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THE AUSTRALIAN LAW REFORM COMMISSION

In the Australian Federation, the constitutional arrangements between the Commonwealth and the States leaves to the States the design of most of the laws affecting medicine and the medical profession. It might therefore seem to be a curious thing that the Commonwealth's law reform agency, the Australian Law Reform Commission, has become involved in a number of topics which evidence the growing interface between law and medicine.

The Commission is established to advise the Attorney-General and Parliament on the reform, modernisation and simplification of federal laws. It is set up in Sydney. There are 11 Commissioners, four of whom are full-time. Sir Zelman Cowen, who has long interested himself in the relationship between law and medicine, was, until his appointment as Governor-General, a part-time Commissioner.

The Commission works on references received from the Commonwealth Attorney-General. It prepares reports, many of which have been picked up and implemented both at a Commonwealth and State level.[1] Before doing so, however, it engages in the debate with the expert and lay community about the defects in the current law and the ways in which those defects can be cured.

One of the greatest forces that is at work for change in Australian society is the impact on it of science and technology. There has never been a time when technological change occurred at today's pace. The machinery of legal change moves slowly. Technological developments, including in the area of medicine, sometimes occur quite rapidly. The time cushion within which society and its lawmakers can adjust to change is often removed. Events move quickly and new medical developments are upon us, the law unchanged and even ethical and moral values being in question and a matter of uncertainty and even controversy.

LAW REFORM, MEDICINE AND TISSUE TRANSPLANTS

This short article can do little more than sketch some of the projects which the A.L.R.C. has been involved with medicine and its practitioners.

The first reference to the Commission required us to propose laws that should govern criminal investigation by federal law enforcement officers. The result was the report, Criminal Investigation[2] which led on to the Criminal Investigation Bill 1977. Amongst the proposals for reform, adopted in the Bill, is the suggestion that intimate police or Customs searches of the bodies of suspects should be carried out, at their option, by a medical practitioner not a law enforcement officer.[3]

In the report on Alcohol, Drugs & Driving[4] suggestions were made about new ways to establish alcohol or drug intoxication which impairs driving efficiency. This was a case of technological developments coming to the aid of the law. There is little doubt that the courts could not have coped with the serious social problem of the drinking driver, without the aid of the Breathalyzer. As it is, our legal response to this problem is of limited effectiveness

In 1976 the Commission was asked to report on the law that should govern human tissue transplants and associated matters. In terms, the report was limited to legal change in the Australian Capital Territory. However, as the Commission has special responsibilities to consider uniformity of laws[5] and as this was a subject upon which uniform legislation was considered warranted[6]

the Commission proceeded to work on the basis that its proposals would be considered for the whole of Australia.

Windeyer J. once said that the law marched with medicine "but in the rear and limping a little".[7] This observation seems charitable nowadays. The common law offers no rule or principle for dealing with the transplantation of human organs and tissues, for the simple reason that, until recently, the problem did not have to be confronted. The body's immunology rejected transplantation In these circumstances, the law gave no thought to the question of operations on donors for the positive removal of non-regenerative tissue which was not for the cure of the donor but for some other person. Likewise, the taking of organs from a dead human body was scarcely considered. The law recognised, at most, only a limited right to property in a dead body and offered few rules about the rights and obligations of the legal personal representative, relatives and others with respect to [illegible]

In the course of the Commission's inquiry it also emerged that the best "donors" of viable tissues such as kidneys, were often young, otherwise healthy patients, brought into hospitals with massive brain damage, blood circulation maintained by the use of mechanical ventilators, until the decision had to be made to terminate this artificial support. The law, like common sense, tends to think that death is an instantaneous phenomenon. Medical science, however, shows that death is a process.[8] Before artificial ventilators were developed, the classical criterion for determining death was a cessation of respiration and circulation of the blood. Interpose a mechanical device, and this definition of "death" becomes mischievious. In R v. Potter,[9] a man stopped breathing fourteen hours after being admitted to hospital with head injuries sustained in a fight with the accused. He was then connected to an artificial respirator for 24 hours, after which time a kidney was removed and transplanted. The respirator was thereafter disconnected. There was no spontaneous breathing and heartbeat. At the Coroner's inquest a question arose as to whether the accused had caused the victim's death. Medical evidence was called to show that the patient had no hope of recovery from the brain injury sustained in the fight. The Coroner's jury found that the removal

of the kidney had not caused the patient's death. It returned a verdict of manslaughter against the assailant who was committed for trial. He was later found guilty of common assault. The case is in many ways unsatisfactory. It demonstrates the doubts and confusions in the present law.

