220

SIXTH AUSTRALIAN MEDICAL CONGRESS

LAUNCESTON, 12 FEBRUARY 1981, 8 P.M.

THE SIR HENRY SIMPSON NEWLAND ORATION

MEDICINE, LAW REFORM AND THE FUTURE

The Hon. Mr. Justice M.D. Kirby
Chairman of the Australian Law Reform Commission

February 1981

SIXTH AUSTRALIAN MEDICAL CONGRESS

LAUNCESTON, 12 FEBRUARY 1981, 8 P.M.

THE SIR HENRY SIMPSON NEWLAND ORATION

MEDICINE, LAW REFORM AND THE FUTURE

The Hon. Mr. Justice M.D. Kirby
Chairman of the Australian Law Reform Commission

SIR HENRY SIMPSON NEWLAND

The Oration Series in which I speak was established more than 30 years ago to commemorate the service of Sir Henry Newland to the medical profession and to Australia. On Australia Day, this year, His Excellency reminded the nation that 80 years have passed since Federation. Yet even today, we remain a group of largely independent polities within the federal bond. Within the professions, it took a long time even after 1901 for effective links to be established between professional groups, most of which remain organised, State by State. Sir Henry Newland devoted himself to furthering the common cause of the medical profession on the national stage of Australia. His first appearance at the then Federal Committee of the British Medical Association in Australia was in 1920 as representative of the South Australian Branch. In 1933 he was an Inaugural Member of the Federal Council and he was appointed its President at the first meeting in August of that year. He continued in the office until his retirement in March 1949. Many honours, civil and professional, were heaped upon him. His Presidency of the Federal Council coincided with great controversies, including political controversies. His interests were above all the improvement of public health, the co-ordination of the medical profession so that it could speak with one voice on matters of national concern and the good name of the profession, without which there can be only erosion of public respect and confidence.

Such a man as this is worthy of living on in memory. He was a distinguished Australian, whose claim to commemoration goes beyond the medical profession. I am distinctly honoured to contribute to this series. Though some of the topics I will deal with are novel and some of the problems of the medical profession today are acuter and more complex today than they were in Sir Henry's time, it is trite to say that the profession must continue to send forward leaders and spokesmen of his quality. There are many critics. There is a need for a better dialogue with the public, in your profession as in mine.

In my time at Sydney University and lately at the University of Newcastle, I have heard many orators on occasions such as this. Solemnly and in procession they have marched to the stage. Their time come, they have delivered their orations. Leaders of the community, they have expounded at length on this subject or that. It is a sobering thought as I face you tonight that I cannot call to mind a single utterance of those orators, not a single jest, wise saying or flash of insight. I have chosen as my theme 'Law Reform, Medicine and the Future'. By a happy coincidence I am honoured to appear on the same platform as His Excellency. The subject of my address is one that he has taken to his heart over the years. For a time we were proud to number him as a part-time Member of the Law Reform Commission, before he assumed his present office. In his writings and speeches he has laboured to sustain the dialogue between law and medicine.

MEDICINE IN A TIME OF CONTROVERSY

There can be little doubt that this Congress meets at a time of controversy for medicine and its practitioners. Scarcely a day goes by but we open the newspaper to read of another moral or professional dilemma facing our doctors. I leave aside entirely the issues of funding and organisation: the Jamison Report and the reported consideration by the Cabinet Committee of the sale of Medibank to private health funds.[1] I say nothing of the criticism such as that of the very high incomes paid to radiologists with contracts at public hospitals.[3] Nor will I deal with last week's call by the A.M.A. for new health fund arrangements.

Consider this random sample of news items, culled from the daily press over the past two months. In Melbourne, in December, the report of the Consumer Affairs Director questioned the ethics of doctors who referred patients to hospitals they owned. He compared the practice with the case of a judge having shares in a gaol and being paid accommodation charges for inmates. In fact, Mr Geschke probably knew of the practices of long ago when justices were paid for each conviction they recorded, and gaolers for each person they held in custody. Holdsworth tells us that such practices were terminated because of the public outcry of self-interested decisions.[4] But in a recent inquiry of the Law Reform Commission, we found that many Aborigines are kept in local police lockups in remote areas of Australia under arrangements by which a per capita sum is paid for meals.[5] We recommended abolition of the practice. Mr Geschke joined earlier official reports in urging that doctors owning private hospitals should be required to disclose their pecuniary interests before arranging to admit a patient to his hospital.[6]

