from arrest.

4. Switzerland

In 1963, the Schweizische Medizinische Wochenschrift carried an article on "change of sex by surgical operation and subsequent legal recognition of the feminine status of a transvestist". The case was one of "genuine 'constitutional' transvestism based on psychic and psychosexual (pseudo) hermaphroditism". Dr. Benjamin would undoubtedly consider such a severe case of "constitutional" transvestism to be transsexualism, because, of the deep mental conflict of the individual /

78 Ibid.; E. Schanze, loc. cit.
79 Benjamin, The Transsexual Phenomenon, p. 140.
80 1963 Excerpta criminologica 430 (81066).
81 Ibid.
individual described, who in this case resorted to self-mutilation (amputatio penis) due to the characteristic hatred and disgust engendered by his external genitalia. Benjamin dislikes the use of the term "transvestite" to describe all these severely abnormal psychosexuals as it merely names the complex emotional and behavioral disturbance involved after only one of its symptoms — that of dressing in clothes of the other (normally female) sex. The use of the term also clouds the distinctions which exist between the simple transvestite — whose emotional cravings are largely appeased by such unorthodox dressing habits — the more emotionally disturbed who require psychologic guidance and probably endocrine therapy and the yet more deeply disturbed transsexual with his obsessive desire for "conversion" surgery due to the repugnant belief that he is a "woman in a man's body".

In this Swiss case, the subject was initially married and the father of one son. Subsequent to his self-mutilation, operative castration was carried out. Furthermore, after having obtained a divorce, the patient succeeded in having his genitals operatively assimilated to the female, presumably meaning the creation of an artificial vagina by inlay grafting and plastic surgery. As an ultimate result, contrary to the earlier /

82 Benjamin, 6 Am J. Psy. 219.
83 Benjamin, 18 Am J. Psy. 459.
earlier discussed Scottish and German cases, the patient was able to have his newly-acquired female status sanctioned by a court of law.

All these rather remarkable changes apparently improved the patient's psychic and social condition over a ten year period, which prompted a commentator to state that,

"there appears to be some ethical justification for such unconventional methods of 'treatment', and consequently for their use by a doctor". 84

5. Canada

In Canada, while there is no specific legal authority dealing with "conversion" surgery as a therapeutic measure, as is true in most countries (because the law has not foreseen the need or purpose of such operations), it has been suggested 85 that §45 of the Criminal Code of Canada should govern the situation. §45 reads as follows,

"Everyone is protected from criminal responsibility for performing a surgical operation upon any person for the benefit of that person if:
(a) the operation is performed with reasonable care and skill, and
(b) it is reasonable to perform the operation, having regard to the state of health of the person at the time the operation is performed and to all the circumstances of the case."

The commentator further suggests that a distinction be made /

84 1963 Excerpta criminologica, loc.cit.
85 Edwards, loc.cit.
made between those who suffer "only" from psychological sexual abnormality - sex deviates and transvestites - and those who suffer also from anatomical abnormality - intersexes and hermaphrodites. Presumably, under this formulation, the transsexual will be placed into the former category, or perhaps fall into a "no-man's-land" in-between. Those in the former category would be outside the scope of admissible surgical help under §45, whereas those in the latter could have their sexual organs repaired or changed to achieve what medicine feels is their "rightful" sex. This, of course, presumes medical science is capable of reaching a consensus on just what determines an individual's "rightful" sex.

The author goes on to state that "conversion" surgery is generally regarded as illegal by the Canadian medical profession, but feels that where the mental and psychological pressure on the sex deviate is so great as to put him on the verge of self-mutilation or suicide (as often is the case with transsexuals), then "conversion" surgery should be treated as legal within §45 as carried out "for the benefit" of the patient, assuming the necessary medical-psychiatric certification and the patient's written consent were obtained prior to surgery.

86 Ibid., p.125.
87 Ibid., p.126.
88 Ibid.
In the United States, a paradoxical legal climate towards transsexualism and attendant "conversion" surgery prevails, "for, in the strict sense of the word, there are no laws concerning either transvestism or the various medical aspects concerned with sex transformation. But this fact in no way prevents or nullifies the popular conception that everything connected with this subject is illegal in this country." 89

While fear of prosecution under the various mayhem statutes exists, there appear to have been no such actions brought.

Regardless of such popular feeling concerning the illegality of "conversion" surgical techniques, a number of such surgeries are, in fact, carried out and are increasing. This is undoubtedly because of the flexibility and selective enforcement of many United States laws dealing with sexual matters. 90

While this author has been able to find but one American judicial authority 91 dealing with one problem - that of registration - raised by transsexualism, there is indirect evidence of other concern both by the courts 92 and by various public, governmental administrative agencies 93 with the subject.

For example, Dr. Harry Benjamin, reporting on the performance /

90 Bowman and Engle, op.cit., p.308.
92 Benjamin, 18 Am. J.Psy. 466-467.
93 Bowman and Engle, loc.cit.
performance of forty-four "conversion" operations, noted that twelve of the subjects had since been married, some divorced and one granted a legal child adoption.94

Two other practitioners from the west coast of the United States report on several interesting cases involving transsexuals.95 In one, a man underwent "conversion" surgery in Mexico and subsequently filed a petition for change of his name and civil status in a California court, which denied the petition. In another California case a similar petition was granted. However, the facts were unusual in that petitioner's birth certificate had been made out in the name of "Baby S..." and bore no given name. Furthermore, the county recorder was willing to register the new name and stated sex, so resort was made unnecessary to the courts. In still another case, the individual was apparently able to obtain a change in name, though no action was taken by the court with reference to change of the person's sex registration. Finally, the authors mention an individual granted a United States passport in his female role and characterisation, once his physician had written to the proper government authorities recommending such action.96

95 Bowman & Engle, loc.cit.
96 Ibid.
A rather daring judicial case is that of a Baltimore, Maryland court in 1965. The judge issued a court order to have a sex change operation performed on a seventeen year old transsexual boy and relieved the surgeon of criminal liability therefor. This action followed repeated delinquency by the boy (i.e., stealing wigs for personal use) and application by his parents, the probation officer concerned and a noted Johns Hopkins University psychologist for the operation.

Despite these cases, from most of which a formal judicial ruling was absent, the imprecise application of certain broadly drafted United States laws to these very personal problems looms. For instance, the transvestite's desire to wear and often appear publicly in women's attire is not expressly prohibited by local law, yet it is not unreasonable to suggest that any such behaviour - at least by men, as women are commonly accepted attired in masculine clothing - could be declared illegal and punished under most "disorderly conduct", "impersonating", "creating a public nuisance" or "disturbing the peace" local statutes.

An example of the type of law that can be, and is in fact, used /

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98 Sherwin, loc.cit.
used against transvestite behavior is New York Code of Criminal Procedure §888(7), a statute that was passed more than 100 years ago before any thought existed of applying it to transvestites and transsexuals.99 The law prohibits a person from appearing with his face

"painted, discolored or covered or concealed or being otherwise disguised in a manner calculated to prevent his being identified."

Its original purpose was to prevent farmers from masquerading as Indians and attacking law officers who were trying to enforce an unpopular rent law. In its present application to transvestites, §887(7) has been attacked as an unconstitutional deprivation of due process of law, but so far the United States Supreme Court has refused to review the matter.

Similar reasoning is present with respect to "conversion" surgery. No laws specifically prohibit this type of operation, done in good faith by a physician with his patient's consent. Nevertheless, it has been opined,100

"...there is hardly a district attorney in the country who would not inform a doctor that it would be illegal for the doctor to perform such an operation."

However, it should be noted that there may well be considerable divergence between what a district attorney warns against

100 Sherwin, pp.243-244.
against as illegal and what he in fact would actually prosecute as such. While little used "mayhem" statutes might be stretched to apply, the case reports of Dr. Benjamin and others already mentioned would indicate such is not the prevailing practice in the United States today. While the threat of prosecution is restrictive, it is clearly not prohibitive where the surgeon feels sufficient medical necessity exists. Nonetheless, it is probably true that most surgeons would not approve of the "conversion" operation for fear of criticism, while others - who may be willing - cannot get permission from their hospital boards. As a result, the patient's chief obstacle is where to go for help. He may resort to medical sources outside America and undertake a trip to Europe - in recent years, to Casablanca - for treatment. But this may well be beyond his means. The patient can expect to spend about $3,000 in fees and three to four weeks in hospital on such a trip.

The only recent American judicial pronouncement on registration matters incident to transsexualism does not improve this rather bleak picture to advocates of more lenient legal /

102 Ibid.
103 Benjamin, The Transsexual Phenomenon, p.129.
legal treatment and greater recognition of transsexuals. As reported, petitioner sought a change in status of sex on his birth certificate. Petitioner had apparently been able to undergo "conversion" surgery and assume the name and role of a woman in society without legal restriction. The New York City Board of Health had referred the question of whether it should grant such a change of sex registration to the New York Academy of Medicine. The Academy report decided not to follow the lead of the ten states which had permitted similar registration changes. It stated that "male-to-female transsexuals are still chromosomally males while ostensibly females," apparently considering the chromosomal criterion of sex dispositive. The Academy questioned whether it was the wisest course to cater to the transsexual's needs by granting him a female's legal status. It stated, "It is questionable whether laws and records such as the birth certificate should be changed and thereby used as a means to help psychologically ill persons in their social adaptation. . . . The desire of concealment of a change of sex by the transsexual is out-weighed by the public interest for protection against fraud. . . . Sex can be changed where there is an error of course, but not when there is a later attempt to change psychological orientation of the patient and including such surgery as goes with it." 

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The New York Board of Health accepted and incorporated the Academy of Medicine's reported conclusions in denying petitioner's request. The Court upheld the Board's action as being within its administrative discretion.

The case appears, from the author's research, to be the most recent legal authority in the United States dealing with transsexualism.

7. Argentina

Research further indicates that the most recent judicial pronouncement, and apparently the only case dealing directly with the legality of a consented to "conversion" surgery, comes from the Argentine. An opinion by the "Fiscal de Camara", affirmed by the "Poder Judicial de la Nacion". The case,\footnote{Reported in the Argentine law journal, \textit{La Ley} ("Revista Juridica"), for Sept. 21, 1966 and commented upon extensively in English by S.A. Strauss in 84 \textit{S.A.L.J.} 214(1967), who also mentions the recent performance of several "sex operations" in S. Africa.} \footnote{84 \textit{S.A.L.J.} 214, 217.} a state prosecution against one Dr. Ricardo San Martin, involved a charge of criminal assault brought against the doctor for performing "corrective" surgery (i.e. castration and peotony) on a male homosexual whom the court felt did not manifest feminine characteristics. What criteria the court used in coming to this conclusion is not stated, but it would seem they too relied on chromosomal sex, for the judgment states only that "no female chromatin bodies were found in his cellular nuclei".\footnote{Reported in the Argentine law journal, \textit{La Ley} ("Revista Juridica"), for Sept. 21, 1966 and commented upon extensively in English by S.A. Strauss in 84 \textit{S.A.L.J.} 214(1967), who also mentions the recent performance of several "sex operations" in S. Africa.}
The Fiscal de Camara's opinion, without any consideration of the obvious mental-psychological problems of the patient, stated strongly and flatly that,

"There is no scientific reason for the removal of a healthy penis from a physically healthy man. No aesthetic reasons, not the satisfaction of an unhealthy sociological interest, nor the desire to placate the perverted sexual craving of the victim can justify such a removal. The experience of qualified medical staff, the use of proper instruments and medical technique during the operation do not suffice to licitly condone the fact that it is a grievous bodily injury, recognised as a crime by the Penal code..." (emphasis added) 112

It appears from the translation of the case, however, that problems as to the validity of the patient's consent played a part in influencing the judgement against Dr. San Martin. Addressing himself to the defence of consent, the Fiscal rejected it, pointing up the fact that the patient had a "perverted" mind with a mental age of twelve years which effectively prevented him from "rightfully" disposing of his body. 113 The question of whether a normal, intelligent individual could so "rightfully" dispose of his body was left unanswered by the lower court. However, on appeal to the "Poder Judicial de la Nación" the consent of the patient was held to be no defence to the criminality of the surgical assault /

112 Ibid., p.218.
113 Ibid.
assault regardless of his unimpaired mental state. Such surgery could not be consented to lawfully. The higher court stated,

"the consent of the victim is not a defence. The act constitutes grievous bodily injury, and in view of the consequences, society cannot accept the consent of the victim, whose interests are protected by this court. It cannot be submitted that the physician, who accepted this consent, was ignorant of the fact that the consent of the victim was invalidated by the mental incompetence of the victim whose perverted sexual craving distorted the real scope and significance of the operation, even supposing the best results. Fabregas could not be somatically changed into a woman; the differences between body and mind could not be remedied by these means. Although it could be held that it were psychologically possible to give real relief to the craving of Fabregas, such a limited and incomplete solution could not justify the irremediable corporal harm caused, apart from the moral and social implications." 114

C. CONCLUSIONS

True cases of transsexualism are exceedingly rare and their less serious counterpart transvestism are more frequent but still relatively rare. Because of the infrequency of both deviations and their common distastefulness, there is a tendency not to come to grips with their attendant legal problems. This is unfair to those unfortunate enough to suffer these abnormalities. As medical science seeks for an answer to /

114 Ibid.
to their maladies, the law should, it is submitted, look upon present methods of treatment compassionately.

While supporters of "conversion" surgical treatment for transsexuals counsel that psychiatric and hormonal treatment is of no help in severe cases, they cannot guarantee the success of surgical treatment either. Some commentators suggest that a distinction should be drawn between the hermaphrodite or intersex who is in need of anatomical cure (a physiological change to match genetic sex) and the transvestite and other such sex deviates who presumably are anatomically normal, but in need of psychological cure to bring their mental state into harmony with their physique (a "cosmetic" physiological change to satisfy psyche). Under such a classification, the transsexual would be in the latter class. The proponents of such a distinction suggest surgery as proper in the first instance only to repair or change the individual's sex organs for his benefit and so as to achieve his "rightful" sex.

The motivation for drawing such a distinction undoubtedly stems from the belief that a person's anatomy may be altered surgically, where it includes contradictory sexual elements, to align it with "proper", genetic or chromosomal sex, but not /

not where the psychosexual orientation of the individual - not his anatomy - is the only element inconsistent with genetic sex. The assumption behind this distinction may be that all persons are immutably either male or female (though in weaker or stronger degree117) and while this fact may be "clarified" by surgery (intersexualism), it should not and cannot be "rebutted" by surgery (transsexualism).118 While this distinction is a valuable one and while surgical treatment should be permitted in cases of physiological intersexualism (hermaphroditism), such treatment, it is submitted, cannot be inevitably condemned in cases of transsexualism.

The New York Academy of Medicine in the Weiner case opined that the abnormal psychological wants of the transsexual should not be aided by legal co-operation in the individual's attempts at social adaptation and recognition as a female. This co-operation, while perhaps easing his torment, does nothing to alleviate or cure his abnormal feelings toward himself. This argument is a strong one against the legality of "conversion" surgery as well as against official recognition - via public records and vital statistics registration - of "changed" sex.

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117 Stoller, loc.cit.
118 Pauly, op.cit., p.178; Benjamin, 8 Am. J. Psy. 219, 228; Wodden & Marsh, loc.cit.
The New York Academy of Medicine came to the conclusion that male-to-female transsexuals are still chromosomally males. While this may not be invariably true, it will normally be the case because of the transsexual's psychological, not physiological, abnormality. As a result, physical "conversion" surgery is at the same time an irreversible yet incomplete therapy. Surely, in these circumstances, the thrust of the law should be to encourage the pursuit of insights into cure of the transsexual's mental and psychosexual condition, not to encourage severe physical invasions of the individual's bodily integrity.

This is not to say, however, that all "conversion" surgery should be outlawed, for in some, very few, but very severe, cases, it may be the only measure to prevent self-mutilation, demembration, suicide or permanent mental derangement. In such cases, it would seem the law must take account of the terrible pressures on the patient and the humanitarian, therapeutic motives of his surgeon.

As with other controversial operations which are or may be unlawful unless carried out for therapeutic purposes - abortion and sterilisation - conversion surgery could be likewise made subject to a similar exception, although lawmakers may /

119 Moore, 97 Canad. Med. Assoc. J. 262(1967); et al.
may well feel compelled to give carefully limited scope to the "therapeutic" justification for conversion surgery.

The analogy to sterilisation here is particularly relevant. The public policy considerations that will determine the permissible scope of "conversion" surgery are similar to those that will set the legal limits for sterilisation. The inquiry in both cases is concerned fundamentally with the extent to which an individual's consent will insulate the performing surgeon from criminal liability for a surgical invasion of the body that is repugnant or unjustified to many.

It may eventually be resolved that consent to such operations will only negate their criminality when their purpose is considered to be therapeutic. The question then to be resolved will be, what is therapeutic?

While "conversion" surgery for transsexuals involves a more severe, more repugnant bodily infringement, it is also sought to be justified on wider, rather atypical "therapeutic" grounds. The practice is often advocated not so much to ease the torment and suffering of the transsexual as it is to serve as a "therapeutic" measure to prevent him from harming himself either physically (by self-mutilation or auto-castration) or mentally. The therapeutic effect then of the surgery is indirect, in deterring the patient from subsequently injuring himself /
himself. This is an extension of traditional interpretations of therapeutic motive and it remains to be seen whether public policy will accept such an extension in this controversial context.

If full, knowing consent has been given by the patient and medical opinion feels "conversion" surgery in some degree is irrefutably indicated, then, it is submitted, the public has no interest in denying the acute transsexual the only means currently known to medical science for relief of his severe, self-endangering condition by threatening the performing surgeon with criminal prosecution.

The criminal law of most countries to-day appears flexible enough to handle this problem without amendment. However, jurists and medics should consider the peculiar difficulties facing patient and physician in certain transsexual cases. They should keep proper perspective. Obviously it is unwise and impossible for the surgeon to solve all psychological urges and needs by physical operation. It is unlawful for a physician to aid a patient with an obsessive psychological urge to die, or to cut off the arm of one who wants to stop masturbating. At the same time, however, if it is a question between surgical intervention and suicide, self-mutilation or permanent psychosis it would seem that the weight of opinion must fall in favour of the former measure - incomplete and stop-gap in approach as it may /
may be. Eventually, hopefully, the transsexual's torment can be attacked and solved where it originates - deep in his psyche. But until that time, the law should strive as best it can to come into harmony with the current state of medical knowledge, opinion and prescribed treatment in this delicate area. This task is made more difficult because transsexualism doesn't raise merely medico-legal problems, it casts its shadow over a wide area of ethics, religion and morality.

It would seem that medical opinion has not yet reached a consensus on the proper method of treating transsexualism. There does, however, appear to be near unanimity of opinion among those writing on the subject that "conversion" surgery should not be considered as illegal when carried out in those relatively rare cases where it presents the only available alternative at the moment to the patient's likely self-mutilation, suicide or permanent mental derangement.

Once it is acknowledged that "conversion" surgery may be justified and legally defensible in certain severe circumstances, the attendant problem of public records alteration and re-registration must be considered. Clearly there is a strong element of public reliance on the accuracy and conclusiveness of public records. They are a check against fraud and misrepresentation as well as a means of identification and verification. As a result, society has a strong interest in preserving /
preserving the accuracy of such devices of registration as birth certificates, marriage licences and passports. It cannot afford to sacrifice the integrity of such documents and related laws in order to placate certain abnormal elements within society and facilitate their social adaptation.

Arguably, it is an anomalous solution to permit "conversion" surgery in clearly indicated cases, yet refuse to allow amendment of public records and official private documents to accord with the newly altered physical status of the transsexual. As one authority in the field has commented,

"One thing seems certain. While great conservatism should prevail in advising, consenting to, and performing a conversion operation, all possible help should be given to those who present a fait accompli by having undergone the irrevocable step of surgery. It seems to me to be the duty not only of physicians, but also of the community, to pave the way as much as possible for such persons (by legal sanctioning and recording of the sex change carried out by surgery) so that they can succeed in their new pattern of life as members of the opposite sex." 120

The allowance of "conversion" surgery, but the prohibition of concomitant public record alterations is not necessarily anomalous if additions to, but not changes in, sexual status on these records is permitted. It is submitted that the most desirable solution to this problem is in fact the compromise solution. Namely, amendment of sexual status on public /

120 Benjamin, The Transsexual Phenomenon, pp.144-145.
public records could be allowed by including the "new" sex after "conversion" surgery, while still retaining the original sex classification on the documents. Of course, cases where the original classification of sex had been made incorrectly, as, for example, in cases of 'true hermaphroditism', would not be governed by this limitation, but rather sex registration could be changed completely upon the showing of appropriate evidence.

This suggested compromise solution would insure the public interest in accurate, non-fraudulent public records and indices of identification as such interest must be considered overriding. At the same time, the "new" sexual status achieved could govern legal rights - including marriage - while the "old", originally entered (and not proved to be incorrect when entered) sex designation would remain as a check against misrepresentation and fraud. By such a device, third parties would be protected to some extent in their dealings with the feminised, but not female, transsexual male (and vice-versa).

In the last analysis, cases of transsexualism are too few and too little understood to prompt the formulation of inhibiting, specific legal rules. The law as written, imperfect yet flexible, is elastic enough in most countries to treat the transsexual problem wisely and adequately, if it is interpreted and /
and applied by men of understanding temperament, unshackled by religious dogma or legal formalism in their approach to what are intensely personal problems which must be solved in the most compassionate manner possible, consistent with the general good.
CHAPTER IV

MEDICAL EXPERIMENTATION

A. INTRODUCTION AND BACKGROUND

"Although it is the duty of the physician or surgeon to keep up with advancements, it is also his duty to refrain from experiments." 1

This statement, perhaps as well as any other, expresses the seeming dilemma in which the current state of the law dealing with medical experimentation places the practitioner-experimenter.

Medical science relies on research and experimentation, as do all other sciences, to advance its knowledge in man's fight against sickness and disease. Inevitably, such experimentation must utilise human subjects if it is to have primary significance. For any new therapy, drug or treatment there must always be the first patient or subject. There must always be those who serve, in a sense, as the "Guinea Pigs of Hippocrates". 2

The need for and the existence of human medical experimentation is illustrated by the awesome fact that to-day's typical /

2 Taken from Lansdown, "Guinea Pigs of Hippocrates and the Criminal Law", 77 S.A.L.J. 117(1960).
typical physician relies on drugs developed since 1950 in approximately ninety per cent of his patient prescriptions. Medical experimentation has been practised since the early days of Galen through the centuries, not infrequently on unwilling prison subjects, yet it has yet to be clearly recognised legally as a legitimate part of medical practice. In other words, cases involving "planned and directed medical research on human beings" have not been adequately, if actually at all, examined and tested in the courts.

As one of the most prominent legal authorities in the field has noted,

"There has...not yet crystallized a set of specific guidelines, commonly understood and applicable, to insure that human research may go forward on the highest scientific and ethical planes with due legal protection for both the subject and the investigator." 6

Before proceeding to the rather hazy legal picture regarding medical experimentation, some attempt should first be made to define what this nebulous term encompasses. Some 7 equate medical experimentation and medical research, considering both to include all attempts at inducing or altering bodily /

3 Haggins, "Due Care by Physicians in Use of New Drugs", 14 CLEV.-MAR.L.R. 506, 508 (1965).
5 Ibid.
7 Ibid., p. 482.
bodily or mental functions by standard clinical procedures for the general advance of health. Others see experimentation as involving a wide range of practices; deviation from accepted modes of treatment; therapy in areas where there is no accepted mode of treatment; use of drugs and the like on patients not for immediate therapy, but for the eventual improvement of sufferers who may or may not include the patient; and finally, use of nonpatients as experimental subjects. A fairly concise, though incomplete, definition of medical experimentation has been offered by one student of its legal aspects. He fails to include experimentation carried out with no intention of helping the particular patient. He states that it encompasses,

"those situations where there is an application of a new, insufficiently proved drug, instrument or method of treatment, the validity of which has neither been accepted nor rejected by the medical profession and the purpose of which is to help the patient and to advance medical science."

Medical experimentation, it is submitted, must be defined both in terms of means and purpose. Its purpose can be either to cure or heal a particular patient, to find a cure for patients/

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patients similarly situated, merely to advance the state of medical science's knowledge for application to future, unidenti-
tified patients or, to accomplish any combination of these objectives. However, the purpose of any given medical treatment really becomes experimental only when the means used to accomplish that purpose are ones not generally accepted, though not generally rejected, by the medical profession or its appropriate sector. The experimental means utilised may be either unique or deviational in light of accepted practice.

Aside from these above definitions of medical experimenta-
tion, all of which type it as distinct from the general practice of medicine, there are those who feel the latter involves experimentation too, differing only in degree, not kind. It is true, in one sense, that all medicine is experimental, by its very nature of dealing with the never identical symptoms, reactions and needs of individual patients.

There are those who argue that experimentation is never absent from the physician's office, for he does no more than "practice" medicine on patients who are in fact "voluntary experimental subjects". However, in the general practice of

11 Ivy, "The History and Ethics of the Use of Human Subjects in Medical Experiments", 108 Science 1 (1948).
of medicine, the patient's cure or comfort must be considered as always paramount. In strict medical experimentation, the outcome of treatment applied to the subject may well not be intended to, nor actually, result in any personal benefit to him. And for that matter, the experimenter's "subject" may not be a "patient" at all, being in perfect health himself.

While the law has not as yet set out the permissible limits for experimentation as it has basically done with general medical practice,\(^{12}\) this has not seemingly impeded the carrying out of wide ranging experiments or clinical tests on human beings in recent times. For instance, the following medical experimentation was undertaken in the United States during and after World War II: The use of healthy prisoners in malaria, hepatitis, common cold and intestinal protozoa testing; the use of servicemen for physiological stress testing, school children for poliomyelitis (Salk-vaccine) and influenza, "normal" mental patients for nutrition and even whole communities for water supply fluoridation to prevent dental caries.\(^{13}\) Just how widespread medical experimentation is to-day is difficult to guage, other than recognising its /

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\(^{13}\) Ladimer, 3 J.Pub.Law 467, 474(1954).
its existence.

From a legal point of view, medical treatment which falls within the confines of accepted, standard practice causes few problems. Such treatment must be consented to - expressly or impliedly - by the patient, though undertaken for his benefit by the physician. Under a broad definition, recognised medical treatment might be classified as experimental due to the peculiarity presented by any given patient's case. However, it is not thought of as such in the public mind, barring some undesirable or unforeseen results. The carrying out of standard medical practice is regulated by formulations of legal negligence, which determine the duty of care owed the patient in circumstances when "malpractice" is alleged.

It is, however, that medical treatment which does not fall within the above, rather flexible category of ordinary or accepted practice with which we are predominantly concerned here...It is this type of devitional, unpractised or unaccepted treatment /

14 See Lansdown, loc.cit.; Hymen v. Jewish Chronic Disease Hospital, 251 N.Y.S. 2d 818(1964) discussed infra; Lear, "Do we Need New Rules for Experiments on People?", 1966 Sadt. Review (Feb. 5th) 1961. One example - In New York City, after exposure of research being carried out without being reported to the authorities, it was felt necessary to issue a General Order in 1949 to all City hospitals requiring formal review and approval of research proposals and limitation of medical investigation to that specifically designed to benefit the involved patient. Ladimer, 257 N. Eng.J.Med. 18, 23(1957).


16 Any of the standard texts in delict or tort may be consulted for the standard of care expected of a physician in the undertaking of accepted or ordinary medical treatment. See especially, the note in 29 Col.L.R. 985(1929).
treatment that the law has classed, rather imperfectly often, as experimentation.

B. THE LAW: UNSETTLED AND UNSATISFACTORY

There is almost no statutory law in the area of medical experimentation. None exists in England or Scotland and the only American enactment which appears to explicitly recognize experimentation is the "New Drug" section of the Food, Drug, and Cosmetic Act.\textsuperscript{17} The Act prohibits introduction of a drug into interstate commerce prior to a full investigation into its safety for use. However, the legislation recognizes an experimental exception to this prohibition in the case of "drugs /

\textsuperscript{17} 52 Stat. 1040, 1052 (1938), as amended 21 U.S.C. §355 (1952) (Supp., 1954), in Ladimer, 3 J. Pub. Law 467, 474 (1954). It should, in passing, be noted that a 1900 bill proposed for the District of Columbia would explicitly have controlled medical experimentation as no other American statute does. The bill, which failed passage, would have prohibited research on children, incompetents and pregnant women and any investigations not intended for the amelioration of the patient's condition. The bill contained all the major safeguards that would eventually be written into the 1948 Nuremberg Code (discussed infra); written description of the proposal, review by an authoritative body, performance only by qualified doctors, voluntary and fully competent consent by the individual concerned, termination on request of the subject and reporting of the results obtained. Ladimer, 257 N. Eng. J. Med. 18, 23 (1957).
"drugs intended solely for investigational use by experts qualified by scientific training and experience to investigate the safety of drugs." 18

A further 1962 amendment to the Act 19 exhorts physicians to obtain advance, informed consent of all those to whom the experimental drugs are prescribed, but permits the doctor to decide within his own discretion whether and when it is in "the best interests of such human beings" to tell them their use of the drugs is experimental, far less to ask these patient-subjects their permission beforehand.