The Law Reform Commission presented its report and proposed that the law should recognise a definition of death, for all purposes of the law (not just transplants) which had regard not only to irreversible cessation of circulation of blood but also to "irreversible cessation of all functions of the brain of the person".[10]

A large number of other contentious questions had to be faced by the Commission. I list some of them to indicate the sensitive and difficult questions which law reform in such an area must address :

* Should consent be required for donations at death or is it appropriate, in today's society, to infer consent to the removal of organs at death, unless a person has in his lifetime registered an objection? The law of France has now adopted the latter approach/
* Should the same legal regime cover transplantation of human spermatozoa and ova or is the transplantation of human life itself in a special class, requiring legal treatment separate from the transfer of a kidney, cornea and so on?
* Should a child in any circumstances be permitted to donate a non-regenerative paired organ to a sibling, say, or should the law absolutely forbid this to protect the family and a young person from facing such a dilemma, no matter what the consequences may be of the non-availability of an organ for transplant?
* Should Coroners be empowered to give a pre-death consent to tissue removal?
* Should the present retention of pituitary glands, removed from bodies at autopsy, be legitimised, because of the great social benefit in the treatment of dwarfism that is derived from the hormone extract secured from such removed glands?

All of these are sensitive, controversial questions forced upon us by the sudden advent of transplant surgery. The law which is supposed to state society's standards has been left behind. In confronting the questions, the Law Reform Commission turned to a team of consultants drawn from the medical profession in all parts of Australia and from moral philosophers and theologians. Public hearings were held in all parts of the country. A consultative document was issued and widely discussed. The media was engagaged in the debate. Finally we presented a report which has been thoroughly praised not only in Australia but also overseas. The British Medical Journal called it "the latest of an outstanding series".

> "The publicity which the Commission's activities attracted in the course of preparing and publishing its report did a lot in Australia to remedy the ignorance of the public and apathy of the medical profession towards this important subject".[11]

The hottest point of controversy has been raised in a recent issue of the Medical Journal of Australia.[12] It relates to whether removal from legal minors should ever be permitted. This was a matter upon which the Commission itself divided. The majority felt that in a family crisis, such a question should be left for family resolution, the law playing a minor protective part. Machinery was provided for judicial consent so long as doctors, parents and the child donor understood and agreed to the operation. The minority (Sir Zelman Cowen and Mr. Justice Brennan of the Federal Court) rejected any such exception, even where the life of a sibling was at stake. In their view, the business of the law was to protect young people from such a dreadful dilemma, where a non-regenerative organ was involved.[13]

Already governments in Australia are adopting the Commission' report. The Commonwealth adopted it for the Australian Capital Territory and enacted the Anatomy and Transplantation Ordinance 1978. The Queensland Government has announced its intention to adopt the proposals, with the modification that Queensland legislation will follow the views of the minority on the issue of donations by minors. In Victoria the Minister of Health told Parliament that his Ministry is "to a large extent favourably disposed towards the

proposed legislation". A Working Party has been set up, chaired by Mr. H.W. Pascoe S.M. In other States too, the report is under consideration and the process of securing generally uniform laws seems to be having better success than usual.

Perhaps the most novel development is the request from South America for permission to translate the report into Spanish for consideration by the governments of South America. I cannot recall to mind another case of legal transplants from Australia to Hispanic America.

MEDICAL RECORDS AND PRIVACY

The investigation by the Law Reform Commission of new laws for privacy protection has required it to consider medical and hospital records and the extent to which they should come under a new general regime designed to protect personal information. In recent years the bulk of such records has grown enormously. No longer are intimate health details locked away in the safe crevices of the physician's mind. Because of the size of hospitals and medical practices, there is a vast increase in the amou of medical data and access to it. This has led American investigatic to suggest that there is a need to enforce the general principle of privacy, viz: the right of the individual to have access to personal data about himself.[14] Such a suggestion, however palatable in the area of government files, strikes resistance in the medical profession, accustomed to keeping its files to itself. In the data protection laws of North America and Europe, the "golden rule" which has been universally adopted to protect individualism in the age of proliferating and often computerised files, is the right of access and the consequential facility for correction. Medical and hospital records are a small but vital area of the individual's private information. They may require special, discrete treatment by the law, so that frankness is not inhibited. The Commission has issued a research paper which embraces the general principle of patient access, with machinery for exceptions and for intermediate access in certain cases.