Criticism of excessive surgery has followed the release by health funds of figures comparing the Australian and overseas positions. A study of an American researcher is said to show a hysterectomy rate for Australia of 3.8 per 1000 as against 1.79 for Scotland and 2.94 for England and Wales. One critic has called on the Health Ministers to release information on the number and type of medical services being performed in Australia, asserting that we have the world's highest surgical intervention rates, not only in hysterectomy but also in appendectomy and tonsillectomy.[7] For his part, the Minister for Health, Mr. MacKellar, says that the Commonwealth Government will continue to 'take every opportunity available to it to move against doctors who provide unnecessary medical services in order to exploit the medical benefits arrangements'.[8]

In the wake of the controversy about excessive numbers entering the profession, the editorialists lifted their pens. The Sydney Morning Herald declared that the A.M.A. suggestion of a 20% reduction in medical student intakes was a suggestion for a 'disguised form of protection'. The community would get better value for money, it declared, if there were 'a close monitoring of the way doctors use the highly subsidised medical services available at hospitals'.[9] The Chairman of the New South Wales Ethnic Affairs Commission called attention to a special problem:

> We showed that for the tens of thousands of Turkish, Portuguese and Indo-Chinese women, men and children in N.S.W., there is not one single psychiatrist we know who can diagnose, counsel and treat them in their own language. For the Italo-Australian communities in N.S.W., which probably still have more than 50,000 people with very little English, there are no more than two psychiatrists with enough knowledge of Italian language and culture to be able to help in a breakdown of mental health.[10]

At the turn of the year, a controversy erupted in New South Wales related to proposed amendments to the Consumer Protection Act of that State whereby officers of the Consumer Affairs Department were to be given power to examine and seize confidential patient records.[11] The policies and practices of the Commonwealth Department of Health and of the Federal Police were the subject of many complaints to the Law Reform Commission in its public hearings on privacy held throughout Australia during November 1980.

In December came the report that serious complaints by patients against doctors for alleged negligence had doubled in five years.[12] Fear of a dramatic increase in medical and hospital negligence cases is a recurring theme in popular and professional journalism[13], though probably for want of contingency fees for the legal profession, we are a long way short of the American spectre.

One major national weekly, in January 1981, devoted a lengthy article on 'How to choose a good doctor'. It listed the alleged signs that a doctor was 'getting too old for the job'. It cautioned against the doctor insensitive to patient confidentiality, the doctor always in a rush, the doctor inattentive to overall health and the doctor over-inclined to prescribe drugs of addiction or indeed drugs of any sort.[14] But on the same day came reassuring news from a publication by the Bureau of Statistics. It disclosed that 92% of patients surveyed were either satisfied or very satisfied with their general practitioner. And the survey suggested that the patients knew what they were talking about. 64.2% of them had been to a doctor in the previous six months.[15]

It would be wrong to put too much faith in a survey. Public perceptions are changing and may be malleable in the hands of the powerful modern media. The intelligent layman is assailed by serious books, critical of the medical profession, generally written by 'insiders'. Dr Richard Taylor, a former Secretary of the Doctors' Reform Society in New South Wales, has published a provocative and disturbing book, 'Medicine Out of Control'[16], which he sub-titles 'The Anatomy of a Malignant Technology'. In the United States Dr Robert Mendelsohn has written his well publicised 'Confessions of a Medical Heretic'.[17] One could go on. But enough has been said to show that the medical profession is nowadays constantly in the public's eye. In an age when all institutions are subject to scrutiny and criticism, there is not a little of love and hate in the relationship between society and its doctors. Certainly the public issues which confront the medical profession today are more acute and more complex than in Sir Henry Newland's day. But they cannot be avoided and they will not go away.

MORAL DILEMMAS

So far, I have concentrated on what might be called public or organisational problems. Whether we limit the number of medical students, train them in different ways (as at the University of Newcastle); change the funding of radiologists, increase the number of psychiatrists of ethnic origin or require declarations of pecuniary interests, are all questions susceptible to debate and ready, if controversial, solution through the political process. Much more difficult of resolution are the many medico-legal questions of a moral character which have pressed upon us in recent years and about which the law and medicine have exhibited diffidence and uncertainty: each discipline reflecting the deeply felt divisions of opinion in the community at large. The intractable nature of these issues is admitted every time a speaker turns his attention to them. In 1978 Sir Roger Ormrod, a Lord Justice of Appeal of England and himself a trained physician, delivered his paper, 'A Lawyer Looks at Medical Ethics'. He suggested that part of the problem of resolving the profoundly difficult moral questions that arise in ever-increasing number out of advances in medical technology, was the fact that 'there have been marked and widespread changes in moral attitudes':