There are a number of statutes aside from the above which regulate the medical profession, but they do not deal expressly with experimentation and are largely concerned with licensing.

Most United States statutes confine the practice of medicine to the four fundamentals of (1) diagnosis, (2) treatment, (3) operation and (4) prescription, for disease, pain, injury and the like. Research or experimentation, while perhaps implicitly part and parcel of all the above fundamentals, is nonetheless not expressly included in any of the statutes. The California provision 20 is fairly typical /

19 §505(1), in Lear, op.cit., p.65.
typical and states,

"The physician's and surgeon's certificate authorises the holder to use drugs or what are known as medical preparations in or upon human beings and to sever or penetrate the tissues of human beings and to use any and all other methods in the treatment of diseases, injuries, deformities, or other physical or mental conditions."

It can be seen that the provision does not expressly make reference to experimentation, nor is it of sufficient latitude to include medical experimentation that does not have as its immediate purpose treatment of the human being involved, but rather which aims at the advancement of science, the development of medicine or the safeguarding of health and that may, at best, only promise incidental or indirect benefit to the subject.

While what little statutory material that does exist does not provide for this latterly-mentioned type of experimental situation, neither have the relatively few cases discussing "experimentation" have confronted by such facts. The bulk of the cases have involved foolish or careless deviations from a recognised or standard form of treatment, sometimes by quacks and charlatans, not qualified experimenters observing the "proper precautions" of clinical research, such as full subject consent, thoroughly professional (scientific) preparation, execution /
execution and the like. 21

The first judicial pronouncement in the Common Law world involving liability for an alleged medical experiment appears to be Slater v. Baker and Stapleton. 22 The facts involved an action on the case against a surgeon and an apothecary for unskillfully disuniting the callous of plaintiff's leg in an attempt to reset a prior break. This novel procedure, carried out by a well-known physician of the times, was done without the patient's consent and, according to expert medical testimony, was contrary to existing, satisfactory methods of mending broken legs by compression and consequently was not indicated. Plaintiff was awarded damages.

The Baker case came to be cited as authority for the bald proposition that a physician experiments at his peril and is liable for any ill results flowing from such treatment. 23 There was experimentation in Baker, the defendants using a "heavy /

"heavy steel thing that had teeth" vainly to extend (rather than the accepted practice to compress) the complainant's leg into straightness. The Court mentioned that "(i)t seems as if Mr. Baker wanted to try an experiment with this new instrument". The Court, however, was apparently satisfied to ground liability simply in negligence, "ignorance and unskilfulness", for defendant did, "what no surgeon ought to have done".24

Baker did not approach the defendant's actions as truly medical research or experimentation, being carried out under proper conditions to expand the knowledge of medical science. The facts did not commend such an approach. Rather, the Court saw defendants' treatment as nothing more than an unskilled departure from recognised, satisfactory practice concerning a relatively simple medical problem.25

1. The American Cases

Slater v. Baker was followed by the leading American case of Carpenter v. Blake.26 Carpenter, as Baker had some one hundred years before, involved a physician's deviation in treating plaintiff from an "established mode of practice".

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26 60 Barb. 488 (N.Y. 1871), rev'd. on other grounds, 50 N.Y. 696 (1872).
practice". The New York Court, attempting to establish an objective standard for this type of case, stated that such departures would constitute negligence unless it could be shown by practical tests to be just as likely to work a cure as prevailing treatment. 27 The Court went on to state,

"(W)hen the case is one as to which a system of treatment has been followed for a long time, there should be no departure from it, unless the surgeon who does it is prepared to take the risk of establishing, by his success, the propriety and safety of his experiment.

The rule protects the community against reckless experiments, while it admits the adoption of new remedies and modes of treatment only when their benefits have been demonstrated, or when, from the necessity of the case, the surgeon or physician must be left to the exercise of his own skill and experience." 28

The rule pronounced in Carpenter only covered those situations where some departure was made from a recognised method of treatment. The rule was too narrow to cover those cases of experimentation where no approved medical practice existed. Even so, Carpenter did not provide much leeway for cases where there was an accepted practice, but a new and improved method presented itself, though still in experimental form. Carpenter appeared to largely squelch experimental incentive /

27 Ibid., p.477.
28 Ibid.; 60 Barb. at 523.
incentive in such cases, as liability would follow any harm in their use, no matter what care and skill was exercised.

A more liberal approach to these types of experimental cases was propounded in Jackson v. Burnham. The Court said a physician utilising a method contrary to one already established must "justify his experiment by some reasonable theory". This test, instead of holding the experimenting physician liable or not depending on the success of his departure in treatment, rather shifted the burden of proof to him by requiring him to show, in effect, that a qualified physician exercising ordinary care and skill in the circumstances would have acted (experimented) similarly. In so holding, the Colorado Court came very close to what appears to be the preferred modern outlook in this area, although the burden of proof has again changed hands.

Nonetheless, it appears likely that Carpenter continues to express the majority opinion in the United States where departure from routine or accepted medical treatment is alleged. This is because the normal test as to whether proper medical treatment was employed is its conformity or lack thereof with the

29 20 Colo, 532, 39 P. 577(1895).
30 Keaton, op.cit., p.163.
the consensus of qualified physicians and surgeons in the area.\textsuperscript{32} If the case presents a new problem or condition, for which no routine therapy exists, the patient must largely trust to the skill and experience of the physician selected and can recover damages only by showing ignorance or unskilfulness in treatment, not the failure of treatment per se. Under Carpenter, the physician is simply held liable for the results of his chosen treatment, when it is a departure from a practice long followed within the profession.\textsuperscript{33}

However, circumstances may condone a departure from recognized practice, even though its results are unsuccessful. An example is the case of Miller v. Tober.\textsuperscript{34} Therein, the physician used a leg treatment not generally accepted, but which had been known on rare occasion to succeed. The treatment failed and defendant surgeon was held not liable, the only alternative having been immediate amputation of the patient's limb.

In Langford v. Kosterlitz,\textsuperscript{35} a California court upheld an action in negligence against a surgeon who, without advising his patient, had "experimented" in the treatment of his asthma condition by injecting alcohol and then novocaine into the nasal /

\textsuperscript{32} 29 Col.L.R. 985, 988(1929); Prosser, Tort (2d ed., 1956), \textsuperscript{33} Ibid., p.989.
\textsuperscript{34} 183 Mich. 252, 150 N.W. 118(1914).
\textsuperscript{35} 107 Cal. 175, 290 p.80 (1930).
nasal ganglion, rather than the normal, reverse process. The error damaged the patient's optic nerve, resulting in blindness. While the court talked of experimentation, the case went off on a theory of negligent departure from accepted practice, due to ignorance and/or lack of skill (malpractice) on the physician's part.

It was early held that a physician should not be held criminally liable where he had embarked on human experimentation in good faith to effect a cure unsuccessfully, even if his medical credentials were not satisfactory. In State v. Schultz, 36 a conviction of criminal manslaughter against a quack doctor, who had given his patient-victim a substance without even knowing its contents in an effort to attain cure, was reversed. The Court stated,

"The interests of society will be subserved by holding a physician civilly liable in damages for the consequences of his ignorance, without imposing upon him criminal liability when he acts with good motives and honest intentions." 37

While the few cases in point indicate it is unlikely that more than civil liability will be imposed on a doctor who acts with due care and good motive, 38 the reasonableness of the chosen /

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36 55 Iowa 628, 8 N.W. 469(1881).
37 8 N.W. 469, at 471; to the same effect are Rice v. State, 8 Mo. 561 and Commonwealth v. Thonsen, 6 Mass. 134.
chosen treatment is obviously relevant. For instance, in State v. Lester, a charge of second degree manslaughter was upheld against the defendant physician for causing his patient's death by X-ray burns. The patient had consented to the well-intentioned treatment, but her physician's unreasonable means of performing it was considered sufficiently careless to be classed as "culpable negligence" and a public offence.

Many American courts remain inhospitable to medical experimentation, as evidenced by the sweeping statement in Owens v. McCleary that,

"A failure to employ the methods followed or approved by his school of practice evidences either ignorance or experimentation on his part. The law tolerates neither."

On the other hand, there are courts that have at least recognised the need to grant experimentation some legal protection if medical science is to progress. As, for instance, in Portman v. Koch, where a doctor was sued for allegedly using improper, harmful drugs in treatment, the court remarked at p. 765,

"We recognise the fact that, if the general practice of medicine and surgery is to progress, there must be a certain amount of experimentation carried on, but such experiments must be done /

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39 127 Minn. 282, 149 N.W. 297(1914).
40 (No.) 261 S.W. 682.
done with the knowledge and consent of the patient or those responsible for him, and must not vary too radically from the accepted method of procedure."

One of the most recent American cases involving, though indirectly, the question of medical experimentation was *Human v. Jewish Chronic Disease Hospital.* The case directly involved only the narrow procedural issue of the Hospital Director's right to examine the private, hospital records of twenty-two patients. However, the inquiry arose out of an experiment carried out on these patients without their consent, for which both prominent physicians were censured. The physicians injected live cancer cells into the patients in an experiment to test their immunity and reactions. The patients were not told the injections contained cancer cells and were led to believe the injections were a part of their normal therapy.

The physicians claimed their action was justified, their being no increased medical risk to the patients of contracting cancer from the injections. This was disputed. A Medical Association Review Board found the two doctors guilty of fraudulent and deceitful conduct and recommended suspension of their licences. Eventually, the two physicians, one particularly well known and regarded in cancer research, were put on /

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on probation for a year, but no administrative suspension or judicial proceedings were undertaken. 44

There was repugnance felt regarding the physicians nondisclosure to the patients at the Jewish Chronic Disease Hospital particularly because the experimentation was not carried out with the intention of aiding their maladies, but rather was solely for the good of science and the general advance of cancer research. 45

Thus, the reported American cases touching on medical experimentation do not seem to present either a clear or consistent picture. One of the leading authorities has commented, 

"Reported cases have not yet considered modern controlled medical research as such, and have not yet established limits within which human research may be pursued. Cases which have involved conduct labelled 'experimentation' have been decided basically on issues of disclosures or consent, negligence, lack of qualification, improper activity (quack procedures, medicines or devices) or unlicensed practice of medicine usually arising in cases of departure from accepted diagnosis, therapy or other practice. These fact situations, sometimes erroneously called experimentation, have tended to confuse or have failed to recognise the distinction between research and practice." 46

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44 Lear, op.cit., p.64.
2. The British Cases

There are few British cases in point in this area. Death, of course, is always a risk in human experimentation and good motive or inadvertence will not inevitably protect the physician from criminal liability. In *Rex v. Burdey*, a manslaughter conviction was upheld against another quack physician who had prescribed cold water foot baths and a three day fast for the acutely ailing patient. Death soon followed. Expert medical testimony stated that such treatment had "accelerated" death, which actually resulted from an undoubted heart condition. The holding of the case was summed up in the following terms:

"Any person, whether licensed or unlicensed, who deals with the life or health of another person is bound to use competent skill and sufficient attention; if the patient dies for the want of either, the person is guilty of manslaughter." 48

In Scotland, a charge of culpable homicide could conceivably be brought against a physician for a death caused negligently during experimental treatment. However, in the absence of malice or wickedness - implying an element of subjectivity in the physician's mental state - no such prosecution would /

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48 25 Cox 598.
would be likely to be brought.\textsuperscript{49}

Perhaps the case most aware of the balance to be struck between the advance of medical science and the reliability of treatment in individual cases is a Scottish decision, \textit{Hunter v. Hanley}.\textsuperscript{50} The opinion by Lord President Clyde is one of the very few pronouncements in Scottish law on medical negligence, presumably "a tribute to the high standard in general of the medical profession in Scotland".\textsuperscript{51}

\textit{Hunter} was a case of alleged negligent treatment. The pursuer was receiving intramuscular injections of penicillin in the hip for treatment of chest troubles. On the twelfth injection of the series, the hypodermic needle broke off inside the patient, between hip and pelvis. The pursuer alleged negligence both in selection of the type of needle used and also in its actual use by the defendant physician. Suit was unsuccessful, it being held that the mere fact that defendant had deviated from standard practice did not, of itself, constitute proof of negligence. \textit{Hunter v. Hanley} only touched on experimentation in the context of using a new treatment in order to cure the affliction of the individual patient in question.\textsuperscript{50}

\begin{itemize}
\item \textsuperscript{49} Gordon, \textit{The Criminal Law of Scotland}, pp. 361, 738, 775.
\item \textsuperscript{50} 1955 S.C.T. 213, 1955 S.C. 200.
\item \textsuperscript{51} Lord President Clyde, at 1955 S.C. 205; Farquhar v. Murray, 3F. 869(1910), deciding the test of negligence for a physician to be the ordinary one of a reasonable man in the circumstances, was the only prior reported medical negligence case found.
\end{itemize}
question. Nonetheless, the lucid reasoning of Lord President Clyde in the case is worth quoting at length for the light it sheds on the whole area of medical negligence in general, but more particularly on the standards under concern by which to judge medical experimentation.

"In the realm of diagnosis and treatment there is ample scope for genuine difference of opinion and one man clearly is not negligent merely because his conclusion differs from that of other professional men, nor because he has displayed less skill or knowledge than others would have shown. The true test for establishing negligence in diagnosis or treatment on the part of the doctor is whether he has been proved to be guilty of such failure as no doctor of ordinary skill would be guilty if acting with ordinary care...The standard seems to be the same in England..." (Emphasis added).

The following remarks, it is submitted, could easily be applied by analogy beyond the limited factual situation of the case to cover instances of pure or generalised medical experimentation,

"It follows from what I have said that in regard to allegations of deviation from ordinary professional practice...such a deviation is not necessarily evidence of negligence. Indeed it would be disastrous if this were so, for all inducement to progress in medical science would then be destroyed. Even a substantial deviation from normal practice may be warranted by the particular circumstances. To establish liability by a doctor where deviation from normal practice is alleged, three facts require to be established. First of all it must be proved that there is a usual and normal practice; secondly it must be proved that the defender has not adopted that practice; and thirdly (and this is of crucial importance) it must be established that the course the /
the doctor adopted is one which no professional
man of ordinary skill would have taken if he had
been acting with ordinary care. There is clearly
a heavy onus on the pursuer to establish these
three facts, and without all three his case will
fail. If this is the test, then it matters
nothing how far or how little he deviates from
the ordinary practice. For the extent of the
development is not the test. The deviation must
be of a kind which satisfies the third of the
requirements just stated." 52 (Emphasis added)

Hunter, is significant, for these guidelines laid down
by the Lord President Clyde could by analogy cover cases of
disputed medical treatment involving experimentation both
where a recognised practice exists and a departure therefrom
is made and also where no recognised practice does exist.
In either instance, the physician's conduct is only action-
able if in fact no doctor of ordinary skill would have so
acted in the exercise of ordinary care. The test is a
flexible and liberal one for physicians, but clear, coherent,
and arguably adequate for dealing with all types of experi-
mentation cases, attributes notably lacking from nearly all
the American decisions canvassed.

There appears to be only one Scottish decision since
Hunter v. Hanley which relies on the case. In McHardy v.
Dundee General Hospitals' Board of Management, 53 the issue
of a physician's duty of care to his patient was again raised
in/

52 1955 S.C. at 204-206.
in light of allegations of negligence. Lord Cameron indicated the onus of proving negligence was a heavy one for the pursuer and that mere error of judgment or even of diagnosis would not, by itself, be presumptive proof of negligence. Lord Cameron's direction in the case is worth quoting, for, as with Lord President Clyde's reasoning in Hunter, it represents what, it is submitted, is an enlightened and realistic Scottish judicial attitude towards medical practice in general and one which could be brought to bear equally as satisfactorily in cases of pure medical experimentation where therapeutic benefit to the particular patient may not be the object of the treatment imposed. In relevant part, Lord Cameron stated,

"...I think it is well that the search for further knowledge and experience should not be inhibited by undue apprehension of charges of negligence for the consequences to a patient of treatment or diagnosis where such may diverge from the normal... Medicine is not an exact science and the solutions of its problems are not susceptible of mathematical calculation, while the frontiers of medical knowledge are always moving and advance may often be achieved only at the cost of what in retrospect appear to be errors and divergences from the correct path as that is ultimately mapped out."

Hunter /

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54 Accord, Brivon v. Barnet, etc. (1958) C.L.Y. 2283 (wrong diagnosis of cancer and consequent wrong treatment) not necessarily the same as negligent or unskilful diagnosis).

Hunter has been followed in several English cases, among them Bolam v. Friern Hospital Management Committee,56 where the defendant was absolved from liability for injury to plaintiff resulting from Electro-Convulsive Therapy. The court found no negligence in the application of a treatment supported by a responsible body of medical opinion skilled in the area, the existence of another school of thought on the proper mode of treatment required in the circumstances notwithstanding.

In a more recent English case involving deviation from accepted practice, Holland v. Devitt and Moore Nautical College57, the judge held that a physician did not evidence negligence merely because he had made a slight departure from the textbook solution. He was entitled to rely on his common sense, experience and judgment in the treatment of each particular case as well.

Perhaps the best-known recent English case in this area concerning a physician's duty of care is Roe v. Ministry of Health58 which alleged negligence in the administration of a spinal anaesthetic. Lord Justice Denning (as he then was) summed up the competing interests in characteristic succinctness by stating,59

"Medical /

56 (1957) 1 W.L.R. 582.
58 (1954) 2 Q.B. 66.
59 At p.83; see also, Addison, "The Medico-Legal Aspects of Accepted Practice and Recognised Hazards in Medical Treatment", 2 Med.Sci.Law 284(1961).
"Medical science has conferred great benefits on mankind, but these benefits are attended by considerable risks. Every surgical operation is attended by risks. We cannot take the benefits without taking the risks. Every advance in technique is also attended by risks. Doctors, like the rest of us, have to learn by experience, and experience often teaches in a hard way."

3. Summation

Although these cases are helpful in understanding the duty of care a physician must exercise, they are, like most of their American counterparts, of limited value in helping to shed light on the legal attitude towards experimentation. The cases nearly all involve alleged negligence arising from therapeutically-motivated treatment of a particular patient; they do not involve planned clinical research and experimentation carried out professionally with appropriate safeguards to increase medical science's knowledge. Cases of the latter category, when they arise in the courts, will have to be judged by standards of care and duty appropriate to the experimental situation, not those applied in cases involving negligence in standard, accepted practice. However, as Hunter and other cases indicate, the test of the "reasonable man in the circumstances" could well be applied in evaluating experimental conduct as negligent or non-negligent. The important /

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60 Hunter is a possible exception, but the case involved only a procedural point of evidence.
important thing for the courts to realise is that the circumstances under which the "reasonable experimenter" acts are distinct and not subject to the same tests of treatment and cure as are those circumstances in which the "reasonable general practitioner" acts. The standard of what is reasonable can only be properly judged once this distinction in circumstances is recognised.

C. CODES AND ETHICS

While there are few cases dealing with medical experimentation and fewer statutes, there have been a sizable number of codes drafted by various bodies in an attempt to set out the proper framework and safeguards for the conducting of medical experimentation and research. The most famous code is undoubtedly the Nuremberg Code of 1948, which grew out of the Allied War Criminal trials against the experimental excesses of Hitler's Nazi physicians. The Code's ten points, which are set out in full in Appendix II are headed by the first provision requiring the subject's full, knowing and voluntary consent.

The 1964 Code of Ethics of the World Medical Association, included in full in Appendix III, is significant for the distinction /

distinction it outlines between experimentation whose aim is essentially therapeutic for the "patient" and that whose essential object is purely scientific without direct therapeutic value to the "subject" involved. In the former situation, the Code stresses the physician's informed belief that the new measure will be of therapeutic value and that the risk of its use is justified by the patient's need. In the latter situation, the World Medical Association Code stresses the acquisition of a fully informed, knowing and free consent.

Professor Paul Freund of Harvard in a recent article, has also emphasised the distinction between clinical research or experimentation with a directly therapeutic aim for the "patient" and that involving a "subject" not likely to benefit directly from the treatment. He states,

"The appropriate safeguards I would suggest may well vary as we move from the doctor-patient relation at one end to the normal or so-called normal subject at the other. In dealing with the patient, the doctor is guided by his dominant therapeutic aim and responsibility...The patient is considered as an end and not a means."

If the law is to deal satisfactorily with experimentation, it will need to recognise this distinction between therapeutic and non-therapeutic purpose more clearly than it has to date.

62 Freund, op.cit., p.689.
If no commonly accepted therapy exists and a patient is severely ill, experimental treatment reasonably undertaken in his behalf is likely to be well regarded by the courts, regardless of its success or failure.63 The same cannot be said of experimentation undertaken on a healthy subject or one suffering from an ill irrelevant to the purpose of the experiment and which is not for the person's benefit. In this situation, the courts are not unlikely to hold the experimenter absolutely liable for the outcome of his experimental treatment.64

Many experiments, however, may be considered for the "benefit" of a person who is not sick or in need of therapeutic treatment. This was the case, for instance, with those women who tested — and continue to test — oral contraceptives.

Even in situations where no "benefit" accrues to the experimental subject or is hoped to accrue, the law should make it possible for altruistic individuals to so volunteer. The root question — one common throughout this paper and one which will be reiterated even in this chapter — is, to what degree of bodily intrusion or risk thereof — both physiological and psychological —

63 Miller v. Tober, supra, at p.161 (footnote 34).
64 cf. Carpenter v. Blake, supra, at p.178 (footnote 26),
psychological - can the individual expose himself by means of consent, consistent with public policy and general social notions of proper conduct regarding the inviolability of the human body? This issue, though a difficult one, can be resolved in general terms and the major elements necessary to its resolution will be submitted in the concluding remarks of this chapter so far as the context of experimentation is concerned.

The American Medical Association has long had a simple code of ethics for human experimentation. It demands the adherence to three basic requirements: the voluntary consent of the subject; the prior use of animal experimentation to investigate the dangers of each experiment; and the performance of the experiment under proper medical protections and management.

Many other organisations have promulgated codes to govern clinical research and experimentation, but none have the force and effect of law, although they might well be used as a guide by which to assess the propriety of a given experimenter's conduct, were it challenged in a court of law.

One of the most recent code of rules governing conduct to be observed in the performance of experimentation on patients is /

66 A number are referred to by Lader in 3 J.Pub.Law 467, 487-496(1954).
is one prepared by a special committee of the Karolinska Hospital in Stockholm.  

The ethical and moral limits of human experimentation were commented upon by Pope Pius XII in a 1952 speech and before the First International Congress of Histopathology of the Nervous System.  

Stressing the incomplete right man has over the disposition of his own body and life according to Catholic theology, the Pope said a patient,

"has no right to involve his physical or psychic integrity in medical experiments or research when they entail serious destruction, mutilation, wounds or perils."

His Holiness stated further that new scientific knowledge was not the greatest good and must be subordinated to the rights of humans and any "moral rule of absolute value". Science in other words, must take its place in the order of values somewhere below the top.

Catholic theologians concerned with medical morals do, however, recognise that risks to life may be undertaken and even life taken "indirectly" when "proportionate reasons" exist. Such reasoning admits the place of experimentation in/

68 Beecher, op.cit., p.470.
69 Ibid.
70 Kelly, "Ethical and Religious Directives for Catholic Hospitals", Morals and Medicine, op.cit., p.314.
in the medical scheme of things.

Few of the codes of ethics on experimentation comment on the type of subjects that should or should not be used in any given procedure. In experiments not for the immediate therapeutic value of the subject, all would require a full, knowing, freely given consent. To avoid subtle forces of coercion, some commentators suggest that no "volunteers" should be accepted from among medical students or laboratory personnel, prisoners, children, or the institutionalised. Unless the procedure is intended to benefit the subject directly, some say the only exception to the rule of experimentation being for the benefit of the subject should be when an adult of unimpaired judgment consents to the treatment. It has been suggested that a fully informed consent to experimentation in any other circumstances is nearly impossible to obtain "in any complete sense" because people are not usually willing to risk their health or lives for a scientific experiment not for their immediate benefit.

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\text{\textsuperscript{71}}\text{ Beecher, } \text{op.cit.}, \text{ p.467.} \\
\text{\textsuperscript{72}}\text{ "Ethics Governing the Service of Prisoners as Subjects in Medical Experiments", 136 J.A.M.A. } 457(1948). \\
\text{\textsuperscript{73}}\text{ 1953 The Lancet } 2,993; \text{ Leys "Ethical Standards in Clinical Research", 1953 The Lancet } 2,104+. \\
\text{\textsuperscript{74}}\text{ Kidd, } \text{op.cit.}, \text{ p.212}; \text{ Roxburgh, "Experiments on Human Subjects", 3 Med., ci. & Law } 132(1962). \\
\text{\textsuperscript{75}}\text{ Leys, } \text{loc.cit.} \\
At the same time, others believe the use of experimental subjects should not be so restricted. How are we to solve children's diseases, they query, if children cannot be used in experimentation? Medical opinion is clearly divided concerning the use of normal healthy children or children suffering from some irrelevant disease as controls in medical research. There are those who advocate that,77

"No medical procedure involving the slightest physical or mental pain may be inflicted on a child for experimental purposes unless there is a reasonable chance, or at least a hope, that the child may benefit thereby."

At the same time, other practitioners advocate that,78

"no procedure should be carried out involving risk or discomfort without a reasonable chance of benefit to that child or other children."

(emphasis added)

Perhaps the latter observation is the more realistic one, as even the Code of Ethics of the World Medical Association (1964, Appendix III) recognises the need for non-therapeutic clinical research involving minors (§III, sub-§3a). The really difficult and unanswered question in this area, as might be expected, is to what degree of non-therapeutic experimental risk of harm may the legal guardians of a child expose him where the child either dissents79 or where he is incapable of /

77 1953 The Lancet, 2, 993 (letters).
78 Ibid.
79 In Britain, under the National Health Service Act Regs., 16 is made the age of consent and presumably, though there are no cases in point, a physician could not undertake non-emergency treatment of a child between 16 and 21 years old without the child's consent, even if his parents or guardian had consented to the treatment. See Forbes, "Legal Aspects of Blood Transfusion and Therapy in General", 1964 Med.Sci.Law 4, 26.
of understanding the nature of the risk and of consenting to his exposure to it? It is submitted that the exposure of a child, at least one under sixteen, to anything more than a very slight risk of harm or injury resulting from an experiment not for his benefit cannot be justified. Experimentation, in these circumstances, must give way.

While most agree that no substantial reductions in sentence should be granted prisoners for submitting to experimentation, some see nothing reprehensible per se about letting prisoners serve as volunteer experimental subjects. Furthermore, some would suggest that such conduct should be classed as good behaviour and commend itself to parole and prison boards in reviewing a given prisoner's record.

Though the majority of comment would exclude large classes of individuals as acceptable subjects for medical experimentation on grounds of the danger of express or implied coercion, a recent article is not so oriented, at least at first blush. In this article, all experiments are suggested as permissible, given only the limitations of "informed consent" and that they be "carefully conceived and thought to be of potential benefit". The suggested procedure outlined to insure "informed consent" is /

81 Ibid., p.102.
is, however, quite thorough, requiring it to be in writing, notarised, countersigned by the experimenter and another colleague not involved in the experiment and witnessed by two other individuals - such as relatives, friends or a court-appointed attorney for the subject - all in the presence of the subject.  

The author adds several caveats to his initial broad suggestion for the scope of permissible experimentation which restrict it considerably. Namely, that the experiment must be potentially directly beneficial to the subject where the possibility of death exists or the subject is less than sixteen years old and that a local administrative board with a mixed panel of medical experts and laymen would have to approve any planned experiment.  

One other ethical difficulty posed by much of medical experimentation is its inevitable reliance on a "control group": those who take sugar pills, for example, instead of a penicillin derivative and are used as a measure to determine the effects of the experimental substance or treatment. These people must consent to undergo the full rigors of the experimental therapy.  

82 Ibid., p.103.  
83 Ibid., pp.104-109 (This suggestion that experimentation on children 16 or older need not be directly therapeutic to them is perhaps a sensible compromise between the two prevailing schools of thought on this issue discussed supra; it is consistent with the apparently recognised age of consent to medical treatment in Britain and makes it "likely" that non-therapeutic experimentation will only be consented to by those capable of understanding the nature of the personal risk it poses.)
therapy and cannot be told they will serve only as decoys. This, of course, involves a subtle but patent series of misrepresentations and may be ethically unpalatable to some. However, it is submitted, such a practice is generally recognised as inherent in many experiments involving more than one individual and people, in offering themselves to act as subjects for (non-therapeutic) experimentation, must be presumed to have understood and accepted this fact.

D. CONCLUSIONS

It is somewhat strange that while so many private codes to govern medical experimentation have been promulgated in recent years and opinions delivered by various practitioners, churchmen and laymen, that few of these pronouncements have found their way into recognised legal expressions of the courts and legislatures. It appears that, at least in the Common Law world, no comprehensive statutory guidelines on clinical research and experimentation have been set down. Furthermore, few if any Courts in the English-speaking world have attempted to come to grips, in any definitive or comprehensive sense, with the limitations and criteria of permissibility that should govern these matters.