EXPERIMENTING WITH PATIENT TREATMENT

At the heart of the privacy debate is the tension between the new and old approach to medicine. The old was a kind of professional paternalism. It was sometimes described as the doctor's "therapeutic privilege" not to impart information to the patient, even though it might vitally affect him. The formal position of the common law has always been clear. It upholds the integrity of the will of the patient. Governments of South America.

> "Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault for which he is liable in damages".[15]

Like principles govern non-surgical therapy. Put shortly, so far as the law is concerned, the patient calls the shots. In practice, it is not so straightforward. Resourceful, paternalistic and sometimes overbearing professions may nominally favour the patient or the client with a choice or right not to consent. But often little real choice is left to the individual most concerned.

Society is especially ambivalent about the extensive experiments that must take place in the introduction of new drugs and new forms of therapy. It embraces every new medical breakthrough in treatment. But it is not willing to countenance the treatment of human beings as a mere object which, like goods in the storm, can be thrown overboard to save the residue.

As the treatment of disease moves away from surgical and radiological intervention to chemo-therapy, vast national and international experiments must be conducted, in which individual patients are treated, not in isolation but as part of a controlled test.

Such experiments raise many problems for resolution. Some of them are problems for the law. To what extent should a doctor continue with a controlled system of treatment, even though he may have a conviction that another, as yet quite unproved, treatment would be more beneficial to his patient? Within the medical profession itself, views are divided on this issue. Some take the

view that co-operation in clinical research should only proceed compatibly with the prime duty to treat the patient. Others point out that breakthroughs in treatment, such as kidney transplants themselves, occurred in the face of orthodox medical views that the new treatment procedures would not work.

The Nazi euthanasia programme began as an effort to "relieve" the severely and chronically sick.[16] The horrors of the revelations which followed the War have made succeeding generations extremely cautious about any deviation from the physician's concentrated duty to heal the patient in his care.

On the other hand, the prevention of the worst disasters of thailidomide was achieved in the United States by the gradual introduction of the drug under controlled conditions to large numbers of citizens, who were almost certainly not warned about the possible side effects. Specifically, nearly 4,000 women of child-bearing age were used in the controlled release of the drug, before it was withdrawn. These women were submitted to the test for the benefit of a wider society.

Although there are many international statements and agreements on limitations on human experimentation, there is little domestic law. Canadian cases suggest that as treatment becomes more experimental, a higher duty descends on the medical practitioner to exercise "very great care if not the greatest care possible".[17] English authorities suggests that a physician is under a strict duty to read all relevant medical literature, at least in his speciality.[18] Failure to do so will amount to professional negligence. These are onerous requirements but they are the counterpart to the law's recognition of the very great confidence and trust which the medical practitioner enjoys. They assert that right of the individual to make informed decisions about his medical treatment. A patient today is better educated and society is better informed. There is even a general understanding of the need for medical and surgical experimentation, particularly in such intractable conditions as cancer treatment. The law takes its stand that the individual should be able to decide his destiny, however foolish that decision may seem to others. But how is this law to be enforced in practical terms? Should we be concerned if it is not?

OTHER ISSUES

There are many other issues which will require the attention of lawmakers in years to come. Amongst them I would list the possible need for the development of a legal regime in such matters as :

* Test tube fertilisation
* Artificial insemination generally
* Transplantation of foetal material
* Genetic engineering
* The right to die

The lastnamed topic is the subject of hot debate in the United States where several of the States, in the wake of the Karen Quinlan tragedy, have moved to provide for an enforceable "living will" by which a person of full capacity can, in his lifetime, direct that "extraordinary" means will not be used to keep a person "alive", as for example on a hospital ventilator.[19] This legislation proposes the right of an adult person of sound mind to execute a declaration which directs the withholding or withdrawing of "extraordinary life-sustaining procedures", once he or she is adjudged to have a terminal condition. Though there is no present agitation in Australia for such legislation, it is likely that calls for laws of this kind will increase as extraordinary medical procedures are developed which prolong "a life which is no longer fully human and which is drawing naturally to its end".[20]