> The questioning of accepted knowledge has extended to the questioning of moral attitudes, that is, of course, in the Western world, the moral teachings of Christianity. ... This means that the support of a form of authority, the accepted moral code, has largely gone, with the consequence that we are now faced repeatedly with choices which have to be made by each one of us on each occasion for ourselves, where before little or no question of choosing would arise'.[18]

His Lordship cautioned that this obligation of choice should not necessarily be regarded as a 'regression':

> However disturbing and difficult the consequences may be, the ability to choose imposes immense responsiblities, but it represents one of the greatest achievements of humanity.[19]

No issue of this kind has attracted so much public attention as the question of the law relating to abortion. Laws and practices differ profoundly. For example, the West German Federal Constitutional Court has declared that abortion is an act of killing. It could not, so the Court said, be camouflaged by 'the description now common, "interruption of pregnancy"'.[20] On the other hand, in 1973, the United States Supreme Court laid down a detailed regime to govern the basic rights of the pregnant woman under the United States Constitution.[21] As to the asserted right of the foetus to life, the Supreme Court observed:

> We need not resolve the difficult question of when life begins. When those trained in the respective disciplines of medicine, philosophy and theology are unable to arrive at a consensus, the judiciary, at this point in the development of man's knowledge, is not in a position to speculate as to the answer.[22]

In New Zealand bitter debate continues to surround changes in the legislation regulating abortion.[23] In Australia, community groups opposed to abortion undoubtedly influenced the failure of the House of Representatives in 1980 to pass a Human Rights Commission Bill, which contained no reference to the human rights of a foetus. They may also have influenced the outcome in one or more electorates in the last general election. Members of the Young Liberal Movement have attacked these groups.[24] But so too has a recent

Women's Conference of the Labor Party. An Australian development to detect and assess abnormalities in embryos less than 20 weeks old[25] coincides with a visit to this country of an evangelical former abortionist who urges against abortion, even in the case of established gross physical or mental disability. Here then is a fundamental difference of view upon which sincere and decent people on both sides feel powerfully. Yet it is only one of many such problems confronting medicine and the law today.

The counterpart to the 'right to life' movement is the group in society who urge the 'right to die'. Voluntary euthanasia, at least in the case of the seriously ill, incapacitated and dying, is not the notion of a few disturbed cranks. In England, Australia and elsewhere, sincere people have taken up the cause as an aspect of civil liberties. In some parts of Australia, attempted suicide is still a crime.[26] When that law was repealed in England in 1961, aiding and abetting another to take his or her own life remained a serious criminal offence. In October last year, Exit, the British Society for the Right to Die with Dignity, published a book containing a great deal of information specifically aimed to ensure that those who attempt to kill themselves do so with efficiency and success. The London Times cautioned that people who contemplate suicide do not always do so calmly and dispassionately, taking all factors for and against into consideration. It urged that the book could lead to unnecessary deaths and should not be published.[27] The Secretary of the British Medical Association added his voice, urging a reconsideration of the publication of the booklet. Countless letters to The Times followed, including some by failed suicides.[28]

There is a clear line between active euthanasia, the deliberate termination of life, with the concurrence of society, generally to avoid pointless suffering, and passive euthanasia, by which people are allowed to die naturally without intrusive medical treatment. But the problems raised by this debate merge into the abortion debate when we face the dilemma posed by the birth of a child monstrously deformed. According to Professor Peter Singer of Monash University, doctors are increasingly facing up to the question and saying 'enough is enough'. Professor Singer is quoted as saying:

> What sometimes happens is the parents will leave the baby in hospital and eventually it will develop some form of infection, possibly pneumonia. ... The doctors will then not treat it. They could easily give it a shot of penicillin ... but they let it die.[29]

Sir Macfarlane Burnet , reflecting on the nearly universal taboo against discussion of death, argues vigorously for the right to die and in some circumstances the right to let die. He too asserts, as a fact, that this already happens in Australia:

> [C]ompassionate infanticide is already standard practice where the product of birth is such as to justify the term 'monstrous', i.e. where there is a gross and physically disgusting malformation such as anencephaly (complete absence of brain). Severe spina bifida, where there is no possibility of effective surgery, is not infrequently dealt with by allowing the infant to die under sedation.[30]

To fill the gap and to seek to answer the questions raised by euthanasia in a less haphazard way, a new Bio-ethics Research Centre is being established at Monash University. Specifically, it is to address the question of whether the distinction between knowingly allowing a patient to die, and postively helping in the process, is one that is and can be preserved in medical ethics and law.