The medical practitioners in this area, as in others we have discussed heretofore involving surgical intervention of
a controversial nature, must work in the shadow of the criminal law and its unclearly defined assault and negligent homicide jurisdictions. Clearly, the law would appear to accept the recognised amount of therapeutically-aimed "experimentation" that goes on in so many physician-patient relationships.

It is probably also true that the law will accept consent as a justification for minor injuries and temporary impairments of health suffered in order to test sound scientific hypotheses in the interests of medical science and the advance of knowledge. As the current law stands, the boundaries of this legal acceptance are ill defined. That they must necessarily be loosely defined is one thing; that they must remain ill or undefined is quite another. It is, however, undoubtedly true that reckless experimentation not aimed at the acquisition of scientific knowledge will not be tolerated by the law, nor probably will non-therapeutic experimentation which entails the likelihood of serious harm to the health or bodily integrity of the subject, absent compelling public interest, as in the training of astronauts.

Still /

84 As in sterilisation and de-masculinisation operations.
86 Ibid.
Still, however, these are largely only predictions, not statements of existing law dealing with experimentation.

Whether the law will eventually develop satisfactory rules to govern medical experimentation remains largely to be seen. Any acceptable solution must inevitably involve a delicate and flexible balancing policy. The balance must be struck somewhere between the not infrequently competing values of advancing mankind's lot by medical research and experimentation on the one hand and insuring the security and preservation of his body, health and personality on the other. It still remains to establish the legal boundaries of experimentation as a valuable and recognised practice so that it can be pursued prudently, but without fear, by those qualified and so that, in cases of criticism or complaint, it can be presented honestly as a proper defence. "Experimentation" should not, as it has often been in the past, be submitted to a court as evidencing in and of itself improper medical practice and the practitioner's liability for any untoward result. In other words, experimentation should be legally defined and treated so that the issue becomes not one of research and experimentation as opposed to accepted medical practice, but rather one of whether the experimentation was justified.

justified in the circumstances, carried out with proper
skill and care and with due regard for the interests of the
subject concerned. 88

A reasonable and much-needed legal approach to experi¬
mentation could be worked out with tools that are already
available. An enacted legislative programme could take
advantage of some of the well-regarded codes that have been
worked out in this area, such as those of Nurnberg (Appendix
II) or of the World Medical Association, 1964 (Appendix III).
The basic concepts of these Codes could be incorporated into
a broad and flexible statutory framework to guide and govern
medical experimentation, as could the oft-expressed thoughts
and practices of leading practitioners and students in the
field.

While legislation could set out guiding principles and
basic procedural guarantees, the substantive value and justifi¬
cation for any given experimentation could be left for
resolution in the courts, if challenged. The judicial
approach to those cases of medical experimentation giving rise
to alleged legal liability would be best implemented by a
flexible and liberal standard such as evidenced by Lord Pres¬
ident Clyde's quoted criteria in Hunter v. Hanley, supra.

The /

88 Ibid., p. 482.
The guiding principle to determine liability, due care and consent issues aside, it is submitted, should be whether the value of the experiment undertaken is at least commensurate with the risk to the (complainant) subject involved. The greater the personal risk posed by an experiment, the greater also must be the therapeutic value of the experiment to the subject or to others and the social benefits to be gained or interests to be advanced. This principle can be criticised as too general and while firm or explicit legal rules are inappropriate in the field of medical experimentation, some basic guidelines by which to judge such conduct can, it is submitted, be laid down. Several elements must be appointed weights in the balancing process between acceptance of the need for experimentation to go on - with at least some encouragement and protection - and security of the individual from undesirable and unnecessary harm.

First, the risk of harm to the individual must be considered. Second, the degree of the harm risked should be evaluated; here psychological as well as physical harm must be recognised. Third, the mental capacity of the individual concerned is relevant, as it effects his ability to consent.

Against these considerations must be weighed the physical condition of the person and the benefit he stands to gain from /
from exposure to the experimentation. In a non-therapeutic context, as already mentioned, there is no immediate potential benefit to the individual that can be readily used to neutralise the degree and risk of harm involved. The extent of the benefit potentially to be gained is important, as is its existence. If a high degree of risk is involved in an attempt to benefit an individual by experimental removal of a mere wart or mole, then it is unlikely to be justifiable experimentation. The same will, however, not be true if an individual's very life is at stake, for the degree of benefit possibly to be derived is much greater.

The basic assessment to be made in therapeutic experimentation is, then, does the personal potential benefit and its degree justify the risk of personal harm that is involved and its degree?

In non-therapeutic experimentation, the risks remain, but the benefit to be evaluated becomes not the hoped-for benefit to, or cure of, the individual, but rather the "advance of medical science". The most difficult problem is what weight to ascribe to the "advance of medical science" as an offset to the risk to human personality and bodily integrity that is often concomitant. One thing is clear, it should not be given as much weight as is given to conduct whose purpose is cure of the /
the particular patient.

The use of certain presumptions might be relied on in dealing with the legality of medical experimentation. For instance, where any serious or permanent physical or psychological harm was caused the subject, the experimental conduct could be presumed unlawful, the individual's consent notwithstanding. It would then be up to the experimenter to justify the harm caused on the general principles of balancing risk, harm and benefit suggested heretofore.

The standards by which to judge and condone or condemn experimentation will not be easy to define and every case will, by its very nature, present different weights to be appointed in the balance. Standards will change with advances in science and medical knowledge and, not to be overlooked, with the prevailing moral, social and political consensus in any given jurisdiction. For this latter reason, the obligation of defining those standards by which to evaluate experimentation is on the medical profession as much as it is on the legal profession, for the former, thanks to the confidence and respect it enjoys in the public eye, has the unique ability to inform on and clarify the safeguards needed in the field of clinical research and experimentation, which the law has yet to provide. As one authority wisely summed up this /
this need recently,

"The law on the whole subject of experimentation will be worked out in close reliance on the moral sensibilities of the community. It therefore behooves the medical profession to take the public into its confidence and to educate public opinion rather than to risk the shock and explosion of pent-up revulsion if the lid is pressed down on information and then blown up by some melodramatic case..." 89

89 Freund, op.cit., pp.691-2.
HUMAN TRANSPLANTATION OF ORGANS

A. INTRODUCTORY MEDICAL ASPECTS

The transplantation of body parts or substances can be carried out from animal to human being (heterotransplantation), from one to another, unrelated human being (homotransplantation), from one human twin to another (isotransplantation), or from the patient himself (autotransplantation). While legends have discussed early efforts at human transplantations, it took the development of modern surgical procedures over the past two centuries to make such efforts practical. The first transplants involved skin grafts, bones, teeth and corneas and by the time of World War I blood transfusion was widespread. In 1954, history was made at Peter Bent Brigham Hospital in Boston with the successful transplantation of a kidney from a healthy twin into the other twin who was gravely ill with kidney failure. Kidney transplants in the interim have become nearly "commonplace" and some eleven hundred have been performed.

2 Ibid.
4 Wasmuth and Stewart, loc.cit.
performed in the past dozen years. The success rate of such kidney transplants, while varying considerably depending on the genetic relation of donor and donee (which will be discussed infra), has been such that it has prompted some to state that

"Clinical renal transplantation can no longer be regarded as an experimental form of treatment." 7

Transplantation of the liver, technically probably the most difficult vital organ to remove and transfer to another, has been undertaken. Up until Professor Roy Gaine of Cambridge performed the operation on May 2, 1968, 8 only Professor T. E. Starzl of Denver, Colorado, had successfully transplanted /

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5 "Prefatory Note" by Special Committee on the Uniform Anatomical Gift Act, of the National Conference of Commissioners on Uniform State Laws (2d tentative draft, January, 1968), p.2. (Hereafter cited, "Prefatory Note").

6 For example, Barnes reports in 1965 Transplantation 3, 812, that of 700 kidney transplants involving parental or sibling donors, more than fifty per cent were surviving after one year. If the donors are unrelated, renal transplants are far less successful. A thoroughgoing discussion and documentation of related against non-related donor kidney transplants over a four year period is, Hume, et. al., "Comparative Results of Cadaver and Related Donor Renal Homografts in Man and Immunologic Implications of the Outcome of Second and Paired Transplants", 164 Annals of Surgery 352 (1966).

7 "Haemodialysis and Transplantation" (ed.), 1967 The Lancet 1, 370.

transplanted a liver. Dr. Starzl has performed some sixteen human liver transplants since 1960. Only two of his earliest eight patients survived for as long as three weeks, but of his patients since last June, four of eight survive, one after nine months. The improved results are attributable basically to improved methods of administering immunosuppressive drugs to prevent rejection of the graft by the body and to newly developed means of storing donated kidneys for up to six hours.

And, of course, the press has recently been full of the news of the world's first heart transplant recipient, Mr. Louis Washkansky, who lived eighteen days on his transplanted heart. However, the second patient of South Africa's Dr. Christiaan N. Barnard, Dr. Philip Blaiberg, aged fifty-eight, has now been living with the transplanted heart of Mr. Clive Haupt, aged twenty four, since January 3, 1968. He remains as yet the only survivor for any substantial period of time. The high rate of failure with the nearly twenty heart transplants that have been performed does not seem to have dampened medical /

10 The Times, May 5, 1968, p.3.
11 Ibid.
14 As of June 10, 1968.
medical opinion in favour of continuing the practice. Twenty transplant teams assembled at fifteen medical centres in America plan to do some 100 heart transplants within the next year.\textsuperscript{15} Defenders of the practice indicate that although the survival record is poor, it is no worse than that of early, non-twin kidney transplants.\textsuperscript{16}

There has also been recent discussion of the advisability of lung transplants,\textsuperscript{17} especially as incidental to a heart transplantation, even before Dr. Barnard's heart transplant operation was carried out.\textsuperscript{18} A one lung transplant has just been carried out in Edinburgh, but it appears the implanted lung never functioned.\textsuperscript{19}

The major medical limitation upon the increase of successful transplants is the problem of "incompatibility".\textsuperscript{20} Incompatibility means that the human body regards tissue transplanted from another individual as a "foreign" substance and consequently, as in bodily infections by bacteria or viruses, it reacts by producing lymphocytes or antibodies that react to and /

\begin{itemize}
\item \textsuperscript{15} Internatl. Herald Tribune, May 8, 1968, p.5.
\item \textsuperscript{16} Ibid.
\item \textsuperscript{17} Blumenstock, "Transplantation of the Lung", 1967 Transplantation 5, 917; The Times, May 5, 1968, p.1.
\item \textsuperscript{18} The Observer, Nov.26, 1967, p.1.
\item \textsuperscript{19} The Scotsman, May 17, 1968, p.1 (The 14 year old boy recipient died two weeks later); Time, June 7, 1968, p.54.
\item \textsuperscript{20} An easily readable discussion is provided by Dr. W.A.R. Thomson in a lengthy letter to The Times, Dec.5, 1967, p.9.
\end{itemize}
and reject the foreign invader. This rejection process or immunological opposition usually takes place soon after a transplantation and the greater the genetic difference between donor and recipient of the tissue involved, the more rapid and vigorous this rejection reaction will be. As a result, transplants from a twin (isotransplantation) or from the patient himself (autotransplantation) will normally not involve any risk of rejection due to incompatibility. The use of blood relatives will substantially improve the chances of a successful kidney transplant over the use of non-related donors. The use of non-related donors is becoming more feasible because of two developments: the use of immunosuppressive or anti-rejection reaction drugs and the improvement in

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<th>Donors</th>
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<td>Cadaver Donor</td>
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<td>Non-related Donor</td>
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21 Ibid.
22 Wasmuth and Stewart, op.cit., p. 412.
23 See sources cited in 6. Hume, et. al., op.cit., give the following relevant figures at p. 353; 89 non-twin renal homotransplants over the past four years involved the following.
in methods of cross-matching or typing the tissue of donor and patient, as has long been done in blood typing. However, both techniques, while successfully used to soften the rejection of transplanted tissue, are as yet a long way from perfection. Both were, for instance, used with the world's first heart transplant patient, Mr. Washkansky, and despite protestations to the contrary by his surgeon, it appears that an irreparable rejection process started soon after the transplant. While the heart transplant cases have undoubtedly increased medical knowledge regarding both the use of suppressant drugs and of tissue typing to minimise incompatibility and consequent rejection, it is still not yet thought possible accurately and consistently to match tissues from different individuals prior to transplantation.

Dr. Blalberg, the as yet only long term surviving heart transplant recipient, had some rejection trouble shortly after his operation in January, but the immuno-suppressive drugs, though used more sparingly with him, appear to have the problem under control, and perhaps solved.

Britain's /

Britain's first heart transplant, performed May 3, 1968, at London's National Heart Hospital, was aided by recent knowledge gained about tissue typing and about the immunology and rejection reactions of a transplanted organ. The donor and recipient were typed and matched as to blood type, protein content and chemical composition of tissue before the transplant went forward. Also, the British team should be benefited by new research into the use of anti-lymphocytic serum (ALS), which attempts to avoid rejection by preventing the body's defenders against foreign invasions - white blood cells - from attacking the muscle cells of the heart.

ALS and ALG (anti-lymphocytic globulin) are blood fractions produced in horses by exposing them to human white blood cells. Both substances have been used with striking success in recent kidney transplants at the University of Colorado and A.L.S. may eventually pave the breakthrough in animal to man transplants.

The

29 The Observer, May 5, 1968, p.3.
31 The Observer, May 5, 1968, p.3.
33 The Times, May 9, 1968, p.10.
The immunological reaction problem aside, another serious medical limitation on the increase of successful organ transplants is the insufficient supply of available organs. While some naturally replaceable tissue such as blood or skin may be taken from a living donor, as well as one of two paired organs such as the kidneys, without a substantial detriment to his health, the same is obviously not true of the vital organs - liver, heart and lungs. For these organs, as well as corneas, blood vessels and bone, the only practical source is a dead donor, a cadaver. However, this poses serious difficulties of time. While "non-critical" tissues such as skin (within twelve hours after death) and corneas (within six to twelve or even eighteen hours after death) may be leisurely removed after the donor's death, "critical" tissue such as the kidney, the liver and the heart must, at present, be removed within about thirty minutes of the arrest of circulation.34 However, the problem of organ storage may largely be a technical one of simulating body circulation in a cadaver kidney or other tissue. Dr. Folkert O. Belzer of the University of California has developed a machine which, by feeding plasma fortified with body chemicals and penicillin into a cadaver kidney, may be able to maintain its healthy existence outside /

34 "Prefatory Note", op.cit., p.3.
outside the deceased donor and enable its use in transplants up to three days after removal. Even at present, kidneys stored at 5°C may be kept viable for up to six hours. The same is true of the liver, when stored at between 6°C and 12°C and supplied with blood by a miniature heart-lung type machine.

The precious time factor in the utilisation of cadaver tissues for transplantation is not the only difficulty to be overcome. It is, however, at least one that can be overcome by medicine. Other, perhaps less soluble problems in the use of cadaver donors for transplants are created by the law dealing with the status, treatment and disposal of dead individuals. There are many who feel that these and other legal problems are the greatest present impediment or road-block to progress in human organ transplantation. Whether or not this is true cannot be appreciated without an analysis of the legal difficulties in this area, which now follows.

B. THE COMMON LAW AND THE USE OR TREATMENT OF DEAD BODIES

Granted that cadaver donors are likely to be the only large source of tissue for homotransplants, the law regulating their /
their use must be ascertained. We can start from the proposition that, barring the enactment of relevant statutory guidelines, the common law limits the individual's power to give valid directions regarding the disposal of his body or selected parts thereof after his death. What statutory material does exist in this area, and it is growing, will be discussed subsequently. Here, for the moment, however, we are concerned with the operation of the common law in this area. Once that is ascertained, we can more clearly superimpose those legislative enactments that are relevant and thereby more clearly gauge their application and scope.

That the individual had only a limited power under English common law to prescribe disposition of his cadaver probably stems from the fact that originally in England the Church and the ecclesiastical courts exercised jurisdiction over matters involving dead bodies. Lord Coke recognised such jurisdiction and stated such matters generally not to be within the cognisance of the common law courts. When, in the seventeenth century, the common law began to take jurisdiction of

39 Wasmuth and Stewart, op.cit., p.147.
41 Ibid.
of religious offences, it was accepted that no property rights existed in a dead body, the corpse was _res nullius_.

While no property right existed in the traditional sense, the courts nonetheless recognised a right of possession for purposes of burial in the surviving spouse, the children or the next of kin (in that order).

Whoever took charge of the dead body after death was not considered the owner, but merely held it "as a trust" for those with an interest in the body, subject to the protection of the public. The very early American decisions adopted this trust concept, but they subsequently developed the theory that a quasi-property right in dead bodies vested in the nearest relatives because of their duty to bury their own dead.

This quasi-property right included the right to custody of the body for proper burial, the right to have the body remain undisturbed where properly buried and the right to bring an action for damages if any outrage, indecency or injury were caused.

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42 Louisell, _op. cit._, p. 87.
43 Vestal, Taber & Shoemaker, _op. cit._, p. 275.
44 Foster v. Dodd (1867) 3 Q.B. 67, 77.
45 Wasmuth & Stewart, _op. cit._, p. 452, citing Pierce v. Swan Point Cemetery, 10 R.I. 227, 14 Am. Rep. 667 (1872) at p. 453 to the following effect, "That there is no property right in a dead body, using the word in the ordinary sense, may well be admitted. Yet, the burial of the dead is a subject which interests the feelings of mankind to a much greater degree than many matters of actual property. There is a duty imposed by the universal feelings of mankind to be discharged by someone towards the dead; a duty, and we may also say a right, to protect from violation; and a duty on the part of others to abstain from violation; it may therefore be considered as a sort of quasi-property."
the body of the deceased.$^{46}$

While Scots law did not recognise any property rights in a dead body after it was committed to the grave, $^{47}$ it is not so clear what rights remained in the relations before interment of the deceased, for during that time an indictment could be raised for abstraction of the corpse. $^{48}$ There is some theoretical difficulty in concluding that a corpse is property before burial, but not after interment. Nonetheless, modern authority in Scots law appears to support the contention that a corpse could be owned by those entitled to it for burial and that an improper taking of the corpse is theft. $^{49}$

Generally, the person with the legal right to possession of the cadaver is entitled to receive it in the same condition as when death occurred. $^{50}$ While the public interest may justify mutilation by autopsy, the person entitled to post-mortem possession of the body — be it spouse or next of kin — may sue for damages for unlawful mutilation of or injury to the corpse. The action is not, however, to recover damages for harming the corpse, but rather as solatium for the injured feelings/
feelings of the relations. In other words, the basic interests in the surviving spouse, children or next of kin of the deceased are emotional interests connected with the dignity of the disposition of the body.

The legal right to bury a corpse as a practical matter vests in the nearest relative of the decedent who is in a position to be able and is willing to perform that duty. If need be, this duty of burial may be imposed upon the executor or administrator of the deceased's estate.

If the party entrusted with the duty to bury the dead body either attempts to sell it or make any other disposal of it which offends public feelings or endangers public health, he may well be subject to criminal prosecution for commission of a common law crime as well as a civil wrong. "Any disposal of a dead body which is contrary to common decency/"

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51 Wasmuth & Stewart, op.cit., p.454 (Larson v. Chase, 47 Minn. 307, 50 N.W. 238(1891), in overruling a demurrer to a complaint for damages due to unlawful mutilation of the complainant's deceased husband, concluded, "That mental suffering and injury to the feelings would be ordinarily, the natural and proximate result of knowledge that the remains of a deceased husband had been mutilated, is too plain to admit of argument." The wife's mental suffering and nervous shock were the only damages alleged); Accord, Pollock v. Workman, 1900) 2 F.354.

52 "Prefatory Note", op.cit., p.4.

53 Wasmuth and Stewart, op.cit., p.455.

54 "Prefatory Note", op.cit., p.5.

decency is an offense at common law." 56

In the Scottish case of Dewar v. H.M. Adv. 57 the panel received a severe sentence for the theft of coffin lids of those deceased entrusted to him for cremation. The Lord Justice-General (Normand) held such action to be "inhuman disrespect for the dead" as well as "callous indifference to the feelings of the living." 58

A further charge of "shameless, shocking and irreligious" conduct for mishandling of the corpses assigned to Dewar for cremation was preferred by the police, but the Crown did not proceed on it in the case. 59

Thomson v. State 60 held it an offense for an undertaker to attempt to sell the body of a pauper entrusted to his care for burial. In Baker v. State, 61 the defendant exposed a boarder's dead body to public view for several days, propping it up and concealing the fact of death, in order to collect his monthly welfare check. Without statute, she was convicted of /

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57 1945 Ill. 5.
58 Id., at p.10.
59 This bizarre charge apparently was drawn from Hume, who cites it in relation to an Edinburgh man hanged for throwing the unclothed body of his dead wife out of a third story window onto the High Street.
60 105 Tenn. 177, 98 S.W. 213(1900).
61 215 Ark. 851, 223 S.W. 2d. 809(1949).
of a common law crime for indecently treating a corpse.

The rights of the relatives to immediate possession of
the corpse in the same condition as when death occurred must,
at times, give way to the public interest. It may be
necessary to detain and examine the body because of its
evidentiary value in litigation. One obvious instance
is a life insurance policy or workers compensation award
dependent for resolution on cause of death and surrounding
circumstances. Not infrequently, life insurance policies
will contain autopsy clauses. Another such instance is
when death occurs under suspicious circumstances and an
autopsy or post-mortem examination is ordered by the public
medical examiner or coroner to ascertain the cause of death
or to make some contribution to medical science. Such may
be the case where death occurs suddenly, violently, unexpectedly,
with no physician in attendance, or while the patient is under
an anaesthetic. In Scotland, such deaths are referred to
the Procurator Fiscal for inquiry and the performance of a
post-mortem dissection of the corpse is within his discretion.
The Coroner or medical examiner has similar jurisdiction in
England.

62 Vestal, Taber & Shoemaker, op. cit., p. 279.
63 "Prefatory Note", op. cit., p. 7.
64 See generally Glaister, Med. Jurisprudence and Toxicology.
65 Ibid., pp. 15-19.
England and America. 66

If, however, an autopsy is unauthorised, the next of kin may sue for damages. Their right to possession of the body for burial is normally a right to the body intact. 67

"The theory is that an unauthorised autopsy interferes with this custodial right because the dissection of the body prevents burial in a proper manner." 68

The person with the burial right of the corpse may grant permission for an autopsy as well as sue for an unauthorised dissection. 69 It is also true that generally the deceased may consent by written authorisation during his lifetime or by will, to the performance of an autopsy. 70 However, in the absence of enabling statutes, this power in the decedent is not without question and some states would allow the inconsistent wishes of close relatives to prevail. 71 Massachusetts law, for example, does not apparently give binding effect to the decedent's directive for consignment of his corpse to science for anatomic dissection or post-mortem examination, but rather allows the next of kin to deny such a disposition. 72 Nonetheless, a recent case in the Commonwealth, may well have altered /

67 Ibid.
68 Ibid., pp. 268-269.
69 Wasmuth and Stewart, op. cit., p. 459; Chayet, loc. cit.
70 Ibid.; Vestal, Taber & Shoemaker, op. cit., p. 251.
71 Couch, Curran and Moore, op. cit., p. 693.
72 Ibid.
altered this Massachusetts law. In O'Dea v. Mitchell, 213 N.E. 2d 870 (1966), the Supreme Judicial Court of Massachusetts dismissed an action brought against an undertaker by the decedent's next of kin for alleged misconduct in handling the corpse and improper burial. Addressing itself to the fact that the undertaker had apparently followed the decedent's ante-mortem instructions in so acting, the Court stated,

"The plaintiff's standing (to bring the action) rests on the statement that they are 'next of kin' to the decedent, and therefore have the right to possession of the decedent's body. That right rests however in the next of kin only when there is no surviving spouse or no contrary provision by the decedent concerning the disposition of his remains...The absence of...contrary directions by the decedent must be alleged by the next of kin in order to establish their standing to sue." 73

Whether consent for autopsy has been given ante-mortem by the decedent or post-mortem by those with the right to burial of the corpse, the dissection must be carried out within the scope of the consent given and, more importantly for purposes of transplantation, does not include the removal and retention of organs.74 There are several Scottish and American cases in point. Hughes v. Robertson75 involved a damage action for unlawful /

75 1913 S.C.394.
unlawful post-mortem examination of the widow's deceased husband, which autopsy included removal of several vital organs from the corpse before it was returned to her. In an earlier Scottish case, Conway v. Dalziel,76 the court stressed that the unauthorised retention of organs from the dead body examined is another and more serious wrong than the unlawful post-mortem itself.

In Hill v. Travelers Ins. Co.,77 defendants were held liable for violating the stipulation of the decedent's surviving spouse that the autopsy should not be performed in a public place and should not involve mutilation of the body. The defendant's had removed decedent's heart for use as evidence to defeat an insurance claim. In Korber v. Patek,78 a physician was held liable for removing the corpse's stomach and refusing to return it when he had only been authorised to "examine" the body.79 Again, in Hassard v. Lehane,80 an action was brought against the coroner who, during the course of an authorised autopsy, had removed the corpse's heart and spleen without satisfactory explanation.81

Once /

76 (1901) 3 F. 918.
77 154 Tenn. 295, 294 S.W. 1097(1929).
78 128 Wis. 453, 102 N.W. 40.
79 Chayet, loc. cit.
80 128 N.Y.S. 161(1911).
81 Vestal, Taber & Shoemaker, op.cit., p.288.
Once the body has been buried, the state still exercises a protective function over it against unauthorised removal. The improper unearthing of a dead body was early recognised as an offence "highly indecent and contra bonos mores" and as cognisable in the criminal courts. The fact that the exhumation was for scientific purposes (dissection) did not change its characterisation as a criminal offence. However, later Scottish practice and commentary indicates if the body was unearthed for personal, medical study, rather than for profit or perverted ends, the punishment would be much milder. The removal of a body from the grave was not in Scotland, considered as theft, but as a separate common law offence of crimen violati sepulchri. As the court in Dewar, supra, concluded at p. 11:

"In our law, the crime of disinterring human remains after interment is not punishable as theft, but as the crime of violation of sepulchres."

The essence of the Scottish crime, applicable only once the corpse has been buried or otherwise removed from the protection /

83 Ibid.
84 Alison, op.cit., p.463, discussing the case of John Campbell, the medical student from Aberdeen, who was only imprisoned for fourteen days and ordered to pay £100 to the Aberdeen Infirmary.
85 Alison, op.cit., p.461; Hume, i, 85.
protection of the law of theft, is disturbance of the dead body without permission of the relatives, executor or authority otherwise in charge of the corpse and interested in its undisturbed repose. 86

The English position, somewhat artificially, apparently considered the offence as theft when the body's clothes were taken from the grave along with the cadaver. 87

It appears that Roman-Dutch law is quite similar to the Scots law and Anglo-American common law in matters involving dead bodies, post-mortems and related legal rights and duties. In Roman law, the rights of custody, control and disposal of the corpse was in the hands of the heirs, who were to dispose of it in accordance with ideas of decency and religion. 88 This was also the position in Roman-Dutch law, the heirs or executor being required to carry out the terms of the decedent's will regarding burial as faithfully as possible - probably a greater burden than the English law would have imposed. 89 It is likely that the unauthorised conduct involved in Hughes, supra, would render the perpetrator liable to the relative possessing the burial rights in an actio injuriarum. 90

However /

87 Hume, Commentaries, i., pp.65-66.
88 Price, "Legal Rights and Duties in Regard to Dead Bodies, Post-Mortems and Dissections", 68 S.A.L.J. 403, 405(1951).
89 Ibid., pp.405-406.
90 Ibid., p.407.
However, this is not to say that the Roman-Dutch common law would hold any cutting into a dead body as *prima facie* actionable in the absence of enabling statute. The position is more flexible, so that,

"Any operation on a dead body which is generally accepted by custom is legal. This includes not only the activities of undertakers and embalmers, but also the long accepted customary practices of the medical profession in regard to post-mortem examinations and dissections of any kind made for *bona fide* medical or scientific purposes, provided that due attention is paid to the testamentary wishes of the deceased, or failing these, to the wishes of the next-of-kin or executor (if there is no next-of-kin)."

The Roman-Dutch law would apparently allow for cadaver tissue to be removed during statutory autopsies,

"provided that it is done *bona fide* and decently for medical or scientific purposes in accordance with long established custom in the medical profession."

This is probably the common law position also, if "medical purposes" is not interpreted to include the use of such removed tissue for purposes of transplantation.

This brings us to the question of whether and under what circumstances tissues may be removed from dead bodies for use in transplants. More than a dozen years ago, several American writers /

92 Ibid.
writers in the field stated carefully,

"It would seem to be fair to conclude that a person at the present time in the United States probably has the right to control the disposition of his body after death so long as no public policy is contravened, and it seems to follow that an individual, in his lifetime can give permission for the taking of tissue from his body after death." 94

It is true that the Anglo-American common law, in the absence of statutory provision, requires permission for the removal of organs from the corpse to be obtained from the person who possesses the right to burial. 95 While a post-mortem consent from such a relative will suffice, absent explicit direction for a contrary disposition by the deceased during his lifetime, it is often difficult to obtain in time to utilise rapidly deteriorating tissues.