CONCLUSIONS

In this article I have only scratched the surface of some of the issues which, in the future more than in the past, will bring practitioners of the legal and medical professions, and lawmakers, together. I have not, for example, mentioned the vexed problems of balancing the cost of treatment of the individual and the demand for social accounting of the expense, when it is borne by the community.[21] I fully realise the dangers of seeking to build a legal regime upon "shifting sands" when society itself has not made up its mind on the legal implications of the medical developments that are occurring. For example, some of the Churches have strong views about artificial insemination, and *in vitro* fertilisation. All religions have relevant teaching on euthanasia.

But whilst it is undesirable for the law to get too far ahead of community understanding and moral consensus, there is an equal danger in an ostrich-like refusal to face up to the legal consequences of medical therapy that is already occurring. Artificial insemination is occurring in Australia on an increasing scale since the availability of children for adoption has fallen because of abortions and the Pill. In vitro fertilisation is in its experimental stages but cannot be far away. Various forms of experimentation in genetic engineering already take place in Australi Ventilators are turned off. Transplant surgery is taking place.

The problems mentioned above will not conveniently go away because the law is silent on them. Unless the law can keep pace with these changes, there will be no guidance for the medical profession and laws of a general kind, developed in an earlier age to address different problems, will lie in wait for their chance, unexpected operation in new circumstances.

I believe that law reform bodies will increasingly become involved in assisting Parliaments to face up to the difficult questions which advances in medical techniques pose for us. Given the right methodology, an interdisciplinary machinery may have been found to harness public debate and to capture the attention of distracted lawmakers.

FOOTNOTES

1. See The Law Reform Commission (Cth) Annual Report 1979 (ALRC 13), 23.

2. ibid, Criminal Investigation, 1975 (ALRC 2), 57.

3. Criminal Investigation Bill 1977 (Cth), cl.42.

4. The Law Reform Commission (Cth), Alcohol, Drugs & Driving, (ALRC 4), 1976.

5. The Law Reform Commission Act, 1973 (Cth), s.6(1)(d).

6. The Law Reform Commission (Cth), Human Tissue Transplants (ALRC 7), 1977, 2.

7. Mt. Isa Mines Limited v. Pusey, (1971), 45 A.L.J.R. 88.

8. ALRC 7, 52.

9. Unreported, The Times, 26 July 1963. See also (1963) 31 Medico Legal Journal, 193.

10. ALRC 7, 136 (cl.42(a)).

11. British Medical Journal, 28 January 1978, 195.

12. P. Gerber, "Some Medico-Legal Implications of the Human Tissue Transplant Act", (1979) 2 Medical Journal of Australia, 533.

13. ALRC 7, 51.

14. United States Privacy Protection Study Commission, Personal Privacy in an Information Society, 1977, 280.

15. Cardozo J. in Schloendorff v. Society of New York Hospital, 211 N.Y. 125, 129 (1914).

16. J. Kamisar, "Some Non-Religious Views Against Proposed 'Mercy Killing' Legislation", 42 Minn.L.Rev. 969, 1031 (1958). Note : cited "A Proposed Living Will Statute, 64 Iowa L.Rev. 575 (1979).

17. Ballis v. Boulanger (1924) 2 D.L.R. 1083. Cf. L.W. Sanridge, "Experiments on Humans : Controls at the International Level and in Foreign Nations" (1979) 3 Legal Medical Quarterly, 3.

18. Roe v. Minister of Health [1954] 2 Q.B. 66, 83.

19. See Iowa Law Review Note, Op cit, 649.

20. McCormick, "The Moral Right to Privacy", Hospital Progress, August 1976, 38.

21. See for example Lord Justice Ormrod's article "A Lawyer Looks at Medical Ethics" (1978) 46 Medico Legal Journal, 18. Mr. Justice Brennan "Law, Ethics and Medicine" (1978) 2 Medical Journal of Australia, 577 and Sir Zelman Cowen, "Law and Society", The Listerian Oration, mimeo, 19 May 1979, 21ff.