According to a Gallup Poll, 72% of Australians believe that if a patient suffering from an incurable and distressing illness wishes to end his life, a doctor should be 'allowed to supply the means'. 24% disagreed and 4% were undecided.[31] In the United States, following the Karen Quinlan tragedy, legislation was enacted in a number of States to permit 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 met certain preconditions, including terminal illness.[32] In South Australia, a Bill for a Natural Death Act has been introduced to:

> enable persons to make declarations of their desire not to be subjected to extraordinary measures designed artificially to prolong life in the event of a terminal illness.

A Select Committee of the Legislative Council reported on the Bill in September 1980. It is a sign to us all that this debate has now reached our shores. It will have to be addressed by the medical and legal professions, not left to the moral judgment of the individual doctor who happens to be on duty, guided by uncertain laws and not always reinforced by clear and commonly accepted moral percepts.

The so-called right to die leads naturally to the debate about the definition of death, a matter considered by the Law Reform Commission in its report on Human Tissue Transplants.[33] A definition in terms of irreversible loss of function of the brain was proposed by the Commission. It has been accepted in a number of jurisdictions of Australia. However, in Britain in 1980 a tremendous controversy broke out following a Panorama programme criticising the adequacy of current practice in Britain for the determination of brain death. Ministers and the organised medical profession attacked the B.B.C. The number of kidney transplant operations in Britain fell by half following the programme, allegedly because of a fall in the availability of donors.[34]

Rather than beat the air of protest, The Lancet urged that the Royal Colleges should organise an immediate study of 500 patients meeting the criteria of brain death, and then submit them to E.E.G. examination to determine whether any show evidence of cortical activity.[35] Influenced by British practice, and resistant to tying a legal draft to a particular technology the Law Reform Commission omitted a prerequisite statutory requirement of E.E.G. examination before a legal determination of brain death could be made.[36] The British debate illustrates the importance of lawyers and doctors having a clear understanding of the problems and practice of the other, where their disciplines intersect. This is not to say that we should write E.E.G. examination into our laws. Medical knowledge is advancing and changing with such rapidity that particular specific criteria or equipment embedded in a statute may well become outmoded or obsolete, yet remain legally compulsory.[37] But where language of generality is used in the law, it is important that the medical profession adopt adequate checks to assure consistency of practice with proper standards. Otherwise self-discipline will give way, under public pressure, to discipline by others.

The development of test tube fertilisation requires urgent attention to legal problems, many of which have been outlined in a recent note by Mr Justice Asche of the Family Court of Australia.[38] But as if to complicate that debate, already difficult enough in itself, the media at the turn of the year carried the news of a Chinese atttempt to breed an animal/human symbiont by hybridising pantroglodytes (chimpanzees) and homo sapiens. Some described the notion as scientifically ludicrous.[39] But Professor Karl Wood, a leader of those working in Australia on in vitro fertilisation, has said that it was up to governments to legislate against such possible abuse.[40]

Medical privacy is a matter which the Law Reform Commission has examined from the point of view of its general reference on the provision of federal laws in Australia for the protection of individual privacy. Overwhelmingly, the problems are the result of the new information technology. Many difficult problems need to be resolved:

- Should patients generally have a right of access to medical and hospital records about themselves and if not, with what exceptions, according to what principle and with what alternative safeguards for accuracy and up-to-dateness as personal medical records are increasingly computerised?

- Should a parent have a right of access to medical information about a child, and if so, to what age and with what exceptions if the child claims a privilege to have advice on intimate personal medical problems kept confidential with the doctor?

Should courts have an unlimited right of access to personal medical files, as is the case in most jurisdictions in Australia, or should there be privilege against disclosure to the court, without the patient's consent? Should the court be required to weigh the competing interests of the administration of justice and the claim to privacy and confidentiality before requiring the production of medical records? Are psychiatric records, with their intimate disclosures, in a special class? Should safeguards as to notice be introduced when a patient's records are subpoenaed?

Any one of these topics could delay us for the 40 minutes assigned to me. You will be relieved to know that I intend to resist temptation.