If the deceased himself during his lifetime has executed a gift or direction 96 in proper form of his organs for transplant purposes, it will be normally upheld as a matter of common law, just as his ante-mortem right to direct an autopsy for /

94 Vestal, Tuber and Shoemaker, on.cit., p.287.
95 Wasmuth and Stewart, on.cit., pp.463-64.
96 Technically, a donor can only "give" or make a "gift" of his cadaver or its organs if he owns it in a "property" sense. It is not clear whether an individual "owns" his body after death, or even during his life. As a result, it may well be that a person can only make a direction of how he wishes his cadaver to be used, but cannot make a gift of what he technically does not and cannot own, of what is res extra commercio. It is submitted that a person, by virtue of a limited or quasi-property right in his body, may make a gift of it for post-mortem use, as long as such use is not contrary to public policy or good morals, thus the use of the terms "gift" and "donate" in this paper.
for any reasonable purpose will be. However, if his next-of-kin repudiate an attempted ante-mortem gift by the decedent, the earlier common law doctrines discussed may well support their wishes. While the Massachusetts case of O'Dea, supra, seems to have altered the prevalence of such a position there, about a dozen American states still follow the early English law and would uphold the repudiation. In these states, obviously, the authorities would not be safe acting on decedent's directions alone in removing an organ for transplantation. However, these states are in a minority gradually growing smaller due to legislative changes, which will be hereafter discussed.

C. LEGISLATION DEALING WITH USE OF THE BODY AND ITS VARIOUS PARTS FOR MEDICAL OR SCIENTIFIC PURPOSES.

1. Britain

The criminal law in England and Scotland early dealt with the unlawful taking and use of a cadaver as we have seen. However, it took the abominable, wholesale murders of the notorious Burke and Hare, which came before the Scottish courts /

98 "Prefatory Note", op. cit., p.9; this is the position in the British Anatomy Act of 1832, to be discussed shortly.
99 Ibid.; Couch, Curran and Moore, loc. cit.
courts in 1828, to prompt legislation dealing with post-mortem treatment of human bodies.\textsuperscript{100} As a direct consequence of public indignation at Burke and Hare's unsavoury trafficking in corpses, the Anatomy Act of 1832\textsuperscript{101} was passed and remains to this day.\textsuperscript{102} The Act provides for the deceased to direct, ante-mortem, that his body undergo anatomical examination after his death, so as to facilitate the carrying on of anatomy in the medical schools. The Act is of importance in the transplantation field for the light it sheds on the words, "party having lawful possession of a dead body", which have been borrowed and incorporated into the Human Tissue Act, 1961, as "person lawfully in possession of the body"\textsuperscript{103}. The words presumably have a similar meaning under both Acts and cases interpreting their use in the Anatomy Act may be helpful in clarifying their presently uncertain meaning in the Human Tissue Act.\textsuperscript{104} In \textit{Rex v. Feist} (1858)\textsuperscript{105} the master of a workhouse was held, for purposes of the Anatomy Act, to be the party "having lawful possession" of those dying in the institution. From this case, Lord Kilbrandon has reasoned that /

\begin{itemize}
  \item \textsuperscript{100} Lord Kilbrandon, "The Human Body and the Law", a paper presented to the University of Aberdeen Law Society, Feb. 26, 1968, pp. 3-4.
  \item \textsuperscript{101} 2 and 3 Will. 4, c. 75.
  \item \textsuperscript{102} Kilbrandon, loc. cit.
  \item \textsuperscript{103} 9 and 10 Eliz. 2, c. 54, 55.
  \item \textsuperscript{104} Kilbrandon, op. cit., p. 4.
  \item \textsuperscript{105} Dears and B., 590.
\end{itemize}
that the Board of Management of the hospital where an individual dies is likewise the "person lawfully in possession of the body" under the Human Tissue Act, 1961.\(^\text{106}\) If such is the case, then a more expeditious use for transplant purposes could be made of tissue from persons not expressly donating their organs under §1(1) of the Act, than could be made if the authorisation of the spouse or next of kin were held necessary, they being considered the "person lawfully in possession" of the decedent under §1(2) of the Act. Even if the hospital where a patient dies is considered to be the "person lawfully in possession of the body" under §1(2) of the Human Tissue Act, 1961, there is still a substantial impediment to expeditious removal of tissue for transplant purposes. The hospital would still be required to make "such reasonable enquiry as may be practicable" so as to have "no reason to believe" that the deceased had expressed an objection to such tissue removal during his lifetime or if any surviving relative objects thereto. Such "reasonable enquiry" may well be inconsistent with removal of viable tissue for transplantation in many instances.

\(^\text{106}\) \text{Ibid.}\
Lord Kilbrandon's interpretation is not concurred in by the English Medical Defence Union, which has recently been advised by leading counsel that, save in the "exceptional case", the hospital where a patient dies is not the "person lawfully in possession" of the cadaver for purposes of the Human Tissue Act. Rather, it is the executor or close family of the deceased who must authorise removal and who may veto the deceased's ante-mortem donation under §1(2) of the Act.

Lord Kilbrandon's suggested approach to the Human Tissue Act, 1961, is probably, it is submitted, the correct one. A careful distinction needs to be drawn here between the person with right to possession of the corpse - almost certainly the surviving spouse or next of kin under common law - and the person in possession of the deceased's corpse - almost certainly the institution where he expires. The Act is concerned with the latter, tangible possession, which the hospital clearly has, though it may well be otherwise bound to transfer that possession to the relatives.

The Human Tissue Act of 1961 has been criticised because even presuming the person lawfully in possession of the body is ascertained, the Act merely authorises, but does not require him /

108 Ibid.
him to carry out the deceased's donative direction. Furthermore, under §1(2) the surviving spouse or next of kin may bar a donation with which the person lawfully in possession of the body wishes to comply. Even if they are not opposed, the wording of the Act is such that their consent must reasonably be sought by the hospital authorities concerned, which will often involve a time lag fatal to the success of a proposed transplant. No such time-consuming procedure is necessary if the decedent had expressly provided ante-mortem for use of his cadaver under §1(1) of the Act.

It has been suggested that much of the problem posed by the Human Tissue Act would be cleared up by allowing the hospital where a patient dies to direct removal of tissues needed for medical (transplantation) purposes, unless there is reason to believe the deceased or his next of kin would object to such a use. In fact such a suggestion now forms the basis of a bill on "Renal Transplantation" introduced by Sir Gerald Nabarro, M.P., into the Commons on March 13, 1968 (Appendix IV). The Bill excludes application of the Human Tissue Act.

110 Kilbrandon, op. cit., pp. 5-6.
Tissue Act, 1961 and applies only to kidney transplantation.

The key section of the bill, (2), states,

"It shall be lawful to remove from the body of a human person, duly certified as dead, any kidney or kidneys required for medical purposes unless there is reason to believe that the deceased during his lifetime had instructed otherwise."

This new bill on kidney transplants avoids most of the criticisms levelled against the Human Tissue Act. It is interesting to note that the Nabarro Bill basically resurrects the presumption of consent embodied in Britain's first statute dealing with organ transplantation, the Corneal Grafting Act, 1952. Under this Act the "party in lawful possession" of the dead body could authorise the transplant simply in the absence of any reason to believe the deceased, surviving spouse or next of kin objected. While the Corneal Grafting Act has been repealed by the Human Tissue Act, 1961, this presumption as already noted, has not been carried over. The burden of "reasonable enquiry" imposed by the Human Tissue Act requires, as a practical matter, the consent of the deceased's next of kin. Whether the legislative presumption of consent contained in the above proposed legislation on kidney homografts will be applied to other, more or less, developed and accepted organ transplantation /

112 15 and 16 Geo.6 and 1 Eliz.2, c.28.
113 Ibid., §2.
transplantation procedures remains to be seen. The limited application of the renal transplantation Bill is perhaps a recognition that at some point the interests of medical and scientific progress must be balanced against social, moral and theological repugnance at the growing extent of "tampering" with and "interchanging" bodily parts. Politics is, after all, the art of the possible.

The Macarre Bill requires the donor to be "duly certified as dead", a deceptively simple and straightforward concept as we will see when we consider the unsettled, evolving and problematic definition of "death" today.

2. France

The recent news of Europe's first heart transplant operation in Paris has focused attention on French medical developments in this field. While France has not heretofore had legislation providing for the use of cadaver organs in transplants, since as far back as 1947 doctors in a restricted list of hospitals have been authorised by a Public Health directive to use organs obtained from autopsies performed without prior donation by the deceased or consent by his relatives for transplants. The directive states in relevant part,

"By /

"By the terms of the decree, the chiefs of services of hospitals are permitted to start an emergency procedure without delay after registration of death, to take organs from the bodies of the deceased patients, for scientific and therapeutic purposes, if the hospital administration has been entered on a list maintained by my department." 116

Excluded from the scope of this directive, although still under the jurisdiction of the coroner or medical examiner, are the victims of crimes, suicides and accidents occurring at work, as well as Moslems for religious reasons. 117

3. United States

There are a wide range of American statutes dealing with use of the human body and its parts for various medical and scientific reasons.

Some forty states now have statutes dealing with the use of unclaimed dead bodies by medicine and science for purposes of teaching anatomy and physiology and for research. 118 It has been said that ideally, each pair of medical students should have a whole cadaver to study and dissect, but the supply is not adequate.

The uncertainty as to whom is capable of authorising an autopsy has been clarified by legislation in a number of states. For /

116 Reentsma, loc. cit. (citing French source as 'Ministers de la Sante Publique et de la Population; Direction de l'Hygiene Publique et des Hopitaux, Circulaire no.17, 27 Janvier 1955').

117 Ibid.


119 "Prefatory Note", op. cit., p.7.
For instance, Conn. Gen. Stat. Ann. §19-143 allows an autopsy to be performed on written permission being granted by any of the following over eighteen years of age:

"Father, mother, husband, wife, child, guardian, next of kin, friend, or any person charged by law with responsibility for burial." 120

Since 1950 more than half the states have enacted legislation dealing with ante-mortem gifts by the decedent of his body and its parts. These statutes differ considerably as to content and coverage; some of them do not grant the surviving spouse or next of kin a veto over the decedent's disposition. 121 Some are quite limited in their enumeration of /

121 As La.Rev.Stats (1962) 17 §2351-5, which states in §2351 that,

"Every inhabitant of this state of the age of 21 years or older, of sound mind, may, by an instrument in writing and constituting a donation, arrange or provide for the disposition to be made of his body or any part of organ thereof, after death; provided that the disposition mentioned is made for the purpose of advancing medical science, or for the replacement or rehabilitation of diseased or injured parts or organs of the bodies of living persons. Any body or part or organ thereof...may be used in accordance with the terms of the donation immediately upon the death of the donor and without order of court or authorization by next of kin, or any other person..."
of permissible donees and purposes for donation of the organs, others are not. 122 The minimum age of the donor, commonly twenty-one, and the method of execution vary. 123 Many of the statutory schemes fail to provide for revocation of the gift and even more fail to take account of the conflict of laws problems posed by a transient donor. 124 This whole statutory situation has been recently characterised as one of "inadequacy, diversity, and confusion". 125

One of the best of the existing pieces of legislation dealing with ante-mortem gifts is that of California, which specifies the persons with a right of control over the disposal of a dead body where the decedent left no contrary instructions. 126 The order of assumption of this right of control is specified: spouse, children, parents, persons in next degree of kindred in the order fixed by law as entitled to succeed to the estate. 127 California Health and Safety Code §7100, in most relevant part, provides that,

"A decedent, prior to his death, may direct the preparation for, type or place of interment of his remains, either by oral or written instructions. If such instructions are in a will or other written instrument, he may direct that the whole or any part of his remains be given to a teaching institution, university, college, legally /

122 "Prefatory Note", op. cit., p.12.
123 Ibid.
124 Ibid.
125 Ibid., p.13.
127 Ibid.
legally licensed hospital, or to the State Director of Public Health, or to or for the use of any nonprofit blood bank, artery bank, eye bank or other therapeutic service operated by any agency approved by the Director of Public Health under rules and regulations established by the Director. The person or persons otherwise entitled to control the disposition of the remains under the provisions of this section shall faithfully carry out the directions of the decedent subject only to the provisions of this chapter with respect to the duties of the coroner."

The section has been criticized because it imposes no liability for failure to comply with the decedent's ante-mortem wishes regarding disposition of his body. And, of course, it does not provide for donation of the cadaver in the absence of the decedent's express consent.

The most recent statute facilitating the use of cadaver tissue for transplantation appears to be Ohio Rev. Code §2108.01.06 (May, 1967). The Act allows anyone of sound mind over twenty-one years old to give all or part of his body for research, educational or transplantation purposes, "effective upon his death", regardless of the wishes of his relatives to the contrary. Specified donees include physicians, hospitals, schools and non-profit human parts banks. The donee is notified of the gift under the Act by a written card which can be revoked up to death in the same manner as any gift.

Because /

128 Ibid., p.428.
Because of the often piece-meal and inadequate approach to legislation represented by the above-mentioned American statutes dealing with donation of cadaver tissues, the National Conference of Commissioners on Uniform State Laws, a prestigious advisory body, has been working on a uniform draft law entitled "The Uniform Anatomical Gift Act" (hereafter "Uniform Act"). The most recent, second tentative draft of the Act, along with full comment in explanation, is contained in Appendix V. The Uniform Act seeks to cover several fundamental points that no legislation heretofore has done satisfactorily\textsuperscript{129} and thereby facilitate proper legal treatment in America of organ/tissue transplantation from cadavers. The principal points of concern the Act seeks to cover are: by whom a gift of human tissues may be made; to whom; how the gift may be executed, delivered and revoked; and what effect the gift should have on the rights of relatives and the liability of the performing physicians.\textsuperscript{130}

The proposed Uniform Act, by §2, allows removal to be authorised by persons in a stated order of priority where the decedent has executed no ante-mortem consent, unless the specified individual "has knowledge that contrary directions have been /

\textsuperscript{129} "Prefatory Note", \textit{op.cit.}, p.16.
\textsuperscript{130} \textit{Ibid.}, pp.15-16.
been given by the decedent" (§2(b)). By so providing, the Uniform Act avoids the "person lawfully in possession" of the cadaver interpretation problems of the Human Tissue Act, 1961. The Uniform Act also appreciates the very limited time after death available for the removal of critical tissues like the kidney, liver and heart by setting out a specified list of survivors preferred order so as to facilitate expeditious execution of permission for removal and transplantation (§2(b)).

Any individual competent to execute a will is permitted by the Uniform Act to donate all or any part of his body, ante-mortem, to any accredited physician, hospital, school, body parts bank, or even individual for medical education, research, scientific advancement, individual therapy or transplantation (§2(a), §3).

The Uniform Act allows execution of the gift by will or by any writing signed in the presence of and by two witnesses and duly delivered to the donee, if one is specified (§4). Means for revocation of the gift are enumerated (§5).

The Uniform Act insures the donee or other person authorized to utilise the gift (performing physician) who acts in good faith against civil liability (§7(b)).

§7(a) of the Uniform Act contains two wise provisions not /
not apparently specified in any other legislation enacted to date. First, time of death is left to be determined by the donor's attending physician alone. Second, the donor's physician in attendance at the terminal illness is not to be a member of the team of surgeons which transplants the donor's part or parts to another individual.

These latter provisions, assuring for distinction between donor and donee's physicians, recognises the almost inevitable conflict of interest that must arise in most, "time is of the essence" transplantations where the transplant surgeon is also attending the donor and anxious to remove a critical organ at the earliest moment after "death" to avoid tissue deterioration. This provision wisely prevents a physician from being placed in the compromising position that Dr. Barnard in South Africa has accepted for himself, despite criticism. 131

Furthermore, by allowing "death" to be determined "by the physician in attendance upon the donor's terminal illness or certifying his death", the Uniform Act avoids a formal legal attempt to define what many feel is basically a medical concept and one presently undergoing a rapid evolution. 132

It is expected that this Uniform Act will be available

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132 See discussion, infra, of problems raised in the transplantation field due to the unsettled definition of "death".
for legislative adoption in basically its present form later this year.

D. THE DEFINITION OF DEATH

Death is intimately tied up with transplant surgery.

The Roblain transplant in France was facilitated by a new definition of death decreed upon by the Government on April 24, 1968, which enabled the surgeons to remove the donor's heart, once electro-encephalograph records showed a complete absence of brain activity and reaction, while still maintaining the young donor's heart by artificial ventilation. The Government decree followed upon a decision by the French Academy of Medicine to recommend a private member's bill which defined "clinical death" in relation to the transplantation of human organs. The Act apparently allows removal of organs from cadavers (those who have undergone "cerebral death" as shown by a flat electro-encephalograph) which are artificially maintained; biological death of the brain is substituted for cessation of respiration and circulation. Article I of the French Bill, as presented to the legislature, is the relevant section and states,

"Clinical /

135 Revillard, Ethics in Med. Progress, p.95.
136 The Times, April 30, 1968, p.1; see more detailed discussion of this subject in general, infra.
"Clinical death is considered to have taken place when a person is affected by lesions incompatible with continued life, though maintained in a state of vegetable existence by various devices, and when an electro-encephalogram has shown, for a period of at least ten minutes, lack of function in the higher nervous centres, that is to say when the electro-encephalographic tracing is a straight line."

This recent French law concerning a satisfactory definition of death for purposes of transplantation is the only attempt among recent legislative enactments involving human transplants to come to grips with this problematic issue. The recent statutes, including the British Human Tissue Act, 1961, The Ontario Human Tissue Act, 1962-63, and the Danish Act, 1967, merely refer to "death" without attempting to offer any definition.

Whether much of existent legislation has wisely avoided any attempt to define death for transplantation purposes, as the new French Act has, is uncertain. It is, however, certain that many of the legal and ethical questions now surrounding transplant procedures, not to mention the medical problems for the moment, hinge on the fact that no clear cut definition exists as to time of death.

In the light of advancing scientific knowledge concerning simulation of life, traditional definitions of death are no longer /

137 Kilbrandon, op.cit., p.7.
longer accurate. Dorland's illustrated Medical Dictionary, twenty-fourth edition, defines death as, "The apparent extinc-
tion of life, as manifested by the absence of heartbeat and respiration." Glaister defines death as "complete and persistent cessation of respiration and circulation". However, these standards definitions do not take adequate account of modern use of analeptic and tensive drugs, hypothermia, coronary perfusion, pacing and massage, and artificial res-
piration by pulmoflater, which can allow the body metabolism to function for hours, days and in some cases even months beyond traditional limits.

Death, in the current context of transplant surgery, is suggested by most as occurring at one of two times - either when the patient reaches the "hopeless" stage or when the apparatus being used to maintain him is discontinued. While some define the "hopeless" situation in terms of lack of brain function, a more traditional and universal determinant and one related to brain death is the heart's inability to maintain a spontaneous beat.

In accordance with this basic dichotomy of opinion re-

regarding the so-called "moment" of death, the Canadian Medical Association /

138 Wassam and Stewart, op.cit., p.464.
140 See Keith Simpson, "Moment of Death", 3 Abbottsme 22, 23(1967).
141 Elliott, "When is the Moment of Death", (1964) 4 Med. Sci. & Law 77.
Association recently appointed a select committee to define life and death, distinguishing as to "biological" and "mechanical" life and death. 142

The major difficulty in defining the time of death is that "death is a process and not a moment in time as the law believes". As one observer has noted,

"Biologically we die in bits and pieces. Not all parts of the body lose their vital properties equally and synchronously, i.e., not all parts of the body are equally 'dead' at the same time. Indeed it is this simple thanatological fact that makes organ transplantation possible at all." 144

It is quite correct that death is a process and may occur on a number of planes. The immediate death of the individual is termed "somatic" death and this is the most difficult point in the process to pinpoint, but must be determined as soon as possible after occurrence so as to facilitate the removal of organs for transplantation which have suffered little or no cellular deterioration. Professor Keith Simpson summarises the signs of somatic death as insensitivity and loss of electro-encephalograph rhythms, cessation of respiration and of circulation. 145 He tempers these remarks by stating,

"There /

"There is still life so long as a circulation of oxygenated blood is being maintained to LIVE vital centres - i.e., brain...whether it (the vital centre) is alive or dead can only be tested by withdrawal of artificial sustenance; a subject who cannot 'pick up' spontaneously and survive upon the withdrawal of artificial maintenance can be certified dead - but not before this test is imposed." 146

Somatic death is followed by cellular or molecular death, which involves death of the body tissues. The brain is the first tissue to die and undergoes irrecoverable damage if it is deprived of an oxygenated blood flow for five minutes. 147

The kidneys can function for up to one hour after somatic death, the striped muscle for hours and such tissue as the hair and nails for days. 148

Because of its extreme sensitivity to the absence of a normal oxygenated blood flow and its general inability to regenerate its tissue, the brain's "death" is rapid and irreversible. The completely anoxic brain will generate no valid electro-encephalographic impulses. 149 There are those who believe that once such a condition has been determined, the flat electro-encephalographic rhythms may be relied upon to determine when loss of brain function has become irreparable, which in turn implies an irreversible absence of life. 150

This /

146 Ibid.
147 Ibid., p. 71.
149 Hamlin, "Life or Death by EEG", 190 J. A. M. A. 112 (1964).
150 Ibid.
This apparently was the criterion of death used by the French physicians in their recent heart transplant. \(^{151}\) Electroencephalographic tests on the heart donor had recorded no reaction from the brain for several hours before removal of the artificially maintained heart was undertaken. \(^{152}\) Advocates of this procedure as a criterion for death have recommended at least a one hour's flat (no reaction) electro-encephalograph to have been recorded, as well as no spontaneous respiration during the same period. \(^{153}\) Not all physicians, however, place faith in a flat electro-encephalograph recording as the dispositive criterion for death. \(^{154}\)

The difficulty with accepting irreversible brain damage as the criterion for somatic death ("cerebral death") is that a person may "die" before his heart and lungs cease operation. Under this approach, the "vegetable" with irrecoverable brain damage is "dead", though he continues to "exist" at a very low level by carrying on the basic metabolic functions of breathing, circulation, swallowing and excretion. \(^{155}\) Even if severe brain haemorrhage has rendered the patient apneic (unable to breathe), he may be maintained, often for a considerable period of time, if...

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152 Ibid.
154 Dr. J. Gillingham (Surgical Neurology, Edinburgh U.) in a symposium, "When is life?", sponsored by the Edinburgh Medical Group, Oct. 31, 1967.
155 Louisell, op. cit., p.92.
by the artificial ventilation of an automatic respirator.\textsuperscript{156}

It is not easy to call such a patient dead, for so long as the artificial maintenance is continued "life" continues in his tissues. There will inevitably come a time when "life" in terms of respiration and circulation cannot be maintained, for all methods of artificial maintenance sooner or later fail and cellular death leading to putrefactive change occurs. However, in traditional terms at least, while artificial maintenance continues to simulate life, "death" can come only after the decision is made to shut off the mechanical support and the patient is unable to sustain his vital functions of circulation and respiration independently.\textsuperscript{157}

The fact that death will follow immediately upon termination of artificial means to maintain respiration and/or circulation is no means for determining the patient so dependent to be "dead".\textsuperscript{158} A poliomyelitis victim, for instance, may be fully dependent on an iron lung to sustain respiration, yet he is very much alive and likely has no brain damage whatsoever.

Some\textsuperscript{159} conclude that "brain death" is an important factor

\textsuperscript{156} Wasmuth and Stewart, \textit{op. cit.}, p.465.
\textsuperscript{157} Simpson, \textit{op. cit.}, p.70, quoted in 125.
\textsuperscript{158} Wasmuth and Stewart, \textit{loc. cit.}
\textsuperscript{159} Ibid., p.466.
in the determination of death, and that it can be said to have occurred when all chances of the patient recovering consciousness have been eliminated. Death is seen primarily by the state of unconsciousness, yet the long-term coma cases are not resolved.

The unreported case of Regina v. Potter perhaps points up better than any other the difficulties that present inadequate definitions of death can pose for the would-be transplant surgeon. 160 In Potter, it seems, a man was admitted to hospital with a severe head injury he had sustained in a fight with the named defendant. He stopped breathing after fourteen hours and was placed on an artificial respirator for twenty-four hours, at the end of which a kidney was removed for transplantation. After this nephrectomy the respirator was shut off and there was no spontaneous respiration or circulation.

Under traditional definitions of death, the victim in Potter was not dead until his breathing and circulation came to a persistent and complete halt when the respirator was finally turned off nearly two days after his admission to hospital. 161 Professor Simpson and Professor Woodruff would seem to agree.

161 See 119, 120 definitions.
Yet if this were the case, was not the physician who removed the victim's kidney guilty of a crime (malicious wounding) and a civil wrong (battery), for the removal took place while the victim was still "alive", without his consent and was not for his benefit. Furthermore, it would seem that the physician, in shutting off the respirator and allowing the patient-victim to die, serves to break the chain of causation between the original wrongful act (the assault in Potter) and the death that finally is allowed to occur; the physician constitutes a novus actus interveniens which releases the original wrongdoer from legal liability for homicide. It would seem that the judge considered such to be the case in Potter, for the defendant was committed for trial by the Coroner after a jury's finding of manslaughter, yet was convicted only of common assault by the court. Finally, using this same line of reasoning, it can be argued that by shutting off the artificial respirator the physician is the immediate cause of the patient's death and guilty of homicide, that technically it is not manslaughter but murder, while the physician has in a legal sense caused /

162 See 125 definition and 157.
163 Elliott, loc.cit.
164 Ibid.
165 Ibid., p.78.
166 Ibid.
caused death, the conduct is presumably not unlawful for he has only terminated the artificial prolongation of life not independently viable in accordance with accepted medical ethics and practice. 167

A recent transplant case in Houston, Texas, raised similar problems to those raised by Potter. Surgeons used the heart of a homicide victim after obtaining the county medical examiner's permission and after declaring the donor dead when his heart ceased functioning, even with mechanical support. The medical examiner certified death somewhat earlier on lack of brain function as measured electrically. 168

Aside from aforesaid causation problems in the homicide prosecution, other difficulties arise: can an autopsy, required in homicide cases, be considered complete without a heart? can an incomplete autopsy affect the murder prosecution and defence at trial? and, aside from possibly causing death, can the transplant team be prosecuted for interfering with a planned autopsy by removal of the victim's vital organs? 169

Most of the problems discussed above should and could be avoided, it is submitted, by excluding suspected homicide victims as transplant donors.

A /

A more subtle difficulty involved in not considering death as having occurred so long as a patient's respiration and circulation are artificially maintained is the high degree of discretion it vests in the attending physician to determine when death shall in fact occur. By flipping a switch the physician can literally choose the time of the patient's death and might be strongly pressured to do it at a time most propitious to an interested party - such as an heir who must survive another or to a given time in order to inherit property, obtain insurance and estate duty benefits and the like.\(^\text{170}\) Or what of the over-anxious heir who plunges a dagger into his benefactor or who switches off the machine himself to assure that the man does not come "back to life". Is the malefactor guilty of murder or only of interfering with a corpse?\(^\text{171}\) The result depends, of course, on when death occurred.

Under the more recently suggested definitions of death discussed that rely on irreversible brain damage as the criterion, many of the above problems are avoided. The physician cannot be tempted to prolong a life artificially in order to benefit some individual. Nor can the physician be accused of homicide for deciding to "shut off the switch" in /

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\(^\text{170}\) Simpson, J Abbottemo 22, 26(1967).
\(^\text{171}\) Williams, The Sanctity of Life and the Criminal Law, p.18.
in a hopeless, "vegetable" case. There is no danger of the physician's acts breaking the causation chain of criminal liability connecting the wrongful act and the death, as appeared to happen in Potter. At the same time, however, is the heir who shuts off the switch or stabs the patient being artificially maintained to be held innocent of homicide because of prior irreversible brain damage?

Many of the disquieting facts raised by Potter and the Houston (Nicks-Stuckwish) transplant cases may well be resolved by a damages suit recently filed against a Virginia transplant surgeon by relatives of the heart donor. Allegedly, no permission was given by the donor or his family to use his heart for transplant purposes and it is unsettled when "death" occurred.

A case involving facts very similar to Potter arose several years ago at the Karolinska Institute in Stockholm. Surgeons removed and transplanted a kidney from a dying woman, who was comatose from a cerebral haemorrhage, but not dependent on artificial means at the time for either respiration or circulation. The woman donor, whose husband had consented to the removal as had the victim's wife in Potter, died two days /

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173 Wasmuth and Stewart, op. cit., p. 467.
days later in a respirator. The surgeons defended their actions (as in Potter) on the theory that irreparable damage had occurred to the brain and central nervous system, the woman’s chances were considered one hundred per cent hopeless and that conventional definitions of death were unsatisfactory in the circumstances. The case has been criticised from legal and moral grounds, but apparently no legal liability ensued.

"As can be seen, the time of death, which formerly depended mainly on factors WITHIN the patient may now depend increasingly on factors OUTSIDE the patient; the availability of facilities, the decision to resuscitate, the choice of alternative death concepts and the decision to discontinue treatment." 175

Many, probably the majority, of the commentators seem to feel that the definition of death is a medical one only, to be determined by the attending physician. 176 As a result, medical definitions continue to be offered and the Committee of Ethics of the World Medical Association is struggling with the problem. 177 Professor C.N. Barnard is quoted as defining death as,

"one /
"one, no reflexive action for a period of
time indicating the brain is disconnected
from the body functions; two, no spontan-
eous respiratory movement; and, three,
no evidence of heart activity, as shown by
electrical measurements." 178

Voigt 179 has suggested that

"Death has occurred when every SPONTANEOUS
VITAL function has ceased permanently."

Under such a comprehensive definition, brain damage of an
irreversible nature would not alone be sufficient to con-
istitute death.

Professor Woodruff of Edinburgh seems to feel 180 that
no change in traditional definitions of death is needed due
to recent advances in medical science's ability to keep people
"alive". He stresses, rather, the need for a new code of
conduct to govern the use of such new medico-scientific re-
sources by the profession. The prominent surgeon feels the
attending physician must determine death by the standard crit-
eria after he has made the decision to "shut off" the machine.
If he is satisfied as to death at that time, then he may refer
the deceased to a transplant team.

Other commentators have concluded that the definition of
death /

178 Quoted from Hawthorne, The Transplanted Heart (1968),
p.143, by Hunt, op.cit., p.4.
179 Voigt, loc.cit.
180 M.F.A. Woodruff, "The Ethics of Organ Transplantation",
Address to the Edinburgh Medical Group, May 7, 1968.
death is not purely a medical question, but has become a social question also that must be considered and resolved by the appropriate legislative and judicial authorities on a public policy basis. It would seem that social or public policy considerations favouring transplantation surgery were at least partly responsible for the new definition of death recently decreed upon the French Government, which paved the way for the Gyppaz-Roblain transplant, Europe's first. It is not unlikely that similar policy considerations might prompt other legislation on the French model when more convincing medical signs of irreversible brain damage become known. Certainly such an approach has less legal problems to resolve than a definition that finds death only after all artificial means of resuscitation and prolongation of "life" have proved unsuccessful. The latter type of definition would have to protect the physician who ethically shuts off the machine without encouraging unethical determinations of death by the same method; it would likewise have to resolve problems of causation relating to the original wrongdoer involved, if any, as in Potter.

E/

182 Hunt, on cit., p.3.
183 Wasworth and Stewart, loc. cit.
184 Hunt, loc. cit.
E. THE PROBLEM OF THE "CONSENTING" LIVING DONOR

The recently enacted Danish "Act About Removal of Human Tissue" (June 9, 1967) is one of the few statutes to deal with the use of living as well as cadaver donors for organ transplantation. §1 of the Act requires only a written consent to justify the removal of tissue from a living donor "to treat illness or bodily harm in another person". §2 requires the donor in normal cases to be twenty-one years old. However, §4 allows such removal only if it can be accomplished "without obvious risk to the patient". This caveat limits the scope of acceptable removals. It also raised two fundamental questions concerning the giving and gaining of consent by and from transplant donors: namely, what is the necessary "capacity" for a proper consent and, what is the permissible "extent" of consent in this area?

We have had recourse to consider the thorny area of consent in a medical context before, while dealing with sterilisation and the so-called "conversion" operation, and we shall have need to consider it once again when discussing voluntary euthanasia.

Several generalisations can be fairly safely ventured in regard to consent for medical purposes. If the treatment consented /
consented to has a recognised and accepted "therapeutic" purpose, no liability will ensue per se for the physician's invasion of the person in an attempt to achieve that end. 185 It is probably also true that consent makes lawful minor non-therapeutic (cosmetic) operations on the individual, such as straightening of the teeth, removal of skin blemishes, perforation of the ears and tattooing. 186 However consent will not justify homicide, maiming or the infliction of serious harm, particularly where aspects of indecency, brutality or the evasion of public duties are involved. 188

An important distinction must be drawn between consent for tissue removal that will not, and that which will, or might, be harmful to the living donor. The removal of naturally replaceable or repairable tissue - such as blood transfusions and skin grafts - does not create much, if any, problem where proper consent is obtained. 189 Where no permanent or serious damage will result to the donor from the removal /

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185 See relevant discussion, particularly on the uncertain scope of "therapeutic", in Chap. of Voluntary Sterilisation, footnotes 4-25; Gordon, Crim.Law of Scotland, P. 774.
188 See Rex v Donovan (1934) 2K.B. 498 (sexual indecency); Wright's Case, Co.Litt. 127a(1604), (begging); generally, Hughes, "Two Views on Consent in the Criminal Law", (1963) 26 Med.Lr. 233.
removal of tissue and where he and the donee are competent adults who knowingly and intelligently consent to the transplant, after a full explanation, no serious legal problem is likely to arise. 190 The important consideration here is not the "extent" of the consent, but rather the "capacity" for consent. The law is concerned only that the consent be given freely and knowledgeably and for that reason will be interested in the age, mental condition and capacity of the donor and the circumstances in which he consented. 191

Cognizant of this basic distinction, the South African Union Post-Mortem Act 192 treats the removal of "tissue replaceable by natural processes of repair" from living donors differently than the removal of "naturally irreplaceable tissue". The former class of tissue may be freely removed, the latter may be removed for transplantation purposes only where the donor consents in writing and two other physicians certify in writing that the removal will not "prejudice that person in any way". The latter limitation has left the legality of removing one of two healthy kidneys from a willing living donor in /

190 Louisell, op. cit., p. 80, citing Justice Cardozo's remark in Schloendorn v. N.Y. Hospital, 211 N.Y. 125, 105 N.E. 92(1914), that "Every human being of adult years and sound mind has a right to determine what shall be done with his own body".
191 Ibid.
in considerable doubt and elimination of the "in any way" strict limitation has been recommended recently as a means of facilitating the use of living kidney donors. 193

The legal effect of consent by a living donor to the removal of tissue not naturally replaceable by his body remains uncertain. At present, the use of a healthy living donor for a kidney transplant, as mentioned above, focuses this uncertainty most immediately. But beyond that, the whole question of what one willing individual can donate for the medical improvement or health of another - particularly a close, loved one - has yet to be fully considered by the law. The uncertainty revolves around the traditional legal attitude of hostility towards surgery not carried out for the benefit of the patient, though with his consent. 194

Few legal problems have arisen from the use of live kidney donors, though the removals cannot be without some harm - at least potentially in weakening the donor's reserve should his remaining healthy kidney fail - to the donor. The high chances of satisfactory existence on one kidney probably explain why legal liability has not sought to be imposed for removal of one /

193 Shapiro, op.cit., p. 144.
194 Harvey, (1967) 30 Mod.L.R. 591, 593.
of one of the paired organs. And even if the loss of one kidney does involve a slightly increased risk to the donor, most have felt it is clearly outweighed by the need of the prospective recipient.

At the same time as the law will not allow consent to justify homicide, it is consistent that it not allow the removal from living donors of unpaired vital organs such as the liver, lungs and heart. At least for the present, the law is not willing to justify a donor's death by the severity of the prospective recipient's need. Some suggest this is not necessarily the proper order of priorities, particularly where the donor is nearing death. Professor Smith, for example, finds it difficult to accept the legal state of affairs that allows a person to give his life to save another from drowning, but does not allow a person to save another who is dying from a defective vital organ.

Between these two extremes then - on the one hand that a living donor may consent to the removal of tissue that will involve little or no risk to his health, such as skin or blood and on the other hand that a living donor may not give up his life /

195 Shapiro, loc. cit.
197 Ibid.
198 T.B. Smith, "Law and the Human Body: the Relevance of Consent", Address to the Royal College of Surgeons, Edinburgh, Nov. 17, 1967; Woodruff, loc. cit., would probably agree, at least if the donation were of one of two healthy kidneys, but here death does not result and is not a serious risk.
life in the form of a vital, unpaired organ for another's benefit - exists a difficult and unsettled legal terrain. Most hope they will not have to chart it and pin their hopes on improving transplantation techniques - particularly tissue preservation and storage - that will make cadaver donors a satisfactory, sufficient, and exclusive source of tissue.

Several recent cases from Massachusetts have served to point out that situations may arise where both the "capacity" to consent and the "extent" of the consent are at issue.

The cases involved the question of whether the consent given by the parents/guardian of twin children was sufficient to protect the hospital and involved staff from legal liability (assault and battery) for the performance of surgery beneficial to one twin (the recipient), but not to the other (donor). All three cases involved kidney transplants of one organ from one healthy twin to the other. In all the cases the children consented as well as their parents or guardians.

Before proceeding with the kidney removal and transplants, the hospital in each case sought a declaratory judgment from the Massachusetts court as to the lawfulness of the procedure. The opinions /

199 The cases are reported and discussed in Curran, "A Problem of Consent: Kidney Transplantation in Minors", 34 N.Y. U.L.Rev. 891(1959).
opinions handed down are very similar. The courts held no civil or criminal liability would be incurred by the hospital where the operation was necessary to save the sick twin and where the healthy twin consented to and knew all the consequences of the operation. Basing their opinion on expert medical and psychiatric testimony, the courts held the operation to be also, in effect, for the "benefit" of the donor twin, for if the transplant were not allowed and the ailing twin died as a result the healthy twin would suffer "grave emotional disturbance". The donor twins in each case were in their teens.

These Massachusetts cases have drawn considerable comment. They appear to be the only judicial pronouncements of the kind. Lord Kilbrandon, the well-known Scottish jurist, has referred to the cases as "a courageous piece of sophisticated reasoning". Professor Daube of Oxford, contrariwise, feels that children on no account should be transplant donors and implies the Massachusetts cases were "cheating by maintaining ... that the child would suffer a trauma if he were not allowed to give his twin a kidney or whatever it might be". Professor Freund of Harvard would agree with Daube that minors are, in fact, incapable of consenting to removal and transplantation.

201 Daube, op.cit., p.198.
transplantation, but only in those situations where the operation would not be of "benefit" to them. Such a suggestion unfortunately does not resolve the problem raised by the Massachusetts cases. The question of what in fact constitutes a 'benefit' to the donor must still be ascertained.

An older American case, *Bonner v. Moran*, 126 F.2d 121 (D.C.Cir.1941), is instructive for the light it sheds on the issue we have been considering - namely, the ability of a child to consent to a tissue removal not strictly for his own benefit, but for transplantation to another. Aside from the unreported Massachusetts cases, it appears to be the only other judicial pronouncement in point. The defendant physician in *Bonner* took a skin graft from a fifteen year old boy without getting his parent's consent. The graft was to aid the boy's cousin and he apparently consented. The Circuit court, in remanding the case for a new trial, held that, (1) the parents' consent was necessary before operating on a child; (2) a surgical operation is a technical battery and excusable only by the patient's consent, express or implied; (3) where a child is close to maturity the surgeon may be justified in operating on the basis of his consent alone (citing Michigan cases that allowed such a procedure when the child was seventeen, but /

but not when he was only nine); and (4) because the present operation was not for the benefit of the child (though it involved naturally replaceable tissue), it was a necessity to obtain the consent of the parents before proceeding.

The case is significant in that it did not conclude because the operation was not for the benefit of the patient that a valid consent to proceed could not be given the physician. It should be borne in mind, however, that a skin graft — notwithstanding the unusual complications that developed in Bonner — normally involves only a temporary and minor discomfort to the donor, no permanent or severe disablement.

While there is some uncertainty about the practice, American physicians are said to refuse to operate on children for their benefit if they are less than ten years old unless their parents' consent has first been obtained. 203 This would seem to be the lower limit; a "knowing" consent by an eleven or twelve year old, even to the most simple surgical procedure, is not easy to presume. Most would agree that a minor should have full capacity to consent at eighteen and, in fact, sixteen appears to be the age accepted as a practical matter in Scotland and England. 204 /

203 Curran, op.cit., p. 393.
204 Forbes, loc.cit.; Harvey, loc.cit.
England. And as a matter of law, minors (boys at fourteen, girls at twelve) may consent to medical treatment for their own benefit in Scotland. 205

Professor Daube, while advocating that "children should on no account be donors", suggests that the age of consent for transplants be lowered to the general age of conscription, seventeen or eighteen years old. 206

It should be remembered that the age when one is allowed to consent to beneficial medical treatment is quite a different thing from Professor Daube's suggested age for a child to be allowed to consent to serve as a transplant donor.

Other potential transplant donors than children are considered to pose problems of "capacity" to consent. Among them are prisoners, soldiers, the feeble-minded or insane, wards, medical students and relatives of the prospective recipient.

Perhaps relatives pose the most subtle difficulties. Their sometimes dubiously free and full capacity to consent is not caused by elements of external coercion or lack of understanding. It is caused rather by their affinity to the needy recipient, by internal coercion if you will. It has been suggested that psychological as well as physical testing should be utilised to /

205 Kilbrandon, op. cit., p.10.
206 Daube, op. cit., pp.198-199.
to screen potential donors, particularly relatives who may volunteer to donate under familial pressures, but are actually ambivalent or hostile to the operation. 207

Finally, capacity to consent can be corrupted by the offering of payment in return for "donation" of an organ for transplantation. While indemnification for organ donors is perhaps desirable, 208 few think it wise by purchasing a patient's consent 209 to encourage an unsavoury traffic in body parts, as in the days of Burke and Hare. Nonetheless, there are those who see no real difference between the voluntary and the paid donor, so long as both are well aware of the risk involved. 210 The two may be similar, but the complications arising from their use may be quite different.

F. SOME MORAL AND ETHICAL ASPECTS OF ORGAN TRANSPLANTATION

The whole area of organ transplantation is beset by moral and ethical questions and concerns - many of which are implicit in what has already been discussed - not yet answered and abated. The recent rush of heart transplants in early May has prompted many to assert that the most difficult problems to /

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207 Osler, 'In Two Minds About the Same Kidney", The Times, April 28, 1968, p.10.
208 Daube, loc. cit.
209 Harvey, loc. cit.
to be resolved are ethical ones, not technical or even legal ones. At the moment no consensus of ethical opinion exists. The British medical profession is widely split on the propriety of performing heart transplants at the present time. The majority of the profession probably are in favour of a lull in heart transplants until available data is reviewed, future actions planned and the reaction of the community at large assessed. Attempts to reach a consensus have only just begun, as evidenced by the Minister of Health's recent conference chaired by Sir Hector McLennan dealing with the whole subject of transplants.

Aside from the Catholic Church's traditionally strong influence in the field of medical ethics, few others have ventured to suggest any ethical or moral guidelines. The Church of Scotland has recently expressed its approval of transplants carried out for man's health and happiness, but the Catholic position is considerably more explicit. In traditional Catholic terms, the basic moral problem of transplantation is the question whether one individual may allow himself to be mutilated, not for his own good, but for the benefit of another. Such action is inconsistent with the temporal and incomplete control a person is seen as possessing over his own body. In the

214 Kelly, Medico-Moral Problems, p.192.
the words of Pope Pius XI,

"Christian doctrine establishes, and the light of human reason makes it most clear, that private individuals have no power over the members of their bodies than that which pertains to their natural ends; and that they are not free to destroy or mutilate their members, or in any way render themselves unfit for their natural functions, except when no other provision can be made for the good of the whole body." 215

These remarks, it will be observed, apply only to living donors and would not appear to restrict those situations where naturally replaceable tissue is taken from a living donor.

It will also be observed that the law, as it presently exists, finds itself in basic conformity with this, at least traditional, Catholic viewpoint.

However, it should be noted that under a more liberal Catholic viewpoint the use of living donors may be morally justified for "proportionate" reasons, if the benefit to the recipient is in just proportion to the harm done the donor, if there is no proximate danger the operation will result in the donor's death, and if the donor's sterility will not be induced. 217 It could be likewise argued that this more liberal Catholic viewpoint on the licitness of transplant donations /

215 *Ibid.*, p.195 (the Pope was referring here specifically to state-sponsored, eugenic sterilisation).
216 See the discussion, *supra*, in section E.
donations is closer to the law, as applied, in this area than the more traditional view.

In any case, the generally hostile attitude of the Catholic Church to living donors does not prevail when the use of cadaver donors is at issue. The organs of a human body certified as dead may be used for purposes of transplantation without moral restraint. For as Pope Pius XII, addressing a group of physicians in 1959, is said to have stated,

"The cadaver is no longer in the true sense of the word, a subject of right ... the cadaver's organs no longer possess the characteristics of goods, because they are of no use to him and are not to fulfil any objectives." 218

This Catholic distinction between the use of living and cadaver donors, while perhaps a valuable one, leaves open the decisive determination, discussed supra, of when death in fact transforms a living donor into a cadaver donor. Defining death, then, clearly poses ethical as well as legal problems.

While some would allow for the use of vital organs donated from the living, 219 and while such organs may in fact be actually being removed from patients in the "twilight zone" between life and death, 220 the consensus appears to favour the utilisation of cadaver donors only. Some suggest that no legislation should or could properly attempt to define "death";

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218 Cortesini, Ethics in Medical Progress, p.175.
219 See 175.
220 The Guardian, April 26, 1966; Regina v. Potter, supra.
the French government apparently thought otherwise.

The French, by providing a legal definition of death, have put the protection and the prestige of the law behind transplant surgeons removing organs while artificial maintenance continues the respiration and circulation of the donor. Without such legal protection in Britain, Mr. Ross, the chief surgeon in Britain's first heart transplant, had to admit that the donor was clinically dead, but legally alive by some criteria when his heart was taken. 221 Surely such a situation is not satisfactory from an ethical, far less a legal, standpoint. While the physician's discretion in determining death must be trusted to in the final instance, public education and legislation clarifying the criteria for determining death might well prove necessary if transplants are to proceed with appropriate public approbation (see conclusion, infra).

Aside from determining and defining the moment of death for transplant purposes, the basic ethical issue is just how great an invasion of the individual can be justified. Mr. Donald Longmore, consultant physiologist in Britain's first heart transplant, has stated the ethical case for transplants in his new book Spare-Part Surgery in the following terms:

"We /

221 The Daily Telegraph, May 6, 1968, p.15; for a more disturbing example from Brazil, see Time, June 7, 1968, p.53.
"We can either preserve the ancient laws that guarantee the inviolability of the dead and the present rights of the next of kin or we can rewrite those laws in favour of the living." 222

Simply, the question is, just how far are people willing to go in the donation of their bodies for the benefit of others? Already the testes of one man are reported to have been transplanted and engrafted upon another. 223 What organ or body part will be next? The brain? Unlikely, because of the technical complexity of getting "all the wires connected up again". 224 But, as we know, science is remarkably unheeding of "technical" difficulties. At some point, do the interests of human individuality, personality and bodily integrity intervene? Perhaps Mr. Longmore's above-quoted remarks from Spare-Part Surgery are tempered by those of Professor David W. Louisell of the University of California, who acknowledges,

"... the common law's concern about the rights of the surviving spouse and next of kin. Maybe that is really only a consideration of sentiment. [But] the right the decedent had to control the disposition of his body may be much more basic and integral to the human personality." 225

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The newly introduced measure facilitating kidney transplantation in Britain by presuming a patient's willingness to donate in the absence of reason to believe otherwise recognizes the decedent's right to control disposal of his body. However, it puts the burden on the individual to overcome a presumption favouring donation. If transplants are considered good public policy, then the placing of this burden on the person to encourage "donations by default" so-to-speak can perhaps be defended. However, certain safeguards should insure that the donor's refusal to serve as an organ donor will be effective. This could be done by requiring the individual so opposed to carry a card, to have his body marked in a certain small way, or to register his dissent with a central authority to whom the hospital authorities at the time of his death could refer expeditiously.

The success of such a scheme requires public support for the involved transplantation procedures and a general willingness to donate one's cadaver to accomplish such aims. Consensus in this area presupposes discussion among, and education of, the public. Steps are being taken in this direction.

Aside from the new legislation pending, the establishment of /

226 The Nabarro Bill (App. IV) may be extended to cover heart and kidneys, but probably not until such operations achieve the acceptance and success rate that kidney transplants now enjoy. The Times, May 6, 1968, p.2.
of permanent commissions to meet the new moral, social and ethical problems raised by advances in medical science, discuss them and come to some common code of conduct or plan of action, has been called for in Britain, \(^227\) and in the United States. \(^228\)

On a more specific and practical plane, the heart transplants already performed raise several ethical problems. The first is the conflict of interest that must inevitably arise when a single doctor is physician for both the donor and the recipient of an organ. While Dr. Barnard in South Africa, for one, has acted from such a conflicting position, he has been criticised squarely for it. \(^229\)

Another practical ethical problem is the danger that publicity and the desire to promote medical reputations will become overriding motivants for further, less tested or sound transplants. Claims recently seen about "Europe's first heart transplant" could become dangerously symptomatic more of national and professional rivalry than of the ideals of the Hippocratic Oath. \(^230\) While modern means of communication can play an important service in the coverage of modern transplants /

\(^{229}\) Internat'l Herald Tribune, Jan. 20-21, 1968, p. 4, (by the Russian Health Minister Boris Petrovsky); The Observer, March 10, 1968, p. 27.
\(^{230}\) The Times, May 4, 1968, p. 8; The Observer, May 5, 1968, p. 3.
transplants and the education of the public, at the same time the surgeon should guard against claims of publicity, seeking.\textsuperscript{231} This point was wisely heeded by Professor Roy Calne and his associates in Britain's first liver transplant and by the Edinburgh Royal Infirmary in Britain's first lung transplant, both carried out confidentially and without fanfare. The anonymity of the donor should surely be maintained in all transplants, as has proved wise procedure in cases of blood donation and transfusion and semen donation and artificial insemination.\textsuperscript{232}

An ethical problem raised by the Blaiberg heart transplant in South Africa, as well as the West transplant in Britain, concerns transporting a donor in critical condition to insure his proximity to the recipient upon death. This cuts across both the ethical problems of defining death and of allowing the same physician to care for both donor and recipient. In Dr. Blaiberg's transplant, Dr. Barnard was criticised for transporting a critically injured Clyde Haupt across town to await his death.\textsuperscript{233} In Mr. West's case it is not perfectly clear whether the eventual donor, Mr. Patrick Ryan, was "alive" with a spontaneously beating heart when he was /

was transported from King's College Hospital to the National Heart Hospital; reports differ.\textsuperscript{234} However, it does appear that in both cases the patient-donor had suffered irreparable injury to the brain (massive cerebral haemorrhage) and was considered a "hopeless" case. Mr. Ryan had recorded no brain activity (a flat electro-encephalograph) for six hours before he was transferred. He had been allegedly certified dead by four independent teams, yet his transplant surgeon had to admit he was not dead by all legal criteria. Legislation on the French model would have removed all doubts as to the donor's death.

The fact that Mr. West may remain in the main operating suite at the National Heart Hospital for a number of weeks raised yet another ethical problem: the question of priority in medical treatment in the face of insufficient resources for all.\textsuperscript{235} What other "regular" heart operations had to be postponed - some forever perhaps - because of Mr. West's unusually extended occupation of the suite? Who is to benefit from the insufficient number of donated organs available? The drunkard? The musician? The scientist? The boy? The old man? The atheist? The priest? By what criteria will the recipient be /


be chosen? Who will be neglected by the physicians overly-occupied with the "glamour" of bigger and better transplants?

The physician must choose his recipient and allocate his resources on solely medical indication. The physician should not have to choose between patients on any but the principles of a humanitarian healer. If society is unwilling to pay the price necessary to provide maximum medical resources, then the physician can only pick and choose as best he can in an effort to bring the most relief and comfort and to do the most medical good. Society can spend for hot school lunches, a battleship or a new transplant unit, as it wishes; if it decides on the former, the physician cannot save everyone, but can only select patients for treatment on the basis of where he feels the "most good can be done". 236 No more can be asked of him.

G. CONCLUSION AND RECOMMENDATIONS

"Surgery is now too important to be left in the hands of the surgeons." 237

"Science has made us Gods before we are even worthy of being men". 238

Perhaps these quotations, as well as any other, sum up the issues and concerns posed for resolution by the advent of human organ transplantation. Science has enabled man to conquer many of the technical problems barring the interchange of /

236 Schreiner, Ethics in Med. Progress, pp. 127, 130.
of human bodily parts for the benefit of the living. The ethical and moral problems remain largely to be identified and clarified, far less solved.

It is probably true that further solution of the technical antecedents to successful transplantation will go a long way towards resolving the ethical issues. For instance, improved techniques of treating, storing and preserving tissue could eventually obviate the need for live donors, as well as lessening the rush immediately after death to obtain the tissues undamaged. As means of determining "death" of the brain and central nervous system become more effective, dependable and understood, more individuals should be encouraged to donate vital tissue, even though their body may yet be amenable to transitory maintenance of respiration and circulation artificially. As experience makes tissue typing more dependable and, combined with increasingly effective use of immunosuppressive drugs, greatly reduces problems of rejection and incompatibility, the lowered risks of organ transplantation will undoubtedly enhance its success rate and thereby speed its acceptance by the public, as is occurring now with kidney transplants, and occurred long ago with blood transfusions.

Furthermore, it is submitted that most of the remaining ethical /
ethical objections to organ transplantation can be eliminated by careful legislation. Assuming that it is consistent with the public interest and general welfare to preserve life and promote health, most would sanction the encouragement of organ transplantation. Such encouragement should, however, have its bounds.

(1) First of all, the use of living donors should be limited and even avoided wherever possible if the donation would permanently deprive the donor of a part or a function of his physiology, or, if temporary, it would be of substantial detriment to his functioning integrity as a human being and personality. Only adults, of full capacity, should be allowed to consent to "donate" tissue in such circumstances and then only when the benefit to be derived by the recipient clearly outweighs the detriment agreed to be suffered /

239 Lord Kilbrandon has suggested similar legislation along these lines; his rough draft, "Any person of full age and capacity may consent, in writing, to any medical or surgical treatment which is to be carried out in a designated hospital, provided that the risks attendant thereon are not excessive and notwithstanding that the treatment is not being carried out for the benefit of the person himself." (Ethics in Med. Progress, pp.213-214.)
suffered by the donor (this would make the giving of a vital organ, resulting in the donor's death, unlawful). Children as well as incompetents would be ineligible to serve as such donors. This type of legislation would, nonetheless, liberalise the law which at present does not allow anyone to consent to a surgical operation (tissue removal) not for his benefit, but rather to his detriment for the benefit of another. Additionally, it would not prevent a broad or liberal use of the concept of "benefit" being necessary for a child or individual of somewhat less than full capacity to consent.

(2) The Massachusetts declaratory judgment cases in point and Professor Daube to the contrary notwithstanding, the donor should be considered as a totality of physical, spiritual and psychiatric components, and if the donation will "benefit" him on any of these grounds it should be upheld as ethical and lawful. 240

However, as a safeguard, it is submitted that no tissue donation, other than one of naturally replaceable tissue (e.g., skin, blood), should be acceptable from a minor unless the fact of its "benefit" to him, under the above formulation, is concurred in by a second physician not a member of the transplant team immediately concerned. The gift of one kidney to /

to a twin or immediate family member to prevent the latter's death may well be the only acceptable exception.

(3) While many would disagree, it is submitted that a legal redefinition of death is necessary if transplants are to be carried out with public confidence and approbation. In transplantation,

"the moment of death (of the donor) is the starting pistol for a race to save life." 241

As such, the public requires more reassurance as to when death occurs than merely saying "it's up to the doctor", if they are to be expected to volunteer their "dead" bodies for spare-part surgery. The definition of death in these circumstances becomes a social question of public policy as well as a solely medical concern. The conscience of the people - on which the theologian, the physicians and the politicians in any given society will have a great influence - must be ascertained, weighed and reflected in any legislative definition of death. If the recent French act decreeing clinical death to be irreversible brain damage as measured by electrical measurement is to be the test, it must be realised that ordinary doctors do not carry the necessary electro-encephalographs in their little black bags.

This /

This raised the point of whether a definition of clinical death could be formulated largely for purposes of removing cadaver tissue for transplantation, but that other, traditional criteria of death be retained for patients not needed or desired as organ donors. Two definitions for death might not be as unreasonable a solution as it may first appear. If patients were desired as tissue donors, a legislative definition of death in terms of certain minimal, ascertainable conditions might be formulated, as with the French law which presumes a flat electro-encephalograph reading for ten minutes or more indicates brain and clinical death. The means of compliance with such a definition would be available presumably, as the prospective donors would be under hospital or institutional supervision with the necessary facilities during the last illness to confirm death.

Such a legislative definition of death could outline the minimum proof necessary to confirm death and allow for transplants. It would give the public some certainty that their organs, if donated, would not be over-hastily removed by the ambitious transplant team. If widespread public organ donations are to occur, the present uncertainties surrounding the moment of death must be resolved to some extent by legislation. The concerns are no longer merely those of the doctor and his patient, but they relate to the general willingness /
willingness of the public to endorse and co-operate with organ transplantation, understanding its demands, or alternatively, to at least partially reject it because of fears that physicians, with full discretion as to when death is to be pronounced, might be subject more to the appeals of prestige, publicity and playing-God than to the immediate needs of the patient. In short, it is submitted, the public is no longer willing to leave the determination of death up to the discretion of the medical profession alone. The potentially conflicting demands that the transplantation of vital organs have imposed on the physician are responsible.

In the longrun many of these conflicts will undoubtedly be resolved by improved methods of organ procurement and storage and by safeguards insuring independence of the patient's attending physician and the eventual transplant surgeon. For the present, however, an authoritative clarification of death must come from beyond the medical profession alone - both legal (§D) and ethical (§D,G) judgment recommends it.