One matter which has not attracted much attention in Australia, and rarely raised a ripple in the Law Reform Commission's inquiry into privacy, is the question of resolving the competing claims of individual privacy and of scientific research. The Council of Europe held a conference on this aspect of European law in Belgium in September 1980. The report of the conference and the papers delivered there have just reached us in Australia. It is pointed out that nowhere that data protection laws have been adopted throughout Europe has research, including medical research, been regarded as a 'protection-free area'.[41] Before the computer, a few rather vague criticisms of access to medical files were answered by reference to codes of ethics. But as European privacy laws were developed, so that data was seen as an extension of the personality of the subject, greater sensitivity was raised concerning the use of personal medical data, even for so important a subject as medical research. The American Psychiatric Association and other American associations were among the first to amend their professional regulations to comply with demands for better data protection for the subjects used. In August 1977 a conference held at Bellagio adopted principles which incorporated emphasis upon the voluntary agreement of the subject to the collection of his data, for research purposes. This principles emphasised informed consent as a leading precondition to the use of such data, priority as far as possible to the use of anonymised data and the rights of access to one's own data — the golden rule of privacy law — wherever the subject might be identified.[42]

The report of the United States Privacy Protection Study Commission gave particular attention to privacy in scientific research for three stated reasons. The first was the growing demand for information collected and maintained by administrative agencies. It was claimed that this insatiable demand increases the dissemination of personal data and therefore requires additional protections. Secondly, the number and variety of research activities going on raise serious doubts about the ability of the research community to enforce adequate measures by self-regulation.

Thirdly, the Commission expressed concern about the danger which could arise from the use of individually identifiable research and statistical records for administrative, regulatory and law enforcement purposes.[43] Where there is a file there is usually an administrator with reasons why he should have access to the file.

There is no doubt that research use of medical records has produced many benefits for mankind. Side effects in the use of oral contraceptives were discovered primarily as a result of large-scale studies in which hospital and medical records were used — studies that would have been impossible to carry out had actual consent of the patient been required.[44] Commenting on the issues at stake, Gordis and Gold have asserted:

> Society has a vital stake in epidemiologic and other medical research. We must ensure that the dignity and privacy of subjects will be protected without hindering the advancement of knowledge and disease. The social contract that facilitates the existence of individuals within social groups requires that each individual occasionally yields some of his rights, including privacy and freedom of action, for the benefit of society as a whole.[45]

At the moment, the rules which balance the rights of the subject, and which protect him against misuse of data about him, or alert him as to any possible harm he may suffer, exist in the realm of fair practice judged by the individual researcher. The potential coming together of so many sources of information as a result of the new information technology and the spectre of the total personal data profile will require better protection in the future than we have required in the past. As the Council of Europe conference indicates, this is not just a local concern of a few people sensitive to individual privacy. It is an international debate, largely the product of the new technology and its realised potential.

THE SOLUTIONS?

So far, I have outlined some of the problems that will face the medical profession in the decade ahead. I have mentioned the so-called right to life and to death, the definition of death, artificial insemination and privacy. I have done no more than to scratch the surface. I have said nothing of the dilemmas raised by the possibility of cloning.[46] The special problems of the ageing in our nursing homes were recently commented upon by a magistrate[47] and will increase as a matter of public and professional concern with the demographic shift to the aged.[48] I have said nothing on this occasion about cancer treatment, the right of the patient to know and the duty of a doctor to tell.[49] I have said nothing about mental health law reform, though I do hope that in this International Year of Disabled Persons, the medical profession at least does not make the mistake of considering that 'disability' is a physical thing only. The laws governing mental health require reform. It will be an important achievement of the Year if the significant reforms lately adopted in South Australia can be accepted, with local adaptations, throughout the Commonwealth.[49] I have said nothing about the consent of young persons to medical treatment, though we all know that this is a subject of great moral and legal uncertainty. It has been the subject of many law reform reports.[50] I have not mentioned the dilemmas of the surrogate mother and I have barely hinted at the problems of genetic engineering, the first of which came last year before a bemused and divided Supreme Court of the United States.[51]

How are we as a society to confront these difficult legal and moral dilemmas? One solution is to leave them to our respective Parliaments, in the hope that they may attend to the calls for guidance and new laws. Unfortunately, the matters of which I have spoken are uniformly difficult, controversial and unclear: they raise deep feelings. Politicians distracted by the rude necessities of democracy find the temptation almost irresistable to put them in the too hard basket. Occasionally they venture forth: as has been seen lately in South Australia in the Natural Death Bill. But generally speaking, nothing is done. We have no tradition of Private Member's Bills in Australia. In matters such as this, we have a tradition of timorousness and apathy.

There are other solutions. Perhaps the least satisfactory is that outlined by Ian Kennedy in the first of his 1980 Keith Lectures on the B.B.C. titled 'Unmasking Medicine'. He reminds us that six years ago the American Psychiatric Association took a vote and decided in that democratic fashion that homosexuality was not an illness after all. Accordingly,following this vote, since 1974 it has not been an illness. Kennedy's comment?