In all other cases, death could be left undefined beyond requiring the physician in attendance to have

"satisfied himself by personal examination of the body that life is extinct." 242

As /

As far as prospective transplant donors are concerned at least, irreversible brain damage would appear at present to be the most satisfactory criterion of clinical death. However, additional neurological research and more dependable means of monitoring irreparable brain damage is needed, as well as education of the public in the effectiveness of these methods. It must be shown not just that the brain has been irreparably damaged, but also that the extent of this damage is absolutely inconsistent with continued maintenance of independent life in the individual. If electro-encephalograph testing can in fact show this, then it is a valuable definitional tool in ascertaining clinical death, but the medical profession appears to be divided on its reliability. In such circumstances, the public cannot be expected to accept its incorporation in a legislative definition of death.

The means of determining death must be sufficiently certain, minimally to the extent of being supported by an overwhelming majority of expert medical opinion, before the law should attempt to play a role. Whether those means now exist, as the French Government appears to think, is largely though not totally for the medical profession to agree on and present to the public. Until that time, present uncertainties surrounding /

243 Gillingham, loc.cit.
surrounding death will serve to discourage vital organ donors and will expose transplant surgeons to continued claims of overstepping the mark or acting too hastily.

In the final analysis, a definition of death will have to be reassuring to the public, yet flexible enough not to hamstring physicians dealing with the inevitable variables posed by scientific advances and human uniqueness. The following roughly drawn statute is submitted as a starting point:

"Human tissue to be used after death for authorised scientific or medical purposes may be removed from an individual only after two physicians other than those who will remove or use the tissue certify that the individual's vital functions have ceased spontaneous operation and cannot, in their opinion, be restored by any means so as to support the individual in a viable state."

(4) An acceptable definition of death still requires proper implementation. To this end, the surgeon desiring a prospective donor's tissues should play no role in determination of his death. That death has in fact occurred, consistent with the prevailing definition for transplant purposes, should be certified by two physicians who are independent of the transplanting teams. In no case should the transplanting surgeon or his staff be in charge of, or influential in treating the potential donor. It is not, however, unreasonable to allow the prospective donor's attending physician to notify the transplanting team that his patient is a likely and suitable donor. The second physician who concurs with /
with the physician in attendance on certification of death of the prospective donor should not be in communication at any time with members of the transplanting team. The requirement of two concurring medical opinions is not an unreasonable one when the deceased is contemplated as an organ donor. In other controversial situations, such as mental illness, abortion and cremation, a similar requirement is imposed.

As an added precaution, some have suggested the establishment of a national tissue bank to serve as an insulated third party between the donor’s and the recipient’s surgeons. Such a bank could allocate organs based on information received from donors – as to immunological data and donations expressed – and from potential recipients – as to organs needed, when and the like. Such an institution could serve as a clearing house for donated organs, but it presumes substantial public support if it is to operate successfully.

(5) Once a satisfactory definition of death and its certification procedure for transplant purposes is formulated, the use of cadaver donors can go forward more acceptably.

It has been suggested that the public interest in obtaining cadaver tissues for living recipients should be capable of subordination only by the wish of the decedent himself expressed before /

before death. To this end the law could, it is argued, presume consent to donate organs in all cases where the deceased had not objected formally by registration before his demise. The burden of registering a written refusal to donate his tissues after death might not be an unduly heavy one to impose on the individual, particularly in today's increasingly computerised world. The refusal to donate could be a simple form publicised and provided by the state to be signed, verified and notarised, if desired, by the individual and returned to a central records registration office. Only hospitals authorised to perform transplants could be granted immediate access to these records upon the person's admission to the hospital in a terminal state. The carrying of such a refusal card on the person, as recommended by the American Uniform Act, or the wearing of a pendant or identification bracelet.

245 Lord Kilbrandon, the Scottish jurist and chairman of the Scottish Law Commission, has, once again, provided us with the rough statutory framework:

"In any designated hospital it shall be lawful to remove from a dead person any organ required for medical or scientific purposes unless the hospital authorities have reason to believe that the deceased in his lifetime had forbidden this to be done, provided that such removal shall not disfigure the dead body."

(Ethics in Med. Progress, p. 158).

246 As is done by the 200,000 victims of diabetes, haemophilia, penicillin allergy and other such conditions who belong to the Medic Alert Foundation in California. Time, April 6, 1966, pp. 50-51.
bracelet authorising tissue removal upon death, are more uncertain and less desirable ways of accomplishing the same end. They could, however, be made supplemental to a central registration scheme.

Such a legislative presumption of consent would cut off the discussed rights in the relatives at common law to acquire the dead body intact for burial. If desired, the transplanting surgeons could be disallowed from using any bodily parts that would "disfigure" the cadaver prior to burial. While such a proviso might be an invitation to "pointless litigation" by bereaved relatives, it would wisely place some value on the emotional feelings of loved ones and next of kin and probably be more readily accepted by the public.

However, the enactment of such a legislative presumption of consent (to donate one's organs at death) can only be justified if it is clearly supported by a consensus among the lay public at large. It has the effect of requiring the individual to "contract out" of his presumed donor status if he does not wish to so serve. While the burden on the individual may be light, it is nonetheless a restriction on his freedom of action that perhaps should not exist if there appear to be any /

247 See quote at 222.
248 Baube, Ethics in Med. Progress, p.192. Would the removal of an eye, for example, be considered to "disfigure" the corpse?
any substantial ethical objections to it.

It is submitted that such is, in fact, the case, and that it would be more desirable to rely on legislation of a more restrictive nature merely allowing individuals absolute freedom to provide by instrument for donation of their organs after death. It would then be for the medical profession and others to encourage public spirited citizens expressly to donate their organs.

The time-honoured respect shown the dead, partly stemming from a healthy feeling for the sanctity of life, the general, if limited, right of the individual over his own body and the currently controversial nature of transplantation surgery all suggest a not over-hasty legislative "solution" in this area. If the public is to support transplant surgery, it should do so through express donations, it is submitted. The law should not preempt private initiative by an enacted presumption - at least not just yet. The pros and cons, the values and limitations of spare-part surgery must be aired, discussed and a consensus reached, but time is not of the essence. Many practical, everyday medical problems remain to be overcome.

For the present then, it is submitted, the task is to ascertain what type of legislation the public is willing to support before proceeding further along the statutory road in this area.
(6) It would not be unwise to provide that organ donors remain anonymous and that publicity be consistent with prudence and good taste. These, however, are more matters for professional good sense and regulations than for legislation.

(7) Finally, it is recommended that a permanent committee of prominent physicians, lawyers, theologians and laymen be set up to study ways of accommodating the advances of medical science with traditional conceptions of ethics, morality and the dignity of man. A proper balance must be maintained between the advance of medical science and the attendant risks to human beings. General and thoroughgoing discussion and thought is needed to insure medicine remains responsible and consistent with the idea that patients are human beings, not human guinea pigs or pawns.
EUTHANASIA

Euthanasia comes from the Greek, it being a contraction of two words meaning "happy death". In modern practice, euthanasia has come to be associated with the concept of "mercy-killing": the painless release from life of those to whom death is thought to be a merciful remedy.

Euthanasia can be applied as a voluntary or as an involuntary - without the consent of the subject - measure. However, in recent times proponents have advocated only its voluntary use, and then only by qualified medical practitioners to relieve the severe pain and distress of a patient suffering from an illness thought to be incurable and terminal.

Certainly there are other instances that one could profitably discuss under the topic of euthanasia, such as the shooting of an injured companion at arms, disabled in the face of a savage, advancing /

1 St. John-Stevas, Life, Death and the Law, p. 262.
2 The Nazi period in Germany is, of course, a glaring example to the contrary and inevitably it ranks in arguments against the practice of voluntary euthanasia. For a discussion of the practice of euthanasia under Hitler, responsible for the death of some 275,000 individuals, see either Loy, "Nazi War Crimes of a Medical Nature", 139 J.A.M.A. 131 (1949), or Alexander, "Medical Science under Dictatorship", 241 New Eng. J. Med. 39 (1949).
3 See discussion of proposed legislation by Euthanasia Societies of England and America in Williams, The Sanctity of Life and the Criminal Law, p. 277.
advancing enemy. However, this paper is a medico-legal analysis and as such discussion will be limited to situations involving doctor and patient, where the mercy-motivated killing is requested.

Even in this limited sense, the debate over euthanasia rages with little respite and much ink is spilled by members of the three disciplines most intimately concerned: medicine, theology and law.

At the core, at least in its theological implications, the problem seems to be whether man can rightly exercise control over the time and manner of his death. Whether there exists, in fact, a "right to die" in the individual as well as the much more assured status of a right to live. The more immediate medical and legal problems raised by voluntary euthanasia are probably secondary to and dependent upon the answer given by the forces that be in a society to the core, moral-theological question concerning a suffering patient's unilateral "right to die".

To the traditional Catholic theologian, euthanasia is condemned by two basic principles. First, and foremost, that only God has the right to take innocent life; that any direct killing of the innocent without the authority of God is wrong and /

and against the natural law. The "innocence" of the life is stressed so that the principle of its inviolability can be upheld at the same time as a limited right to take life is granted those involved in matters such as self-defence, punishment of crime and war. The fact that the individual concerned gives his consent to the killing does not change its characterisation in the eyes of the Catholic Church. It is still homicide by the physician and suicide by the patient. Both commit morally evil actions and, at the same time, crimes against society since the euthanasia is contrary to the state's obligation to preserve human life.

The second traditional Catholic principle condemning euthanasia is that in light of Redemption, human suffering has a particular value to Christians, making those who suffer (as through a last painful illness in this context) with the right disposition as well as those who care for them, especially dear to God. One Catholic physician, discussing this point recently, has stated that,

"this /

5 Catholic theology is, of course, most strongly opposed to suicide. St. Thomas Aquinas called suicide "the most fatal of sins, because it cannot be repented of". See Fletcher, Morals and Medicine, p.179.
7 Kelly, loc.cit.
"this acceptance of suffering is an integral part of the Christian life, and without it we cannot hope to attain salvation". 8

While this is the traditional Catholic viewpoint, the more liberal, post-Vatican II theologians probably do not attach such an objective significance to the redemptive value of suffering, per se, but rather see the matter more flexibly as being one determined "by the verdict of a personal decision of conscience". 9

Nonetheless, even the current liberal wing of the Catholic Church, exemplified by the Bishops of the Netherlands, continues to see euthanasia of the sick as contrary to man's limited control over God-given life. The following quotation from the new Dutch Catechism is instructive,

"...it is also one of the rights of man to be free, if he wills, to refuse to put himself in the hands of doctors. Likewise, there is no absolute need to prolong indefinitely a life which has been dispaired of, by means of medicines and machines, especially if the life in question is purely vegetal, without signs of human reaction. In the latter case above all, extraordinary means may be omitted and the natural process allowed to take its course."

On the other hand, it is wrong to put an end to life wilfully - to kill those who are incurably ill physically or mentally /

mentally (by euthanasia, for instance) or to commit suicide. Our life has been given us by God and we cannot end it as we will. The reason given for ending life is always that it has become meaningless and valueless. This can never be accepted by the Christian faith, which believes in every life, from the first moment of conception. Abortion is a sin against life.  

Issue is taken with the application of both of these principles of traditional Catholic theology to euthanasia by the Episcopalian moral theologian, Joseph Fletcher. Rev. Fletcher injects the concept of quality of existence into his argument for voluntary euthanasia, stating that the mere fact of being alive and breathing is not so important to the man of "moral integrity and spiritual purpose" as are the terms or quality of that living. He believes euthanasia does not raise the issue of life and death, but rather the kind of death - peaceful or agonized - which a person is to meet. To Fletcher, the question is, "Shall we meet death in personal integrity or in personal disintegration?" He feels that God has given man the power over life to some extent /

10 Ibid.; see 71 for a nearly identical Protestant viewpoint by the Rt. Rev. R.C. Mortimer.
11 Fletcher, Morals and Medicine, p. 172.
12 Ibid., p. 107.
13 Ibid., p. 208.
extent, provided him with the tools and knowledge for pro-
longing life, and, for bringing the cause of dying to a
merciful end when the individual has prepared himself for
death and requested it of his physician. 14

Catholic thinking is probably not far away from this
position, in practice, for it allows the patient's conscious-
ness to be taken from him and his life shortened (or his
death hastened) by the use of powerful drugs to relieve pain,
when he has settled his "temporal and spiritual affairs" and
seeks such relief from his suffering. 15 This practice is
undoubtedly somewhat inconsistent with earlier-mentioned
theories of suffering and Redemption, but is countenanced
under the well-known Catholic "double effect" doctrine. 16
The object of the drugs is to relieve pain, a desirable objective

14 As Fletcher puts it, at p.191, "To prolong life uselessly,
while the personal qualities of freedom, knowledge, self-
possession and control, and responsibility are sacrificed
is to attack the moral status of a person. It actually
denies morality in order to submit to fatality."
16 "Risk to life and even the indirect taking of life are
morally justifiable for proportionate reasons. (Life
is taken indirectly when death is the unavoidable accom-
paniment of result of a procedure which is immediately
directed to the attainment of some other purpose...)
Ethical and Religious Directives for Catholic Hospitals,
in the circumstances. The fact that death is an indirect effect is undesirable, but not blame-worthy. This doctrine of "double-effect", while often criticised, is supported in this context by the likes of Professor David Daube of Oxford, for to him it emphasises, the motive he feels should be responsible for the physician's action.\(^\text{17}\) The doctrine would seem, however, to be of limited value, for virtually all actions have more than one consequence or effect and one may merely pick the desirable result as the "direct" effect. Any action, it is submitted, must be judged on the balance of its good or bad consequences, not on the rather casuistic reasoning of "double effect".

Another Protestant theologian, Professor Paul Ramsey of Princeton Theological Seminary, has pointed out\(^\text{18}\) a fundamental weakness in Reverend Fletcher's approach. While Fletcher argues a strong and perhaps complete moral case for voluntary euthanasia from the patient's point of view, he does not do so from that of the physician. Reverend Fletcher poses the quandary in which the not-always consistent demands of the Hippocratic /

\(^{17}\) Daube, "Sanctity of Life", 60 Proc. R. Soc. Med. 1:35(1967), wherein the author expresses his favour for the "double effect" rule in the following words, "A doctor who simply asks himself whether it is better to kill the patient or not to kill him is more easily led to overstep (the limits beyond which he may not go) than one who asks himself, whether, in the particular situation, it is his duty to relieve the pain even though it will kill the patient."

Hippocratic Oath place the physician, by requiring him to relieve pain and suffering, yet at the same time prolong and protect life. The Reverend does not, however, provide the moral solution to this quandary in Professor Ramsey's view.

That the suggestion of voluntary euthanasia raises a very disturbing moral question for the physician above all is undoubtedly true. It is he who the would-be reformers rely upon to carry out the "coup de grace" on their willing patients. The most commonly voiced fear is that putting such responsibility in the hands of the physician would effectively destroy the relationship of trust and confidence that needs to exist between doctor and patient, particularly when a serious illness is involved. If a patient knows that his physician can bring about death upon the patient's consent, then he may begin to wonder if the doctor might not presume consent in the face of the patient's agonies, even if he wanted to live on. Speaking again from the Protestant viewpoint, the Right Reverend R.C. Mortimer, Lord Bishop of Exeter, has emphasised this point, as have Professor Daube and more particularly Professor Kamiser among others, from the secular viewpoint.

AS /

19 Ibid.
21 Daube, op.cit., p.1236.
As to how the physicians themselves view voluntary euthanasia, it is difficult to get an accurate picture, and controversy exists, but it would seem that the majority of the profession, with notable exceptions, are not openly in favour of making the practice legally and morally acceptable.  

Specifically, of course, medical opinion of every shading may be found in the literature concerning euthanasia. As one proponent of voluntary euthanasia has put it,  

"Today our society has no laws by which the use of the instruments of advanced medicine, which were designed to prolong human life, may be limited so that it serve only to improve the condition of human life as it increases the life span, and not the useless prolongation of human suffering which it is causing in an increasing number of instances."  

Conversely, as one opponent of voluntary euthanasia has put it,  

"I could never deliberately choose the time of another's dying. The preservation of human life is not only the primary but the all-encompassing general law underlying the code of the physician... Do not ask life's guardian to be also its executor."  

And yet another, recently addressing a group of the caring /

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caring professions, has stated 26

"Patients should never ask for euthanasia. It is your failure if they do."

Perhaps a young American doctor has summed up the competing considerations most perceptively by stating the crux of the matter is,

"Medical science's ability to maintain a physiologically active body with a neurologically inactive component - a 'vegetable' results. when one sees an elderly (76) 'vegetable' - one's first decision must involve the irreversibility of the situation; if you can say with authority that the situation can not be repaired then I believe you still have the obligation to utilize all current modes of therapy in an attempt to mollify or to maintain the status quo. Once one has attempted a therapeutic trial for what one considers to be a reasonable amount of time then I believe your primary obligation now rests with the family of the patient; to assess their ability to afford a lengthy hospital stay or to afford nurses in the home, and to assess their ability to undergo continual emotional grief. I definitely believe that so far as possible a person should be allowed to die without protracted misery, without tubes and catheters protruding from all orifices and without his family watching him become a mere skeleton lacking personality, will or ability to recognize others." 27

While /

27 Personal correspondence to the author, March 17, 1968.
While the medical profession, as are others, remains basically split on the issue of voluntary euthanasia, much of the controversy is resolved in practice by the use of analgesic, pain-killing drugs. Such practice, as mentioned, is generally accepted by theologians and the law in the Western world on a basically "double effect" theory: that the effect of the drugs is to ease pain and suffering, and any hastening of death (often inevitable in the administration of morphia due to gradual immunity being developed by the patient, necessitating more frequent and more powerful doses, eventually reaching the fatal level of respiratory depression) is solely an incidental and unavoidable result.

While modern analgesic drugs do blunt the argument for voluntary euthanasia, they do not neutralise it. Certain terminal illness, including some cancers, is not fully responsive to sedation and analgesics. Their application may cause or fail to prevent restlessness, nausea, vomiting, dyspnoea, and long hours of conscious awareness of oncoming death. While in the majority of cases medicine to-day allows people to meet death without much physical discomfort, this is not true of all patients. Still, some argue that pain need not /

30 Hinton, loc.cit.
not accompany dying and will not when proper opiate administration is only part of a "whole" treatment of the patient; physical, psychological and philosophical in nature and extent. 31

As to these few cases of unavoidable pain the proponents of voluntary euthanasia argue the law should be changed to allow those suffering to end their existence without needlessly experiencing a slow disintegration of physical and mental integrity preceding death. The opponents of the legalising of voluntary euthanasia argue from one of two basic legal viewpoints: that the law is sufficiently elastic as administered, if not as written, to allow for equitable treatment in appropriate circumstances of physicians and others who carry out voluntary euthanasia on those near to them who request it as a "merciful release", or, that the benefit to those few of legalising voluntary euthanasia would be far outweighed by the undesired social consequences of putting the law in the position of affirmatively sanctioning and therefore sponsoring such killings, of enlarging the scope of justifiable homicide and narrowing the broad sanctity accorded human life. 32

31 Saunders, loc.cit.
But before discussion can be made of the need for reform in the law or lack thereof, the law as presently written and administered dealing with euthanasia should be discussed.

B. THE LEGAL POSITION

1. Scotland

There are no reported Scottish cases dealing with euthanasia. There is no doubt that euthanasia is homicide under Scots law, and technically murder, although in practice it might well only bring a charge by the Lord Advocate of culpable homicide and would not likely be punished with the "full pains of the law."

The fact that the physician might act from the highest of motives in carrying out a "mercy-killing" on a willing patient would not change the characterisation of the offence as murder, at least in theory, for the required mens rea or mental element of the crime - the intention to kill - would be present nonetheless. To quote from Hume on this point might be instructive,

"It /

\begin{itemize}
\item[34] Gordon defines homicide as the "destruction of a self-existent human life" and states that it can be committed "by any act or culpable omission resulting in death". *Ibid.*, pp.674-675.
\item[35] *Ibid.*, p.712 (reporting this as Lord Cooper's view, but Lord Keith’s view to the effect that there is no reason not to charge euthanasia as murder); T.B. Smith, *Short Commentary*, p.182.
\end{itemize}
"It is not material to the notion of guilt, that the offender have himself been fully conscious of the wickedness of what he did. Though he were persuaded that it was innocent, or even meritorious, yet still this cannot save him from the judgment of the law, which must be determined by the nature of the act, and its evil consequences to the public..." 37

The alleged evil consequence of the act in this case is the taking of a human life, no matter how willing and weakened.

Furthermore, the fact that the patient had requested the killing as a merciful release would not serve to exculpate the obliging physician or friend. For as the High Court of Justiciary in Scotland has clearly stated, 38

"...if life is taken under circumstances which would otherwise infer guilt of murder, the crime does not cease to be murder merely because the victim consented to be murdered, or even urged the assailant to strike the fatal blow."

Against this seemingly strict legal censure of voluntary euthanasia must be superimposed the high degree of immunity from criminal prosecution enjoyed by the recognised medical profession in Scotland. No prosecution has ever been instigated against a practitioner for murder by euthanasia and it is unlikely that any would be brought if the physician brings a patient’s process of dying to a hastened end through the administration /

37 Hume, Commentaries, Vol. 1, Ch. 1, p. 25.
administration of drugs ostensibly, at least, for the alleviation of pain, providing such a practice was consistent with accepted professional standards and as the result of an otherwise non-criminal state of mind. 39

That the law as thus constituted can be elastic and flexible in its application without condoning euthanasia per se is illustrated by the unreported case of Dryden Alexander Brown. 40 In that case, a husband who pleaded guilty to killing his mentally ill wife who feared her return to a mental hospital was charged with culpable homicide and sentenced to only fifteen months. The charge was based on diminished responsibility due to the husband's concern over his wife's long illness and to the strain of caring for her. The Court avoided characterisation of the case as euthanasia, but the circumstances were obviously parallel. 41

Were the patient to administer euthanasia himself, it would not be homicide, for it is not homicide to take one's own life, 42 but it would be suicide. While suicide and attempted suicide was once a crime in Scotland (during Mackenzie's time), neither is recognised as such today. 43

Since /

41 Ibid.
42 Ibid., p. 671.
43 T.B. Smith, Short Commentary, p. 183; "Legal Aspects of Suicide", 1958 S.L.T. 141, 143.
Since there is no principle crime of suicide in Scotland, presumably there would be no art and part guilt for the individual facilitating the other's suicide.

Finally, the physician or relative must be careful to fulfil his respective duty to a dying patient, lest be find himself liable for homicide by his failure to exercise a duty imposed by law due to the special relationship involved. While the law is unclear as to when such a duty arises and how far it extends, it is clear that homicide can be committed by a "culpable omission" as well as an affirmative act. The case of Regina v. Instan, submitted to also be the law of Scotland, is illustrative. It found the defendant niece guilty of killing her aunt (manslaughter), with whom she lived, for failing to provide the bed-ridden lady with nourishment, knowing full well that no one else would provide it in her place.

In a medical context, it is worth distinguishing here between cases where the physician has undertaken a positive responsibility /

45 See note 34 supra.
46 (1893) 1 Q.B. 450.
responsibility to the patient, and those where he has not. In the former situation, the physician — having assumed a generally volitional duty to act — must carry out treatment of the patient to the extent reasonably necessary and with due skill and care. Clearly, the practitioner cannot assume a duty towards the patient, then abandon it short of completion, thereby leaving "the patient open on the (operating) table." If he does, he may well be liable for homicide.

While it is true that the patient cannot absolve his physician of liability for homicide by requesting him to stop treatment vital to life after it has been undertaken, the situation may be quite different where the treatment has not yet commenced. In the latter case, the physician may be obliged to act if the patient requests treatment or is unable to request it due to chronic or acute incapacity. At the same time, the capable patient may well have the right to refuse medical treatment necessary to life before it is commenced, particularly where it would involve so-called "extraordinary" procedures. Furthermore, probably it is true /

48 T.B. Smith, Short Commentary, p.673.
51 Gordon, op.cit., p.774.
52 Louisell, Ethics in Med. Progress, pp.82-83.
true in practice, though unsettled, that the physician is exempted from his normal, affirmative duty of using reasonable care and diligence to preserve his patient's life once that life has become an unwanted burden to the patient, capable of preservation only by extraordinary means.  

2. England

Legislation to legalise voluntary euthanasia has been sponsored in England by the Euthanasia Society. The Society's bill was first debated in the House of Lords in 1936 and again in 1950, both times without acceptance. In 1953, the Royal Commission on Capital Punishment concluded "reluctantly" that voluntary euthanasia could not feasibly be taken out of the category of murder. The Commission felt it would be "impossible to define a category (of mercy-killing) which could not be seriously abused", let alone completely immunised from criminal sanctions. Thus, euthanasia remains as part of the law of murder in England.

If a physician gives his patient a fatal drug dose with the intention of killing him thereby, and the patient in fact dies, the physician is guilty of murder. Neither the consent nor /
or request of the patient, the extremity of his suffering, nor the imminence of his natural death serves as a defence, although apparently no English case has argued the concurrence of these three factors as constituting a good defence. 58 It has been suggested that if such a defence were in fact pleaded, a "bold and humane" judge, following in the footsteps of Macnaghten, J., 59 might direct a jury that the facts justified voluntary euthanasia being undertaken by the physician under the doctrine of necessity. 60

If instead of giving the patient the fatal dose the doctor merely makes it available for the patient to use, he has supplied the means for self-murder (suicide) by the patient. While it is no longer a crime to commit suicide in England, 61 the physician would be guilty as an aider and abetter and liable for up to fourteen years imprisonment. 62

If, however, the physician must give his patient a drug dose which is the minimum necessary to deaden severe pain, but is also a fatal dose in the short or longer run, he may do so without fear of criminal liability. 63 In the trial of Dr. Adams in /

58 Williams, The Sanctity of Life and the Criminal Law, p.284.
60 Williams, loc.cit.
61 Suicide Act 1961 (England), §1 (9 & 10 Elizabeth 2, c.60).
62 Ibid., §2(1).
63 Williams, op.cit., p.285 (Williams suggests the real justification for such an attitude by the law is necessity, and that it is dishonest to avoid the conclusion that a physician who gives a fatal drug dose in such circumstances intends the resultant death, for he can foresee this result with certainty - a state of mind said to be synonymous with intending the result. See Williams, The Mental Element in Crime, Jerusalem: Magnes Press, 1965).
in 1957 for murder, wherein the defence relied on this theory, the jury were instructed in the following terms: 64

"If the first purpose of medicine, the restoration of health, can no longer be achieved there is still much for a doctor to do, and he is entitled to do all that is proper and necessary to relieve pain and suffering, even if the measures he takes may incidentally shorten human life."

As far as "mercy-killing" by inaction or omission is concerned, there is little or no direct authority on how far the physician's duty of care to his patient requires him to go in preserving the latter's life. One English commentator has stated 65 that,

"Although most persons are not liable for omissions a doctor is so liable vis-a-vis his patient, unless he can justify the failure to give treatment on the grounds that such was useless."

Dr. Glanville Williams has claimed that the physician is "probably exempted from that duty if life has become a burden to the patient". 66 He gives no authority for the statement, nor specifies what he means by the rather vague term "burden".

On the other hand, Regina v. Instan, supra, remains good law in England. Also, there is the rather uncertain but interesting dictum concerning criminal omission from the Judge's jury instruction on the law regarding abortion for therapeutic reasons /

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64 Ibid., p. 289 (Per Mr. J. Devlin, as he then was).
66 Williams, The Sanctity of Life and the Criminal Law, p. 291.
reasons in Bourne, supra, to the following effect,

"...On the other hand there are people who, from what are said to be religious reasons, object to the operation being performed under any circumstances. This is not the law either. On the contrary, a person who holds such an opinion, ought not to be an obstetrical surgeon, for if a case arose where the life of the woman could be saved by performing the operation and the doctor refused to perform it because of his religious opinions and the woman died, he would be in grave peril of being brought before this Court on a charge of manslaughter by negligence." 67

Furthermore, Professor Kanisar of Minnesota, in what is perhaps the most exhaustive indictment against voluntary euthanasia from the secular viewpoint, 68 takes issue with Dr. Williams' statement that the physician is not liable for mercy killing by omission to act further once a patient's life has become a "burden" to him, such as by failing to replace a depleted oxygen bottle or the like. 69 Kanisar suggests the law recognises a distinction in this regard already mentioned and one not suggested by Professor Williams. Namely, the distinction between life-preserving medical care and mere artificial means of keeping a patient technically alive once his vital processes have ceased spontaneous operation (by the use of a heart-lung respirator for instance). This distinction raised by Professor Kanisar /

68 Kamisar, loc.cit.
69 Ibid., p.982.
Kamisar is perhaps the crux to the entire issue of euthanasia, in practical medical terms, today. Unfortunately, advances in medical science have blurred this distinction by making obsolete traditional definitions of death and leaving a wide area of uncertainty as to where life-preserving activities become no more than a palliative means of prolonging imminent death. Many of the scientific devices by which people are kept "alive" today must be classed as "extraordinary" means: haemodialysis units, "iron-lung" respirators, heart circulation pumps, intravenous feeding and the like. The line between ordinary and extraordinary therapy to preserve life is not an objective or straight one. It can only be discerned in individual cases, based on the presented circumstances, which will always be somewhat dissimilar. However, both Protestant and Catholic theology accept this distinction and both require the application of "ordinary" means only in all cases. The Right Reverend R.C. Mortimer, Lord Bishop of Exeter, has made one of the very few attempts to come to grips more specifically with this distinction. He has stated, 71

"It is, in general, the Christian view that while there is a moral obligation to maintain life by all ordinary means, there is no obligation to use extra-ordinary means.

Ordinary /

70 See relevant discussion in Chapter on "Transplantation" for a more thoroughgoing consideration of these developments.

71 Mortimer, op.cit., p.129.
Ordinary means are such actions as do not cause grave hardship to the patient and which offer a reasonable hope of success. Extraordinary means are means which involve a very great expense, inconvenience, or hardship and which at the same time offer no reasonable expectation either of success or of benefit.

To subject very old people to the acute discomfort of a serious operation or of feeding by intravenous drip would seem to be morally wrong. Such extraordinary means of preserving life should only be used where there is a reasonable hope of recovery from the disease and where some benefit or happiness is conferred upon the patient other than the mere prolongation of his bare existence.

Catholic theologians, while condemning euthanasia in all forms, consider only the failure to supply the "ordinary" means of medical treatment in order to preserve life as being equivalent to euthanasia. This up-to-now largely theological distinction between ordinary and extraordinary medical treatment would appear to offer a reasonable and flexible framework within which the physician's compassion and experience could be left to decide on the type and extent of treatment to be applied in cases where patients had requested euthanasia. The law, however, has yet to clarify the scope of the physician's discretion within this area. Perhaps, wisely, in light of the rapidity with which scientific knowledge is developing artificial means of preserving "life" or postponing "death".

In /

72 See A New Catechism, loc. cit., quoted at footnote 10, p.279, also Kelly, op.cit., p.316. Note also the comments, from a medical viewpoint, quoted in footnote 27, p.284.
In the true life-preserving situation, Professor Kamisar suggests, the special physician-patient relationship places a "legal duty to act" on the doctor, particularly where the patient is helpless and dependent upon the physician for maintaining and preserving his life.\(^7\)

As with the unreported Scots case of Brown, there are several English cases showing the flexibility of the criminal law in practice. In the well-known Brownhill case, the defendant parent was sentenced to death, with a recommendation of mercy, for passing his imbecile thirty-one year old son. Yet only three months later, in response to the public outcry, he was pardoned.\(^7\) However, in an earlier case, Rex v. Simpson,\(^7\) a soldier was convicted of murder for killing his severely ill child. The trial judge was held to have properly instructed that the jury were not entitled to return a verdict of manslaughter regardless of the defendant's merciful motives.

Among the most articulate of those who feel the criminal law is not sufficiently flexible as it stands in relation to euthanasia is Professor Glanville Williams. He has suggested that the situation is in need of clarification, arguing from the viewpoint that voluntary euthanasia should be immnised from /

\(^7\) Ibid., p.983.
\(^7\) Ibid., pp.1020-1021.
from the criminal law when performed by a physician. Williams recommends the enactment of legislation to provide that no doctor shall be guilty of any criminal offence for intentionally accelerating the death of a patient unless it can be proved.

"that the act was not done in good faith with the consent of the patient and for the purpose of saving him from severe pain in an illness believed to be of an incurable and fatal character." 76

Under such a formulation as envisaged by Dr. Williams it would be for the physician to prove his patient was seriously ill, for the prosecution to prove the physician had acted from an other than humanitarian motive, which the law would allow him in the circumstances.

In arguing his case for enactment of the above presumption, Williams suggests that it does no more than recognise what is already wide-spread practice among physicians, that it does not open the way to murder at will for the skilled physician already can kill without leaving a trace if he so desires, that it avoids the cumbersome, formal requirements so distasteful to many that were a feature of the old Euthanasia Society bills and that it leaves this intensely personal matter to the individual consciences of the patient and his physician - who may /

76 Williams, The Sanctity of Life, p.303.
may or may not choose to oblige the former's death request — by requiring consent on the part of the patient and good faith on the part of the doctor. Williams is satisfied under this formulation, to leave "rightness or wrongness" of a particular euthanasia to the "discretion and conscience of the individual medical practitioner". There are those who take issue with Professor Williams' granting of such a wide trust to the doctors. Professor Kamisar, for one, submits that such a trust is unwarranted, subject to too great a risk of abuse and mistake and therefore does not justify a change in the present posture of the criminal law. In Kamisar's words,

'If the range of skill and judgment among licensed physicians approaches the wider gap between the very best and the very worst members of the bar — and I have no reason to think it does not — then the minimally competent physician is hardly the man to be given the responsibility for ending another's life.'

There has as yet been no official move to implement Williams' suggested reform in England, despite his continued support of the proposal, and the law in regard to voluntary euthanasia remains as stated, considering the practice as murder or /

77 Ibid., pp. 303-304.
78 Ibid., p. 304.
79 Kamisar, supra, p. 976.
80 Ibid., p. 976.
81 G. Williams, 43 Minn. L. R. 1(1958); G. Williams, 38 U. Colo. L. R. 178(1966).
or suicide, or a combination thereof and punishable accordingly.

3. United States

In the United States the legal status of euthanasia is basically the same as in Scotland and, more particularly, England. The doctor cannot perform voluntary euthanasia in the absence of enabling legislation, none of which exists, in light of its common law prohibition as murder. The "malice aforethought" requirement of murder does not require any evil motive, anger, hatred or revenge to be in the mind of the actor, but only an intent, plain and simple, to take the life of another.

The characterisation of an offence as murder is in no way changed by the consent or request of the victim. Such factors are irrelevant in homicide cases; they do not constitute "defences, adequate excuses or provocations".

It appears that the only American prosecution involving an alleged mercy-killing of a patient by his physician was brought in 1950. The case, from New Hampshire, State v. Sander, resulted in an acquittal of Dr. Sander, the jury apparently accepting his defence that the air he had injected into the victim's...
victim's veins was not the cause of his patient's death.\textsuperscript{85} Either that, or the jury felt compelled in the circumstances, where the cancer-stricken patient had repeatedly begged Dr. Sander to end his misery, to acquit the physician, regardless of what he had actually done.

While Sander is the only "mercy-killing" case involving a practicing physician as the defendant, there have been a number of other euthanasia cases in the United States involving relatives of the respective victims. In the 1950 case of Bailey, a daughter who shot her father, severely ill with cancer, was acquitted; in Greenfield, a father was acquitted of a reduced charge of manslaughter after having gassed his imbecile son for whom he had provided seventeen years of devoted care; in Repouille \textit{v. U.S.},\textsuperscript{86} the defendant was convicted of gassing his blind, imbecile, bed-ridden son, but was released on a five to ten years suspended sentence imposed by the court; in Noxon, an attorney electrocuted his six months old mongoloid son and was convicted of first degree murder, but had his sentence commuted to life and then was released on parole;\textsuperscript{87} in Braundsdorf, the accused, who was proved to have /

\begin{footnotes}
\item[85] The record kept by Dr. Sander showed several injections of air had in fact been given the patient. See Kamisar, \textit{op. cit.}, p.993.
\item[86] 165 F.2d 153 (2d cir 1947).
\item[87] Noxon was, however, disbarred.
\end{footnotes}
have shot her spastic-crippled daughter and then to have attempted suicide, was found not guilty of murder by reason of temporary insanity; and finally, in Mohr, the defendant was given a mere three-six months sentence for killing his cancerous brother, at the latter's request.

As is evident, none of these "mercy-killings" resulted in normal punishment for the actors, although a good number were convicted. The cases do show, as Brown, supra, in Scotland and Brownhill, supra, in England, that the criminal law as written and the criminal law as administered in practice can be two quite different things. The leniency shown in all these cases is persuasive evidence that the present law of homicide in these countries is sufficiently flexible to allow a judge and jury convinced of a slayer's merciful and humanitarian motives to treat him accordingly. Hypocritical as such results may be to many, few would find them unfair or ill-advised, even among those most opposed to any affirmative legalisation of euthanasia. Most of those in the latter category find such verdicts most desirable, for they reach a just result in the particular case, but leave the thrust of the criminal law on the side of preserving all life, regardless of /

88 All the above cases are discussed in Namisar, op.cit., pp.1021-1022.
89 Ibid., p.972.
of its "quality" to the individual concerned or to society. 91

Aside from these cases, there are reports of one fairly recent American case in which its obvious euthanasia character is most clearly (and honestly) recognised by the court. The case, People v. Werner, 92 involved a defendant who had suffocated his wife, a hopelessly crippled arthritic who had suffered severely for many years before her devoted husband put her out of her misery at her request. In arraignment the defendant was permitted to plead to a manslaughter charge and was found guilty on his own admission. However, in an unusual move, after hearing testimony from the defendant's children and his pastor regarding the devotion he had shown his wife and after receiving a letter from the decedent's doctor explaining the wife's life of excruciating pain and mental despair, the court allowed the defendant to withdraw his plea and found him not guilty on the ground that a jury "would not be inclined" to convict in the circumstances. Seeing no reason for recidivism, the judge allowed the defendant,

"...to go home... and live out the rest of (his) life in as much peace as (he) can find it in (his) heart to have." 93

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91 Kamisar, op.cit., p.1030 ff; Ramsey, op.cit., p.1201.
92 Crim.No.38-3636, Cook Co.,St., Ill., Dec.30,1958. The case is noted in 34 Notre Dame Lawyer 460(1959), and by Williams, in 38 U.Colo.L.Rev. 178(1966).
93 34 Notre Dame Lawyer 460(1959).
4. Germany

Contrary to Scotland, England and the United States, where "mercy-killing" is not a special category of the criminal law, there are other countries where it is in fact accorded special status, either because of the actor's motive, the request by the victim, or both. We will now look briefly at some of these jurisdictions.

The German Penal Code in §216 makes provision for "homicide upon the request of the person killed". The punishment of one who kills another at his express and earnest request is limited to two years and if extenuating circumstances are present, the punishment can be reduced to an imprisonment of not less than six months. However, the offence is still classed as homicide, though the guilt is thought to be mild.

While the mercy-killing is not expressly mentioned in the St.G.B. as a factor in guilt mitigation, it is considered as an "extenuating circumstance" within the definition of §216(2), when that section is otherwise applicable. Earlier German statutes, interestingly enough, did specifically mention the euthanasia or mercy-killing motive as a mitigating factor, and Binding and Hocher in their well-known Die Freigabe der Vernichtung Lebensunwerten Lebens (1920) advocated the mercy /

95 (Such as the Prussian Landrecht of 1794, and the penal codes of Wurttemberg of 1839 and of Thuringia of 1850)
96 "The Elimination of Life Not Worth Living"
mercy-killing of those no longer of any objective usefulness to the community to avoid the drawn out agony of inevitable death. Because the practice of euthanasia was carried to extremes by the Nazi regime, there is perhaps inordinate reluctance in Germany to-day to give even voluntary euthanasia any express statutory recognition, though such a move might well be considered favourable otherwise and is more closely approximated by other continental penal codes.

Nonetheless, it is probably true that physicians in Germany need not fear criminal sanctions under present law for failing to artificially prolong an expiring, painful life, as by camphor injections or the like. However, the position as regards the administration of increasing doses of opiates to ease pain, which incidentally hastens death, is far from clear. There is respectable authority that states such action by a physician is just and no homicide is involved. Still, there appear to be no cases directly in point and the position remains uncertain to-day.

In a case where the wife's inaction - failing to cut down her husband who had hung himself after an argument until dead - was held to be punishable manslaughter in breach of her duty to /

97 See sources mentioned in footnote 2.
98 Silving, op.cit., p.329.
100 Schönke-Schröder (1967 ed.) §§211, 212.
to act, the Bundesgerichtshof\textsuperscript{101} emphasised that the victim was not incurably ill. The Court pointed out that where the crime charged is one of non-feasance rather than active conduct by the accused, his motive - the reason for his inaction - is of increased importance.\textsuperscript{102} While the legal limits of inaction by a physician are yet to be defined in Germany, this case is one suggestion that the courts may be willing to accept the mercy-motive in mitigation in cases of alleged euthanasia due to omission to act by the attending physician.\textsuperscript{103}

5. Norway and Sweden

In Norway, the Penal Code contains a special provision for mercy-motivated or requested killing of hopelessly ill persons.\textsuperscript{104} The section (§235), dating from 1902, but amended in 1961, exempts the mercy-killer from the normal homicide provisions if the victim consented or if the victim was hopelessly ill.\textsuperscript{105}

In /

\begin{flushleft}
\hspace{1cm}101 \text{The highest German Court in civil and criminal matters, 2 B.G.H.St.150 (Feb.12, 1952).}\n\hspace{1cm}102 \text{Silving, \textit{op.cit.}, pp.359-360.}\n\hspace{1cm}103 \text{Ibid.}\n\hspace{1cm}104 \text{St.John-Stevia, \textit{op.cit.}, p.264.}\n\hspace{1cm}105 \text{American Series of Foreign Penal Codes, No.3; The Norwegian Penal Code, 1961, which states, If somebody is killed or seriously injured in body or health with his own consent or if anybody kills a hopelessly sick person out of mercy, or is an accessory thereto, the punishment may be reduced below the minimum provided, and to a milder form of punishment.}\
\end{flushleft}
In Sweden, some time ago, a hospital physician was accused of having contributed to the death of an elderly woman patient.  

She was suffering from a cerebrovascular lesion with loss of consciousness. The physician, with the consent of the patient's relatives, ordered her glucose drip infusion to be discontinued, to "let her to die peacefully". The court involved felt the continuance of such drip treatment would have fulfilled "neither a medical nor a humane purpose" and acquitted the accused doctor.

A commentator on this case in point suggests,

"It was apparent from the verdict that the court considered the woman dying and beyond reasonable hope of recovery, and that in such a situation, no particular efforts to prolong life were necessary and a discontinuation of previous treatment, which had been without palpable effect on the disease process as such, was allowed." 107

The same author suggests that such cases of "passive euthanasia", where artificial life-supporting therapy is withdrawn from the patient considered to be "dying and beyond hope" are permitted in Sweden to-day.

6. Switzerland.

The Swiss Federal Penal Code (1942) does not have specific provisions /

107 Ibid.
provisions concerning euthanasia and does not specifically mention the mercy-motive or the condition of health of the victim in its homicide provisions. However, if one kills another upon the latter's "serious and urgent request", §114 provides a lesser degree of punishment (three days to three years) than for other types of homicide. 108 Additionally, if the judge finds the defendant acted from "honourable motives" he may only have to fine him or submit him to minimum detention (§64(1), 65). 109

Under §115 of the S.F.P.C., a person who instigates another to commit suicide from "self-seeking" motives is punishable by up to five years imprisonment, but presumably a physician who makes the means available for his suffering patient to commit suicide would not come within the prohibition of this provision. 110 However, the position is not apparently as clear in this regard as Dr. Williams seems to think, 111 for the physician could at least be arguably found guilty of negligent homicide under §117 ("He who negligently causes the death of a human being is punishable...") 112.

While /

109 Ibid.
110 Ibid., p.397.
111 See Williams, The Sanctity of Life and the Criminal Law, p.271, where he mentions §117 and concludes, "hence a physician who provides poison for a patient suffering from fatal illness is free from responsibility (Arts. 111-15)."
112 Pestalozzi-Henggeler, loc.cit.
While Swiss Federal Penal Code §114 would seem to cover cases of voluntary euthanasia, the question of involuntary euthanasia - as by the physician's inaction or omission to provide certain care without consulting the patient - is not so clear. One recent Swiss commentator suggests there is no general answer to this problem, but that the doctor's contractual duty to his patient includes at least the use of all "ordinary" means to save the patient's life. 113 The same author suggests the paucity of Swiss material on euthanasia is not so much a result of the fact that the practice does not occur as it is of the fact that such cases are very unlikely ever to reach the courts. 114

7. Other Countries

Contrary to three of the continental jurisdictions mentioned thus far, France provides no mitigation in its penal laws for homicide carried out at the request of another. In this respect, it approximates the British and American systems. Consent is held irrelevant in homicide cases, yet at the same time suicide and assistance in suicide are not crimes in France. 115

This situation results in the somewhat anomalous distinction /

113 Ibid.
114 Ibid., p.398.
distinction that putting poison next to a dying person's bed to facilitate his suicide is not a crime, but feeding him the poison at his wish is murder. Clearly, the distinction is a weak one at best on which to ground criminal liability for murder and has been so criticised.

The Italian Penal Code, the Netherlands Penal Code, the Spanish Penal Code, the Polish Penal Code and the Japanese Penal Code all allow mitigation in penalty if the killing were carried out at the request of the victim.

While /

116 cf. People v Roberts, 211 Mich. 187, 178 N.W. 690 (1920) and other cases cited by St. John-Stevan, op. cit., p. 244, for the contrary American viewpoint.

117 Hughes, loc. cit.

118 Art. 579.

119 Arts. 293-294.

120 Art. 409.

121 Art. 227 (1932).

122 Art. 269. The recent Japanese code, which combines homicide upon request and assisting suicide, reads as follows:

(1) A person who kills another upon his request or with his consent shall be punished by imprisonment for not less than one year nor more than ten years. (Intentional homicide normally carries a penalty of five years to life)

(2) The same shall apply to a person who through encouragement or assistance brings about the suicide of another.

(From American Series of Foreign Penal Codes, Japan, 1961).
While Professor Williams appears to think that Switzerland has made the closest approach of any country to legalising voluntary euthanasia in fatal illnesses, the same claim might easily be made about Uruguan law. Under Article 37 of the Penal Code of Uruguay (1933), the judges are authorised to forego punishment completely of a defendant whose previous life has been honourable where he commits a homicide motivated by compassion and induced by repeated requests of the victim. The provision has been interpreted as conferring a power of judicial pardon in cases meeting the stated requirements.

C. CONCLUDING REMARKS

While Roman Law, Canon Law and the common law of England and America all have condemned euthanasia in any form and make no guilt mitigating provisions for either the mercy-motive of the actor or the request of the victim, the Civilian systems generally do find mitigation of guilt due to the presence of one or both of these factors.

At least in the limited sphere where the physician is asked by a suffering, terminal patient, the latter approach seems desirable. While not taking such cases out of the homicide /

124 Hughes, op.cit., p.241.
125 Silving, op.cit., p.369 (footnote 80).
126 Ibid., p.380.
homicide category, it at least recognises the difference in culpability between such an actor and a cold-blooded killer or one killing only for "self-interest", to borrow the words of the Swiss Federal Penal Code.

Perhaps this latter approach offers a reasonable alternative or middle ground to what many see as either continuing the present approach, and trusting to the flexibility of the law as administered, or changing the law and affirmatively sponsoring such mercy-killings. 127

In any event, it would seem that as medical science increases longevity without preventing deterioration and people are able to "physically" exist for longer and longer life-spans, the act of dying may become more drawn-out, and inevitably in some instances, agonised.

While Christians everywhere champion man's right to live, can they overlook his attendant right to die? If Christianity has properly prepared the patient to meet death, what should prevent him from requesting this fate when he is spiritually ready to "pass on"? 128

In the final analysis the enormous responsibility of any euthanasia programme is placed on the physician. Should he at least be allowed, if he so chooses, to end his patient's suffering /

127 Kalven, op.cit., p.1234; Ramsey, op.cit., 1201.
128 Joseph Fletcher, loc.cit.; J.C.Blackie, Address to Edinburgh Medical Group ("When is Life?: death and the prolongation of life"), Oct.31, 1967.)
suffering, when requested to do so and when he feels he can no longer serve his patient by "improving his living conditions".\textsuperscript{129} Can the physician do this without tarnishing his role as healer and protector of life?

These questions concerning euthanasia deserve answers. Whether they will be forthcoming is another question, for euthanasia deals with death and,

"death is the great taboo subject in our civil-

"iation - more so even than sex... and, until death comes, we choose to know as little as possible about it. This attitude... is perhaps the main reason for the general lack of support given to the cause of euthanasia," \textsuperscript{130}

Perhaps what is needed in to-day's ever more crowded world is a new attitude towards death. It has been suggested that man must not turn his back on death as an inevitable, wholly unpleasant occurrence for which no mental preparation is required, but must appreciate death for the favourable and essential part it plays in human economy and the preservation of society and prepare to meet it.\textsuperscript{131}

On a more practical plane, voluntary euthanasia will be legalised only if it is felt that the advantages it offers - in terms of the avoidance of suffering prior to death in some cases /

\textsuperscript{129} Kilbrandon (same symposium as Blackie, at 128), Oct.31, 1967.
\textsuperscript{130} Williams, 35 H.Cale.L.R. 178(1966).
cases, allowing people the right to meet death before they and their loved ones are shattered by the deterioration of a last, agonised illness - outweigh the abuses to which it might be subject and the negative results it might have - in lowering the value of human life, weakening the trusting relation of doctor and patient, increasing the possibility of overbearing, fatal mistakes and abuse by the physician, and encouraging unwise, shortsighted or irrational requests to die by the patient.

The problem exists, the questions await answering in most legal systems. That society should place itself in favour of preserving and protecting human life is presumed; that it should take this duty as an absolute is quite a different presumption. The right to life has its limits. The philosopher, Korace Kallen, has crystallised this fact as well as anyone and few who have seen a loved one suffer through the agonised, personal disintegration of a painful and fatal illness would disagree with his observation that,

"Human existence is consciousness...when pain and suffering invade it, to become incurably dominant, the consciousness contracts, the good reverses into evil until it ends itself reflexly in a faint, or is ended purposely by means of anodynes and anaesthetics which have the effect of replacing a suffering human person with an unconscious organisation of animal reflexes. The human person ceases when awareness goes out and /
and unawareness comes in, and awareness goes out when it becomes intolerable to itself. Death is only the lasting, as sleep, anaesthesia and narcosis are the intermittent extinctions of consciousness." 132

This statement at the same time points up the strength of the argument of many who contend any 'real' consent can be given by the patient, and therefore any voluntary euthanasia, is impossible in the circumstances. Granted, the argument has merit, but it is not incontrovertible. Consent could be obtained, or more properly, requests made of the doctor before the final, most agonised phases of the illness were reached, and then only to be acted upon when the illness did in fact become so progressive.

Aside from the law's basic reverence for life, this problem of consent by the patient is perhaps the biggest stumbling block to any fundamental change in the law. Consent during a last agonised illness is not truly free, voluntary consent by any reasonable interpretation. At the same time, consent given before the onset of a last illness, while free and voluntary, can never do more than trust to the physician's discretion to act when he feels that point of suffering has been reached which the patient would not have wanted to endure. This, of course, puts a good deal more faith in the physician's discretion than many /

many are willing to do, not to mention the very heavy burden indeed that it places on the doctor's shoulders. A concurring doctor or even two's opinion that the patient was terminally ill in their minds, in severe pain, and had expressly and earnestly requested a final peaceful release could be required as a safety measure and might lighten the burden carried by the obliging physician. This would be a wise safeguard and could easily be required in verified, written form.

We trust physicians to bring us through the often accident and illness scarred passage of life, many times trusting our very survival to their good judgment. Why then, deny them this trust when we have reached the other side of our journey through life and need a hand to make our exit as short, painless and dignified as possible, and with the least consternation caused our loved ones?

Even those who oppose voluntary euthanasia as an irreverent interference with God's control over each mortal's life and death allow the administration of anaesthetics and narcotics in ever-increasing doses that may eventually bring about death in a deepening haze of consciousness and finally coma. Surely, the /

133 See quote by Kamisar, loc.cit., at footnote 80, page 300.
the individual should be able to meet his Maker in what Reverend Joseph Fletcher has called "personal integrity" and conscious, responsible choice, before the terminal stages of an illness or of narcosis allegedly remove the individual's free choice and require him to meet death in "personal disintegration". 134

Still, it is submitted, and without great conviction, that the final answer to this problem is to be provided not by the "heavy handed" entrance of the criminal law into the terminal patient ward, but by increased concern with the care of the dying and an increased emphasis on training, treatment and insights into the patient's condition of dying and the pain that may, but need not necessarily, 135 accompany the ending of our life on earth.

If this becomes the case, it must be clearly realised at the same time that it is not the province of medicine to attempt the useless prolongation of dying, but rather to realise when all hope is gone and to give up the struggle when it is obvious that death must now come as a "natural phenomenon" 136 and should be allowed to run its course as peacefully as it can possibly /

134 Fletcher, op. cit., p. 208.
135 Saunders, loc. cit.
possibly be made to. As Canon Douglas Rhymes of London has recently said, doctors need not arm themselves to combat death under all circumstances, but should realise through their understanding of nature's processes of human regeneration that sometimes "letting nature know best when a life has been deprived of almost everything except the mere fact of continuing to exist" is the best course to follow.\textsuperscript{137}

If it comes to be accepted that a patient is, in fact, dead, though certain processes continue or may be stimulated or simulated by artificial, "extraordinary" medical treatment, then no changes in the prevailing laws of homicide would need to be made. If the patient were considered already "dead", then the turning off of a respirator, the disconnecting of a catheter or the withholding of an injection could not be considered homicide. There would be no \textit{actus reus}.

Perhaps then, at least part of the answer to the question of legalising euthanasia is not to be found in the criminal law of homicide and its amendment, but rather in newly-adopted and applied definitions of death.\textsuperscript{138} It is not difficult to consider a patient whose heart and lungs cease operation dead and not to hold a physician liable for complying with the patient's /

\textsuperscript{137} \textit{The Times}, Nov. 6, 1967, p. 3.

\textsuperscript{138} The reader is again referred to evolving medical concepts concerning death discussed \textit{supra} in the chapter on "Transplantation"; \textit{The Times}, May 10, 1968, p. 3.
patient's prior request not to resuscitate. Under traditional definition, the patient is dead, though resuscitation might allow the organs to function with artificial assistance for several hours or even days. If the brain had suffered irreversible damage, then a decision by the doctor not to prolong the patient's "existence" any longer with medicine or machine could be likewise justified.

In fact, however, these cases are not the difficult ones. It is in situations where disease or infirmity makes life slowly more agonising for the patient without causing his vital processes of heart, lungs and brain to cease that even revolutionary changes in the definition of clinical death will have no foreseeable effect. Euthanasia, commonly sought in just such cases, will still be homicide in the eyes of the law. Only legislation, in effect allowing an individual to decide when his death should come and absolving another for carrying out the patient's wish, can clearly protect the obliging physician in these cases.

In the last analysis, it is submitted, absent specific changes in the criminal law codes, we must trust to this professional ethics of our physicians to guide them in choosing how far the circumstances of any given case require adherence to /
to the words of Arthur Hugh Clough:

"Thou shalt not kill; but needs's not strive officiously to keep alive." 139

we must realise that all life comes to an end and distinguish that while life must be preserved in all cases, there is no use or morality in drawing out the inevitable process of dying by extraordinary means. The point at which life if no longer being preserved, but death is being prolonged, will be a tenuous and difficult one to pinpoint, but it is a task for the humanity of the physician, not for the formality of the law.

139 Louiseill, op.cit., p.93.
Article 78 proceeding in nature of mandamus for order directing the official of the New York City Department of Health to change sex designation on petitioner's birth certificate. The Supreme Court, Special Term, Joseph A. Sarafite, J., held that in context of record before it, judicial intervention in an Article 78 proceeding in the nature of mandamus for order directing to require the change in sex designation on birth certificate of petitioner, a transsexual who had undergone "conversion" surgery and had assumed the name and role of a female in society, from "male" to "female" following Department's refusal to do so on application of petitioner would constitute a usurpation of function of executive branch of government.

Application denied and petition dismissed.

1. Health § 34

Primary jurisdiction to formulate and implement New York City's policy with regard to records of birth, fetal deaths and deaths is vested in the Board of Health and the provisions of the New York City Health Code relating to amendment of birth certificates have the force and effect of statutory law. New York City Charter, §§ 558, 567.

2. Mandamus § 172

Issue in Article 78 proceeding in nature of mandamus for order directing change of sex designation on petitioner's birth certificate was whether official had acted in an arbitrary, capricious or otherwise illegal manner in deciding that petitioner had not established that the evidence submitted shows the true facts and that error was made at time of preparing and filing certificate in accordance with provisions of New York City Health Code and in denying the application for amendment and issuance of a new certificate. New York City Charter, §§ 558, 567; CPLR § 7801 et seq.

3. Health § 34

Court could not substitute its views for those of administrative body which was charged by law with the authority and responsibility of maintaining records of births and deaths and which refused to amend petitioner's birth certificate to change the sex designation thereof.

4. Health § 34

In its role as ultimate arbiter of legality of New York City De-
designation on petitioner's birth certificate, court could not weigh wisdom of Department's acts.

5. Constitutional Law

In context of record before it, judicial intervention to require New York City Department of Health to change the sex designation on birth certificate of petitioner, a transsexual who had undergone "conversive" surgery and had assumed the name and role of a female in our society, from "male" to "female" following a refusal to do so on application of petitioner would constitute a usurpation of function of executive branch of government. CPLR § 7801 et seq.; New York City Charter, §§ 558, 567.

6. Health

Fact that prior to the study of problem and a resolution by the New York City Department of Health determining that it would deny right to amend sex designation in birth certificates of transsexuals amendments had been made to birth certificates of three transsexuals did not militate against a denial of an amendment following the study and resolution.