> How extraordinary, you may think, to decide what illness is by taking a vote. What exactly is going on here? The practice of medicine has changed. There is a feeling abroad that all may not be well. The feeling grows out of a sense of distance, out of a sense that medicine is in the hands of experts and sets its own path. We can take it or leave it.[52]

I commend Kennedy's Keith Lectures to those of you who are not hypertensive.

If we cannot resolve the problem by ready parliamentary debate or by votes at conventions such as this, what is left? There are some who urge their resolution in the courts. When our American cousins are not extending democracy to its limits, they are seeking resolution of difficult questions by the judges. One instance I have already cited: the abortion debate in the United States was set at rest, for the time being at least, not in the Congress but in the Supreme Court: nine unelected judges, determining that volatile issue. The British Medical Journal, in October 1980, contained a letter from a Chicago doctor with detailed comments upon and empirical data about, a new virulent malignancy which he called 'Hyperactive Judges'.[53] Dr George Dunea described his findings thus:

> These are busy times for our black-robes Judges as they toil in their chambers, pouring over dusty volumes and burning the midnight oil to solve the problems of a perplexing world. ... Increasingly it is the Judges — not the elected representatives of the people — who decide who shall be terminated, compensated, reinstated, executed or resuscitated, vivisected or desegregated, dialysed, certified or involuntarily medicated, mercy killed, educated ... (etc.)[54]

Quite apart from questions of abortion, American judges, wrote the Chicago correspondent, are continually been drawn into controversies. Some of them have parallels in our country. Are medical interns students or workers? Are anaesthetists interfering with free trade? Can hospitals deny staff privileges to doctors and can they require them to take out malpractice insurance? Can insurance companies and pharmacists make deals on prescription drug prices? Should doctors advertise and can States legally prohibit them from doing so? And now, as new forms of life stand ready to be spliced from the old, it was the judges who had to decide whether a patent could be given for a micro-organism.

Excessive reliance on the courts, it was feared, would ultimately subvert the proper balance between the judiciary and the other branches of government. The issue is not a new one. In the United States it has called forth a flood of learned writing in legal and medical journals, the contestants being so-called 'medical paternalism', in the one corner and 'judicial imperialism' in the other. The spectre raised by Dr Dunea is put in ironical language, to make a greater impact:

> With admirable restraint [the judges] have so far confined their investigations to the court house — but soon they might be expected to come to the bedside, perhaps at the head of an integrated medico-judicial team, having exchanged their black robes for white coats and using the gavel to test the knee jerks; 'The heart has stopped, your honour', cries the nurse.

> 'Objection', shouts the patient's advocate. 'Objection sustained', agrees the Judge. Exhibition A, the cardiac monitor, is now disconnected. 'I wish your honour to review the electro-encephalogram, for which for the past week has been flat line'. 'Objection', cries the attorney for the State. 'Objection denied', answers the judge, settling down to examine the optic fundi. 'Objection', yells one of the attorneys. Whereupon the judge objectively but passionately clobbers him on the head with the gavel and orders the respirator to be turned off.[55]

Grim humour in the B.M.J. but for a serious point. Though judges have an entirely legitimate role to uphold the law and indeed to find and declare the law, if any, on a topic and to protect patients against haphazard and harmfully idiosyncratic medical decisions, the forum in which they operate may not always be well suited to a consideration of administrative problems, costs and moral questions.

The Journal of Neurology, Neurosurgery and Psychiatry, through which I was browsing recently, contained an article by Professor Lewis Rowland concerning controversies over the treatment of myasthenia gravis. Answering a criticism that a paper of his had been responsible for a 'chilling effect' in the use of immunosuppressive drug therapy, Rowland denied the charge:

> What stopped research on the use of immunosuppressive drugs in the U.S. was the litigious nature of American society. At the 1970 meeting, I described the tragic case of a woman with life-threatening myasthenia who had an exaggerated bone marrow response ... became infected, suffered a myasthenic crisis and died. That case resulted in a law suit, euphemistically called 'professional liability' here; the patient died in 1963 and legal action continued until the case was settled in 1973. The case was widely known among American investigators and probably did more to inhibit the use of these drugs than anything else; no physician wants to be accused of malpractice. For that reason, now, as in 1970, we have to look to European experience to evaluate immunosuppressive drug therapy.[56]

If the Parliament is generally unwilling to face up to these difficult, technical and moral problems, if we cannot leave it to a democratic vote at a Medical Congress and if the courts and the forensic medium cannot offer ready solutions for all the problems of the world, what is left? Are we simply to ignore these issues? I say that that would be quite unsafe. Surrogate mothers will be used. Genetic manipulation will go on. Research with patient files will increase apace with the use of computers fed with data often compulsorily supplied. Artificial insemination will go on, laying down problems for the law, society and individual human beings in a decade or so. The mentally ill, the aged, the young, will continue to present their special problems. The abortion debate will remain with us. The balance between cost of treatment and quality of life will remain a fundamental dilemma. Are we to muddle through with ad hoc improvisations dependent upon the idiosyncracies of the individual practitioner? Or does society and its medical profession deserve something better?

We in Australia have developed an unlikely, but I believe successful, mode of addressing many of these problems. I refer to the Law Reform Commission. It is a curious notion that a body of lawyers should be asked to solve problems of this kind. Some will see it as simply a variant of unacceptable judicial imperialism. But it is not. Released from the court room limitations, armed with a team of consultants from all branches of the medical profession, theologians, moral philosophers and others, we can face up to the dilemmas of our time and provide guidelines and laws that will benefit doctor and patient alike. I well remember the days in which Sir Zelman Cowen and Mr Justice Brennan (last month appointed to our highest court) sat at the table of the Law Reform Commission. With the top medical talents of the country, we sought to solve the problems of one particular dilemma, human tissue transplants. Our solutions we submitted to public hearings and professional seminars in all parts of the country. The vehicle of television and radio was used to present the issues and to raise community appreciation of the vexing problems at stake. In the end, a report was drawn where the options were clearly stated. On one or two issues the Commissioners themselves divided. But the legislative arm of government was helped in a unique way to face up to the issues involved. Legislation has followed in the State and Federal spheres. Clearer guidance is given to all involved: patients, their relatives, hospital staff and medical practitioners.

The Law Reform Commission is continuing its work: on medical privacy, on the admission into evidence of medical records, of compulsory reporting of child abuse cases and so on. The laws proposed are being adopted in all parts of the country. Furthermore, they are being adopted by the elected representatives of the people.

I do not pretend that all of the issues I have mentioned are susceptible to easy resolution. Some intractable problems do not even submit to debate and discussion. Others do not result in a consensus, however informed, however sincere the participants. But many do. And many will require attention in the decade ahead. On issues such as I have canvassed, our parliamentary representatives need help. It is a matter of satisfaction to me that the Australian Law Reform Commission has in a number of projects brought together lawyers and medical practitioners of the highest calibre to offer that help. I hope we will see more of it. Enough has been said to show that more of it is needed.

FOONOTES

1. As reported in The Melbourne Herald, 30 December 1980.

2. See The Australian, 30 December 1980.

3. Mr C Roper MP, Opposition Spokesman on Health, tabled in the Victorian Parliament a list of 47 radiologists, together with details of very high incomes allegedly received by them as a result of contractual arrangements with the State.

4. Holdsworth, A History of English Law, Seventh Edition, 1956, Vol. X, 180-183; Vol. XI, 507.

5. The Law Reform Commission, Sentencing of Federal Offenders, ALRC 15 - Interim, 121.

6. See The Age, 4 December 1980.

7. The Australian, 2 January 1981.

8. News release of Mr M J MacKellar MP (Minister of Health), 7 January 1981 (2/81).

9. See Sydney Morning Herald, 22 November 1980. Cf. Adelaide Advertiser, 9 January 1981 ('Fewer Doctors').

10. The Sydney Morning Herald, 22 January 1981.

11. The Australian, 13 January 1981.

12. The Age, 6 December 1980.

13. See, for example, The Age, 6 December 1980, 4 ('Court Ruling Creates a Time Bomb').

15. The Age, 23 January 1981.

16. R Taylor, Medicine Out of Control, Sun Books, Melbourne, 1980.

17. R S Mendelsohn, 'Confessions of a Medical Heretic', Warner, N.Y., 1980.

18. Sir Roger Ormrod, 'A Lawyer Looks at Medical Ethics', in (1978) 46 Medico-Legal Journal 18, 21.

19. ibid.

20. Cited in J D Gorby, 'The "Right" to an Abortion, The Scope of the Fourteenth Amendment, "Personhood" and the Supreme Court's Birth Requirement', Southern Illinois Uni LJ, No. 1 (1979).

21. Maher v. Roe, 410 US 113 (1973).

22. ibid. cited Ormrod, 23.