7. Estoppel

No estoppel is countenanced by courts against public officials performing their legal duty.

J. Lee Rankin, Corp. Counsel, for respondent.
Morris Schmaulbach, New York City, for petitioner.

JOSEPH A. SARAFITE, Justice:

Petitioner instituted this Article 78 CPLR proceeding, in the nature of mandamus, for an order directing respondent to change the sex designated on petitioner's birth certificate from "male" to "female" and, consonant therewith to change the given name thereon to one assumed by petitioner subsequent to birth and to issue and substitute a new certificate.


"The syndrome of transsexualism" involves "a truly untrodden, controversial and largely unexplored field of medicine." (Benjamin, Clinical Aspects of Transsexualism in the Male and Female, supra, at 458.) With appropriate hesitation because of the paucity of knowledge in this area of science, transsexualism has been described by a leading authority, Dr. Harry Benjamin, as "a striking disturbance of gender role and gender orientation * * * a disorder of the harmony and uniformity of the
psychosexual personality * * * [a] split between the psychological and the morphological sex * * * " (Nature and Management of Transsexualism, supra, at 106.)

This petitioner has undergone "conversive" surgery and has assumed the name and role of a female in our society as a means of correcting the disharmony to which Dr. Benjamin refers. To consummate so far as possible this change in gender, an application for the issuance of a new birth certificate was submitted to the Director of the Bureau of Records and Statistics of the Department of Health of the City of New York. The request was held in abeyance pending the consideration and determination by the Board of Health of the general subject of change of birth certificates of transsexuals. An earlier similar application had caused respondent's predecessor to seek the guidance of the Board of Health.

When confronted with this need for a formulation of policy and possible implementation by regulation, the Board of Health, in recognition of the serious consequences attendant upon a decision in the affirmative or in the negative, initiated an exhaustive inquiry into the subject and called upon the New York Academy of Medicine to study the problem and to submit its recommendations to the Board. This recognition of the need for full exploration of the problem posed reflects the Board's awareness of its obligation to society to ensure the accuracy of public records. It also indicates its deep concern for the individual, the transsexual, who has been described by Dr. Harry Benjamin as "among the most miserable people I have ever met." (Benjamin, Nature and Management of Transsexualism, supra, at 106.) Most significant, it represents adherence to the highest standards of the administrative process.

The New York Academy of Medicine is also to be commended for assuming this delegated responsibility and for the manner in which it fulfilled its undertaking. In its report "Change of Sex on Birth Certificates for Transsexuals", the Committee on Public Health of the New York Academy of Medicine, states:

"Because of the complexity of the subject which cuts across biology and medicine and projects into the domain of law, the Committee called on a group of specialists in several fields to study the problem. This group included gynecologists, endocrinologists, cytogenetics, psychiatrists and a lawyer."

After detailed analysis of the many facets and ramifications of the change of sex on the birth certificate of a transsexual, including cognizance of the fact that at present ten states have permitted such change (Alabama, California, Hawaii, Illinois, Maryland, New Jersey, North
Carolina, Pennsylvania, Virginia and Tennessee), the Committee concluded that:

“1. male-to-female transsexuals are still chromosomally males while ostensibly females;

“2. it is questionable whether laws and records such as the birth certificate should be changed and thereby used as a means to help psychologically ill persons in their social adaptation.

“The Committee is therefore opposed to a change of sex on birth certificates in transsexualism.”

“* * * The desire of concealment of a change of sex by the transsexual is outweighed by the public interest for protection against fraud.”

On October 13, 1965, the Board of Health passed the following resolution:

“RESOLVED, that in view of all the evidence considered including the report of the Committee on Public Health of the New York Academy of Medicine, it is the sense of the Board of Health that the Health Code not be amended to provide for a change of sex on birth certificates in cases of transsexuals.”

At the same meeting, the Board, by unanimous vote, decided to “go on record as generally favoring the recommendations of the Committee on Public Health of the Academy of Medicine, and, in effect, stating that an individual born one sex cannot be changed for the reasons proposed by the request which was made to us. Sex can be changed where there is an error, of course, but not when there is a later attempt to change psychological orientation of the patient and including such surgery as goes with it [sic].”

In accordance with the resolution and statement of policy by the Board of Health, respondent denied petitioner’s application for amendment or issuance of a new birth certificate.

[1] The proper scope of the judicial role (other than power granted pursuant to Civil Rights Law, section 61 et seq.) in reviewing the denial of petitioner’s application is greatly restricted. Primary jurisdiction to formulate and implement the City’s policy with regard to the records of “birth, fetal deaths and deaths” is vested in the Board of Health. (New York City Charter, section 567.)

The prerequisite standards for amendment of a birth certificate are prescribed by the provisions of the New York City Health Code. These provisions—which have the force and effect of statutory law—represent and reflect the plenary jurisdiction of the Board of Health in this area. (See City Charter, sec. 558; Matter of Baker’s Mutual Insurance Co. of New York [Dept. of Health], 301 N.Y. 21, 27, 92 N.E.2d 49, 52.)

Article 207 of the Health Code provides, in pertinent part, for amendment of a birth certificate only if “the Commissioner or his designee is
satisfied that the evidence submitted shows the true facts and that an error was made at the time of preparing and filing of the certificate, or that the name of a person named in a birth certificate has been changed pursuant to court order." (Section 207.01 [c].) The normal method of amendment is the drawing of a single line through the information subject to amendment and the insertion of the correct information above it (Section 207.03 [a]). An exception to this method is provided in section 207.05 [c] which empowers the "Commissioner or other personnel of the Department designated by him" to file a new birth certificate if he "finds it desirable by reason of the nature and extent of the amendments." These two sections are the exclusive bases in the Health Code for the relief presently requested.

[2] Thus, the critical issue before the Court is whether the respondent acted in an arbitrary, capricious or otherwise illegal manner in deciding that the petitioner did not establish "that the evidence submitted shows the true facts and that an error was made at the time of preparing and filing of the certificate" and, accordingly, in denying the application for amendment and issuance of a new certificate.

[3, 4] The test of arbitrariness does not permit the Court to substitute its views for those of the administrative body charged by law with the authority and responsibility of maintaining the records of births and deaths. In its role as ultimate arbiter of the legality of administrative action the judiciary may not arrogate to itself the power of a super-Board of Health to weigh the wisdom of respondent's acts. (Paraphrasing Day-Brite Lighting, Inc. v. State of Missouri, 342 U.S. 421, 423, 72 S.Ct. 405, 96 L.Ed. 469.)

Indeed, the nature of the problem posed initially to the Board of Health and now to the Court requires a specialized training and skill for which the Board is uniquely equipped. Judicial deference to the decision of those members of the Board of Health who are physicians or otherwise uniquely qualified appears mandatory in the singular circumstances here involved.

[5] The determination of respondent was predicated upon the decision of the Board of Health that the Health Code "not be amended to provide for a change of sex on birth certificates in cases of transsexuals." Implicit in this resolution is the Board's interpretation of the Health Code, to the effect that as presently constituted, no authorization exists for the amendment requested by petitioner. As the Supreme Court of the United States declared recently under analogous circumstances (Udall v. Tallman, 380 U.S. 1, 16, 85 S.Ct. 792, 801, 13 L.Ed.2d 616):

"When faced with a problem of statutory construction * * *

[the] Court shows great deference to the interpretation given the statute by the officers or agency charged with its administration. "To sustain the * * * [Board's] application of this statutory
term ["an error was made at the time of preparing and filing of
the certificate"], we need not find that its construction is the only
reasonable one or even that it is the result we would have reached
had the question arisen in the first instance in judicial proceedings.'
[citing cases] * * * When the construction of an administrative
regulation rather than a statute is in issue, deference is even more
clearly in order." [Matter in brackets supplied.]

Within the context of the present record, the court concludes that ju-
dicial intervention would constitute an usurpation of the function of the
executive branch of government.

[6, 7] In support of the petition it is argued that prior to the afore-
said study and resolution by the Board of Health, amendments were made
to the birth certificates of three transsexuals by respondent’s predecessor.
This fact does not militate against denial of the present application.
(See Matter of Harwood v. Cornelius, 21 A.D.2d 961, 962, 251 N.Y.S.
2d 604, 605; Federal Crop Insurance Corp. v. Merrill, 332 U.S. 380,
68 S.Ct. 1, 92 L.Ed. 10.) “There is no estoppel countenanced by the
courts against public officials performing their legal duty.” (Matter
of Harwood v. Cornelius, 21 A.D.2d 961, 962, 251 N.Y.S.2d 604, 606.)

Accordingly, the present application is denied and the petition dis-
missed.

The present proceeding has not been instituted nor has it been con-
sidered by the court as an application for a change in name in compliance
with Civil Rights Law, section 61.
APPENDIX II.

THE NUREMBERG CODE *

PERMISSIBLE MEDICAL EXPERIMENTS.

"The great weight of the evidence before us is to the effect that certain types of medical experiments on human beings, when kept within reasonably well-defined bounds, conform to the ethics of the medical profession generally. The protagonists of the practice of human experimentation justify their views on the basis that such experiments yield results for the good of society that are unprocurable by other methods or means of study. All agree, however, that certain basic principles must be observed in order to satisfy moral, ethical and legal concepts:

1. The voluntary consent of the human subject is absolutely essential. This means that the person involved should have legal capacity to give consent; should be so situated as to be able to exercise free power of choice without the intervention of any element of force, fraud, deceit, duress, overreaching, or other ulterior form of restraint or coercion; and should have sufficient knowledge and comprehension of the elements of the subject matter involved as to enable him to make an understanding and enlightened decision. This latter element requires that before the acceptance of an affirmative decision by the experimental subject there should be made known to him the nature, duration, and purpose of the experiment; the method and means by which it is to be conducted; all inconveniences and hazards reasonably to be expected; and the effects upon his health or person which may possibly come from his participation in the experiment.

* Taken from Ethics in Medical Progress. London: Churchill. 1966 pp. 216 - 218
The duty and responsibility for ascertaining the quality of the consent rests upon each individual who initiates, directs, or engages in the experiment. It is a personal duty and responsibility which may not be delegated to another with impunity.

2. The experiment should be such as to yield fruitful results for the good of society, unprocureable by other methods or means of study, and not random and unnecessary in nature.

3. The experiment should be so designed and based on the results of animal experimentation and a knowledge of the natural history of the disease or other problem under study that the anticipated results justify the performance of the experiment.

4. The experiment should be so conducted as to avoid all unnecessary, physical and mental suffering and injury.

5. No experiment should be conducted where there is an a priori reason to believe that death or disabling injury will occur; except perhaps in those experiments where the experimental physicians also serve as subjects.

6. The degree of risk to be taken should never exceed that determined by the humanitarian importance of the problem to be solved by experiment.

7. Proper preparations should be made and adequate facilities provided to protect the experimental subject against even remote possibilities of injury, disability or death.

8. The experiment should be conducted only by scientifically qualified persons. The highest degree of skill and care should be required through all stages of the experiment of those who conduct or engage in the experiment.

9. During the course of the experiment the human subject should be at liberty to bring the experiment to an end if he has reached the physical or mental state where continuation of the experiment seems to him to be impossible.
10. During the course of the experiment the scientist in charge must be prepared to terminate the experiment at any stage, if he has probable cause to believe, in the exercise of the good faith, superior skill, and careful judgment required of him that a continuation of the experiment is likely to result in injury, disability or death to the experimental subject."
It is the mission of the doctor to safeguard the health of the people. His knowledge and conscience are dedicated to the fulfilment of this mission.

The Declaration of Geneva of the World Medical Association binds the doctor with the words "the health of my patient will be my first consideration"; and the International Code of Medical Ethics which declares that "Any act or advice which could weaken physical or mental resistance of a human being may be used only in his interest."

Because it is essential that the results of laboratory experiments be applied to human beings to further scientific knowledge and to help suffering humanity, the World Medical Association has prepared the following recommendations as a guide to each doctor in clinical research. It must be stressed that the standards as drafted are only a guide to physicians all over the world. Doctors are not relieved from criminal, civil and ethical responsibilities under the laws of their own countries.

In the field of clinical research a fundamental distinction must be recognised between clinical research in which the aim is essentially therapeutic for a patient, and clinical research the essential object of which is purely scientific and without therapeutic value to the person subjected to the research.

I. BASIC PRINCIPLES.

1. Clinical research must conform to the moral and scientific principles that justify research, and should be based on laboratory and animal experiments or other scientifically established facts.

2. Clinical research should be conducted only by scientifically qualified persons and under the supervision of a qualified medical man.

3. Clinical research cannot legitimately be carried out unless the importance of the objective is in proportion to the inherent risk to the subject.

4. Every clinical research project should be preceded by careful assessment of inherent risks in comparison to foreseeable benefits to the subject or to others.

5. Special caution should be exercised by the doctor in performing clinical research in which the personality of the subject is liable to be altered by drugs or experimental procedure.

II. CLINICAL RESEARCH COMBINED WITH PROFESSIONAL CARE.

1. In the treatment of the sick person the doctor must be free to use a new therapeutic measure if in his judgment it offers hope of saving life, re-establishing health or alleviating suffering.

   If at all possible, consistent with patient psychology, the doctor should obtain the patient's freely given consent after the patient has been given a full explanation. In case of legal incapacity consent should also be procured from the legal guardian; in case of physical incapacity the permission of the legal guardian replaces that of the patient.

2. The doctor can combine clinical research with professional care, the objective being the acquisition of new medical knowledge, only to the extent that clinical research is justified by its therapeutic value for the patient.
III. NON-THERAPEUTIC CLINICAL RESEARCH.

1. In the purely scientific application of clinical research carried out on a human being it is the duty of the doctor to remain the protector of the life and health of that person on whom clinical research is being carried out.

2. The nature, the purpose, and the risk of clinical research must be explained to the subject by the doctor.

3a. Clinical research on a human being cannot be undertaken without his free consent after he has been fully informed; if he is legally incompetent the consent of the legal guardian should be procured.

3b. The subject of clinical research should be in such a mental, physical, and legal state as to be able to exercise fully his power of choice.

3c. Consent should as a rule be obtained in writing. However, the responsibility for clinical research always remains with the research worker; it never falls on the subject, even after consent is obtained.

4a. The investigator must respect the right of each individual to safeguard his personal integrity, especially if the subject is in a dependent relationship to the investigator.

4b. At any time during the course of clinical research the subject or his guardian should be free to withdraw permission for research to be continued. The investigator or the investigating team should discontinue the research if in his or their judgment it may, if continued, be harmful to the individual.
APPENDIX IV.

Renal Transplantation

A BILL

TO

Permit removal from the body of a human person, duly certified as dead, of any kidney or kidneys required for medical purposes, unless there is reason to believe that the deceased during his lifetime had instructed otherwise.

BE IT ENACTED by the Queen's most Excellent Majesty, by and with the advice and consent of the Lords Spiritual and Temporal, and Commons, in this present Parliament assembled, and by the authority of the same, as follows:—


2. It shall be lawful to remove from the body of a human person, duly certified as dead, any kidney or kidneys required for medical purposes unless there is reason to believe that the deceased during his lifetime had instructed otherwise.

3. For the purposes of section 2 of this Act, a death certificate must be signed by two medical practitioners other than the surgeon conducting the renal transplantation.

4. This Act may be cited as the Renal Transplantation Act Short title.
UNIFORM ANATOMICAL GIFT ACT

An act authorizing the gift of all or part of a donor's body after death for specified purposes.

SECTION 1. [Definitions]

(a) "Person means individual, corporation, government or governmental subdivision or agency, business trust, estate, trust, partnership or association, or any other legal entity.

Comment

This subsection is taken verbatim from the National Conference Uniform Statutory Construction Act approved in 1965, Section 2(b)(4). In any state that has adopted the Uniform Act or its equivalent, Subsection 1 (a) will be unnecessary.

(b) "Body or part of body" includes organs, tissues, bones, blood and other body fluids in the body of the donor, and "part" includes "parts".

Comment

Section 3 of the Uniform Statutory Construction Act provides "The singular includes the plural, and the plural includes the singular." In any state that has adopted the Uniform Act or its equivalent, the concluding clause of Subsection 1 (b) will be unnecessary.
(c) "Licensed hospital" includes any hospital licensed or approved by appropriate authorities under the laws of any state, and it also includes any hospital operated by the United States government although not required to be licensed under state laws.

(d) "Licensed physician or surgeon" means a physician or surgeon licensed to practice under the laws of any state. "Licensed Technician" means a medical assistant licensed as such under the laws of any state.

(e) "Licensed bank or storage facility" means a facility licensed or approved by appropriate authorities under the laws of any state.

(f) "State" means any state, territory or possession of the United States, the District of Columbia or the Commonwealth of Puerto Rico.

SECTION 2. [Persons Who May Execute an Anatomical Gift.]

(a) Any individual who is competent to execute a will may give all or any part of his body for any one or more of the purposes specified in this Act, the gift to take effect after death.

(b) Unless he has knowledge that contrary directions have been given by the decedent, the following persons, in the order
of priority stated, may give all or any part of a decedent's body for any one or more of the purposes specified in this Act:

(1) the spouse if one survives. If not,
(2) an adult child,
(3) either parent,
(4) an adult brother or sister,
(5) the guardian of the person of the decedent at the time of his death,
(6) any other person or agency authorized or under obligation to dispose of the body.

If there is no surviving spouse and an adult child is not immediately available at the time of death, the gift may be made by either parent; if a parent is not immediately available, it may be made by any adult brother or sister; but if the donee or his agent knows that there is controversy among the classes of relatives named with respect to making the gift, it shall not be accepted. The persons authorized by this subsection to make the gift may execute the document of gift either after death or immediately before death during a terminal illness. The decedent may be a minor or a still-born infant.
Comment

Existing statutes differ in their respective standards establishing competence to execute an anatomical gift. Competence to execute a will is used as the standard in seven states, namely, Arizona, Illinois, Indiana, Nebraska, North Carolina and Oregon and the District of Columbia. Twenty one years and sound mind is the stated standard in the statutes of fourteen states. In New York "a person who is eighteen years of age or older" may make the gift, and in California, Colorado, Florida, Nebraska and Pennsylvania "any person" may do so.

There is merit in enlarging the class of possible donors as much as possible, but in its present draft the Uniform Act accepts the majority rule.

Only a few statutes spell out the right of survivors to make the gift. Such provisions are found in California, the District of Columbia, Iowa, Kentucky, New Mexico and Washington. Taking into account the very limited time following death for the removal of such critical tissues as the kidney, the liver and the heart, it seems desirable to eliminate all possible questions by stating the rights of and the priorities among the survivors; also, to cover the matter of differences of view among the survivors; and to authorize the survivors to execute the necessary documents even prior to death. In view of the further fact that minors are excluded from subsection (a), it is especially desirable to cover the status of survivors so minors may be included as donors.

SECTION 3. [Persons Who May Become Donees, and Purposes for Which Anatomical Gifts May be Made.]

The following persons are eligible to receive gifts of human bodies or parts thereof for the purposes stated:

(1) any licensed hospital, surgeon or physician, for medical education, research, advancement of medical science, therapy or transplantation to individuals;
(2) any medical school, college or university engaged in medical education or research for educational, research or medical science purposes;

(3) any person operating a licensed bank or storage facility for blood, arteries, eyes, or other human parts, for use in medical education, research, therapy or transplantation to individuals;

(4) any specified donee, for therapy or transplantation needed by him.

Comment

Existing statutes reveal great diversity of provisions concerning possible donees and the purposes for which anatomical gifts may be made.

As to donees the list includes licensed hospitals, storage banks, teaching institutions, universities, colleges, medical schools, state anatomy boards, and institutions approved by the state department of health. Some of the statutes are detailed and comprehensive. Others are limited, brief and general. A few, including those of Alabama, Arkansas, Colorado, the District of Columbia, Iowa and Louisiana do not seek in any way, to name or limit the donees. They are confined to stating the purposes for which donations are permissible. The Uniform Act attempts to achieve a maximum of clarity and precision by carefully naming the permissible donees. Several of the statutes that include storage banks, namely those of California, Nebraska, Pennsylvania, and Washington, prescribe that they shall be non-profit organizations. On the other hand, most of the states that specifically mention such banks seemingly are not concerned over the profit motive and no mention is made of it.
This is the case in Arizona, the District of Columbia, Florida, Indiana, Kentucky, Massachusetts, New Jersey, New York, Texas, Wisconsin. The Uniform Act follows the latter course in this regard.

As to purposes, again we find diversity among the statutes. The list of purposes includes teaching, research, advancement of medical science, therapy, transplantation, rehabilitation, and scientific uses. Again some of the statutes are detailed, and some are brief and general. A few statutes, such as those of Colorado, the District of Columbia, and Illinois, contain no limitation whatsoever - merely naming the donees and leaving the selection of purposes to their discretion.

In general it seems desirable to be selective in naming the donees and then inclusive in naming the purposes in broad terms.

SECTION 4. [Manner of Executing Anatomical Gifts.]

(a) A gift of all or part of the body for purposes of this Act may be made by will, in which case the gift becomes effective immediately upon death of the testator without waiting for probate. If the will is not probated, or if it is declared invalid for testamentary purposes, the gift, to the extent that it has been acted upon in good faith, is nevertheless valid and effective.

(b) A gift of all or part of the body for purposes of this Act may also be made by document other than a will. The document must be signed by the donor, in the presence of two witnesses who shall in turn sign the document in his presence. If the donor cannot sign in person, the document may be signed for him at his direction and in his presence, and in the
presence of two witnesses who shall in turn sign the document in his presence. Delivery of the document of gift during the donor's lifetime is not necessary to make the gift valid. The document may consist of a properly executed card carried on the donor's person or in his immediate effects. The gift becomes effective immediately upon the death of the donor.

(c) The gift may be made either to a named donee or without the naming of a donee. If the latter, the gift may be accepted by and utilized under the direction of the attending physician at or following death. If the gift is made to a named donee who is not reasonably available at the time and place of death, and if the gift is evidenced by a properly executed card or other writing carried on the donor's person or in his immediate effects, the attending physician at or following death may, in reliance upon the card or writing, accept and utilize the gift in his discretion as the agent of the donee. The agent possesses and may exercise all of the rights and is entitled to all of the immunities of the donee under this Act.

(d) The donor may designate in his will or other document of gift the surgeon, physician, or technician to carry out the appropriate procedures. In the absence of a designation, the donee or other person authorized to accept the gift may employ or authorize any licensed surgeon, physician, or technician for the purpose.
(e) If the gift is made by a person designated in section 2(b) of this Act, it shall be executed by a document signed by the person authorized by that section and witnesses are not required.

Comment

A majority of the existing statutes authorize the making of the gift by a document signed by the donor and with two witnesses who also sign. Massachusetts requires three witnesses; Arkansas, California, Colorado, Florida, Maine, Nebraska, Pennsylvania and Washington require a written instrument but do not require witnesses; Connecticut and Minnesota require "execution as a will"; Arizona and Tennessee require a written and acknowledged instrument; Alabama and Iowa require "executing as a deed". The Uniform Act follows the majority practice.

Many states also provide as an alternative mode that the gift may be made by will, and in such event that the gift become effective immediately on death without awaiting probate. Such alternative modes of making the gift are found in California, Connecticut, the District of Columbia, Florida, Illinois, Indiana, Nebraska, North Carolina, Oregon, Pennsylvania and Tennessee. The Uniform Act contains such provisions.

The provision in subsection (b) to the effect that the document of gift may be in the form of a card carried by the donee is unique and important. We are a peripatetic people, and gift will be facilitated by carrying on our persons the evidence of our donative intentions. This provision is supplemented by the provision in subsection (c) to the effect that if the donee is named but is not reasonably available, the gift may nevertheless be carried out and for the benefit of persons on the ground at the time. The statutes of the District of Columbia, Massachusetts, New Mexico and Texas provide that if no donee is named the hospital where the donor dies, or, if none, the attending physician shall be deemed the donee and may make use of the gift. The Uniform Act carries this idea one step further in the direction of more adequate utilization of gifts.
A few states have provided that no remuneration shall be paid or received for gifts of bodies or parts thereof. Such provisions are found in Georgia (for eyes only), Maine (for eyes only), Massachusetts and New York. No such provision has been included in the Uniform Act.

SECTION 5. [Delivery to Donee.] If the gift is made to a named donee, the will or other document, or an attested true copy thereof, may be delivered to him to expedite the appropriate procedures immediately after death, but such delivery is not necessary to validity of the gift. Upon request of any interested party on or after the donor's death, the person in possession must produce, for examination the will or other document of gift.

Comment

Some of the statutes make rather formal provisions for filing of documents of gift. Thus in Alabama and Arkansas the gift must be "filed for record in the office of the judge of probate." In Connecticut the document must be filed either before death or within 60 hours after death with the state Department of Health. In Louisiana the instrument must be filed for record "in the office of the clerk of the district court of the parish wherein the person making the gift resides." In Tennessee it is provided that the instrument "shall be delivered by the donor to the donee." On the other hand, in the great majority of the states, no provision is made for filing, recording or delivery to the donee. The gift is by implication effective without such formality. Section 5 of the Uniform Act follows the majority practice, but includes permissive provisions to expedite post-mortem procedures.
SECTION 6. [Revocation of the Gift.]

(a) If the document of gift has been delivered to a named donee, it may be revoked either

(1) by the execution and delivery to the donee or his agent of a revocation in writing signed by the donor, or

(2) by an oral statement of revocation witnessed by two persons, addressed and communicated to the donee or his agent, or

(3) by a statement during a terminal illness addressed to the attending physician, and communicated to the donee, or his agent, or

(4) by a card or writing, signed by the donee and carried on his person or in his immediate effects, revoking the gift.

(b) If the written document of gift has not been delivered to the donee, the gift may be revoked by destruction, cancel- lation or mutilation of the document.

(c) If the gift is made by a will, it may be revoked in the manner provided for revocation or amendment of wills.
Comment

In about one half of the states no provision is made for revocation. However, in the interest of carrying out the ultimate desires of the donor, there is good reason for facilitating revocation. Accordingly, about half of the states make affirmative provisions concerning the matter. Usually it is provided that revocation may be accomplished by executing a "like instrument" filed in the manner provided for the instrument of gift and delivered to the donor. The Uniform Act makes careful and complete provision for revocation under various contingencies.

SECTION 7. [Effect of Gift on Rights of Donee.]

(a) The donee may accept or reject the gift. If the donee accepts, and if the gift is of the entire body, the donee or his agent may, if he deems it desirable, authorize embalming and funeral services. The donee or his agent may, immediately after death of the donor and prior to embalming, cause any part included in the gift to be removed from the body, without undue mutilation. The time of death shall be determined by the physician in attendance upon the donor's terminal illness or certifying his death, and he shall not be a member of the team of surgeons which transplants the part to another individual.

(b) The donee, agent of a donee, or other person authorized to accept and utilize the gift who acts in good faith, in reliance upon, and in accord with the terms of a gift under th
Act, or any similar Act, or upon a document carried by the donor as herein provided, and who is without actual notice of revocation of the gift, shall not be held liable for damages in any civil suit brought against him for his act.

(c) The provisions of this Act are subject to the laws of this state prescribing powers and duties with respect to autopsies.

Comment

Section 7 contains several important provisions. First, there is the provision that the time of death shall be determined by the donor's physician in attendance and that he shall not be a part of the transplant team. These provisions are not found in any of the existing statutes; yet, they are essential. The time of death is not subject to clear-cut definition. Modern methods of heart pacing, cardiac massage, artificial blood circulation and artificial respiration can continue bodily metabolism and the simulation of life far beyond former limits. The question is when have irreversible changes taken place that completely preclude anything like normal brain activity and self-sustaining bodily functions. The answer depends upon many variables which cannot be spelled out in a statute. Reliance must be placed upon the professional skill and judgment of the physician in attendance. Because time is of the essence, the transplant team wishes to remove the critical organs at the earliest possible moment and before deterioration takes place. Hence, there is an inevitable conflict of interest, and accordingly, provision should be made to exclude the physician in charge of the patient from the transplant team. None of the existing statutes cover this point but the provision of the Uniform Act seems essential to public acceptance of the procedure.
The exculpation clauses of subsection (b) are just and necessary, and they are in accord with the corresponding provisions expressly set forth in the statutes of Arizona, Colorado, Connecticut, Illinois, Indiana, Louisiana, Michigan, Nebraska, Oregon, Tennessee, Texas, Wisconsin and Washington. In the other states it can be presumed that freedom from liability would be inferred from the validity of the gift. The statutes of Michigan and Tennessee require that the donee exercise reasonable care to avoid undue mutilation of the body.

The final provision, subsection (c) is essential to preclude the spouse or other survivor from authorizing a removal of a part that might frustrate the performance of the medical examiner's function in case of death under suspicious circumstances.

SECTION 8. [Uniformity of Interpretation.] This Act shall be so construed as to effectuate its general purpose to make uniform the law of those states which enact it.

SECTION 9. [Short Title.] This Act may be cited as the Uniform Anatomical Gift Act.

SECTION 10. [Repeal.] The following acts and parts of acts are repealed:

(1)
(2)
(3)

SECTION 11. [Time of Taking Effect.] This Act shall take effect.