23. J B Elkin, 'Definition Issue in the Abortion Row', in Auckland Star (N.Z.), 22 December 1980.

24. The Age, 5 January 1981.

25. Reported The Australian, 9 October 1980, 2.

26. See Suicide Act 1961 (U.K.), s.1. Cf. Canadian Criminal Code, s.224. The Crimes Act was amended in Victoria in 1967, in the Criminal Code in Tasmania in 1957 and in Western Australia in 1972. In New South Wales and South Australia, it is a common law misdemeanour to attempt to commit suicide. Despite recommendations for reform, no reform has been enacted.

27. The Times (London), 18 October 1980 ('The Road to Dusty Death').

28. See, for example, The Times, 24 October 1980, 13.

29. Cited The Age, 19 November 1980.

30. Sir Macfarlane Burnet, 'Endurance of Life: The Implications of Genetics to Human Life', 1978, 96. Cf. P J Kearney, 'Medical Wisdom and Ethics in Treatment of Severely Defective Newborn and Young Children', ed D Day, Eden Press, Montreal, 1976, 60.

31. Australian Public Opinion Polls (The Gallup method), 4 December 1979, Poll No. 06/6/79.

32. Burnet , 97-8.

33. The Law Reform Commission, Human Tissue Transplants (ALRC 7), 1977, 111.

34. The Times, 14 November 1980, 4.

35. The Lancet, 18 October 1980, 841.

36. ALRC 7, 55.

37. ibid, 60.

38. A Asche, 'A.I.D. and the Law' in C Wood (ed), Artificial Insemination by Donor, Melbourne, 1980. Cf. J Hanmer, Reproductive Engineering: the final solution?, New Society, 24 July 1980, 163.

39. Cited The Australian, 30 December 1980.

40. Reported in The West Australian, 25 September 1980. Address to Melbourne Rotary Club.

41. S Simitis, 'Data Protection and Research: A Case Study on the Impact of a Control System', in Papers for the Tenth Council of Europe Colloquy on European Law, 23 September 1980, Scientific Research and the Law, mimeo. See also J Visser, 'Control Mechanisms and Bodies with Special Reference to Medical and Genetic Research' in Papers, and P Sieghart, 'Need for Control Systems and Interests Involved', ibid, and L F Bravo, 'International Aspects of the Control of Scientific Research', in ibid.

42. Simitis, 5.

43. United States Privacy Study Protection Commission, Personal Privacy in an Information Society, 1977, 567.

44. L Gordis and E Gold, 'Privacy, Confidentiality and the Use of Medical Records in Research', Science, 207 (4427): 153, 206 (11 January 1980).

45. ibid, 207.

46. T Connolly, 'The Morality of Cloning and Artificial Insemination', in Faith and Culture, Vol. 1, 1978 (The Catholic Institute of Sydney).

47. Miss S Shreiner S.M., Report to The Australian, 15 January 1981, 2.

48. Australian Council on the Ageing, Growing Older, Vol. 7, No. 17 (September 1980).

49. M D Kirby, 'New Dilemmas for Law and Medicine', Malcolm Gillies Oration 1980, mimeo, September 1980.

49. ibid. Mental Health Law Reform, 20th Barton Pope Lecture, 1980, mimeo, September 1980.

50. See Law Reform Commission of Canada, Consent to Medical Care, Study Paper, 1979; ibid, Medical Treatment and Criminal Law, Working Paper 26, 1980; Law Reform Commission of Saskatchewan, Proposals for a Consent of Minors to Health Care Act, Report, 1980. Institute of Law Research and Reform (Alberta), Consent of Minors to Health Care, Report No. 19, December 1975; Report from the Statute Law Revision Committee, Victoria, Age of Majority, 1977. See also P D Skegg, 'Consent to Medical Procedures on Minors', (1973) 76 Modern Law Review 370 and reports there cited.

51. Diamond v. Chakrabarty (1979-80), 48 USLW 4714 (1980).

52. I Kennedy, The Reith Lectures, 'Unmasking Medicine', published in The Listener, 6 November 1980, 600; 13 November 1980, 641; 20 November 1980, 677; 27 November 1980, 713; 4 December 1980, 745 and 11 December 1980, 775.

53. G Dunea, 'Hyperactive judges', in British Medical Journal, Vol. 281, 4 October 1980, 926.

54. ibid.

55. id, 927.

56. L P Rowland, 'Controversies about the treatment of myasthenia gravis', in Journal of Neurology, Neurosurgery and Psychiatry, 1980. 43, 644, 651.